Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program

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EXECUTIVE SUMMARY

The Federal Employees Health Benefits Program (FEHBP) currently covers over 9 million lives, including Members of Congress, the President of the United States, and their families. Permitting the uninsured to use health insurance tax credits to enroll in FEHBP would be a cost-effective, efficient way to extend coverage. Expanding FEHBP should also have broad political appeal, although in order for such a program to be feasible, federal workers already enrolled must not see their premiums rise, nor their benefits decline.

FEHBP is administered by the Office of Personnel Management (OPM). Participants choose an insurance plan from a number of managed fee-for-service plans and HMOs offered under FEHBP. Benefits are generally comprehensive, and participants have an annual opportunity to switch plans. Extended FEHBP or E-FEHBP would operate in parallel with this program.

E-FEHBP would run in conjunction with a program offering health insurance tax credits to low-income workers. E-FEHBP would be open to all individuals who are not covered by employee sponsored plans or public programs such as Medicaid, and who also are eligible for health insurance tax credits. These tax credits could only be used to purchase insurance through E-FEHBP.

In addition, E-FEHBP would be open to all employees of firms with fewer than 10 workers, regardless of whether they were eligible for tax credits. Small-firm employers would be required to pay at least 75 percent of the premium for either the lowest-cost plan in the area, or the most prevalent national plan, whichever is less. Workers could use tax credits to pay all or part of the remainder, but the value of their tax credits could not exceed their share of the premium. In order to participate in E-FEHBP, small firms would also be required to enroll at least 75 percent of all workers not covered by another source of insurance.

Most of the plans available to FEHBP participants would be required to offer enrollment to E-FEHBP participants. Benefits and other terms of coverage would be the same for both FEHBP and E-FEHBP, and would usually include prescription drugs, certain preventative services, childhood immunizations, transplants, maternity care, and contraceptives. Benefits and premiums would necessarily differ in different regions of the country, just as they currently do for FEHBP.

There is a risk that E-FEHBP could be undermined if healthier individuals purchase insurance in the outside market, leaving the relatively unhealthy to the federal program. In order to reduce risk selection, insurers would be allowed to impose preexisting-condition waiting periods for previously uninsured individuals. This would prevent people from waiting to enroll in E-FEHBP until they were already ill. In addition, FEHBP and E-FEHBP would be separately rated, and very-high-risk individuals enrolled in E-FEHBP would be diverted to a separate high-risk pool, the cost of which would be subsidized by the federal government out of general revenues.

The existing OPM lacks the resources to handle the significant new administrative burden that would result from E-FEHBP. Thus a new administrative structure is envisioned, in which it would be administered either by the states, or if a state declined to carry out this function, by a contractor hired by OPM. States would receive federal start-up grants to establish E-FEHBP, but subsequent administrative costs would be paid for by a small surcharge on premiums.

The administering agency would operate in a similar way to OPM when it manages federal annuitants. At present, OPM determines eligibility, handles enrollment, changes in enrollment and disenrollment, oversees payments to insurers, informs annuitants of changes in rates and benefits, and handles inquiries. Individuals would send a form indicating their choice of insurer to the administering agency. Premium payments may also flow through this entity. Employers would send their share of their employees' premium payments, along with the employees' share, to this entity as well.

E-FEHBP would provide group insurance coverage to people who could not otherwise get it, but premiums may still exceed the tax-credit amount, and some people may still not be able to afford even subsidized coverage. In addition, most small firms that do not currently provide insurance cite reasons of cost. Since E-FEHBP would subsidize the employee's, but not the employer's, premium contribution, many small firms may still decline to offer insurance under the program. Besides cost, other aspects of E-FEHBP that may discourage enrollment might be the complexity of the enrollment process, the fact that many eligible people may not be aware of it, and the stigma that may be associated with participation in any program for which income or other eligibility criteria have to be demonstrated.

INCREASING HEALTH INSURANCE COVERAGE THROUGH AN EXTENDED FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

I. OVERVIEW OF APPROACH

This paper outlines an approach to expanding health insurance coverage that would open up the Federal Employees Health Benefits Program (FEHBP) to some groups of the uninsured. The aim is to make available to millions of uninsured and underinsured Americans the same health care coverage that is available to the President, Members of Congress, and millions of federal employees and retirees.

The FEHBP currently covers over 9 million lives, has low administrative overhead, a relatively stable group of participating insurers, and offers multiple choice of health insurance options to every participant. Although the program is administered by an agency of the federal government (the Office of Personnel Management (OPM)), insurance is provided by carriers and Health Maintenance Organizations (HMOs) that sell in the commercial marketplace. Benefits are relatively comprehensive and participants have an annual opportunity to change plans. Opening up FEHBP would expand affordable coverage to many Americans now lacking it, without significantly disrupting the health care arrangements of the majority of insured individuals. The program is hereafter referred to as Extended FEHBP (E-FEHBP).

Many proposals to cover the uninsured have surfaced over the years that borrow elements of FEHBP or are in some way modeled after the way FEHBP "manages competition" between private insurance carriers for enrollees. For example, some proposals, including the 1993–1994 Clinton Health Security Act, resemble FEHBP in that they provide for a regulated form of competition between qualified health plans for enrollees. Some proposals have required that carriers and HMOs contracting with FEHBP sell coverage to uninsured individuals or small employers, permitting different benefit packages from those offered to federal workers. And some proposals have benchmarked their required benefit package to the benefit package offered under the most prevalent FEHBP plan. Few measures, however, have actually proposed that uninsured individuals have access to the same plans and benefit packages provided under FEHBP, offered through a program run effectively the same way as FEHBP. This paper deals with this type of approach.

To what extent is opening up FEHBP feasible? And why insist on preserving the basic elements of FEHBP for covering the uninsured? Making the same health insurance available to the uninsured that is widely touted as a model for cost-effective insurance and

that is the same coverage as available to Members of Congress is likely to be more politically compelling than most other options for covering the uninsured. However, certain modifications are clearly necessary to ensure political viability. For example, the premiums of federal workers and annuitants must not rise as a result of new populations entering the program.

Eligibility. This proposal takes advantage of the existing FEHBP to extend access to group health insurance to individuals who are currently without coverage or who obtain their health insurance in the private individual insurance market. Specifically, individuals who do not participate in employer-sponsored health plans or in public insurance programs, and who qualify for a new federal refundable tax-credit based on income, would be able to enroll in most of the same insurance plans that participate under FEHBP.

Enrollment in E-FEHBP also would be open to smaller employers (firms with fewer than 10 employees), their employees, and their families. Such employees and their families would not be required to be eligible for the refundable tax credit. If they were, however, they could only receive a tax credit for an amount not to exceed their share of the employer's premium. To participate in E-FEHBP, eligible small employers would have to contribute a specified share of their employees' premiums. They would also have to meet any minimum participation requirements imposed by the insurer or HMO. Employees would make their own plan selection from among the E-FEHBP plans offered in the firm's area. The administrative challenges and implications for risk selection of these design features are explored in some detail below.

Enrollment, Plan Choices, and Benefits. With exceptions, newly eligible populations for E-FEHBP coverage would have the same plans available to them as current participants do. Individuals would enroll with the plan of their choice by sending a form to the enrolling agent, which may be a state entity or an OPM contractor. Employers would collect premiums from their employees and send them, together with the employer's share of the premium contributions, to the administering entity. Insurers (managed fee-for-service plans, HMOs, and point of service (POS) plans), would have to agree to accept these new enrollees as a condition of participating in FEHBP. Plan benefits and most other terms of coverage (e.g., cost-sharing, open enrollment, and continuation coverage) would be the same for enrollees in E-FEHBP as for current FEHBP enrollees. Unlike in FEHBP, however, insurers would be allowed to impose preexisting-condition waiting periods on newly enrolled individuals lacking immediate prior coverage consistent with the rules under the Health Insurance Portability and Accountability Act (HIPAA).

