

Lessons for Health Reform from the Federal Employees Health Benefits Program

Timely Analysis of Immediate Health Policy Issues

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Summary

The Federal Employees Health Benefits Program (FEHBP) has insured federal workers, dependents, and retirees for over half a century. Health reformers have seen many of its features as improvements over current health insurance arrangements, and most federal reform proposals include some version of an insurance purchasing "exchange," a way to offer insurance choices like those of the FEHBP to a broader population.

The FEHBP's central mechanism of enrollee choice among competing health plans is a popular way of providing access to health insurance. For its participants, the program has performed well, maintaining good benefits and wide choice of plan without fear of rejection or differential pricing by health status or age. Coverage is also portable across federal jobs and into retirement. For health plans, the FEHBP continues to be attractive enough to draw a large number of participants. Some HMOs have dropped out, evidently because of FEHBP's pricing policy, and once popular open-access fee-for-service plans have not survived because they attracted too many high-cost enrollees, which raised their premiums relative to competitors.

Politically, the program as a model for reform has appeal across the spectrum. Conservatives like the program's reliance on private health plans and market competition. Liberals like the prospect of expanding to everyone the FEHBP's large-employer-style benefits, community rating, and close oversight of insurer pricing. However, it does not seem to be wise simply to open the existing FEHBP to non-federal enrollment nor feasible to precisely replicate the FEHBP and its national approach outside the context of federal employment.

FEHBP experience suggests three main lessons for new reforms. First, selection issues can be severe and program altering. It seems very likely that stronger countermeasures will be needed for a new exchange than the FEHBP has as yet deployed. Second, it is challenging to maintain a wide spread of benefit packages for enrollees to choose among. Plausibly, better risk adjustment or other anti-selection mechanisms would assist in achieving this goal. Third, the FEHBP approach of negotiating with health plans and maintaining reserves that can be used to offset unexpected costs in a given year or temper year-to-year premium fluctuations is an alternative to direct public regulation of premiums.

Introduction

The Federal Employees Health Benefits Program (FEHBP) is the country's largest employer-sponsored insurance plan and has provided good coverage to millions of enrollees for over half a century. Each year, enrollees choose among many competing health plans, and the program has kept health plan participation high, administrative costs low, and

premiums affordable for federal workers and their families.¹

Politically, the program as a model for reform has long held appeal across the spectrum.²

Conservatives like the program's private health plans and its reliance on market competition rather than public controls to set benefits and dampen price increases. Liberals like the prospect of expanding to everyone the FEHBP's large-employer-style benefits,

community rating, and close oversight of insurer pricing. Barack Obama spoke approvingly of it during his campaign. He and others have signaled that reform should reflect similar principles,³ and some form of similar purchasing pool or "exchange" is part of many current proposals.⁴ It has also been suggested that health reform simply open the existing FEHBP for broader enrollment.⁵



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This brief suggests that FEHBP experience offers important insights about how to structure fair and effective health plan competition, an important component of the proposed health insurance exchanges. However, policy makers should not lose sight of the important differences between structuring and administering an employee benefits program and operating an insurance purchasing mechanism for a diverse set of people choosing to enroll from the general population. Moreover, it does not seem to be wise simply to open the existing FEHBP to non-federal enrollment nor feasible to precisely replicate the FEHBP and its national approach outside its current context of federal employment. Those operating a new exchange can still learn from FEHBP's experience, particularly about benefits design, selection and risk segmentation, and relations with participating health plans.

How the Federal Program Works

What are the FEHBP's key features?⁶ *Eligibility* extends to almost all federal civilian employees and retirees, as well as to their dependents.⁷ Enrollment occurs at time of hire and thereafter during annual open enrollment. Coverage is portable from federal job to federal job and, for national plans, across regions. Eligibility continues into retirement on the same basis as during employment. *Participating plans* include national fee-for-service plans (PPOs), location-specific health maintenance organizations (HMOs), and new high-deductible, consumer-

directed options. Nearly 300 plans participate nationwide, and dozens of plans serve areas with a high concentration of federal employment, like metropolitan Washington, DC. However, enrollees in less populous areas have far fewer choices, and some 9 states lack HMOs altogether.⁸

Benefit packages and premiums vary because they are developed by plans themselves, each seeking to attract enrollees. However, waiting periods and exclusions of pre-existing health conditions are not allowed. The Office of Personnel Management (OPM) must agree to benefit packages and prices each year, but does so through negotiation rather than mandates.⁹

