Moving Medicare To The FEHBP Model, Or How To Make An Elephant Fly

Can Medicare really be modernized?

by Harry P. Cain II

PROLOGUE: The National Bipartisan Commission on the Future of Medicare recently considered a proposal to reform Medicare by recasting it as a consumer-choice program similar to the Federal Employees Health Benefits Program (FEHBP). Although that proposal did not garner enough votes to be endorsed by the commission, it is still supported by many of its members, and its cochairman, Sen. John Breaux (D-LA), has announced his intention to pursue the reforms legislatively.

Public discussion of the Medicare-to-FEHBP proposal, combined with recent difficulties in implementing the Medicare+Choice program, led Harry Cain to write this paper. Cain’s perspective is that of a former administrator of both the largest contract under the FEHBP (the governmentwide service benefit plan known as the Blue Cross Blue Shield Plan) and the Medicare “Prime Contract” for fiscal intermediary services. The Blue Cross and Blue Shield Association (BCBSA), where Cain is an executive vice-president, has held both of those contracts since the beginnings of both the FEHBP and Medicare. Cain’s responsibility for them ran from 1986 through 1997.

Cain, who has been with the BCBSA since 1982, now directs its Office of Regional Executives, a group of senior executives who are accountable for understanding the business needs of the Blues plans and modifying the BCBSA programs to meet those needs. Before 1982 Cain worked in the U.S. Public Health Service and then directed the American Health Planning Association. Cain holds a doctorate in social policy from Brandeis University.
ABSTRACT: Transforming Medicare into a Federal Employees Health Benefits Program (FEHBP)-type program holds the promise of more choice, lower costs (in the long term), and higher quality—a fine concept that will collapse in its implementation unless at least three conditions are met. (1) Congress gets the regulatory structure right and then refrains from annual tinkering, (2) Congress does not set unrealistic expectations regarding “cost savings,” especially if a prescription drug benefit is added, and (3) administrative agency staff have the requisite training and a “privatizing” orientation. Given Medicare’s history and the “Medicare-industrial complex,” none of those conditions is likely to be met.

Ten years ago the Bush administration (specifically, the Office of Personal Management, or OPM, and the Office of Management and Budget, or OMB) proposed that the Federal Employees Health Benefits Program (FEHBP) be reformed to resemble Medicare. The OPM felt that if it could “self-insure” (that is, assume the risk for) the governmentwide health benefit plans, it could use its consolidated purchasing power—as Medicare does—to effectively dictate prices and get a better deal all around. Many FEHBP participants argued vigorously against that idea, saying that it would unnecessarily cripple a very successful program, and ultimately the proposal went nowhere.¹ Now that policy worm has turned, and many politicians and policy wonks are asking, Why not make Medicare like the FEHBP? Although the idea is much better than the earlier proposal, it is no sure-fire winner either.

Medicare and the FEHBP are alike in several ways. Both began in the 1960s, both provide relatively generous benefits (although the FEHBP’s are more generous), and both cover very large populations (although Medicare’s is four times larger). Both prohibit medical underwriting, age rating, and waiting periods for preexisting conditions. No one eligible to join either program can be excluded. As federally legislated programs, both also override the states’ relevant laws. Thus, they both are reasonably uniform in their operation across the country. Both are providing what they were set up to provide, although they were set up very differently.

Here I seek to highlight the administrative and political similarities and differences between Medicare and the FEHBP, the reasons for them, and the cautions they raise. I conclude with suggestions on a legal and regulatory structure for a reformed Medicare that might work. My biases are revealed in an earlier essay in Health Affairs contrasting the mind-sets of public-izers and private-izers.² In brief, a public-izer trusts the government (especially the federal variety), distrusts the market, and embraces the cooperative spirit of community health planning. A private-izer does none of those things. To further illustrate the differences, throughout this paper I offer a private-izer’s comments (mine) on Bruce Vladeck’s excellent piece...
in this year’s first issue of Health Affairs. Vladeck is my favorite unrepentant public-izer.

Different Beginnings

- Medicare. Medicare arose from health policy debates that spanned decades. Before its enactment the elderly as a population had meager financial resources and miserable access to “mainstream medicine.” Medicare was enacted in 1965 to address the health care financing problem. Not knowing what else to do, the government followed the then-prevalent private-sector fee-for-service (FFS) model for physician care and the cost-reimbursement model for hospital care. The elderly got mainstream medicine; the providers did well and multiplied. Government became the dominant force in the health care industry, began to bleed red ink, and was the stimulus for many major, industrywide changes, for better or for worse.

