Appendix C.— Federal Employees Health Benefits Program

Introduction

Shortcomings in the medical care marketplace have become major policy issues of the last decade. A somewhat variegated landscape of "procompetitive" proposals have emerged as possible solutions to the perceived problems of the industry. But these proposals have been complicated by debate and disagreement over the likely feasibility and results to be expected from implementation of the various policy options. To some extent, the lack of consensus has stemmed from lack of experience with competitive-type plans (106).

One plan which might elucidate current policy discussions is the Federal Employees Health Benefits Program (FEHBP), which provides one of the few operational experiences with a competitive-type approach. For over 20 years, FEHBP has provided Federal employees and annuitants with an annual choice among a range of health insurance alternatives and plans. Because of its design, FEHBP experience has, somewhat ironically, generated interest among both proponents of the recent procompetitive proposals and advocates of the universal health insurance proposals of the early and mid-1970's, Competition advocates, such as Enthoven and others, suggest that the 20 years of FEHBP experience have demonstrated both effectiveness and remarkable administrative simplicity, and that its potential as a model for procompetitive strategies should not be overlooked (79).

Similarly, others a decade ago hailed FEHBP as "a viable model for the implementation of universal health insurance in the country, accommodating the aspirations of the providers of services and the recipients of services within politically tolerable cost limits" (2). On the other hand, the critics of procompetitive proposals have used FEHBP experience to warn that multiple choice of plans will not lead to enhanced competition, or that if it does, the competition will occur at the expense of creating other problems, such as "free-riding," cream-skimming, or adverse selection (19,106).

This appendix synthesizes existing research and evidence on the history, structure, and experience of FEHBP. Information has been gathered from published and unpublished sources, as well as from several discussions and interviews with individuals previously or presently connected with the program. The appendix should be read especially from the perspective of the major impact areas of the overall study: 1) utilization of medical technologies, 2) quality assurance, and 3) information availability and consumer choice.

History and Structure of FEHBP

FEI+3P was considered by Congress for **12** years. First introduced in **1947,** the program was established by the Federal Employees Health Benefits Act (Public Law 86-382) in September 1959, and went into operation on July 1, **1960.** Enrollment was (and remains) voluntary and initially covered 1.7 million enrollees and **3.7** million dependents (198).

The initial rationale for FEHBP was the attempt by the Federal Government to retain competent people in its employment. By 1950, it was considered a normal part of the operation of private industry for the employer to pay some or all of the health insurance premiums of employees. Health insurance benefits became a regular part of the fringe benefits package along with disability and retirement pensions. Private industry and organized labor became the backbone of the financing of health insurance in this country. Although it has been the largest single employer in the country, the Federal Government began paying for health insurance premiums for its employees after it became common for private industry to do so (2,120). The bill, then, was designed to "close the gap" which existed and bring the Government abreast of most private employers. *

The Civil Service Commission (CSC) was originally partial to an indemnity plan, one basic type that could be let out for bids to private insurance companies and simplify administration. Despite the commission's wariness of unlimited choice of health insurance benefit packages and delivery methods, vested insurance interests who had thousands of Government employees on their rolls convinced Congress of the need for different plans ***(2,120).*** As a result, FEHBP finally authorized a wide range of choice of plans by all employees and was, in effect, a negotiated compromise among many divergent and highly organized interests.

It was the only approach which at any time during the 12-year legislative process gained acceptance by all of the principals: the American Medical Association, Blue Cross/Blue Shield, insurance companies, employee unions, group prepayment plans, and individual practice plans. As a result, the Federal

● **U.S. House of Representatives,** *United States Code: Congressional and Administrative News* **(St. Paul,** Minn.: **West Publishing Co, Aug. 20,** 1959).

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Employees Health Benefits Act has permitted all types of health benefits plans—service, indemnity, group practice, and individual practice—and various intermixtures of these types to continue development along their own individual lines (234).

With the passage of the act, a "task force" approach was taken to transfer legislation into implementation over a brief 10-month span. Individual task force members were drawn from a broad range of backgrounds and affiliations, and placed within the Retirement Bureau of CSC. Interestingly, the Department of Health, Education, and Welfare (DHEW)* argued the program would be better placed within its own organizational walls, but there was a deliberate congressional decision to define the program not as a health care program but as an employee benefit program (120).

Over the 10 months, regulations were written, carriers selected and approved, and FEHBP generally operationalized (120). In the final negotiations with the carriers, four basic types of approved plans emerged within each of which there were "low" and "high" options (2,198):

1. Contracts with two ***Government-wide plans,*** open to all employees. One was a service benefit contract with Blue Cross/Blue Shield for basic coverage plus a major medical plan for high-cost episodes with a deductible and ceilings. The other was an indemnity contract with Aetna, a private insurance company, for basic and major medical insurance with deductibles, coinsurance, and ceilings.
2. Contracts with 13 separate ***employee*** *organization plans* for coverage analogous to the indemnity contract and hence of the same type.
3. **Contracts with eight separate** *individual practice plans,* open only to those residing in the covered area and providing direct payment to participating physicians and hospitals. These contracts differed from the Blue Cross/Blue Shield service contract only in that they covered all physician services in- and out-of-hospital, with very modest charges at times of services, as well as hospital services.
4. Contracts with 13 separate ***prepaid group practice plans*** with salaried doctors and comprehensive physician services regardless of site of service plus hospital service. Again, these plans were open only to those residing in the covered area.

These four basic categories of health insurance are still provided today, and with more than 9.2 million Federal employees, annuitants and their dependents have an annual choice among a range of over **120** private health plans. Each participant has access to two Government-wide plans: Blue Cross/Blue Shield, and Aetna, plans which provide, respectively, service benefits and indemnity benefits coverage, each with a high and low option. Depending on geographical location and affiliation, participants can also choose from 20 employee organization plans. (Established by various unions and employee associations, these insurance plans vary in availability. Some are available only to members, while most are available to all employees, either on an unrestricted basis or on the basis of payment of annual association dues which typically range from $25 to $35.) As many as six group practice plans and individual practice associations can be found as well, depending on one's area of residence (106).

The authorizing provisions of the Federal Employees Health Benefits Act established what were perceived in 1959 as "significant" requirements and minimum standards for participating plans **(120).** All plans must: cover a range of benefits; offer conversion privileges; enroll without regard to age, health status or hazardous employment; provide coverage without regard to waiting periods or exclusions for most preexisting conditions; and cover care regardless of geographic location, Participating plans are required to establish reserves and report statistics to the administering Government agency. Plans are required to establish a rate structure with a single individual and a single family for each option and rate. No plan may offer more than two options (e.g., high, low) (106).

As employer, the Federal Government's contribution was originally fixed by law at one-half the cost of the least expensive option offered by either one of the two Government-wide plans. However, the marked preference by employees in the early years for high-option enrollments steadily reduced the percentage of total premium contributed by the Government. Between 1961 and 1970, the Government contribution slipped from 38 percent to 24 percent of the average total premium (234,259).

In the 1970's, the Federal Employees Health Benefits Act was amended more than once to allow the Government to contribute a fixed dollar amount based on specified cost-sharing ratios. The Government now contributes a fixed dollar amount equal to 60 percent of the average premium cost for the six largest plans, subject to the restriction that the total Government contribution cannot exceed 75 percent of the premium of any plan. For postal workers, the Government contributes 75 percent of the average, subject to a 93.75 percent limit. In 1981, the annual maximum Government contribution for nonpostal worker participants

● NOW the Department of Health and Human Services (DHHS).

was $366 and $796, respectively, for individual and family plans (198).

Participants make their choices upon entering employment and are eligible to change plans whenever their status changes (e.g., upon marriage) or certain other changes occur (e.g., a move makes use of an HMO plan infeasible or the enrollee is terminated by an employee plan). Each participant may also switch plans once a year on an unrestricted basis.

During this "open season" period, employees and annuitants are provided with comparative information on the coming year's benefits and rates for each available plan. Changes can be initiated by completion of a brief form; those who do nothing remain enrolled in their previous plan. Participation is voluntary and no person may be covered by two plans. If both members of a married couple are Federal employees, each may join an individual plan but they jointly may choose only one family plan.

FEHBP is today administered by the Office of Personnel Management (OPM), the organizational descendant of CSC. In addition, OPM determines the plans qualified to participate, handles grievances and complaints, negotiates rates, and disseminates information on each plan (106). The program is authorized by a mere 8 pages of legislative language and approximately 13 pages of regulations.

Enthoven (79) and others have lauded the relative legislative simplicity and administrative efficiency of the Federal Employees Health Benefits Act, especially when compared with another Federal program, Medicare, with its legislation of 142 pages and accompanying 400 pages of regulations. A study by Hsiao (124) also found that Federal administrative expenses per unit of output (i. e., number of claims processed) were less under FEHBP than under Medicare.

Competition Within FEHBP

A recent study (106) produced by the Department of Health and Human Services suggests that some amount of competition exists within FEHBP. This is reflected most prominently in the shift by FEHBP enrollees from Government-wide plans to employee organization plans and, to a lesser extent, health maintenance organizations (HMOS). In the past 5 years in particular, enrollees appear to have selected a wider group of plans. The choices also appear sensitive to shifts in the relative premium prices across the plans. The following discussion draws from this study,

FEHBP Differences From Proposals To Increase Competition

The design of FEHBP obviously dictates the limits on what can be learned from FEHBP experience. While the program incorporates several features which are included in proposals to increase competition, it does not contain all the features of the various procompetition alternatives. For example, while FEHBP provides for multiple choice among plans, the employer contribution varies across plans, and no rebate is provided to encourage choice of low-cost plans.

Discrepancies between FEHBP and the various competitive models need to be considered and are discussed below. The analysis suggests that FEHBP experience is most relevant to competition proposals that focus on the provider side and stress competition among plans with similar benefit scope and least relevant to proposals that stress use of tax and rebate incentives to promote low-cost, low-benefit coverage.

VARIATION IN BENEFIT RANGE ACROSS PLANS IS LIMITED

The plans offered within FEHBP tend to have comprehensive benefits. Even for those plans marketed as low-option, the amount of cost sharing is limited. For example, the 1981 Blue Cross/Blue Shield low-option plan pays 100 percent of covered hospital charges for the first 90 days of confinement and 75 percent of charges for later hospital days, physician visits, prescription drugs and other supplementary services; and 60 percent of mental health outpatient care up to a lifetime maximum benefit of $50,000. * Surgical procedures, in-hospital visits, and diagnostic tests are reimbursed in full up to a schedule of allowances and thereafter at 75 percent. There is a $200 deductible for supplementary services ($400 maximum per family) and a $2,000 catastrophic limit on services other than mental health services.

In 1980, 71 percent of all low-option enrollees were in the low-option Blue Cross/Blue Shield plan, 27 percent were in Aetna, and the remaining few were in two employee plans (Postmaster, Mailhandlers) and one HMO (Group Health Association (GHA) of Washington, D.C.).

While plans tend to cover a comprehensive range of services, the structure of the benefits offered by the

● Ordy recently have these benefits been changed. See section entitled "Current Problems of FEHBP" for a discussion of these changes.

different plans included within FEHBP varies. The greatest variation arises as a result of differences in coverageformental health and dental services. However, the plans also vary in the structure of the cost sharing they impose on various covered services, the use of a catastrophic cap or limit, and the types of other benefit restrictions or exclusions used. For example, the employee-based Government Employees Health Association (GEHA) plan emphasizes extensive first-dollar coverage combined with some copayment on hospital care and a low catastrophic limit. The Postmaster's high-option plan restricts reimbursement for outpatient and ambulatory care but includes an extensive dental benefit.

