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**Structuring Health Care Benefits:  
A Comparison of  
Medicare and the FEHBP**

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## EXECUTIVE SUMMARY

### Background

Medicare's future structure is now the focus of Congressional debate. Policymakers have explored, among other options, the concept of a *premium support* system to replace the current defined benefit program. Under a premium support system, each beneficiary would select an approved private health plan to provide his or her Medicare coverage. The government would contribute a share of the plan's premium, and the beneficiary would contribute an additional portion, if necessary, to purchase the plan of his or her choice. One frequently discussed example of an existing premium support model is the Federal Employees Health Benefits Program (FEHBP). While restructuring Medicare along the lines of the FEHBP could affect many aspects of the program, including premiums and eligibility rules, one of the greatest impacts would be on Medicare's benefit package.

### Purpose

The purpose of this Issue Paper is to provide a basis for analyzing a premium support system in terms of the potential impact on Medicare benefits as they are currently structured. The core features of the FEHBP are found in most premium support proposals for Medicare. Indeed, the FEHBP exemplifies the use of premium support to finance a national public health benefits program. This Issue Paper describes Medicare and the FEHBP and their structures primarily as they are created by law and regulation. It highlights individual components of the original Medicare program, and how they serve to reinforce Medicare's benefit package as an entitlement. It also details how Medicare+Choice, although different from original Medicare in structure, maintains or builds upon these components. Finally, it considers whether the FEHBP contains similar features within the program's structure.

### Methodology

The authors reviewed federal laws and regulations and published health policy materials; communicated with various Medicare program and FEHBP experts; and analyzed core features of Medicare's benefits entitlement in comparison with the FEHBP.

### Principal Findings

Currently, Medicare benefits are protected in value and scope by a combination of structural elements, including mechanisms that:

- Define specified benefits as an entitlement for all beneficiaries;
- Protect beneficiaries from exposure to certain financial risks through specific rules that govern cost-sharing and provider billing; and
- Create a process by which beneficiaries can seek to enforce their rights to the Medicare benefits as defined in the original program.

Although Medicare+Choice differs from original Medicare in important ways, core aspects of the underlying entitlement are preserved. Original Medicare establishes the basic benefits to which beneficiaries are entitled, whether or not they choose to enroll in Medicare+Choice. The specificity of the benefits package in original Medicare provides ready standards for determining the basic benefits guaranteed under Medicare+Choice, as well as original Medicare. Each program offers a structured appeals process through which decisions are based on defined benefits.

While only original Medicare provides uniform requirements for beneficiary cost-sharing (i.e., deductible and coinsurance levels), certain cost-sharing limits do exist in Medicare+Choice, as plans' cost-sharing requirements cannot exceed the aggregate level imposed under original Medicare. Also, within the limitations of the enrollment rules, the Medicare+Choice framework ensures the beneficiary's option to remain in, or return to, original Medicare. An additional provision for beneficiaries in both original Medicare and Medicare+Choice is a "hold harmless" provision that limits the impact of Part B premium increases on the amount of a beneficiary's monthly Social Security retirement benefit.

The FEHBP is administered by the federal Office of Personal Management (OPM), which oversees contracts with health plans as well as the subscriber enrollment process. In general, the FEHBP statute lists broad "types" of benefits that plans "may" cover, suggesting only that plans offer benefits to cover hospital care, surgery, ambulatory care, and obstetrics. The FEHBP does not explicitly regulate premiums and subscriber cost-sharing (i.e., deductibles and coinsurance). In general, subscribers can reduce their premium and cost-sharing liabilities by choosing lower-cost plans. However, in contrast to Medicare with its "hold harmless" provision, there is no legal mechanism that limits the impact of annual premium increases on subscribers. The OPM uses discretionary authority in negotiating with plans to influence the types of benefit offerings and maintain budget stability. The agency's flexibility in this regard has been seen as promoting innovations in plan design and management. However, the OPM's discretion also permits it to re-allocate the burden of increased health care costs between the program and subscribers in any given year. Like Medicare, the FEHBP includes a process for subscribers to seek review of coverage and payment decisions. The reviews are based on individual plan contracts, rather than a defined set of benefits to which all subscribers are entitled.

## **Conclusion**

As a health insurance program for older individuals and persons with disabilities, the Medicare program is more than just the simple sum of its parts. Important program components combine in various ways to reinforce the value of Medicare benefits to these populations. The key components described in this Issue Paper are 1) a package of defined benefits administered, at the beneficiary's option, by the original Medicare program or a Medicare+Choice plan; 2) certain built-in limits on beneficiary cost-sharing; and 3) for coverage disputes, a review and appeals process in which decisions are made, for the most part, with reference to a single set of benefits that form the basis of the entitlement. Medicare+Choice offers private sector options for organizing and financing the benefits, but it does so while maintaining or building upon essential characteristics of the original

program. One conclusion that could be drawn from examining the structure of Medicare itself is that improvements to the fee-for-service program are particularly important, as the original program remains the foundation of the Medicare entitlement.

When comparing Medicare to a premium support system like the FEHBP, it is useful to keep in mind that provisions of original Medicare are integral to the structure of the entire Medicare program, including Medicare+Choice. With regard to the FEHBP, several salient points emerge. First, although the FEHBP statute has a fairly comprehensive list of *categories* of covered services, there is no legally defined package of specific benefits, as there is in Medicare. Second, many of the potential financial protections afforded to FEHBP subscribers derive from discretionary actions of OPM, not laws or regulations. In fact, the government's discretion in approving FEHBP plan offerings each year does not necessarily work in favor of subscribers. OPM can exercise its discretion to reallocate the burdens of increased health care costs from the federal government to subscribers over time.

The FEHBP is considered by many analysts to be successful at providing health care coverage for federal workers and their dependents. These analysts commend the quality of plan information available in the FEHBP, and credit OPM and market competition with keeping subscriber out-of-pocket costs low and maintaining a range of acceptable benefit packages. Whether restructuring Medicare on the FEHBP model would engender comparable advantages for the Medicare population remains an important question, and a difficult one to answer.

In any case, the FEHBP lacks several of the structural characteristics that currently reinforce the value of the Medicare program to its beneficiaries, whether they are enrolled in the original program or Medicare+Choice. It is not the introduction of more private sector options that would necessarily undermine Medicare as an entitlement to health benefits. Rather, any premium support proposal that weakens the structure of the original program, which is the foundation of the Medicare entitlement, could have serious ramifications for current and future beneficiaries.

# STRUCTURING HEALTH CARE BENEFITS: A COMPARISON OF MEDICARE AND THE FEHBP

## Introduction

Medicare provides health care coverage to 39 million eligible beneficiaries, including more than 33 million people age 65 and older. Demographers predict that the aging of the United States population will result in a doubling of the number of Medicare beneficiaries in the next generation. This forecast has raised concerns about Medicare's capacity to meet the future health care needs of the "baby boom" generation, given substantial projected growth of Medicare costs (and health care spending in general) and questionable sufficiency of future revenues. These concerns have spurred serious discussions about major Medicare reform, which could include changes in program eligibility, benefits, and premiums, or increased payroll taxes. Among other options, policymakers have explored the concept of a *premium support* system for Medicare.

The structure of the Federal Employees Health Benefits Program (FEHBP) reflects a premium support approach, in which the federal government contributes defined amounts toward subscribers' health plan premiums,<sup>1</sup> and the subscribers pay any remaining premium amount out-of-pocket. This approach differs from Medicare's current *defined benefit* structure in various ways, which are discussed in this Issue Paper. This Issue Paper compares key design components of Medicare and the FEHBP, in order to provide a basis for analyzing the potential impact of premium support on the structure of Medicare benefits. It describes Medicare and the FEHBP and their structures primarily as they are defined by law and regulation.

Currently, Medicare benefits are protected in value and scope by a combination of structural elements, including mechanisms that:

- Define specified benefits as an entitlement for all beneficiaries;
- Protect beneficiaries from exposure to certain financial risks through specific rules that govern cost-sharing and provider billing; and
- Create a process by which beneficiaries can seek to enforce their rights to the Medicare benefits as defined in the original program.

These elements of Medicare design are described in more detail below and in Appendix A, with comparisons to the FEHBP.

A reasonable starting point for comparison is the acknowledgment that the FEHBP and Medicare have fundamentally different objectives, covered populations, and program operations. Given the significant differences in how these programs cover the health care expenses of their constituents, direct or point-by-point comparisons across the board are not always possible or useful. Further, the absence of a feature in the FEHBP does not necessarily

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<sup>1</sup> See, for example, Gail R. Wilensky and Joseph P. Newhouse, "Medicare: What's Right? What's Wrong? What's Next?" *Health Affairs*, 18(1): 92-106, January/February 1999.

signal its absence in a hypothetical Medicare premium support approach. Accordingly, the comparisons outlined below are drawn for the purposes of illustration and reference, rather than for evaluation of Medicare, the FEHBP, or premium support in general.

The structure of this Issue Paper is as follows. The first section provides overviews of Medicare and the FEHBP. Subsequent sections describe individual components of the original Medicare program, and discuss how they serve to reinforce the value and scope of the Medicare benefits. These sections also highlight how Medicare+Choice, which offers private sector options for organizing and financing Medicare's benefits, differs from original fee-for-service Medicare yet maintains or builds upon important characteristics of the original program's structure. These sections further consider whether the FEHBP contains similar features within its structure. The concluding section highlights the structural aspects of existing beneficiary protections that deserve careful consideration in evaluating proposals for a premium support option.

