HEALTH INSURANCE EXCHANGES:

WHAT LESSONS CAN BE LEARNED FROM THE CONCENTRATION OR COMPETITION IN FEDERAL EMPLOYEE HEALTH BENEFIT PLANS?

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Just Monday, the proposed rule for “Affordable Insurance Exchanges” was announced...

DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Parts 155 and 156
[CMS-9989-P]
RIN 0938-AQ67
Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans

AGENCY: Department of Health and Human Services.
ACTION: Proposed rule.
SUMMARY: This proposed rule would implement the new Affordable Insurance Exchanges

“…These proposed rules are a major step forward in implementing the Exchanges. Starting in 2014, individuals and small businesses will have the same affordable insurance choices as Members of Congress and will be able to purchase private health insurance through the Exchanges.”

From “Obama Administration Rolls Out Standards for Health Insurance Marketplaces,” Robert Pear, New York Times, 7/11/11: “Trumpeting the advent of the exchanges, the administration said Monday that they would ‘give Americans the same insurance choices as members of Congress.’ However, in response to questions after a news conference on Monday, health officials acknowledged that this claim was not necessarily correct.”
By January 1, 2014, states will establish Affordable Insurance Exchanges for individuals and for small business employees. If not, the DHHS Secretary will establish and operate an Exchange in the state.

Exchanges are entities for:
- purchasing health insurance in a structured and competitive market,
- emphasizing choice of health plans,
- rules for offering and pricing of insurance, and
- transparency – providing information to help consumers better understand and navigate through options available to them.

Eligibility: U.S. citizens, Legal immigrants, Small business employees

Legal Obligations:
- Certify qualified health plans (QHP),
- Transparency,
- Communicate with beneficiaries,
- Administrative Tasks,
- Consult with stakeholders
Per the rule: "Section 1334(a) of the Affordable Care Act establishes multi-State plans; the Office of Personnel Management (OPM) will enter into contracts with health insurance issuers to offer at least two multi-State QHPs through each Exchange in each State."

- Directs OPM to administer and negotiate with plans as they do with FEHBP contracts
- Uniform benefit package nationwide that meets ACA requirements for “qualified health plans”
- Must be licensed in every state and in compliance with all state laws not inconsistent with ACA §1334
- For individuals and small groups
- A least one must be with a non-profit entity
FEHBP has been seen as a model for Exchanges for years

- “The HIE concept is broadly similar to the popular and successful Federal Employees Health Benefits Program (FEHBP), the consumer-driven system that covers Members of Congress, federal workers and retirees, and their families…

- The FEHBP is the only large group insurance system in the nation in which individuals can choose the plans and benefits that they want at prices they wish to pay.

- As state officials work to reform their health insurance markets, they should take the best features of the FEHBP and apply them to their own markets…”

FEHBP Plans

- **Nationwide Fee-For-Service Open to All**
  - Blue Cross/Blue Shield Service Benefit Plans
    - Standard Option PPO
    - Basic Option Closed Network PPPO
  - PPO Plans sponsored by unions, employee associations
    - GEHA (various insurers provide network)
    - NALC (Cigna Network)
    - APWU (Cigna Network)
    - SAMBA Nationwide (Cigna Network)
    - Mail Handlers (Coventry Network in all states except NJ and OH)

- **Nationwide Fee-For-Service for Specific Groups**
  - Rural Carrier Benefit Plan
  - + 3 others (Foreign Service, Panama Canal, Compass Ross)

- **State Specific HMOs, HDHPs and CDHPs**
Question: What lessons can we learn from FEHBP program?

- Why? FEHBP program is:
  - Nationwide
  - Offers private plans
  - Broad choice of plans and benefits
  - Not as heavily regulated as other models (e.g. Medicare Advantage)
  - Provision of consumer information
  - Offered to a mixed set of enrollees (individuals, families)

- Key differences?
  - FEHBP not as bound by state benefit mandates
  - FEHBP is group purchasing agent
  - FEHBP does restrict entry of plans
  - Federal employees: not much exposure to low-income population

Research and Policy Questions

- What is the range of choice of plans offered in FEHBP in states and counties?
- How much competition and concentration do we see in plans, in terms of how individuals enroll in the plans?
- What is the variation in plan premiums and benefits, across the country, and in relation to plan characteristics?
Data sources and methods

- **Data sources**
  - Federal Employees Health Benefits Program (FEHBP)
    - Enrollment data obtained from U.S. Office of Personnel Management (OPM) in response to a FOIA request
    - FEHBP premium and benefits data obtained from OPM website and participating plan brochures
  - County level data:
    - Area Resources File (ARF)
    - US Department of HHS, Health Resources and Services Administration

- **Methods**
  - Files merged at county level
  - Descriptive analysis shown here today
  - Leading towards multivariate analysis
Concentration in FEHBP, by Type of Plan

- FEHBP Enrollment by Type of Plan

Total Enrollment = 7.942 million

- 63% BCBS National Plans
- 21% Other National Plans
- 15% State Specific Plans
- 1% National Plans - Limited Enrollment
FEHBP Enrollment, By Region and Plan Type

Northeast
- National Plans: 79%
- State Specific Plans: 20%
- National Plans Limited Enrollment: 1%

Midwest
- National Plans: 83%
- State Specific Plans: 15%
- National Plans Limited Enrollment: 2%

South
- National Plans: 84%
- State Specific Plans: 15%
- National Plans Limited Enrollment: 1%

West
- National Plans: 61%
- State Specific Plans: 38%
- National Plans Limited Enrollment: 1%
Concentration, by Rural/Urban

Urban
Enrollment = 6,869,000 (86%)

- BCBS Plans: 61%
- Other National Plans: 23%
- State Specific Plans: 15%
- National - Limited Enrollment Plans: 1%

Rural
Enrollment = 1,072,000 (14%)

- BCBS Plans: 72%
- Other National Plans: 19%
- State Specific Plans: 6%
- National - Limited Enrollment Plans: 3%
Why so much concentration?

