EFFECTIVE MANAGEMENT OF COMPETITION IN THE FEHBP

by Alain C. Enthoven

Prologue: *The Federal Employees Health Benefits Program (FEHBP), once regarded as a prototypical example of medical marketplace competition at work, has fallen on difficult times. The program offers federal employees a vast number of health insurance plans that add to administrative costs but contribute little to real competition at the provider level. In the process, they give health insurers an incentive to segment the market in ways that make it more difficult for those requiring substantial medical care to purchase it on an affordable basis. In this paper, Stanford University professor Alain Enthoven discusses the problems facing the FEHBP and offers a prescription for reform that is relevant not only to the federal program, but to all enterprises that seek to be cost-effective purchasers of health care. For more than a decade, Enthoven has been at the forefront of health policy thinkers who have sought to transform the rhetoric of marketplace competition into a policy agenda. While Republicans and Democrats alike have been slow to embrace his vision, it remains a viable alternative at a time when the United States is casting around for a reform plan. His thinking has influenced policymakers not only in the United States, but in Europe as well, particularly Holland, the United Kingdom, and Sweden. Enthoven's influence on the Thatcher government in Britain has been particularly profound. In January, the prime minister unveiled a controversial reform proposal to transform the National Health Service by introducing managed competition. Through it, hospitals and other suppliers of health care would compete for contracts from health authorities and other purchasers of care. The British Medical Association is waging an all-out war to kill Thatcher's plan. To provide another perspective on Enthoven's plan, we invited Stanley Jones to react to it in a paper that immediately follows. Jones has devoted a great deal of time to the study of the FEHBP as an employee of and consultant to the National Association of Blue Cross and Blue Shield Plans.*

During its twenty-eight-year lifetime, the Federal Employees Health Benefits Program (FEHBP) has served as a large-scale model of price competition and cost-conscious consumer choice in a diverse market. The FEHBP covers about nine million people, including active employees, retirees (with and without Medicare eligibility), and dependents. It offers a choice of two "governmentwide" carriers offering traditional "free choice" fee-for-service (FFS) indemnity and service benefits, each with a high and low or standard option; about twenty-six "employee organization plans," which are largely traditional FFS indemnity plans and most of which are open to all federal employees by payment of "associate member dues;" and over 400 "comprehensive plans" or health maintenance organizations (HMOs). Within wide limits, the plans are free to offer the benefits packages they want to offer—lists of covered services, schedules of coinsurance and deductibles, indemnity payments, and limits on services covered—though federally qualified HMOs are more tightly constrained by the HMO Act. Most plans cover prescription drugs. Some cover dental costs quite fully, some have only very limited coverage, and some have none. The FEHBP offers individual and "family" (that is, one or more dependents) coverages.

The multiple-plan aspect of the program has made it more open to innovation than the single-plan model characteristic of Medicare and of most of the private sector until the HMO Act of 1973 required employers to offer choices. The FEHBP offered HMOs long before Medicare or most private-sector employers did so; now it is introducing preferred provider insurance (see below). Thus, the program has given many federal employees the opportunity to get more value for their money by choosing relatively efficient health plans. But, from the outset, the FEHBP has suffered from significant, though correctable, design deficiencies. In the 1960s and 1970s, these deficiencies did not cause serious problems. In the 1980s, they have. While the basic notions of cost-conscious consumer choice remain valid, greater care and attention to the details of the economic incentives in the program are needed to translate these general ideas into successful practice.

In the 1980s, the FEHBP has not been as effective a model of managed competition as it can and should be. For example, it does not make use of available tools to prevent or compensate for biased risk selection among health plans, resulting in instability in price and enrollment. Some plans are gaining or losing market share not because they are more or less efficient, but because they have attracted a less or more costly clientele.

The FEHBP allows the competing plans to differentiate their products, that is, to mix various features (deductibles, coinsurance rates, limits on services covered or excluded, and so on) in complicated ways to make it

costly and difficult for consumers to make a straight price comparison. Walton Francis, author of *Checkbook's Guide to Health Insurance Plans for Federal Employees,* writes: " . . . Choosing the right plan is difficult, even if you have the time to read hundreds of pages of small print. . . . The complexity and details of plan comparison are enormous."[1] This difficulty deters consumers from deciding to change plans based on price. The fact that different plans can offer significantly different mixes of important benefits (for example, mental health, indemnity payments for maternity, dental care, and prescription drugs) segments the market. That is, it leads people to choose plans whose mix of benefits best suits their needs, thereby reducing the number of people who would change plans because of price. Thus, these features of the FEHBP greatly attenuate price competition and market pressures for competitors to improve efficiency.

