THE FEHBP AS A MODEL FOR MEDICARE REFORM:

SEPARATING FACT FROM FICTION

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In my dual careers and capacities as a consumer advocate and advisor on how to choose the best health insurance plan,[1] and policy analyst advising on government policy options and reforms, I have long argued that the FEHBP is a highly promising model for Medicare reform. This testimony addresses the myths and realities of that comparison. It is based on, and expands, testimony I provided to the Special Committee on Aging of the United States Senate on May 6, 2003.[2] I address specifically some of the design issues facing this Committee as it prepares a bill for submission to the Senate.

A careful student of both the FEHBP and Medicare programs opined several years ago that "the FEHBP has outperformed Medicare every which way--in containment of costs both to consumers and the government, in benefit and product innovation and modernization, and in consumer satisfaction."[3] I agree. In this testimony I provide data that will support these conclusions and also dispel misconceptions about the FEHBP.

Careful analysis of these issues is particularly important because in recent years there has been a steady growth in misrepresentation of the FEHBP's performance, directly or by implication, from defenders of the statist Medicare model. For example, a recent analysis is described in its abstract as an answer to those who "seek to remake the federal health insurance program for the elderly … on the model of the … Federal Employees Health Benefits Program. This paper … rebuts those arguments by showing that Medicare beneficiaries are more satisfied with, have better access to, and have greater confidence about their access to health care, and they report having fewer financial problems as a result of medical bills" than those enrolled in private employer plans.[4] The body of the analysis, and the survey data themselves (discussed below) do not support the claims in the Abstract. Another analysis says that "FEHBP has done …slightly worse than Medicare, on average, [in controlling costs] since 1996.[5] The selection of 1996 as a base year leads to a conclusion contradicting the author's own analysis in a prior report showing that the FEHBP outperformed Medicare very substantially from 1992 to 1997.[6] This same author persistently states that there are only 6 plans available to all Federal employees and retirees when there are in fact 12 plans available to all, and 15 to 20 available to most?[7]

Benefits. Medicare serves as a lifeline to the elderly of America. Its coverage of hospital and doctor costs is vital to the economic well being and survival of millions. Yet, Medicare is infamous for its obsolete, vintage 1960 design. It does not provide a catastrophic ceiling on costs even for those costs it covers. It does not cover prescription drugs (except in rare instances). It does not cover many preventive services. It does not cover dental services. By failing to cover health care costs incurred abroad (except in Canada and Mexico), it forces the elderly either to forgo retirement travel outside of North America or to obtain other coverage. Indeed, so deficient is Medicare coverage that over ninety percent of its enrollees purchase supplementary insurance, or have it purchased for them.[8]

None of these deficiencies affect the FEHBP. That program was also created vintage 1960, but it has painlessly evolved over time through the competitive, consumer-driven process that is its central feature. The Medicare plan can be rated for its benefit coverage in 2003, compared to average FEHBP plans. For a retired person without dual coverage I obtain the following results (these data include dental costs and exclude premiums) using the methodology of *CHECKBOOK's Guide to Health Plans for Federal employees*:

Category	Medicare	FEHBP
Average Out of Pocket Cost	$2,640	$1,260

Likely Cost at Expense Level of $84,000	$12,580	$6,080
Ceiling on Combined Hospital, Doctor, and Drug costs	None	$5,000 plus or minus $1,000

These cost comparisons demonstrate that **FEHBP retirement benefit coverage is far superior to Medicare's**.

There is another significant dimension of benefit superiority. In both programs the great majority of common hospital and physician procedures are covered routinely. However, at the margin Medicare coverage choices are dictated either by statutory law or by administrative law dictated through the Medicare coverage processes. Although there is some variation by area because of carrier discretion, this tends to be minimal. Further, all Medicare HMOs are required to offer benefit coverage identical to that in traditional Medicare. In the FEHBP, in contrast, coverage choices are made by individual plans. This means that consumers can seek out plans that have better coverage for particular services of importance to them. Acupuncture, cardiac rehabilitation, expensive dental procedures, and other services are usually available, at a price, in some available plan. Medically proven procedures, such as pancreas-only transplants, and the latest advances in pacemakers, are covered in all or almost all FEHBP plans, but are often covered by Medicare only after years of delay, if ever. And FEHBP plans are free to, and often do, cover services that they would not ordinarily cover at all if these are approved as part of a case management package tailored to a particular enrollee's needs.

FEHBP benefits have improved markedly over time. During the ten year period ending in 1992, out-of-pocket costs in the FEHBP for a market basket of hospital, medical, drug, and dental costs decreased from about 32 percent of total per enrollee costs to about 20 percent of total costs.[9] This improvement resulted from benefit improvements in both fee-for-service and HMO plans, and from a significant shift in enrollment from the former (higher cost) to the latter (lower cost). Both sources of improvement have largely halted in the last decade, primarily because of rising prescription drug costs and increases in copayments aimed at restraining these. Furthermore, copayments play a significant role in restraining FEHBP costs, and plans have very little room left for copayment reduction without facing untenable cost and premium increases. Finally, as plans approach complete coverage, the margin for further improvements necessarily decreases. However, no such improvement has ever occurred in Medicare, whose benefits have, on a market basket basis, deteriorated over this entire period.

Provider Choice and Access. Medicare is, in a sense, one of the relatively few remaining fee-for-service (FFS) medical plans in America. Most private plans either limit provider choices substantially or, as is quite common, provide differential cost sharing depending on whether or not the provider is "preferred". Of course, Medicare is not really fee-for-service since it regulates prices and, indeed, makes it illegal for providers to negotiate higher prices with enrollees and still obtain any reimbursement.[10] The FEHBP national plans almost all allow enrollees to go "out of plan" and pay only one fourth of a reasonable charge above that level. These plans' reimbursements are more favorable for "preferred" physicians, but some payment is available whether the physician has any arrangement of any kind with the insurance company. At worst, the patient pays the bill and then gets reimbursed directly from the insurance company. **Every Federal retiree can join a dozen health plans that reimburse him for most of his costs for virtually any physician who accepts private patients at all. More physicians are available through the FEHBP than through Medicare.**

The Medicare Payment Advisory Commission conducts surveys of physicians and in its most recent report found that physicians are significantly less willing to accept Medicare patients than private plan patients.[11] Specifically, in 2002 over 99 percent of physicians accepted private FFS and PPO patients, but only 96 percent accepted Medicare patients. This is a seemingly small difference but if it is your doctor, or the best specialist in town, who will not accept you, it can have a major effect on your health care. And until recently enacted payment increases, it appeared that the proportion of physicians unwilling to accept Medicare patients was about to rise substantially.