Funding comes from premiums shared by enrollees and the federal employer. Each plan charges the same community-rated premium to all enrollees—regardless of age, sex, race, health, or work or retirement status—but different plans charge different rates. Fee-for-service plans set nationally uniform rates, but HMO premiums vary by location. Federal enrollees typically pay 25 percent of premium for lower priced plans, but a greater share for higher priced plans.¹⁰ Non-federal workers in group plans, on average, pay a similar premium share for family coverage, but less for individual coverage.¹¹

Price-sensitive competition among plans is the centerpiece of the FEHBP's structure, as enrollees choose among plans based on varying benefits and costs. Prices across FEHBP plans are driven by the mix of enrollees attracted, the precise benefits and provider

networks offered, cost-sharing requirements, and other provisions. Between premiums and cost sharing, enrollee costs can be substantial.¹² Enrollees must pay the full marginal premium difference when they chose a higher-priced plan.¹³ Insurers can then observe to what extent enrollees are willing to pay more, for example, to get easier access to more participating providers, and over time adjust their coverage offerings.

Administration of the program is split between the federal agencies where employees work and the OPM. The agencies, like large private employers, operate benefits offices to assist their employees' choice among plans; OPM enrolls retirees. OPM also contracts with participating health plans, oversees their premiums, limits administrative loadings, generates standardized information about participating plans, conducts annual open enrollment, and pays plans with premium contributions collected from agencies, employees, and retirees. OPM retains one percent of premium contributions as its administrative fee. It also withholds some three percent of each plan's premiums as a reserve that can offset a plan's losses in a year if actual medical claims spending exceeds projections, or alternatively may be applied to premiums in advance, to reduce an otherwise unusually large annual increase.¹⁴

Some 8 million people are now enrolled in FEHBP. Retirees are almost as numerous as workplace enrollees—a pattern that is very different than for private insurance. Over two thirds of enrollees select fee-for-service

(PPO) plans; about 31 percent choose HMOs. Almost half of enrollees are in the dominant Blue Cross Blue Shield plan, and about three quarters enroll in one of the five largest plans.¹⁵

Why the FEHBP Looks Attractive for Reform

The FEHBP's structured competition among community-rated insurers is popular. It is liked by politicians and federal employees and envied by many Americans who have access only to small group or non-group coverage. Part of what they envy is the FEHBP's lack of medical underwriting.¹⁶ Federal enrollees enjoy not only guaranteed access to coverage without waiting periods nor pre-existing condition exclusions, but also free choice among multiple plans during open enrollment each year, an opportunity often lacking even in large private workplaces.¹⁷ Moreover, the FEHBP's combination of competition and private choices with public oversight make its structure a plausible political middle ground between those favoring smaller and larger roles for government in health coverage.

FEHBP coverage has been kept affordable by a combination of public administration and price-conscious enrollee choice among competing private health plans. The most popular coverage, a PPO offered nationwide, costs much the same as average coverage among large private groups, while many FEHBP HMOs cost less.¹⁸ During the 1980s, annual FEHBP increases in premiums were below those of private plans, most of which in that era had not moved to

managed care.¹⁹ Since 1990, FEHBP increases have been similar to those in other group plans, according to the Government Accountability Office.²⁰

The program offers an alternative model of insurance regulation. FEHBP is exempt from state mandated benefits, and allows enrollee choice to determine what benefit levels prevail. Enrollee shopping and moderate program oversight have generated good, though not exceptional, benefits. Federal benefits fall a bit short of large private plans in actuarial value, and the employee share of premiums is often higher.²¹ Yet the FEHBP offers more choice among plans, and its benefit levels exceed those of most small employer groups or individuals buying on their own—insurance sectors that contain the bulk of people likely to be served by new plans under health reform. Some have promoted FEHBP—or a lookalike program—as the best approach.²²

Why It Is Difficult Simply to Open up the FEHBP or Replicate It for New Enrollees

Suggestions that the current FEHBP accept any American not satisfied with their current coverage imply that other forms of insurance and ways of obtaining it would remain unchanged.²³ This approach would threaten substantial adverse selection against the program, considerable disruption for current federal enrollees, and substantial premium burdens and cost sharing for unsubsidized new enrollees.

Moreover, OPM would face major administrative challenges in recruiting substantial new plan participation in most of the country as well as in relating to an unpredictable but large number of new individuals and employers who lack the common interests and fiscal ties created by employment. An open FEHBP would also raise issues of fairness, as new enrollees could be better subsidized than existing workers.²⁴ This approach has been opposed by some current federal enrollees and rejected by President Obama.²⁵

For many reasons, an FEHBP-like program—through a new exchange—would need to be designed and operate differently than the FEHBP. Design would need to change because the enrollee population would differ sharply from current enrollees, being more diverse in age, health needs, preferences, and income than today's FEHBP enrollees, notably with respect to abilities to meet the cost-sharing requirements of current plans. Operations would need to change to deal with new enrollees outside the context of large group employment and with health plans in direct competition with outside plans, including ones that might be run by entities with plans in the exchange. What changes would be appropriate depends on the exact scope of the new program, including eligibility, existence of mandates and other factors.²⁶ An FEHBP-like approach seems likely to become more like a free-standing exchange run at the state, regional, or national level than like the FEHBP, which is limited to federal enrollees.

