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HOW SICK IS THE FEDERAL HEALTH INSURANCE SYSTEM?

Open season is approaching, bringing with it another astronomical increase in premiums, especially for the elderly and the ill. ■ BY LESLEY BARNES

The patient is ill, and a variety of specialists have been called to the sickbed to offer their diagnoses. But there's no consensus on a cure.

That's how many people might describe the state of the federal health insurance system. Today as never before, its maladies are under the microscope.

The symptoms are painfully evident to thousands of enrollees in more than 500 federal plans who watch helplessly as costs continue their dramatic rise. This month, the government will announce that its share of premiums will cost roughly 30 percent more in 1989 than it did in 1988; the increase comes on top of a 31 percent jump between 1987 and 1988. Enrollees also have to shoulder an increase: Those in typical family plans will pay more than $1,200 next year, or about $500 more than in 1987.

And yet the typical family is a lot better off than some. Older and less healthy enrollees can face premiums exceeding $250 a month, or more than $3,000 a year.

That's another troubling symptom of the system's illness. With a large variety of plans to choose from, healthy people usually choose the cheapest and least comprehensive. This process of "risk selection" leaves the less healthy and most federal retirees grouped together in the expensive, more comprehensive plans.

To add insult to injury, the government's system is more expensive for employees than many private sector plans. Whereas federal workers on average pay about a third of the cost of their insurance, with the government picking up the rest, private sector workers often pay no more than a quarter of the cost of plans bought by their employers.

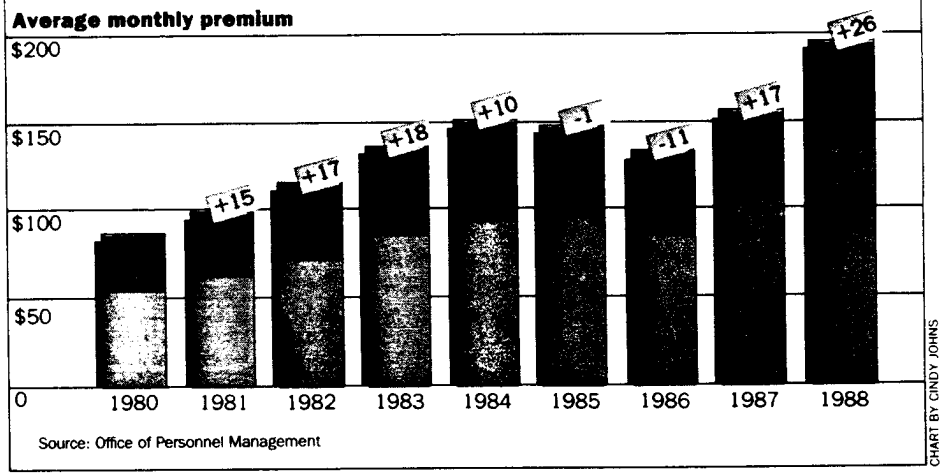
The system has attracted much attention this year. A consulting firm retained by the Office of Personnel Management (OPM) in May recommended that Congress "urgently" consider a sweeping overhaul to correct "major problems." Later that month, a pair of congressional hearings provided another forum for critics. And at the end of July, an OPM hearing brought forth witnesses with dozens of conflicting ideas about the health of the system and possible remedies for ailments they perceived.

One of the most dolorous of diagnoses at the OPM session came from John Harris of the American Federation of Government Employees. The rising costs of the insurance program, "even exceeding the rate of inflation in medical care, make [it] unacceptable as an employee benefit," said Harris. "Benefits have been cut, and premiums for employees have risen to a point where it is one of the worst health benefit plans offered to employees in the country."

RIDING THE HEALTH INSURANCE ESCALATOR

Since 1980, the monthly premium cost of the average policy under the federal health insurance program has more than doubled, rising from $86.52 to $195.99. The government's share of the total in 1988 is $135.32, or 69 percent, while the employee's share is $60.67, or 31 percent. The figures represent the average premiums for both families and individuals in the 500-plus plans that operate in the $7 billion program.

