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Mr. Chairman, and Members of the Committee:

I am delighted to testify before you today concerning the lessons of the FEHBP for Medicare modernization. In my dual careers and capacities as a consumer advocate and advisor on how to choose the best health insurance plan (Francis 2002a), and policy analyst advising on government policy options and reforms, I have long argued that the FEHBP is a superb model for Medicare reform.

A distinguished student of both programs opined several years ago that "the FEHBP has outperformed Medicare every which way--in containment of costs both to consumers and the government, in benefit and product innovation and modernization, and in consumer satisfaction" (Cain 1999). I agree. In my testimony I will try to provide data that will support these conclusions and also dispel misconceptions about the FEHBP.

Benefits. Medicare serves as a lifeline to the elderly of America. Its coverage of hospital and doctor costs is vital to the economic well being and survival of millions. Yet, Medicare is infamous for its obsolete, vintage 1960 design. It does not provide a catastrophic ceiling on costs even for those costs it covers. It does not cover prescription drugs (except in rare instances). It does not cover many preventive services. It does not cover dental services. And, by failing to cover health care costs incurred abroad (except in Canada and Mexico), it forces the elderly either to forgo retirement travel outside of North America or to obtain other coverage. Indeed, so deficient is Medicare coverage that some ninety percent of its enrollees purchase or have purchased for them some form of supplementary insurance.

None of these deficiencies affect the FEHBP. That program was also created vintage 1960, but it has painlessly evolved over time through the competitive, consumer-driven process that is its central feature. In preparing for this hearing, I rated the Medicare plan for its benefit coverage in 2003, compared to typical FEHBP plans. For a retired person without dual coverage I obtained the following results (these data include dental costs and exclude premiums):

Category	Medicare	FEHBP
Average Out of Pocket Cost	$2,640	$1,260
Likely Cost at Expense Level of $84,000	$12,580	$6,080
Ceiling on Combined Hospital, Doctor, and Drug costs	None	$5,000 plus or minus $1,000

These data demonstrate that **FEHBP retirement benefit coverage is far superior to Medicare's**.

There is another significant dimension of benefit superiority. In both programs the great majority of common hospital and physician procedures are covered routinely. However, at the margin Medicare coverage choices are dictated either by statutory law or by administrative law dictated through the Medicare coverage processes. In the FEHBP, in contrast, coverage choices at the margin are made by individual plans. This means that consumers can seek out plans that have better coverage for particular services of importance to them. Acupuncture, cardiac rehabilitation, expensive dental procedures, and other services are usually available, at a price, in some available plan. Medically proven procedures, such as pancreas-only transplants, are covered in all or almost all FEHBP plans

but are often covered by Medicare only after years of delay, if ever. And FEHBP plans are free to, and often do, cover services that they would not ordinarily cover at all if these are approved as part of a case management package tailored to a particular enrollee.

Provider Choice and Access. Medicare is, in a sense, one of the relatively few remaining pure fee-for-service (FFS) medical plans in America. Most private plans either limit provider choices substantially or, as is quite common, provide differential cost sharing depending on whether or not the provider is "preferred". Of course, Medicare is not really fee-for-service since it regulates prices and, indeed, makes it illegal for providers to negotiate higher prices with enrollees and still obtain any reimbursement (Hoff 1998). The FEHBP national plans almost all allow enrollees to go "out of plan" and pay only one fourth of a reasonable charge above that level. These plans' reimbursements are more favorable for "preferred" physicians, but some payment is available whether the physician has any arrangement of any kind with the insurance company. At worst, the patient pays the bill and then gets reimbursed directly from the insurance company. **Every Federal retiree can join health plans that reimburse him for most of his costs for virtually any physician who accepts private patients at all. More physicians are available through the FEHBP than through Medicare.**

The Medicare Payment Advisory Commission conducts surveys of physicians and in its most recent report found that physicians are significantly less willing to accept Medicare patients than private plan patients (MedPAC 2003). Specifically, in 2002 over 99 percent of physicians accepted private FFS and PPO patients, but only 96 percent accepted Medicare patients. This is a seemingly small difference but if it is your doctor, or the best specialist in town, who will not accept you, it can have a major effect on your health care. And until recently enacted payment increases, it appeared that the proportion of physicians unwilling to accept Medicare patients was about to rise substantially.

In this context, the FEHBP has a significant advantage over Medicare because of its multiplicity of plans. **Every Federal employee or retiree, no matter where he or she lives, anywhere in America or anywhere in the world, has no fewer than twelve plan options from which to choose in 2003.** (This includes both "high" and "standard" options offered by the same carrier, since these options always differ significantly in benefits and in premium.)