This paper attempts to describe these programs and their structures primarily as they are designed and created through laws and regulations. It does not compare Medicare and the FEHBP in terms of their economic impact on the marketplace or on the lives of the people these programs insure. However, references are provided to the growing number of articles that provide substantial information and analysis on these topics.

## **Overview of Medicare and the FEHBP**

### Medicare

Today, the Medicare program consists of original Medicare and Medicare+Choice. In 1965, federal legislation established Medicare as a fee-for-service health insurance program for eligible Americans age 65 and older. Later amendments extended coverage to disabled workers and persons with end-stage renal disease. As of the enactment of the Balanced Budget Act of 1997 (BBA), this fee-for-service program is referred to as "original" Medicare.

Since its inception, original Medicare has had two parts—Part A and Part B—each of which plays a unique role in the structure of the program.<sup>2</sup> Part A, which pays for certain inpatient hospital care and limited post-acute care services, was created as an entitlement program whereby eligible individuals contribute through a payroll tax during their working years and begin receiving benefits once they reach age 65. In contrast, Part B, which helps cover the costs of physician services, outpatient care, and other medical and post-acute services, was designed as a federally subsidized voluntary program. Participation in Part B requires payment of a monthly premium (\$45.50 in 2000), which represents approximately 25 percent of Part B costs. (The federal government subsidizes the remaining 75 percent of

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<sup>2</sup> Some Medicare reform proposals, including some premium support proposals, suggest combining Parts A and B. For a detailed overview of the issues involved in such a proposal, see Craig F. Caplan and David J. Gross, *The Effects of Merging Part A and Part B of Medicare*, AARP PPI Issue Paper #9901, January 1999.

program costs through general tax revenues.) Most beneficiaries enrolled in Part A also enroll in Part B.<sup>3</sup>

Medicare+Choice (Medicare Part C) was created by the BBA. Medicare+Choice expanded the Medicare entitlement by offering beneficiaries the choice to enroll in a private health plan. In addition, Medicare+Choice expanded the risk-based managed care approaches that had been introduced in the Medicare program over the years.<sup>4</sup> Among Medicare+Choice options are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider sponsored organizations (PSOs).<sup>5</sup> Typically, Medicare+Choice plan options offer beneficiaries reduced out-of-pocket costs, as well as supplemental benefits, such as coverage for prescription drugs. However, these plans also tend to restrict a beneficiary's choice of providers, or require higher beneficiary cost-sharing on services from providers that are not in the plan network. In 1999, 17 percent of the Medicare population had elected to enroll in Medicare+Choice.<sup>6</sup> Joining a Medicare+Choice plan requires simultaneous enrollment in both Part A and Part B.<sup>7</sup>

Original Medicare and Medicare+Choice are both administered by the Health Care Financing Administration (HCFA), which is part of the U.S. Department of Health and Human Services (HHS). In general, HCFA is considered the ultimate "purchaser" of program services. As a purchaser, HCFA disburses Medicare funds to providers under original Medicare and to Medicare+Choice plans through federal contracts governed by statutes and regulations. In Medicare+Choice, HCFA has the additional responsibility for providing beneficiaries with relevant information to assist them in choosing among plan options. HCFA retains authority and oversight responsibilities for health care quality and program integrity in both programs. In original Medicare, HCFA has authority to establish provider fee schedules and cost limits for most covered services. In Medicare+Choice, each individual plan determines its payments to its physicians and other providers.

### The Federal Employee Health Benefits Program (FEHBP)

The FEHBP provides health coverage to about nine million federal workers and retirees, and their dependents, nationwide. As do many large employers, the federal government offers such health coverage as a fringe benefit for its employees. Implemented on July 1, 1960, as authorized by the Federal Employees Health Benefits Act of 1959 (P.L.

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<sup>3</sup> On July 1, 1997, about 38.1 million individuals were enrolled in Part A, while about 36.5 million were enrolled in Part B. Figures are from Table 5 in Health Care Financing Administration, *Health Care Financing Review, 1999 Statistical Supplement*, Washington, DC: 1999.

<sup>4</sup> Implemented in 1985, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 98-21) first introduced full-risk managed care options in Medicare on a program-wide basis. See, for example, Health Care Financing Administration, *Health Care Financing Review, 1996 Statistical Supplement*, Washington, DC: 1996.

<sup>5</sup> Other options include private fee-for-service plans and medical savings accounts. To date, almost all of the Medicare+Choice enrollment has been in HMOs. For more information on Medicare+Choice, see the federal Medicare website, <http://www.medicare.gov>.

<sup>6</sup> Health Care Financing Administration, "Medicare Managed Care Contract Report," May 1999.

<sup>7</sup> Certain enrollees are exempt from this requirement through a grandfathering provision.

86-382),<sup>8</sup> the program offers a range of plan options that vary by such factors as premiums, cost-sharing, and types of benefits. The menu of plans available to subscribers varies geographically, although at least 10 nationwide options have always been available.<sup>9</sup> In most major cities, subscribers can choose from among ten or more local options. About 300 plans participate in the FEHBP program altogether. Historically, the range of FEHBP plan options included various versions of national fee-for-service (or indemnity-type) plans and local HMOs, although there are some areas of the country in which no HMO options exist. Today, almost all fee-for-service plans incorporate preferred provider components.<sup>10</sup> As described further in the next section, certain benefits are included in every plan, although plans may vary widely in the combinations of benefits offered.<sup>11</sup> The federal government, as an employer, contributes defined amounts toward premiums, based on a formula set by statute.<sup>12</sup> The employee pays the difference between the cost of the plan and the government contribution.

The federal Office of Personnel Management (OPM) administers the FEHBP. The OPM manages the annual enrollment process, including its review of plan offerings in an annual process of negotiation. Participating plans may alter their benefits and coinsurance requirements only once a year, with OPM approval. Through its negotiations with plans, the OPM can influence plan premium levels as well as the benefits.<sup>13</sup>

Enrollment is initially offered to an employee at the beginning of federal service. Subscribers may change their enrollment only during a set period, or “open season,” which typically lasts for about one month each year around November, following OPM’s negotiations with the plans.<sup>14</sup> OPM is responsible for producing and distributing relevant information about plans, to assist subscribers in selecting among options initially and during open season. Another source of information subscribers may purchase is the annual booklet,

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<sup>8</sup> Carolyn L. Merck, “Federal Employees Health Benefits Program,” U.S. Congressional Research Service, The Library of Congress, November 13, 1998.

<sup>9</sup> Several national plans (e.g., Blue Cross and Blue Shield) offer more than one benefit package—a “standard” option and a “high” option with enhanced benefits.

<sup>10</sup> Walton Francis, “The FEHBP as a Model for Reform,” *Medicare in the 21<sup>st</sup> Century: Seeking Fair and Efficient Reform*, Robert B. Helms, ed., Washington, DC: The AEI Press, 1999.

<sup>11</sup> One analyst uses an analogy with the automobile market when describing the FEHBP. Virtually every car has the basic elements consumers demand, such as braking, steering, and engine systems. However, the market provides wide variation in size, cargo capacity, and other amenities. Similarly, FEHBP plans have the same core similarities, and the same range of secondary features, including provider choice and claims procedures, in addition to specialized coverage and services (Walton Francis, personal communication, September 15, 1999).

<sup>12</sup> The maximum federal contribution is the lesser of (a) 72 percent of the average total premium costs of all plans in the FEHBP, weighted by the number of participants in each plan, or (b) 75 percent of the premium for the plan selected. Prior to 1999, the government contribution had been tied to the prices of only the largest, rather than all, plans. See Mark Merlis, “Medicare Restructuring: The FEHBP Model,” Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, February 1999.

<sup>13</sup> As an example, the OPM required Blue Cross and Blue Shield to enrich its mental health benefits in 1983. In the 1990s, the OPM has encouraged insurers to enhance mental health coverage while holding down premium increases (Sandra M. Foote and Stanley B. Jones, “Consumer-Choice Markets: Lessons from FEHBP Mental Health Coverage,” *Health Affairs*, 18(5): 125-130, September/October 1999).

<sup>14</sup> In most years, approximately 5 percent of federal enrollees switch plans in open season (Francis, “The FEHBP as a Model for Reform,” 1999).

*Checkbook's Guide to Health Insurance Plans for Federal Employees*, published by the non-profit Center for the Study of Services.

## **Entitlement to Benefits and Coverage of Health Care Services**

### Medicare Benefits and Coverage

Medicare benefits are set by statute. Although coverage is shaped by regulations and administrative interpretations, benefits can be added or eliminated only by legislation. Original Medicare and Medicare+Choice differ in how benefits are administered.

**Original Medicare:** Original Medicare reimburses providers directly for each discrete health care service provided to a beneficiary (hence the term “fee-for-service”). The Medicare law provides that fully participating beneficiaries in the original program (i.e., those enrolled in both Part A and Part B), are “entitled to have payment made” to providers on their behalf for covered services.<sup>15</sup> This is a basic legal guarantee of reimbursement for provider charges or fees for covered services provided to Medicare beneficiaries. The total package of benefits is described in detail in Appendix B. The law also establishes limits to this guarantee, through reimbursement and coverage principles. Depending on the particular service, reimbursement is for the most part regulated by fee schedules, rate formulae, and other payment limits. The Medicare statute also specifies which items and services are covered, and which items and services are excluded or have limited coverage.