When the Medicare cost problem became clear in the early 1970s, Medicare policy wonks on and off of Capitol Hill turned to the strategy of governmental regulation of prices. They had no real alternative. The prevailing wisdom of the time was that price competition in this industry could not, would not work. Providers were too strong, the product was too arcane, consumers were too ignorant, and insurance itself created perverse incentives. That same wisdom gave rise to health-planning legislation, certificate-of-need programs, hospital rate setting, and other regulatory solutions.

Beyond the perceptual problem (“price competition won’t work”), the 1960s and 1970s also were a time of much higher faith in and expectations of the federal government. Our government could and would, many thought, lead America to a Great Society. The battle between capitalism and socialism was still engaged around the world, and many of our thought leaders were at least ambivalent as to how that battle might eventually be decided. That was then. Now, nearly three decades later, capitalism has reached “commanding heights” around the world. Price competition is the name of the game in almost every industry, and its dynamics cross national boundaries with ease. Public-izers are on the run, and faith in Big Government is shrinking.

- The Medicare-industrial complex. Unfortunately, when the federal government got wrapped up in Medicare cost regulation, the Medicare-industrial complex (Vladeck’s term) arose and is still with us in force. I am in it, as are most of the readers of this journal. Indeed, I feel honored by Vladeck’s characterization of Medicare contractors in general, and my company in particular, as “the sine qua non of effective interest-group politics.” Vladeck and I would differ on the causes and effects of the Medicare contractors’ lobbying...
prowess, but not on the fact of its existence.\footnote{1}

In a similar vein, Vladeck bemoans the incredible level of detail that Congress writes into the Medicare laws, especially related to payment policies. He ascribes the cause of such congressional micromanagement to “narrowly focused interest groups” aggressively pursuing their part of the $200 billion Medicare pie. Those interest groups are narrowly focused, and they do seek to protect and expand their “turf,” but I ascribe the micromanagement to the structure of Medicare: The financial risk is in the federal government, and either Congress or the executive branch will make all of the decisions. The fight is not really over the level of detail but over which federal actor gets to make all of the decisions.

In the past three decades the Health Care Financing Administration (HCFA) has mostly lost that fight. When Congress distrusts the executive branch, Congress will keep more of the key decisions to itself. Congress’s lack of trust in HCFA, I believe, goes back to, and gets elevated by, the periods since the early 1970s when one political party held the White House and the other controlled Congress. We will never avoid that dynamic completely, so why not get out of the structure that sets up the fight?

Regrettably, the strength of the Medicare-industrial complex will make it very difficult for Congress to fundamentally overhaul the program. With all of Medicare’s distributive and redistributive effects that Vladeck describes, interest-group politics and their campaign-funding practices are thriving and are not designed to facilitate a governmental shift to a new paradigm. If Medicare were not on a clear slope to financial disaster, the status quo would prevail, even if it is out of tune with the times.

The FEHBP. The FEHBP arose even earlier than Medicare (1960), not from any health policy ideas but from a large employer’s need to offer better benefits to its employees. President Dwight D. Eisenhower first recommended health insurance for federal employees in 1955. By that time most large private employers (with which government had to compete for its workforce) had been offering health care benefits for several years. By the late 1950s many government employees (often organized into employee groups or associations) were already paying for health insurance out of their own pockets, so Congress just built on that structure. Current coverage was, in effect, allowed to continue; more employee associations,
more carriers, and a few early health maintenance organizations (HMOs) were allowed to enter the market and offer new packages. The government would contribute some fixed amount to the premiums charged, using a formula set by the new law.

There were not many health policy wonks on the Hill in 1960, and even if there had been, given the committees of jurisdiction (the Civil Service committees), no policy wonk would have paid attention to this proposal. Some insurance industry experts did testify at hearings on the matter, warning that offering a multiplicity of carriers was a bad idea; adverse selection would endanger the program, and so forth. The Civil Service Commission actually recommended that there be only one carrier. But other political interests (primarily employee groups and existing carriers) wanted to preserve the choices, and Congress went along.