In this context, the FEHBP has a significant advantage over Medicare because of its multiplicity of plans. **Every Federal employee or retiree, no matter where he or she lives, anywhere in America or anywhere in the world, has no fewer than twelve plan options from which to choose in 2003.** (This includes both "high" and "standard" options offered by the same carrier, since these options always differ significantly in both benefits and premium.)

Federal retirees in areas covered by participating HMOs have additional plans from which to choose. Thus, while a retiree in North Dakota or Wyoming may "only" have twelve plan choices, a retiree living in or near medium and large size cities in almost all states will typically have several more plan options. In the larger metropolitan areas, where the great majority of both Medicare and FEHBP retirees reside, there are often about 20 plan choices available to Federal retirees.

Rural Access. Of particular concern to rural Americans is the absence of plan choices in the areas in which they live. One recent analysis by the Rural Policy Research Institute (RUPRI) shows that under Medicare+Choice, only 7 percent of rural counties offer Medicare beneficiaries any choice of plan beyond traditional Medicare.[12] In contrast, using an overly conservative methodology that significantly understates choice in the FEHBP (by using enrollment levels rather than actual plan availability), the RUPRI study finds that 87 percent of rural counties enroll Federal employees and retirees in 6 or more plans, and 98 percent in 3 or more plans.

Another study attempts to minimize the FEHBP's strong rural access by claiming that "unless participants in more isolated areas are willing to travel long distances or pay extra amounts for care, they may find that only one or two plans offer meaningful access to services."[13] This analysis focuses on Lebanon, Kansas, and states that only 2 plans (actually, 4 plans because the analyst erroneously ignores dual plan options) offer preferred primary care providers within 25 miles. This is true. But three of the dismissed FEHBP plans (including NALC and the two Mail Handlers plans) use the FirstHealth network and offer 694 preferred physicians and clinics within 50 miles, a seemingly large total for a town that is not within one hundred miles of a metropolitan area. Further, why should these and other plans be dismissed cavalierly when they in fact will pay 70 or 75 percent of the charge for ANY physician in or near Lebanon simply because this requires participants to "pay extra amounts for care" compared to the less costly preferred provider rate? Why is 75 percent reimbursement of reasonable physician charges characterized as less than "meaningful access" to services?

Regardless of how one characterizes access in Lebanon, Kansas, a proper comparison would cover far more rural areas. After all, preferred provider networks vary from place to place and any one network is not equally comprehensive everywhere. Furthermore, the fundamental access problem for rural Americans encompasses not just primary care, but also specialist care and hospitals. One of the interesting areas in the RUPRI analysis is Kenedy County in southwest Texas. This county has fewer than 500 residents. RUPRI scores it as one of the 2 percent most underserved areas in the FEHBP because Federal employees and annuitants among these residents have signed up for no more than two plans.[14] Residents of Sarita, the primary town in this county, have no physicians or hospitals that

are preferred providers within 20 miles under the FirstHealth network. But Kenedy County is only one county removed from Corpus Christi. Using a 50 mile radius search that reaches that metropolitan area, Sarita residents have 13 hospitals and 694 physicians and clinics available under the supposedly inferior FirstHealth network.[15]

FirstHealth may not be quite as comprehensive as Blue Cross or some of the other FEHBP networks. But it does contract as preferred providers with over 4,000 hospitals and almost 400,000 ambulatory providers. With this kind of reach, it obviously provides substantial preferred provider access to virtually all rural residents of the United States. The same can be said for all of the provider networks used by the national FEHBP plans.

Benefit Innovation. The importance of plan choices, of course, goes far beyond serving patient needs for provider choice and benefit options. The fundamental model of the FEHBP, like most services in our economy, relies on competition in attracting consumers as the driving force for both quality improvements and restraint of costs. For example, plans are free to add, drop, increase, or decrease deductibles. These are not trivial decisions. Deductibles have substantial effects on consumer acceptance, on premiums, and on health care utilization. Plans that strike the right balance do best over time. The fact that wide variations in deductibles persist over time suggests that there is more than one "right" model.

In fact, most plan benefits are quite stable. Deductibles are not frequently changed. But some benefits do change rapidly in most plans. Notable for experimentation and change are plan payments for prescription drugs. Ten or fifteen years ago, most plans either charged a nominal copayment or a modest coinsurance percentage for all drugs. Enrollees were free to go to the drug store of their choice. Mail order and formularies were almost nonexistent. In the last decade, with ever increasing spending on drugs--reflecting mainly new drugs with major new therapeutic benefits--plans have vigorously changed their approaches. Today, most plans have a six-tier benefit structure for drugs. There is one set of copayments for mail order, and another somewhat higher set for using preferred pharmacies. Generic drugs cost the enrollee the lowest copayment, preferred name brand drugs on the formulary somewhat more, and other name brand drugs the most. One can only imagine the political turmoil and potential for unnecessarily costly or constraining decisions were price controls and formularies to be proposed as features of a Medicare drug benefit. (Perhaps one had better say: just look at the last several years of political paralysis!) And it is inconceivable that such a benefit, once enacted into law under the standard Medicare approach, would receive the kind of nimble evolutionary adjustments used in the FEHBP as plans jockey for the best mix of generosity and cost control to attract customers.

Current FEHBP drug benefit structures place both the burden and the opportunity for decision making on the enrollee. They encourage frugality, but allow for medical necessity. They have evolved virtually without political controversy or legislative or bureaucratic fiat. And these approaches to benefit design have been proven to keep down drug spending and save both the payer and the enrollees a great deal in premium costs.[16] Based on RAND research, I estimate that the annual savings to the FEHBP from current tiered payment systems is somewhere around $500 million annually, about 2 or 3 percent of program-wide premium costs, shared by the government and enrollees.[17] Additional savings from the use of Pharmacy Benefit Managers may equal or exceed those from tiered copayments.[1] **Adoption and continuing reform of prescription drug and other benefits in the FEHBP has been politically and programmatically painless, while saving billions of dollars over time**.

Open Season is the annual opportunity for Federal employees and annuitants to "vote with their feet" by switching plans. Although only about 5 percent elect to change plans each year, this provides relentless and continuing pressure on all plans to adapt and improve services while controlling costs. In contrast, most private employers frequently attempt to lower costs by changing their single plan from one insurance company to another. This imposes major disruptions on their employees, who are forced to change physicians when involuntarily transferred from Plan A to Plan B. Paradoxically, the seemingly radical FEHBP system of continuous competition is in far more stable. This stability benefits enrollees not only directly and immediately, but over time, since plans retain incentives to invest in preventive care today to avoid higher expense years down the road.

