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BRIEFING BOOK ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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I. BACKGROUND

A. GENERAL INFORMATION ABOUT ThE FEDERAL EMPLOYEES HEALTh BENEFITS PROGRAM (FEHBP)

· The program covers over nine million participants (2.5 million full-time and part-time permanent employees, 1.7 million retirees, 5.0 million dependents).

· There is an annual Open Season for enrollees to review informational materials and make a new election if they choose.

· There are no exclusions for pre-existing conditions or waiting periods when enrolling in any plan in the program..

B. **MULTIPLE CHOICE**

· There are seven fee-for-service (FFS) plans open to all federal employees and retirees; there are also eight employee organization plans that are limited to certain groups.

· The fee-for-service plan enrollees choose their own health care providers or take advantage of the plan's Preferred Provider Organization (PPO).

· Over 300 participating Health Maintenance Organizations (HMOs) provide prepaid health care through specific providers to employees and dependents living in their service areas.

C. EMPLOYER CONTRIBUTION

· Both the government, as an employer, and enrollees contribute a portion of the premium costs for health insurance coverage.

· With the exception of the Postal Service, which makes a greater employer contribution as a result of its collective bargaining agreements, the employer contributes up to 75 percent of a plan's premium (i.e., the employer contribution is capped at 75 percent). On average, the employer contribution is 72 percent of the premium costs for non-postal enrollees.

· In 1992, 53 percent of the plans were bound by the 75 percent cap. In 1987, 25 percent of the plans were bound by the 75 percent cap. This change was the result of large numbers of enrollees selecting plans, that would maximize the government contribution and minimize their own. In most of these cases, benefits were reduced.

· No adjustment is made for the different risk levels of each health plan's FEHBP population, nor are there any special provisions for low-income individuals.

D. PROGRAM COST INCREASES

· This year (FY 1993) the employer's costs for FEHBP are estimated at $11.8 billion. Total program costs, including enrollee contributions, are estimated at $15.7 billion.

· Overall program costs have risen at an average annual rate of 9.5 percent (6.5 percent above inflation) since 1983. The employer has absorbed the bulk of these FEHBP premium increases.

E. ENROLLMENT PATTERNS

· The Blue Cross and Blue Shield fee-for-serv~ice plan is by far the most popular choice, selected by almost 40 percent of FEHBP enrollees.

· The percentage of those choosing to participate in HMO plans has steadily increased, from six percent in 1970 to 28 percent in 1992 (based on 38 percent of active employees and 13 percent of retirees being enrolled in HMO's).

· Enrollees can select either Self or Self & Family coverage, and in some plans, they may choose between a Standard or High level of benefits. According to a 1989 participant survey, price was the primary factor in active employees plan selection; familiarity with the plan ranked first for retirees.

· Of approximately 2.9 million Federal employees, an estimated 15 percent or 435,000 are not enrolled under FEHBP. About 58 percent of all non- participants are covered by a spouse's insurance. There are approximately 175,000 to 185,000 employees are not covered elsewhere and therefore have no health insurance.

· Approximately 620,000 retirees from a population of 23 million are not participating in FEHBP; most are covered under Medicare.

F. **COMPREHENSIVE BENEFITS**

· Although FEHBP has no standard benefit package, certain coverage is required of the health plans.

· Mental health coverage is provided; the level of benefits is better than what is offered by many private sector employers, but is still not as generous as benefits for physical conditions.

G. **ThE ROLE OF ThE O~CE OF PERSONNEL MANAGEMENT (OPM)**

· OPM administers the FEHBP. It prescribes minimum standards for health benefits plans; sets the employer premium contributions each year according to a statutory formula; negotiates contracts with the carriers over benefits and

premiums; runs an Open Season; decides claim disputes between the carriers and enrollees; and audits records of participating plans.

· Agencies transmit both the employer and the employee share of premiums to OPM. Funds are disbursed to the carriers from the Employees Health Benefits Fund. Until now, OPM has not maintalned any centralized enrolimwt information other than number of enrollments by plan. A pilot project is currently underway to provide more centralized data.

II. ISSUES

A. EFFECT OF ThE NEW SYSTEM

Changes to the FEHBP should not take away the Federal government's ability to maintain control over the cost and quality of the health benefits purchased and to recruit and retrain qualified workers in competition with other employers.