Federal retirees in areas covered by participating HMOs have additional plans from which to choose. Thus, while a retiree in North Dakota or Wyoming may "only" have twelve plan choices, a retiree in medium and large size cities in almost all states will typically have several more plan options. In the larger metropolitan areas, where the great majority of both Medicare and FEHBP retirees reside, there are often about 20 plan choices available to Federal retirees.

Benefit Innovation. The importance of plan choices, of course, goes far beyond serving patient needs for provider choice and benefit options. The fundamental model of the FEHBP, like most services in our economy, relies on competition in attracting consumers as the driving force for quality improvements and restraint of costs. For example, plans are free to add, drop, increase, or decrease deductibles. These are not trivial decisions. Deductibles have substantial effects on consumer acceptance, on premiums, and on health care utilization. Plans that strike the right balance do best over time. The fact that wide variations in deductibles persist over time suggests that there is more than one "right" model.

In fact, most plan benefits are quite stable. Deductibles are not frequently changed. But some benefits do change rapidly in most plans. Notable for experimentation and change are plan payments for prescription drugs. Ten or fifteen years ago, most plans either charged a nominal copayment or modest coinsurance percentage for all drugs. Enrollees were free to go to the drug store of their

choice. Mail order and formularies were almost nonexistent. In the last decade, with ever increasing spending on drugs--reflecting mainly new drugs with major new therapeutic benefits--plans have vigorously changed their approaches. Today, most plans have a six-tier benefit structure for drugs. There is one set of copayments for mail order, and another somewhat higher set for using preferred pharmacies. Generic drugs cost the enrollee the lowest copayment, preferred name brand drugs on the formulary somewhat more, and other name brand drugs the most. One can only imagine the political turmoil and potential for unnecessarily costly or constraining decisions were price controls and formularies to be proposed as features of a Medicare drug benefit. (Perhaps I had better say: just look at the last several years of political paralysis!) And it is inconceivable that such a benefit, once enacted into law under the standard Medicare approach, would receive the kind of nimble evolutionary adjustments used in the FEHBP as plans jockey for the best mix of generosity and cost control to attract customers.

Current FEHBP drug benefit structures place both the burden and the opportunity for decision making on the enrollee. They encourage frugality, but allow for medical necessity. They have evolved virtually without political controversy or legislative or bureaucratic fiat. And these approaches to benefit design been proven to keep down drug spending and save both the payer and the enrollees a great deal in premium costs (Joyce 2002). Based on RAND research, I estimate that the annual savings to the FEHBP from current tiered payment systems is somewhere around $500 million annually, about 2 or 3 percent of program-wide premium costs, shared by the government and enrollees (Francis 2002b). **Adoption and continuing reform of prescription drug and other benefits in the FEHBP has been politically and programmatically painless, while saving billions of dollars over time**.

Consumer Satisfaction. Consumer satisfaction is very difficult to measure fairly, and I am not aware of any studies that directly compare Medicare to the FEHBP using elderly persons as the sample universe. However, we have some important information. OPM has innovated in the use of quality information in the FEHBP program, and led the way to adoption of participant surveys. By providing this information to enrollees, OPM has significantly aided them in plan selection. These surveys focus mainly on specific dimensions of plan performance, such as getting needed care, how well doctors communicate, and claims processing, but also measure overall satisfaction. The most recent survey information shows that on a scale of 1 to 10, about 79 percent of FFS and PPO enrollees and 63 percent of HMO enrollees rate their plans 8 or higher.

We also have information from the annual Open Season, in which enrollees decide whether to stay in their plan or "vote with their feet" by moving to another plan. Each year, fewer than 10 percent of employees and fewer than 5 percent of retirees elect to switch plans. **The overall level of enrollee satisfaction with the FEHBP is clearly very high**.

A recent Commonwealth Fund Survey of Health Insurance did compare Medicare and private insurance generally (Davis 2002). It found, for example, that 85 percent of Medicare elderly rated their plan as good, very good, or excellent. In contrast, "only" 81 percent of those privately insured and of working age rated their plans as highly. However, these results really prove nothing. It is well known that plan satisfaction increases with age of respondent. Younger enrollees are more critical. This largely explains the differential between FFS and PPO ratings in the FEHBP, since the HMOs disproportionately attract younger enrollees. In the Commonwealth survey, I would interpret an 81 percent favorable rating by those aged 19 to 64, compared to 85 percent favorable among those aged 65 or more, as showing that **private health plans would actually be rated by consumers far higher than Medicare if available to each age group**. After all, both the experts and the elderly

agree that Medicare's benefit gaps are serious in comparison to private plans, so how could Medicare be more popular than private insurance if enrollees were given a chance to select better plans?