Consumer Satisfaction. Consumer satisfaction is very difficult to measure fairly, and there may be no studies that directly compare Medicare to the FEHBP using elderly persons as the sample universe. However, we have some important information. OPM has innovated in the use of quality information in the FEHBP program, and led the way to adoption of participant surveys. By providing this information to enrollees, OPM has significantly aided them in plan selection. These surveys focus mainly on specific dimensions of plan performance, such as getting needed care, how well doctors communicate, and claims processing, but also measure overall satisfaction. The most recent survey information shows that on a scale of 1 to 10, about 79 percent of FFS and PPO enrollees and 63 percent of HMO enrollees rate their plans 8 or higher.[18]

We also have information from the annual Open Season, in which enrollees decide whether to stay in their plan or "vote with their feet" by moving to another plan. Each year, fewer than 10 percent of employees and fewer than 5 percent of retirees elect to switch plans. **The overall level of enrollee satisfaction with the FEHBP is clearly very high**.

A recent Commonwealth Fund Survey of Health Insurance did compare Medicare and private insurance.[19] It found that 85 percent of Medicare elderly rated their plan as good, very good, or excellent. In contrast, "only" 81 percent of those privately insured and of working age rated their plans as highly. However, these results really prove nothing. It is well known that plan satisfaction increases with age of respondent. Younger enrollees are far more critical. This largely explains the differential between FFS and PPO ratings in the FEHBP, since the HMOs disproportionately attract younger enrollees. HMOs enroll 40 percent of Federal employees but only 10 percent of retirees. In the Commonwealth survey, an 81 percent favorable rating by those aged 19 to 64, compared to 85 percent favorable among those aged 65 or more, arguably shows that **private health plans would actually be rated by consumers far higher than Medicare if available equally to each age group**. Finally, the reported results failed to distinguish between the elderly enrolled in Medicare alone, without any supplementary benefits, and the roughly nine out of ten who have supplemental plans including, among others, retirees simultaneously enrolled in the Medicare and the FEHBP (an extraordinarily rich benefit combination). Thus, the results say nothing at all about satisfaction with traditional Medicare standing alone. Indeed, the survey shows that the Medicare disabled, a younger group much less likely to have a supplemental benefit, give Medicare only a 66 percent favorable rating. Thus, among the respondents who are below age 65, Medicare scores far worse than private plans.

Another recent survey, sponsored by the American Association of Health Plans offers additional evidence on seniors' views of health plans.[20] This survey, whose respondents were exclusively elderly, found that 72 percent of seniors enrolled in traditional Medicare believed that a choice of plans was important (among M+C enrollees, this percentage rose to 88 percent). On a variety of measures of plan satisfaction, enrollees in traditional Medicare and M+C showed essentially identical

satisfaction levels. For example, 82 percent of the former and 79 percent of the latter were very or somewhat satisfied with the benefits they received. One would expect this result since the overwhelming majority of the former group has supplemental benefits and presumably responded on the basis of their total benefit package. Just as for the Commonwealth survey, one can reasonably assume that those enrolled in traditional Medicare alone and without either supplemental benefits or an M+C option would have registered far lower satisfaction levels.

Guaranteed Benefits. The FEHBP and Medicare programs differ fundamentally in several ways, one of which is the difference between a "premium support" as opposed to "defined benefit" structure. An AARP study argues that the Medicare approach is better because the benefits are "entitlements" that are "protected" because defined in law.[21] This line of argument is fundamentally flawed in three ways.

First, statutorily defined benefits can be taken away whether or not defined as legal entitlements. The Medicare deductible used to be defined by law at $50 but is now $100. The Congress once enacted prescription drug benefits and then repealed them. Indeed, the Congress amends the Medicare statute every year. As the program steadily progresses toward insolvency, maintenance of current benefit levels hardly seems assured. Relatedly, the FEHBP is just as much an "entitlement" as Medicare. It is simply handled a different way. **The FEHBP premium level is "protected" by being defined in law and the "entitlement" formula that defines the premium level provides a substantially better level of insurance benefits than Medicare**. The entitlement says, in essence, that the government pays 75 percent of the average cost of plans that enrollees voluntarily choose. Indeed, unlike Medicare the FEHBP statute has never been amended to reduce enrollee benefits.

Second, FEHBP benefits have been superior to those of Medicare for decades. The "defined benefit" turns out to be no more than a guarantee for a second rate product, and the allegedly weaker "premium support" guarantee has proven a superior guarantor of benefits by actual experience.

Third, both premiums and benefits can be guaranteed in statute without using the "enumerate every benefit in excruciating micro-managed detail" approach used by Medicare. Enrollees can be guaranteed by law an actuarially reasonable value of benefits, both overall and in broad categories such as hospital or drugs. Within such a constraint(s), plans can make the decisions as to which deductibles (if any) to use, where to set deductible levels, where to set copayment and coinsurance levels, whether or not to tier benefits, which treatments to accept as medically proven, where to set the catastrophic guarantee level, etc. In fact, this is essentially the way that OPM operates the FEHBP. The FEHBP statute could be amended to make the actuarial fairness and soundness tests explicit guarantees better than those of Medicare, without changing the program in any way. **The "premium support" model used by the FEHBP has proven to be both better and safer as an entitlement than the "defined benefit" Medicare model**.

Consumer Understanding. It has often been alleged that consumers, particularly elderly consumers, cannot handle the complications of a competitive plan system. After all, it is claimed (and true) that many consumers do not understand traditional Medicare itself.[22] While by definition choice certainly is more complicated than no choice, there is no evidence that consumer choice poses any more of a problem for health insurance than for any other product or service. The elderly choose their own doctors, their own automobiles, their own foods, and their own living arrangements. Any or all of these are as or more complicated than health insurance. Bizarrely, discussions of this topic often contain no, or minimal, references to the rich informational resources available to one and half million Federal retirees.[23]

Furthermore, criticisms of plan choice implicitly assume that traditional Medicare poses little or no information burden. In fact, traditional Medicare creates difficult informational problems and choices.[24] For example, most persons, upon turning age 65, have a choice among various Medigap plans, yet receive little or no information from Medicare or any other source as to the value of such plans individually or compared to one another. Low income beneficiaries may be eligible for Medicare supplementation and premium payments, yet are rarely informed of these benefits and if they attempt to explore them are faced with the daunting welfare bureaucracies that administer Medicaid. Hundreds of thousands of older workers are not even eligible for Medicare but do not know it (these are, typically, state employees hired before 1986).[25] Errors in Medicare decision making expose the elderly to financially disastrous mistakes. So serious are these problems that one analyst calls for new informational campaigns and for reforming State application processes. Without waiting to reform Medicare, we should "act now to fix the programs that we already have in place".[26] In contrast, the FEHBP program poses few "gotchas" and is essentially free of complex decision issues. The worst potential financial error arises from the requirement that enrollees participate continuously in the program for five years before retirement to retain benefits after retirement. The most complex decision is the choice at age 65 as to whether or not to enroll in Medicare Part B to supplement the FEHBP benefit. (It turns out that Medicare Part B is a bad financial buy for Federal retirees turning age 65, but one virtually forced on them by unnecessary financial penalties and the uncertainty of future political decisions.[27] In the FEHBP, unlike traditional Medicare, errors in plan enrollment decisions and changing circumstances can be remedied or accommodated each year in the annual Open Season.