- Limited Availability of State-Specific Offerings
  - While consumer-directed health plans and high-deductible health plans are offered in all states
  - 11 States have no HMO offered
    - AK, AL, MS, NE, NC, SC, CT, RI, VT, NH, ME
  - 12 states have only one HMO offered
    - OR, NV, MT, WY, CO, OK, AR, LA, TN, WV, DE, MA
Federal Employees Health Benefits Program (FEHBP): Regional Differences in State Specific HMO, HDHP and CDHP Plans by County, 2010

Source of data: U.S. Office of Personnel Management (OPM) 2010 data.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2011.

Coordinate System: North America Albers Equal Area Conic

Note: Alaska and Hawaii are not to scale.
Federal Employees Health Benefits Program (FEHBP): Availability in State Specific HMO, HDHP and CDHP Plans in Western Region by County, 2010


Coordinate System: North America Albers Equal Area Conic
Not shown are nationwide plans, one high-deductible plan (Aetna) available in most counties in the state, and one consumer-directed plan available in 10 counties.

- Most counties have few choices of state-specific plans available.
- About 30 counties have no state-specific HMO plans available.

99% of enrollees in counties with no state-specific plans are in nationwide plans.

74% of enrollees in counties with state-specific plans are in nationwide plans.
**Competition levels derived from Herfindahl index values, which measure concentration of firms. "High competition" refers to low-to-moderate Herfindahl indices (under 0.25), while "Moderate", "Low", and "Extremely Low" categories correspond to high Herfindahl indices of 0.25-0.35, 0.35-0.45, and above 0.45, respectively.**
Level of Competition by Urban and Rural Counties

**Competition levels derived from Herfindahl index values, which measure concentration of firms. "High competition" refers to low-to-moderate Herfindahl indices (under 0.25), while "Moderate", "Low", and "Extremely Low" categories correspond to high Herfindahl indices of 0.25-0.35, 0.35-0.45, and above 0.45, respectively.**
# State-by-State Comparison

<table>
<thead>
<tr>
<th>State Comparisons</th>
<th>Herfindahl Index*</th>
<th>Premium</th>
</tr>
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<tbody>
<tr>
<td>Utah</td>
<td>.25</td>
<td>$43.10</td>
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<tr>
<td>Wyoming</td>
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<td>Alabama</td>
<td>.59</td>
<td>$45.20</td>
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National plans include the nationwide FFS open to all and nationwide FFS open only to specific groups.

* A lower Herfindahl index equals a higher level of competition.
**FEHBP Plan Attributes by Level of Competition**

<table>
<thead>
<tr>
<th>Level of Competition (Based on Herfindahl Index)</th>
<th>Premium (individual's share)</th>
<th>Copayments for:</th>
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<tr>
<td></td>
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<td>Primary Visits</td>
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<tr>
<td>High (&lt;.15)</td>
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<tr>
<td>High (.15-.25)</td>
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<td>Moderate (.25-.35)</td>
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<td>Extremely Low (.45-.55)</td>
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<tr>
<td>Extremely Low (&gt; .55)</td>
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**Source of data:** U.S. Office of Personnel Management (OPM) 2010 data. Produced by: RUPRI Center for Rural Health Policy Analysis, 2011

**Competition levels derived from Herfindahl index values, which measure concentration of firms. "High competition" refers to low-to-moderate Herfindahl indices (under 0.25), while "Moderate", “Low”, and "Extremely Low" categories correspond to high Herfindahl indices of 0.25-0.35, 0.35-0.45, and above 0.45, respectively.**
Summary and Policy Implications

- **Findings**
  - FEHBP has a wide array of plan choices ostensibly offered, but most enroll in just the nationwide plans.
  - This likely is result of choices facing many enrollees or networks in their areas; but a historical connection of BC/BS organization with FEHBP.

- **Policy Implications**
  - ACA assures at least two national plans in every area.
  - FEHBP offers a cautionary tale: is this enough competition?
  - State and federal policymakers may need to assure that the regulations are written to assure choice and competition.
A potential limitation?

- FEHBP enrollees includes a good number of “annuitants”, that is retirees
  - 2.8 million out of 7.9 million FEHBP enrollees are retirees
- Thinking forward, the uninsured population entering Exchanges will not include retirees
  - Only 676,000 out of the 50.7 million uninsured are over age 65.
- However, note that we still have a large number (5.1 million of non-retirees in the FEHBP data)
  - And 7.6 million outside of the D.C. area, and 4.9 million non-retirees.
Acknowledgements

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  - [http://gwbweb.wustl.edu/Pages/Home.aspx](http://gwbweb.wustl.edu/Pages/Home.aspx)
- Saint Louis University,
  - Center for Health Law Studies
  - [http://law.slu.edu/healthlaw/index.html](http://law.slu.edu/healthlaw/index.html)