The insurance experts were almost right. Adverse selection nearly killed the FEHBP. In 1981–1982 the Blue Cross plan, then enrolling about 45 percent of workers (including most of the oldest and sickest), nearly pulled out of the program, which would have swamped most of the other plans and generally caused havoc. Beyond the underlying risk-selection problem caused by consumer choice, the Civil Service Commission (now called the OPM) had inadvertently exacerbated the situation by “unbalancing the competition.” For example, the OPM required only the Blue Cross plan to offer rich mental health benefits, and it advised retiring federal employees to join the Blues plan. The story of how we escaped that mess is for another time. The point here is that we had the opportunity, and learned, to become aggressive competitors and to succeed in a program that was not supposed to work. The whole program succeeded, in spite of a regulatory and administrative structure not well designed for the purpose. And even with more than $15 billion annually at stake, there is no FEHBP-industrial complex.

Differences In Medicare And The FEHBP

Medicare uses its huge size and governmental authority to dictate the prices it will pay for services bundled or unbundled the way the government wants them. For the FEHBP, the OPM tries to regulate the boundaries of a market and the behavior of the plans competing in that market. Medicare offers one set of extensively defined benefits and tells all of the players in the industry—fiscal intermediaries, hospitals, physicians, beneficiaries, and numerous adjunct agents—what they must do and not do for the money to flow. The OPM only negotiates with the health plans, and the outcome is agreement with each plan on its benefits and premiums for the next year. As a result, federal employees and retirees have an annual open-season choice
among many health plans that differ in price, benefits, providers, and copayments.

Looking at the past ten years—the “modern era” in which HMOs became a major force and other kinds of health plans were forced to emulate HMOs’ managed care techniques—the annual rates of cost increase have been about 5 percent for the FEHBP and about 9 percent for Medicare. The FEHBP got the direct benefit of all of the private-sector innovations in medical care management; Medicare benefited only moderately and indirectly. The FEHBP’s consumers have consistently expressed satisfaction with their choices (measured via surveys). HCFA only recently began surveying its beneficiaries and has found, not surprisingly, that the program is heavily faulted for inadequate benefits (especially the lack of drug coverage), which is not under HCFA’s control.

Another difference I feel confident of, but cannot prove, is that the amount of fraud and abuse in Medicare is significantly higher, per dollar available, than it is in the FEHBP. Medicare has done more to focus on fraud detection and prevention than most other payers have done, but it also has a larger problem to deal with. That is partly because of the huge sums of money being dispensed, which naturally attract crooks, and partly because of the program’s structure. Opportunities for mischief rise in proportion to (1) the distance between the holder of the financial risk and the recipients of the money, and (2) the complexity of the trail between the two.

In sum, the FEHBP has outperformed Medicare every which way—in cost containment, benefit innovation, and customer satisfaction. Most of those differences, I argue, are the result of the structures and operations of the two programs, which I explore below. But some of the differences are also the result of “immutable conditions,” which must be acknowledged. In particular, the FEHBP population, on average, is educated, middle-class, and relatively well off. Medicare, on the other hand, covers large groups of lower-income, less educated, more sick and disabled, and more vulnerable persons. Effective communication with the Medicare population is much more difficult than it is with the FEHBP population. Also, the government can afford the FEHBP. For Medicare, however, the government has made promises it is unable to keep, at market prices in the beginning and now at well below
market prices.

Structure. The key structural question that distinguishes Medicare from the FEHBP is, Who holds the risk? And that in turn determines the process by which key decisions are made and carried out. In Medicare the government holds nearly all of the financial (and political) risk and thus must keep all of the critical decisions to itself. This means that Congress is the key decisionmaker.

The Medicare law undergoes an average of fifty changes each year, most of them minor, dealing with reimbursement policy. Occasionally there is another “big bang,” such as the Balanced Budget Act (BBA) of 1997, in which changes tumble out by the hundreds. Sometimes, in the aggregate, the changes do not make sense, a fact that is not surprising, given the size and complexity of what Congress is working with and all of the interests that need to be satisfied. HCFA then must translate those legislative changes into multitudes of regulatory changes.

If one counts the volume of laws and regulations, the Medicare tally exceeds 800 pages per million beneficiaries. The comparable FEHBP figure is about twenty pages, a ratio of forty to one. The difference between the two is actually much greater than that when one also counts the pages of instructions and other forms of guidance from HCFA to the intermediaries or health plans. The last time I counted (1993), the intermediaries and carriers had received, on average, a new instruction from HCFA every five hours of every day of every year. Sitting on our end of the business, it is a constant administrative headache, not only mechanically but also financially, because Congress seldom realizes that those changes require administrative time and money.