All federally qualified HMOS also may participate in FEHBP. Over 100 have elected to do so. The inclusion of a large number of HMOS within the FEHBP system also results in a range of plan choice, including choices involving group and individual practice organizations.

Because FEHBP does not emphasize plans with extensive cost sharing, the experience of the program does not provide a good indication of the relative popularity of these plans. Alternative FEHBP plans, however, do **vary** in structure of their benefits. For this reason, it is possible to use FEHBP experience to examine enrollment choice among multiple plans with extensive benefits. It is also possible to use the experience to consider choices between traditional insurance plans and HMOS.

FINANCIAL INCENTIVES TO BE COST CONSCIOUS ARE CONSTRAINED

FEHBP provides an incentive for participants to consider cost in selecting plans. Except for postal workers, each employee or annuitant who decides to enroll pays a minimum of 25 percent of the premium cost for the plan selected, and given the methods used to compute the employer contribution, employees may pay as much as 50 percent of the premium. * This situation differs substantially from private industry, where nearly three-quarters of all workers have health plans totally financed by their employer and just over half receive coverage for their dependents without cost ***(30).***

Table C-1 provides a summary of the cost incentives built into FEHBP, focusing on a selected number of high-volume plans. As can be seen, the total premium cost varies substantially by plan.**

Differences in premium rates lead to substantial variation in the required employee contribution for the various plans. The most consistent differences are between the high- and low-option versions of the Government-wide plans in which high option enrollees pay from $20 to $600 more per year than those enrolled in low-option plans. Substantial differences also exist between the high-option versions of the Govemment-wide plans and several of the other plans offered. For example, GEHA enrollees pay from $257 (individual) to $522 (family) less per year than those enrolled in Blue Cross/Blue Shield high option. Given these statistics, the financial incentives to consider cost in selecting plans within FEHBP would appear substantial. *

Two provisions of FEHBP constrain the size of the financial incentives built into the system and the impact of these incentives. The first is the cap on the employer contribution at 75 percent. Persons enrolling in lower cost plans forego a portion of the potential Federal contribution to their premium. This raises the cost of these plans to the individual and reduces the difference in price between competing plans. It also reduces the incentive for sponsoring organizations to develop low-option or low-cost plans within FEHBP.

At present, the capon employer contribution affects most of the Government-wide low-option plans, whose enrollees must pay $64 to $197 that would otherwise be paid for by the Government. The full impact of the cap on employer contribution is difficult to evaluate because of its potential effect on the types of plans offered.

The second constraint on the financial incentives included in FEHBP arises because the program provides no rebate for those choosing plans where the Federal contribution is below the maximum allowed. As with the cap on employer contribution, this affects most those who choose low-option plans and therefore forego $146 to $369 of the potential maximum Federal contribution. Thus, both the cap on employer contribution and the lack of a rebate reduce incentives within FEHBP to choose or market low-option plans.

CROSS SUBSIDIES DISTORT CHOICE TO SOME EXTENT

Within FEHBP, a single premium rate is established for each option (high/low) and membership category

● Employees enrolled in Blue Cross/Blue Shield high-option plans pay 46 to 50 percent premium cost because the plan has a total premium which is greater than the average premium used in computing the Federal employee contribution. As indicated previously, cost sharing on the premium is lower for postal workers than for others. Postal workers pay from 6.25 to 35 percent of the premium cost for the plan.

●● It is interesting to note that this occurs despite a generally similar scope of benefits across many of the plans. However, premium price should not be used to provide a measure of relative actuarial value across plans. Aside from HMOs (which with the exception of Group Health Association are community-rated), FEHBP plans are experience-rated. The premium reflects the utilization experience of persons electing to enroll, as well as the scope of benefits offered.

● It is possible that enrollees consider the per pay period cost rather than the yearly cost in determining which plan to select. While these two costs may be similar economically, the psychological impact may be greater when expressed as a yearly figure. If true, the financial incentives built into FEHBP may be less than they appear, since employees may not be consciously aware of the magnitude of the cost differentials between plans.

Table C-1.—Cost Incentives in the FEHBP Allocation of Premiums Between Government and Employee by Plan, 1981

Plan[a]	Individual plan				Family plan			
	Total premium	Employee contribution per year[b]	Equal employer contribution shortfall	Amount foregone by 750/0 cap[d]	Total premium	Employee contribution per year[b]	Equal employer contribution shortfall	Amount foregone by 750/0 cap[d]
Blue Cross—high option	$781	.$366		$203	$1,720	$794		
Blue Cross—low option	256	64	$203		745	186	$369	$186
Aetna—high option	660	264	0	0	1,319	393	o	0
Aetna—low option	333	83	146	63	786	197	337	197
American Federation of Government Employees	614	219	0	0	1,342	415	0	0
Alliance Health Benefit Plan	618	222	0	0	1,516	589	0	0
American Postal Workers Union	657	262	0	0	1,589	662	0	0
Government Employees Benefit Association	635	239	0	0	1,692	765	0	0
Government Employees Hospital Association	517	129	7	7	1,089	272	110	110
Mail handlers—high option	432	108	71	71	1,188	297	36	36
Mail handlers—low option	332	83	146	63	934	233	226	226
National Association of Letter Carriers	663	288	0	0	1,436	708	0	0
California—lNA	701	306	0	0	1,758	832	0	0
California Kaiser (N)	514	128	10	10	1,309	382	0	0
California Kaiser (S)	660	264	0	0	1,694	690	0	0
D.C. GHA—high option	754	359	0	0	1,921	995	0	0
GHA—low option	538	142	0	0	1,445	518	0	0
Kaiser Georgetown	701	306	0	0	1,770	843	0	0
George Washington University	707	312	0	0	1,828	901	0	0

[a] This is a partial list of all plans within FEHBP.
[b] Employee contributions refer t. nonpostal workers only. The premiums and financial requirements for annuitants are identical to those for employees in FEHBP.
[c] In 1981 th, Federal Government paid a maximum of $395.46 for an individual plan and $926.64 for a family plan for workers other than postal workers. This figure reflects the difference between this amount and the amount of the actual Federal contribution to the indicated plan.
[d] This reflects th, amount of Federal contribution for the indicated plan which was lost because of the 75 percent cap on maximum employer contribution. The figure reflects the contribution necessary to eliminate any employee contribution or obtain the maximum Federal contribution, whichever is less.

SOURCE: M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D. C., November 1981.

(individual/family) within each plan. HMOS establish their premiums using community rating principles. Other plans use experience rating. Under experience rating, the premium is a function of the benefits provided, the use of those benefits given the characteristics of those enrolled, and the reimbursement made for the services used. This method of rate-setting may make it more attractive for certain kinds of individuals to join some plans than others. For example, older persons more likely to have high expenditures may favor more generous benefit plans, as their expected value per premium dollar is lower than younger members'.

Aside from these obvious adverse selection concerns, one possible effect is that joining HMOS becomes less attractive for persons residing in high-cost cities. Such organizations are geographically based, with rates that reflect the costs of medical care in those communities. In contrast, Government-wide and similarly dispersed membership plans have rates which reflect the average experience across both high- and low-cost areas. Because of its diverse functions (e.g., postal service, social security), the Federal work force is dispersed throughout the Nation as well as abroad.

In 1978, only 13 percent of the paid civilian work force was in the D.C, area. About half of the work force was located either in D.C. or in one of the 10 States with Federal regional offices (57). The influence of geographic location on premium levels for various plans cannot be examined without considerably more analysis. HMOS appear to have kept their rates competitive with those of Blue Cross/Blue Shield (see table C-1). Whether they have done so by reducing the actuarial value of the benefits cannot be determined, however.

Some suggest that the low-option Government-wide plans subsidize the high-option plans, which would enhance the popularity of the latter by reducing premium cost relative to actuarial benefits. Data on the recent experience with the Government-wide plans within FEHBP as shown in table C-2 do not support this argument. Since 1974, the payout ratio (i.e., benefit costs as a percentage of subscription income) has been lower for Blue Cross/Blue Shield high-option plans

Table C-2.—FEHBP Benefit Costs as a Percentage of Subscription income by Plan and Option: Government=wide Plans, 1963-77 (selected years)

Plan and option	November 1963-October 1964	Year									
		1967	1969	1970	1972	1974	1975	1976	1977	1978	1979
Blue Cress/Blue Shield											
High option	107.2	92.6	99.1	105.4	86.6	93.9	97,2	85.7	88.6	87.3	98.9
Low option	73.1	63.1	66.4	84.4	81.6	117.8	136.2	136.8	127.4	120.0	109.5
Aetna											
High option	110.3	101.5	86.4	91.8	92.2	104.6	103.6	77.1	95.4	92.4	104.1
Low option	84.2	108.8	97.9	99.4	91.5	96.7	98.2	78.9	97.8	101.1	111.7

SOURCE: M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D. C., November 1981.

than for low-option plans. Aetna has experienced similar patterns since 1976.

USE OF LOW-OPTION PLANS BY ANNUITANTS MAKES FEHBP LOW-OPTION EXPERIENCE ATYPICAL

Many annuitants use the low-option FEHBP plans to supplement Medicare benefits. Although changes have been proposed, Medicare is the first payer under present coordination of the FEHBP benefits provisions, as it is with private insurance. Because this arrangement reduces expected plan expenditures, the Government-wide plans and others have elected not to charge individuals with Medicare coverage for deductibles or copayments. Many annuitants choose the low-option Government-wide plans as the equivalent of insurance to supplement Medicare coverage. OPM has encouraged this practice. This circumstance makes analysis of the low-option FEHBP plans difficult and detracts from its utility. *

AVAILABLE INFORMATION AND CONSUMER CHOICE HAVE BEEN LIMITED

This will be discussed in the section entitled "Information Dissemination and Consumer Choice. "

Trends in Plan Choice

Figure C-1 presents the distribution of enrollment by type of plan. Over the past 10 years, the share of the FEHBP market held by the Government-wide plans has dropped substantially, with sizable gains for employee plans and, to a lesser extent, comprehensive plans (e.g., HMOS).

From 1970 to 1980, the Blue Cross / Blue Shield market share dropped from 60 to 51 percent. Most of the decline occurred in the past 5 years. Aetna experienced a 5-percent decline in market share, from 18 to 13 percent, generally spread over the 10-year period. In contrast, employee plan enrollment has grown by 75 percent, group practice enrollment by 50 percent, and individual practice enrollment by 40 percent. By 1980, the Government-wide plans held about two-thirds of the market, with employee plans holding about a quarter, and the HMO plans (mainly group practice plans) the rest. The shift away from Blue Cross / Blue Shield occurred at the same time as Blue Cross / Blue Shield's rates increased.