Administration. Proponents of opening up FEHBP to nonfederal workers often point to the significant economies of scale that could be achieved over smaller, regional purchasing cooperatives or the individual and small-group insurance markets. But opening up FEHBP to people who are not connected to the federal workforce presents administrative challenges. The employee benefit personnel at the federal agencies who bear a significant part of the administrative load for OPM would not be available to nonfederal participants. Moreover, some of the enrollment/disenrollment, premium collection, and other administrative functions that have to be carried out to make FEHBP work are more complicated when dealing with small employers and individuals than with federal workers and annuitants.

Recognizing these concerns, it is proposed that states be given the opportunity to administer this program in collaboration with the federal government. Federal grants would be made available to the states to help them establish an entity (or piggyback on an existing state program) to carry out enrollment, information dissemination, and other responsibilities that typically would be handled by OPM for federal workers. In states that declined to carry out these functions, OPM would appoint a designated entity, perhaps a contractor or another federal agency. Both the cost of the federal grant program and the added costs to OPM of administering E-FEHBP would be subsidized by general revenues, at least for the first few years. Once E-FEHBP was firmly established, the added administrative costs could be charged to participants in the form of a surcharge on premiums.

Pricing of Policies. To ensure the political viability of the proposal, it is critical that existing FEHBP participants be insulated from any increased costs resulting from E-FEHBP. Insurers would, therefore, be required to separately rate the newly eligible group of participants. The administering entity would review and approve plan premiums in the same manner OPM does for the current program.

In addition, insurers participating in E-FEHBP would be able to place high-risk enrollees in a reinsurance pool, which would be run by the administering entity. This transaction, designed to buffer participating insurers against adverse risk selection, would be invisible to the enrollees. Costs for these enrollees in excess of some predetermined threshold would be borne by the reinsurance pool, with subsidies from the federal government, paid out of general revenues. The reinsurance program would be designed to give insurers an incentive to manage risks below the threshold in which their costs were ceded to the reinsurance pool.

Subsidized Premiums for Low-Income Participants. As noted above, E-FEHBP would be available to individuals eligible for a new federal refundable tax credit as well as all small business employees. The design of this tax credit would be consistent with that specified in other "workable solutions" proposals. For employees of small businesses participating in E-FEHBP, the amount of the refundable tax credit could not exceed the enrollee's share of the premium contribution.

Financing. New federal funds would be required to pay for the refundable tax credit for qualified low-income participants in E-FEHBP. They would also be required to help pay for the reinsurance pool for high-risk enrollees, as well as the new costs associated with setting up E-FEHBP. Additional costs would include grants to the states to encourage their participation in administering E-FEHBP, or to pay OPM contractors or other designated agents to carry out such functions in states that elected not to participate.

Results. Based on modeling work done for this project by Glied et al., about 145 million people would be eligible for the refundable health insurance tax credits. An additional 18 million people would be eligible for E-FEHBP as a result of their connection to a small firm.[1] The number of people who would actually become enrolled in E-FEHBP would be smaller. It is estimated that about 32 million people eligible for the tax credit would take up the coverage, including over 11 million people who were previously uninsured. Over 8 million people with non-group coverage would switch to E-FEHBP, resulting for most in significantly improved insurance. However, close to 11 million individuals with employer-sponsored coverage also would switch, a substitution of coverage that might result due to a "better buy" offered by E-FEHBP.[2] The number of people enrolling through small employers but who are not also eligible for the tax credits has not been determined.

The cost to the federal government for E-FEHBP would largely be driven by the cost of the health insurance tax credits, which at the levels specified here are estimated to cost as much as $34 billion a year.[3] The cost per newly insured, inclusive of the cost of the E-FEHBP reinsurance pool, is estimated to be $3,000 per year. The additional costs for administration and state grants have not been estimated.

II. BACKGROUND

At no time have large numbers of uninsured, nonfederal workers been allowed to buy into a federal public employee plan. However, the section of the law that authorizes FEHBP—chapter 89 of title 5 of the U.S. Code—has been amended over the years to make eligible for FEHBP specific categories of individuals who would otherwise not meet the definition

of a federal employee, annuitant or their dependents.[4] These expansions seemed to have been made smoothly, without disrupting the existing pool of insured participants.

A demonstration project, probably the largest potential expansion of FEHBP to date, will take place between 2000 and the end of 2002. The demonstration will make coverage available to up to 66,000 Medicare-eligible military retirees and related beneficiaries.[5] Mandated by Congress, it is being jointly administered by the OPM and the Department of Defense. All open fee-for-service plans are required to participate in the project. Some HMOs also will be required to participate, "based on their service areas and the defined boundaries of the eight demonstration sites…." Some HMOs will be invited to participate but will not be required to do so because their FEHBP enrollment is very small, or their service area overlaps only a small portion of the demonstration area. The statute requires that a separate risk pool be established for Department of Defense enrollees. Accordingly, participating plans are required to submit separate rate proposals, based on the benefits that are identical to those available to all other FEHBP enrollees.[6] For 2000, the enrollee share of the premiums for the two Blue Cross Blue Shield plans and for GEHA are the same for new military-retiree participants and for traditional FEHBP participants. However, the premiums for the six other participating national plans are mostly higher, and in some cases, substantially higher. The evaluation of the demonstration should be helpful in designing any further expansion of FEHBP.

In a few cases, health plans sponsored by state or local governments for their own employees have been opened to private employee groups. Such public employee plans tend to be the single largest purchasing group by size of membership, excluding Medicaid, in a state, ranging from 20,000 to over 1 million enrollees. A major advantage to participants is that they are given a choice of more than one, and sometimes many, health options. As of 1993, about 19 state employee programs were open to non-state public employee groups, such as local government and school employees. A couple of state employee plans were open to quasi-public and nonprofit agencies receiving state funds.[7] State programs in Minnesota, Washington, and Kentucky offered coverage to private employer groups. Minnesota, for example, opened its public employee health benefits program to private employers with at least two employees. Employers had to contribute at least 50 percent of the premium. Kentucky offered a public buy-in that allowed residents other than public employees to obtain coverage through its public employees health benefit plan. And, enrollment in the Washington State Basic Health Plan was opened to any individual or employer on a non-subsidized basis.[8]

When state public employee plans open up to non-state employees, they sometimes rate as one large pool, and sometimes as separate pools, depending on the nature of the participants. Rating these pools separately prevents state employees from having to bear the expected higher costs of other enrollee groups. But in some cases, the pool may be designed to ensure that groups in the same geographic area have the same set of plan options at the same price, partly to ensure that plans are available to rural residents. For example, carriers may be required to offer insurance in an entire region in order to participate in the state employee program.

If there is any useful lesson for the E-FEHBP approach, it is that individuals and small employers can improve their purchasing power, obtain more plan choices, and save some premium dollars by combining into larger purchasing units such as public employee plans. However, the terms and conditions under which such public purchasing arrangements have operated in the past may not apply under an E-FEHBP approach. For example, it may not be politically feasible to give the administering entity as much latitude as OPM has to negotiate the terms and conditions of coverage or premiums for a program that is going to be in direct competition with the individual and small-group insurance markets across 50 states for millions of potential insured individuals.

Prior Proposals

The most concrete proposals to use FEHBP to cover the uninsured emerged in the 1993-1994 debate over health reform. Senator Roth, then chair of the committee with jurisdiction over FEHBP, introduced S. 1978, the Federal Health Care Expansion Act of 1994, which would have phased in coverage of small employer groups under FEHBP. Several of the Republican alternatives to the Clinton Health Security Act also would have opened up FEHBP to non-federal workers and their families.[9] Such proposals were not popular with federal workers and retirees who feared that their premiums would rise and benefits would erode.

