Medicare Analysis

The FEHBP As A Model For A New Medicare Program

by Stuart M. Butler and Robert E. Moffit

Abstract: The deficiencies of the Medicare program are rooted in its defined-benefit structure and in its use of price controls. Medicare should be transformed into a defined cash contribution made to beneficiaries' private plans or to the traditional Medicare program. The Federal Employees Health Benefits Program (FEHBP) is essentially such a system and is a good model for Medicare reform. The FEHBP has been highly successful at holding down costs while offering a wide range of benefits and types of plans. Its features for consumer information and plan standards also would be useful in a reformed Medicare program.

The 1995 Medicare trustees' report has helped to focus attention on the need for structural reform of the Medicare program. For reform to be successful, however, it must address two central features of the program that are basic to the program's flaws. The first is that Medicare is a defined-benefit program; like other defined benefits in the public or the private sector, this invites cost escalation. The second is that Medicare relies on price controls and central planning. Medicare exhibits all of the typical problems associated with price controls, including “gaming” by providers, and the centralized nature of decision making in Medicare means that cost-saving innovations in the delivery of services are incorporated into the program at a glacial pace.

To address these flaws and their root causes, Medicare must be re-designed to incorporate two very different features: (1) Medicare should be transformed into a defined-contribution program. This essentially means transforming Medicare into a program that gives a specific amount of financial assistance to the elderly to offset the cost of obtaining health care. A defined contribution would limit the government's financial exposure (but not, of course, the enrollee's, without other reforms). (2) Medicare should certify a range of competing private plans that the Medicare-eligible population could purchase. The government would specify the general

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criteria for private plans but would no longer set payment levels for particular services, procedures, or treatments. In conjunction with the defined contribution, the incentive would be for plans to compete for Medicare enrollees’ dollars by developing innovative methods of providing care in the most cost-effective manner. Beneficiaries would have an incentive to seek the best value for their money among these plans.

To be sure, a host of concerns would have to be addressed by such a consumer-choice model. Would it be subject to destabilizing adverse selection? How would the interests of less sophisticated buyers be protected? How would the defined contribution be calculated and adjusted for differing circumstances? Fortunately, a working model exists, which provides valuable guidance for this task.

The FEHBP As A Model For Medicare Reform

Created by Congress in 1959, the Federal Employees Health Benefits Program (FEHBP) offers more than 400 competing private plans to active and retired members of Congress and congressional staff, as well as active and retired federal and postal workers and their families—altogether almost nine million people.\(^1\) The FEHBP works well despite some aspects of its design. Modifying some of its features in the context of a redesigned Medicare program would greatly improve the program for the nation’s elderly and disabled citizens.

The FEHBP population is not an ideal insurance pool. For one thing, the FEHBP population of active employees is older on average (43.8 years) than employees in the private sector (37.4 years).\(^2\) For another, enrollment is optional, and eligibility requirements are quite liberal. Also, plans in the FEHBP cannot impose waiting periods or limitations or exclusions from coverage for preexisting medical conditions.

Further, the proportion of higher-cost federal retirees enrolled in the FEHBP has grown steadily. In 1975, 858,000 retirees accounted for 27 percent of the FEHBP’s policyholders. By 1992 some 1.6 million retirees accounted for 40 percent of FEHBP policyholders.\(^3\) According to Office of Personnel Management (OPM) actuaries, the average age of the covered lives in the program (which includes dependents) also has been increasing.\(^4\) The program’s strict community rating requirement prohibits plans from pricing their coverage differently for this higher-risk group.

How the FEHBP works. Federal workers and retirees can choose from a variety of health plans, ranging from traditional fee-for-service plans, to insurance plans sponsored by employee organizations or unions, to managed care plans. Approximately 40 percent of all federal worker subscribers, and 18 percent of all federal retirees, are now enrolled in health mainte-
All HMOs in the FEHBP have benefits that are especially attractive to the elderly, including catastrophic and mental health coverage. Almost all of the plans cover care in an “extended care facility,” some with no dollar or day limits. No federal retiree has a range of choice of fewer than seven plans.²

The National Association of Retired Federal Employees (NARFE), a private organization representing approximately half a million federal retirees, has declared, “All FEHBP plans are good. All cover hospital and physician care, prescriptions, outpatient diagnostic lab tests, treatment of mental illness, home health care, routine mammograms for women over 35, routine prostate cancer tests for men over 40, and stop smoking programs.”³

Unlike Medicare, most FEHBP plans cover prescription drugs and a wide range of dental services. Furthermore, the elderly can choose very specialized items, such as diabetic supplies.