Premiums would have been even higher this year if the mix of insurance plans chosen by federal employees were the same as in 1980. But many enrollees have been moving from high-option to standard-option plans, thus holding down premium costs. This trend also has the effect of increasing the government's share of total premiums. In 1980, the government paid 61 percent of average premium costs.



Source: Office of Personnel Management

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But others say the system doesn't need such a drastic overhaul, arguing that it gives workers a wide range of options at a modest cost to the government.

While debate on reforming the system continues this fall, federal employees face the beginning of "open season" in November. Once again, they will choose from a plethora of confusing options, each costing much more than it did one year earlier.

The Federal System

The Federal Employees Health Benefits Program began in 1960, with two plans offered government-wide and coverage also available from a few health maintenance organizations (HMOs) and employee groups. The program covers all federal employees and their dependents, as well as retirees with at least five years of government service. Feds who retired before 1983 are ineligible for Medicare, so many depend solely on the program to pay their medical bills.

Today, about 11 million employees and their dependents are covered by 520 plans. But because most of the providers are regional HMOs, each individual has about 25 options to choose from. Eighty-five percent of eligible active employees participate.

The two government-wide insurers, Blue Cross/Blue Shield and Aetna, enroll 41 percent of active employees and retirees in standard- or high-option plans, while 37 percent belong to plans sponsored by unions and other employee organizations and 22 percent are in HMOs.

Standard-option plans, HMOs and employee organization health policies cover all or part of such expenses as hospital room and board for surgical or medical care; surgery; X-ray and laboratory procedures; doctor visits; prescription drugs; physical therapy; and routine dental care.

High-option plans differ from standard-option plans both in premium costs and in the extent of coverage. The 1988 Blue Cross/Blue Shield standard-option plan, for example, costs a family $57.58 a month in premiums, while the high option costs $228.25. In the standard plan, a family suffering a very expensive illness would face out-of-pocket costs, not covered by insurance, of up to $2,500, while such costs are limited to $1,500 in the high-option version.

The standard option covers 75 percent of doctors' bills for in-patient care, while the high option covers 80 percent. The standard plan covers dental care, while the high option doesn't.

OPM is also charged with setting qualifying standards for HMOs and employee organization plans. HMOs, comprehensive prepaid plans which operate through affiliated doctors and hospitals, are generally less expensive than traditional plans and emphasize preventive and out-of-hospital services.

Employee organization plans, which are underwritten by insurance companies, generally tailor their benefits packages to members' needs and wants, and many offer both high and standard options. With only a few exceptions, all federal employees can enroll in any given organization's plan even if they are not organization members, as long as they pay an associate membership fee, usually no more than $30.

Employee organizations pull in about $25 million a year in associate membership dues, and some count on the revenue for their very survival, experts say. The National Federation of Federal Employees, the National Association of Government Employees and the Mail Handlers Union are among groups that depend on associate membership fees. Not surprisingly, employee groups generally support the current structure of the federal health insurance system.

OPM sets the benefits and costs of each plan annually, under contracts with the providers. In fiscal 1987, the cost to the government of all of the plans was about $4.7 billion, and employees paid another $2.3 billion in premiums and deductibles.

The employees' share is set by a formula that calculates 60 percent of the average premium costs of the six biggest plans and then sets the government's share at 75 percent of that, not to exceed $2,010 in premiums for a family and $930 for an individual in 1988. Employees can control their own premium costs by wisely choosing an adequate plan from the wide variety available.

Walton Francis, an economist and co-author of *CHECKBOOK's Guide to Health Insurance Plans for Federal Employees*, calculated costs for 20 of the federal program's biggest plans—which cover 80 percent of all enrollees—in 1988 and found that on average the premiums for a family plan cost $2,960, of which $1,990 was paid for by the government and $970 by the employee.

Workers in the private sector get a better deal. According to a survey of policies maintained by large and medium-sized companies in 1986, 54 percent of workers with individual coverage and 35 percent with family policies paid no premiums at all. In companies requiring employee contributions, premiums averaged $13 a month for individuals and $41 a month for families, the survey by the Bureau of Labor Statistics found.