In recent years, the Clinton Administration has proposed a more modest version of this option. Under at least one of the annual Clinton budget proposals, a federal grant program to the states would have been established to encourage voluntary purchasing cooperatives for employer groups of 1 to 50 employees. The cooperatives would have enabled small businesses to bargain collectively for lower premiums and obtain more choices of plans for their employees than would otherwise be available. One provision of the proposal would have given these purchasing cooperatives access to health plans sold through FEHBP. Recipient States could request the Secretary of Health and Human Services to establish a cooperative in coordination with FEHBP. The cooperative could

use the FEHBP name in marketing and require FEHBP plan carriers and HMOs that sell coverage in the private market to offer appropriate health insurance policies to small employers at prices negotiated by the cooperative. But the cooperative could also negotiate with other carriers not participating in FEHBP to sell to its small-group members.[10]

The latest wave of interest in a FEHBP buy-in has been sparked by Bill Bradley's presidential campaign health care reform proposal. Under the Bradley plan, FEHBP would be opened up to all Americans under age 65 not covered by an employer-sponsored health plan. A special pool would be established for those with greater-than-usual health care needs. The federal government would subsidize the health insurance premiums (for FEHBP or other health insurance plans) of low-income families, largely through tax credits. The details of the proposal were never fleshed out, however, leaving many questions about how the plan would actually work.[11]

Finally, Representative Pete Stark (D, CA) introduced in the 106th Congress H.R. 2185, the "Health Insurance for All Americans Act of 1999," which provides a more concrete proposal for expanding health insurance coverage using FEHBP. The bill would make available refundable tax credits of $1,200 for an individual, $1,200 for the spouse, and $600 for each of up to two dependents for the purchase of qualified health insurance. These amounts would increase for inflation. The refundable tax credits would not be available for any months in which the individual participated in an employer-subsidized health plan or in a public insurance plan (e.g., Medicaid, Medicare), or certain other coverage (e.g., military health care). Advance credit payments could be made to the provider of each person's qualified health insurance.

A new federal Office of Health Insurance would be established under H.R. 2185 to sell FEHBP insurance. Any carrier or plan participating in FEHBP would have to make coverage available to qualified individuals during an annual open season (and at other specified times), without any preexisting condition exclusion or waiting period. But there would be a provision allowing the benefit packages sold to tax-credit recipients to differ from those offered under FEHBP. The Office of Health Insurance would be required to permit FEHBP plans to vary so that carriers and plans could offer packages costing the value of the refundable tax credits. However, benefits could not be varied in order to improve risk selection. Moreover, the premiums for these policies, which would be rated separately, would be negotiated between the participating carriers and the new Office of Health Insurance. Carriers would have to apply the rates on a uniform, community-rated basis. Only individuals buying the FEHBP-related coverage would be eligible for the refundable tax credits. H.R. 2185 shares some features with the option described in this

article and suggests ways of preserving some linkage to FEHBP without actually extending FEHBP plans.

III. DETAILS OF THE PROPOSAL

Target Population

The E-FEHBP proposal is designed to expand health insurance coverage to two target groups. The first group consists of low-income adults and children who are otherwise not *participating* in an employer-sponsored health plan or in an existing public health insurance program, including Medicare, Medicaid, and SCHIP. To be eligible for E-FEHBP, individuals in this group must qualify for the new refundable health insurance tax credit (hereafter referred to as the HI Tax Credit). This group totals about 146 million people, of whom about 39 million are uninsured and 10 million currently have individual insurance (based on the March 1999 Current Population Survey).[12]

E-FEHBP should be an attractive option to many falling into this target group because it would offer a choice of *group* insurance plans at lower premiums unlikely to be otherwise available. The shortcoming, of course, is that the price of policies offered under the program may significantly exceed the tax-credit subsidy amounts. The cost of E-FEHBP policies could discourage even those receiving the maximum tax credit ($2,000 for an individual and $4,000 for a family) from participating. For example, if E-FEHBP were available in 2000, the most prevalent plan—Blue Cross Blue Shield standard option—would cost about $2,830 for self-only coverage and over $6,000 for family coverage. Assuming that the separately rated premium for E-FEHBP was similar, an individual would have to spend out-of-pocket $830, and a family, $2,000. Less expensive HMOs might be available, but this would depend on where the individual or family lived. If risk selection resulted in higher E-FEHBP premiums, then the tax credits may be even less effective in encouraging the target population to buy coverage.

Based on the modeling done for this project by Glied et al., about 32 million people eligible for the HI Tax Credit would actually enroll in E-FEHBP. This includes 11.5 million previously uninsured individuals. Also electing E-FEHBP would be about 11 million people previously covered through employer-sponsored coverage, 8.3 million people with non-group coverage, and about 1.1 million people with Medicaid.

The second population group targeted for coverage under E-FEHBP is employees working for firms with fewer than 10 employees. Most uninsured workers are attached to small firms; in 1999, about 6.5 million uninsured workers and their families were connected to firms with fewer than 10 employees.[13] Under E-FEHBP, such employees

and their families would not have to qualify for the HI Tax Credit, although most in fact would. If they did qualify for the credit, they could use it to pay their share of the premium for E-FEHBP coverage. The tax credit could not, however, exceed the employee's premium contribution amount.

E-FEHBP would appeal mainly to small firms that would like to offer insurance but have failed to do so because the time and effort needed to find and buy insurance is too great, few plans are available for small groups, and among those that exist, benefits and premiums are often unstable. E-FEHBP would be less attractive to firms that cannot afford to provide coverage. Most small firms that do not provide coverage cite cost, and not availability, as the reason. Since E-FEHBP would require employers to contribute a significant share of the premium, few small firms may take up E-FEHBP coverage.

Administrative Structure

The Role of the Federal Government

The OPM was given the responsibility of administering FEHBP under the 1959 statute establishing the program. The agency is authorized to contract with insurance carriers; approve plans for participation in the program; negotiate with plans about benefits and premium levels; determine the times and conditions for open season; make information available to employees concerning plan options; and administer the financing of the program. It is also responsible for maintaining a fund for receiving and disbursing premium payments and holding contingency reserves.

In turn, however, OPM relies on the employers (that is, the federal agencies) of active federal workers to carry out numerous functions, including determining eligibility, distributing plan brochures, enrolling and disenrolling participants, and deducting the employee's share of the insurance premium from payroll. The intermediary or middleman role played by these agencies in carrying out these functions is very important and would not be present in E-FEHBP.

A closer parallel for E-FEHBP is the way in which OPM handles administrative functions related to federal annuitants, because for this population there is no middleman. OPM determines whether retiring employees or survivor annuitants meet the requirements to continue health insurance under FEHBP; handles enrollment and disenrollment; oversees automatic deduction of premiums from monthly annuity checks and credits the premiums, along with the applicable government contribution, to the appropriate health plan accounts; processes all enrollment changes; notifies affected carriers of such changes; and keeps annuitants advised of rate and benefit changes within their

plans. Annuitants are responsible for requesting detailed plan brochures from the health plans. Such information is also available on the Internet.[14]

OPM spends less than 1 percent of the aggregate cost of plan premiums on FEHBP administration. Administrative costs include the personnel costs of about 200 OPM actuaries and employees who negotiate with health plans, monitor plans, and carry out general program administration. OPM adds an amount to each plan's premium to cover these administrative costs. No estimate is available for the amount spent by the individual federal agencies carrying out tasks related to FEHBP.[15]

Could OPM be expanded to administer E-FEHBP? Probably, but only if the agency looked and operated differently than it does today. Significant new resources would be needed to handle the millions of individuals who would be eligible to enroll in E-FEHBP plans.[16] Separate plan negotiations and rate reviews would be needed. Individuals without any employer sponsor would be relying on OPM for enrollment and disenrollment, general inquiries, premium collection, appeals and grievances, and more. Although small employers could be required to do the payroll deductions for participating employees, they would still be reliant on OPM for most other administrative functions. Also, the large amount of federal tax-dollar subsidies of E-FEHBP plans might justify increased public disclosure and accountability.

Since E-FEHBP would create new administrative demands on OPM, it is likely that such responsibilities would have to be delegated to another administrative entity, perhaps an agency or office under the Secretary of Health and Human Services. A precedent for this type of interagency cooperation exists. As described above, the Department of Defense is collaborating with OPM to administer its FEHBP demonstration program. However, it is more likely that each state would be encouraged to administer E-FEHBP for its eligible residents. Federal grants could be made available to the states to support start-up and development of necessary administrative systems.