How the elderly choose plans. Each year, in preparation for the annual fall “open season,” when retirees and regular employees choose plans for the following year, the OPM sends beneficiaries an FEHBP Guide, which includes a health plan comparison chart. Health plans also provide retirees with information on benefits and premiums in a variety of ways, including advertising. Perhaps the most valued consumer resource for federal employees and retirees is Checkbook’s Guide to Health Insurance Plans for Federal Employees.⁷ This popular guide compares plans, gives employees and retirees general advice on how to pick a plan, outlines plan features and special benefits, presents detailed cost tables (including out-of-pocket limits for catastrophic coverage), and presents results of “customer satisfaction surveys” on plans’ performance. The guide also provides specialized advice for federal retirees, with or without Medicare, including information on HMO options and Medicare.

The guide’s customer satisfaction surveys are quite detailed; they rate plans’ performance in such areas as access to care, quality of care, availability of doctors, willingness to provide customer information and advice by phone, ease of getting appointments for treatments or check-ups, typical waiting times in doctors’ offices, access to specialty care, and follow-up care. The surveys also review patients’ experiences with such things as explanation of care, the degree to which the patient is involved in decisions relating to care, the degree to which the plan’s doctors take a “personal interest” in the patient’s case, advice on prevention, the amount of time available with doctors, the available choice of primary care physicians and specialists, and the speed with which the patient can contact the plan’s service representative.⁸

Beyond this valuable information, federal retirees receive additional guidance from NARFE. With a network of more than 1,700 chapters
throughout the country, NARFE works closely with the OPM in answering questions and resolving problems related to health insurance and retirement matters. In preparation for open season, NARFE publishes its annual *Federal Health Benefits Information and Open Season Guide*. Most importantly, NARFE actually rates plans on benefit packages that would be most attractive to the elderly.

**The role of the OPM.** The OPM is given authority in the FEHBP statute to contract with health insurance carriers; prescribe “reasonable minimal standards” for plans; prescribe regulations governing participation by federal employees and retirees and their dependents, as well as approve or disapprove plan participation in the FEHBP; set government contribution rates in accordance with federal law; make plan information available to enrollees; and administer the FEHBP trust fund, the special fund containing contributions from the government and enrollees and from which all payments to health plans are made.

Unlike the Health Care Financing Administration (HCFA), the OPM does not impose price controls or fee schedules, issue detailed guidelines to doctors or hospitals, or standardize benefits. Private plans within the FEHBP must meet “reasonable minimal standards” regarding benefits. But the law creating the FEHBP does not specify a comprehensive set of standardized benefits. Congress has merely defined the “types” of benefits that “may be” provided.

The OPM sends out a “call letter” every spring to insurance carriers, inviting them to discuss rates and benefits for the following calendar year. In these confidential discussions, the OPM outlines its expectations for rates and benefits to the carriers, and the carriers respond by offering proposals. This is an unusual, and largely successful, mixture of discussion and “jawboning.” Congress rarely intrudes into this process.

In setting the government contribution to retirees’ health benefits, the OPM must make its calculations according to a formula established by law, on the basis of the average premium of the governmentwide service benefit plan, the indemnity benefit plan, the two largest employee organization plans, and the two largest comprehensive medical plans. This is commonly called the “Big Six” formula. The OPM calculates the average premium of these six largest plans and multiplies that average by 60 percent. This determines the maximum annual government contribution, which is applied to each plan and option. For 1995 this maximum contribution is $1,600 for individuals and $3,490 for families. The formula has one other crucial adjustment: In no case can the federal government contribute more than 75 percent of the cost of the premium of any plan.

The OPM prepares kits outlining rates and benefits for the coming calendar year and distributes the information to all eligible persons. Benefi-
Medicare beneficiaries then pick a plan during open season. The OPM maintains an Open Season Task Force to help beneficiaries in making decisions and a hot line that retirees (or regular workers) can call during open season.

Whatever plan is chosen, the government’s premium is sent directly to the plan. The enrollee’s premium contribution normally is deducted from his or her paycheck (for workers) or annuity (for retirees) and also is sent by the OPM directly to the chosen plan. The OPM also helps retirees and employees to settle disputed claims.