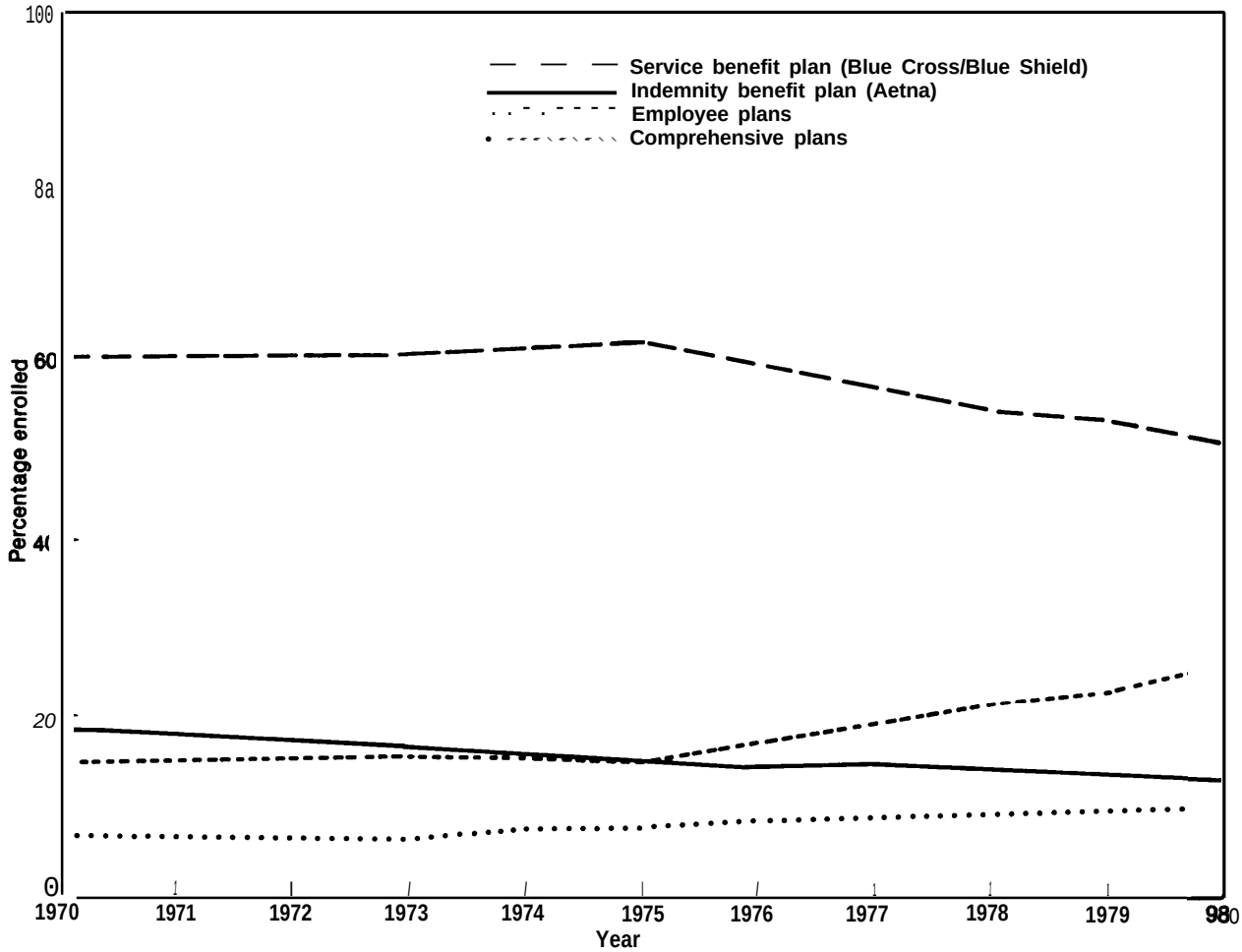
Figure C-Z shows graphically the shift in Blue Cross / Blue Shield enrollment in comparison with the change in premium charges. It shows that the largest decreases in enrollment followed a large 1976 rate increase for Blue Cross / Blue Shield. The statistics in figures C-1 and C-2 suggest that over the past 5 years, competition among FEHBP plans for enrollees has increased, with some competition apparently sensitive to price.

In comparison, the selection of low-option plans has remained relatively stable over time, as shown in figure C-3. Enrollment in low-option plans is limited to about 12 percent of the total FEHBP market. Low-option plan penetration has remained relatively stable for the past 5 years after a decline in the early 1970's. An increased proportion of low-option plan enrollees hold Blue Cross / Blue Shield low-option policies. This group now represents 17 percent of the total Blue Cross / Blue Shield enrollment and an increasing proportion of total FEHBP enrollment.

The data presented also bear on the relative popularity of HMOS and their likely role in a competitive environment. In 1980, HMOS held 10 percent of the FEHBP market. About three-quarters of the HMO enrollees were in group plans. Whether this reflects a small or large penetration is difficult to determine from available data, which merge effects based on consumer choice with those responding to the available supply. HMOS, particularly group HMOS, tend to be located in large cities. Federal employees are geographically dispersed, resulting in only a portion of FEHBP enroll-

● The number of individuals enrolled in low-option plans is limited to 442,800 contract holders in total. For meaningful analysis, one should omit or analyze separately the employee from the annuitant group. This further reduces the size of the low-option experience and makes difficult any analysis with refined breakdowns or consideration of rare events (e.g., catastrophic care).

Figure C.l.—Percentage of FEHBP Enrollment by Type of Plan, 1970-80



SOURCE: FEHBP Program Statistics-OPM, as cited in M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evacuation, Department of Health and Human Services, Washington, D.C, November 1981

ment's having access to HMO-type plans. Because of these considerations, the FEHBP experience provides a better measure of the likely penetration of HMOS in the total U.S. than in particular local markets.

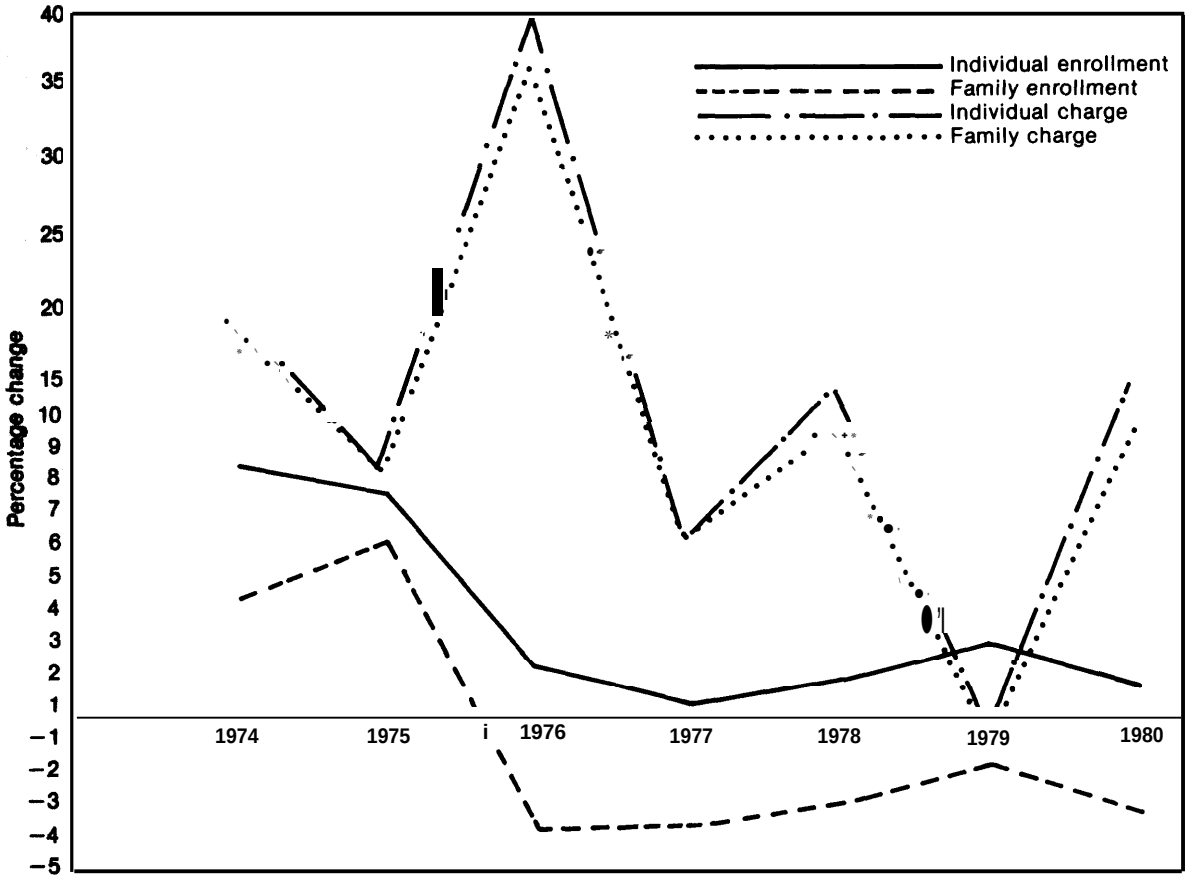
Patterns in Selection and Utilization of Services

Comparison by Types of Plans

There have been few studies comparing patterns in selection among the general types of FEHBP plans and the subsequent utilization of services by enrollees. The earliest study was undertaken by Perrott (219), who looked at the hospital experience of Federal employees covered under the four broad types of insurance plans for the period of 1960 through 1963. The data generally showed a relatively low rate of hospital utilization among individuals insured in the prepaid group practice plans. Perrott's analysis showed that members enrolled in prepaid group practice plans, both options, during the second contract year (1961-62) used 454 nonmaternity hospital days per 1,000 persons covered, as compared with 826 days for Blue Cross/Blue Shield, 729 for employee organization plans, 708 for Government-wide indemnity plans, and 538 for individual practice plans.

The two Government-wide programs combined (Blue Cross/Blue Shield and Aetna) showed a hospital

Figure C-2.—Percentage Change in FEHBP Enrollment and Biweekly Subscription Charge: Blue Cross/Blue Shield High-Option Plan Individual and Family, 1973=80



SOURCE: FEHBP Program Statistics-OPM, as cited in M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D. C., November 1981.