Some Lessons of FEHBP Experience for New Exchanges

However a new insurance market is structured, its design and operations should recognize FEHBP experience. Several areas deserve highlighting: self-selection of enrollees into or out of the program, selection of enrollees across health plans within the program, the design of health care benefits, and relationships with participating health plans.

Adverse Selection of Enrollees into the Exchange

The FEHBP as constituted has not faced a substantial problem of selective enrollment into the FEHBP by employees or retirees. Some 85 percent of employees participate, about the same as in the private sector.²⁷ A large majority of those not enrolling are nonetheless insured, likely with another employer group that they find advantageous.²⁸ FEHBP's reasons for high participation are the same as for other large employers: Workers are eligible because they have been hired, not because they want health coverage. The employer makes available the benefits part of workers' pay only for group-plan enrollees. Federal law exempts premiums from tax only for employer-group enrollment. And enrollees' choices of benefits and of time of enrollment are constrained.

An FEHBP-like exchange, however, could alter incentives for enrollment among newly eligible people. The open enrollment and community rating of an exchange could incur some level of "adverse selection," or enrollment of above-

average risk people, who face higher prices or even rejection under traditional insurance practice outside of large groups. This situation could persist unless reform calls for everyone to buy insurance through the new exchange and requires insurers outside the exchange to follow the same rules as exchange insurers.²⁹ Enrolling people disadvantaged by current private insurance markets is a policy goal of reform, as older, sicker people are most in need of coverage. However, such enrollment raises the premiums of the new exchange's health plans that they join, which further increases the motivation for younger, healthier people to choose non-exchange insurance if it can offer better rates. Such adverse selection was visible among enrollees in the Massachusetts Connector, especially before the state's mandate for individuals to obtain coverage was fully implemented and enforced.³⁰

Some countermeasures are likely to be needed. The guidance from FEHBP experience is mainly to have any new exchange adapt methods that large employers use to boost broad-based participation. For example, one countermeasure is a mandate to buy insurance, which is certainly under policy discussion. Another is to provide subsidy or tax advantages only to coverage within the exchange, akin to employers contributing only for their own coverage. Another approach is greater regulation of private insurance, which is also under discussion—but somewhat incongruent with the competing desire to allow people to keep their current coverage if they like it.

Biased Selection among Participating Health Plans within an Exchange

Not only could an FEHBP-like exchange compete with other insurers, but the various participating exchange plans would also compete with one another. Under any multiple-choice system, one or more plans may disproportionately attract people who are older or sicker than average—for example, by offering easier access to specialists or other differences in benefits.³¹ Then such a plan must charge above-average premiums, which in turn encourages people whose premiums are now below average to leave, thus raising premiums for the remaining people, which drives away yet more people. Such recurring adverse selection can create a "death spiral" that makes the plan unsustainable, whether or not it provides better or more efficient care, given the particular mix of health risks within its enrolled population.³²

Historically, within the FEHBP, higher-cost enrollees have tended to cluster disproportionately within the fee-for-service plans.³³ Moreover, participating health plans have been found to differ from one another by much more in premiums than in the actuarial value of the benefits that they offer—a result consistent with risk segmentation across plans.³⁴ For practical observers, the most visible evidence from FEHBP has been that adverse selection drove out the Aetna indemnity plan in 1990 and the Blues high option plan in the early 2000s, both of which had been popular among older enrollees.

A key point to remember is that community rating does not keep all prices at average levels; it applies only within each plan. Cross-plan differences are driven heavily by the risk profile of enrollees—sixty year olds cost about six times as much as twenty year olds³⁵—as well as by benefit and provider payment structures and other factors. The introduction of new benefits in the form of consumer-directed, high-deductible plans seems to be changing the age distribution of enrollees selecting different plans.³⁶

Segmentation has recurred within FEHBP even though the program lacks many of the features of private insurance markets often cited as promoting selection.³⁷ There is completely open enrollment, FEHBP forbids underwriting by plans, no agents stand between applicants and insurers who may also effectively screen prospective enrollees, and the structured market lacks the kind of aggressive, for-profit insurers active in other insurance markets. Only comprehensive benefits are allowed, and the Office of Management and Budget (OMB) has sought to reduce benefit differentials over time. The structure of the federal contribution also reduces selection pressure because low-cost people cannot benefit from the full premium savings of a low-cost plan, nor do high-cost people pay the full cost of enrolling in a higher-cost plan.