A supporter of traditional Medicare might argue that the volume-of-paper comparison is not as one-sided as it sounds because many of the Medicare rules, especially those dealing with reimbursement policy, have had positive effects far beyond Medicare. The diagnosis-related group (DRG) and resource-based relative value scale (RBRVS) payment schemes, for example, have been widely adopted by private-sector payers and consequently have saved large sums of money and changed providers’ behavior for everyone’s benefit (except perhaps the providers’). I agree with that, although one could argue in turn that Medicare’s largesse created the cost problem that government had to solve. In any event, given the dynamics of the industry in the 1970s and 1980s, there may have been no way to achieve such cost and behavior changes other than using the power of the government as a price regulator. (Today, given the dramatic rise of pharmaceutical costs, many health policy types might regret that traditional Medicare does not cover prescription drugs and...
therefore does not regulate those prices, too. A few thousand more pages of regulation on that subject might be worth it—unless there is a better way.)

Beyond administrative problems, the weakness of Medicare’s decision-making ability is highlighted by the changes in the medical care marketplace during the past decade. To take advantage of recent private-sector innovations, HCFA staff would like to be able to discriminate among providers and to give beneficiaries incentives to use certain providers in traditional Medicare. But the politics of making such discriminations in Medicare makes the idea simply infeasible. Even if it became politically feasible, would it be wise for the government to go beyond setting the rules for everyone and start designating the preferred “good guys” and, by implication, the non-preferred “bad guys?” Private actors in private markets do that every day, but we all rely on government and the Rule of Law to set the boundaries within which all are treated equally.

Conclusion: If one believes that the medical marketplace will and should keep changing (with ever-increasing abilities to distinguish good medicine from lesser varieties), then leaving the operational decisions in the hands of government is basically a bad idea—on top of which, a legislative decision-making process is simply asking for inflexibility and managerial incoherence.

In the FEHBP, because the employer is the government, Congress also gets involved. But because the FEHBP is an employment program, it is handled by the Post Office and Civil Service Committee (now just subcommittees) of Congress rather than the Ways and Means and Finance Committees, which handle Medicare. Unlike these finance committees, the Civil Service committees are not noted for their interest in health policy, among either the committee members or the professional staff. Because the government can reasonably well control its employees’ health benefit costs, because the health plans hold the financial risk, and because each consumer has a wide array of choices, these committees do not feel the need to micromanage the program.12 In fact, they clearly shy away from the politics and complexities of the health insurance business.

The FEHBP does, of course, have an enabling law, which lays out the framework of the program. It has been amended many times over the past forty years, usually just to make an adjustment in the contribution formula. And it does issue regulations and instructions, which can be onerous, but when compared with Medicare’s, they are mostly manageable.

■ The staffing component of bureaucracy. Given the structure of Medicare, it is not surprising that HCFA’s staff outnumbers the OPM’s staff (per million beneficiaries) by a large margin (about
six to one) and that that margin is not nearly enough. A recent “Open Letter to Congress and the Executive” in this journal, from a bipartisan group of the most knowledgeable people in the industry, urged that significantly more resources be devoted to the administration of Medicare, saying that the current resource levels “threaten to cripple HCFA” and imperil the whole program.\(^\text{13}\)

Beyond the big-though-inadequate numbers, HCFA’s staff has long been stronger than the OPM’s staff in terms of health policy sophistication. HCFA staff members, in my experience, not only are more knowledgeable, they also are more emotionally committed to what they are doing in health care financing. They are public-izers, of course, or they wouldn’t be there. Nearly all of them lack private-sector experience, but again, given what traditional Medicare is about, that is not an overwhelming problem. (It is a problem when it comes to Medicare+Choice, but more on that later.) HCFA staff often have been and are now overwhelmed by their responsibilities, but not because they are not a talented, hard-working group of professionals. It is because of the size and complexity of their tasks as defined by Congress (compounded by all of the second-guessing done by other strong players in the bureaucracy).

HCFA staff do not worry primarily about making the health care marketplace more efficient or effective or competitive, even though they powerfully affect it. Their focus is on administering a hugely complex program so as to protect Medicare beneficiaries and constrain their health care costs. Their task, however it is done, affects virtually every provider in the country and at least one of every five Americans. It annually affects the flow of at least $200 billion, a number that will keep growing. And it is all done centrally. Thus, it requires thousands of coordinated decisions and is inherently an administrative nightmare.