Although the FEHBP has been successful, two persistent and interrelated problems have been associated with its design: adverse selection and an outdated system of insurance underwriting.

Adverse selection has been an irritant in the FEHBP for many years and is exacerbated by the program’s strict community rating requirement. Still, it has not undermined the program. Indeed, after exhaustive analysis of the strengths and weaknesses of the FEHBP, the Congressional Research Service (CRS) concluded that the program is structurally sound. According to the CRS, “That FEHBP has continued to ‘work’ over the years, despite major changes in the environment in which it has operated, reflects the soundness of its basic design.”

A Reformed Medicare Program

Transforming Medicare into a program similar to the FEHBP would mean fundamentally changing the role of the federal government and, more specifically, the Department of Health and Human Services (HHS) and HCFA. It would mean that instead of setting prices, paying for specific services, and regulating virtually every facet of the system, HHS would—like the OPM in the FEHBP system—have only two broad functions: calculating and dispensing a payment to Medicare beneficiaries, to be used for the purchase of health care; and overseeing a market of health plans approved for sale to the Medicare population. A new Medicare system conforming to this framework should be designed in the following way.

Element one: Entitlement to a defined contribution. As today, retired or disabled Americans would be entitled to Medicare. But the entitlement would be to a voucher worth a specific dollar amount (based on several factors discussed below) for the purchase of health insurance, and not to a reimbursement schedule for particular services. Annual adjustments to the voucher would be in line with a national budget for Medicare, possibly in turn related in some way to the general prices of health plans or medical services. This reform would change Medicare into a defined-contribution program, permitting the government to limit outflows from the trust funds and the general Treasury to ensure the long-term solvency of the program.
This necessarily means that Medicare beneficiaries would be exposed to future differences between the budgeted voucher and their total cost of coverage. But as we discuss later, there are good reasons to suppose that the degree of financial exposure would be acceptable. Further, this financial exposure is crucial to creating an incentive to moderate costs.

**Element two: Calculating the voucher amount.** The distinction between Parts A and B of Medicare would disappear under this reform, and the budgeted net Medicare expenditure for the initial year of the new program would be divided by the number of eligible persons to determine a base rate for the voucher. In future years the combined cost of the vouchers would be adjusted in line with the Medicare budget to determine the voucher’s base rate for the year. This base rate would then be adjusted according to three factors: (1) Primary risk factors: The base rate would be adjusted according to an enrollee’s age, sex, reason for eligibility (age or disability), institutional status, and end-stage renal disease status. (2) Local market variance: The base rate also would be adjusted to reflect a weighted average enrollee cost of a “basket” of plans offering certain categories of benefits (we return to this point later). (3) Income adjustment: To incorporate the objective of income-adjusting the general revenue subsidy to the current Part B program, the portion of the base rate roughly equivalent to the government’s net Part B contribution would be adjusted in this way. The portion equivalent to Part A would not. To do this, we propose that one-third of the voucher amount be subject to an income adjustment.

This adjusted base rate, the new “Medicare benefit,” would be payable directly by HCFA to the Medicare-approved plan of each enrollee’s choice.

**Element three: Standards for participation by a plan.** Any private health plan would be eligible to receive a person’s Medicare benefits as partial payment for providing health care, provided that the plan met certain threshold requirements. The requirements would apply to plans marketed by affinity organizations, such as churches, unions, or senior citizens’ groups, not just to plans marketed by insurers or provider organizations. There would be no restrictions on the number or types of plans available in an area, and plans could operate in different service areas and provide different benefits. A plan could gain approval to market to Medicare beneficiaries if the following conditions are met: (1) The plan has a license to issue health insurance in the state, or gains approval directly from HHS. (2) The plan provides services in a service area acceptable to HHS. (3) The plan meets solvency requirements. (4) The plan includes a core package of basic coverage determined by legislation. The basic package would have to cover “medically necessary” acute medical services, including physician services; inpatient, outpatient, and emergency hospital services; and inpatient prescription drugs, with a catastrophic stop-loss amount
for these services. A plan thus could offer a much leaner package than today's Medicare program (although it would have to provide catastrophic protection, unlike Medicare), but it could offer a range of services beyond the base coverage. For example, some plans might offer dental benefits or prescription drug coverage. States would be preempted from mandating additional benefits for plans serving the Medicare population. (5) The plan files with HHS a standardized statement of benefits, a table of rates for the same actuarial categories used to determine Medicare benefits (age, institutional status, and so on), and consumer information as determined by an advisory board. Plans would not be able to deny coverage or change rates because of health status. The price, benefit, and consumer information also would have to be available to any Medicare beneficiary upon request. (6) The plan accepts and continues coverage for any Medicare beneficiary applying during the annual open season.