Guaranteed Benefits. The FEHBP and Medicare programs differ fundamentally in several ways, one of which is the difference between a "premium support" as opposed to "defined benefit" structure. One recent study argues that the Medicare approach is better because the benefits are "entitlements" that are "protected" because defined in law (Caplan 2000). This line of argument is fundamentally flawed in three ways.

First, statutorily defined benefits can be taken away whether or not defined as legal entitlements. The Medicare deductible used to be defined by law at $50 but is now $100. The Congress once enacted prescription drug benefits and then repealed them. Indeed, the Congress amends the Medicare statute every year. As the program steadily progresses toward bankruptcy, maintenance of current benefit levels hardly seems assured. Relatedly, the FEHBP is just as much an "entitlement" as Medicare. It is simply handled a different way. **The FEHBP premium level is "protected" by being defined in law and the "entitlement" formula that defines the premium level provides a substantially better than Medicare level of insurance benefits**. The entitlement says, in essence, that the government pays 75 percent of the average cost of plans that enrollees voluntarily choose. Indeed, unlike Medicare the FEHBP statute has never been amended to reduce enrollee benefits.

Second, FEHBP benefits are superior to those of Medicare for decades. The "defined benefit" turns out to be no more than a guarantee for a second rate product, and the allegedly weaker "premium support" guarantee has proven a superior guarantor by actual experience.

Third, both premiums and benefits can be guaranteed in statute without using the "enumerate every benefit in excruciating micro-managed detail" approach used by Medicare. Enrollees can be guaranteed by law an actuarially reasonable value of benefits, both overall and in broad categories such as hospital or drugs. Within such a constraint(s), plans can make the decisions as to which deductibles (if any) to use, where to set deductible levels, where to set copayment and coinsurance levels, whether or not to tier benefits, which treatments to accept as medically proven, where to set the catastrophic guarantee level, etc. In fact, this is essentially the way that OPM operates the FEHBP. The FEHBP statute could be amended to make the actuarial fairness and soundness tests explicit guarantees better than those of Medicare, without changing the program in any way. **The "premium support" model used by the FEHBP has proven to be both better and safer as an entitlement than the "defined benefit" Medicare model**.

Consumer Understanding. It has often been alleged that consumers, particularly elderly consumers, cannot handle the complications of a competitive plan system (for an extensive discussion, see MedPAC 1999). While by definition choice certainly is more complicated than no choice, there is no evidence that consumer choice poses any more of a problem for health insurance than for any other product or service. The elderly choose their own doctors, their own automobiles, their own foods, and their own living arrangements. Any or all of these are as or more complicated than health insurance.

How many consumers of any age understand the innate workings of automobiles--the technology used in engine, transmission, braking, and other systems? Yet, somehow, through magazine ratings, recommendations of friends, test drives, modest government oversight and regulation, and above all the pressures of a competitive market place, the elderly are able to select and use cars that are effective, durable, safe, comfortable, and economical.

Competitive choice among health plans is certainly facilitated by careful oversight and information dissemination. OPM has proven to be effective in these matters, and the private market has provided additional information that consumers and those family and friends who advise them can use effectively. See the latest *CHECKBOOK's Guide to Health Insurance Plans* (Francis 2002a, at www.retireehealthplans.org), and the OPM Web site at http://www.opm.gov/insure/health for thorough and user friendly displays of information.

Confusion in choosing among competing products has simply not been a problem for the millions of Federal annuitants who, over the years, have benefited from their plan selection decisions. **Should Medicare be reformed into a pro-consumer choice system, assuring adequate information will not be difficult if the OPM approach is emulated, and the private sector encouraged to supplement government information**.

Adverse Selection. Some argue that any form of multiple plan choice will necessarily lead to destructive risk selection and unpredictable exit and entrance of plans--the dreaded "death spiral." I have criticized the FEHBP for having no system of any kind for managing risk selection (Francis 2002b). In contrast, Medicare ceaselessly searches for improved methods of fine-tuning its risk management features. Reform of the absurd AAPCC (Adjusted Average Per Capita Cost) system was delayed for a decade or more because no one could devise a perfect system. The long delayed reform failed again to correct the fundamental problem that managed health care still does not in fact cost half again more in Miami than in Des Moines, or in Prince Georges County than in Fairfax County.