In addition, Medicare employs administrative methods to define, restrict, and shape Medicare coverage. Ranging in formality, these methods include promulgating regulations, providing programmatic guidance from HCFA to its payment contractors, and issuing written decisions of hearing officers and review boards. The more informal interpretations, such as those made at the level of regional payment contractors, may at times lead to regional variations in coverage of some benefits. Medicare coverage laws have been criticized for being too complex, confusing, and excessively detailed. However, these laws and their administrative interpretations are the foundation of a beneficiary’s right to have covered items and services reimbursed.

**Medicare+Choice:** Medicare+Choice administers the same benefits package defined by original Medicare, but it does so in a different manner. In Medicare+Choice, Medicare does not directly reimburse health care providers for services rendered, but rather entitles a beneficiary to participate as an enrollee in a Medicare+Choice plan.<sup>16</sup> Medicare payments to the plans are not directly linked to each service provided to an enrollee, except in the case of hospice care. Instead, Medicare makes capitated payments under plan contracts that obligate the plans to cover each enrollee with at least the same package of items and services that is

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<sup>15</sup> Sections 1812 and 1832 of the Social Security Act, 42 U.S.C.A. §1395d and §1395k (1999 Supp.). A similar entitlement exists for those in Part A only (or Part B only).

<sup>16</sup> Section 1851 of the Social Security Act, 42 U.S.C. A. §1395w-21 (1999 Supp.).

defined in the original Medicare law.<sup>17</sup> However, in providing services, a Medicare+Choice plan may place certain conditions on coverage, such as requiring an enrollee to choose a provider associated with the plan, or requiring the enrollee to consult with his or her primary care physician prior to seeing a specialist. The plan may not impose such conditions in emergency situations or in other special circumstances specified in the law.

The Medicare+Choice law also includes mechanisms through which the plans may offer and provide “additional” or “supplemental” benefits, i.e., coverage expanding that which is available under original Medicare, such as prescription drugs, dental services, vision care, and annual physical examinations. Additional benefits may be provided by plans that project a Medicare payment surplus in a given year. Such plans are required either to offer additional benefits in that same year, reserve the excess amount in a “stabilization fund” to prevent future fluctuations in benefits, or repay the excess amount to Medicare. Under this requirement, additional benefits could consist of reductions in premiums and cost-sharing, as well as expanded coverage for the types of services mentioned above. Under a separate provision, Medicare+Choice plans may offer supplemental benefits approved by HCFA. For these benefits, supplemental premiums may be required.

Another feature of Medicare+Choice that plays an important role in the structure of benefits is provision for enrollment and disenrollment. During the specified enrollment periods set by statute, a Medicare beneficiary may elect to enroll in a Medicare+Choice plan. The set enrollment periods include an open enrollment period in November of each year, and a disenrollment period which, when fully implemented in 2003, will be the first three months of every year.<sup>18</sup> In practice, most plans have maintained an open enrollment policy through-out the year, but this will change as month-to-month enrollment is phased out. Beginning in 2003, once the first three months of the year have passed, an enrollee will be “locked-in” to his or her plan choice for the remainder of the year. The enrollee may change his or her plan election only once during this three-month period. If a Medicare beneficiary does not take the affirmative step of electing enrollment in a Medicare+Choice plan, enrollment in original Medicare will be considered a “default.” (In 2000, beneficiaries can disenroll from a Medicare+Choice plan at any time during the year to enroll in original Medicare.) Subject to these rules, a Medicare+Choice enrollee may elect to change from one plan to another or enroll in the original Medicare program, without regard to pre-existing conditions.<sup>19</sup>

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<sup>17</sup> Section 1852 of the Social Security Act, 42 U.S.C.A. §1395w-22 (1999 Supp.).

<sup>18</sup> The disenrollment is being phased in by periods. Until 2002, a beneficiary may elect to disenroll from a Medicare+Choice plan at any time. In 2002, the disenrollment period is limited to the first six months of that year. Additional rules about the number of times a beneficiary may make an election will also take effect. After 2002, disenrollment will take place in the first three months of every year. See Section 1851(e) of the Social Security Act, 42 U.S.C.A. §1395w-21 (1999 Supp.).

<sup>19</sup> If they choose to supplement original Medicare coverage with Medigap insurance, Medicare+Choice enrollees who choose to re-enroll in original Medicare may be subject to certain restrictions.

## FEHBP Benefits and Coverage

In the FEHBP, plans are required by law to cover the “costs associated with care in a general hospital and for other health services of a catastrophic nature.”<sup>20</sup> The FEHBP statute lists broad “types” of benefits that plans “may” cover, suggesting only that plans offer benefits to cover hospital care, surgery, ambulatory care, and obstetrics.<sup>21</sup> For certain types of plans, the statutory requirement includes prescription drugs and medical equipment and supplies.<sup>22</sup> Although the FEHBP law itself does not limit the benefits plans may offer, other restrictive federal laws may apply to the FEHBP. An example is the government-wide limitation on coverage of women’s reproductive health services.<sup>23</sup> The statutory provision governing FEHBP benefits can be found in Appendix C.

The OPM has used its discretionary authority to influence benefit offerings so that certain services are offered by all plans. Today, all plans cover outpatient prescription drugs, set annual stop-loss limits<sup>24</sup> (i.e., limits on out-of-pocket expenditures), and provide certain other benefits such as coverage for illness and accidents abroad<sup>25</sup> that are not part of Medicare’s benefit package. In addition, the OPM has historically sought to maintain budget stability, so that participating plans initiating benefit changes are required to offset the cost of any new benefit that they choose to provide with a reduction in another benefit. However, if OPM initiates the benefit change by plans, it does not require the new benefit to be budget neutral.

In addition to managing the open enrollment season, the OPM has significant authority in the annual negotiation process with plans. Such flexibility by OPM has been seen as promoting innovations in plan design and management through the negotiation process since OPM does not have to resort to federal legislation in order to make significant program changes. However, in delegating this authority, Congress has empowered the OPM to reallocate the burdens of increased health care costs between the program and subscribers in any given year.

As discussed earlier, subscribers can switch among plans only during the set open enrollment period (usually in November). Once they have made their selections, subscribers are locked in to their plan choice for one year. Indeed, subscribers have no “90-day free-look” period, as will exist in Medicare+Choice beginning in 2003. Subscribers switching plans during open season have guaranteed enrollment without regard to pre-existing conditions.<sup>26</sup>

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<sup>20</sup> Pub. L. 89-554 (1966), 5 U.S.C.A. §8904 (a) (1996).

<sup>21</sup> Merck, 1998.

<sup>22</sup> Pub. L. 89-554 (1966), 5 U.S.C.A. § 8904 (a) (1996). The statute lists separate benefits packages for “indemnity” and “service benefit” plans.

<sup>23</sup> OPM may also be directed by Executive Order to implement new coverage policy such as requirements for parity in mental health coverage.

<sup>24</sup> Merlis, 1999.

<sup>25</sup> Francis, personal communication.

<sup>26</sup> Walton Francis, “The Political Economy of the Federal Employees Health Benefits Program,” *Health Policy Reform—Competition and Controls*, Robert B. Helms, ed. (Washington, DC: The AEI Press, 1993).

## Premiums and Cost-Sharing

### Medicare Premiums and Cost-Sharing

As with most private insurance plans, beneficiaries in original Medicare and in Medicare+Choice generally are responsible for premium contributions and cost-sharing to receive full Medicare benefits. For most beneficiaries, the premium obligation takes the form of the monthly Part B premium, deducted from a beneficiary's monthly Social Security benefit payment.<sup>27</sup> The amount of the beneficiary's monthly Social Security payment may change from year to year, increased by cost-of-living adjustments (COLAs) or decreased due to added Part B premium deductions.<sup>28</sup> Theoretically, in a given year, an increase in the Part B premium could exceed the COLA amount, resulting in a net reduction in the amount of the monthly Social Security payment. However, the Medicare provision authorizing Part B premium increases also has a "hold harmless" clause. This clause stipulates that any annual increase in the Part B premium cannot have the effect of reducing the amount of the monthly Social Security benefit in the affected year.<sup>29</sup> For all beneficiaries, this is a significant protection against short-term and long-term increases in the cost of health care.

In addition to paying the Part B premium, Medicare beneficiaries are subject to cost-sharing provisions that can be substantial. Nevertheless, there are specific rules governing cost-sharing and provider billing that protect beneficiaries from exposure to certain financial risks.

**Original Medicare:** In original Medicare, a beneficiary's cost-sharing obligations are explicitly established by statute, and are uniformly applied to all beneficiaries. Cost-sharing takes the form of Part A and Part B deductibles and coinsurance.<sup>30</sup> The cost-sharing requirements highlighted in this section are described in more detail in Appendix B. The cost-sharing for inpatient hospital and skilled nursing facility (SNF) stays under Part A are structured around a "spell of illness," which begins with the first day of care and ends 60 consecutive days following a discharge if the beneficiary is not re-admitted. Part B cost-sharing is structured around a calendar year. Original Medicare's Part B coinsurance typically relates to an approved fee or charge for a particular service, such as a physician's office visit. The applicable coinsurance is calculated in terms of the Medicare-approved amount. For

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<sup>27</sup> Certain individuals receive Medicaid assistance in paying their Part B premiums and cost-sharing. Although the Part A-Part B distinction does not exist for beneficiaries receiving Medicare benefits through a Medicare+Choice plan, these beneficiaries still must pay the Part B premium, and sometimes must pay a supplemental premium as well.