The federal government would mainly use general revenues to pay for the start-up administrative costs for E-FEHBP. Eventually, participants' premiums would pay for some or all of the costs of administering the program. Presently, the administrative load of FEHBP plans is less than 1 percent. Under E-FEHBP, this percentage would rise, with the added costs of reviewing a second set of plan rates, disseminating information to individuals and small employers, handling increased contacts for information and complaints, and handling additional appeals. A reasonable assumption is that such administrative costs might double or even triple, but 2 percent or 3 percent is still modest,

relative to other private insurance products. Administrative overhead in the individual market can be as high as 40 cents out of every premium dollar.[17] Another federal cost would be any grants used to encourage state administration of E-FEHBP. It is likely that such costs would be relatively modest, perhaps $50 to $100 million in the first year.

Finally, there would be a cost to the federal government to administer the HI Tax Credit. The Internal Revenue Service and Department of Treasury's experience with an earlier health insurance tax credit, the Earned Income Tax Credit—Health Insurance, suggests that such credits pose significant administrative challenges because of the potential for fraudulent claims.[18] These costs, however, would not be reflected in formal budget estimates for the proposal.

The Role of the States

The E-FEHBP is not intended to replace state Medicaid or State Child Health Insurance Programs (SCHIP), although some replacement, or what is known as "crowd-out" might occur. As discussed below, states could be required to maintain their current effort in providing health insurance to low-income individuals through these programs. Another possibility is that some states might expand coverage by helping eligible individuals pay for their share of E-FEHBP premiums by leveraging the federal subsidies provided through E-FEHBP. This would be a relatively inexpensive way for states to expand coverage, assuming they had the political will to do so. Finally, some or all states could arrange with the federal government to administer E-FEHBP at the state level.

Private Health Plan Participation

Plans contract with OPM each year to participate in FEHBP. They respond to an annual "call letter" sent out early in the year requesting plans to submit their benefit and rate proposals for the next year. This letter also includes any required changes in benefits and other new policies that contractors have to meet. Some plan turnover is expected from year to year. In 2000, almost 100 fewer HMOs are participating than in 1998 as a result of both departures and mergers.[19]

Participation Rules

Most of the existing plans offered under today's FEHBP would be required as a condition of participation to also accept E-FEHBP enrollees. Plans currently open only to specific groups (e.g., plans for the Secret Service, Foreign Service, etc.) would be excluded from E-FEHBP. In 2000, 10 managed fee-for-service options are available nationwide: Blue Cross Blue Shield (BCBS) Standard and High options, Alliance Health Plan, APWU Health Plan, GEHA, Mail-Handlers Standard and High, NALC, and Post Masters

Standard and High. In addition, approximately 300 HMO participate in FEHBP. All of these plans (with the exception of those reaching capacity limits) would be required to accept eligible E-FEHBP enrollees.[20]

Plans that participate in FEHBP have to comply with various requirements relating to eligibility and enrollment. For example, FEHBP plans: (1) are not allowed to deny coverage to any eligible employee or their family members; (2) may not deny a benefit for a member solely because of a preexisting condition; (2) cannot impose any preexisting-condition waiting period for a covered benefit (except for dental and cosmetic benefits; (3) must provide for continued coverage in the event of certain qualifying events (e.g., change in employment status or change in family status [death, divorce, child becomes age of majority]); and (4) must offer conversion contracts for disenrolled members that are guaranteed renewable except for fraud, nonpayment of premiums, or "overinsurance." These rules would also apply to plans for their E-FEHBP enrollees with one major exception. Plans would be allowed to impose preexisting-condition waiting periods for conditions diagnosed or treated in the 6 months prior to enrollment for up to one year, consistent with the provisions of HIPAA. This exception to FEHBP rules would be permitted to discourage uninsured individuals from waiting until they were sick to enroll in E-FEHBP. While this could reduce enrollment in E-FEHBP, it would probably be necessary to minimize adverse selection and hold premiums down.

Monitoring Plan Compliance and Performance

While OPM currently oversees the health benefits of close to 9 million enrollees, its oversight is largely passive. Plans must agree to meet specific requirements and standards but OPM personnel do not engage in hands-on accreditation or quality assurance activities. However, to be a FEHBP plan, a carrier must be licensed to sell group health insurance in every area of a state in which it operates as a FEHBP plan. Accordingly, the HMOs must comply with state laws. In most states, that means the HMOs must meet standards relating to solvency; organization, structure, and governance; access; quality, etc.

OPM requires participating plans to disclose the results of the Consumer Assessment of Health Plans Survey (CAHPS) that are administered by each participating plan and its accreditation status. The CAHPS asks health plan enrollees questions about whether they get needed care, whether they get care quickly, and how well doctors communicate: how courteous and helpful office staff are; whether they have complaints about customer service and claims processing; and whether they are satisfied with the overall plan. The results are published in the annual open enrollment guide. A plan may not be rated if it is new to the program, has fewer than 500 federal subscribers, or failed to

administer the survey as asked by OPM. The open enrollment guide also indicates whether a participating HMO has been accredited by the National Committee for Quality Assurance or the Joint Commission on Accreditation of Healthcare Organizations, and the nature of the accreditation. However, HMOs are encouraged, but are not required, to be accredited to participate.[21]

Another way to monitor plan performance is by the volume and nature of enrollee grievances and appeals. Enrollees can appeal adverse plan decisions to OPM and ultimately sue the plan in federal district court for the benefits in question. (The enrollee cannot sue the plan for compensatory or punitive damages.) Enrollees can also contact OPM to register a complaint or grievance about issues that are not appealable. Such issues include enrollment and disenrollment problems, nonresponsiveness to enrollee questions, etc.

Since enrollment in FEHBP plans would increase under E-FEHBP, would OPM or its designated agent have the capacity to monitor plan performance? If it were only required to continue its current limited oversight role, the answer is probably yes. The number of plans may not increase, and the volume of appeals and grievances is unlikely to grow very much. However, premium "bids" and rate reviews (participating plans would be submitting separate rates) might significantly increase monitoring responsibilities. Also, more hands-on oversight might be required to safeguard the program against plan efforts to risk select. As more states elected to administer E-FEHBP, these concerns would be mitigated.

Plan Availability

FEHBP is often touted for the wide range of health plan choices that it makes available to federal workers. However, the range of choices is less expansive in some parts of the country. In 1999, for example, there were about 15 states in which there were areas of the state (e.g., outside of the larger urban areas of Tennessee or counties outside of Billings, Montana), or the state in its entirety (e.g., Alaska and Wyoming), in which no HMO existed. Thus, in those states or areas, participants in FEHBP could only enroll in one of the national managed fee-for-service plans.[22]

Plan participation may or may not remain the same under E-FEHBP as it is under the current program. Especially in the first few years of operation, the risk profile of new enrollees may be less predictable than it is for FEHBP. Although the reinsurance pool described below could alleviate plan concerns that individual high-cost enrollees could cause significant losses, plans might still be concerned about the effect on their bottom line of enrolling the target groups of nonemployed individuals and small-firm workers. On the

other hand, the target group of enrollees could present an opportunity to some health plans to expand their market shares. In any event, turnover of plans may be expected as they test the new market. Moreover, certain rural and frontier areas of the country are unlikely to attract HMOs regardless of the risk profile of the target populations.[23]

Eligibility

As noted above, the E-FEHBP proposal would extend refundable tax credits to low-income Americans who elect to buy their health insurance from E-FEHBP. In addition, the employees (and their families) of small firms would be eligible to participate in the program if certain conditions were met.

There would be two categories of eligible individuals for E-FEHBP:

a. Individuals who are *not participating* in employer-sponsored coverage, Medicare, Medicaid, SCHIP (and military health programs) and who are eligible for the federal refundable HI Tax Credits. The full credit of $2,000 (individual) and $4,000 (family) would be available to those with adjusted gross incomes at or below 200 percent of the federal poverty level and would phase out at income levels of $30,000 for an individual and $48,600 for a couple or family. *E-FEHBP would be the only qualified coverage for the HI Tax Credit.* Eligible individuals would elect from the E-FEHBP plans offered in their area; families would enroll as a unit in the same plan.

b. Employees (and their spouses and children) of small firms (1 to 10 employees) that have not offered health insurance in the previous 6 months. Such employees meeting the income-eligibility requirements for the HI Tax Credit could use the credit to pay their share of the premium for E-FEHBP coverage. The tax credit could not exceed the employee's premium contribution amount.