There is even a respectable argument that some risk selection is desirable. For example, if people with dental problems tend to join plans with better dental benefits, willingly paying the full marginal cost of their decision, what ethical or managerial principle is violated?

The FEHBP has survived for four decades with no management of risk selection other than the stability inherently produced by its insurance subsidy. A recent study concluded that the program has almost no measurable adverse risk selection (Florence and Thorpe 2003). Whatever circumstances may lead to the "death spiral", they do not obtain in a plan choice program like the FEHBP.

The Medicare+Choice Experience. Some claim that because Medicare+Choice has had a rocky start, and failed to reduce overall Medicare costs, consumer choice has been tried and has failed. However, under the reimbursement formula used in that program, relying on the fundamentally flawed AAPCC estimates of geographic variability in health costs, and tied to the yo-yo of annual changes in Medicare spending levels, Medicare+Choice never had a chance to perform properly (Gold 2003). A well designed defined contribution program using rolling averages or all-plan averages and minimal geographic adjustments (if any) would have functioned far better. In addition, a set of draconian and unreasonable mandates made participation expensive and burdensome for any FFS or PPO plan, and for most HMOs. One regulatory mandate, for language interpreter services paid by each plan, is illegal in at least three different ways. Incredibly, despite these problems Medicare+Choice still manages to attract about 150 plans and some 5 million enrollees, about 1 in 8 Medicare clients.

A program that made it financially infeasible for HMOs in most of the Midwest to participate, and that has even forced Kaiser plans to withdraw, is a fundamentally flawed program. **The FEHBP shows far better ways than Medicare+Choice to implement effective plan choice**.

Cost Control. When I last examined cost control in detail (Francis 1993) I found, to my surprise, that the FEHBP had actually controlled costs slightly better than Medicare. I have updated my analysis and now conclude that the two programs roughly tie.

Each program has good years and bad years, and these do not correspond in any simple way. By careful selection of base year, it is easy to "prove" that one program outperforms the other. And depending on whether the comparison covers one, three, five, or ten years, the answer is very different. To get around these problems, I prefer to use the method of multiple rolling averages covering 10 years. This shows long term performance without the noise that affects shorter comparisons. One needs multiple ten year comparisons because the latest one can be (and usually is) unduly influenced by a particular good or bad base year in one program or the other. The table below shows my latest results, all taken from publicly available budgetary data covering 28 years (I have appended the raw data at the end of this testimony).

Ending in Fiscal Year	Medicare 10 Year Record	FEHBP 10 Year Record	Difference	Cumulative Difference
1985	15%	12%	-2%	-2%
1986	13%	8%	-5%	-7%
1987	12%	10%	-2%	-9%
1988	11%	11%	0%	-8%
1989	10%	11%	1%	-7%
1990	10%	11%	1%	-6%
1991	9%	10%	1%	-5%
1992	8%	11%	2%	-3%
1993	8%	10%	2%	-2%
1994	8%	8%	0%	-1%
1995	8%	9%	1%	0%
1996	8%	10%	3%	3%
1997	8%	7%	-1%	2%
1998	8%	6%	-1%	1%
1999	7%	6%	0%	0%
2000	6%	6%	0%	1%
2001	6%	5%	-1%	0%
2002	5%	5%	0%	0%
2003 est	5%	6%	1%	1%

What these data show is that in recent years both programs have had a 10 year average cost increase of around 5 or 6 percent a year, and that even over the full set of comparisons the programs have only differed by more than a percentage point a few times. The cumulative difference over comparisons covering 28 years of data is a1 percent advantage for Medicare. The best way to interpret this trivial difference is that Medicare has kept costs down better than FEHBP by so little (if at all) that even after 28 years there is no measurable difference in overall performance.

I stopped my analysis in FY 2003, because the budgetary projections for 2004 are unreliable for both programs. But we have recently learned from the Medicare actuary that there is an unexpected increase of 12% in Medicare Part B costs for 2004. Had I been able to obtain later estimates for both programs, the FEHBP would likely have outperformed Medicare in the cumulative comparison. **In**

summary, the FEHBP and Medicare programs have virtually identical records over time on keeping cost increases down.

It should not really be surprising that the records are similar, since both programs operate in the context of the American health care system, with the same underlying structure of hospitals, doctors, costs, technological changes, and a myriad of other commonalities.