The OPM staff are not focused on health policy or on improving the health care market either. They are oriented to assuring a set of benefits for federal employees and retirees. Also, they see the “managed competition” character of the FEHBP as an unfortunate irritant: It requires them to annually negotiate contracts with all of the health plans and to monitor the plans’ behavior. In their life insurance program for federal employees, the OPM staff choose one carrier and that is all there is to it—clearly a much simpler, more easily controlled process. Even worse, as far as health benefits go, the OPM cannot do what HCFA can: aggregate all of its potential purchasing power. The OPM’s purchasing power is scattered across the private sector. Understandably, the OPM staff have looked at the HCFA staff with envy. They dream of the OPM’s potential clout if it could only use all of the billions of dollars that flow through the FEHBP to
spend directly on health care for its beneficiaries.

In my opinion, if the OPM staff were as knowledgeable about and committed to their managed competition program as the HCFA staff are to their regulated price program, the performance gap between the two programs would be even greater than it is. In particular, the OPM could have supported extensive research on the workings of managed competition, including the criteria and processes needed for allowing or encouraging new plans to enter the competition, and the mechanisms needed for better risk adjustments. In accordance with their respective charges and histories, however, the OPM has supported no research on managed competition, whereas HCFA has long operated an extensive research program related to Medicare.

Parenthetically, in this HCFA/OPM comparison there is an obvious and disquieting truth about publicly managing a private competitive system. In the absence of some special background or training, public-sector managers, like private-sector managers, will continually seek ways to augment their control over resources, their power to manage, and their ability to do a “better job” of it. Private competitors’ innovations will typically be seen by the public managers as irritants, disruptions, and unanticipated problems that need to be controlled or quashed. There have been many incidents in the FEHBP’s long history that underscore that danger. (And now, as I understand it, the OPM staff have caught a Medicare virus and are running a micromanagement fever. I hope that it will pass.)

■ Who’s the customer? To a Medicare contractor, the primary customer is clear: It is HCFA. HCFA staff, in turn, are sensitive to their beneficiaries primarily through the political process, most frequently expressed in a legislative process, in which activists for the elderly negotiate with government staff (executive and congressional) for benefit enhancements or protections, which usually are financed by reducing payments to providers. Providers are not now as strong politically as beneficiaries are, so providers pay for the beneficiaries’ gains, especially in a time of federal budget constraints. There are clear consequences of HCFA’s having to rely on Congress to hear, translate, and act on the expressed wishes of the organizations of beneficiaries. This process unequivocally enlarges the power of both Congress and the beneficiary organizations. And since Congress sets the rules, that process will be hard to stop.

To an FEHBP contractor, the primary customer has to be the federal employee or retiree—the “member,” not the OPM (a fact that the OPM does not always appreciate). Using the Blues Federal Employees’ Plan (FEP) as an example, we have to understand our current subscribers very well, or we risk losing their business in the
next open season. It does us no good to be close to the organizations of federal employees and retirees, or to the OPM, unless we are also very sensitive to what the “consumer on the street” actually thinks. Thus, we conduct annual market surveys to discover what factors were influential in the subscribers’ decisions to change or remain in their health plans.

**Can We Make The Elephant Fly?**

In the beginning, and for its time, the design of Medicare was carefully and reasonably thought out. For three decades since then, enormous congressional attention, executive talent, and financial resources have been devoted to Medicare’s success. Yet the program is fundamentally in trouble. The FEHBP’s design, on the other hand, was haphazard. Its federal administrators do not care for its design or its operations. For most of its four decades the FEHBP has received little attention from anyone. The program is not perfection in action, but it does have the advantage over Medicare in cost containment, innovation, customer satisfaction, and regulatory requirements. The program is thriving.

Why this paradox? The fundamental answer is that Medicare uses centralized, political, and bureaucratic decision-making processes to try to keep pace with a fast-changing, demanding world. The FEHBP tries only to guide some of the forces of market competition to reach the same end.

Can Medicare be restructured to resemble the FEHBP? I doubt it. So many powerful components of the Medicare-industrial complex will feel threatened by a fundamental change. Very strong political leadership and courage would be required. And, if the purpose of Medicare reform is to save large sums of money, then the FEHBP model is not the answer, at least in the short run. There are excellent reasons for going to the FEHBP model, but they do not include further reductions in Medicare expenditures.

But suppose, for the sake of argument, that the idea of an FEHBP-type reform of Medicare takes hold, and suppose that Congress wants to go with it. I offer eight suggestions for Congress to consider.