B. COST-EFFECTIVENESS AND EFFICIENCY

The most cost-effective and efficient management structure for the FEHBP under national health reform needs to be determined. There are a number of issues that need to be taken into consideration:

· Should the Federal government (the largest employer in the country) be treated the same or differently than other large employers?

· How should the government as an employer contribute to the anticipated increased risk pool costs generated by covering the uninsured if other large employers are required to do so?

· Should the FEHBP be totally regionalized, including fee-for-service plans, or should only some administrative functions be regionalized while others remain centralized?

· Should the FEHBP continue to function as supplemental coverage to Medicare for people over 65? In addition, should the minority of people over 65 covered by FEHBP but not enrolled in Medicare be aljowed to continue to do so?

· Should other Federal programs be integrated with the FEHBP, and if so, which programs and how should they be integrated?

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· What is the most effective way to maintain health plan choice while minimizing or eliminating the negative effects of adverse selection?

C. CONCENTRATION OF FEHBP AND OThER FEDERAL HEALTh INSURANCE ENROLLEES

Analysis indicates a wide range of Federal population sizes, from high concentrations in certain areas to intermediate or nominal in others (see accompanying charts and tables in the Appendix). Such information is vital in deciding how to structure the administration of health plans on a regional basis.

D. BEHAVIOR OF FEHBP ENROLLEES IN SELECTING A HEALTh PLAN

Managed competition assumes that people will make rational choices about their health care coverage based on information about costs and benefits. However, FEHBP enrollees in large metropolitan areas frequently select health plans that are **NOT** the best value (see accompanying charts and tables in the Appendix).

· Other large employer populations (see the Service Employee International Union study of the California Public Employees' Retirement System (CalPERS), included in the Background Literature section) demonstrate similar patterns.

· This suggests that addition al concerns motivate FEHBP enrollees to select particular health plans, an important consideration when evaluating how to design the national health system.

m. **RECOMMENDATIONS AND RATIONALE**

After extensive deliberations, the group decided on two final'options.

A. OPTION 1: MAINTAIN AN INDEPENDENT FEHBP FOR FEDERAL ENROLLEES MODIFIED TO CONFORM WITh NATIONAL HEALTh REFORM

RECOMMENDATION:

Retain the FEHBP as an independent Federal health alliance that would conform with the Health Alliances established under the new system. That arrangement could be modified at a later date based on the experiences of the national program.

Under this option, the FEHBP would be treated as a large employer provided plan, but would conform to the health alliance model and, perhaps, integrate other Federal populations. FEHBP would act as a health alliance, and would adopt the standardized benefits and employer coxitribution formula, and continue to have the statutory authority to administer the program, and would have the latitude to determine plan participation.

This option would retain the independent existence of the FEHBP as a large employer administered health alliance with a conforming structure.

RATIONALE:

If all large employers are allowed to sponsor or purchase health insurance for their employees, then the Federal government, the largest employer, should likewise administer a health alliance for Federal enrollees. Since the FEHBP (or Federal health alliance) would adopt the same benefits package, employer contribution level, risk adjusters, and other structural features

of the health alliances, **this** approach ensures that the Federal commu~nity would be treated the same as others in the system.

In this model, the Federal government would be able to address its interests as the largest multi-state employer. It would continue to maintain a substantial amount of control over the cost and quality of health benefits foJ its employees. Further, OPM would continue to assume the same role that other large employers do in acting as intermediary between its employees and the health care plans, resolving service disputes, monitoring plan viability and quality and facilitating provision of benefits by employees and retirees.

Once the FEHBP is transformed into a Federal health alliance, it could, if deemed desirable allow all individuals connected to the Federal workplace to be covered by the Federal health alliance. By remaining a free-standing health alliance for the Federal population, the FEHBP would avoid burdening the newly-emerging state health alliances with the administrative responsibility of serving at least nine and possibly as many as 15 million people.

Transforming FEHBP into a health alliance could be accomplished quickly if the fee- for-service plans, adhering to the prescribed benefits package, were competitively selected. A global budget would need to be determined. With relatively few changes, the path to health care reform could be explored through the rapid transformation of the FEHBP to a Federal health alliance.