To be sure, Federal employees and retirees are on average better educated than Medicare beneficiaries. Working Americans, on average, are better educated than the elderly and far less likely to suffer mental impairments. But no system of choices in our society, whether choices of friends, spouses, foods, automobiles, or anything else depends on every single consumer being smart and well informed. As the inevitable errors occur, we accept that as the price of individual autonomy in decision making.

Most fundamentally, criticisms of choice based on decision complexity create a ridiculous standard. How many consumers of any age or educational level understand the innate workings of automobiles--the physics of and technology used in engine, transmission, braking, and other systems? Yet, somehow, through magazine ratings, recommendations of friends, test drives, modest government oversight and regulation, past experience, and above all the pressures of a competitive market place, the elderly are overwhelmingly able to select and use cars that are effective, durable, safe, comfortable, and economical. Should we ban competition in the automobile industry because some consumers are ignorant or uninformed or even incapable of understanding certain complexities and a few make bad choices? And why stop at automobiles? The entire economy rests on consumers making choices among tens of thousands of competing goods and services, choices that are analytically complex beyond even the abilities of *Consumer Reports* to simplify in its relative handful of comparative analyses. Somehow, despite all these complexities, it is seemingly only health insurance that is held forth by critics as the one service that will overwhelm cognitive abilities, and choice among plans as the one decision that consumers cannot be trusted to make.

Competitive choice among health plans is certainly facilitated by careful oversight and information dissemination. OPM has proven to be effective in these matters, and the private market has provided additional information that consumers and those family and friends who advise them can use effectively. See the latest *CHECKBOOK's Guide to Health Plans* (www.retireehealthplans.org), and the OPM Web site (www.opm.gov/insure/health) for thorough and user friendly displays of information. These formal and organized information sources, of course, are not those that most

consumers primarily rely on. Instead, they use their own experience, and the experience of friends and neighbors, and above all the market driven menu of good options they face, to make annual decisions among plans. Since most FEHBP plans are excellent choices, overwhelmingly satisfying enrollee preferences for benefits, provider choices, responsiveness, and cost, 95 percent or so make the simplest possible choice each year: remaining in the same plan. To be sure, the elderly do not have coworkers to advise them on plan selection, in contrast to Federal employees.[28] But seniors have information networks of their own, including an extensive system of counselors located in Area Aging Agencies.

Confusion in choosing among competing products has simply not been a problem for the millions of Federal annuitants who, over the years, have benefited from their plan selection decisions. **Should Medicare be reformed into a pro-consumer choice system, assuring adequate information will not be difficult if the OPM approach is emulated, and the private sector encouraged to supplement government information**.

Adverse Selection. Some argue that any form of multiple plan choice will necessarily lead to destructive risk selection and unpredictable exit and entrance of plans--the dreaded "death spiral." Certainly the FEHBP has no system of any kind for managing risk selection.[29] In contrast, Medicare ceaselessly searches for improved methods of fine-tuning its risk management features. Reform of the AAPCC (Adjusted Average Per Capita Cost) system was delayed for a decade or more because no one could devise a perfect system. The long delayed reform failed again to correct the fundamental problem that well managed health care does not in fact cost half again more in Miami than in Des Moines, or in Prince Georges County than in Fairfax County among the Washington suburbs.

There is even a respectable argument that some risk selection is desirable. For example, if people with dental problems tend to join plans with better dental benefits, willingly paying the full marginal cost of their decision, what ethical or managerial principle is violated?

The FEHBP has survived for four decades with no management of risk selection other than the stability inherently produced by its insurance subsidy. A recent study by eminent economists concluded that the program has almost no measurable adverse risk selection.[30] An amateur study, more critical, nonetheless concluded that "FEHBP's stability may amount to stable biased selection".[31] Whatever circumstances may lead to the "death spiral", they do not obtain in a plan choice program designed along the lines of the FEHBP. Amusingly, program critics like to cite the single example of the departure of the Aetna FFS plan from the program in 1990. The fact is that Aetna was dropping all of its FFS products at that time, and found its increasingly marginal FEHBP position a handy excuse to drop out of the program.

The Medicare+Choice Experience. Some claim that because Medicare+Choice has had a rocky start, and failed to reduce overall Medicare costs, consumer choice has been tried and has failed. However, under the reimbursement formula used in that program, relying on the fundamentally flawed AAPCC estimates of geographic variability in health costs, and tied to the yo-yo of annual changes in Medicare spending levels, Medicare+Choice never had a chance to perform properly.[32] Indeed, an important and mostly ignored research study has demonstrated that geographic variations in managed health care costs are minimal, rarely exceeding a 10 percent variation above or below the national average anywhere in the country.[33] A well designed defined contribution program using rolling averages or all-plan averages and minimal geographic adjustments (if any) would have functioned far better. In addition, a set of draconian and unreasonable mandates made participation expensive and burdensome for any FFS or PPO plan, and for most HMOs. One regulatory mandate, for language

interpreter services paid by each plan, is arguably illegal in at least three different ways.[34] Incredibly, despite these problems Medicare+Choice still manages to attract about 150 plans and almost 5 million enrollees, about 1 in 8 Medicare clients.

Regulatory mandates, unreliable funding levels, constant change, unrealistic government expectations, and other rocky issues have led to perhaps the most fundamental problem of M+C. Health plans do not regard Medicare (both CMS and the Congress) as a good business partner. Even the promise of substantial additional business has proven a weak incentive in the face of the underlying distrust, distrust based on a well known track record.