Selection pressures might be greater within a new exchange than under the FEHBP, as people outside of large employer groups, including the uninsured, appear to be more diverse in health status

and income than federal workers and their families. Exchanges may need additional measures to maintain a relatively stable array of HMOs and fee-for-service plans. Such measures might include a high-risk pool, reinsurance, or risk-adjusted premiums that could help maintain the focus of competition as good value rather than attracting good risks.³⁸

Achieving Appropriate Benefit Levels

Several points about FEHBP's approach to benefits deserve emphasis. First, enrollees greatly value having a choice of plans even though all must have comprehensive benefits in the sense of covering the same broad range of service categories, from inpatient care to pharmaceuticals. Provider networks, premium shares, cost sharing, and many other features vary widely. Enrollees appear able to assess those choices with the help of substantial federal and private information about plans. Federal unions and others complain that FEHBP and its plans have over time tightened covered networks of providers and increased premium shares and cost sharing—but so have private employers and their plans.

Second, variation in benefits has the downside of fostering risk segmentation as well as “moral hazard,” increased consumption due to such things as enrollees' ability to shift plans when expecting certain types of health spending in a following year. As a class, enrollees in higher priced FEHBP plans show their willingness to pay for better access or other features because they face

the full marginal premium above the capped federal contribution.³⁹ This approach reduces the likelihood of “gold plated” benefits. It can be argued that benefits should be more standardized to promote price competition. How much benefits variation a new exchange would want to foster probably depends upon reformers' preferences among competing policy goals, as well as what other complementary provisions are also politically feasible. If there is robust risk adjustment for premiums, for example, wide variation in benefits may seem more appropriate.

Third, challenges may arise in using the FEHBP approach of valuing benefits through market-based choices if a large share of exchange enrollees cannot pay their own way. Explicitly tiered benefits for different income strata, as in Massachusetts, is one possible resolution.

Fourth, reformers may need to adjust political expectations. Many Americans believe that they should have the same benefits as their Congressmen, and perceive that high officials have wonderful benefits with easy access to any provider. As already noted, however, FEHBP plans are not more generous than large private employer plans. General impressions of FEHBP generosity are colored by years of news about presidential and congressional care at military hospitals or the Congressional health clinic, but the latter are separately funded and not part of FEHBP.⁴⁰

Another widespread misimpression is that the FEHBP offers low-cost care because the government is

such a large purchaser. FEHBP's size surely enables the program to attract participation from many health plans in areas of large federal employment, and its administrative provisions likely hold down that share of insurance costs. However, utilization and price of benefits have the largest impact on premiums, and it is not clear that FEHBP participation helps its health plans to lower prices they must pay to providers.⁴¹ Costs to consumers can be held down if they select a lower-premium plan with relatively low cost sharing, but the FEHBP itself does not exercise any public purchasing power vis à vis medical providers. It simply helps enrollees buy *private* insurance and is thus quite different from *public* coverage, such as a fee-for-service public plan like traditional Medicare or the proposed public plan option for health reform.⁴²

Finally, FEHBP-like reform as generally discussed is intended to be generous, but there may be grounds for concern about the intersection of benefit levels and selection. Existing federal benefits have evolved to serve a population that is older and has substantially higher incomes than the uninsured,⁴³ and as already noted, participating plans are expensive despite the administrative savings of FEHBP. Substantial premium subsidies might be needed to keep them affordable for the uninsured, of whom about 80 percent have incomes under 300 percent of the federal poverty level (the ceiling for subsidies in Massachusetts).⁴⁴ How affordable an FEHBP level of benefits would be depends heavily on the mix of new enrollees attracted, in terms of their age and

health status. The uninsured as a class are younger than federal enrollees but have a higher share of people who describe themselves as in fair or poor health.⁴⁵ The uncertainty about who will be attracted has implications for how the exchange relates to participating plans.

The FEHBP as a Model for Relationships with Participating Health Plans

The FEHBP's relationship with participating health plans differs from traditional state insurance regulation. Regulators may, for example, require insurance companies to include certain mandated benefits, to maintain minimum ratios of benefit payments to premiums, or to justify premium increases on some types of policies before selling them. The FEHBP operates more through contracts than through legal requirements, and its contracting is done more as negotiation than as formal bidding.