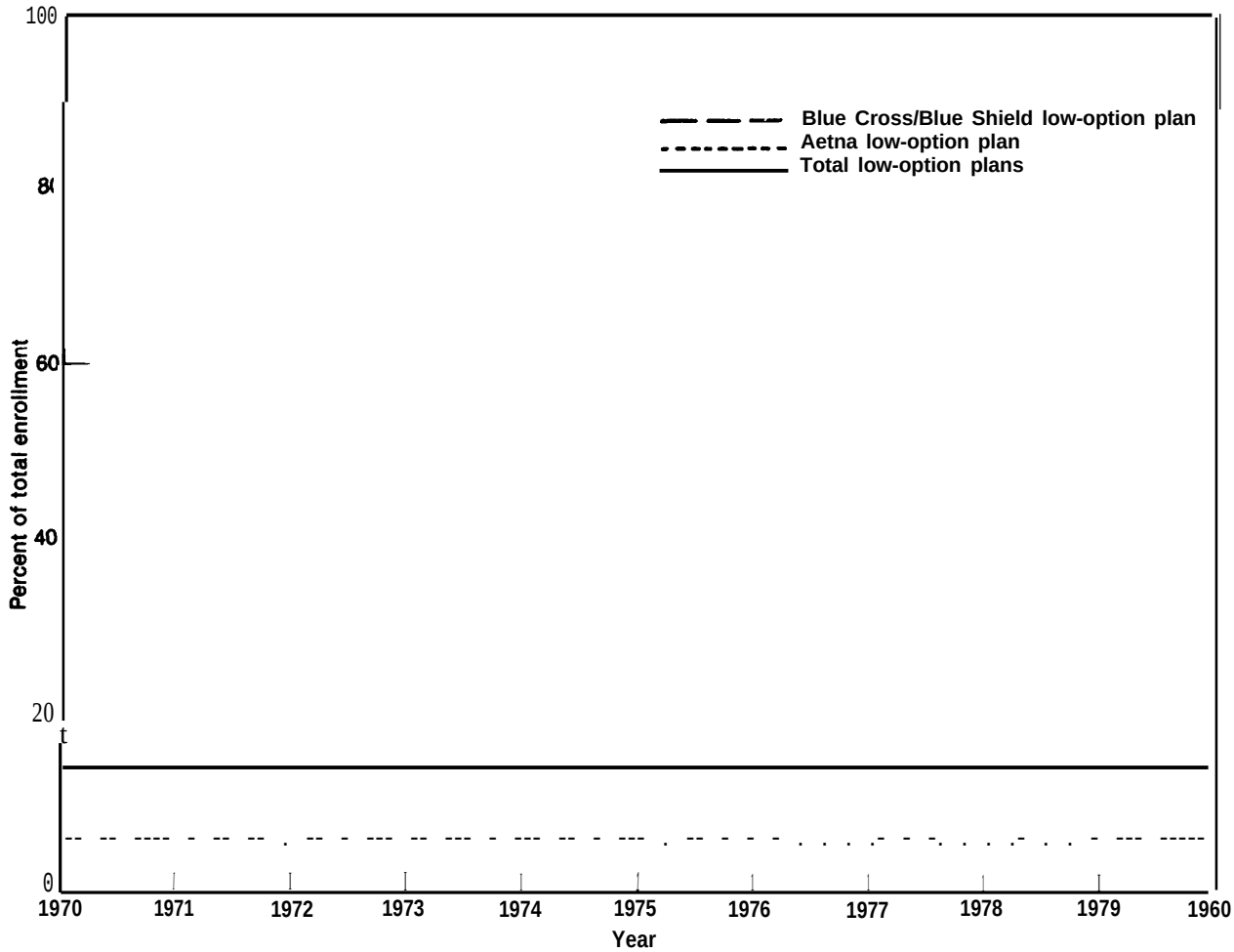
utilization of 791 days for 1,000 persons, or nearly 75 percent higher than the group practice plans (219). While there was some variation from year to year, the same relation held for the other two contract periods (1960-61 and 1962-63) examined. Adjustments for geographical region and then for age exhibited the same patterns of use. Perrott found that the relative differences for days per admission showed no particular trend; rather, it was the difference in admission rates that was responsible for the lower utilization by group practice employees.

Perrott also examined surgical procedure rates for 1961-62. For the Government-wide Blue Shield plan, the tonsillectomy rate was over 2.5 times that of the prepaid group practice plans; the "female surgery" (mastectomy, hysterectomy, and dilation and curettage nonmaterial) rate was 1.5 times that of the prepaid group practices; and the appendectomy rate was nearly double that of the prepaid group practices (219).

Anderson and May (2) examined FEHBP from 1961 to 1969 as a possible model for universal health insurance in this country. The study found a "truly staggering range of use" among the various types of plans. The range of variation was from nearly 900 days per 1,000 employees in the service benefit and indemnity plans to near 400 in group practice plans (see table C-3). Hospital admission rates by plan also revealed significant differences (see table C-4). The data were not adjusted, however, for age, sex or any other variables.

Over the 8-year period studied by Anderson and May, enrollment shifts toward the service benefit plan

Figure C-3.–Percentage of FEHBP Enrollment in Low-Option Plans, 1970.80



SOURCE: FEHBP Program Statistics-OPM, as cited in M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D C., November 1981.

Table C-3.—FEHBP Nonmaternity Hospital Days per 1,000 Enrollees by Type of Plan, 1961.68 (both options)

Year	Total	Service benefit plan[a]	Indemnity benefit plan[b]	Employee organization plans	Individual practice plans	Prepaid group practice plans
1961	880.8	896.4	875.4	950.6	673.8	542.4
1362	762.5	826.2	707.9	729.0	538.0	454.2
1963	802.0	865.4	767.4	754.7	519.9	430.8
1964	831.5	880.5	880.5	722.4	539.9	451.3
1965	999.5	1,078.4	1,102.3	775.8	629.6	484.7
1966	840.2	876.5	883.6	808.6	498.9	408.0
1967	815.6	871.0	836.0	748.8	467.1	392.5
1968	835.1	878.6	884.5	775.1	472.3	418.7
Average all years	845.9	896.6	867.2	783.1	542.4	447.8

[a]Blue Cross/Blue Shield.
[b]Aetna.

SOURCE: O. W. Anderson and J. J. May, *The federal Employees Health Benefits Program, 1961-1968: A Model for National Health Insurance?* (Chicago: Center for Health Administration Studies, University of Chicago, 1971).

Table C-4.—FEHBP Nonmaternity Hospital Admission Rates per 1,000 Enrollees by Type of Plan, 1961=68 (both options)

Year	Total	Service benefit plan[a]	Indemnity benefit plan[b]	Employee organization plans	Individual practice plans	Prepaid group practice plans
1961	108.9	105.0	103,2	106.8	133.9	70.8
1962	92.1	98.8	77.8	98.3	97.5	57.3
1963	94.0	99.5	85.4	97.2	92.1	55.4
1964	94.9	101.9	83.8	95.5	91.4	54.2
1965	106.7	117.2	99.5	94.0	92.6	58.7
1966	91.6	97.8	84.7	92.7	70.9	46.0
1967	88.9	96.5	81.6	85.5	69.5	44.3
1968	88.9	95.4	84.4	85.5	64.4	48.2
Average all years	95.8	101.5	87.6	94.4	89.0	54.4

[a]Blue Cross/Blue Shield.
[b]Aetna.

SOURCE: O. W. Anderson and J. J. May, *The Federal Employees Health Benefits Program, 1961-1968: A Model for National Health* Insurance? (Chicago: Center for Health Administration Studies, University of Chicago, 1971).

(Blue Cross/Blue Shield) and the cavitation payment plans and away from the indemnity plan (Aetna) and employee organization plans were noted. The authors also concluded a strong and growing preference for comprehensive insurance. Comprehensive or "high-option" plans were chosen by 78 percent of Federal employees in 1961; by 1969, 84 percent were in high-option plans. Importantly, though, the formula for Government premium contribution during this period was one-half the cost of the "low option," making comparability with enrollment shifts under later contributory formulas more problematic.

Perhaps the most extensive and best known study was undertaken by Riedel, et al. **(227),** in the early 1970's. The research compared the characteristics and utilization of enrollees in the Blue Cross/Blue Shield high-option plans with enrollees in Group Health Association (GHA), a large prepaid group practice in Washington, D.C. Annuitants were excluded, as *were* employees residing outside the Washington, D. C., area. Results indicate that the age and sex distribution was comparable across the two plans. Blue Cross/BIue Shield enrollees tended to have smaller families and to have been members of their plan longer. GHA members were more likely to be black, have incomes under $10,000, and have a working spouse. Total expenditures were equal for those enrolled in individual plans. For families, the GHA enrollee expenditures were greater, reflecting higher payments for premiums but lower out-of-pocket costs,

The study found substantial differences in rates of hospital admission. Overall, the hospital admission rate per 1,000 membership years for Blue Cross/Blue Shield was 121 **cases** and ***69* cases** for GHA. These differences held even after correction for small demographic differences. An examination of diagnostic-specific admission rates indicated that in 39 of the 46 diagnostic categories, the Blue Cross/Blue Shield rate was significantly higher than the GHA rate. In only one category (wounds and burns) was the GHA rate greater. Categories with the greatest differences, which could not be attributed to differences in the benefit structure, were disorders of menstruation, acute respiratory infections, and hypertrophy of tonsils and adenoids and chronic tonsillitis.

Differences in length of stay between members of the two plans were of a smaller magnitude than those found for hospital admission rates. But there were substantial differences in patient-day rate between the two plans. Overall, for Blue Cross/Blue Shield there were 724 patient-days per 1,000 membership years; for GHA it was **383.** The general patterns of differences by age, sex, and type of contract found for hospital admission rates were also found for patient-day rates.

Using the same data base, Meyers, et al. (180), examined ambulatory medical use by Blue Cross/Blue Shield and GHA. The authors concluded that any assumed "substitution" of ambulatory care for inpatient services, as an explanation of the generally lower rate of hospitalization among prepaid group practice members, could not be empirically found.

This same study also identified several interesting and statistically significant patterns when the dominant difference between the two plans, the racial distribution of their membership, was controlled (180). A higher proportion of the prepaid group members made contact with the care system and used a higher volume of services, regardless of race. And while blacks generally used services less than whites in both plans, blacks in the prepaid plan had a higher volume of emergency visits and ambulance trips than did whites. Among blacks, a higher proportion in the prepaid group made contact with the care system, but the volume of use in terms of mean numbers of contacts was similar to that for blacks in the fee-for-service plan, whereas the reverse was true for whites in both plans (54).

Another study by Blumberg (20) used data from the 1975 National Health Interview Survey for California residents under age 65. A small part of the work examined plan selection for those covered by FEHBP or the California employees system, which has some similarities to FEHBP. The FEHBP-California sample was restricted to 697 individuals. Results indicate that 32 percent chose a prepaid group practice. * Compared with the rest, prepaid group practice enrollees were more likely to have a limitation in their usual activity and to indicate fair or poor health status. However, they experienced fewer restricted activity days. Prepaid group practice enrollees in this study were found to have a lower rate of hospital utilization as well. For prepaid group enrollees overall, there were 364 patient-days per 1,000 person-years; for other private coverage plans the aggregate number was 582.

The studies reviewed in this section, while varying in methodological rigor, are consistent in asserting that hospital utilization rates in FEHBP have been generally less for enrollees in prepaid group practices than for other general types of plans, especially the service benefit plan (Blue Cross/Blue Shield). The Riedel (227) and Blumberg (20) studies, while limited to a small number of sites, also provide little support for the view that prepaid group practice plans enroll healthier individuals.

Low- v. High-Option Plans*

The Blue Cross and Blue Shield Associations suggest that the FEHBP structure results in adverse selection (19). Citing analyses using data from their plans, they note that the actuarial values of the high-option plan are substantially less than double those of the low-option plan, while claims costs and premiums of the high-option plan are more than double. In the absence of adverse selection, similar differentials between actuarial values and premiums would be expected in each plan. Given the discrepancy, Blue Cross/Blue Shield concludes that the low- and high-option enrollees are not equivalent, with the high-option plan drawing a population more likely to use services.

Available data tend to support the Blue Cross/Blue Shield conclusions based on the experience for the Government-wide carriers. Tables C-5 through C-9 present data on the age and sex distribution of enrollees and claimants in high- and low-option Blue Cross/Blue Shield and Aetna plans. Enrollment data profile the 1980 age and sex distribution of contract holders only (not dependents) and were provided by the individual plans. The claimant data are based on those who filed claims for services received in 1979 and include statistics on the total billed expenditures as well as age and sex distribution of those making claims. The claimant data were obtained from data reported to OPM and are based on a sample of all claimants to the Blue Cross/Blue Shield and Aetna FEHBP plans. While less reliable than data on enrollment, the claimant data are of interest since they allow for a comparison of the medical care expenditures generated by high- and low-option enrollees controlled for age and sex.