A program that made it financially infeasible for HMOs in most of the Midwest to participate, and that has even forced Kaiser plans to withdraw, is a fundamentally flawed program. Furthermore, the OPM/plan relationship is one of steady cooperation and predictable behavior. **The FEHBP shows far better ways than Medicare+Choice to implement effective plan choice.**

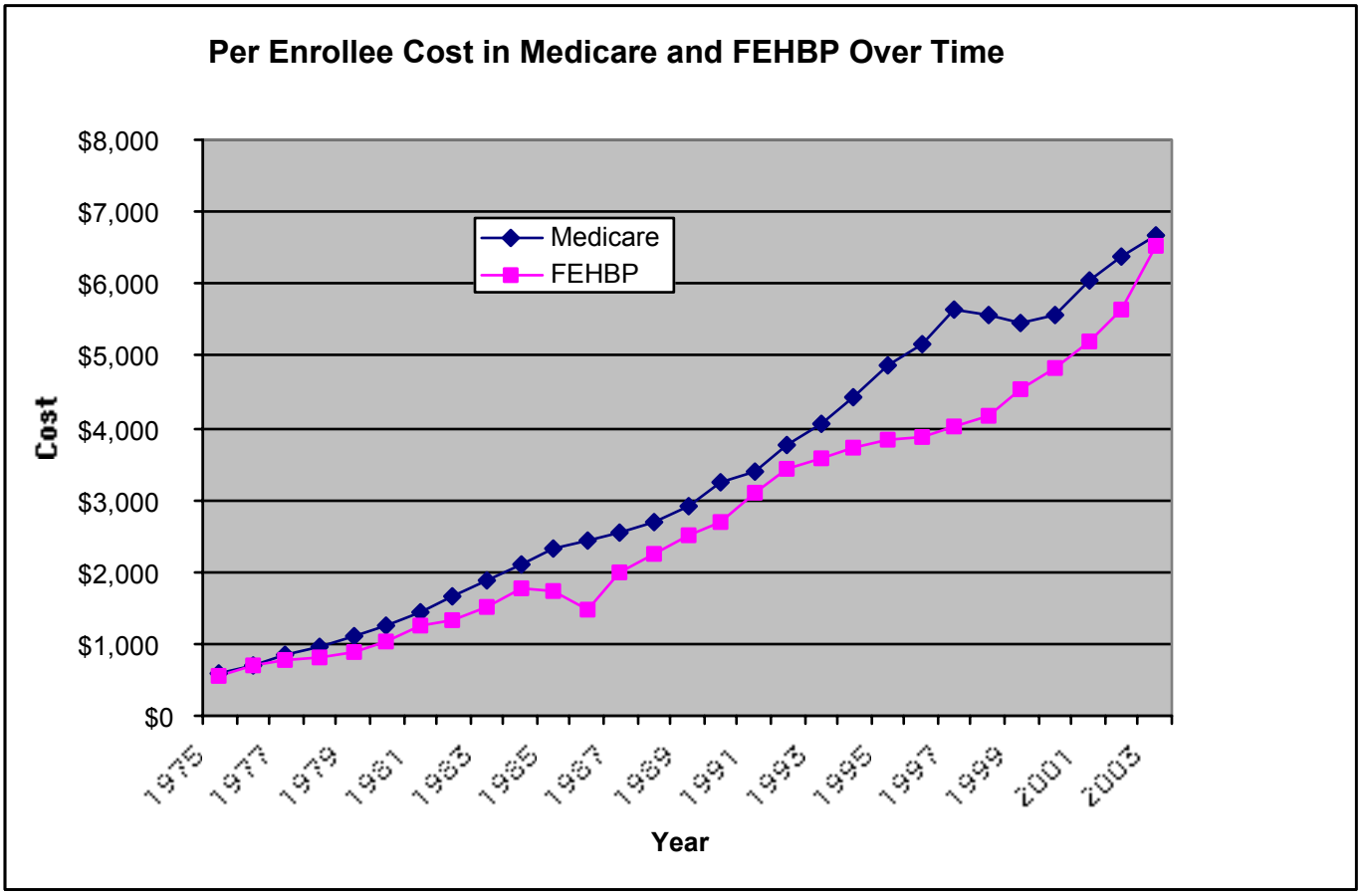
Cost Control. The last comprehensive examination of cost control found, surprisingly, that the FEHBP had actually controlled costs slightly better than Medicare.[35] My updated analysis now shows that the two programs roughly tie when costs are looked at without regard to benefit changes. However, when benefit improvements are taken into account, **the FEHBP maintains its superiority in cost control.**

Each program has good years and bad years, and these do not correspond in any simple way. By careful selection of base year, it is easy to "prove" that one program outperforms the other. And depending on whether the comparison covers one, three, five, or ten years, the answer is very different. To get around these problems, one good method is to use multiple rolling averages covering 10 years. This shows long term performance without the noise that affects shorter comparisons. One needs multiple ten year comparisons because the latest one can be (and usually is) unduly influenced by a particular good or bad base year in one program or the other. The table below shows the latest results, all taken from publicly available budgetary data covering 28 years (the raw data are appended at the end of this testimony).

Ending in Fiscal Year	Medicare 10 Year Record	FEHBP 10 Year Record	Difference	Cumulative Difference
1985	15%	12%	-2%	-2%
1986	13%	8%	-5%	-7%
1987	12%	10%	-2%	-9%
1988	11%	11%	0%	-8%
1989	10%	11%	1%	-7%
1990	10%	11%	1%	-6%
1991	9%	10%	1%	-5%
1992	8%	11%	2%	-3%
1993	8%	10%	2%	-2%
1994	8%	8%	0%	-1%
1995	8%	9%	1%	0%
1996	8%	10%	3%	3%
1997	8%	7%	-1%	2%
1998	8%	6%	-1%	1%

1999	7%	6%	0%	0%
2000	6%	6%	0%	1%
2001	6%	5%	-1%	0%
2002	5%	5%	0%	0%
2003 est	5%	6%	1%	1%

What these data show is that in recent years both programs have had a 10 year average cost increase of around 5 or 6 percent a year, and that even over the full set of comparisons the programs have only differed by more than a percentage point a few times. Measured this way, the cumulative difference over comparisons covering 28 years of data is a one percent advantage for Medicare.



Another way to view relative performance over time is to chart the average cost per enrollee, using the same data quoted above. As shown below, the FEHBP and Medicare both started and ended at almost exactly the same levels over the 28 year period. However, during this period the FEHBP was consistently below the Medicare level, often by substantial amounts, and hence cumulatively saved substantial amounts compared to what it would have spent had its trajectory matched Medicare's. This comparison does **not** include adjustments for improvements in FEHBP benefits over time.