OPM's withholding of some three percent of each plan's premiums as a reserve protects plans from cost overruns due to actuarial underestimation, and can also be used to ease the year-to-year increase in premiums—thus avoiding the rapid price changes and churning of membership that seem to occur within small group markets, for example.⁴⁶ Even greater sharing of risk between participating plans and a public exchange might be appropriate in the early years of its operation, as that claims experience will be much less predictable than in a mature program.⁴⁷

It can be argued that FEHBP should be more assertive in

seeking lower prices, as the Massachusetts Connector has been, and its negotiation with plans might be enhanced by obtaining better information about plan costs or by doing more ex post auditing of claims experience. Instead, the traditional FEHBP approach relies more on enrollee choice to drive plans' benefit designs, provider payment levels, and other factors that influence premiums. Exactly how well FEHBP oversight has performed is not clear, but overall cost growth appears comparable to that of private plans. The FEHBP model itself might be modified, and it may already constitute an improvement upon public contracting methods used for Medicare Advantage, where there is great concern that the public is overpaying for benefits obtained.⁴⁸ This aspect of FEHBP operations merits more attention.

Finally, it appears that the FEHBP's mechanism of funding its central administration through a small percentage withhold from premiums is effective in maintaining steady funding, which is not subject to the periodic disruptions of legislative appropriations. Such independence seems good for program continuity, although it can also be seen as reducing accountability. The Massachusetts Connector adopted the same administrative funding mechanism, but with a much higher withholding percentage.⁴⁹

Conclusion

The FEHBP's central mechanism of well informed and motivated enrollee choice among competing health plans—structured or managed competition—is a sound

and very popular way of providing access to health insurance. Various existing and proposed reforms involve a similar insurance-purchasing “exchange.”

For its participants, the FEHBP has performed well, maintaining good benefits and wide choice of plan without fear of rejection or differential pricing by health status or age. Coverage is also portable. For health plans, the FEHBP continues to be attractive enough to draw active participation from many diverse firms. Some HMOs have dropped out, evidently because of FEHBP’s pricing

policy, and some formerly large open-access fee-for-service plans have failed because of adverse selection. For politicians, the FEHBP model appeals to political conservatives with its private health plans and competition and to liberals with its large-employer benefits, community rating, and oversight of insurers.⁵⁰

FEHBP experience suggests three main lessons for new reforms.

First, selection issues are serious and have over time altered program operations. It seems very likely that stronger countermeasures will be needed

for a new exchange than the FEHBP has as yet deployed. Second, it is a challenge, but so far feasible, to maintain a wide spread of benefit packages for enrollees to choose among. Plausibly, better risk adjustment or other anti-selection mechanisms would assist in this goal. Third, the FEHBP model of relating to health plans through negotiation and reducing the risk that plans take is an alternative to conventional public contracting or regulation. With modifications, it is worth further consideration as a model.

Notes

¹ Good descriptions of the FEHBP appear in Walton Francis and the Editors of Washington Consumers’ Checkbook magazine, *Checkbook’s 2009 Guide to Health Plans for Federal Employees* (editions appear annually) and Mark Merlis, *Opening the Federal Employees Health Benefits Program to Individual Purchasers*, report to DHHS/ASPE, July 31, 2001, <http://www.markmerlis.com/FEHBP.pdf>. This brief is based upon literature review and key informant interviews.

² Reform proposals inspired by the FEHBP go back at least as far as Alain C. Enthoven, “Consumer Choice Health Plan (part 2): A National Health Insurance Proposal Based on Regulated Competition in the Private Sector,” *New England Journal of Medicine* 298(13):709-720 (1978).

³ See the set of prominent 2009 proposals explained in Senate Finance Committee, *Description of Policy Options—Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*, May 14, 2009, <http://www.finance.senate.gov/sitepages/leg/LEG%202009/051109%20Health%20Care%20Description%20of%20Policy%20Options.pdf>, as well as the Kaiser Family Foundation’s frequently updated comparison of leading proposals, “Side-by-Side Comparison of Major Health Care Reform Proposals,” <http://www.kff.org/healthreform/sidebyside.cfm>.

⁴ See, for example, Linda J. Blumberg and Karen Pollitz, “Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals,” Washington, DC: The Urban Institute, Policy Brief, April 2009, <http://www.urban.org/publications/411877.html>, and Paul Fronstin and Murray N. Ross, “Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider,” Washington, DC: Employee Benefit Research Institute, EBRI brief no. 330, June 2009.

⁵ See, for example, Letter to the Editor, “Give Insurance like Congress Gets to All,” *Des Moines Register*, June 14, 2009, <http://www.desmoinesregister.com/article/20090614/OPINION04/906140319/-1/BUSINESS04>. As a formal proposal, this idea was more common in the 1990s than today, Robert Pear, “Health Care Debate to Shift To Federal Employees’ Plan,” *NY Times*, September 7, 1994, <http://www.nytimes.com/1994/09/07/us/health-care-debate-to-shift-to-federal-employees-plan.html>; Frank B. McArdle, “Opening up the Federal Employees Health Benefits Program,” *Health Affairs* 14(2):40-50 (1995); Eric B. Schnurer, “A Health-Care Plan Most of Us Could Buy: It’s Right under Congress’ Nose—Federal Employee Health Benefits Program,” *Washington Monthly*, April 1998.