Tables C-5 and **C-6** show the age and sex distribution of contract-holders in the Blue Cross/Blue Shield FEHBP plan, distinguishing between employee (table C-5) and annuitant (table C-6) experience. These data indicate that the low-option plan draws individuals with a lower expected utilization of health services. Among employees, the proportion enrolled in high-option plans steadily increases with increasing age until age 65, where it drops-presumably because many employees become eligible for Medicare as a result of previous non-Federal employment. The high option tends to draw those involved in child-bearing (e.g., younger males with family contracts), while the low-option plan tends to draw single younger males. The annuitant data (table C-6) also show that selection of high-option coverage increases with age and health circumstances. The most striking thing about these data is the heavy enrollment of the potentially disabled, sick, high-utilizer annuitants under aged 65 in the high-option plans.

The Aetna enrollment data include a smaller population. Hence, estimates on enrollment differences in age and sex mix of the low- and high-option plans may be unstable. Also, the Aetna data, unlike the Blue Cross/Blue Shield data, do not distinguish between individual and family contacts. Nonetheless, the Aetna enrollment data presented in table C-7 tend to confirm the major trends in enrollment shown in the Blue Cross/Blue Shield data. For both employees and annuitants, there is a precipitous drop in the proportion enrolled in high-option plans at age 65. Unlike Blue Cross/Blue Shield, however, the Aetna enrollees are not so heavily concentrated in the high-option plans and the Aetna low-option plan comprises a larger share of the total Aetna market.

Claimant data tend to parallel those for enrollees. Tables C-8 and C-9 profile the age and sex distribution of claimants in the Blue Cross/BIue ShieId and Aetna plans, respectively. Because Blue Cross/Blue Shield FEHBP has expressed some reservations about the quality of the reported data which they draw from

'It should be noted that Blumberg (20) made a distinction in this study between prepaid group practices and individual practice associations, choosing to include the latter category with "other private coverage plans. "

● The remainder of this section is drawn from Marsha Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence, " unpublished, November 1981 (106).

Table C-5.—Blue Cross/Blue Shield FEHBP Contract Holders by Plan, Option, Age, and Sex: Active Employee Contracts, 1980

	Individual plan				Family plan			
	Male		Female		Male		Female	
Option and age	Number	Percent	Number	Percent	Number	Percent	Number	Percent
High option:								
Under 20.	388	0.3	2,004	1.2	227	0.0	338	0.2
20-24	9,568	7.9	19,308	11.1	4,848		7,402	5,3
25-29	24,589	20.3	28,299	16.3	33,210		19,357	13.9
30-34	24.890	20.6	24,194	13.9	72,578	14.6	25,852	18.5
35-39	14,029	11.6	15,299	8.8	65,263	13.1	20,972	15,0
40-44	8,975	7.4	11,737	6.8	62,219	12.5	17,263	12.4
45-49	9,060	7.5	13,712	7.9	73,850	14.9	15,050	10.8
50-54	11,410	9.4	18,814	10.8	79,483	16.0	14,271	10.2
55-59	10,095	8.3	22,090	12.7	63,935	12.9	12,483	8.9
60-64	5,504	4.5	13,203	7.6	31,300	6.3	5,225	3.7
65 and over	2,599	2.1	5,138	3.0	10,265	2.1	1,434	1.0
Total	121,008	—	173,798	—	497,178	—	139,647	—
Low option:								
Under do.....	158	0.5	789	2.8	27	0.0	108	0.3
20-24	4,682	14.7	6,913	24.2	1,209		2,387	7.0
25-29	9,607	30.2	7,009	24.4	6,796	8.9	5,546	16.2
30-34	7,465	23.5	3,915	13.7	11,768	15.3	6,278	18.3
35-39	3,061	9.6	1,961	6.9	9,546	12.4	4,839	14.1
40-44	1,620	5.1	1,308	4.6	10,177	13.3	4,347	12.7
45-49	1,469	4.6	1,301	4.5	12,283	16.0	3,784	11.1
50-54	1,495	4.7	1,659	5.8	11,360	14.8	3,059	8.9
55-59	1,185	3.7	1,856	6.5	7,818	10.2	2,516	7.3
60-64	572	1.8	961	3.4	4,031	5.3	913	2.7
65 and over	498	1.6	942	3.3	1,709	2.2	458	1.3
Total	31,812	—	28,617	—	76,724	—	34,235	—
Rat/o: high to low option:								
Under do.....		2.5		2.5		8.4		3.1
20-24		2.0		2.8		4.0		3.1
25-29		2.6		4.0		4.9		3.5
30-34		3.3		6.2		6.2		4.1
35-39		4.6		7.8		6.8		4.3
40-44		5.5		9.0		6.1		4.0
45-49		6.2		10.5		6.0		4.0
50-54		7.6		11.3		7.0		4.7
55-59		8.5		11.9		8.2		5.0
60-64		9.6		13.7		7.8		5.7
65 and over		4.5		5.5		6.0		3.1
Total		3.8		6.1		6.5		4.1

SOURCE: M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C., November 1961.

a 5-percent sample merging several data sources, the focus will be on the Aetna experience (table C-9).

Data on expenditures are of greater interest. In general, they show that the total submitted expenditures for high-option enrollees tend to be greater than those for low-option enrollees. On average, the low-option plan claimants incur fewer claims even when age and sex are controlled. The patterns probably result from a combination of several factors, including differences in rates of claims submission based on coverage differentials and lowered utilization resulting from less coverage in the low-option plan. A selection preference for high-optionplansbasedon health status, independent of age and sex, also appears likely.

Choices by Annuitants and the Elderly in FEHBP

FEHBP includes both employees and annuitants, some of whom may also be eligible for Medicare. Annuitants include disabled individuals, survivors of deceased Federal employees, and retired individuals of various ages. As a group, annuitants are older and less healthy than employees. Their high utilization should

Table C-6.—Blue Cross/Blue Shield FEHBP by Plan, Option, Age, and Sex: Annuitant Contracts, 1980

	Individual plan				Family plan			
	Male		Female		Male		Female	
Option and age	Number	Percent	Number	Percent	Number	Percent	Number	Percent
High option:								
Under 20	432	0.6	401	0.2	684	0.2	615	1.5
20-24	292	0.4	373	0.2	157	0.1	150	0.4
25-29	222	0.3	216	0.1	188	0.1	260	0.6
30-34	370	0.5	373	0.2	1,017	0.4	786	1.9
35-39	444	0.6	453	0.2	1,899	0.7	1,338	3.3
40-44	560	0.8	794	0.4	3,271	1.1	2,316	5.7
45-49	1,087	1.5	2,246	1.2	7,133	2.5	3,696	9.1
50-54	3,141	4.3	8,114	4.3	16,887	5.9	5,988	14.8
55-59	11,088	15.2	24,320	12.8	62,382	21.7	8,471	21.0
60-64	16,814	23.0	38,886	20.4	82,063	28.5	8,024	19.8
65 and over	38,580	52.8	114,006	59.9	111,947	38.9	8,783	21.7
Total	73,030	—	190,183	—	287,628	—	40,427	—
Low option:								
Under 20	80	0.4	82	0.2	111	0.2	109	1.2
20-24	56	0.3	47	0.1	33	0.1	22	0.2
25-29	37	0.2	36	0.1	17	0.0	27	0.3
30-34	52	0.3	34	0.1	95	0.1	73	0.8
35-39	59	0.4	39	0.1	192	0.3	142	1.5
40-44	61	0.4	64	0.1	315	0.5	264	2.8
45-49	141	0.9	209	0.4	841	1.3	436	4.7
50-54	343	2.1	683	1.3	2,025	3.1	671	7.2
55-59	997	6.1	1,788	3.4	6,986	10.8	1,041	11.2
60-64	1,363	8.3	2,794	5.3	9,779	15.2	1,052	11.3
65 and over	13,163	80.5	47,077	89.1	44,016	68.3	5,498	58.9
Total	16,352	—	52,854	—	64,410	—	9,335	—
Ratio: high to low option:								
Under do.,.....		5.4		4.9		6.2		5.6
20-24		5.2		7.8		4.8		6.8
25-29		6.0		6.0		11.1		9.6
30-34		7.1		11.0		10.7		10.8
35-39		7.5		11.6		9.9		9.4
40-44		9.2		12.4		10.4		8.8
45-49		7.7		10.7		8.5		8.5
50-54		9.2		11.9		8.3		
55-59		11.1		13.6		8.9		8.1
60-64		12.3		13.9		8.4		7.6
65 and over		2.9		2.4		2.5		1.6
Total		4.5		3.6		4.5		4.3

SOURCE: M.Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Departmentof Health and Human Services, Washington, D.C., November 1981.

drive up the premiums of those plans in which they are most heavily represented. Premium increases are partially offset, to the extent that the annuitants also have Medicare coverage which pays for a large proportion of their bills. Similar considerations apply for the elderly, most of whom are annuitants.

Annuitants represent about one-thirdof all high-option contract holders with particular concentration in the Government-wide plans. They represent 39 percent and 51 percent, respectively, of the high-option Blue Cross/Blue Shield and Aetna enrollment, and about a fifth of the enrollment in employee andHMOs plans (198). Overall, annuitants represent about half of the low-option plan enrollment.

Since almost three-quarters of all low-option enrollees are in the Blue Cross/Blue Shield plan, the experience of this plan provides a good indication of the choices annuitants are making. Enrollment data from Blue Cross/Blue Shield (see tables C-5 and C-6) indicate that annuitants represent about 45 percent of the low-option enrollment and 39 percent of the high-option enrollment. The high-option annuitant enrolles tend to be split about evenly between those underage 65 and those 65 and older, with the latter more likely

Table C-7.—Aetna FEHBP Contract Holders by Option, Age, and Sex: Active Employee and Annuitant Contracts, 1980

	Employee contracts				Annuitant contracts			
	Male		Female		Male		Female	
Option and age	Number	Percent	Number	Percent	Number	Percent	Number	Percent
High option:								
Under 20.	112	0.1	281	0.5	192	0.2	269	0.4
20-24	1,920	1.6	3,574	6.5	106	0.1	128	0.2
25-29	8,651	7.0	6,965	12.7	61	0.1	144	0.2
30-34	15,860	12.9	7,919	14.4	132	0.1	144	0.2
35-39	15,228	12.3	6,595	12.0	237	0.2	255	0.4
40-44	15,811	12.8	5,650	10.3	499	0.5	547	0.8
45-49 .....,	19,456	15.8	5,317	9.7	1,268	1.2	1,141	1.6
50-54	19,785	16.0	6,278	11.4	3,955	3.8	2,908	4.0
55-59	15,671	12.7	6,762	12.3	16,714	16.0	8,014	11.0
60-64	7,681	6.2	3,787	6.9	25,491	24.4	13,232	18.2
65 and over	3,210	2.6	1,873	3.4	55,960	53.4	46,028	63.3
Total	123,385	100.0	55,001	100.1	104,615	99.8	72,746	100.2
Low option:								
Under do.....	46	0.1	107	0.7	73	0.2	80	0.3
20-24	832	2.4	1,182	8.1	38	0.1	30	0.1
25-29	2,816	8.1	2,073	14.1	17	0.0	27	0.1
30-34	4,720	13.6	2,181	14.9	48	0.1	42	0.1
35-39	4,838	13.9	1,695	11.6	94	0.2	69	0.2
40-44	4,917	14.2	1,507	10.3	149	0.4	129	0.4
45-49	5,385	15.5	1,483	10.1	341	0.9	271	0.9
50-54	4,996	14,4	1,520	10.4	1,069	2.7	602	2.1
55-59	3,539	10.2	1,557	10.6	3,877	9.9	1,405	4.8
60-64	1,790	5.1	758	5.4	5,973	15.2	2,108	7.2
65 and over	879	2.5	596	4.1	27,493	70.2	24,493	83.7
Total	34,758	99.9	14,659	100.3	39,172	99.9	29,256	83.7
Ration:high to low option:								
Under do.....		2.43		2.63		2.63		3.36
20-24		2.31		3.02		2.79		4.27
25-29		3.07		3.36		3.59		2.96
30-34		3.36		3.63		2.75		3.42
35-39		3.15		3.89		2.52		3.70
40-44		3.22		3.75		3.35		4.24
45-49		3.61		3.59		3.72		4,21
50-54		3.96		4.34		3.70		4.83
55-59		4.43		5.00		4.31		5,70
60-64		4,29		5.00		4.27		6.28
65 and over		3.65		3.14		2.03		1.88
Total		3.55		3.75		2.67		2.49

SOURCE: M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empiric Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C., November 1981.

to be covered by Medicare. In contrast, more than three-quarters of those in the low-option group are 65 or older.