The data end in FY 2003 because the budgetary projections for 2004 are unreliable for both programs. However, Medicare's chief actuary has recently announced that there is an unexpected increase of 12% in Medicare Part B costs for 2004. Using later estimates for both programs, the FEHBP would likely have outperformed Medicare in the cumulative comparison. **In summary, the FEHBP and Medicare programs have virtually identical records over time on keeping cost**

increases down, despite substantial and costly benefit improvements in the FEHBP. Put another way, **were benefit improvements used to adjust cost figures, the FEHBP unambiguously outperforms Medicare in cost control.** In recent years, however, Medicare has had an advantage and the future performance of these programs is almost impossible to predict. One substantial problem facing the FEHBP is that with recent increases in government cost sharing, enrollees pay only about 17 percent of premium costs, and incentives to attenuate cost and premium differences are greatly attenuated from those of past years.[36]

It should not really be surprising that the records are broadly similar, since both programs operate in the context of the American health care system, with the same underlying structure of hospitals, doctors, costs, technological changes, and a myriad of other commonalities.

However, viewed another way, there is a surprise. The Medicare Administrator operates a system of price controls. As the Congress has so amply demonstrated in its recent flip flop attempts to set physician, hospital, and Medicare+Choice reimbursements at the "right" levels, determined in large part by the decibel level of the political outcry, price controls can be set arbitrarily within a fairly broad range. Thus, Medicare could outperform the FEHBP in reducing premium costs through cutbacks in provider prices and income, through benefit reductions, and through other government-mandated reductions. Health care resources, both human and bricks and mortar, are not in the short run perfectly mobile. Thus, the Medicare budget is set ultimately by what the political system tolerates, not by the market or any objective method.

There is also the pertinent question of how Medicare compares to the private sector's cost control experience generally. One recent study claims that "Medicare can be counted on to control per enrollee spending growth over time, more than private insurers can".[37] This study relies on a comparison of Medicare and private insurance payment data derived from National Health Accounts data provided by the agency that administers Medicare. The data purport to show that since the mid-1980s Medicare has consistently outperformed the private sector in controlling spending on comparable services (e.g., excluding prescription drugs because these are not covered by Medicare). Another analysis uses the National Health Account data together with data from the National Medical Care Expenditure Survey (MEPS) and other sources to demonstrate that when cost increases are adjusted for benefit improvements, the private sector at large has outperformed Medicare over the last 30 years.[38] In other words, **whether looking at private spending in general, or the FEHBP in particular, benefit-adjusted private sector costs have increased less than Medicare costs over most or all of the life of the Medicare program**. In the case of the FEHBP, its cost growth is so superior that it ties or slightly out performs Medicare even without adjusting for benefit improvement over time.

This cost control performance has come despite (or because of) higher administrative costs for the FEHBP, despite paying physicians and other providers more than Medicare,[39] and despite the near absence of direct managerial controls. One reason, of course, is that Medicare lurches from one crisis to another as both consumers and providers find ways to game the system. In the FEHBP, plans ceaselessly find ways to speedily control unnecessary spending, relying on a wide range of techniques. OPM can urge plans to adopt useful innovations by simple letter requests, unencumbered by the *Federal Register* process used by CMS, which on average requires years from inception to final publication of binding rules. For example, it took years of regulatory indecision, and ultimately an Act of Congress, to stop Medicare payment for unnecessarily expense seat lift chairs, once routinely prescribed by doctors for patients who saw beautiful and expense lounge chairs advertised on television as covered by Medicare. In the FEHBP, OPM was not involved, and plans simply

refused to pay for anything other than the most austere models of seat lifts, relying on "reasonableness" clauses in their policies.

Approaches to Medicare Reform. I have attempted to address each of the major areas in which fundamentally different approaches to health insurance programs can be compared. On each dimension of performance, the FEHBP is arguably at least equal, and usually superior, to Medicare as currently constructed. This doesn't lead to any simple conclusion as how best to reform Medicare. The issues are many and complicated. And it certainly does not mean that the FEHBP program is perfect--it has many important problems. Several of these, to which I hope this Committee can attend, are embodied in the Medicare statute. There is a senseless and costly restriction in Medicare law prohibiting FEHBP plans (and no other employer plans) from paying Part B premiums. That restriction costs both Medicare and the FEHBP a good deal of money because it forces plans to offer unusually high benefit wraparounds rather than offer lower premiums, which leads to unconstrained utilization incentives. A second problem is the needless 10 percent a year penalty imposed on late enrollment in Medicare Part B. This penalty is imposed even if the enrollee is covered by comprehensive insurance and the possibility of adverse selection is remote. Lifting this restriction for those covered by comprehensive plans would induce more elderly to remain in employer sponsored retirement plans, thereby directly reducing Medicare costs.[40]

My testimony is not intended to suggest a blueprint for actual Medicare reform. Obviously, the FEHBP model cannot and should not be adopted in every detail or even every major feature. Many carefully analyzed decisions would have to be reached to make an FEHBP-like system a viable Medicare model. However, certain pitfalls and solutions are obvious.

1. Above all, the FEHBP is a good business partner. The rules of the game are few, robust, and rarely changed. In sharp contrast, the next wrenching Medicare reversal is rarely farther away than the next Congressional session. To succeed, Medicare reform must provide for reasonable assurance of stable and growing payment rates, stability of plan participation (no risk of being evicted from the program if a plan's premiums go up just slightly "too much" next year), freedom from both costly mandates and nuisance regulations, and other significant changes from current practice.

2. The FEHBP provides a reasonable and predictable level of financing to health plans. Again in sharp contrast, Medicare+Choice has been greatly hampered by its reliance on the annual level of spending in traditional Medicare, and the reliance on the absurd assumption that widely varying levels of per capita health care spending from county to county are even an imperfect proxy to the costs of delivering managed health care. Unfortunately, reliance on competitive bidding in any form is likely to introduce unpredictable results, with plan participation varying unpredictably depending on the annual bidding decisions of other plans. Surely a better approach can be devised, such as a government payment level based on a rolling average of prior costs in traditional Medicare, and allowing plans to charge whatever premium they must in order to cover their costs while attracting enrollees. Ideally, such a payment would be level, or nearly so, throughout the country.

3. The FEHBP lets plans decide benefit and coverage details, and Medicare should as well. Many otherwise astute students of reform have suggested that competing plans should have identical benefits, specified in detail by the government.[41] However seemingly attractive this idea may be in terms of simplifying decisions for enrollees, it would be a fatal mistake. It would transform what would otherwise be private decisions on a myriad of benefit details into government decisions on the details of the uniform benefit structure, just as under traditional Medicare. Because those government decisions would be made through bureaucratic processes and often on political grounds, rather than through evolving consumer choices and plan responses, the essential mechanisms of

timely benefit innovations and cost control would be destroyed. Requiring all plans to adhere to government-specified benefit details would be roughly comparable to requiring all automobile manufacturers to follow uniform "one size fits all" government specifications as to size, seats, horsepower, cup holders, paint colors, and all the other myriad features that today distinguish one model of car from another. There are obvious alternatives to detailed benefit specification, such as providing benefits that, in total, meet an actuarial test.[42] This test should be applied to core benefits, not just extra benefits. No plan should have to meet the precise parameters of Medicare Parts A and B for hospital and outpatient services, when these are so often unnecessarily costly, limiting, or arbitrary.