Glossary of terms. Several different types of coverage are offered in the FEHBP. *Traditional indemnity insurance* refers to coverage in which the insurer indemnifies the patient for certain medical expenses but in which there is no contractual relationship between provider and insurance carrier, thus no negotiation between provider and carrier over fees and utilization controls. *Service benefit insurance,* offered by Blue Cross/Blue Shield, refers to coverage in which there is a contract on price between provider and payer but in which any licensed provider willing to accept the carrier's price as full payment is free to participate. Indemnity and service benefit plans are ineffective in controlling cost because their "free choice of provider" feature leaves them no power to bargain selectively and to exclude providers whose price and performance are not right.[2]

Using *preferred provider insurance* (PPI), the patient receives preferential coverage for the services of selected providers who have contracted with the carrier for set prices and utilization controls, and substantial but less favorable coverage for the services of noncontracting providers. The patient's incentive to use contracting providers gives the carrier bargaining power with the providers. Leaving aside a few self-insured employers shielded from state insurance codes by the Employment Retirement Income Security Act (ERISA), PPI was first authorized by the passage of AB3480 in California in summer 1982. Similar legislation was subsequently passed in many other states.[3] Thus, PPI is a recent innovation.

Individual practice association (IPA) HMOs cover the services of physicians in individual practice. They differ from PPI in that the patient generally receives no coverage for services by nonparticipating providers, except in the case of out-of-service-area emergencies, and the providers share in the financial risk of the cost of services. In *prepaid group practice* (PGP) HMOs, covered services are provided by a medical group affiliated with the HMO. The distinctive feature of PGPs is that they actually

organize delivery systems. For example, they control the numbers and types of physicians in relation to the needs of their enrolled populations so that all physicians will be busy and proficient in their subspecialties. PGPs can trade patient volume for price.

Array of plans. The FEHBP offers participants a bewildering array of traditional fee-for-service indemnity insurance and service benefit plans that contributes little or nothing to meaningful consumer choice or to competition among providers to improve the quality and economy of care. This proliferation adds to administrative costs for both the FEHBP and consumers and invites sophisticated risk-selection games. These plans have the least ability to control costs. Some employers such as the State of California and Stanford University have abandoned such coverage and replaced it with PPI (in addition to HMOs). While PPI coverage of traditional fee-for-service practice is not likely to solve the problem of health care cost growth, it represents a great potential improvement over traditional indemnity and service benefit coverage.

By statute, the government makes a contribution equal to 60 percent of the (unweighted) average premium of the "Big Six" plans: the two governmentwide high-option (indemnity and service benefit) plans, the two largest employee organization (indemnity) plans, and the two HMOs with the most federal employees. (The contribution is closer to 70 percent of the average of plans in the program.) This provision was intended to provide an annual indexing of the contribution to a representative sample of health care costs. But the two governmentwide high-option plans are caught in a spiral of adverse risk selection, and the government contribution is now growing faster than health care costs in general.

The FEHBP covers employees and retirees, only some of whom are eligible for Medicare. Yet, it offers them all the same coverages at the same prices. Retirees without Medicare are much more costly to cover than are active employees or retirees with Medicare (because for them Medicare is the primary payer). Thus, the fortunes of health plans can be strongly influenced by their share of retirees without Medicare. The FEHBP design has not been integrated with Medicare, despite the fact that about 83 percent of retirees age sixty-five and over are also covered by Medicare. These people use the FEHBP as a "Medicare supplemental" coverage. The way the FEHBP works does not allow the Medicare-eligible retiree to receive the savings generated by a decision to join an HMO contracting with Medicare. Thus, the retiree does not receive an appropriate economic incentive to join a cost-effective system, and the growth of participation in HMOs by Medicare eligibles is impeded.

Lack of relevant information. Finally, the theory that consumer choice will help to promote quality and economy is based partially on the

assumption that consumers are well informed. The FEHBP, like employers generally, is missing important opportunities to promote informed choice because it does not gather, analyze, publish, and use relevant information on the quality of care and service of the participating plans.