These data are interesting insofar as they may indicate a tendency for the elderly to choose high-option **plans even when potentially duplicative Medicarecoverage may be available. Although the elderly with Medicare coverage tend more to select low-option plans, a substantial proportion of the elderly elect to enroll in high-option plans. The extensive selection of high-option benefits by those with potentially duplicate benefits suggests that in addition to likely expenditure and need for coverage, the choice of health insurance plans also may reflect considerable risk aversion and fear of uncovered expense.**

Blue Cross/Blue Shield High-Option Plan Enrollees

The Blue Cross/Blue Shield high-option plan provides coverage for a substantial proportion of the FEHBP enrollment. While its market share has declined in recent years, this plan still constituted almost half of the 1980 FEHBP enrollment. Because of its domi-

Table C-8.—Blue Cross/Blue Shield FEHBP Enrollees Who Received Benefits by Plan, Option, Age, and Sex, 1979 (5 percent sample data)

	Male						Female					
	Claimants						Claimants					
	Number		Percent		Expense/Claimant		Number		Percent		Expense/Claimant	
Option and age	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family
High option:												
Under 25	241	**590**	**4.8**	**2.5**	**427**	215	**702**	**487**	6.1	**7.5**	**574**	**659**
25-29	565	**938**	**11.2**	**3.9**	**987**	468	**909**	**808**	7.9	**12.5**	**804**	**974**
30-34	527	**1,811**	**10.4**	**7.6**	**784**	518	**764**	**870**	6.6	**13.4**	**1,164**	**1,054**
35-39	332	**1,778**	**6.6**	**7,5**	**1,017**	577	**441**	**724**	3.8	**11.2**	**1,062**	**1,013**
40-44	227	**1,722**	**4.5**	**7.2**	**1,127**	683	**347**	**597**	3.0	**9.2**	**1.121**	**980**
45-49	265	**2,343**	**5.2**	**9.8**	**1,216**	1,015	**502**	**644**	4.3	**9.9**	**1,105**	**1,082**
50-54	397	**2,957**	**7.8**	**12.4**	**1,249**	1,002	**875**	**691**	7.6	**10.6**	**1,213**	**1,072**
55-59	607	**3,944**	**12.0**	**16.5**	**1,831**	1,267	**1,440**	**728**	12.5	**11.2**	**1,143**	**1,152**
60-64	624	**3,362**	**12.3**	**14.1**	**1,584**	1,487	**1,641**	**462**	14.2	**7.1**	**1,509**	**992**
65+ Medicare	651	**2,051**	**12.9**	**8.6**	**2,818**	2,521	**2,334**	**264**	20.2	**4.1**	**2,157**	**1,746**
65+ No Medicare	622	**2,364**	**12.3**	**9.9**	**1,934**	1,327	**1,597**	**214**	13.8	**3.3**	**1,233**	**907**
Total	5,058	**23,860**	—	—	**1,507**	1,146	11,552	**6,489**	—	—	**1,352**	1,038
Low ***option:***												
Under 25	79	61	**9.3**	**2.0**	56	**258**	158	**85**	7.6	**7.7**	**379**	**854**
25-29	126	105	**14.9**	**3.4**	531	**401**	158	**153**	7.6	**13.8**	**645**	**769**
30-34	87	178	**10.3**	**5.7**	328	**359**		**119**	3.5	**10.7**	**694**	**798**
35-39	50	185	**5.9**	**5.9**	428	**456**	36	**110**	1.7	**9.9**	**833**	**892**
40-44	21	166	**2.5**	**5.3**	**1,010**	**713**	35	**103**	1.7	**9.3**	**1,057**	**891**
45-49	25	208	**2.9**	**6.7**	**644**	**605**	30	**87**	1.4	**7.8**	**578**	**798**
50-54	25	239	**2.9**	**7.7**	**975**	**1,244**	43	**84**	2.1	**7.6**	**635**	**960**
55-59	25	311	**2.9**	**10.0**	**1,804**	**919**	73	**85**	3.5	**7.7**	**1,087**	**643**
60-64	25	245	**2.9**	**7.9**	**473**	**1,135**	69	**58**	3.3	**5.2**	**1,037**	**1,237**
65+ Medicare	314	1,114	**37.0**	**35.8**	**1,774**	**1,943**	1,190	**185**	57.4	**16,7**	**1,595**	**1,124**
65+ No Medicare	71	299	**8.4**	**9.6**	**319**	**533**	207	**41**	10.0	**3.7**	**311**	**863**
Total	848	3,111	—	—	1,014	1,169	**2,072**	**1,110**	—	—	1,176	**894**
Ratio: high to low option:												
Under 25	3.05	9.68	**.52**	**1.25**	**7.63**	**.83**	**4.44**	**5.73**	.80	**.97**	1.51	**,77**
25-29	4.48	8.93	**.75**	**1.15**	**1.86**	**1.17**	**5.75**	**5.28**	1.04	**.91**	1.25	**1.27**
30-34	6.06	10.17	**1.01**	**1.33**	**2.39**	**1.44**	10.47	**7.31**	1.89	**1.25**	1.68	**1.32**
35-39	6.64	9.61	**1.12**	**1.27**	**2.38**	**1.27**	12.25	**6.58**	2.24	**1.13**	1.27	**1.14**
40-44	10.81	10.37	**1.80**	**1.36**	**1.12**	**.96**	9.91	**5.78**	1.76	**.99**	1.06	**1.10**
45-49	10.60	11.26	**1.79**	**1.46**	**1.89**	**1.68**	16.73	**7.40**	3.07	**1.27**	1.91	1.36
50-54	15.88	12,37	**2.69**	**1.61**	**1.28**	**.81**	20.35	**8.23**	3.62	**1.39**	1.91	1.12
55-59	24.28	12.68	**4.14**	**1.65**	**1.01**	**1.38**	19.73	**8.56**	3.57	**1.45**	1.05	1,79
60-64	24.28	13.72	**4.24**	**1.78**	**3.35**	**1.31**	23.78	**7.97**	4.30	**1.37**	1.46	.80
65+ Medicare	2.07	1.84	**.35**	**.24**	**1.59**	**1.30**	1.96	**1.43**	.35	**.25**	1.35	1.55
65+ No Medicare	8.76	7.91	**1.46**	**1.03**	**6.06**	**2.49**	7.71	**5.22**	1.38	**.89**	3.96	1.05
Total	5.96	**7.67**	—	—	1.49	***.98***	***5.58***	**5.85**	—	—	1.15	1.16

SOURCE: M.Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C., November 1981.

nant role, it is important to analyze the available evidence on issues of selection as they bear on the long-range prospects for plans such as this one in a competitive system.

Blue Cross/Blue Shield staff are concerned that adverse selection within FEHBP has led to increasingly high premium rates for the plan (19). They suggest that competition will lead to "cream-skimming," resulting in adverse selection which makes some comprehensive high-option plans residuals for the sick and otherwise unattractive enrollee, eventually driving these plans out of business. As evidence for this, they cite the utilization experience of their high-option enrollees in **1976.** The **1976** expenditures for those who joined in open season that year were **29** to **44** percent above average for high-option enrollees; expenditures for those who left at the end of that year were 28 to 38 percent below average. Analysts conclude that a continuation of these patterns overtime will lead to increasingly high rates that will encourage lower utilizers to leave the plan.

Congressional Budget Office (CBO) staff analyzed this issue in the courseof undertaking related research (104). Ginsburg cites work by Koretz indicating that those leaving the Blue Cross/Blue Shield high-option plan at the end of 1977 had claims 39 percent below average, or 35 percent below average when mental health claims were excluded. Ginsburg suggests that better mental health benefits and higher hospital use rates, especially for maternity, were only some of the factors involved in the selection effects.

Table C-9.—Aetna FEHBP Enrollees Who Received Benefits by Option, Age, and Sex: Total Across Individual and Family Plans, 1979 (sample data)

	Male			Female		
	Claimants			Claimants		
Option and age	Number	Percent	Expense per claimant	Number	Percent	Expense per claimant
High option:						
Under 25	42	0.43	$ 607	150	2.44	$1,209
25-29	223	2.29	821	290	4.73	1,128
30-34	392	4.03	762	330	5.38	1,207
35-39	453	4.66	707	247	4.02	1,003
40-44	554	5.70	1,024	219	3.57	1,331
45-49	726	7.47	1,170	281	4.58	1,494
50-54	1,013	10.42	1,599	474	7.72	1,545
55-59	1,499	15.42	1,744	764	12.45	1,741
60-64	1,598	16.44	1,963	894	14.57	1,555
> 65 Medicare	1,714	17.63	3,472	1,505	24,52	2,496
> 65 No Medicare	1,509	15.52	1.902	983	16.02	1,561
Total	9,723	100.01	$1,896	6,137	100.00	$1,729
Low option:						
Under 25.	18	0.62	$ 769	32	1.68	$ 873
25-29	71	2.46	576	92	4.83	1,061
30-34	108	3.74	681	62	3.26	935
35-39	149	5.16	604	61	3.20	957
40-44	122	4.22	699	46	2.41	1,602
45-49	177	6.13	873	67	3.52	1,388
50-54	217	7.51	1,634	79	4.14	1,410
55-59	284	9,83	1,334	130	6.82	1,127
60-64	303	10.49	1,793	119	6.24	1,263
> 65 Medicare	1,094	37.87	2,482	993	52.10	2,129
> 65 No Medicare.	346	11.98	940	225	11.80	791
Total	2,889	100.01	$1,653	1,906	100.00	$1,631
Ratio: high to low option:						
Under 25	2.33	.69	.79	4.69	1.45	1.38
25-29	3.14	.93	1.43	3.15	.98	1.06
30-34	3.63	1.08	1.12	5.32	1.65	1.29
35-39	3.04	.90	1.17	4.05	1.26	1.05
40-44	4.54	1.35	1.46	4.76	1.48	.83
45-49	4.10	1.22	1.34	4.19	1.30	1.08
50-54	4.69	1.40	.98	6.00	1.86	1.10
55-59	5.28	1.57	1.31	5.88	1.83	1.54
60-64	5.27	1.57	1.09	7.51	2.33	1.23
> 65 Medicare	1.57	.47	1.40	1.52	.47	1.17
> 65 No Medicare. ,	4.36	1.30	2.02	4.37	1.36	1.97
Total	3.37	1.00	1.15	3.22	1.00	1.06

SOURCE: Data submitted to the U.S. Office of Personnel Management; as quoted in M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C., November 1981,

The Blue Cross/Blue Shield and CBO analyses agree that expenditures are lower for those leaving the plan, but they disagree on the expenditures for joiners. Sampling, methodology, and data source factors do not appear sufficient to account for the differences in the two analyses.Thediscrepancyinresuhsmaybeattributable to the different years considered in the two analysis, however. Around 1976, Aetna dropped its mental health benefit, while the Blue Cross/Blue Shield plan retained an extensive one. Perhaps more importantly, 1976 also was the year of a majorrate increase of 35 to 40 percent for the Blue Shield plan (see fig. C-2). As discussed previously, this led to a substantial decline in Blue Cross/Blue Shield enrollment.