**Element four: Government’s role.** In the reformed Medicare system, HHS would have monitoring and payment clearinghouse functions similar to those of the OPM within the FEHBP. HHS would be responsible for making disbursements to the plans selected by Medicare beneficiaries, but it would be prevented by law from regulating the premiums of plans or the prices of services. In addition, the government would maintain a “traditional” Medicare plan for those who wished to use their defined contribution toward the cost of, such a plan. Government would engage in three specific activities: (1) Congress would establish a federally sponsored not-for-profit corporation to sponsor a Medicare Standard Plan. The corporation would be governed by its own government-appointed board and would offer the standard Part A and Part B benefits as ultimately determined by Congress. It would not be required to provide catastrophic protection unless the board added that benefit or Congress required it. The board would set the services, premium, deductibles, and copayments for the Standard Plan, which would be necessary to maintain the long-term solvency of the plan. The Standard Plan otherwise would be subject to the same solvency, disclosure, and other information requirements as all other plans. The Medicare Standard Plan would be available in all markets, at least if there remained sufficient demand.

(2) HCFA would calculate the voucher amount for each Medicare beneficiary, using the primary risk factors and income information and an adjustment to reflect the total Medicare budget for the year and the estimated average cost to enrollees of a weighted local market basket of plans (based on plan information supplied for the open season). This basket would comprise “typical” plans, such as the Medicare Standard Plan, a catastrophic/medical savings account (MSA) plan, a Blue Cross standard plan, and a comprehensive HMO plan. This is a refinement of the “Big Six”
formula used by the OPM to set the government’s contribution to the FEHBP. The calculation of the Medicare voucher would be made after the plans had filed their price and benefit information for the open season, so that the voucher would reflect the actual market prices encountered by the beneficiary.

3) Like the OPM in the FEHBP system, HHS would conduct the annual Medicare open season. During open season beneficiaries would choose their plan for the following year. This would be the only time during the year when beneficiaries could change plans. Before open season each Medicare beneficiary would receive an information kit from HHS, including the amount of his or her voucher and the standardized information on prices, benefits, and consumer satisfaction for Medicare-approved plans in the area, including the Standard Plan. Beneficiaries also would receive a selection form on which to indicate their choice of plans.

Once a plan was chosen, HCFA would send the beneficiary’s voucher to that plan. If no plan were selected, the beneficiary would be assigned to the Standard Plan. The beneficiary would be responsible for any difference between the voucher and the premium costs of his or her chosen plan but could elect to have the government pay that difference and reduce the beneficiary’s Social Security check (similar to the Part B option today). If the voucher amount exceeded the chosen plan’s premium, the difference would be deposited by HCFA into an MSA of the beneficiary’s choice. Disbursements from MSAs could be used only for medical expenditures eligible for the Schedule A tax deduction.

Implications Of The Reforms

If such reforms as we have described were enacted, Medicare beneficiaries would be able to pick a private plan that included the services they wanted (beyond the core package), delivered in the way they wanted, and, if they wished, perhaps through an organization with which they were affiliated. Or they could decide to put their voucher toward the premium of the Medicare Standard Plan. Because beneficiaries would receive a voucher of a specific amount (paid directly to the plan of their choice), they would have a strong economic incentive to pick the plan that best met their preferences for price, quality, and services.

The organization of services, the selection of benefits, and payments to providers would be in the hands of the plan managers who were competing for enrollees. Unlike the federal officials managing Medicare today, these managers would have the freedom and the financial incentive to experiment with new ways to deliver care at a competitive price. HCFA would have no role in setting provider reimbursement rates, deductibles, or cost-
sharing levels for any private plan, nor any role in requiring benefits beyond those required by statute. The federal corporation, not HCFA, would be responsible for these decisions in the case of the Medicare Standard Plan.