(1) Market the idea. Sell the public on the reasons for moving to a consumer-choice model and the problems with government-regulated prices. (This will be difficult because most of the public does not understand how Medicare operates now and has never heard of the FEHBP.)

(2) Move to an adjusted “defined-contribution” approach, such as the “premium-support” mode recommended by Gail Wilensky and Joseph Newhouse and by others. The purpose of the defined con-
tribution is not only to contain government’s costs but also to shift as much of the risk (and decisions) as possible away from government and into private health plans. Such a contribution should be adjusted as effectively as possible for income and risk selection.

(3) Create a new administrative structure aimed at making the market work. Lynn Etheredge’s public/private model, as it might be applied to Medicare, looks promising. In 1996 the Institute of Medicine issued a report encouraging the kinds of market-oriented changes that did emerge in the BBA. Its final recommendation, however, was unattractive to the administration and ignored by Congress. It said, “Please consider assigning the administrative implementation job to an agency other than HCFA, one that would be designed and staffed to facilitate the creation of a Medicare market.”

The focus of the new agency would be on such matters as health plan disclosures, consumer information requirements, minimum benefits, marketing boundaries, and antitrust rules. I would not ask the new agency to “standardize benefits,” even though the theory of managed competition calls for it. Especially in an era of managed care, when the delivery mechanisms and provider networks mean everything, standardized benefits would be both too complicated and too innovation-quashing. In the Blues FEP many of its most productive benefit innovations (such as retail pharmacy networks, demand-management call centers, point-of-service options) either would have been delayed for years or would never have happened if all of the health plans had had to offer the same benefits. The FEHBP’s history suggests that benefits become very similar over time, as a function of competition, without the need to standardize. A reasonable set of minimum benefits and a sophisticated administrative agency will suffice.

(4) Define success in terms of choices available, effective price competition, and beneficiary satisfaction. This recommendation, especially as related to beneficiary satisfaction, will require some fail-safe alternative for beneficiaries to go to if their health plan goes under (which will happen). The FEHBP handles that problem easily because at least some of the options (other health plans) that beneficiaries can immediately switch to have both good benefits and broad access to most providers. Disruption for the beneficiaries is minimized. In the past fifteen years many health plans, including one big one, have pulled out of the FEHBP market, with very little
upset on the part of enrollees.

HCFA/traditional Medicare could play that safe-haven role if its benefits were enhanced and if it were one of the competitors. But the competitive field would be unbalanced unless HCFA were stripped of its regulatory and police powers. Without those powers, however, what kind of a competitor could HCFA be? How could its product be fairly priced in the market? How could it make policy decisions to keep pace with the market?

I would recommend that Congress authorize the use of two or more nationwide preferred provider organizations (PPOs). Let the administrative agency bid out the opportunity, using selection criteria based on total costs/premiums (not administrative costs), access, benefits, protections, and so forth. The reserve requirements for such PPOs might preclude most (maybe all) private bidders, but let’s see. (When the FEHBP was created, it was a potentially huge account, with unknown risk, so the Blues had to aggregate their resources to pursue it, and several commercial insurers formed a coalition with Aetna to do the same thing.) If needed, government could share in the risk of the traditional contracts, as long as private-sector players had large risk themselves.

(5) Use performance-based contracting with health plans, allowing rewards for success and market exit for failure. Get some private-izers in on defining the terms of the contracts. Profit is not an evil concept. The more of it that can be earned through excellent performance, the better performance you will get. And keep the inspectors general out of rule making and contract development. They are now trying to define any kind of mistake in any of the federally funded health programs as “noncompliance,” subject to civil and criminal penalties.

(6) Allow adequate time and resources for transition. Outfitting an elephant to fly takes an abundance of careful planning—to prepare the elephant and to get everybody out from under its flight path. Perhaps the most ridiculous part of the Medicare+Choice statute is the congressional requirement that HCFA change its world fundamentally and immediately (and make somebody else pay for it). That is only a slight exaggeration. My advice: Go slowly; give the administrators time.

(7) Constantly weigh the costs and benefits of more regulation. The government is supposed to do this now, under some administrative procedures laws. However, this responsibility does not appear to get great attention from the agencies I am familiar with.