However, viewed another way, there is a surprise. The Medicare Administrator, he operates a system of price controls. As the Congress has so amply demonstrated in its recent flip flop attempts to set physician, hospital, and Medicare+Choice reimbursements at the "right" levels, determined in large part by the decibel level of the political outcry, price controls can be set arbitrarily within a fairly broad range. Thus, Medicare could outperform the FEHBP in reducing premium costs through cutbacks in provider prices and income, through benefit reductions, and through other government-mandated reductions. Health care resources, both human and bricks and mortar, are not in the short run perfectly mobile. Thus, the Medicare budget is set ultimately by what the political system tolerates, not by the market or any objective method.

One recent study claims that "Medicare can be counted on to control per enrollee spending growth over time, more than private insurers can" (Boccuti and Moon 2003). This study relies on a comparison of Medicare and private insurance payment data derived from National Health Accounts data provided by the agency that administers Medicare. The data purport to show that since the mid-1980s Medicare has consistently outperformed the private sector in controlling spending on comparable services (e.g., excluding prescription drugs because these are not covered by Medicare). Unfortunately, the paper fails to explain its methods and does not display the underlying data and how they are derived, massaged, and interpreted. I am skeptical that the National Health Account data really allow for analysis of this kind. Regardless, the conclusion of the paper is wrong, at least insofar as it applies to managed competition like the FEHBP. My data on comparative performance of the FEHBP and Medicare programs over the last 28 years demonstrate that **well-designed health insurance programs such as the FEHBP that rely on competing private plans that respond to consumer choices can and do perform as well as Medicare in controlling costs**.

Conclusion. I have attempted to address each of the major areas in which fundamentally different approaches to health insurance programs can be compared. On each dimension of performance, the FEHBP is arguably at least equal, and usually superior, to Medicare as currently constructed. This doesn't lead to any simple conclusion as how best to reform Medicare. The issues are many and complicated. And it certainly does not mean that the FEHBP program is perfect--it has many important problems (Francis 2002b).

But there is one fundamental issue that should be prominent in deciding among reform options and alternatives. The Medicare program is overwhelmingly statist. Medicare uses political fiat and centralized bureaucratic process to try and regulate an infinitely complicated trillion dollar health care market. Every decision that Medicare makes is necessarily a compromise that is wrong, often deeply wrong, for large numbers of enrollees and providers. Medicare is like a government designed automobile (actually, we have had two of these: the jeep and the Humvee). Designed by committee, changed too late, final details set by legislative or bureaucratic fiat, based on the principal that "one size fits all" and the corollary ethical proposition that every one should get an identical benefit because anything else is "unfair", Medicare lurches along like Dumbo the elephant (Cain 1999). And like the jeep and the Humvee, it fits very few as well as the plan (or auto) they would choose for themselves, if offered a choice.

In contrast, the FEHBP uses the mildest forms of government direction and oversight to allow the forces of choice and competition to determine health plan costs, benefits, provider choice, administrative convenience, and a host of details. For example, every single FEHBP plan covers health care anywhere in the world (HMOs offer care anywhere outside the plan area for emergencies). Why is this? Because very few consumers would voluntarily enroll in a plan that didn't offer this feature, even if they had no travel plans. If this feature cost a great deal, some plans would decline to offer it to their members, seeking to attract the "stay at home" group. The fact that hundreds of health plans do not act this way demonstrates that the extra costs of this feature are small. Why then does Medicare not offer this benefit? The answer surely lies in bureaucratic inertia and perceived cost. Cost might indeed be high for Medicare due to its inflexible methods of reimbursement--very few providers around the world would ever agree to regulation by the United States government, even such seemingly benign regulation as obtaining a provider number. But that just begs the question. Why should Medicare feel obliged to regulate foreign providers by Medicare methods? Which leads us back to bureaucratic inertia, though paralysis might be a better word.

I don't mean to dwell on coverage abroad, which is a far less important issue than prescription drug coverage and many others. But a program run on the bureaucratic model necessarily fails to deal optimally with many problems both large and small. Indeed, we all know that the chief impediment to a Medicare drug benefit is that the Medicare program is a price control program run along lines not seen elsewhere in most of the American economy since World War II. Price controls are anathema not only to the pharmaceutical industry, but also to all of us who expect that cures for Alzheimer's disease (and many others) are likely only from a profit-driven industry free to charge "high prices" without government control.

The choice before the Congress ultimately is between these two models--consumer choice or detailed legislative and bureaucratic control. By good fortune we have as an example the successful performance of the consumer choice model in meeting the health insurance needs of 9 million employees and retirees. Surely we can use that model to aid in reforming the Medicare program.

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