<sup>28</sup> COLAs are based on changes in the Consumer Price Index (CPI). The Part B premium is based on Medicare Part B costs. In some years, such as between 1997 and 1998, and between 1999 and 2000, the Part B premium remained the same. Thus, the Social Security check increased by the full amount of the COLA.

<sup>29</sup> Section 1839(f) of the Social Security Act, 42 U.S.C.A. §1395r (1999 Supp.). Also, see Laurel Beedon and David Gross, *Social Security COLAs and Medicare Part B Premium Increases*, AARP Public Policy Institute, Fact Sheet #73, November 1998.

<sup>30</sup> Medicare's unique deductible for blood is sometimes regarded as a third type. Beneficiaries must pay for the first three pints of blood in a given year.

example, in most cases, a beneficiary is charged 20 percent of the fee schedule amount for an office visit, regardless of the physician's actual charge.<sup>31</sup>

Certain benefits are subject to special provisions that limit a beneficiary's cost-sharing liability. Under original Medicare, beneficiaries pay no deductible or coinsurance for clinical laboratory services or for annual flu shots, both of which are covered under Part B. Similarly, beneficiaries make no payments for covered home health care services, a benefit that is partially covered under Part A and partially covered under Part B.<sup>32</sup>

Another cost-sharing protection in original Medicare is the provision limiting "balance billing" by physicians.<sup>33</sup> For visits to a physician who "accepts assignment" of Medicare claims, a beneficiary typically pays coinsurance of 20 percent of the approved fee.<sup>34</sup> For office visits to physicians who do not accept assignment, the beneficiary must pay the 20 percent coinsurance and the physician may also charge in excess of the approved rate (i.e., the balance). However, Medicare law limits this additional charge to 15 percent of Medicare's approved fee. HCFA can sanction physicians who are found to charge knowingly in excess of the balance billing rate.

Although Medicare cost-sharing provisions limit beneficiary out-of-pocket spending to a certain extent, concerns persist about the sufficiency of Medicare's current benefit package in protecting beneficiaries from high levels of out-of-pocket spending. Altogether, in 1999, non-institutionalized beneficiaries of all ages are projected to have spent an average of \$2,370 (or 18 percent of their income) out-of-pocket on health care costs.<sup>35</sup>

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<sup>31</sup> The coinsurance policy with respect to hospital outpatient services has marked a significant departure from this framework. Prior to passage of the Balanced Budget Act of 1997 (BBA), a beneficiary had to pay 20 percent of the actual *hospital charges* for outpatient services, as opposed to 20 percent of the Medicare-approved amount. As a result, beneficiaries could be liable for substantially more than 20 percent of the amount the hospital is allowed as payment for services from Medicare. The BBA instituted a change to this rule. After a very gradual phase-in period, beneficiaries' coinsurance will be reduced to 20 percent of the Medicare-approved payment (rather than 20 percent of the actual hospital charges). However, until this phase-in is completed in about 2020, beneficiaries will continue to be liable for shares that are greater than 20 percent of the approved amount. The Balanced Budget Refinement Act of 1999 (BBRA) limits the amount for which a beneficiary can be billed to the Medicare Part A deductible amount (\$776 per spell of illness in 2000). See U.S. Congress, Library of Congress, Congressional Research Service, "Summary of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999" (Washington, DC: 1999) for more information on the BBRA.

<sup>32</sup> As a result of the BBA, home health care for up to 100 visits following a hospital stay of three or more days is covered under Part A, while visits over the 100-day Part A limit are covered under Part B, as are visits not preceded by an inpatient stay.

<sup>33</sup> Certain states' laws protect beneficiaries from balance billing; these states are Connecticut, Florida, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Vermont. See David J. Gross and Normandy Brangan, *The Medicare Program*, AARP Public Policy Institute, Fact Sheet #45, April 1998.

<sup>34</sup> The approved rate comes from Medicare's fee schedule.

<sup>35</sup> This total includes spending for Medicare cost-sharing, premiums for Part B and private insurance, balance billing charges, short-term nursing home care, and payments for non-covered goods and services (e.g., prescription drugs, dental, vision). It does not include the costs of home care or long-term nursing home care. See Mary Jo Gibson, et al., "How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?" AARP Public Policy Institute, #9914, September 1999.

Certain Medicare cost-sharing requirements are substantial. The first is the Part A hospital deductible, which in 2000 is \$776 per spell of illness. Moreover, as this deductible is specified in terms of the spell of illness, beneficiaries may be required to pay the Part A deductible multiple times during a year if they are hospitalized more than once.<sup>36</sup> Additionally, for care in a SNF,<sup>37</sup> there is a separate Part A coinsurance requirement. The SNF coinsurance in 2000 is \$97 per day, applicable after 20 days of a SNF stay. In Part B, beneficiaries must generally pay the first \$100 of approved charges during each calendar year. Certain other benefits (i.e., physical, speech, and occupational therapy) may be subject to annual reimbursement limits.<sup>38</sup> In Medicare, there is no annual limit on the amount that a beneficiary may be required to pay out of pocket for health care services.

Original Medicare's cost-sharing requirements, lack of a stop-loss limit, and deficiencies in its benefit package have created a significant market for private supplemental insurance. In fact, about 60 percent of all non-institutionalized beneficiaries either purchase individual private supplemental coverage or receive such a policy through their employer. Only about 10 percent of beneficiaries are enrolled in original Medicare and have no form of private (or public) supplemental coverage.<sup>39</sup>

**Medicare+Choice:** Beneficiaries who have chosen to enroll in Medicare+Choice plans on average spend significantly less out-of-pocket on health care overall than those in original Medicare.<sup>40</sup> Plans have flexibility in determining the cost-sharing for services. However, by statute, a beneficiary's aggregate cost-sharing in plans (defined as the plan's premium, plus the actuarial value of the plan's cost-sharing) may not exceed aggregate cost-sharing in original Medicare (defined as the actuarial value of original Medicare's deductibles and coinsurance).<sup>41</sup>

For Medicare+Choice enrollees, cost-sharing requirements and the richness of additional and supplemental benefits vary widely across plans. For example, copayments for primary care physician visits ranged from \$0 to \$20 per office visit in 1999, with the majority of enrollees (two-thirds) paying either \$5 or \$10.<sup>42</sup> Moreover, about 36 percent of Medicare+Choice enrollees paid supplemental premiums to their plan, ranging from about \$9 a month in some plans to \$45 or more in other plans.<sup>43</sup> While the types of additional benefits

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<sup>36</sup> If a beneficiary re-enters the hospital within 60 days following a discharge from a hospital or skilled nursing facility, that individual will not have to pay the Part A deductible again. However, a beneficiary re-entering a hospital after more than 60 days following a discharge must pay the Part A deductible once again.

<sup>37</sup> SNF care may be provided for up to 100 days following a hospital stay of at least three days.

<sup>38</sup> In the BBA, Congress set an annual cap of \$1,500 for outpatient therapy services, effective in January 1999. Under the BBRA, implementation of the cap was placed under a two-year moratorium beginning January 2000.

<sup>39</sup> Gibson, et al., September 1999.

<sup>40</sup> Gibson, et al., September 1999.

<sup>41</sup> 63 F. R. 34968, June 26, 1998.

<sup>42</sup> Such a physician visit would be subject to the 20 percent coinsurance under Part B of Medicare for those beneficiaries in the original Medicare program.

<sup>43</sup> The supplemental premium is in addition to the monthly Part B premium. A few plans charged premiums that extended to \$250 a month. See Kathryn Langwell, et al., "Analysis of Benefits Offered by Medicare HMOs, 1999: Complexities and Implications," Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, August 1999.

provided by a Medicare+Choice plan also vary across plans, 83 percent of plans offered a prescription drug benefit in 1999. Copayments for each prescription filled ranged from \$0 to \$15 or more, with plans typically charging lower copayments for generic drugs. However, about 76 percent of Medicare+Choice plans offering a prescription drug benefit imposed annual plan payment limits for prescription drugs.<sup>44</sup> In 1999, these limits ranged from less than \$600 per year to about \$4,500 per year, with 47 percent imposing annual maximum drug limits between \$1,000 and \$2,999.<sup>45</sup> Plans' prescription drug benefits may vary substantially from year to year, and many plans are more restrictive in 2000 than they were in 1999. In 2000, 86 percent of plans have annual plan payment limits for prescription drugs, and 32 percent of plans have an annual limit of \$500 or less (as compared to 21 percent in 1999).<sup>46</sup>

### FEHBP Premiums and Cost-Sharing

In contrast to original Medicare, the FEHBP law does not explicitly regulate premiums and subscriber cost-sharing (i.e., deductibles and coinsurance). In general, subscribers can reduce their premium and cost-sharing liabilities by choosing lower-cost plans. FEHBP premiums and cost-sharing are established by each contract. Practically all fee-for-service plans operate nationally with a single premium, while HMOs operate locally.<sup>47</sup> The cost-sharing levels, as well as premium amounts for similar classes of individuals (e.g., single with no dependents), apply to all enrollees *within a given plan*. In practice, premiums and cost-sharing arrangements, which are subject to OPM approval, vary considerably across participating plans. (See Appendices D-1 and D-2.) In contrast to the Medicare provision for Part B, the FEHBP has no "hold harmless" provision that limits the impact of premium increases on subscribers.

In contrast to HCFA's role in original Medicare, OPM does not administer provider payments. OPM does encourage plans to have participating provider arrangements. The agency has also refused to approve contracts determined to have provider payment provisions that could lead to unacceptable levels of balance billing (i.e., through unrealistically low provider rates).<sup>48</sup> However, such subscriber protections from cost-sharing burdens are provided at OPM's (or a plan's) discretion, not under federal statute.