An important contributor to the persistence of the design defects in the FEHBP is a lack of a shared understanding among key policymakers as to how such a system is supposed to work—a lack of a widely understood and agreed-upon economic model. At its genesis, the FEHBP was a pragmatic, negotiated compromise among the interested parties.[4] In the words of a recent commentator, "The legislative history shows that there was no grand economic theory behind the program. . . ."[5] However, the incentives that shape economic behavior matter a great deal. Lack of a rational economic design can lead to wasteful and unfair, even unstable and unworkable, outcomes. For a design to produce good results, it must be based on incentives that lead people to produce those results. Not just any old thing that someone calls "competition" will lead the participants to efficient and equitable outcomes. To achieve the kind of agreement on diagnosis and prescription for the FEHBP that will lead to a rational economic design, the congressional committees, the Office of Personnel Management (OPM), and the participating health plans must have a shared conceptual framework.

In my study of the FEHBP, I have detected at least three quite different economic theories about what it is or ought to be. All of them are partially reflected in the program's design. In this article, I explain and analyze each of them, making clear which one I believe makes the most sense. In terms of that model, I then offer recommendations on how to correct the major deficiencies.

The Traditional Insurance View

The first of these theories is the traditional insurance view, the view of the commercial insurance companies, of Blue Cross/Blue Shield, at least before this decade. Important elements of this view can be found in a recent study of the FEHBP by Towers, Perrin, Forster and Crosby, a leading benefits management consulting firm.[6] In this view, the FEHBP is supposed to solve an *insurance* problem, that is, to spread financial risk for health care expenses among all participants, and not a *delivery system* problem, that is, the use of purchasing power to motivate more efficient delivery. In its pure form, the traditional insurance view is an application of the casualty insurance model to health care. In casualty insurance for fire, storm, or collision damage, it is a reasonable working assumption that the presence of insurance will not have a major impact on the

amount of the losses. When applied to health care, this view accepts prices and volumes of medical services as a given, determined by "usual and customary fees" and professional standards. It also does not deal systematically with the centrally important fact that the presence of insurance does have a major impact on the amount of services provided and consumed. This view accepts the traditional FFS "free choice of provider" model of payment and organization as a given. While individual people associated with this view may be aware of it, the concept ignores the effects of the payment system incentives on medical practice and on the organization of the delivery system.

The pure form of this view has had to give way to modification under pressure from rising health care costs and the effects of insurance on the prices and volume of services. So this view now accepts such innovations as changes in benefit plan design to encourage economical use of services, preadmission certification and other similar utilization controls, second opinions before surgery, and even selective contracting for prices and provider acceptance of utilization controls. In their public policy advocacy, holders of this view have often favored public utility regulation of provider prices (but not the premiums they charge), believing insurance carriers had little or no ability to control the cost of services.

In the traditional insurance view, the only elements of cost that are legitimate objects of control by the employer and the insurer are the insurer's "retentions," that is, administrative costs and profit margins. Holders of this view measure efficiency by the ratio of retentions to premiums. In the FEHBP, retentions range from about 5 to 12 percent of premium costs.[7] In this view, the ideal way to insure a large employment group is to keep all employees in one large risk pool, and to process all claims by one administrator. This minimizes administrative cost by dealing with only one plan, and it achieves economies of scale for the claims administrator. Competition among carriers for this business should be periodic competition *for* the field and not ongoing competition *in* the field. Thus, in the traditional insurance view, the role of the sponsor (for example, OPM) should be to select one contractor periodically, to negotiate an administrative fee, and to specify the covered benefits and cost containment activities.

Although this view contains some valid insights, it ignores the impact of the way providers are paid on how they are organized and on the services they provide. The traditional view is linked to FFS, which is open-ended to providers (that is, it does not give them firm prospective budgetary limits) and inflationary. It pays them more for doing more, whether or not more is necessary or beneficial. This system contributes much to the unsustainable expenditure growth we are experiencing. The

traditional view assumes that whatever cost containment is possible can be achieved through the techniques mentioned above. The possibility of superior cost containment through basic organization of the delivery system for efficiency, as is the case with PGP, is ignored.[8]

As the rapid growth of HMOs and PPI illustrates, promising avenues toward cost containment link financing and delivery in ways that permit selecting and rewarding efficient providers. The important potential for savings is not in reducing carriers' retentions, but rather in finding systems of organization of and payment for medical care that promote its economical delivery. One of the most important disadvantages of the single-carrier approach is its resistance to innovation. It is more difficult to get agreement to a change when everyone must be served by one plan. It is much easier to change one of several competing plans when people have choices. The FEHBP has been literally decades ahead of Medicare in offering innovative plans. It offered several PGPs at the outset in 1960, and it is now introducing PPI. Medicare did not offer HMOs on a risk basis until 1985, and it only began to experiment with PPI in 1989.[9]