Can a consumer-choice system reduce costs? Whether the proposed program reduces costs depends on how it addresses two distinct aspects of cost. The first of these is the total net outlays of the Medicare trust funds. In other words, would it cut the government’s Medicare budget? The second aspect of cost is how the program would affect the gross costs of serving the elderly. Would trimming government outlays merely shift costs to the elderly, or would a consumer-choice system slow down the growth in service costs? And, linked to this second question, could the voucher be designed so that it tracks, with reasonable accuracy, the market costs of serving enrollees with certain health conditions in different places?

A defined contribution, in contrast to a defined benefit, controls net government outlays directly because the total contribution is determined by a budget. But would savings for the government merely result in higher enrollee costs? In fact, there are good reasons to expect that this combination of market competition and enrollee incentives would reduce the growth of total medical costs for the elderly and hence their financial exposure. The FEHBP’s premium and budget experience strongly suggests that major savings could be achieved in Medicare with a similar market-based design, although conclusions must be somewhat guarded because so little scientific research has been carried out on the program.

In spite of its design shortcomings, the FEHBP has generally outperformed private-sector employer-based health insurance and has greatly outperformed Medicare. A comprehensive 1989 study of the FEHBP by the CRS concluded that the FEHBP’s cost increases were lower than those of the private sector.16 Subsequent analyses have reached similar conclusions.17 Analyzing the FEHBP's premiums in the 1980s, for instance, Lewin-ICF noted, “The available evidence suggests that the FEHBP competitive market dynamics, combined with increased emphasis on cost control, has outperformed the private sector despite increasing benefits in recent years and the impact of an increasing share of retirees.”18 More recently, Frank McArdle concluded that the FEHBP’s rate of premium increases has been lower than that of the private sector.19 During the 1990s the premium performance of the FEHBP has indeed been remarkable. In 1994 the average annual premium increase was only 3 percent, and 40 percent of all enrollees in the program, including retirees, saw decreases in their premiums. In 1995 the entire program experienced an average annual decrease in premiums of 3.3 percent.

Another reason to feel confident about converting Medicare into a system of competing, flexible plans is that Medicare is so far behind other
sectors in introducing design innovations. Enrollment in HMOs is growing but still small, for instance, while preferred provider organizations (PPOs) are heavily restricted, and point-of-service plans are unavailable. Admittedly, the oldest Medicare enrollees may be disinclined to switch to these different service arrangements, but more recent retirees, and the disabled, typically are quite familiar with them from their working days. These persons likely would choose plans containing service innovations if they had the incentive to do so, just as large numbers of FEHBP enrollees do now. With so much ground to make up, giving Medicare beneficiaries the incentive and opportunity to enroll in plans that use less costly arrangements could sharply reduce the growth in total costs. One recent study estimates that a ten-percentage-point increase in HMO market share within Medicare would be associated with a 1-3 percent decrease in aggregate Medicare spending.20

To be sure, the FEHBP does not operate in a market that is completely free of government efforts to regulate prices. Government managers negotiate premiums before they are posted for the open season. Some skeptics of consumer-based approaches suggest that this means that the “pricemaker” power of a government “buyer” actually is holding down costs because plans are afraid of losing access to that market.21 Nonetheless, the plans still must design and price their product shrewdly in strong competition with each other for enrollees if they are to remain in business. Significantly, the OPM devotes most of its negotiating energy to the large plans that undermine the government’s maximum contribution and largely ignores the pricing of other plans. So it is not clear that the government’s “jawboning” function in the FEHBP is more important in holding down costs than is competition for price-sensitive enrollees. What is clear is that the OPM’s bargaining with competing plans is far more successful at holding down costs than are HCFA’s edicts issued to hospitals and physicians.

**Enrollee costs in local markets.** Each enrollee’s financial exposure is affected by the local market, of course, and not just by the economics of the system as a whole. To keep this exposure reasonable, the voucher amount must closely track the local market for serving an enrollee with that enrollee’s health care needs.

The closest equivalent to a Medicare voucher today is the adjusted average per capita cost (AAPCC), used to set capitation amounts for HMOs under the risk contract program. The law sets this fee at 95 percent of the estimated average cost of fee-for-service care for Medicare patients in an area. It then adjusts this rate for certain demographic characteristics, such as age, sex, Medicaid eligibility, and institutional status, to determine the capitation amount.