All plans currently cover prescription drugs, although such coverage varies in scope across plans. An analysis of plan choices available to federal employees and retirees in the Washington, DC, metropolitan area and in Oklahoma City, OK, indicates that no "standardized" prescription drug benefit exists across plans. Deductibles for prescription drugs range from \$0 to \$300.<sup>49</sup> Some plans have a combined medical and prescription drug

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<sup>44</sup> Some plans imposed quarterly, rather than annual, payment limits.

<sup>45</sup> Langwell, et al., August 1999.

<sup>46</sup> Health Care Financing Administration, "Medicare+Choice: Changes for the Year 2000," Washington, DC, September 1999.

<sup>47</sup> Francis, "The FEHBP as a Model for Reform," 1999.

<sup>48</sup> Francis, personal communication.

<sup>49</sup> The Mail Handlers Standard Option contains a prescription drug deductible of \$600, the only plan with a deductible greater than \$300 for prescription drugs.

deductible, while many HMOs have no deductible at all.<sup>50</sup> Coinsurance for prescription drugs also differs among plans, and may be specified in terms of a dollar amount or a percentage. For example, some plans require \$5, \$10, or \$25 copayments for prescription drugs, while others specify coinsurance as 10 percent or 20 percent, with only a few FEHBP plans imposing maximums on the dollar amount of prescription drugs they will cover.<sup>51</sup> See Appendices D-1 and D-2 for comparisons of subscriber premiums and cost-sharing for inpatient hospital stays, physician office visits, and prescription drug coverage in the Washington, DC metropolitan area and in Oklahoma City, respectively.<sup>52</sup>

All FEHBP plans have annual stop-loss limits, ranging from \$300 to \$4,500 in the regions sampled for Appendices D-1 and D-2.<sup>53</sup> Deductible and coinsurance levels tend to be related inversely to stop-loss limits. In general, a plan is more likely to be willing to impose coinsurance on hospital visits when its stop-loss limit is low because the subscriber's out-of-pocket spending exposure is more limited.<sup>54</sup> Most plans currently have limits on the amount they will pay towards certain benefits, such as outpatient mental health coverage.<sup>55</sup> Clearly, then, not only the specific benefits a plan offers, but the levels at which a plan sets its deductibles, coinsurance, coverage limits, and stop-loss limits, affect the value of the plan's benefits.

In contrast to those enrolled in original Medicare, the vast majority of FEHBP subscribers do not purchase supplemental insurance, although some federal employees have secondary insurance (e.g., through a spouse). About 8 percent of eligible employees choose not to participate in the FEHBP because they have another source of insurance. However, another 8 percent of employees eligible to participate in the FEHBP are uninsured.<sup>56</sup> (No beneficiary is uninsured under Medicare by virtue of its structure.)

## **Reconsideration and Appeals**

### Medicare Appeal Rights

An integral part of Medicare's benefits structure is a process for review and appeal when a beneficiary disagrees with a coverage or payment decision. Beneficiaries may not seek

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<sup>50</sup> Francis, personal communication.

<sup>51</sup> The Mail Handlers Standard Option has a 30 percent coinsurance rate, although it does not apply to mail order prescriptions. The drug deductibles and coinsurance may also vary within a plan, depending on whether the enrollee receives care in-network or out-of-network, or uses a generic drug rather than a non-generic drug.

<sup>52</sup> Premiums contributions are different for active employees and federal retirees. In Appendix D, we focus on the cost-sharing for single employees.

<sup>53</sup> AARP PPI analysis of brochures for FEHBP plans serving the Washington, DC, and Oklahoma City, OK, metropolitan areas, using data available online through the Office of Personnel Management's website, <http://www.opm.gov>.

<sup>54</sup> Francis, "The FEHBP as a Model for Reform," 1999.

<sup>55</sup> Walton Francis and the Editors of Washington Consumer Checkbook, *Checkbook's Guide to Health Insurance Plans for Federal Employees*, Washington, DC: Center for the Study of Services, 1999.

<sup>56</sup> Office of Personnel Management, Office of the Actuary, personal communication, November 1998.

remedies from the program or plans beyond those associated with payment for disputed services.

**Original Medicare:** In original Medicare, a beneficiary may use the reconsideration and appeals process if the amount of money involved meets a certain threshold, typically \$200 for cases of inpatient care and \$100 for other cases. The first level of review is a “reconsideration” by the appropriate Medicare office, usually the Part A or Part B payment contractor. In some cases involving hospital care, this initial reconsideration may be performed by a Medicare Peer Review Organization (PRO). If not satisfied with the results of a reconsideration, a beneficiary is permitted to appeal further to officials at the U.S. Department of Health and Human Services (HHS). If the beneficiary still disagrees with the decision, the case may then be reviewed by an Administrative Law Judge (ALJ) and subsequently may also be reviewed by the HHS Departmental Appeals Board (DAB). Depending upon the amount of reimbursement at issue, beneficiaries may ultimately take an appeal to federal court.<sup>57</sup> The threshold amounts are higher for appeal to federal court -- generally \$2,000 for cases of inpatient care and \$1,000 for other cases.

**Medicare+Choice:** Medicare+Choice has a separate process for review and appeal when a beneficiary asserts that a plan has wrongly denied care or payment. This process applies to disputes about supplemental benefits as well as defined Medicare benefits. The first step is to seek reconsideration through the plan. If dissatisfied with the results of the plan’s reconsideration, a beneficiary may appeal to an independent reviewer that operates under contract with HCFA. The beneficiary may eventually seek review from an ALJ and the DAB, provided that the cost of the matter at issue is at least \$100. Cases involving \$1,000 or more, if not resolved at the administrative level, may be appealed in federal court.

### FEHBP Appeals

The OPM has interpreted the FEHBP law as requiring the agency to provide a process for resolving subscriber claims related to denial of health benefits.<sup>58</sup> Under OPM regulations, a subscriber is required first to seek a reconsideration from the plan. If not satisfied, the subscriber may ask OPM to review the claim. If not satisfied with the plan or OPM decisions regarding coverage, the subscriber may bring an action in federal court to compel OPM to direct the plan to pay the amount of disputed benefits.<sup>59</sup> Coverage reviews are made with reference to individual plan contracts, not on the basis of any statutory entitlement to benefits. In contrast to Medicare, appeal rights in the FEHBP are not conditioned upon threshold dollar amounts in controversy.

## **Conclusion**

As a health insurance program for older individuals and persons with disabilities, the Medicare program is more than just the simple sum of its parts. Important program

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<sup>57</sup> 42 C.F.R. Parts 405, 473 (1999).

<sup>58</sup> 60 F. R. 16037 (1995).

<sup>59</sup> 5 C.F.R. Part 890 (1999).

components combine in various ways to reinforce the value of Medicare benefits to these populations. The key components described in this Issue Paper are 1) a package of defined benefits administered, at the beneficiary's option, by the original Medicare program or a Medicare+Choice plan; 2) certain built-in limits on beneficiary cost-sharing; and 3) for coverage disputes, a review and appeals process in which decisions are made, for the most part, with reference to a single set of benefits that form the basis of the entitlement.

Medicare+Choice offers private sector options for organizing and financing the benefits, but it does so while maintaining or building upon essential characteristics of the original program. In Medicare+Choice, the minimum benefits that plans must offer are determined by specific provisions of original Medicare. These provisions form the basis for initial and final coverage decisions across both programs. Also, subject to Medicare+Choice enrollment procedures, a beneficiary has the option, as a legal right, to choose to remain in, or return to, original Medicare. Further, although Medicare+Choice does not provide for uniform cost-sharing requirements as the original program does, caps on cost-sharing in Medicare+Choice nonetheless exist, as plans cannot impose cost-sharing requirements that exceed the aggregate level imposed under original Medicare. Finally, the "hold harmless" clause, limiting the impact of Part B premium increases on Social Security retirement benefits, is a feature of the original program that protects all beneficiaries. One conclusion that could be drawn from examining the structure of Medicare is that improvements to the fee-for-service program are particularly important, as the original program remains the foundation of the Medicare entitlement.

When comparing Medicare to a premium support system like the FEHBP, it is also useful to keep in mind that provisions of original Medicare are integral to the structure of the entire Medicare program, including Medicare+Choice. With regard to the FEHBP, several salient points emerge. First, although the FEHBP statute has a fairly comprehensive list of *categories* of covered services, there is no legally defined package of specific benefits, as there is in Medicare. Accordingly, FEHBP benefits are administered on a plan-by-plan basis, with no mechanism for making coverage determinations as a matter of legal right. It is true that FEHBP subscribers have access to a review and appeals process for coverage denials. However, denials are reviewed as a matter of interpretation of individual plan contracts, rather than in reference to a specific set of benefits to which all subscribers are entitled. Second, many of the potential financial protections afforded to FEHBP subscribers derive from discretionary actions of OPM, not laws or regulations. In fact, the government's discretion in approving FEHBP plan offerings each year does not necessarily work in favor of subscribers. OPM can exercise its discretion to reallocate the burden of increased health care costs between the program and subscribers in any given year. Moreover, no comparable "hold harmless" provision exists in the FEHBP to regulate the impact of premium increases on subscribers.