⁶ The following description draws upon Francis, *Checkbook’s 2009 Guide* and Merlis, *Opening the FEHBP* (2001), and Office of Personnel Management, “Federal Employees Health Benefits Program,” undated but current web page, <http://www.opm.gov/insure/health/index.asp>.

⁷ Exceptions include temporary workers; for a full listing of eligibles, see OPM, “FEHBP” current web page, <http://www.opm.gov/insure/health/index.asp>.

⁸ Mark Merlis, *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform*, The Henry J. Kaiser Family Foundation, May 2003, <http://www.kff.org/medicare/6081-index.cfm>. Rural residents also face constrained choices under Medicare Advantage and private insurance.

⁹ GAO (US Government Accountability Office), *Federal Employees’ Health Plans: Premium Growth and OPM’s Role in Negotiating Benefits*, GAO-03-236, December 31, 2002, <http://www.gao.gov/new.items/d03236.pdf>.

¹⁰ Postal workers and some others have different federal contribution percentages.

¹¹ On average, private firms with three or more employees in 2008 contributed some 84 percent of premium for individual enrollees and 73 percent for family coverage. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2008 Annual Survey*, section 6, accessible from <http://ehbs.kff.org/>.

¹² For example, in Washington, DC, the enrollee share of family premium is now \$1,890 per year for the Kaiser-Permanente-DC low option plan and \$4,280 for the Blues plan, standard option; cost sharing requirements add additional expense for all plans. See Francis, *Checkbook's 2009 Guide*, pp.13 and 26. As noted in a recent news graphic, DC enrollees in the most popular plan must pay \$15,490 out of pocket themselves before they reach their plan's annual limit on cost sharing, Bonnie Berkowitz and Cristina Rivero, "For Federal Workers, Options Abound," *Washington Post*, July 24, 2009, <http://www.washingtonpost.com/wp-dyn/content/graphic/2009/07/24/GR2009072400096.html>.

¹³ Acting as an employer, the federal government contributes 75 percent of premium for lower-priced plans, but the federal share is capped at 72 percent of the weighted average of all plans' premiums, so that enrollees in higher-priced plans pay all of the cost above that level.

¹⁴ Drawdowns of reserves substantially reduced premium growth in 2006 and 2007; other years have seen additions to reserves. GAO, *Federal Employees Health Benefits Program: Premiums Continue to Rise, but Rate of Growth Has Recently Slowed*, GAO-07-141, December 2006, Fig. 4, <http://www.gao.gov/new.items/d07141.pdf>.

¹⁵ Merlis, *Medicare Reform* (2003).

¹⁶ Like the FEHBP, almost all very large employers bar medical underwriting in their health coverages. They can operate in this way because their employees typically constitute a good, stable risk pool (the young and healthy along with the older and less healthy) and because they structure their group plans to achieve high participation, so that few eligibles choose to buy elsewhere or go without coverage. See also the discussion below of selection issues.

¹⁷ Choice among plans is offered only by some 44% of large firms (200+ employees) and 14% of smaller firms (3-199 employees); overall, choice is available to some 51 percent of covered workers in both types of firm. Kaiser/HRET, *2008 Survey*, p. 67. Choice is a major reason for enrollee satisfaction, on which see statement of William E. Flynn III, Office of Personnel Management, Health Care Inflation and Its Impact on the Federal Employees Health Benefits Program, Hearing before the Subcommittee on the Civil Service and Agency Organization of the Committee on Government Reform House of Representatives, 107th Cong, 1st session, October 16, 2001, Serial No. 107-63, p.58.

¹⁸ Comparisons come from Francis, *Checkbook's 2009 Guide* and Kaiser/HRET, *2008 Survey*.

¹⁹ McArdle, "Opening up," (1995, covers experience of 1981-1993).

²⁰ Whether FEHBP increases are the same as, above, or below private increases depends upon the years chosen for comparison. See GAO, *Premium Growth and OPM's Role* (2002; Figure 1 covers 1991-2003); GAO, *Rate of Growth Has Recently Slowed* (2006; Figure 1 covers 1994-2007). Similar findings appear in Merlis, *Medicare Reform* (2003; Table 3 covers 1996-2003).

²¹ Beth C. Fuchs, "Increasing Health Insurance Coverage through an Extended Federal Employees Health Benefits Program," *Inquiry* 38(2):77-192 (2001); Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Congressional Research Service, no. R40491, Table 1, April 6, 2009, http://assets.opencrs.com/rpts/R40491_20090406.pdf.