This method of determining the capitation amount has been criticized
for a number of shortcomings that blunt potential savings to Medicare and make the market less efficient. For instance, all HMOs in an area are paid the same capitation rate, linked to fee-for-service costs. In some cases, this amounts to more than Medicare would pay for a particular enrollee in fee-for-service care. So HMOs often can “game” the system by attracting lower-cost enrollees for any given capitation amount and keeping the difference in cost (subject to profit controls). These and similar problems have led several experts to call for greater flexibility in setting the AAPCC and the incorporation of more sophisticated risk adjustments.

A voucher approach can deal with these deficiencies because it introduces a very different incentive from that in the risk contract system. Because the voucher is not a full payment made to a plan, but a degree of financial support for an enrollee choosing among plans with different prices, it triggers much stronger price/quality competition among plans seeking the business of enrollees. Plans would not be able to price themselves to take advantage of the shortcomings in a bureaucratic structure of capitation payments. They would instead have to compete to satisfy customers who are motivated to pick a plan according to the full package of premium, services, quality, and anticipated out-of-pocket costs.

Is adverse selection a serious problem? Policymakers naturally are concerned about the possibility that adverse selection might destabilize a consumer-choice Medicare system, particularly a system as proposed here, that allows plans to vary benefits. We believe that a stable market with acceptable differences in cost would result from the system we propose without any special risk adjustment mechanism in addition to the primary risk factors used for the vouchers and premiums. But it would be wise to establish a review commission to monitor this aspect of the program and to recommend additional risk adjusters if necessary. Still, while there is little research available on how problematic undesirable adverse selection might be in a Medicare program with vouchers, there are reasons to suppose that it would not be severe.

Perhaps the most persuasive reason for optimism is the experience of the FEHBP. The community-rated FEHBP permits plans to offer a wide range of benefits yet requires plans to charge exactly the same premium to a perfectly healthy nineteen-year-old as to a chronically ill eighty-nine-year-old. It also has no special risk adjustment mechanism. This would seem to be an open invitation to destructive adverse selection pressures. Yet the program is remarkably stable, despite some adverse selection.

We incorporate into the proposed Medicare reform the features of the FEHBP that seem to explain its ability to withstand destructive adverse selection, and we include other features that improve upon the FEHBP in this regard. We believe three features to be particularly important.
First, we limit plan switching to once a year (in Medicare today, an enrollee in the risk contract sector may switch after just thirty days), using the same open season procedure as the FEHBP does. This would make it more difficult for enrollees to destabilize the market by transferring to generous, unrestricted plans just to cover an expensive illness or elective treatment. Second, we allow plans to vary their premiums according to a range of basic risk factors, which the FEHBP does not do. This premium variation would reduce the financial attraction of plans seeking out enrollees likely to be healthier because of their demographic characteristics. Adjusting the vouchers according to the primary risk categories also would insulate enrollees in higher risk categories from their generally higher premium costs. Third, the central marketing and information distribution arrangements we propose (an elaboration of the FEHBP open season) would help to limit “cherry-picking” by plans, as these features appear to do in the FEHBP. Because Medicare enrollees would receive standard information on all plans in their area, it would be impossible for plans to “hide” themselves from applicants they do not desire. And to retain their approval to market to Medicare enrollees, plans could be required to adopt other marketing guidelines to reduce unfair practices.

We do, of course, propose to retain a “traditional” Medicare plan as an option for beneficiaries. But would there be significant adverse selection against the government because only very old and chronically sicker beneficiaries remained with the plan? And would these enrollees face upwardly spiraling net costs under the defined-contribution system?

Although both results are theoretically possible, especially if the government-operated plan remains as inflexible and outdated as today's Medicare program is, the design of the proposed system reduces this danger. For one thing, the premium for every plan is adjusted by the major risk factors, so a plan attracting a large share of very old enrollees would receive much higher premium incomes from these enrollees-who in turn would qualify for a larger voucher. For another thing, the voucher amount would be adjusted in each area according to the weighted costs of a market basket of plans, which would include the Medicare Standard Plan, further refining the voucher and thus helping to limit the potential for large net costs to enrollees in the Standard Plan.