FEHBP benefits have always been offered as a part of an employee's compensation package, and not an entitlement in the same sense as Medicare. Subscribers receive FEHBP benefits only by virtue of being a federal employee or annuitant, or family member, and through choosing to pay a premium. In contrast, one who has paid the payroll tax during his

or her working years is entitled to benefits under Medicare (Part A) without elections and without paying a premium.

The FEHBP is considered by many analysts to be successful at providing health care coverage for federal workers and their dependents. These analysts commend the quality of plan information available in the FEHBP, and credit OPM and market competition with keeping subscriber out-of-pocket costs low and maintaining a range of acceptable benefit packages. Whether restructuring Medicare on the FEHBP model would engender comparable advantages for the Medicare population remains an important question, and a difficult one to answer.

In any case, the FEHBP lacks several of the structural characteristics that currently reinforce the value of the Medicare program to its beneficiaries, whether they are enrolled in the original program or Medicare+Choice. It is not the introduction of more private sector options that would necessarily undermine Medicare as an entitlement to health benefits. Rather, any premium support proposal that weakens the structure of the original program, which is the foundation of the Medicare entitlement, could have serious ramifications for current and future beneficiaries.

## APPENDIX A

### Key Elements of Original Medicare, Medicare+Choice, and the FEHBP

<b>ELEMENT</b>	<b>ORIGINAL MEDICARE</b>	<b>MEDICARE+CHOICE</b>	<b>FEHBP</b>
<b>Specified Benefits Set by Statute</b>	<i>Covered services specified by law; uniformly applicable.</i>	<i>Covered services specified by law; additional plan benefits, such as prescription drug coverage, may vary.</i>	<i>General categories of benefits set by law, but covered services not specified.</i>
<b>Enrollment “Lock-in” Requirements</b>	<i>Not Applicable.</i>	<i>Annual (beginning in 2002). Beneficiaries will have brief trial period at beginning of each year.</i>	<i>Annual.</i>
<b>Cost-Sharing Provisions</b>	<i>Separate Part A and Part B provisions.</i>	<i>Vary by plan, but cost-sharing may not exceed that of original Medicare in the aggregate.</i>	<i>Vary by plan.</i>
<b>Appeals Process/ Federal Enforcement</b>	<i>Appeal of claim denials; decision based on defined benefits.</i>	<i>Appeal of service and payment denials; decision based on defined benefits.</i>	<i>Appeal of service and payment denials; decision based on plan contracts.</i>

## APPENDIX B: Medicare Benefits, 2000

BENEFITS IN FEE-FOR-SERVICE MEDICARE	BENEFICIARY RESPONSIBILITY, 2000	RECONSIDERATION/APPEAL RIGHTS	
<b>Hospital Care</b>	<u>Inpatient care</u> , for up to 90 days per spell of illness. Beneficiaries have 60 lifetime reserve days that may also apply.	Part A deductible (\$776 per spell of illness) Coinsurance: \$194/day for days 61-90; \$388/day for days 91-150	Reconsideration by Peer Review Organization (PRO) Administrative Law Judge (ALJ) hearing (min. \$200) and HHS review Federal Court review (min. \$2,000)
	<u>Outpatient care</u>	Part B deductible (\$100 per year) Coinsurance: 20% of approved amount <i>(Note: Until the 20-year phase-in is complete, the effective coinsurance is greater than 20%.)</i>	Review by Part B carrier Part B carrier hearing (min. \$100) ALJ hearing (min. \$500) and HHS review Federal Court review (min. \$1,000)
	<u>Inpatient psychiatric care</u> , subject to a 190-day lifetime limit.	Part A deductible Coinsurance: \$194/day for days 61-90; \$388/day for days 91-150	Same as “Inpatient care”
	<u>Emergency room services</u>	Part B deductible Coinsurance: 20% of approved amount	Reconsideration by payment intermediary ALJ hearing (min. \$100) and HHS review Federal Court review (min. \$1,000)
<b>Limited Post-Acute Care</b>	<u>Skilled nursing facility care</u> , up to 100 days per spell of illness, following hospitalizations of at least three consecutive days.	Part A deductible ( <i>if not reached during hospitalization</i> ) Coinsurance: \$97/day for days 21-100	Same as “Emergency room services”
	<u>Home health care visits</u> , whether or not preceded by hospitalization, subject to specified home health eligibility criteria.	None	Same as “Emergency room services”
	<u>Physical, occupational and speech therapy</u>	Part B deductible Coinsurance: 20% of approved amount	Same as “Outpatient care”
<b>Hospice Care</b>	<u>Hospice care</u> , subject to certification of eligibility and election of beneficiary. Unless revoked, election precludes non-palliative or “curative” care.	Coinsurance: a maximum of \$5 for prescription drugs; \$5 per day copayment for respite care (varies geographically)	Reconsideration by payment intermediary ALJ hearing (min. \$100) and HHS review Federal Court review (min. \$1,000)
<b>Physician Services</b>	<u>Physician office visits, hospital visits, surgical services, consultations</u> (The definition of “physician” includes very limited chiropractic, dental, and podiatric services.)	Part B deductible Coinsurance: 20% of approved amount <i>(Note: See below for outpatient mental health services.)</i>	Same as “Outpatient care”
<b>Mental Health</b>	<u>Specified outpatient mental health services</u>	Part B deductible Coinsurance: 20% of approved amount <i>(Note: For most outpatient treatments, effective coinsurance is 50% of approved amount.)</i>	Same as “Outpatient care”
<b>Medical Equipment / Supplies</b>	<u>Durable medical equipment</u> —DME (e.g., wheelchairs, oxygen)	Part B deductible (if provided under Part B) Coinsurance: 20% of approved amount, if under Part B	Same as “Outpatient care”

Sources: Health Care Financing Administration, *Medicare & You*, 2000; Center for Medicare Advocacy, Inc., “1999 Medicare Summary (Traditional Fee-for-Service Program),” *Center News XII* (4), Winter 1999; CCH, Inc., *1999 Medicare Explained*; HCFA Medicare website, www.medicare.gov.

## APPENDIX B: Medicare Benefits, 2000 (cont)

BENEFITS IN FEE-FOR-SERVICE MEDICARE	BENEFICIARY RESPONSIBILITY, 2000	RECONSIDERATION/APPEAL RIGHTS
<i>Medical Equipment / Supplies, continued</i> <u>Orthotics and prosthetic devices</u> (e.g., artificial limbs)	Part B deductible (if provided under Part B) Coinsurance: 20% of approved amount, if under Part B	Same as "Outpatient care"
<u>Medical supplies</u> (e.g., surgical dressings)	Part B deductible (if provided under Part B) Coinsurance: 20% of approved amount, if under Part B	Same as "Outpatient care"
<u>Blood</u> , needed as an outpatient or as part of a Part B covered service.	Pay for the first three pints per year Part B deductible and 20% coinsurance apply if it is under Part B	Same as "Outpatient care"
<i>Diagnostic</i> <u>Clinical laboratory</u> (e.g., blood tests, urinalysis)	None	Same as "Outpatient care"
<u>Physiological laboratory</u> (e.g., radiological scans and imaging)	Part B deductible Coinsurance: 20% of approved amount	Same as "Outpatient care"
<i>Preventive Care</i> <u>Mammograms</u> , annually, for women age 40 and over.	Coinsurance: 20% of approved amount <i>(Note: Part B deductible does not apply.)</i>	Same as "Outpatient care"
<u>Pap smears</u> , once every three years for women; more frequently for those at high risk.	Coinsurance: 20% of approved amount for physician services <i>(Note: Part B deductible does not apply.)</i>	Same as "Outpatient care"
<u>Diabetes monitoring</u> for all beneficiaries with diabetes.	Part B deductible Coinsurance: 20% of approved amount	Same as "Outpatient care"
<u>Colorectal cancer screening</u> for all beneficiaries age 50 and over.	Part B deductible and 20% coinsurance may apply	Same as "Outpatient care"
<u>Bone mass measurements</u> for certain beneficiaries at risk for losing bone mass.	Part B deductible Coinsurance: 20% of approved amount	Same as "Outpatient care"
<u>Prostate cancer screening</u> for all male beneficiaries age 50 and over.	Part B deductible and 20% coinsurance may apply	Same as "Outpatient care"
<u>Flu shots</u> for all beneficiaries.	None	Same as "Outpatient care"
<u>Pneumococcal vaccines</u> for all beneficiaries.	None	Same as "Outpatient care"
<u>Hepatitis B vaccines</u> for all beneficiaries.	Part B deductible Coinsurance: 20% of approved amount	Same as "Outpatient care"

Sources: Health Care Financing Administration, *Medicare & You*, 2000; Center for Medicare Advocacy, Inc., "1999 Medicare Summary (Traditional Fee-for-Service Program)," *Center News* XII (4), Winter 1999; CCH, Inc., *1999 Medicare Explained*; HCFA Medicare website, [www.medicare.gov](http://www.medicare.gov).

## APPENDIX C

### **FEHBP Benefits: Statutory Provision** (from 5 U.S.C.A. § 8901 et seq.)

#### Sec. 8904. Types of benefits

(a) The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) Service Benefit Plan.--

(A) Hospital benefits.

(B) Surgical benefits.

(C) In-hospital medical benefits.

(D) Ambulatory patient benefits.

(E) Supplemental benefits.

(F) Obstetrical benefits.

(2) Indemnity Benefit Plan.--

(A) Hospital care.

(B) Surgical care and treatment.

(C) Medical care and treatment.

(D) Obstetrical benefits.

(E) Prescribed drugs, medicines, and prosthetic devices.