The FEHBP As Free Market

Another view is the FEHBP as free market. The basic theory of this view was explained by Adam Smith and the other classical economists: The greatest wealth for the nation will be produced by the free interplay of market forces. Proposals for a voucher plan in health care are extreme examples of this view. As applied to the FEHBP, the free competition of different carriers offering different benefit packages will motivate carriers to be efficient in the design and delivery of their products. It also will enable consumers to choose the benefit packages they want and thus will elicit the most desired benefit packages. The role of the sponsor (OPM) in this view is essentially passive. Because free entry is an important component of a competitive market, the sponsor should admit to the field any competitor that wants to participate, provided it meets reasonable tests of financial security. And, the sponsor should let each carrier offer the benefit package it wants to offer.

The basic flaw in this view is that free competition among health insurance plans does not naturally produce efficient or equitable outcomes. This market does not fit Adam Smith's model. It is susceptible to many forms of market failure.[10] In a free market made up of health plans on the supply side and individual consumers on the demand side, without carefully drawn rules and without active management by sponsors, the health plans would be free to pursue profits or survival by using competitive strategies (primarily risk selection, product differentiation, and mar-

ket segmentation) that would destroy efficiency and equity and that consumers would be powerless to counteract. Because of the complexity of the product and the variety of people's needs for health care, the market for health insurance is particularly vulnerable to these strategies.

For example, in any year, about 75 percent of health care costs are associated with the 10 percent of people who have the highest costs.[11] Thus, it can be extremely advantageous for an insurer to design its plan to encourage the bad risks to enroll elsewhere. The techniques for doing this are many and subtle. The consequence is that some health plans may be rewarded more for selecting good risks than for providing efficient care. Severely biased selection in the FEHBP has been well documented.[12]

The possibility of biased selection can have several negative consequences. For one, it sets up a powerful incentive to discourage enrollment of sick people or to give them poor service, to induce them to disenroll.[13] Thus, it can lead to a system in which some of the most successful insurers are those that most skillfully undermine the goals of the health insurance plan. For another, it violates our basic notions of equity in health insurance. One of the social goals of health insurance is to assure that the sick do not have to pay much more for their health care and health insurance than the well. But if the sick are segmented into some plans while the healthy are attracted into others, without a careful compensating design, the sick will end up paying far more for their insurance than the healthy. For yet another, risk selection techniques are not without cost. This is one reason that administrative costs for individual (nongroup) coverages are notoriously high. These problems, which are potentially very serious, can and must be managed.

Another such strategy is product differentiation. Insurance companies in the FEHBP offer complex bundles of copayments, coinsurance and deductibles, inclusion and exclusion of services, indemnity schedules, and the like, in part to make it costly for people to shop and compare prices. These complexities greatly attenuate price competition. A related strategy is market segmentation. By design of benefit packages and/or choice of location of facilities and emphasis on different types of services, health plans can appeal to some subsets of the market and not to others. In this way, they reduce the number of people who are actively considering a choice of two or more plans based on price.

The vulnerability of the FEHBP to these strategies arises from the mistaken belief that the insurance carrier or HMO, rather than the sponsor, should define the benefit package, and that free entry on the carriers' terms is the appropriate concept of competition. For competition to work well, the sponsor must actively counteract these anticompetitive strategies, starting with firm control of the benefit package.

Managed Care/Managed Competition

The third model for the FEHBP is managed care/managed competition. This model combines two ideas.

Managed care. The first idea concerns the organization of medical practice and the integration of finance and provision of care. The best-documented way to achieve significant gains in efficiency in medical care is through organized managed care systems that are or closely resemble prepaid multispecialty group practice. In varying degrees, such systems are cohesive organizations that attract the loyalty and commitment of their physicians; that engage in systematic quality measurement and control; that match personnel and other resources to the needs of the population served; and that concentrate costly specialized services such as neurosurgery in regional centers to achieve the qualitative and cost advantages of scale and experience. A study by The RAND Corporation found that a prepaid group practice produced outcomes equivalent to FFS at 28 percent less cost.[14] Other studies have found similar results.[15]