²² Senator Bill Bradley's 2000 Democratic primary campaign promised to open the FEHBP to adults, and John Kerry's 2004 proposal would have created a parallel Congressional Health Plan based on FEHBP offerings, Sara R. Collins, Karen Davis, and Jeanne M. Lambrew, *Health Care Reform Returns to the National Agenda: 2004 Presidential Candidates' Proposals*, The Commonwealth Fund, October 2004. Currently, H.R. 2399, the American Health Benefits Program Act of 2009 would create a lookalike program for those ineligible for employer coverage. Senator Amy Klobuchar, D-Minn, campaigned to open access to the FEHBP <http://amyklobuchar.com/issues/health-care.html>.

²³ See the description in RAND, "Overview of Open Access to the Federal Employees Health Benefits Program (FEHBP) Policy Options," undated but current web page, http://www.randcompare.org/options/mechanism/open_enrollment_in_fehbp.

²⁴ In Massachusetts, family premiums above \$154 a month are deemed unaffordable at incomes below \$44,000, Commonwealth Health Insurance Connector Authority, Affordability Information Sheet, August 19, 2008, accessible from www.mahealthconnector.org. One popular low-price FEHBP family plan in Washington, DC, costs \$157 a month, Francis, *Checkbook's 2009 Guide*, and by Massachusetts standards would be unaffordable for new federal hires for 2008 in grades GS-1 through GS-8 in Washington, DC, assuming a single earner household, US Office of Personnel Management, 2008 Salary Tables and Related Information, Salary Table 2008-DCB <http://www.opm.gov/oca/08tables/pdf/saltbl.pdf>.

²⁵ The largest union, AFGE, opposes simple opening of the FEHBP, see American Federal Government Employees, "Federal Employees Health Benefits Program (FEHBP)," February 9, 2009 <http://www.afge.org/index.cfm?page=2009ConferenceIssuePapers&Fuse=Content&ContentID=1742>; this option was not under consideration by the Obama administration, according to Joe Davidson, "FEHB Likely to Be a Model, Not Expanded, Official Says," *Washington Post*, March 18, 2009; D04.

²⁶ For more detailed examinations of modifications needed, see Merlis, *Opening* (2001) and Fuchs, "Increasing Health Insurance" (2001).

²⁷ About 85 percent of eligible federal workers enroll in an offered plan, a slightly higher percentage than for other employees, according to Kaiser/HRET, *2008 Survey* (survey includes private and non-federal public employers with three or more workers).

²⁸ Only 5.6 percent of federal workers under age 65 were uninsured in 2006, according to Urban Institute Tabulations of the 2007 March supplement to the CPS, only 4.6 percent of workers plus dependents. Younger workers and low income workers were much more likely to be uninsured, and many may be part time or otherwise ineligible for FEHBP.

²⁹ Provisions that exacerbate or diminish selection pressure are discussed in American Academy of Actuaries, "Statement Submitted for the Record by Cori E. Uccello," hearing on "Health Reform in the 21st Century: Proposals to Reform the Health System," before the Committee on Ways and Means, U.S. House of Representatives, June 24, 2009, http://www.actuary.org/pdf/health/health_systems_june09.pdf.

³⁰ Massachusetts Health Insurance Connector Authority, *Report to the Massachusetts Legislature: Implementation of the Health Care Reform Law, Chapter 58, 2006-2008*, October 2, 2008, accessible from <http://www.mahealthconnector.org>.

³¹ Conversely, some plans may attract younger and healthier people. On these dynamics in general and within FEHBP, see, for example, Donna O. Farley and Barbara O. Wynn, *Exploration of Selection Bias Issues for the DoD Federal Employees Health Benefits Program Demonstration*, Santa Monica, CA: Rand Monograph Report for the Office of the Secretary of Defense, http://www.rand.org/pubs/monograph_reports/MR1482/.

³² *Ibid.*

³³ Ibid.

³⁴ Merlis, *Opening* (above note [1]).

³⁵ Unpublished communication from Actuarial Research Corporation (2008).

³⁶ GAO, *Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan*, GAO-06-143 (Washington, DC: Nov. 21, 2005); GAO, *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, GAO-06-271 (Washington, DC: Jan. 31, 2006).

³⁷ Statement of Mark A. Hall Before the U.S. Senate Committee on Finance, Hearing on “47 Million and Counting: Why the Health Care Marketplace Is Broken,” June 10, 2008, <http://finance.senate.gov/hearings/testimony/2008test/061008MHTest.pdf>.