(F) Other medical supplies and services.

(3) Employee Organization Plans.--Benefits of the types named under paragraph (1) or (2) of this subsection or both.

(4) Comprehensive Medical Plans.--Benefits of the types named under paragraph (1) or (2) of this subsection or both.

All plans contracted for under paragraphs (1) and (2) of this subsection shall include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature.

**(b)(1)(A)** A plan, other than a prepayment plan described in section 8903(4) of this title, may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not covered to receive Medicare hospital and insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), to pay a charge imposed by any health care provider, for inpatient hospital services which are covered for purposes of benefit payments under this chapter and part A of title XVIII of the Social Security Act, to the extent that such charge exceeds applicable limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Hospital providers who have in force participation agreements with the Secretary of Health and Human Services consistent with sections 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), whereby the participating provider accepts Medicare benefits as full payment for covered items and services after applicable patient copayments under section 1813 of such Act (42 U.S.C. 1395e) have been satisfied, shall accept equivalent benefit payments and enrollee copayments under this chapter as full payment for services described in the preceding sentence. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a hospital is found to knowingly and willfully violate this subsection on a repeated basis and the Secretary may invoke appropriate sanctions in accordance with section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) and applicable regulations.

**(B)(i)** A plan, other than a prepayment plan described in section 8903(4), may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not entitled to Medicare supplementary medical insurance benefits under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), to pay a charge imposed for physicians' services (as defined in section 1848(j) of such Act, 42 U.S.C. 1395w-4(j)) which are covered for purposes of benefit payments under this chapter and under such part, to the extent that such charge exceeds the fee schedule amount under section 1848(a) of such Act (42 U.S.C. 1395w-4(a)).

**(ii)** Physicians and suppliers who have in force participation agreements with the Secretary of Health and Human Services consistent with section 1842(h)(1) of such Act (42 U.S.C. 1395u(h)(1)), whereby the participating provider accepts Medicare benefits (including allowable deductible and coinsurance amounts) as full payment for covered items and services shall accept equivalent benefit and enrollee cost-sharing under this chapter as full payment for services described in clause (i). Physicians and suppliers who are nonparticipating physicians and suppliers for purposes of part B of title XVIII of such Act shall not impose charges that exceed the limiting charge under section 1848(g) of such Act (42 U.S.C. 1395w-4(g)) with respect to services described in clause (i) provided to enrollees described in such clause. The Office of Personnel Management shall notify a physician or supplier who is found to have violated this clause and inform them of the requirements of this clause and sanctions for such a violation. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a physician or supplier is found to knowingly and willfully violate this clause on a repeated basis and the Secretary of Health and Human Services may invoke appropriate sanctions in accordance with sections 1128A(a) and 1848(g)(1) of such Act (42 U.S.C. 1320a-7a(a), 1395w-4(g)(1)) and applicable regulations.

**(C)** If the Secretary of Health and Human Services determines that a violation of this subsection warrants excluding a provider from participation for a specified period under title XVIII of the Social Security Act, the Office shall enforce a corresponding exclusion of such provider for purposes of this chapter.

**(2)** Notwithstanding any other provision of law, the Secretary of Health and Human Services and the Director of the Office of Personnel Management, and their agents, shall exchange any information necessary to implement this subsection.

**(3)(A)** Not later than December 1, 1991, and periodically thereafter, the Secretary of Health and Human Services (in consultation with the Director of the Office of Personnel Management) shall supply to carriers of plans described in paragraphs (1) through (3) of section 8903 the Medicare program information necessary for them to comply with paragraph (1).

**(B)** For purposes of this paragraph, the term “Medicare program information” includes (i) the limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and the identity of hospitals which have in force agreements with the Secretary of Health and Human Services consistent with section 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), and (ii) the fee schedule amounts and limiting charges for physicians' services established under section 1848 of such Act (42 U.S.C. 1395w-4) and the identity of participating physicians and suppliers who have in force agreements with such Secretary under section 1842(h) of such Act (42 U.S.C. 1395u(h)).

**(4)** The Director of the Office of Personnel Management shall enter into an arrangement with the Secretary of Health and Human Services, to be effective before the first day of the fifth month that begins before each contract year, under which--

**(A)** physicians and suppliers (whether or not participating) under the Medicare program will be notified of the requirements of paragraph (1)(B);

**(B)** enforcement procedures will be in place to carry out such paragraph (including enforcement of protections against overcharging of beneficiaries); and

**(C)** Medicare program information described in paragraph (3)(B)(ii) will be supplied to carriers under paragraph (3)(A).

(Pub. L. 89-554, Sept. 6, 1966, 80 Stat. 603; Pub. L. 101-508, title VII, Sec. 7002(f)(1), Nov. 5, 1990, 104 Stat. 1388-330; Pub. L. 102-378, Sec. 2(76), Oct. 2, 1992, 106 Stat. 1355; Pub. L. 103-66, title XI, Sec. 11003(a), Aug. 10, 1993, 107 Stat. 409.)

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**APPENDIX D-1**

**2000 FEHBP Plan Cost-Sharing Information for Single Non-Postal Employee Residing in the Washington, DC Area<sup>+</sup>**

Plan Name- District of Columbia	Plan Type <sup>i</sup>	Monthly Premium	IN or ON Provider <sup>ii</sup>	BENEFICIARY COST-SHARING						Service Area <sup>vii</sup>
				Annual Out- of-Pocket Maximum <sup>iii</sup>	Calendar Year Deductible <sup>iv</sup>	Inpatient Deductible <sup>v</sup> (Per Admission)	Inpatient Hospital Coinsurance	Physician Office Visit/ Copayment	Prescription Drug Copayment <sup>vi</sup>	
Aetna U.S. Healthcare- High	HMO	\$63.63	IN	\$1,500	None	None	None	\$10	\$5 Generic \$10 Formulary \$25 Non-formulary	DC area
Aetna U.S. Healthcare-Std	HMO	\$40.46	IN	\$1,500	None	None	\$240	\$15	\$10 Generic \$15 Formulary \$30 Non-formulary	DC area
Alliance Health Plan	FFS	\$120.44*	IN ON	\$2,000 \$3,000	\$100 \$300	\$150 \$250	10% 30%	10% 30%	20% Generic, 20% Brand	Nationwide
American Postal Workers Union Health Plan	FFS	\$86.06*	IN ON	\$2,000 \$3,500	\$250	None \$200	10% 30%	10% 30%	\$7 Generic, \$25 Brand	Nationwide
Association Benefit Plan	FFS	\$81.10	IN ON	\$2,000 \$3,000	\$250	None \$100	None 20%	10% 20%	\$10 Generic and Brand \$10 Generic, \$20 Brand	Specific groups
Blue Cross and Blue Shield- High	FFS	\$143.63	IN ON	\$1,000 \$2,700	\$150	None \$100	None 30%	5% 20%	\$8 Generic, \$14 Brand	Nationwide
Blue Cross and Blue Shield- Std	FFS	\$65.09	IN ON	\$2,000 \$3,750	\$200	None \$250	None 30%	10% 25%	\$12 Generic, \$20 Brand	Nationwide
CapitalCare	HMO	\$56.03	IN	\$1,900	None	None	None	\$10	\$5 Generic, \$10 Brand	DC area
Foreign Service	FFS	\$70.55	IN ON	\$2,500	\$250	None \$175	None 20%	10% 20%	\$15 Generic, \$25 Brand	Specific groups
Free State Health	POS	\$99.82	N/A	\$2,000	None	None	20%	\$10	\$10 Generic, \$20 Brand	DC area
Government Employees Hospital Association Benefit Plan	FFS	\$99.06	IN ON	\$2,500 \$3,500	\$300	None	None	10% 25%	\$10 Generic, \$30 Brand	Nationwide
George Washington University Health Plan	HMO	\$52.79	IN	\$650	None	None	None	\$10	(after \$35 deductible) \$5 Generic \$15 Formulary \$25 Non-formulary	DC area
Kaiser Permanente	HMO	\$50.92	IN	\$1,500	None	None	None	\$10	\$7 Generic and Brand	DC area
Mail Handlers- High	FFS	\$98.43*	IN ON	\$2,500 \$4,000	\$150	None \$250	None	10% 30%	\$10 Generic, \$30 Brand \$10 Generic, \$45 Brand	Nationwide

**APPENDIX D-1 (Cont.)**

				BENEFICIARY COST-SHARING						
Plan Name-District of Columbia	Plan Type	Monthly Premium	IN or ON Provider	Annual Out-of-Pocket Maximum	Calendar Year Deductible	Inpatient Deductible (Per Admission)	Inpatient Hospital Coinsurance	Physician Office Visit/Copayment	Prescription Drug Copayment	Service Area
Mail Handlers- Std	FFS	\$45.68*	IN	\$4,000	\$200	\$150	None	10%	\$10 Generic, \$40 Brand	Nationwide
			ON			\$300		30%		
Maryland-Individual Practice Association Plan	HMO	\$56.66	IN	\$1,800	None	None	None	\$10	\$5 Generic \$10 Formulary \$25 Non-formulary	DC area
National Association of Letter Carriers	FFS	\$101.55*	IN	\$3,000	\$275	None	None	15%	\$12 Generic, \$25 Brand	Nationwide
			ON	\$3,500		\$100		20%		
Panama Canal Area	FFS	\$53.85	N/A	\$1,000	None	\$125	None	None	N/A	Specific groups
Postmasters- High	FFS	\$264.66*	IN	\$2,500	\$200	None	None	10%	\$5 Generic, \$12 Brand	Nationwide
			ON			\$275		\$150		
Postmasters- Std	FFS	\$94.49*	IN	\$3,000	\$200	None	None	10%	\$10 Generic, \$20 Brand	Nationwide
			ON	\$4,500		\$350		30%		
Prudential HealthCare HMO	HMO	\$72.06	IN	\$2,400	None	None	None	\$10	\$5 Generic \$15 Formulary \$25 Non-formulary	DC area
Rural Carrier Benefit Plan	FFS	\$86.71*	IN	\$2,000	\$250	None	None	15%	\$10 Generic, \$15 Brand	Specific groups
			ON	\$2,500		\$200				
Special Agents Mutual Benefit Association	FFS	\$99.23	IN	\$1,500	\$300	\$200	None	10%	\$15 Generic and Brand	Specific groups
			ON			30%		30%		
Secret Service	FFS	\$52.68*	N/A	\$1,000	\$200	\$100	None	20%	\$5 Generic, \$12 Brand	Specific groups

<sup>+</sup> For more information, see *Checkbook's Guide to Year 2000 Health Insurance Plans for Federal Employees* and the OPM website (www.opm.gov).