   Employer Contribution Requirement. In order for a firm to be eligible to participate, the employer would have to contribute at least 75 percent of the benchmark premium which would be the lesser of: (1) the lowest-cost E-FEHBP plan offered in the area in which the firm is located or (2) the most prevalent nationwide plan (currently Blue Cross Blue Shield standard option).

   Participation requirement. Another prerequisite for small-firm participation is that 75 percent of the firm's employees without another source of coverage through a spouse, parent, or public insurance program would have to participate in E-FEHBP.

However, each employee would be able to chose a particular plan for him or herself and family. Employees who decline coverage would have to indicate this (consistent with HIPAA rules), and would be able to enroll late if they lost another source of coverage.

The Eligibility Determination Process

Individuals would establish their eligibility for the refundable HI Tax Credits through the IRS. Eligibility would be determined based on an individual's prior year adjusted gross income. Those meeting the income eligibility thresholds would be able to claim the credit on their April 15 tax returns and reduce their tax liability or receive a refund. Tax payers whose credit would reduce their tax liability to less than zero could instead receive the credit in advance over the course of the year in the form of credit certificates or vouchers. The certificates/vouchers could not be used for any purpose other than for paying premiums for coverage under E-FEHBP. If people are allowed to receive the credit in advance, some may get credits they are no longer eligible for because their incomes have risen. For this reason, a reconciliation process would be required.

Non-employed and self-employed individuals as well as low-income individuals who work for some small firms would establish their eligibility for E-FEHBP by establishing their eligibility for the refundable tax credits. To participate in E-FEHBP, they would then have to present a certificate from the IRS to the E-FEHBP plan of their choice during the November open season or during special enrollment periods as defined under HIPAA.[24] An unresolved administrative issue is whether such certificates would have to be sent first to the administering entity or directly to the selected plan. This decision would be based on transaction costs, enrollee privacy, tracking of enrollment/disenrollment, and the need for data to operate the reinsurance mechanism, among other issues. Another potentially difficult issue is how to coordinate the timing of the certificates with the November open enrollment period.

Small firms would require a separate eligibility determination process for E-FEHBP. Eligibility would be extended to small employers (firms with fewer than 10 employees), their employees, and their families. As noted above, such employees and their families would not be required to be eligible for the refundable tax credit. If they were, however, they could only receive a tax credit for an amount not to exceed their share of the employer's premium.

To demonstrate eligibility for E-FEHBP, a small employer would apply to the administering entity and indicate the average number of employees working for the firm

in the previous six months, as well as any additional demographic information needed to track participation and facilitate enrollment in the participating plans. This type of information is similar to that required by insurers and brokers selling in the small-group insurance market. Small-employer applicants would also have to indicate their intent to meet the participation and contribution requirements, and sign a statement saying that no coverage had been provided in the previous 6 months. Applications including false or intentionally misleading information would be subject to civil penalties.

The administering entity for E-FEHBP would be required to provide small-firm applicants with program information, including the open season brochure and instructions on enrolling their employees in E-FEHBP plans. Open season would be in November along with that for federal workers, annuitants, and the HI Tax Credit population. Special enrollment periods would be permitted in some cases, as provided under HIPAA. Whether new small firms could enter E-FEHBP at times other than during open season is one of the many policy issues that would have to be resolved.

A significant challenge would be getting the uninsured to participate in the new coverage program voluntarily. The higher the participation rate, the better the odds of attracting a large enough pool of new insureds to reduce adverse selection. Individuals may not wish to enroll because they do not want to pay out-of-pocket costs, they find eligibility and enrollment procedures complex, they do not know about the program, or they fear it might be stigmatizing. The E-FEHBP proposal outlined here should minimize, some but not all, of these problems. Many in the target populations would still be discouraged by the cost of the program. Non-employed individuals would still have to qualify for the tax credits by filing their tax returns with the IRS, including the specific forms required to qualify for the tax credits (such as those required for the Earned Income Tax Credit). This requires knowing the credits are available, being able to fill out the tax forms, and actually filing them. And small firms would still have to make financial and administrative efforts to participate, albeit less arduous ones than they typically face in the commercial marketplace.

Marketing of E-FEHBP Plan Options

One obvious way to encourage more individuals and small firms to participate in E-FEHBP is to publicize the program's existence through an aggressive marketing campaign. The administrative entity would have primary responsibility for advertising the existence of E-FEHBP. It could do this on its own, but more likely, it would contract out to one or more outside entities. Participating states would assume much of this responsibility. Carriers and plans would be required to do marketing as one condition of

contracting with E-FEHBP, and their marketing campaigns would be subject to review by OPM or its designated agent.

In the first few years of E-FEHBP, a major effort would be needed to get the word out about the program. An obvious analogy is the Medicare+Choice program. A national publicity campaign could be initiated to educate the public about the HI Tax Credits and the existence of E-FEHBP.

Key players in the individual and small-group insurance markets are insurance agents and brokers. They help facilitate plan selection and market policies for one or more carriers or plans.[25] Past experience with purchasing cooperatives suggests that agents are an important intermediary and can be critical to achieving acceptable rates of small-firm participation in the purchasing pool. But agent commissions raise administrative costs.[26] Also, regulatory oversight may be needed to prevent plans from using tiered commissions or other techniques that encourage agents to steer good risk applicants their way.

Plan Options and Benefits

The coverage made available under E-FEHBP would be the same as that available to federal workers today: managed fee-for-service health plans that are mostly preferred provider organizations and HMOs. A few point-of-service options are also available.

The benefits offered for E-FEHBP enrollees would be the same as for FEHBP enrollees.[27] The types of benefits offered vary especially for ancillary services such as prescription drugs and dental benefits. Levels of cost-sharing and annual out-of-pocket limits tend to differ more. The range of variation was once greater, but OPM has moved to narrow the differences among plans. Using the plan benefit valuations in *Checkbooks Guide to 1998 Health Insurance plans for Federal Employees,* Merlis illustrated the sizable variation by comparing plans offered in the Washington, D.C., area. He found a 31 percent difference in their value. OPM has said that differences in plan actuarial values are generally as little as 10 percent.[28]

All plans must offer some coverage of prescription drugs, certain preventive services such as childhood immunizations, certain types of transplants, maternity care, contraceptives, and treatment of fertility (but not necessarily coverage of fertility drugs).[29] The one major exclusion that may be of concern to some is coverage of abortion services. Also, participating plans have to comply with various Patients' Rights provisions implemented through presidential executive order.

In general, FEHBP benefits are somewhat less generous than the plans offered by large employers.[30] On the other hand, they probably compare favorably with the benefit packages offered by many carriers in the small-group and individual markets, so they should be attractive to the potential target population for E-FEHBP.

Health reform debates of the past have dealt with the policy and political dilemmas of trying to legally specify a minimum benefit package, and the process by which it might change over time. The E-FEHBP approach may be more promising because benefits are not set by statute but evolve, mostly without the participation of Congress. The current OPM policy is to seek benefit stability; significant year-to-year changes sought by individual carriers and plans are discouraged. Changes proposed by the individual plans are expected to be budget neutral, unless they are required by OPM. Any new benefit must be offset by a reduction in some other benefit.[31] As FEHBP plans are modified, they would also change for E-FEHBP. Another advantage of this approach is that potentially difficult issues relating to the application of state-mandated benefit laws are already largely resolved.[32]

Although E-FEHBP has the advantage of providing a ready-made benefit package, it also falls short in certain respects. The HI Tax Credit would subsidize the purchase of HMO coverage that would differ in benefit value as well as premiums, depending on the plan selected by the participant. In addition, the participant's selection would be limited to those plans available in his or her area. Unless the HI tax subsidy amounts were geographically adjusted, which is impractical, an equity issue could arise. Individuals purchasing an E-FEHBP HMO plan in New York might pay 20 percent more out-of-pocket than those purchasing an HMO policy of similar benefit value in Kansas. Second, the lack of a standardized benefit package would make it difficult for consumers to compare plans.[33] Third, the comprehensive nature of E-FEHBP policies would drive up premiums, pricing many potential participants out of the market, especially those receiving no or partial HI Tax Credits.