Benefit standardization would also be unnecessary for consumers. As discussed previously, there is no persuasive evidence that product standardization is any more necessary for understanding health plans than for any other service or product in the economy.

4. Service areas and preferred provider depth within them should be flexible. Some have suggested that plans be required to have identical service areas specified by the government.[43] The rationales are that if every plan has an identical service area specified by the government, it will not be able to cherry pick the healthiest, that rural areas will be better served, and that employee choice will be simplified. These are purely hypothetical advantages, and the latter fails even the laugh test. Modern Internet technology allows every single enrollee to receive or create plan comparisons based on his or her zip code, without regard to what other areas the plans cover. The CHECKBOOK and OPM web sites for Federal employee plan choices organize and present plan comparisons by geographic area. Furthermore, in the real world plans serve, and enrollees live in, reasonably well defined areas. Anyone can understand that plan A covers all of New Jersey, plan B all of New York and New Jersey, and plan C the metro New York area in those states and in Connecticut. The cherry picking argument deals with a nonexistent problem that has never emerged in the history of the FEHBP.

Uniform boundaries could create an administrative disaster, and would certainly preclude the participation of many and perhaps most HMO plans and other small plans specializing in particular areas. In effect, the government would be telling Kaiser and every other HMO that it has to cover a named multi-state area (perhaps defined in terms of the existing 10 Federal regions), even if Kaiser cannot and will not build or find a network of that size or covering those precise areas. These problems might be less if uniform areas were applied only to PPOs rather than HMOs. However, even here problems could abound if plans were not allowed to provide service outside these areas, or were forced to expand networks in unnatural ways. Thus, the government would presumably require West coast plans to cover Alaska and Hawaii, require plans based in Hawaii to cover the West coast, and ditto for Puerto Rico and the mid-atlantic region. A Pittsburgh plan in the mid-atlantic region might be forbidden from covering Ohio residents, just down the Ohio river, because they would be located in the mid-western region. Even the Blue Cross system, with its ever-evolving boundaries, might have to restructure its service areas throughout the nation to meet the Medicare boundaries.

These are not hypothetical issues. The government sponsored system for organ allocation, the Organ Procurement and Transplantation Network, is plagued with problems created by its system of geographic regions. As an example, patients on waiting lists in the Omaha metropolitan area who live on the Iowa side of the Missouri River are forced to travel to distant Iowa cities to obtain organs, simply because Nebraska and Iowa fall in different regions in the OPTN system. The Medicare Prospective Payment system has extensive problems in determining boundaries among reimbursement areas. No system of service or payment limiting geographic boundaries can avoid anomalies like these. Moving the boundary from one place to another simply moves the locus of error and controversy. Allowing for exceptions (e.g., Puerto Rico plans can appeal to Medicare not to have

to cover the mainland) simply creates another burdensome bureaucratic process and would ultimately lead to a tangled mess.

Nor are geographic restrictions needed to promote rural access. Nothing in either logic or FEHBP experience suggests that every single plan need provide the same depth of provider networks in every geographic subunit. The robust FEHBP performance in Lebanon, Kansas, and Sarita, Texas, shows that there is no compelling reason why every plan in any area has to offer equally broad provider networks to assure good rural access. In most remote areas several plans will offer good provider panels, even if all do not. And why wouldn't plans, anticipating some out of plan use, generally provide for FFS benefits along with preferred provider benefits, as in the FEHBP? Most importantly, requiring every plan to offer equal access will restrict the number of plans willing to offer services in a given area, and reduce the ability of plans to manage their networks efficiently. In other words, **a requirement for "one size fits all" minimum standards for geographic coverage and access could deprive, not foster, enrollee choice of plans and providers, while driving costs borne by enrollees higher than necessary.**

These arguments are not meant to suggest that geography play no role in reform, but that any provisions need to be carefully crafted to assure that they do not create more problems than they solve.

5. Surely participating plans should be exempt from state mandates, as are the national plans in the FEHBP. The FEHBP also limits state regulation of HMO benefits to those of the home state, not every state in which the HMO operates. Thus, the Kaiser plan of the mid-Atlantic enrolls Federal members from six jurisdictions, but must meet only Maryland, not Delaware, DC, Virginia, Pennsylvania, or West Virginia mandates.

6. Obviously, Medicare reform must meet short and long run budgetary objectives. Painful compromises on generosity of benefits are necessary. But if cost constraints force an unduly parsimonious approach to design of the reform package, along with "hole in the doughnut" prescription drug benefits, the entire purpose of reform may be jeopardized. Highly constrained and geographically bounded competitive bidding systems may have the unintended result of zero cost, simply because no sensible health plan will want to participate. In this regard, there is a player in the Medicare reform game who is rarely discussed: the large employers of America. These firms and governmental units will reap windfall reductions in post-retirement health insurance costs with the introduction of prescription drug coverage into traditional Medicare. There are ways to make that windfall smaller. For example, the tax deductibility of health insurance contributions to these firms could be conditioned on at least partial maintenance of effort for retirees, with the firms essentially being obliged to bear part of the cost of premium supplements for both old and new Medicare plans. Further, there are the aged themselves. In a program whose long term insolvency looms ever closer, increasing the proportion of costs borne by the elderly from its current small fraction seems obviously desirable, however much the elderly might prefer a free ride on taxes paid by working Americans. Moreover, the higher the nominal premium borne by the elderly, the higher the level of subsidy that large employers will find themselves forced to bear in subsidizing that premium. Low income elderly without retirement benefits from former employers can and should be protected through premium subsidies, either by improving current arrangements under Medicaid or through direct discounts based on prior year tax returns.

In this regard, I note that the original FEHBP model had employees and retirees bear 40 percent of premium costs, and that over time this inadvertently (due to a drafting error in the statute) decreased to about 28 percent. Recently added tax preferences have reduced the effective employee share to

about 20 percent, but retirees still pay on average about 28 percent. In sharp contrast, the elderly pay rather less than 10 percent of the premium-equivalent cost of Medicare. Working age taxpayers at all income levels, and to a lesser extent elderly and affluent taxpayers, pay the rest. The generosity of the FEHBP lies in its dynamic revision of the reimbursable cost basis for premiums, using an all plan average of current and projected costs, rather than in the percentage of premium that it pays.