"And if costs are higher [in the federal program] than in the private sector, OPM has some explaining to do since the same companies administer almost identical plans for both the private sector and the [federal program]," Francis argues.

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ILLUSTRATION BY CINDY JOHNS

An onslaught of insurance options faces federal employees during open season each November. But a report commissioned by the Office of Personnel Management says that meaningful competition among health plans is actually "a myth."

But companies are now moving to shift more of the costs of health insurance to their employees. This will help control the use of benefits, notes Nelson Ford, a partner at the accounting firm of Coopers and Lybrand, who also says the private sector's health insurance policies are becoming quite similar to the government's.

Diagnosing the Problems

In response to rising costs and growing complaints about the insurance program, OPM last year commissioned Towers, Perrin, Forster & Crosby Inc. to evaluate the federal health program.

The consulting firm's report, released in May, concluded that the program "poorly serves the needs of many enrollees and . . . costs upwards of one-half billion dollars a year more than would be necessary under a more efficiently designed system." The report has been the catalyst for recent cries for reform in Congress, at OPM and among some of the larger employee associations.

The report identifies two main problems with the program: economic inefficiency and the erosion of the group insurance principle by risk selection, as individuals representing the same level of risk have congregated in the same plans.

In theory, the government's practice of contracting with such a large number of insurance carriers promotes competition and offers the consumer wider choice. But the report says that meaningful competition among the health plans is actually a "myth." Competition to qualify for, and stay in, the federal program by offering good coverage at reasonable costs would clearly be in the interests of federal employees. But that kind of competition does not exist; plans need only meet a statutory definition to get in, and once in can stay indefinitely. What competition does take place is designed "almost exclusively to attract the better risks, not to provide a product in the most cost-effective manner," the report says. This "actually exacerbates" inefficiencies in the system that stem from allowing so many carriers in the first place—a practice that multiplies costs and fragments the government's potentially tremendous leverage over plan design.

These inefficiencies are compounded by the fact that each plan must retain adequate reserves that are, in the aggregate, larger than necessary, thus adding to premium costs, the report also says. And there is little incentive to adopt cost-containment strategies; such measures might irritate consumers. Finally, the open season that begins each November costs OPM and the carriers more than $1 million a year in explanatory and marketing materials while offering the average enrollee "little chance of understanding the choice he must make," says the Towers, Perrin report, adding that "in a simpler program with clearer choices, open season would be both less expensive and more effective."

The risk selection problem, which has arisen in part because of the competition to attract healthier clients, has segregated the elderly and the ill in more expensive plans. While a young, healthy family might pay as little as $400 a year in premiums, an elderly or sicker family can pay eight times as much in the high-option plans. About 20 percent of the people in the federal program pay 50 percent of its costs, according to John D. Bohon, an assistant vice president at Aetna. He says that these people, mostly retirees, "pay an average of $1,750 a year for their coverage, compared with average annual contributions of $600 for the remaining 3.1 million employees."

High-option plans were originally intended to offer additional benefits, says Jean Barber, OPM's associate director for retirement and insurance. But that is no longer true in most cases; the plans now have higher costs simply because it costs more for the carriers to insure older and sicker enrollees, who choose high options because they believe they offer better benefits, she adds.

But high-option plans no longer necessarily offer better benefits, just *different* benefits, Barber says. For example, a standard-option may offer modest hospital and basic dental coverage, while a high-option version

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PHOTOS BY BRUCE REEDY

Opposite sides of the coin: Economist and author Walton Francis (left) thinks the Federal Employees Health Benefits Program gives employees "a very good deal." But OPM's Jean Barber, who oversees the program, says it could benefit from an overhaul.

may offer more hospital and no dental coverage. Actuarially, the two plans have the same value, but the older and very ill enrollees will flock to the high option. Since this high-risk group uses the health services relatively intensively, the cost of the plan goes up. The result is a more expensive plan that doesn't really offer better benefits.