Enrollee Premium Contributions

Premium contributions for E-FEHBP plans would be handled differently for the two target populations. For the HI Tax Credit population, enrollees would be required to pay any premium amounts not covered by the credits. An unresolved issue is whether the enrollee share of the premium payments should be sent directly to the health plan or processed through the administering entity. The obvious advantage of paying premiums directly to the plans is that it saves on administrative costs. Plans participating in FEHBP are already accustomed to dealing directly with individual enrollees who are no longer

active federal workers but who have elected continuation or conversion coverage. This method may make sense especially if the HI Tax Credit amounts are sent directly by the IRS to the health plans. On the other hand, channeling the premium payments through the administering entity may be necessary to facilitate risk adjustment of plan payments (see below).

For the small-firm population, employers would pay some portion of the premium. The 75 percent threshold has been selected for this discussion, but lower amounts may be necessary to attract sufficient employer participation. Specifically, employers would be required to contribute 75 percent of the lesser of the total premium for the most prevalent national plan or for the lowest-cost plan in the area. Employers would withhold the employee's share of the premium from their paychecks and forward the payments to the administering entity. Although this introduces additional administrative costs, it seems necessary to reduce the paperwork burden on employers, since each employee can elect a different plan. This may not be such a problem for a firm with 2 or 3 employees, but might be significant for larger firms. In turn, the administering entity would distribute the premiums to the appropriate plans, as indicated on the enrollment forms.

Premium Amount

Current proposals to extend FEHBP to the uninsured tend to gloss over the issue of the cost of insurance. Although the insurance risk of new enrollees could best be spread by pooling them with federal enrollees, this is politically unfeasible. Federal workers and annuitants as well as their unions would strongly oppose including E-FEHBP enrollees in their risk pool because of concerns that their premiums would increase. They may also raise concerns that benefits will erode and that plans will be less able to respond to enrollee problems.[34]

Accordingly, this proposal would base E-FEHBP premiums on a separate risk pool. Plans would price their premiums as they do now, but for the separately rated E-FEHBP enrollees. Nationwide plans would rate their premiums based on the previous year's experience. A small allowance for profit (ranging from 0.5% to 1.0%), an administrative load (perhaps 2%), and a small percentage for a contingency reserve (to cover potential shortfalls in premiums) would be added to the base premium.[35] For the first year of the program, the plans would submit the best estimate based on their commercial experience, adjusted for the projected risk profile of the new enrollees (this could be as simple as age, gender and geography). The administering entity would have the authority to review premium submissions and negotiate changes with the plans. As is

the case for BCBS and the other national plans, any shortfall or excess in premium in one year would be factored into the plan's premium submission for the next year.

HMOs would also set their premiums as they do today under FEHBP. Although a few of them use experience rating, most use a form of community rating. A plan would provide OPM with the rates it charges its two employer groups that are closest in size to the FEHBP enrollment, excluding any group that experience-rates on a retrospective basis. Although the basic rule is that the lower of the two quotations becomes the community rate, this is then adjusted for the expected utilization of the FEHBP group; other technical rules also apply. Like the national plans, the HMOs' rates are increased for administration and reserves.[36]

Risk Adjustment of Premiums

Some analysts have pointed out that a major shortcoming of existing FEHBP is that the government's premium contributions to FEHBP plans are not risk-adjusted.[37] The premiums of plans experiencing severe adverse selection have therefore spiraled upward, resulting in a few notable departures from the program. Mostly, the selection problem has resulted because so many annuitants have signed on to the fee-for-service high-option plans.

E-FEHBP would probably experience adverse selection relative to insurers and plans operating outside of E-FEHBP. Individuals and small firms that could get less expensive coverage in the commercial market would do so. Groups and individuals who could not obtain or afford outside coverage would be left to E-FEHBP. This issue is discussed below (see "Adverse Selection"), and it could be the fatal flaw in E-FEHBP.

Risk adjustment is discussed here not as way to reduce adverse selection against E-FEHBP as a whole, but as a way of reducing the effects of selection bias inside the program. For example, it is likely that the nationwide managed fee-for-service plans could be more vulnerable to adverse selection, especially plans such as BCBS. Such plans tend to be more attractive to the sick because they can maintain their relationship with their physicians. Moreover, plans such as BCBS tend to be more familiar to the public than local HMOs.

No existing risk-adjustment methodology is very effective at actually predicting risk. Basic demographic adjusters such as age, gender, and place of residence (geography) are easy to implement but provide little predictive payoff. Better predictors of risk, such as

prior health status or use of services, require enrollee-specific data that could be prohibitively expensive in time and resources to obtain, especially for new enrollees.

In addition, the mechanics of risk-adjusting payments to health plans might be complicated, since some premiums come from individuals and others from employers. It is likely that if risk adjustment were adopted, premiums would have to flow through the administering entity.

Despite its methodological and mechanical complexities, compelling reasons exist to include risk adjustment in E-FEHBP. As long as health plans fear that their payments do not adequately correct for selection bias, they are likely to engage in behaviors to minimize their risk, such as selective marketing or offering benefit packages that attract healthier than average enrollees, regardless of the extent to which such activities are regulated.

The E-FEHBP proposal envisions an interim system of risk adjustment. A reinsurance mechanism would protect carriers and plans that attract above-average-cost enrollees. Participating carriers and plans could cede to a reinsurance pool enrollees with specific health conditions known to be expensive to insure or who have "marker diagnoses." The reinsurance pool would bear the costs for these enrollees, above some predetermined threshold, with subsidies from the federal government paid out of general revenues. The reinsurance program would be designed to give insurers an incentive to manage risks below the threshold in which their costs were ceded to the reinsurance pool. Design details could be left to the administering entity.[38]

Recognizing the limitations of this approach, the proposal would charge OPM (in collaboration with HHS) with developing a risk-adjustment methodology that could be phased in, with an increasing percentage of plan payments risk-adjusted over time (similar to the phase-in for the Medicare+Choice health status risk adjuster).

Issues and Effects on Reducing the Uninsured

Adverse Selection

Perhaps the most significant hazard confronting E-FEHBP is a selection death spiral. Individuals and small groups unable to obtain adequate insurance in the commercial market might turn to E-FEHBP for their coverage, raising the cost of premiums. This would drive the better risks out of the pool, and premiums for E-FEHBP coverage would gradually rise so high as to be unsustainable. The design of the program reduces the chances that this will happen. People who want to obtain the HI Tax Credit would have

to buy coverage through E-FEHBP. They tend to be younger than those currently covered under FEHBP, which may help reduce initial premium quotes.[39] (The average age of FEHBP enrollees is 55; the average age of the target population is 32.)[40]

Working against E-FEHBP, however, would be the fact that different rules apply to the commercial market, and insurers who market outside of E-FEHBP have an advantage. Many states have yet to adopt guaranteed issue and community rating. In such states, many of the people denied coverage or priced out of the private insurance market would be likely to gravitate to E-FEHBP. Ideally, E-FEHBP would operate within an insurance market that would apply the same rules for carriers and HMOs operating within and outside of the E-FEHBP pool. It is assumed here, however, that in keeping with the current regulatory environment, state underwriting and rating laws would remain largely unchanged, or at least, would not be subject to any new federal insurance requirements. The result is that E-FEHBP could be vulnerable to substantial selection bias in states without guaranteed issue, restricted rating bands, and related requirements applicable to the individual and small-group markets.

Relationship to Existing Sources of Insurance and Crowd-Out

Ideally, E-FEHBP would not replace most existing sources of coverage but would instead extend coverage to persons who would otherwise remain uninsured. The reality is that E-FEHBP, like other incremental proposals, has the potential to replace or "crowd out" some private and public coverage. Although "maintenance of effort" and anti-duplication measures could be included, their effectiveness may be limited.

Some "crowd-out" would result from the E-FEHBP eligibility rules, which are linked to the eligibility rules for the HI Tax Credit. To be eligible for the HI Tax Credit individuals must not be *participating* in an employer-sponsored plan, Medicare, Medicaid, or SCHIP. The term "participating" is important because many persons who are *eligible* for such coverage do not actually obtain it, perhaps because they cannot afford the premiums for employer-sponsored coverage or are discouraged by the complexity of Medicaid. Thus, one way to reduce crowd-out is to limit eligibility for the HI Tax Credit to those individuals who are not *eligible* for other sources of coverage. However, it is not clear whether such a rule could be effectively enforced. Moreover, the goal of expanding access to more affordable and adequate coverage may take priority over ensuring that only the uninsured are enrolled in E-FEHBP.