Blue Cross/Blue Shield and CBO also disagree on the magnitude of the adverse selection problem and its importance in a competitive environment. To consider this point, it is useful to review data on the age and sex distribution of the Blue Cross/Blue Shield enrollment between **1975** and **1980.** Trends in these data are summarized in table C-10.

The data show that enrollment in the Blue Cross/Blue Shield high-option plan is growing increasingly older. The most substantial shift occurred through a

Table C-IO.—Blue Cross/Blue Shield FEHBP Enrollment, by Age and Contract Type: High-Option Contract Hoiders, 1975-80

	December 1975				December 1980				Net changes, December 1975-80			
	Individual		Family		Individual		Family		Individual		Family	
Age	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under 35	167,510	31.5	294,853	24.3	135,920	24.3	166,492	17.3	–31 ,590	–7.2	– 128,361	–7.0
35-44	43,510	31.5	244,995	20.2	52,292	9.4	174,541	18.1	+8,393	+ 1.1	–70,454	–2.1
45-64	211,226	39.8	580,953	47.8	209,584	37.5	490,241	50.9	–7,642	–2.3	–90,712	–3.0
65 and older . . .	108,289	20.4	94,140	7.7	160,323	28.7	132,429	13.7	+52,034	+8.3	+38,289	+6.0
Total.	530,924	100.0	1,214,941	100.0	558,119	99.9	964,860	99.9	–27,195		–250,061	

SOURCES: Blue Gross/Blue Shield internal data; M. Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished draft staff paper, Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D, C., November 1981.

large absolute drop of roughly 7 percent in the enrollment by those under 35 years at the same time as there has occurred an equivalent increase of 6 to 8 percent in the enrollment by the elderly. Because comparable data are not available for the entire FEHBP enrollment, it is not possible to determine the extent to which these patterns reflect shifts in Federal employment and annuitant composition. However, labor force changes of this magnitude are unlikely over a 5-year period. This would tend to suggest that the increasing age of the Blue Cross/Blue Shield enrollment reflects in part at least a selection effect which poses a potential threat to the viability of the plan.

This has certain obvious conclusions for the plan, but the implications from the larger policy perspective are less clear. Under increased competition, more attractive and efficient (i. e., more benefits and/or lower premiums) plans might be expected to grow in membership, while others should decrease. The drop in Blue Cross/Blue Shield membership, may or may not reflect such a phenomenon, resulting from increasing premium rates, the availability of alternative plans, and potential dissatisfaction with the service provided by the Blue Cross/Blue Shield plan. Such a response would reflect competition leading to the encouragement of more efficient plans responsive to enrollee demands.

Theoretically, such responses should occur across all age groups, without the major shifts evidenced in the Blue Cross/Blue Shield enrollment data. Shifts varying by age are a concern because they imply there may be some "cream-skimming" in the system. If so, increased competition may not promote more efficient plans, but rather plans with more successfully targeted marketing efforts. This form of competition would have little effect on the total costs of health care, since its impact would be to shift costs around but not reduce overall expenditures.

The available information suggests that reported trends in Blue Cross/Blue Shield enrollment may reflect more than "cream-skimming." The drop in enrollment for the Blue Cross/Blue Shield plan has been more acute since 1975, the year of the large premium increase. Other data from consumer surveys indicate that customer service ratings for the Government-wide plans fall below that for several other plans (91). FEHBP enrollees may be reacting to these circumstances.

Blue Cross/Blue Shield experience also may provide a lesson on the actual method by which competition among insurance plans may operate. It is possible that the age shift in Blue Cross/Blue Shield enrollment may reflect on the types of individuals likely to respond first or faster in a competitive environment. Those whose expected health expenditures are low face less risk in switching plans. Because their costs are likely to be low in any case, they have "less to lose" if their choice turns out wrong and the coverage is poor, incomplete, or not satisfactory.

The potential risk for older or less healthy individuals is higher, as it is for those who will need care (e.g., those expecting to use maternity benefits, psychiatric care). In addition, those who are older have a potentially longer history with a single plan and maybe hesitant to switch to a less familiar one. These considerations suggest that response to a competitive environment may vary with age, health status, and other related factors. If so, competition without adverse selection is unlikely, and it becomes necessary to trade off the two in determining both the form and the extent of competition to be promoted.

Quality Assurance

Few studies have looked at the quality assurance area of FEHBP. There is little evidence that OPM has ever perceived a need or rationale for institutionalizing for FEHBP a quality assurance policy analogous to the use of Professional Standards Review Organizations (PSROS) for the Medicare program. Instead, it seems, OPM has relied on the market mechanism—at least implicitly—and on existing quality assurance pro-

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grams and regulatory agencies to monitor quality of care across plans.

When FEHBP was originally operationalized in 1959-60, the integrity of each eligible plan was reviewed, and previous plan performance was checked through State and local regulatory agencies, as well as through various other quality assurance organizations. As previously discussed, a minimum set of benefits under each plan had been set out by law.

CSC also delegated the contract management of a plan to the same person and/or office that was responsible for day-to-day administration of the plan. Combining these two tasks allowed enrollee feedback concerning problems or needed benefit improvements to be funneled directly into future contract negotiations with individual plans (120). The result has been not only a variety of basic plans, but also an evolution and intermixture within each of the basic types.

The Riedel, et al., study (227) on FEHBP utilization discussed earlier also touched on the quality assurance areas. Two findings of the study were that: 1) a larger percentage of GHA patients were admitted to teaching hospitals, reflecting the pattern of hospital appointments of physicians in the plans, and that 2) there were no large differences in the proportions of patients attended by physicians of various specialties in the two plans, although a somewhat greater percentage of GHA patients were cared for by physicians in practice a shorter length of time.

Using the Riedel, et al., data base, a followup survey by Koepsell, et al. (139), looked at appropriateness of hospital admission under a prepaid group plan and fee-for-service plan available to Federal employees in the Washington, D. C., area. Judgment on the medical appropriateness of admission was based on two sets of explicit, disease-specific criteria listing the clinical circumstances under which hospitalization is usually considered justified for each disease. One set was developed by the American Medical Association (AMA) to assist PSROS, and the second was developed by physicians in Hawaii for Payne and Lyons' episodes of illness study. Diagnostic validity was assessed on the basis of AMA criteria developed under the same auspices as their admission criteria.

While the authors admit to a certain inherent "grey zone" of clinical situations, they found few medically inappropriate admissions in either plan and few inaccurate diagnoses by the time of discharge in either plan (139). The one statistically significant difference found in the study was that more fee-for-service patients underwent both tonsillectomy and adenoidectomy rather than one procedure only. Thus, somewhat more extensive surgery was performed under the fee-for-service plan.

Information Dissemination and Consumer Choice

According to macroeconomic theory, consumers act rationally in market situations. Accordingly, when provided with the opportunity to make a selection among health care plans, consumers will seek information and maximize their welfare. (Some economists assert that one need not assume that all consumers exhibit this rational behavior, and that it is sufficient if some consumers act rationally; these more sophisticated consumers would be able to affect the market structure and all consumers would benefit (1).)

One of the oldest if not the best example of a multiple consumer-choice health plan system is FEHBP. And one of OPM'S responsibilities under the program is to assure that employees receive sufficient information about it and the various health plans for which they are eligible.

This responsibility is stated in the Federal Employees Health Benefits Act, as amended, as follows (U.S. Code, Health Insurance, ch. 89, title 5, pt. 890, Federal Employees Health Regulations):

> *Information to employees.*
>
> *(a) The Civil* Service Commission shall make available to each employee eligible to enroll in a health benefits plan under this chapter such information, in ***a form*** acceptable to the Commission after consultation with the carrier, as maybe necessary to ***enable the*** employee to *exercise an* ***informed choke*** among the types of plans described by section 8903 of this title.
>
> (b) Each employee enrolled in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—
>
> (1) services or benefits, including maximums, limitations, and exclusions, to which the employee or the employee and members of his family are entitled thereunder;
>
> (2) procedure for obtaining benefits; and
>
> (3) principal provisions of the plan affecting the employee or members of his family. [Emphasis added.]

OPM is to provide information on the various health plans each year before the "open season." Most evidence, though, seems to indicate that the program has been marked by limited availability of information and lack of consistent information on all of its plans for most of its history.

Since inception of the program in 1960, CSC/OPM has (until very recently) relied almost solely on individual brochures to provide information about the program and the various health plans—one brochure for each health plan and one brochure containing instructions on how to change options during open season (102). Typically, CSC/OPM would distribute the brochures to agency personnel centers, but distribution

beyond that point depended on individual agency policies. Information on individual plans has been left to employee initiative in many instances. Brochures on employee organization plans for which all employees are eligible have generally not been distributed each open season, with employees having to specially request these brochures.

The brochure containing information to consider in choosing a health plan and the brochure describing FEHBP have generally been distributed on a one-time basis, usually at the time of hiring by the Government. In the mid-1970's, a General Accounting Office (GAO) study found that during an open season, the average employee received only about 4 of the 11 brochures needed to consider just the 7 plans for which all employees were eligible (102).

Prepaid gorups plans have been particularly vocal in stating that FEHBP dissemination policies have tended to favor the most popular plans. Kaiser Foundation went so far for several years as to distribute brochures on their plans themselves, directly to eligible employees, instead of through CSC/OPM (81).

Even assuming that an employee obtained all the needed informational and health plan benefit brochures, the different format of each brochure and the obscure and technical language in the brochures hindered ready comparisons of the benefits of the plans (102). As a 1970 CSC study regarding the feasibility of summary comparisons of health benefit plans stated (102):

> The brochures, as they are presently designed, lack reasonably uniform formats and do not adequately facilitate an 'informed choice' among the plans.
>
> This was not always true. The brochures followed a reasonably standard outline and format in **1960. At** that time, making the brochures as uniform as possible to facilitate comparison was just as important a goal to the Commission as making the brochures precise enough to show the employee's rights under the contract. All brochures used the same style and size of print to describe limitations and exclusions as well as benefits and contained a page entitled 'Benefits in Brief' which facilitated gross comparison with other available plans, Each had a table of contents so that a specific provision could easily be located in a particular brochure and compared with that in another brochure. This requirement of reasonable standardization benefited Federal employees in several ways:
>
> "Sales pitches were forbidden—and so was the 'fine print' and 'silent treatment' of undesirable features typical of many plan descriptions. As the plans were *laid out in standard outline and format,* under these strict (and, for many carriers, unusual) standards, carrier after carrier went back to reconsider its proposed benefits. Every contract, without exception, was revised in this process. Some contracts were actually changed after the brochures had gone to press, usually in the direction of liberalization benefits, always in the *direction of greater clarity. "* [Emphasis added.]
>
> Because of the variation in the philosophies and benefit structures of the health plans, it was impossible to force each plan into precisely the same format . . . .
>
> Although these differences made a precisely uniform format infeasible, the formats of the brochures were kept similar to the extent possible. This is not the case since that time. Since **1961,** the **Commission has by** choice allowed the brochures to become increasingly dissimilar so that today they contain numerous inconsistencies which cannot be explained by differences in the plans' benefit structures.