Other potential, but as yet unproven, ways to improve efficiency include IPA HMOs and PPI. In 1978, Harold Luft found no documented evidence that costs were lower in IPAs than in conventional insurance.[16] Early IPAs typically were not selective of physician membership, accounted for small percentages of physicians' practices, and used FFS payment almost entirely. W. Pete Welch recently reported that "modern IPAs" are quite different from their 1970s predecessors.[17] Some make extensive use of capitation payments. Some account for larger shares of physicians' practices. And, taking advantage of a greater supply of physicians, some practice greater selectivity in contracting with them. Welch reported that in the mid-1980s, IPA hospital use dropped to approximate that of prepaid group practice. However, uncontrolled use of outpatient services remains a serious problem. PPI uses some of the same cost control techniques that IPAs use. I believe that, to succeed, IPAs and preferred provider networks will have to become more cohesive and to resemble prepaid group practice. Keys to their success will include finding ways to select good physicians; to concentrate care in the hands of busy, proficient physicians; and to attract the loyalty and commitment of their physicians so that resources are not wasted in attempts to police the actions of those who really want to take advantage of the insurance plan.

Managed competition. The second main idea, managed competition, is more complex. It begins with the recognition that the U.S. market for health insurance involves three types of parties: consumers, health insurers (including HMOs and other variations), and sponsors. In the private sector, employers and labor/management health and welfare funds are

sponsors. In the FEHBP, OPM as employer is the sponsor.

In managed competition, the sponsor's job is to design and actively manage a process of informed cost-conscious consumer choice, to motivate managed care plans to produce a favorable combination of efficiency and equity. Efficiency in this case means value for money as seen by informed federal employees. Equity means that the sick do not have to pay much more than the healthy for coverage and care. Perfect efficiency and equity are far from possible. These are quintessentially imperfect markets. And, the goals of efficiency and equity conflict. For example, efficiency favors some consumer cost sharing at the point of service to offset the incentive effect of insurance; that means the sick will have to pay more than those who do not use services.

Thus, OPM should manage a process of consumer choice that rewards with more members health plans that produce better-quality, less costly care, and that does not reward health plans for selecting good risks, differentiating their products, segmenting the market, or other activities that impede high-quality, economical care. In sharp contrast to the free market model, OPM must *actively* manage the process to produce the desired outcome. Tools are available to this large group purchaser to cope with many of the problems that arise in a free market.

Thus, managed competition is not about the proliferation of many choices of insurance plans. Indeed, such proliferation may be counterproductive. In managed competition, the sponsor must limit choices to curb risk selection, product differentiation, and segmentation, and to sharpen price competition. Managed competition is a strategy for purchasing group health coverage that seeks to divide the providers in any community into competing economic units and to create economic incentives for each such unit to organize and deliver care more efficiently. It does this by contracting with managed care plans that link the financing and provision of care so that the premiums people pay are related to the efficiency of the providers they choose. Ten IPAs or PPI plans in town, each contracting with most of the physicians in town, is not "competition" in this sense. Ten competing "free choice" insurance plans serve no useful purpose at all from this point of view.

One of the most effective ways for the sponsor to counteract risk selection, product differentiation, and segmentation is to require all health plans to cover exactly the same list of covered services, subject to the same limits, copayments, and deductibles—that is, to standardize the benefit package. I believe there is a strong presumption in favor of standardization.

The incentives for health plans to attempt to select a favorable mix of risks can be attenuated by "risk-adjusted employer contributions." In

such a system, the employer estimates the expected relative costs of the group of people who are enrolled in each health plan, using characteristics of the people in each health plan known to predict expense, but not including their actual use of services. (To include actual use of services would reward those health plans that use more services to treat the same condition with a greater employer contribution.) If the employer estimates, for example, that the expected costs of people enrolled in Plan A are twenty dollars per month more than those in Plan B, then, on a budget-neutral basis, it contributes twenty dollars per person per month more toward enrollments in Plan A than in Plan B. That way, if the plans set their prices according to their experience in that employment group, the price the subscribers pay to join Plan A will reflect the relative efficiency of Plan A and not the fact that it attracted sicker people. Plan A's competitive position is not damaged by the fact that it attracted sicker people. Medicare uses such a system in making its payments to HMOs. The Medicare formula takes into account age, sex, geographic location (hence local labor costs), and institutional, welfare, and disability status. An important problem for the managed competition model is that these variables account for a small part of the variation in individual medical costs, thus leaving a significant opportunity for risk selection uncorrected. Needed research is under way to find variables that can be used in a payment formula that account for more of the variation in medical costs.

The most obvious place for the FEHBP to start dealing with the risk selection issue would be to create separate risk pools for active employees and their dependents, retirees without Medicare, and retirees with Medicare, or to make employer contributions reflect these cost differences, because average costs in these three groups are so different. Beyond that, it would be desirable to use "risk adjusters" based on age, sex, and geographic area of enrollees. Ultimately, it may prove desirable to use risk adjusters based on specific diagnostic information in a manner analogous to the Medicare diagnosis-related group (DRG) system.