³⁸ See Merlis, *Opening* (2001); American Academy of Actuaries, “Statement” (2009).

³⁹ The cap is 72 percent of the weighted average of all plans, as noted above.

⁴⁰ Typical among complaining articles is Adam Searing, “The Health Care Lawmakers Get,” *Raleigh (NC) News and Observer* (opinion), November 01, 2007, <http://www.newsobserver.com/opinion/columns/story/756340.html>. More recently, recognition has grown that the FEHBP offers good, but not “Cadillac plans,” as noted in John Fritze, “Lawmakers Get ‘Generous’ Health Plans,” *USA Today*, June 24, 2009, http://www.usatoday.com/news/washington/2009-06-23-congress-benefits_N.htm. See also Mark Z. Barabak and Faye Fiore, “Congress’ Own Health Care Benefits: Membership Has its Privileges,” *Los Angeles Times*, August, 2, 2009, <http://www.latimes.com/news/nationworld/nation/la-na-congress-benefits2-2009aug02.0.7524121.story>.

⁴¹ Even in the largest federal plan, Blue Cross, federal enrollees constitute only a very small percentage of total enrollment and likely could increase the insurer’s purchasing power only in a very high-federal-enrollment area like metropolitan Washington, DC. GAO has found that prices paid by FEHBP PPOs are heavily influenced by the market competition and the presence of capitated HMOs. US GAO, *Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*, GAO-05-856, August 2005.

⁴² John Holahan and Linda J. Blumberg, “Is the Public Plan Option a Necessary Part of Health Reform?” Urban Institute Research Report, June 26, 2009, <http://www.urban.org/url.cfm?ID=411915>.

⁴³ Almost 64 percent of federal employee households have incomes of at least 400 percent of the federal poverty line, compared with 11 percent of the uninsured, according to 2008 Urban Institute tabulations of the 2007 March supplement to the CPS (unpublished).

⁴⁴ Ibid.

⁴⁵ Over ten percent of the uninsured are in fair or poor health, compared with under five percent of insured federal workers and dependents. UI analysis of 2007 March supplement to CPS, above.

⁴⁶ See, for example, Milt Freudenheim, “Small Businesses’ Premiums Soar After Illness,” *New York Times*, May 5, 2007, <http://www.nytimes.com/2007/05/05/business/05insure.html>.

⁴⁷ Many states shared risk with early Medicaid managed care plans, Amy W. Lutzky and Randall R. Bovbjerg, *The Role of Reinsurance in Medicaid Managed Care* Princeton, NJ: Center for Health Care Strategies, Inc., October 2003, http://www.chcs.org/usr_doc/reinsurance.pdf. The Massachusetts Connector also initially shared risk with its managed care plans under Commonwealth Care, a special set of coverages for enrollees with incomes of 300 percent or less of the federal poverty level, Massachusetts Connector, *Report* (2008).

⁴⁸ MedPAC (Medicare Payment Advisory Commission), *Report to the Congress: Promoting Greater Efficiency in Medicare* (chapt. 3), June 2007, http://www.medpac.gov/documents/Jun07_Entire_Report.pdf.

⁴⁹ Massachusetts Connector, *Report* (2008); the Connector, however, must cover enrollment-related FEHBP administrative expenses not covered by OPM but by employing agencies.

⁵⁰ An important supporting point here is that an exchange is an operational mechanism that can serve varied political goals. The model is not inherently liberal or conservative. An exchange’s accompanying reform provisions—about eligibility, benefits, subsidy, and regulation—can reflect different political orientations. An exchange can primarily facilitate universal coverage reform with a very large government role, as the Connector does within Massachusetts’ 2006 statute that features sizeable public subsidies, open enrollment and full community rating, as well as mandates on insurers, individuals, and employers. See Massachusetts Connector, *Report* (2008). Alternatively, an exchange can instead serve the goals of enhancing personal responsibility and cost containment with a limited public role. Under Utah’s less publicized 2009 legislation, still being implemented, a new “internet portal” is to help purchasers, especially low-wage workers, connect with competing private insurance plans that are to offer guaranteed issue of portable coverage, with adjusted community rating, and redesigned, lower-cost benefits exempt from traditional state mandates. See Norman Thurston, “Utah’s Approach to Health System Reform,” in *Policy Perspectives*, periodical from the Center for Public Policy & Administration, University of Utah, vol. 5, iss. 3, March 25, 2009, http://www.imakenews.com/cppa/e_article001383109.cfm, and State of Utah, “Utah’s Approach to Health Systems Reform,” undated but current web page, http://goed.utah.gov/site-media/page-media/files/Utahs_Approach_to_Health_System_Reform_final.pdf (accessible from web page of the Office of Consumer Health Services).

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