(8) Insulate this process as much as possible from the political process (admittedly the most difficult, quixotic recommendation).
In spite of his criticism of the current process, Vladeck argues that the notion of getting the multitude of Medicare decisions out of politics/government is “fundamentally antidemocratic,” elitist, and usually advanced for self-serving reasons. My reasons, I hope, are none of those.

At the core, my reasons are twofold. First is the need for stability. If we want a Medicare market to develop, then we need more stability and more predictability regarding the market rules. As the Medicare+Choice experience illustrates, a legislative decision-making process does not promote much stability. Risks are not calculable. To play now, one must trust the government not to change the rules next month in unpredictable ways. No deal.

Second, complexity exceeds competence. I am arguing that no one, or no body, can centrally and sensibly make the decisions for a $200 billion slice of our economy. The complexity of it is too great. Only the dynamics of an effectively regulated market can do the job and keep the industry evolving toward an ever more responsive, adapting, and efficient enterprise.

The author is no longer responsible for any Blue Cross and Blue Shield Association (BCBSA) contracts with the federal government, and this paper reflects his personal hindsights and opinions, not those of the BCBSA. On the other hand, many of the author’s colleagues in the BCBSA helped him to refine the ideas reflected here, for which he is most grateful.

NOTES
1. H.P. Cain, testimony of the Blue Cross and Blue Shield Association on reform of the FEHBP before the House Post Office and Civil Service Subcommittee on Compensation and Employee Benefits, 11 July 1990.
2. H.P. Cain, “Privatizing Medicare: A Battle of Values,” Health Affairs (March/April 1997): 181–186. Two sentences from this essay convey its essence: “The concept of competing, accountable health plans is a great one if the administering agency believes in it and trusts the market and health plans to impose and accept accountability. If, however, the publicizer mind-set prevails in administration, we can anticipate extensive government involvement in health plans’ marketing, enrollment, customer service, appeals, accounting, executive compensation, and so on” (p. 186). (I should have added “quality measurement and improvement” to the list of likely government incursions.)
6. I must observe that the contractors' lobbying prowess has been much more helpful to HCFA over the years than it has been an irritant. HCFA remembers the irritations more than the assistance.
7. Once the competitive playing field became relatively level, the risk-selection
character of the FEHBP has been mostly controlled by the unintended consequences of two features of the current program: (1) the requirement that every beneficiary pay at least 25 percent of the premium for his/her chosen health plan, which reduces the attractive power of the cream-skimmers, and (2) the fact that most FEHBP retirees over age sixty-five also are Medicare beneficiaries, and Medicare is the primary payer for these people, which makes them (to an FEHBP health plan) the cost equivalent of an active employee.

8. Although the FEHBP depends entirely on the private market, do not assume that the FEHBP rules were written by private-izers. Those rules, for example, “disallow” all costs related to the acquisition and retention of members and allow the fee-for-service plans to earn little profit, no matter what their performance. (Performance is weighted heavily in the OPM rules but is subjectively judged in terms of cooperativeness with the OPM.) In the FEP’s best years the Blues have been allowed no more than 0.7 percent of premium in profit (the “service charge”), and then we must use a large chunk of those funds to cover all of our marketing costs and other “disallowables.” As a return-on-investment proposition, this is small enough to cause some privatizing plans to leave the program.

9. In the late spring the OPM issues a “call letter,” which requests proposals for the next year and lays out OPM expectations regarding acceptable (or unacceptable) benefit changes, implementing new legal or regulatory or information requirements, and so on. The plans respond, and negotiations begin.

10. The cost differences vary widely depending on the comparison period chosen. The cost-increase figures for Medicare, however, are interesting in two respects: (1) They include the impact of many Medicare laws designed to constrain such cost increases, and (2) they usually are not adjusted for the increase in the Medicare population, which tends to improve Medicare’s age mix. In actuarial terms, the Medicare experience includes a “negative age factor,” whereas the FEHBP population has remained fairly static. Thus, its cost increase includes a “positive age factor” (that is, the FEHBP’s population, on average, is getting older), although, as stated in Note 7, the Medicare beneficiaries in the FEHBP population mitigate that factor.

11. Although communicating with the FEHBP population is not easy, its long experience with the FEHBP choices and easily available information on comparison shopping have turned this population into unusually savvy health plan shoppers. These shoppers can project, with amazing accuracy, their annual health care costs.

12. Controlling health benefit costs, of course, depends on the contribution formula used. The current FEHBP formula has the government’s contribution rising in direct proportion to the weighted average rise in all of the participating plans’ premiums.