<sup>1</sup> HMO: Health Maintenance Organization; FFS: Fee-for-service plan; POS: Point-of-service plan.

<sup>ii</sup> IN: In-network provider; ON: Out-of-network provider; N/A: Not applicable because this plan does not operate on a network system. By definition, HMOs only cover in-network health care costs. Some FFS plans offer PPOs, hence the PPO is treated as a network. In managed care plans, subscribers typically make lower copayments if they see a provider within the plan's preferred provider network.

<sup>iii</sup> Does not include premiums; may not include deductible.

<sup>iv</sup> Both in-network and out-of-network providers count towards the deductible unless otherwise noted.

<sup>v</sup> If the inpatient deductible is paid, the calendar year deductible will not be paid in addition.

<sup>vi</sup> Plans use different amounts for base in calculating drug coinsurance (e.g. Preferred Provider Allowance). All FFS and POS plan prescription drug prices are reported for mail order service; there are different cost-sharing requirements for mail order service.

<sup>vii</sup> DC area: the Washington, DC, metropolitan area; Nationwide: national plans; Specific groups: eligibility for these plans is only open to specific groups of individuals.

Source: AARP PPI analysis of information from OPM's website (www.opm.gov).

**APPENDIX D-2**  
**2000 FEHBP Plan Cost-Sharing Information for Single Non-Postal Employee Residing in Oklahoma City, OK<sup>+</sup>**

				BENEFICIARY COST-SHARING						
Plan Name- Oklahoma City	Plan Type <sup>i</sup>	Monthly Premium <sup>ii</sup>	IN or ON Provider <sup>iii</sup>	Annual Out- of-Pocket Maximum <sup>iv</sup>	Calendar Year Deductible <sup>v</sup>	Inpatient Deductible <sup>vi</sup> (Per Admission)	Inpatient Hospital Coinsurance	Physician Office Visit/ Copayment	Prescription Drug Coverage <sup>vii</sup>	Service Area <sup>viii</sup>
Alliance Health Plan	FFS	\$120.44*	IN	\$2,000	\$100	\$150	10%	10%	20% Generic and Brand	Nationwide
			ON	\$3,000	\$300	\$250	30%	30%		
American Postal Workers Union Health Plan	FFS	\$86.06*	IN	\$2,000	\$250	None	10%	10%	\$7 Generic, \$25 Brand	Nationwide
			ON	\$3,500		\$200	30%	30%		
Association Benefit Plan	FFS	\$81.10	IN	\$2,000	\$250	None	None	10%	\$10 Generic and Brand \$10 Generic, \$20 Brand	Specific groups
			ON	\$3,000		\$100	20%	20%		
Blue Cross and Blue Shield- High	FFS	\$143.63	IN	\$1,000	\$150	None	None	5%	\$8 Generic, \$14 Brand	Nationwide
			ON	\$2,700		\$100	30%	20%		
Blue Cross and Blue Shield- Std	FFS	\$65.09	IN	\$2,000	\$200	None	None	10%	\$12 Generic, \$20 Brand	Nationwide
			ON	\$3,750		\$250	30%	25%		
Blue Cross and Blue Shield- Std	POS	\$65.09	IN	\$2,000	\$200	None	None	\$10	\$5 Generic, \$15 Brand 45%	Lawton/OK City/Tulsa/ Other areas
			ON	\$3,750		\$250	30%	25%		
BlueLincs HMO	HMO	\$48.63	IN	\$1,000	None	None	None	\$10	\$5 Generic, \$10 Brand	Lawton/OK City/Tulsa/ SW OK areas
CommunityCare HMO	HMO	\$47.01	IN	\$400	None	None	None	\$10	\$5 Formulary \$10 Non-formulary	OK City/Tulsa areas
Foreign Service	FFS	\$70.55	IN	\$2,500	\$250	None	None	10%	\$15 Generic, \$25 Brand N/A	Specific groups
			ON			\$175	20%	20%		
Government Employees Hospital Assoc. Benefit Plan	FFS	\$99.06	IN	\$2,500	\$300	None	10%	10%	\$10 Generic, \$30 Brand	Nationwide
			ON	\$3,500			25%	25%		
Healthcare Oklahoma	HMO	\$41.46	IN	\$300	None	None	None	\$10	\$5 Generic, \$10 Brand	Lawton/OK City/Tulsa/ Enid areas
Mail Handlers- High	FFS	\$98.43*	IN	\$2,500	\$150	None	None	10%	(after deductible) \$10 Generic, \$30 Brand \$10 Generic, \$45 Brand	Nationwide
			ON	\$4,000		\$250	30%	30%		
Mail Handlers- Std	FFS	\$45.68*	IN	\$4,000	\$200	\$150	None	10%	(after deductible) \$10 Generic, \$40 Brand \$10 Generic, \$55 Brand	Nationwide
			ON			\$300	30%	30%		

**APPENDIX D-2 (Cont.)**

Plan Name- Oklahoma City	Plan Type	Monthly Premium	IN or ON Provider	BENEFICIARY COST-SHARING						Service Area
				Annual Out- of-Pocket Maximum	Calendar Year Deductible	Inpatient Deductible (Per Admission)	Inpatient Hospital Coinsurance	Physician Office Visit/ Copayment	Prescription Drug Coverage	
National Association of Letter Carriers	FFS	\$101.55*	IN ON	\$3,000 \$3,500	\$275	None \$100	None 20%	15% 30%	\$12 Generic, \$25 Brand	Nationwide
PacifiCare OK	HMO	\$39.80	IN	\$600	None	None	None	\$10	\$5 Generic \$10 Formulary \$10 Non-formulary	OK City/Tulsa areas
Panama Canal Area	FFS	\$53.85	N/A	\$1,000	None	\$125	None	None	N/A	Specific groups
Postmasters- High	FFS	\$264.66*	IN ON	\$2,500	\$200 \$275	None \$150	None	10% 15%	(after deductible) \$5 Generic, \$12 Brand	Nationwide
Postmasters- Std	FFS	\$94.49*	IN ON	\$3,000 \$4,500	\$200 \$350	None \$250	None 30%	10% 30%	(after deductible) \$10 Generic, \$20 Brand	Nationwide
Prudential HealthCare HMO	HMO	\$47.48	IN	\$500	None	None	None	\$10	\$5 Generic \$15 Formulary \$25 Non-formulary	Central/ Western/ Southern OK
Rural Carrier Benefit Plan	FFS	\$86.71*	IN ON	\$2,000 \$2,500	\$250	None \$200	None \$200	15%	\$10 Generic, \$15 Brand	Specific groups
Special Agents Mutual Benefit Association	FFS	\$99.23	IN ON	\$1,500	\$300	\$200	None 30%	10% 30%	\$15 Generic and Brand	Specific groups
Secret Service	FFS	\$52.68*	N/A	\$1,000	\$200	\$100	None	20%	\$5 Generic, \$12 Brand	Specific groups

\* For more information, see *Checkbook's Guide to Year 2000 Health Insurance Plans for Federal Employees* and the OPM website ([www.opm.gov](http://www.opm.gov)).

<sup>i</sup> HMO: Health Maintenance Organization; FFS: Fee-for-service plan; POS: Point-of-service plan.

<sup>ii</sup> Refers to employee share. \* Does not include annual dues.

<sup>iii</sup> IN: In-network provider; ON: Out-of-network provider; N/A: Not applicable because this plan does not operate on a network system. By definition, HMOs only cover in-network health care costs. Some FFS plans offer PPOs, hence the PPO is treated as a network. In managed care plans, subscribers typically make lower copayments if they see a provider within the plan's preferred provider network.

<sup>iv</sup> Does not include premiums; may not include deductible.

<sup>v</sup> Both in-network and out-of-network providers count towards the deductible unless otherwise noted.

<sup>vi</sup> If the inpatient deductible is paid, the calendar year deductible will not be paid in addition.

<sup>vii</sup> Plans use different amounts for base in calculating drug coinsurance (e.g. Preferred Provider Allowance). All FFS and POS plan prescription drug prices are reported for mail order service; there are different cost-sharing requirements for mail order service.

<sup>viii</sup> Nationwide: national plans; Specific groups: eligibility for the plans is only open to specific groups of individuals.

Source: AARP PPI analysis of information from OPM's website ([www.opm.gov](http://www.opm.gov)).

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