It is intended that E-FEHBP plans will replace individually purchased and state risk-pool coverage. Preliminary estimates indicate that of the 49 million adults and

children eligible for the HI Tax Credit (i.e., those who meet the income criteria and who are not participating in employer-sponsored plans or other public insurance programs), about 21 percent are currently insured in the non-group, mostly individual insurance market.[41] About 100,000 or so of these individuals obtain their insurance through the 28 state high-risk pools.[42] E-FEHBP should be an attractive alternative to individual and risk-pool policies, which tend to be expensive, require higher cost-sharing than group policies, and offer fewer benefits than plans participating in FEHBP. Moreover, in many states, individual policies may impose prolonged preexisting-condition exclusions. There is also instability in the individual market, with carriers entering and exiting as market and regulatory conditions change.[43] Access to E-FEHBP may improve the adequacy and stability of insurance for those currently buying non-group insurance.

Although the E-FEHBP eligibility rules are designed to prevent crowd-out of employer-sponsored insurance, some is likely to occur. Even with maintenance of effort requirements, some employers might reduce their premium contributions or otherwise discourage participation in their plans, knowing that uncovered lower-income employees could buy government-subsidized coverage through E-FEHBP.

Just as E-FEHBP could replace some private insurance, it could also crowd out existing state expenditures on Medicaid and SCHIP. The law establishing E-FEHBP may require states to maintain their efforts with respect to Medicaid and SCHIP. However, some substitution of federal tax-credit dollars for state expenditures is likely, because the populations eligible for existing public programs and E-FEHBP overlap, especially low-income children (mainly children up to 200% of poverty). Under Medicaid and SCHIP, states contribute a portion of the cost of coverage. If the same individuals switched to E-FEHBP, the state could eliminate all of its financial liabilities.

Effects on Reducing the Uninsured

Based on preliminary estimates provided by Glied et al., the E-FEHBP proposal would reduce the number of uninsured by at least 25 percent.[44] This estimate does not include the effects of the provision making E-FEHBP available to the workers and dependents linked to firms with fewer than 10 employees and who are not also eligible for the HI tax credit.

Addressing Weaknesses

There are several ways to increase the numbers of newly insured under E-FEHBP. Obviously, the amount of the tax credit could be increased to reduce the gap between the amount received and the cost of an E-FEHBP policy. Even the full tax credit of

$2,000/$4,000 is unlikely to cover the full cost of coverage in many areas of the country. Also, the credits could be expanded to cover people at higher income levels. The adequacy of the credit becomes especially critical after the program is established. The purchasing power of the credits will steadily erode if they do not keep pace with premium inflation.

Another important way to increase participation would be to reduce the small-employer's premium contribution rate from 75 percent to 50 percent of the benchmark plan. However, low-income employees would have to receive higher tax credits, and this would cost the federal government more.

An additional measure would be to extend eligibility to firms with up to 25 employees. This would extend eligibility to as many as 8 million uninsured or individually insured workers and their families who are connected to firms between 10 and 25 employees.[45] E-FEHBP could also be coupled with new federal insurance reforms that would impose the same rating and underwriting rules on the individual and small-group markets that apply to E-FEHBP plans, such as guaranteed issue.

NOTES

[1] Estimates are based on the March 1999 Current Population Survey and were prepared by Sherry Glied and Danielle Ferry, Columbia University, November 2000. Two sets of estimates were generated. The first assumed that 0.25% of E-FEHBP enrollees would be ceded to a reinsurance pool. The second assumed that 1% of E-FEHBP enrollees would be ceded to a reinsurance pool. It is the results from assuming the ceding of 1% to the reinsurance pool that are reported here.

[2] Ibid. Glied et al. did not take into account the provision of the proposal that restricts E-FEHBP to individuals who are not participating in employer-sponsored coverage, Medicare, Medicaid, SCHIP, and military health programs. As a result, they show a total of almost 32 million people enrolled in E-FEHBP. If the proposal's eligibility requirements were enforced even in part, the actual number of E-FEHBP enrollees would be considerably lower.

[3] Estimates provided by Sherry Glied and Danielle Ferry, Columbia University, November 2000. This upper limit is calculated based on an estimated E-FEHBP enrollment of 32 million individuals. The cost of covering only those persons who were previously uninsured or in the non-group market is estimated to be about $25 billion.

[4] For example, in 1960—one year after FEHBP was established—Congress authorized coverage for Agriculture Stabilization and Conservation County Committee employees. In 1964, Congress authorized FEHBP coverage for teachers in the District of Columbia if they had been temporarily employed as teachers for a total of at least 2 years. In 1979, employees of Gallaudet College were added and in 1984, former spouses of employed, retired, or separated federal employees were made eligible for FEHBP. The latter are required to pay the government share of the premium as well as their own. In 1986, Congress extended eligibility to individuals first employed by the government of the District of Columbia before October 1, 1987. (See 5 USC 8901.)

[5] P.L. 105-261 (title VII, subtitle C, section 721).

[6] U.S. Office of Personnel Management, *FEHBP Program Carrier Letter 1999-016,* April 9, 1999. For 2000, the demonstration includes areas of Delaware, Kentucky, North Carolina, Texas, Louisiana, and Puerto Rico. The Department of Defense contributes a portion of the premium up to the amount that would be contributed by the government for other FEHBP enrollees. Information on the demonstration is available at www.tricare.osd.mil/fehbp. Early indications are that enrollment is building slowly.

[7] Schoen, Cathy et al., "Federal and State Public Employees Health Benefits Programs," in *Critical Issues in U.S. Health Reform,* edited by Eli Ginzberg, Westview Press, Boulder, 1994, p. 208–247.

[8] National Institute for Health Care Management. *States as Purchasers: Innovations in State Employees Health Benefits Programs.* Prepared by Lewin-VHI, Washington, April 1995. It should be noted that by the end of the decade, many of these "buy-in" programs had been terminated for individuals without an employment/retiree relationship with state or local governmental entities.

[9] The outlines of such an approach, and the basis for some of this discussion, is provided in McArdle, Frank B., "Opening Up the Federal Employees Health Benefits Program," *Health Affairs* 14 (Summer 1995): 40–50.

[10] See, for example, U.S. Department of Health and Human Services. FY1998 Budget.

[11] http://billbradley.com

[12] Estimates provided by Sherry Glied and Danielle Ferry, Columbia University, November 2000.

[13] Fronstin, Paul, "Job-Based Health Benefits Continue to Rise While Uninsured Rate Declines," Employee Benefit Research Institute, *Monthly Newsletter*, November 2000.

[14] Information on the responsibilities of OPM is taken from: U.S. Library of Congress, Congressional Research Service, *The Medicare Program and the Federal Employees Health Benefits Program: Purpose, Design, and Operations*, by Carolyn Merck, May 26, 1999. (CRS Report for Congress RL 30181)

[15] Ibid.

[16] Some observers of OPM believe that a "cultural shift" might also be required to ensure more active oversight of participating health insurance plans.

[17] A recent analysis of administrative overhead for individual policies concludes that it has dropped since the 1970s from an average then exceeding 50% to about 30% for standalone individual insurance products. This compares to an average of 20% to 25% for group policies with under 25 lives. See Pauly, Mark, Allison Percy, and Bradley Herring, "Individual Versus Job-Based Health Insurance: Weighing *Health Affairs* 18 (November/December 1999): 28–44.

[18] United States House of Representatives, Committee on Ways and Means. *Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit*, 103rd Congress, 1st Session, Committee Print 103-14, June 1, 1993.

[19] Causey, Mike. "Federal Diary: Greater Demand for Fewer HMOs," *Washington Post,* November 2, 1999.

[20] Plans could request to be excluded from E-FEHBP on the basis of capacity limits or financial hardship. Once excluded, however, they could not return to E-FEHBP for five years.