Beyond standard benefits and risk adjustment, there are several other things a sponsor can do to discourage or deal with risk selection. One is to make regular measurements, to watch what is going on, and to take corrective action where necessary. For example, sponsors should ask everyone who changes plans in an open enrollment to answer a brief questionnaire seeking the reason for the change. If people are leaving a plan because it fails to solve their medical problems, corrective action may be indicated because this can reflect a risk-selecting strategy. The sponsor may find it appropriate to make a specific risk adjustment in its contribution to reflect this, or even to stop offering the plan. The sponsor should check out the tertiary care arrangements offered by each plan to

be sure they rely on high-quality medical centers that have substantial relevant experience and that produce good outcomes. Otherwise, people who consider themselves at elevated risk for such care may shun plans with poor tertiary care arrangements.

In addition, the sponsor should take an active role in measuring quality of care and service and in providing relevant information to subscribers. Two of the most promising avenues here are encouraging the use of risk-adjusted monitoring of outcomes and systematic surveys of employee perceptions concerning quality of care and service in the different health plans.[18] The Center for the Study of Services has developed a measure of the rate at which consumers switch plans at open enrollments, adjusted to take account of relative costs, age of plan, and other factors, to estimate a measure of dissatisfaction with the plan.[19] More such research is needed.

Managed competition is a strategy, not a rigid design. A number of conditions must be present for it to work well. For one, OPM would need a large and expert staff armed with good information systems. Such resources may appear costly in relation to the resources it now has. But the costs would be small in relation to the $12 billion annual cost of the program. OPM, and employers generally, must be willing to use the best tools and talent if they want to get control of this complex industry. Second, the FEHBP cannot be expected to reform the whole U.S. health care system on its own. If the health care financing arrangements for the other 200 million covered Americans remain as inflationary as they are now, the FEHBP will remain a captive of the general upward trend, though it may be able to buy relatively economical care for federal employees. Third, there must be competing managed care plans in each market. The FEHBP alone cannot elicit such a supply of health plans or create a total system reform. Thus, the FEHBP would work far better if most major sponsors followed a similar strategy of managed competition.

The concepts of managed competition may seem complex and subtle to people unfamiliar with the microeconomics of health care. But, conceptual simplicity of administration should not be an overriding objective of this program. Moreover, it is much easier for OPM to deal effectively with 500, or even 1,000, managed care plans, than to take the conceptually simpler approach of contracting with one insurance carrier that, in turn, has to deal directly with hundreds of thousands of physicians and thousands of hospitals. Managing competition is much less complicated than processing individual claims and attempting to evaluate them for quality, economy, and appropriateness. By comparison, the traditional insurance view seems simple only because it does not deal effectively with these crucial issues. Ultimately, there is no satisfactory alternative to an efficient delivery system.

Recommendations For The FEHBP

The concept of managed care/managed competition is the basis for the following recommendations for the FEHBP. These recommendations are made from the point of view of a rational economic design to achieve the efficient and equitable program that taxpayers and federal employees are paying for. These principles should be put into practice and should not be lost in the inevitable political compromises with employee organizations and other special interest groups.

Standardize benefit packages. First, OPM should standardize the benefit packages offered. There should be one list of covered services for all plans. It should include all the services generally covered by large employers who compete with the federal government in the labor market. The coverages offered by HMOs and by indemnity and preferred provider insurance should be the same except for the schedule of coinsurance and deductibles. Lacking effective internal management controls, the indemnity and PPI plans must be able to use coinsurance and deductibles to control cost. But, the schedules should be standardized among all indemnity and PPI plans. OPM should seek to adjust the coinsurance schedules and the copayments in HMOs so that the two types of plans are attractive to a similar mix of risks. Thus, the law should abolish the notion of high and low options, which are a cause of biased risk selection.

Compensate for risk selection. Second, OPM should begin to adjust employer contributions to compensate for risk selection. First, it should immediately divide subscribers into three separate risk pools: active employees, retirees without Medicare, and retirees with Medicare. There should be separate premiums for each group, with employer contributions adjusted on a "budget-neutral" basis so that the absolute difference between the average premium and the employer contribution (that is, the average employee premium share) is the same for each group.