B. OPTION 2: MAKE CHANGES BASED ON REGIONAL VARIATIONS

RECOMMENDATION:

Adopt a "do whatever makes sense" approach that would be dictated by the specific populations and conditions in given arW. In some cases, an independent Federal health alliance would be created. In others, the FEHBP would disappear and enrollees would be absorbed Into the local health alliances. In still others, a combined Federal-local health alliance would be developed.

Under this option, FEHBP would conform to the health alliance structure and would proceed as the national program falls into place to adapt in various ways to local situations. It would begin regionalization and either initiate or respond to requests from health alliances to negotiate any of the. following outcomes as appropriate and feasible:

· Cease operation in "small Federal population regions" and **shift** enrollees to local Health Alliance;

· Operate as a Federal health alliance parallel to a local health alliance in "large Federal population regions", possibly including CHAMPUS enrollees and injured Federal workers covered under workers' compensation as well;

· Merge with local health alliances under arrangements convenient to all parties in "intermediate Federal population regions", for example, non-Federal populations might be covered under the Federal health alliance on some mutually agreeable basis.

Under this option, the FEHBP would embrace all of the elements of reform, and would seek to preserve the flexibility to react appropriately -- therefore differently -- to the many and varied circumstances that are sure to face both the FEHBP and the health alliances as reform progresses.

While this alternative includes key features of the other option, it also introduces an additional possibility. FEHBP as a distinct program would continue -- but only where it made sense to the Federal government as the employer and to the local Health Alliances that it do so.

RATIONALE:

Federal population statistics illustrate why the flexibility to adopt different approaches in different geographic areas makes sense.

· In the Washington, D.C. metropolitan area, the FEHBP insures one-third of the area's population (852,000 FEHBP enrollees and their dependents plus a very substantial number of CHAMPUS eligibles). It makes sense to keep the program together where so many enr~llees are involved and so many dollars are at stake.

· Where it would best serve the reform effort and Federal enrollees for it to do so, the FEHBP could simply disappear. For example, in one small New England state the FEHBP insures only a small portion of the area's population and the Federal Government is not a major employer (14,000 FEHBP enrollees and their dependents and a relatively small number of CHAMPUS eligibles compared with 241,000 employed by others).

· Similarly, one of the Western states has both a small FEHBP enrollment but also a relatively small overall population (18,000 FEHBP enrollees and their dependents and another two-thirds CHAMPUS eligibles compared with 165,000 employed by others). Where there are so few FEHBP enrollees that FEHBP has no leverage, and where adding FEHBP enrollees to a sparse health alliance population would significantly advantage the health alUance, it would make sense to simply disband the Program and insure Federal enrollees through the local health alliance.

· The FEHBP structure and contracts could be use d **to** bring coverage to other groups. The flrst and most obvious inclusion would be: other Government

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employees now insured through other means; injured workers through OWCP; and military families and retirees through CHAMPUS.

The FEHBP could also help a particular health alliance get a head start on insuring employees of small companies by allowing them to enroll in FEHBP until the state Health Alliance is implemented. Such arrangements would have the additional, significant advantage of giving health alliance employees direct, practical experience with administering a new system program. However, this would be the most difficult to do from an administrative, budgetary, and risk pool perspective and would require careful structuring of the details.

IV. INTEREST GROUP POSITIONS

A. FEDERAL EMPLOYEES AND RIlTIREES

The best case scenario as generally perceived by both these groups would be to have reform proceed with as little disruption to the current programs as possible. However, there could also be apprehension in some circles about the degree of power left to the Federal Government as a large employer if it were allowed to remain independent of the national health care system. The overriding concern under any circumstances would be the effects of reform on enrollee health benefits, primarily as part of their overall compensation or retirement package. You can expect strong opposition to any proposal which would:

- increase the premium cost paid by enrollees;

- reduce the benefits offered by the health plans; and

- significantly alter current relationships between enrollees and health care providers.

B. NON-POSTAL UNIONS AND NARFE

These groups will take a position generally in keeping with the one outlined for Federal employees and retirees. We- met with representatives of the A~~CIO, NThU, and NARFE. There would be a positive reaction to extending coverage to the currently uninsured portion of the Federal population.