Further, it is by no means obvious that chronically sicker beneficiaries generally would avoid private plans in favor of the Standard Plan. The private plans could not turn away any beneficiary during open season, no matter how sick the person was. And unless its structure of coverage were significantly changed from that of today’s Medicare, the Standard Plan would not provide stop-loss protection and would lack coverage for services (such as prescription drugs) that are covered routinely under private plans.
Information, marketing, and consumer decision making. A final concern is information. For a market to function that is efficient and that satisfies consumers, those consumers must have the information they need to make good decisions. Health care decisions can be confusing enough for young, well-educated persons, so it is reasonable to question whether elderly persons—who often are easily confused—could make informed decisions in a market of competing plans.

There is little research available on exactly what information the elderly require to make sensible health care decisions, but several categories suggest themselves. These include premium and likely out-of-pocket costs, benefits, information on customer satisfaction, and some measurements of quality. In the information clearinghouse function we would assign to HHS, standardized information on prices and benefits would be included, as would “consumer information.” This latter category might include such things as categorization of plans (similar to the Medigap market); information on typical costs for certain illnesses, perhaps using the “illness episode approach;” and patient evaluations, such as those prepared for FEHBP enrollees by Washington Consumers’ Checkbook. To make this information as helpful as possible, we recommend the creation of a “consumer advisory board,” consisting of representatives of Medicare beneficiaries and the health care industry, to recommend to HHS what information should be made available to beneficiaries and how. Plans would be free to supply additional information and to advertise, as they can in the FEHBP, but they would have to meet certain disclosure criteria to remain approved by Medicare.

Conclusion

To reform the Medicare system successfully, the foundation of the program must be changed from an open-ended entitlement to one that limits the government’s financial exposure while creating incentives for cost control by enrollees. That is best accomplished by moving toward a defined-contribution program within the system of competing private health plans. Under such an arrangement, beneficiaries would have the incentive to seek good value for money in a plan, while plans would have a powerful incentive to offer the best combination of value and price.

Many skeptics of such a system maintain that the elderly would be confused and ill-served by a competitive private market, and that adverse selection would undermine it. But the structure and record of the FEHBP show that if the government plays an appropriate role in applying basic plan standards and acts as an “honest broker” of information, consumers will be protected, and the market will function to improve quality while contain-
ing costs. The FEHBP also suggests, moreover, that the adverse selection problem is greatly overstated and would not cause the collapse of a properly constructed Medicare market consisting of private plans offering different benefits.

Demographic projections indicate clearly that Medicare cannot deliver promised benefits to the next generation of retirees without fundamental changes in the program. The only way to avoid heavy increases in payroll taxes and other revenues, or a sharp cutback in services, is to change the economics of the system to achieve better value for money. The experience of the FEHBP suggests that this can be accomplished.

NOTES


6. Ibid., 39.


8. Ibid., 49-79.


10. This summary of legal authorities can be found in Congressional Research Service, Federal Employees Health Benefits Program (Washington: CRS, 1989), 238.

11. For purposes of the FEHBP, a health plan is defined as “a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.” 48 CFR, Chap. 16, Part 1602.170-8. The minimum standards for health benefits carriers require that the carrier be lawfully engaged in the business of supplying health benefits; meet financial solvency standards, including “reasonable financial and statistical records; open access to records by OPM and General Accounting Office (GAO) investigators or auditors; an acceptance of payment in accordance with contract and contingency reserve requirements; a requirement to perform the contract in accordance with ‘prudent business practices’.” See 48 CFR, Chap. 16, Part 1609, “Contractor Qualifications.” The OPM’s other regulatory
prohibitions and restrictions deal primarily with consumer protection, including prohibitions against false, misleading, deceptive, or unfair advertising, and a requirement for retention of financial records.

12. Title 5, U.S. Code, Section 8904.

13. In this process the OPM maintains strict confidentiality. OPM staff historically have not even shared the document with the Office of Management and Budget.

14. In recent years the governmentwide service benefit plan has been Blue Cross and Blue Shield; the two largest employee organization plans have been the Mailhandlers and the Government Employee Hospital Association Plan; and the two largest comprehensive medical plans have been the Kaiser Foundation Health Plan of Northern California and the Kaiser Foundation Health Plan of Southern California. With Aetna dropping out of the program in 1989, OPM staff have used a mathematical formula to calculate the service indemnity component of the “Big Six” formula.

15. CRS, Federal Employees Health Benefits Program, 231.

16. Ibid., 255.


24. For a discussion of this issue, see S. Sofaer, “Informing and Protecting Consumers under Managed Competition,” Health Affairs (Supplement 1993): 76-86.