In a subsequent step, OPM should adopt a "positive enrollment" procedure in which each subscriber, whether changing plans or not, must fill out a form that identifies each person to be covered, including date of birth and sex. This would enable OPM to know, for the first time, how many dependents are actually covered. And it would permit OPM to make risk adjustments based on age, sex, and family size. (Information provided in the November 1990 enrollment would be turned into estimates of relative risk during 1991, which, in turn, would be used to adjust the employer contributions announced in November 1991 for coverage during 1992. This takes advantage of the fact that usually relatively few people change plans each year.) The FEHBP has worked tolerably well for nearly thirty years without any system of risk adjustment. The feasible

steps I have recommended would improve this aspect of the program greatly and give OPM time to do research and development on the next generation of risk adjustments.

The research program should identify and test questions about health status to ask in the annual enrollment that might serve as the basis for more accurate risk adjustments. The research also should investigate geographic adjustments to reflect differences in labor and other costs. OPM should collaborate with the Health Care Financing Administration (HCFA) in developing more advanced systems of risk adjustment.

Phase out indemnity plans. Third, OPM should phase out the indemnity plans, and it should replace the governmentwide service benefit plan with preferred provider networks in each state. The requirement that a standard benefit package be offered would help to accomplish this objective by rendering pointless the current offering of multiple indemnity plans. Those people who want the complete freedom of choice offered by indemnity coverage can get it in the context of PPI coverage by using their "out-of-plan" provisions. Pure indemnity coverage is the most inflationary and the least satisfactory form of coverage. With no contract between insurer and provider, it leaves patients vulnerable to excessive charges by providers and to unnecessary and dysfunctional uncertainty as to what their coverage will be. Pure indemnity coverage lasted this long only because of the political power of organized medicine; it is rapidly losing ground in the private sector. The State of California dropped it as an option for its employees in January 1989.

OPM should contract with one or several preferred provider insurance plans, which together cover each state. Blue Cross/Blue Shield and the large insurance companies have been developing such networks. This would lead to an end to the "governmentwide" service benefit plan. Pricing state by state would allow preferred provider networks and local HMOs to compete more effectively and on equal terms with each other. While I am not optimistic about the long-term effectiveness of PPI, it offers far more opportunities for cost containment than indemnity coverage offers. The fact that nearly 80 percent of FEHBP enrollees recently have been under indemnity coverage (or the very similar service benefit coverage) suggests that, for whatever reason—the inflexibility of government, the law, political influence, or inadequate administrative budgets for OPM—the FEHBP is not taking full advantage of some of the most important innovations in cost containment. In recommending such a drastic reduction in indemnity offerings, I recognize that some relatively small groups such as foreign service personnel in overseas assignments may require specialized offerings.

Regarding HMOs, there are important distinctions between closed-

panel HMOs (group or staff models) whose contracting providers care mostly or exclusively for members enrolled in that HMO, selective IPAs, and preferred provider networks that offer a distinct set of physicians, and open-panel HMOs (IPAs that contract with most of the providers in town). Multiple closed-panel HMOs, selective IPAs, and selective PPI networks foster desirable competition. Multiple open-panel HMOs and PPI networks, all offering essentially the same providers, contribute little or nothing to economic competition at the provider level.

HMOs and many preferred provider networks are local or regional businesses. Since there are federal employees in many localities, it is in the interests of purchasers to encourage provider-level competition in each community. Several participating closed-panel HMOs and selective IPAs or PPI networks in each community are necessary for managed competition. From the point of view of the individual employee, a large number of HMOs in the FEHBP does not create a bewildering array of choices. The employee need only consider the relatively few HMOs that serve his or her part of the metropolitan area. Even in Washington, D.C., the FEHBP offers twelve HMOs and PPI networks, not an unreasonable burden of choice for the federal employee. Indeed, such a range of choice is healthy. The industry is undergoing rapid change as the private sector struggles with the important problem of containing costs in ways that maintain access and quality. It makes sense for the FEHBP to use multiple choice in the marketplace to sort this out.

Change employer contribution formula. Fourth, the employer contribution formula should be changed to reflect the broad trend in employee health care costs. The present "Big Six" formula is leading the program into trouble. As mentioned earlier, the two governmentwide high-option plans in the formula are no longer representative of costs in general. As a result, the market share of these two plans has fallen from 65 percent in 1974 to 16 percent in 1988.[20] The government contribution now threatens to exceed the price of the most efficient plans. If this trend continues, these plans will lose all incentive to lower their prices further.