[21] Beginning in 2000, OPM began the collection and analysis of standardized plan performance measurements obtained through the Health Plan Employer Data and Information Set (HEDIS) and will report back to enrollees with plan data on specific measures by 2002. U.S. Office of Personnel Management, *FEHB Program Carrier Letter No. 1888-016,* April 9, 1999. In addition, OPM requires HMOs to have an internal quality assurance program that sets standards for quality of care and responsiveness to enrollee inquiries and collects and analyzes data on condition-specific patient outcomes. OPM also requires HMOs to credential and must periodically re-credential participating providers. By law, HMOs participating in FEHBP must inform OPM of changes to their service areas and to demonstrate availability of plan providers within these service areas to FEHBP enrollees. American Association of Health Plans, *The Regulation of Health Plans.* Washington, February 3, 1998.

[22] This is a rough count based on a review of the open season guide.

[23] A contingency plan may be needed whereby E-FEHBP establishes a self-insured PPO that could be offered nationwide, thereby assuring the availability of at least one plan regardless of a person's place of residence.

[24] HIPAA requires health insurance issuers and group health plans to provide for special enrollment periods in which a person who is not covered under the plan may become so without having to satisfy preexisting-condition waiting periods. Such periods would apply, for example, in the event that the individual who had previously declined coverage because they were covered under another plan loses that plan's coverage, or if the person becomes married or has a child and wants to add the spouse or child as a dependent.

[25] They are also a significant political force, and proposals that diminish or eliminate the role of agents run a significant risk of mobilizing their substantial grassroots opposition.

[26] For example, the California Health Insurance Purchasing Cooperative "tried to accommodate insurance agents and brokers in the pool while also attempting to reduce distribution costs of the product. This was done by allowing employers to purchase 'direct' without the services or fees of an agent. However, if the employer uses the services of an agent, they must pay a fee (based on group size), plus a per-person per-month fee, which is shown on the monthly bill as a separate item. In order to participate in the HIPC, agents must present a full range of plan options and provide services to help employers make a choice. In the first year [of the HIPC], 70% of all groups used agent/broker services, and for those employers that used a broker, the flat fee represented 6.4% of total premiums on average." Lipson, Debra J. and Jeanne De Sa, *The Health Insurance Purchasing Plan of California: First Year Results of a Purchasing Cooperative,* Alpha Center, Washington, July, 1995, p. 10–11.

[27] There is no statutorily prescribed minimum benefit package for FEHBP plans. The law requires that plans "include benefit both for costs associated with care in a general hospital and for other health services of a catastrophic nature." 5 USC 8904(a). However, OPM occasionally specifies particular benefit changes that it wants from all plans.

[28] Merlis, Mark, February 1999.

[29] Office of Personnel Management, 1999, Carrier Letter 1996-016.

[30] A 1996 actuarial comparison for a standardized population valued FEHBP BCBS at about 96% of the typical large-employer fee-for-service plan for self-only coverage and about 95% for family coverage. The FEHBP BCBS standard option for self-only was valued at $2,370 versus $2,464 for a typical large-employer fee-for-service plan. For family coverage, the BCBS standard option was valued at $6,382 versus $6,725 for the typical large-employer fee-for-service plan. Hay Huggins estimates prepared for the Congressional Research Service, personal communication.

[31] Merlis, Mark, 1999.

[32] For the national FEHBP plans, such as BCBS, FEHBP preempts all state laws regarding benefits. A FEHBP enrollee in such a plan gets the same benefits regardless of where he or she lives. However, for the HMO plans, OPM typically follows state-mandated benefit requirements unless they conflict with federal law, regulation, or policy. OPM requires HMOs to provide all of their FEHBP enrollees with the mandated benefits of the state in which they reside. Congressional Research Service, Memorandum to Honorable Bill Thomas, *Medicare and FEHBP,* from Beth Fuchs and Carolyn Merck, April 14, 1998.

[33] Efforts in the late 1980s by OPM to standardize the benefit package ran into strong opposition "from the plans and others. OPM backed off but did make benefits more standardized in subsequent years by moderating notably rich packages and requiring enhancements of notably thin packages." Health Care Financing Administration and The Competitive Pricing Advisory Committee, *Innovating Programs on competitive Pricing: Background Paper on Five Programs,* prepared by Abt Associates, Inc., and the Division of Health Services Research and Policy, University of Minnesota, June 9, 1998.

[34] Even with separately rated premiums, federal workers may want assurances that the risk pools are completely segregated. Such language as the following might help ease concerns: In no event shall this new coverage result in any increase in the level of contributions by employees or annuitants including cost-sharing, or result in any decrease in the types of benefits offered under this chapter, or any other change that would adversely affect the coverage afforded under chapter 89 to existing enrollees. Adapted from S. 1384, introduced by Senator Daschle in the 105th Congress.

[35] The reserve is held in the trust funds by OPM and may be drawn upon if a plan's costs exceed its premium receipts. The administrative allowance is used to pay OPM's expenses. Any excess in administrative receipts goes to build up the reserves. Merlis, Mark, 1999, p. 21.

[36] Merlis, Mark, 1999, p. 21.

[37] Technically, "FEHBP does not vary plan payments by enrollee characteristics, but depending on how the participating HMO treats other employer groups, it does adjust the fixed premium level it will accept according to the mix of FEHBP beneficiaries in the local market." However, it clearly does not apply a health status risk adjuster to plan payments made by OPM (or enrollees). Health Care Financing Administration and The Competitive Pricing Advisory Committee, June 9, 1998.

[38] OPM would be able to draw from the experience of the Medicare+Choice program as well as the experience of public employee plans, and state insurance pools and purchasing cooperatives. Most of the 12 or so state public employee plans that claim to risk-adjust their premiums merely use age and gender of enrollees. Two exceptions are the California Public Employees Retirement System (CalPERS) and the Washington State Health Care Authority. CalPERS uses demographic risk adjustment in its rate setting process although "the extent to which premiums reflect the assessments . . . is not clear." Washington was developing a system using diagnoses, but it may not yet be in use. New

York State uses a high-cost condition pool to balance out risks in its individual and small-group insurance markets. It makes pool payments to insurers covering AIDS, transplant, ventilator-dependent, and neonate patients. And the Health Insurance Plan of California (HIPC) uses "marker diagnoses" (high-cost, relatively predictable diagnoses associated with inpatient hospital stays, in addition to age, gender, and family size to compensate carriers fairly. Buntin, Melinda J. et al., *Employer Purchasing Coalitions and Medicaid: Experiments with Risk Adjustment.* New York, The Commonwealth Fund, July 1998.

[39] McArdle, Frank B, "Opening Up the Federal Employees Health Benefits Program," *Health Affairs* 14 (Summer 1995): 40–50.

[40] Estimate provided by Sherry Glied and Jason Rachlin, Columbia University.

[41] Estimates provided by Sherry Glied and Danielle Ferry, Columbia University, November 2000.

[42] In this instance, there would be some substitution of public HI Tax Credit dollars for state as well as private expenditures. Risk pool expenditures are financed by enrollee premiums and either by assessments on insurers, state general revenues, or in a few cases, other sources such as surcharges on hospital admission. For information on risk pools, see Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals*, Eleventh Edition, 1997.

[43] The individual market covers about 5% to 9% of the under-65 population. It has higher administrative costs than group policies and a smaller pool over which to spread risks. While some states have implemented reforms that have helped stabilize the market, price tends to be a big factor in discouraging enrollment. *Health Care Financing and Organization. News and Progress.* The Individual Insurance Market: Now and in the Future—Conference Highlights Possibilities, Challenges in Reforming Individual Market, May 1999.

[44] Estimates provided by Sherry Glied and Danielle Ferry, Columbia University, November 2000.

[45] Estimates provided by Sherry Glied and Jason Rachlin, Columbia University.

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#419 *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so.

#418 *A Federal Tax Credit to Encourage Employers to Offer Health Coverage* (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.

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#416 *Transitional Subsidies for Health Insurance Coverage* (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

#413 *Private Purchasing Pools to Harness Individual Tax Credits for Consumers* (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesnt cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers'Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers'Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers'Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers'Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability

of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers'Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.