C. POSTAL UNIONS

Postal unions, such as the National Association of Letter Carriers (NAL~ and the American Postal Workers Union (APWU), that sponsor their own health plans will

have a vested interest in maintaining an independent FEHBP in which they can continue to participate.

D. OThER CARRIERS CURRENTLY PARTICIPATING IN FEHBP

Health insurance carriers can be expected to support any proposal that minimally disrupts their current practices. Large amounts of money are at stake. Overall, the program paid fee-for service carriers $862.3 million in administrative expenses and $67.3 million in service charges (profits) in 1991. Current participants would certainly prefer not to have to compete to participate in the program and would like to maintain as much control as possible over the benefits packages they offer. However, to the extent that these factors are mandated universally so that all employers and not just those participating in the health alliances play by the same rules, opposition would be mitigated.

We met with representatives of Mid Atlantic Medical Services, Inc. which offers an individual practice plan type HMO under the FEHBP. That particular carrier was generally pleased with the idea of a standard benefits package and indicated the capability to expand capacity to accommodate significant numbers of additional enrollees. Its primary concerns were m regard to financing (i.e., they prefer a general tax rather than a health care industry specific tax), and the degree to which specific state requirements rather than more standard federal requirements will be applied for participation as a health plan under the health alliances.

Presumably most carriers would prefer to continue to deal with OPM as opposed to an untested health alliance, unless of course insurance interests are substantially protected through membership on health alliance boards.

E. CONGRESS

The perception of FEHBP within Congress, as dearl? demonst~rated by the positions adopted by Congressional staff from the House Post Office and Civil Service Committee and Federal Services Subcommittee of the Senate Governmental Affairs Committee who

participated in the working group, is that in general the program provides adequate health care protection to its enrollees and is competently

administered, and that its structural problems can be corrected without major programmatic overhaul. Thus, Congress may oppose any plan to significantly decentralize programmatic control away from the Federal Government, unless it is demonstrated that the resulting cost savings would be substantial.

Members with large numbers of federal employees as constituents would be particularly vocal in opposing any changes perceived by enrollees such as "take- aways" (i.e., reduced benefits and/or increased premium share). Ouestions concerning the fairness of such actions, as well as the impact on employee morale, would be debated at length, although this undoubtedly would be tempered by the degree to which these changes mirror what is required of employees/retirees outside the Federal government.

F. **STATES**

Assuming states are given the primary authority to oversee health alliances, one can expect them to want access to risk pools of maximum size and diversity. Therefore, states would support dissolution of the FEHBP and other federal insurance programs so that their substantial populations would be absorbed into the health alliances. Exceptions might be those areas of high federal employee population concentration, where the benefits of risk pool normalization might be exceeded **by** the overwhelming pressures placed on health alliance administrative capacities. Of course, to the degree that non-participating employers are required to pay a surcharge to compensate for risk pool advantages, this would become a less significant or insignificant issue.

V. **QUESTIONS & ANSWERS**

1. Will changes to the FEHBP affect the ability of Federal employees and retirees to choose coverage from among various health plans?

One of the primary goals of national health care reform is to promote competition among health plans. Federal employees and retirees will still be able to select a health plan from among several different choices, including fee-for-service plans, even if the FEHBP is substantially revised or ceases to exist as an independent program.

2. **Will changes to the FEHBP have an impact on the benefits offered by participating health plans?**

Under national health care reform, all health plans will be required to offer a standard benefits package. This benefit package wil! not differ significantly from the typical package currently offered by most FEHBP plans. It is possible that employee organizations will be able to offer their members supplemental benefits.

3. **Will changes to the FEHBP affect the amount that Federal employees and retirees pay in health insurance premiums?**

The national health care system will feature a standardized employer contribution to total health insurance premiums. The effect this would have on the premium paid by FEHBP enrollees would depend on the formula used to determine the employer contribution and the premium charged by each health plan.

4. **Will those in the Federal population currently without health Insurance be covered under national health care reform, and If so, how?**

Universal coverage is a fundamental goal of reform. The Federal government will be required to provide coverage to all employees like all other employers.