Demands for Reform

The Towers, Perrin study gave new force to critics' charges that the insurance program is inflexible and anachronistic. There are "hundreds of problems" with it, says OPM's Barber. She says that there's been no thorough review of the program since its inception in 1960, "which, in health insurance, is like the Middle Ages," and that it will take nothing short of an overhaul to get the program back on track. Over the years, said Rep. Gary L. Ackerman, D-N.Y., at a hearing last summer, the program "has degenerated into a clumsy patchwork of inadequate and confusing plans, for which federal employees pay far too much." Ackerman chairs the House Subcommittee on Compensation and Employee Benefits.

Barber's biggest complaint is that the program serves the elderly and the very ill—those who need the benefits most—"very poorly."

Gordon Brown, secretary of the National Association of Retired Federal Employees (NARFE), says he has been advising retirees to avoid expensive high-option plans since the program began. Federal retirees, he adds, are hurting in the area of long-term care. He says OPM should require all plans to cover long-term care, and that the cost and the risk of such care should be spread among all participants in the federal program. As the program is designed now, only NARFE's plan and a few other employee organization plans cover long-term care, and so most older people must pay themselves.

The most commonly requested reform is a reduction in the number of plans. "Risk selection is ruining the program, making it unnecessarily expensive and insufficiently responsive to the needs of its enrollees," said Harry P. Cain II, senior vice president for Blue Cross/Blue Shield's federal programs during the subcommittee hearing held by Ackerman. Aetna agrees.

The idea of a single government self-insured plan to be administered by major insurance companies has been embraced by some lawmakers and a few employee organizations. Barber says a single-plan system is "a very interesting idea."

The National Treasury Employees Union (NTEU) has proposed replacing the current system with one basic government health insurance policy provided at employer cost; a limited HMO option; supplemental insurance and benefit packages offered through employee organizations like NTEU; and an independent Federal Employees Health Benefits Board to administer the program.

Saying that "fundamental legislative reform is urgently needed," the Towers, Perrin report suggested that "a limited number of administrators or insurers" should be admitted only on a competitive basis to promote better service at lower cost. Among changes it said might be made by administrative action: establishment of minimum benefit standards for all plans and quality standards for HMOs. Employee organizations should be limited to offering plans only for regular dues-paying members, and should be required to offer both high and low options, it said. The firm recommended that all plans be required to adopt cost-containment measures, and that the least popular plans should be terminated.

Others suggest simply fine-tuning the present structure: having less-frequent open seasons and requiring minimum levels of coverage for benefits such as mental health and alcohol- and drug-related care.

Outlook

And some say the current system is essentially adequate.

"It's not at all clear that anything *has* to be done," argues *CHECKBOOK* author Francis. He paints a theoretical picture of how a system like the one proposed by NTEU would evolve: In a program with one government-wide plan and a limited number of HMOs in all regional areas, risk selection would still show up, although further down the road, and its effects would actually be worse. When most of the "expensive enrollees" join the one government plan, HMOs would become more and more popular and their rates lower and lower. As people flock to HMOs, the costs of the government-wide plan would skyrocket, leading eventually to a worse situation than exists today.

"The federal employee is getting a very good deal right now," even though he may not realize it, Francis concludes.

Ford, of Coopers and Lybrand, says that federal consumers now "have broad choice. At the same time, the government has a plan whose costs are under good control, from the government's perspective." In that sense, he adds, the federal insurance program could be a model for solving the country's medical cost inflation dilemma. Ford was project manager for national health insurance policy at the Office of Management and Budget during the Carter Administration and is still insured by a government plan, in part because his wife is a federal employee.

A single-plan system would unfairly raise premiums for lower-paid employees, says a vice president at CNA Insurance Cos., which has been underwriting employee organization plans for the federal program since the 1970s. "The system would be unfair," he says, "and that's not in the government's best interest."

The House Post Office and Civil Service Committee has requested an extensive review of the federal health insurance program from the Congressional Research Service and the General Accounting Office, to be completed by March 1. And OPM is busy gathering information and advice "so that we will be in a position to inform the new administration very quickly," says Barber. Though she doesn't expect legislation this year, she adds that OPM will push for reforms that will produce better benefits at lower costs.

"Some fine-tuning will help, but in order to get a program that will take us through the year 2000, we need to make some pretty basic changes," she says. □

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