7. As a final suggestion, why not allow the national FEHBP plans themselves to compete for Medicare business under a reform system? These plans could readily segregate finances and enrollment information for the two enrollee groups. Of course, they would not compete if they had to comply with cumbersome rules that would affect their benefits and coverages, their provider networks, their administrative costs, their ability to participate over an extended period of time without eviction from the program, or their autonomy under the FEHBP. Whether or not you adopt this somewhat whimsical idea; if the system that this Committee ultimately chooses would not readily accommodate participation by these plans, then I suspect it will fail.

Conclusion. A fundamental issue should be prominent in deciding among reform options and alternatives. The Medicare program is overwhelmingly statist. Medicare uses political fiat, price controls, and centralized bureaucratic processes to try and regulate an infinitely complicated trillion dollar health care market. Every decision that Medicare makes is necessarily a compromise that is wrong, often deeply wrong, for large numbers of enrollees and providers. Medicare is like a government designed automobile (actually, we have had two of these: the jeep and the Humvee). Designed by committee, changed too late, final details set by legislative or bureaucratic fiat, based on the principal that "one size fits all" and the corollary ethical proposition that every one should get an identical benefit because anything else is "unfair", Medicare lurches along like a grounded Dumbo the elephant. Like the jeep and the Humvee, it fits very few as well as the plan (or auto) they would choose for themselves, if offered a choice.

In contrast, the FEHBP uses the mildest forms of government direction and oversight to allow the forces of choice and competition to determine health plan costs, benefits, provider choice, administrative convenience, and a host of details. As a final example, every single FEHBP plan covers health care anywhere in the world (HMOs offer care anywhere outside the plan area for emergencies). Why is this? Because very few consumers would voluntarily enroll in a plan that didn't offer this feature, even if they had no travel plans. If this feature cost a great deal, some plans would decline to offer it to their members, seeking to attract the "stay at home" group. The fact that hundreds of health plans do not act this way demonstrates that the extra costs of this feature are small. Why then does Medicare not offer this benefit? And why do most of government prescribed and designed Medigap plans not offer this benefit?

Obviously coverage abroad is a far less important issue than prescription drug coverage and many others (though not less important to former immigrants who wish to live in retirement in their lands of origin, without giving up their health insurance or being forced to buy an exorbitantly expensive Medigap supplement). But a program run on the bureaucratic regulatory model necessarily fails to deal optimally with many problems both large and small. Indeed, we all know that the chief impediment to a Medicare drug benefit is that the Medicare program is a price control program run along draconian lines not seen elsewhere in most of the American economy since World War II. Price controls are anathema not only to the pharmaceutical industry, but also to all of us who expect that cures for Alzheimer's disease (and many others) are likely only from a profit-driven industry free to charge "high prices" without government price controls.

The choice before the Congress ultimately is between these two models--consumer choice or detailed legislative and bureaucratic control of benefits and prices. The Food Stamp program has long demonstrated that it is possible to have a government entitlement that leaves purchasing decisions almost entirely with consumers rather than legislators or bureaucrats. By good fortune we have as a health insurance example the successful performance of the consumer choice model in meeting the needs of 9 million Federal employees, retirees, and family members. Surely we can use that model to aid in reforming the Medicare program.

Appendix: FEHBP AND MEDICARE COST CONTROL OVER TIME

FY	Medicare Part A	Medicare Part B	Total Cost per enrollee	Annual M'care Increase	Ten Year M'care Ave.	FEHBP Obliga-tions	End of Year FEHBP Enrollees	Total Cost per Enrollee	Annual FEHBP Increase	Ten Year FEHBP Ave.
1975	$434	$161	$595			$1,753	3147	$557		
1976	*$512*	*$203*	$715	20%		$2,239	3226	$694	25%	
1977	$589	$245	$834	17%		$2,600	3297	$789	14%	
1978	*$680*	*$288*	$968	16%		$2,808	3393	$828	5%	
1979	*$772*	*$331*	$1,103	14%		$3,150	3491	$902	9%	
1980	$863	$374	$1,237	12%		$3,674	3598	$1,021	13%	
1981	*$1,008*	*$446*	$1,454	18%		$4,653	3684	$1,263	24%	
1982	*$1,153*	*$518*	$1,671	15%		$4,980	3729	$1,335	6%	
1983	*$1,297*	*$590*	$1,887	13%		$5,525	3641	$1,517	14%	
1984	*$1,442*	*$662*	$2,104	11%		$6,583	3689	$1,784	18%	
1985	$1,587	$734	$2,321	10%	15%	$6,482	3768	$1,720	-4%	12%
1986	$1,591	$831	$2,422	4%	13%	$5,723	3847	$1,488	-14%	8%
1987	$1,592	$969	$2,561	6%	12%	$7,714	3909	$1,973	33%	10%
1988	$1,630	$1,070	$2,700	5%	11%	$9,016	4010	$2,248	14%	11%
1989	$1,765	$1,158	$2,923	8%	10%	$10,169	4050	$2,511	12%	11%
1990	$1,970	$1,282	$3,252	11%	10%	$10,922	4041	$2,703	8%	11%
1991	$2,009	$1,381	$3,390	4%	9%	$12,657	4077	$3,104	15%	10%
1992	$2,315	$1,445	$3,760	11%	8%	$14,024	4074	$3,442	11%	11%
1993	$2,546	$1,524	$4,070	8%	8%	$14,546	4077	$3,568	4%	10%
1994	$2,783	$1,658	$4,441	9%	8%	$15,218	4096	$3,715	4%	8%
1995	$3,063	$1,788	$4,851	9%	8%	$15,515	4053	$3,828	3%	9%
1996	*$3,289*	*$1,867*	$5,156	6%	8%	$16,148	4159	$3,883	1%	10%
1997	*$3,569*	*$2,054*	$5,623	9%	8%	$16,557	4133	$4,006	3%	7%
1998	$3,493	$2,066	$5,559	-1%	8%	$17,161	4120	$4,165	4%	6%
1999	$3,328	$2,146	$5,474	-2%	7%	$18,654	4123	$4,524	9%	6%
2000	$3,190	$2,370	$5,560	2%	6%	$19,662	4084	$4,814	6%	6%
2001	$3,408	$2,652	$6,060	9%	6%	$21,143	4075	$5,188	8%	5%
2002	$3,588	$2,777	$6,365	5%	5%	$22,820	4046	$5,640	9%	5%
2003	$3,667	$3,024	$6,691	5%	5%	$26,461	4057	$6,522	16%	6%

Notes: FEHBP amounts do not equal annual premium changes because of reserve payments and Open Season shifts. FEHBP data from U.S. Budget Appendix since FY 1982; earlier years from OPM annual Insurance Report. Medicare data before FY 1999 from Green Book; from 1999 forward from HHS Budget in Brief. Some years are interpolated; these are shown in italics.

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