National per capita costs grew from 1984 to 1987 at around 8 percent per year. The Big Six formula ties the contribution to two plans that are in a "death spiral" of adverse selection and membership decline, and to two that are typical of inflationary FFS coverage. If the government's employer contribution had grown from 1984 to 1989 at an average rate of 8 percent instead of at 13.7 percent, the government's 1989 outlay would be roughly $6 billion instead of $8 billion.[21] This is not to suggest that the government ought to be contributing $6 billion instead of $8 billion. In fact, the government's contribution is lower than what is typical of large private employers. The present level of contribution should not be

reduced, but its growth ought to be tied to a weighted (by membership) average of all the plans, not an inflationary subset of them. One good feature of such an average is that its growth is slowed as the market share of lower-cost plans grows, thus allowing the taxpayers to share in the savings generated by the growth of more economical plans.

Unlink government contribution from choice of plan. Fifth, under the law, the most the federal government will contribute toward any plan is 75 percent of its premium. This, in effect, says to the employee, "If you choose an inefficient health plan, we will pay more money on your behalf," and thus attenuates the incentive for employees to choose efficient health plans and for efficient plans to hold down their premiums. It also penalizes low-income earners who are more likely to choose low-priced plans. To maximize the incentives for efficiency, the government contribution should be independent of choice of plan.

Integrate the FEHBP with Medicare. Sixth, the FEHBP ought to be integrated with Medicare for all Medicare-eligible retirees. Medicare-eligible retirees use regular FEHBP plans as Medicare supplemental coverage, which is needed because Medicare does not cover all the benefits available to federal employees in many of their plans, including the first several hundred dollars of outpatient drugs, Medicare deductibles, some preventive services, mental health, and so on. But, as noted earlier, the retiree does not receive an appropriate economic incentive to join a cost-effective system, and the growth of participation in HMOs by Medicare eligibles is impeded. Medicare-eligible retirees ought to be allowed to keep the savings generated by their decision to join HMOs and other relatively efficient managed care plans.

A single Medicare supplemental package should be offered by all participating carriers in the FEHBP. It should offer Medicare-eligible retirees a fixed-dollar contribution toward the cost of this coverage, also usable as part payment for the supplemental premium charged by HMOs on risk-basis contracts with Medicare. If retirees elect a plan that costs less than the fixed-dollar amount, they should be allowed to receive the difference in cash as a contribution to their Medicare Part B premium, the approach used in California's Public Employees Retirement System.

Measure quality actively. Finally, OPM should be given the resources and the charter to conduct an active quality measurement program. The purposes of such a program would include getting more value for money for federal employees, reassuring employees in their choice of high-quality health plans to speed their migration to those plans, and motivating plans with poor quality to improve and to pinpoint their areas of weakness. Such quality measurement programs are in an early stage of development elsewhere, but they are sufficiently promising as to merit

substantial additional resources.

First, OPM should require uniform reporting of all hospital discharges, as, for example, California and Maryland do statewide. And, OPM should collaborate with HCFA, state governments, and large private employers in evaluating HMOs and preferred provider networks, using quantitative outcome-oriented techniques. OPM should support an "outcomes management" program and actively collaborate with HCFA in its "effectiveness initiative" to improve overall quality of care.[22] For example, OPM might usefully go beyond the data in hospital discharge abstracts to question samples of patients several months after a hospital episode about their health status, perceptions of quality, and return to work. OPM should survey a sample of employees in each health plan on their perceptions of the quality of care and service. OPM could feed back the results to health plans to help them identify areas for needed improvement, publish results for use by employees in making choices, and use the results to end contracts with poor performers.

Obviously, many of these recommendations will encounter opposition from established interest groups that will see themselves disadvantaged by such changes. Some of the health plans now in the FEHBP might be put out of this market, or even out business. All would find themselves in an environment of greatly sharpened price competition. But, these changes are necessary if the FEHBP is to deliver efficiently what the taxpayers and federal employees are paying for. Thus, the FEHBP is a good test case of whether the federal government is capable of operating an efficient and effective health insurance plan for its own employees, or whether it is so paralyzed by special interest politics that it can no longer even do that.

The federal government should exercise leadership by designing and managing the FEHBP in the most effective way possible for several reasons. First, doing a good job for its own employees makes it a more attractive employer. Employees who receive better care are likely to suffer less work loss from illness. Second, the government has an opportunity to set a high standard for the private sector. Thus, its activities could affect the entire health care system constructively as the FEHBP has done in the past. Finally, the recommended research and development on such issues as risk adjustments can produce management methods useful in other government programs and in the private sector.

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