The 1970 report also stated that although CSC could recommend that an employee read the brochure of interest and compare it with other brochures, this task was time-consuming, tedious, and often frustrating. Brochures presented so many details that many Federal employees shied away from, or failed in, attempts at making careful comparisons of the plans. Employees became confused and ended up choosing a plan merely on the basis of a few major benefit provisions or as a friend's recommendation. As a result of the report, CSC moved to make the brochures more uniform (102),

Later, the Subcommittee on Retirement and Employment Benefits, House Committee on Post Office and Civil Service, again expressed concern about the information provided to Federal employees on available health plans. In House Report 93-1205, dated July 18, 1974, the subcommittee recommended that CSC better inform Federal employees about such health plans. The GAO study in 1976 recommended that CSC consolidate FEHBP health plan information brochures into publications which would enhance comparability among available plans, leading to increased informed choice (102).

In the most recent years, improved information has become available. For the 1980 open season, OPM made several changes in the informational material given to employees. Specifically, two new types of information were produced about health plan benefits consisting of: 1) columnar comparison charts for the benefits provided by each plan in the program, showing 17 major benefit categories; and 2) Health Plan Benefit Summaries describing each plan's major benefits in a uniform format on a single standard-size page (196).

In addition, OPM experimented in two geographic areas with special "summary booklets" containing summaries of all plans an employee could join in the area; i.e., containing summaries of local comprehensive plans as well as the summaries of the two Govern-

ment-wide plans and 18 employee organization plans. This test was conducted to determine the feasibility of an alternative distribution system in conjunction with regional booklets (195).

Lastly, in a resurrection of an early 1960's FEHBP practice, training seminars for hundreds of other agency personnel working with health benefit matters were conducted. These training seminars took place in numerous locations (120,195).

A followup evaluation of the 1980 open season was conducted by OPM through a random survey in three sites-Philadelphia, Chicago, and southern California. Results indicated that the changes made and the new material produced were welcomed by all interested parties—carriers, agents, and employees—and served to generate new interest in the open season. But while the training seminars were successful, the single-sheet summaries and comparison charts were not. In particular, the majority of those who tried to use the comparison charts found use of the charts difficult if not impossible because of their large size, the number of sheets (up to four for each area of the country), and long narrative wording. Such analysis has allowed OPM to revise the information format for the next open season, which will have all Government plans in one standard-size booklet (28).

Preliminary cost figures show OPM'S printing and distribution budget has remained about the same for the last 2 years, hovering near $1.3 million. Costs for the upcoming open season are anticipated to stay at that level as well (28,195).

In 1979, ***Washington Consumer's Checkbook Magazine*** also initiated publication of an annual guide to Federal plans for Washington, D. C., area employees with the advent of the open season. Unlike OPM materials, it: 1) was supported through private funds ($3.95 per pamphlet), and 2) drew conclusions about the consumer attractiveness of certain plans versus others. Specifically, cost, special features such as dental care, customer service, HMO comparability, and considerations for plan selection have all been categories of FEHBP plans scrutinized by the magazine.

Marketing of the guide has taken place through newspaper coverage, employee association stores, individual plans themselves, newsstands, bookstores, and a drug store chain. First-year sales in the Washington, D. C., area stood at 11,000 copies; second-year sales, with wider distribution and more active promotion, were double that number. The impact that this private consumer guide has had on FEHBP consumer choice is unknown. However, one plan favored by the guide, the Government Employees Health Association (GEHA), enjoyed a dramatic increase in enrollment in the Washington, D. C., area of over 120 percent (compared with less than 20 percent nationally) during the 1980 open season (145).

One last element of change over the last 3 to 4 years has been an apparent upswing in advertising of individual plans, initiated by the plans themselves. This has been particularly true of the employee organization plans. OPM originally prohibited advertising by the plans, but dropped the regulation in the late 1960's when it was felt all plans had become well enough established (120).

It is difficult to determine the impact of potentially limited information in past years on plan choice in FEHBP. Changes and improvements in available information over the last few years have, however, coincided with recent enrollment changes. For example, the number of employee transfers into different plans has increased from 107,000 in 1978 to 149,000 in 1979 and 159,000 in 1980 (198). As discussed in the section entitled "Competition Within FEHBP, " there have also been relative changes in market shares by types of plans, especially over the last 5 years.

Still, there are signs that more steps may be needed to enhance consumer information and choice. The relative percentage of employees switching plans since 1960, for example, has changed little over the years, from the 3 to 4 percent range in the early years to a recent 6 to 7 percent range (28,120). And HMOS have been critical of the information OPM provides on plans and on the general way in which OPM conducts the open season. In testimony before a congressional subcommittee, Group Health Association of America (GHAA), the trade organization for group HMOS, argued that several provisions limit the ability of HMOS to effectively compete in the open season (113).

These include limitations on HMOS' ability to directly market to Federal employees; incomplete distribution of materials on HMO options; and inconsistent and uneven treatment of HMOS by OPM. In general, GHAA feels that OPM needs improved understanding of the structure of HMOS. GHAA also supports strongly a yearly open season combined with a positive enrollment procedure (i.e., all must indicate a preference even if no switch is involved) as a mechanism for enhancing the competitive posture of new or less widely known plans (106,113).

Current Problems of FEHBP

FEHBP has set many good precedents for designing a nationwide competitive health insurance system based on the principles of consumer choice, market incentives, and fair economic competition. Its main features—multiple choice, uniform dollar employer

contributions, and open seasons—have been demonstrated to be workable. Yet there are some important structural flaws in FEHBP, which provided substantial difficulties by the end of 1981.

An open season, scheduled to begin on November 9, 1981, was indefinitely postponed by OPM 3 days prior to its commencement because of a host of problems. The announcement resulted from a confluence of four events: 1) a large escalation in health care costs during 1980 and 1981; 2) severe Federal budgetary constraints imposed by the Reagan administration; 3) assertions of an increasing extent of adverse selection in the Blue Cross/Blue Shield and Aetna high-option plans; and 4) numerous and substantial changes proposed by OPM in participating health plans premium rates, benefits, and deductible and coinsurance provisions at a late stage in the negotiations for the 1982 contract year.

During FEHBP's first 20 years, OPM'S rules resulted in a stable underwriting environment. In recent years, carriers were generally prohibited from making substantial benefit reductions and were permitted to make benefit increases only if the total value of the entire benefit package did not materially change. Because benefit packages remained fairly constant from year to year, carriers were able to predict with reasonable accuracy what their future loss experience would be.

This stability was undermined in 1981 when, for the first time in FEHBP's history, OPM ordered all carriers to reduce 1982 benefits. In August, OPM directed all carriers (except for HMOS) to: 1) increase the deductible on supplemental benefits to $200 per individual, 2) increase the enrollee's coinsurance rate to 25 percent on supplemental benefits, and 3) apply a $200 deductible to outpatient hospital services, or 4) make other changes of equal value.

When OPM determined in October of 1981 that the August reductions were still inadequate to bring the cost of the program within its $2.25 billion congressional appropriation, it mandated a further 6.5 percent benefit reduction for all carriers including HMOS. Without these August and October cuts, the Government's contributions would have amounted to $2.69 billion.

These unprecedented benefit cuts, which included controversial drops in abortion coverage and an altering of mental health benefits, introduced a high degree of uncertainty into FEHBP. Both benefits and premiums would be significantly altered in the 1982 contract year. Moreover, because of the way in which the Government's contribution formula works, increases in enrollee contributions would be greater for high-cost plans than for low-cost plans. Accordingly, many predicted an exceptionally large number of enrollees would switch plans during open season. Since there was no way any carrier could predict the extent of enrollment changes, carriers faced substantial underwriting risks entering the 1982 contract year.

Consequently, nearly 100 carriers sued OPM to roll back some benefit reductions. A few carriers, such as Blue Cross/Blue Shield, fearing the large premium increase could cut enrollment and threaten their survival, sued OPM to cancel the November 1981 open season or to impose a "pre-existing health condition" limitation on all enrollment transfers. In addition, a number of mental health organizations sued OPM, Blue Cross/Blue Shield, and Aetna to prevent reductions in insurance coverage for mental health services (257). Faced with these problems, OPM proposed to delay the open season on an indefinite basis, on the grounds that it could not print and distribute brochures outlining benefit and planning changes in time.

In turn, some carriers then sued to prevent such a postponement. The lower court ruled that OPM acted illegally when it required a reduction in benefits for 1982 plans, and the court invalidated that cutback in benefits. The lower court also ruled that OPM acted illegally when it "indefinitely" postponed the open season for employees to choose health plans. It ordered that an open season be conducted, beginning no later than December 7, 1981. The Court of Appeals later granted a partial stay of that order. The appellate court ruled that open season would not take place for 30 days, or until the court decided whether the benefits cutback was legal, whichever came first.

As of the end of January 1982, the appellate court was still considering whether to order OPM to hold an open season. Regardless of the pending litigation, OPM went ahead with an issuance of new rates and benefits on December 31, 1981, that became immediately effective. The 1982 rates required nonpostal employees and annuitants to pay an average of 31 percent more for their share of the health insurance premium. Moreover, the benefit reductions generally resulted in added cost sharing for the enrollee (257).

In February 1982, the Court of Appeals upheld OPM'S deferral, saying it had acted properly when it scrubbed the open season. Around the same time, OPM announced a new open season period had been scheduled for May 1982. It was subsequently held from May 3 to May 28.

For the future, OPM is considering a proposal that would scrap the complicated method the Government uses to arrive at percentage formula payments for insurance and instead give all workers and retirees the same dollar amount. As previously discussed, the Government's share of health premiums is based on 60 percent of the average high-option premium

charged by six of the largest carriers in the Federal health program. Because of the averaging system, the actual dollar contribution (the maximum is slightly over $39 per pay period) varies depending on which plan the worker or retiree chooses. In some cases, it covers as little as 40 percent of the premium cost, while in others, it pays up to 75 percent.

The proposal being discussed at OPM would give every active-duty worker the same dollar amount to be applied to purchase of insurance. It would be enough to cover the entire premium for employees who chose inexpensive, low-option, minimum-benefit plans. Workers who wanted more protection could buy it, paying the difference out of their own pockets.

For retirees with potentially greater health needs but less money, OPM is considering a two-tier system that would give retired Government workers larger payments than active-duty workers.

The fixed-dollar payment plan is still under discussion. If the President approves it, Congress will have to approve the change. It could be part of a major package of health care cost reforms that the Reagan administration will propose later this year.

The idea would be to create more competition in the Nation's health insurance field by giving fixed payments to individuals, who could then shop around for the best insurance deal for themselves.

OPM would certify carriers for participation in the Federal health program but would no longer dictate rates or benefits (beyond a minimum package) the carriers offer. OPM officials say they would, however, insist that any carrier participating in the Federal health program offer group rates, to keep premiums as low as possible (36).