BRIEF ANALYSIS
No. 107
For immediate release:
Monday, June 13, 1994

Federal Employee Health Plan: Model for Reform?

In his 1994 State of the Union message, President Clinton said the goal of his health care reform proposal is "to give every ... American the same health care security they have already given to ... federal employees." The Federal Employee Health Benefits Program (FEHBP) also has been held up as a prototype for reform by Stanford professor Alain Enthoven, father of managed competition. Liberal Senator Edward Kennedy has advocated allowing individuals and small business employees to join the FEHBP. And the program has been praised by a number of conservative Republicans.

Should the FEHBP be used as a model for health care reform? Let's take a closer look.

Rhetoric vs. Reality. The FEHBP has four main features: (1) federal employees in most places can choose once a year among eight to 12 competing health insurance plans, (2) the government contributes a fixed amount of money that can be as much as 75 percent of each employee's premium, (3) the extra cost of more expensive plans must be paid by the employee and (4) the plans must accept every applicant and charge the same premium to every enrollee (community rating).

Advocates of the FEHBP say that these features produce a health insurance system that works — one based on competition, choice and incentives to hold down costs. Economists who have looked closely at the program, however, have discovered that the FEHBP has few of the desirable characteristics of a competitive system.

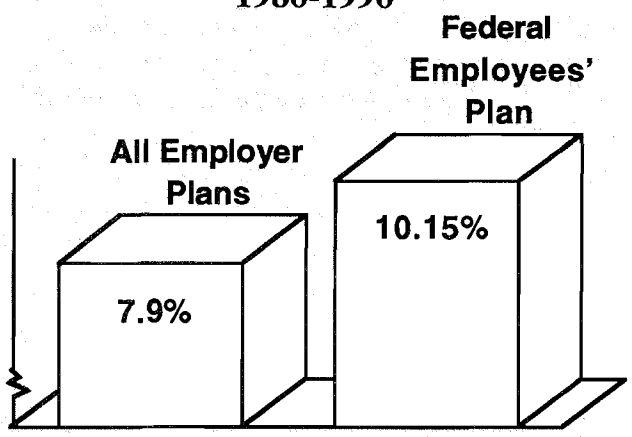
Problem: Employees Are Misled. Consider the two Blue Cross plans that have the lion's share of the market:

- Although federal employees are encouraged to believe that the Blue Cross "high-option" plan has more benefits than the "standard-option" plan, actuaries calculate that there is virtually no difference between the value of the two.
- Yet the employee's share of the premium for single people in the high-option plan is almost four times as high ($2,040 vs. $540 in 1993).

This means that many participants, including a disproportionate number of elderly retirees, are paying four times more than they need to pay for the benefits they receive.

Annual Rate of Growth in Per Capita Health Care Costs[1]

1980-1990



[1] Annual rate of growth in spending per full-time equivalent employee.

Problem: Premiums Do Not Reflect Real Costs. Economists have discovered that the differences in the premiums of competing FEHBP plans are far more likely to reflect risk selection than the underlying value of the benefits. In the case of Blue Cross, the high-option plan is more expensive because so many sick people choose to join it, while the standard option plan attracts more healthy people.

Problem: Competition Among Plans Is Mainly Competition for Good Risks. An insurer's survival in the FEHBP is rarely determined by how well a plan manages health care costs. Plan survival is overwhelmingly dictated by whether the plan succeeds in attracting the healthy and avoiding the sick. To attract the healthy, advertisements show-

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case primary care services and show pictures of young, healthy families. *No plan ever advertises that it has the best specialists.*

Problem: Destructive Competition. Plans that attract a disproportionate number of expensive-to-treat enrollees have to charge above-average premiums. As the high premiums cause healthy people to leave, the plan's cost per enrollee continues to rise, leading to even higher premiums. The result is a "death spiral of adverse selection" that causes the plan to fail. This is precisely what has happened to most of the FEHBP fee-for-service plans.

Problem: Fee-For-Service Plans Are Being Forced Out. People who are seriously ill tend to join fee-for-service plans in order to secure the right to see the doctor of their choice. This makes it virtually impossible for fee-for-service plans to avoid the sick if they are in competition with HMOs. This explains why:

- Between 1987 and 1991, the number of fee-for-service plans available to federal employees somewhere in the country fell from 35 to 19.
- And following the departure of Aetna, *the only systemwide fee-for-service insurer left is Blue Cross.*

Problem: Most Regulation Is Hidden. The Office of Personnel Management (OPM) imposes all kinds of regulations that do not appear in any law passed by Congress. For example, OPM will not allow Blue Cross or any other plan to raise its deductibles or copayments, fearing that plans with greater patient cost-sharing and cheaper premiums would attract younger, healthier employees. Similarily, OPM will not allow a plan to include coverage for teeth cleaning but omit coverage for dentures, on the theory that such a change would make the plan more attractive to young people.

Problem: Failure to Control Cost. Urban Institute economist Pete Welch has identified reforms that would save the FEHBP (and therefore taxpayers) $500 million a year. The basic problem, says Welch, is that "competition for individual employees [at artificial, community-rated premiums] does not control costs, it increases them."

Although comparing aggregate costs in the FEHBP with those in the private sector is a bit like comparing apples and oranges, it does suggest that the FEHBP has not done well in controlling costs. For example:

- During the 1980s, the federal government's spending on employee health benefits grew at a faster annual rate than employer-provided health insurance generally (11.22 percent versus 10.01 percent).
- Adjusted for the number of employees, the federal employees' plan's spending grew more than 25 percent faster than spending for private sector plans. [See the figure.]

Even the Clinton administration predicts that FEHBP spending per employee will grow by 9.3 percent from 1993 to 1995, while the Congressional Budget Office predicts 7.2 percent for the private sector.

Problem: Lagging Behind the Private Sector. One reason why the FEHBP has done a poor job of controlling costs is that its plans have been slow to adopt cost-control techniques widely used by private employers, including utilization review and precertification for hospitalization. Only recently did Blue Cross begin PPO arrangements with doctors and hospitals.

Lessons for Reform. Despite glowing descriptions of the FEHBP by its defenders, the OPM, which manages the program, and other analysts both inside and outside of government have identified its many flaws. Instead of serving as a model for national health care reform, the FEHBP should reform itself.

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