United States General Accounting Office

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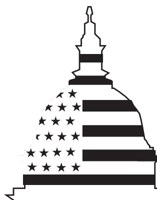
Report to Congressional Committees

June 2003

MILITARY RETIREE HEALTH BENEFITS

Enrollment Low in Federal Employee Health Plans under DOD Demonstration



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GAO-03-547

Highlights of GAO-03-547, a report to Congressional Committees

June 2003

MILITARY RETIREE HEALTH BENEFITS

Enrollment Low in Federal Employee Health Plans under DOD Demonstration

Why GAO Did This Study

Prior to 2001, military retirees who turned age 65 and became eligible for Medicare lost most of their Department of Defense (DOD) health benefits. The DOD-Federal Employees Health Benefits Program (FEHBP) demonstration was one of several demonstrations established to examine alternatives for addressing retirees' lack of Medicare supplemental coverage. The demonstration was mandated by the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999 (NDAA 1999), which also required GAO to evaluate the demonstration. GAO assessed enrollment in the demonstration and the premiums set by demonstration plans. To do this, GAO, in collaboration with the Office of Personnel Management (OPM) and DOD, conducted a survey of enrollees and eligible nonenrollees. GAO also examined DOD enrollment data, Medicare and OPM claims data, and OPM premiums data.

www.gao.gov/cgi-bin/getrpt?GAO-03-547.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marjorie E. Kanof (202) 512-7101.

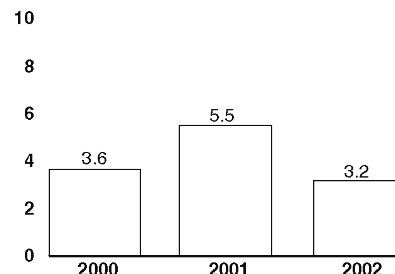
What GAO Found

Enrollment in the DOD-FEHBP demonstration was low, peaking at 5.5 percent of eligible beneficiaries in 2001 (7,521 enrollees) and then falling to 3.2 percent in 2002, after the introduction of comprehensive health coverage for all Medicare-eligible military retirees. Enrollment was considerably greater in Puerto Rico, where it reached 30 percent in 2002. Most retirees who knew about the demonstration and did not enroll said they were satisfied with their current coverage, which had better benefits and lower costs than the coverage they could obtain from FEHBP. Some of these retirees cited, for example, not being able to continue getting prescriptions filled at military treatment facilities if they enrolled in the demonstration. For those who enrolled, the factors that encouraged them to do so included the view that FEHBP offered retirees better benefits, particularly prescription drugs, than were available from their current coverage, as well as the lack of any existing coverage.

Monthly premiums charged to enrollees for individual policies in the demonstration varied widely—from $65 to $208 in 2000—with those plans that had lower premiums and were better known to eligible beneficiaries, capturing the most enrollees. In setting premiums initially, plans had little information about the health and probable cost of care for eligible beneficiaries. Demonstration enrollees proved to have lower average health care costs than either their counterparts in the civilian FEHBP or those eligible for the demonstration who did not enroll. Plans enrolled similar proportions of beneficiaries in poor health, regardless of whether they charged higher, lower, or the same premiums for the demonstration as for the civilian FEHBP.

In commenting on a draft of the report, DOD concurred with the overall findings but disagreed with the description of the demonstration's impact on DOD's budget as small. As noted in the draft report, DOD's costs for the demonstration relative to its total health care budget were less than 0.1 percent of that budget. OPM declined to comment.

DOD-FEHBP Demonstration Enrollment, 2000-2002



Source: DOD.

Note: Enrollment is expressed as a percentage of eligible beneficiaries.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DOD	Department of Defense
FAQ	frequently asked questions
FEHBP	Federal Employees Health Benefits Program
HMO	health maintenance organization
MTF	military treatment facility
NMOP	National Mail Order Pharmacy
OBRA 1990	Omnibus Budget Reconciliation Act of 1990
OPM	Office of Personnel Management
PIP-DCG	Principal Inpatient Diagnostic Cost Group
POS	point-of-service
PPO	preferred provider organization
SNF	skilled nursing facility
TFL	TRICARE For Life
VA	Department of Veterans Affairs

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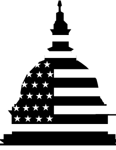

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Prior to 2001, military retirees who turned age 65 and became eligible for Medicare lost most of their Department of Defense (DOD) health care benefits. DOD did not offer its military retirees[1] Medicare supplemental coverage, which some private employers make available to their retirees. Such coverage pays for Medicare deductibles and copayments as well as certain items not covered by Medicare, including most outpatient prescription drugs. Military retirees age 65 and over could obtain free care from the more than 600 military treatment facilities (MTF), but only if space was available after beneficiaries under age 65 had been treated. Older retirees could also get prescription drugs at no charge from MTF pharmacies if the drugs were stocked by the MTFs, although only about 40 percent of retirees age 65 and over lived close to an MTF.

To gather information on alternative ways of addressing military retirees' lack of Medicare supplemental coverage, Congress established several demonstrations that allowed Medicare-eligible military retirees to enroll in DOD-sponsored health care programs.[2] One of those demonstrations was the DOD Federal Employees Health Benefits Program (FEHBP) demonstration ("the demonstration"),[3] which lasted from 2000 through 2002. Under the demonstration, military retirees and several smaller groups of beneficiaries[4]—such as certain former spouses of active duty

[1]Our use of the term "military retirees" includes their dependents and survivors age 65 and over.

[2]The Medicare subvention demonstration allowed retirees to enroll in new DOD-run Medicare managed care plans at six sites. See U.S. General Accounting Office, *Medicare Subvention Demonstration: Pilot Satisfies Enrollees, Raises Cost and Management Issues for DOD Health Care*, GAO-02-284 (Washington, D.C.: Feb. 11, 2002). Another demonstration, called TRICARE Senior Supplement, used TRICARE—the DOD health care program covering military personnel, younger retirees, and their dependents—to supplement retirees' Medicare coverage.

[3]The demonstration was created by the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, (NDAA 1999) Pub. L. No. 105-261, § 721, 112 Stat. 1920, 2061 (1998) (codified at 10 U.S.C. § 1108) (2000).

[4]In this report, the term "beneficiaries" refers to all those eligible for the demonstration: retirees, their spouses and other dependents, and other beneficiaries designated by law. It includes some persons under age 65.

military personnel and retirees—could purchase coverage from one of the private health plans that participate in FEHBP, the federal government's health insurance program for civilian employees and retirees. DOD subsidized this retiree health coverage, paying up to three-quarters of the premium. Enrollees could no longer use MTFs or military pharmacies. The demonstration was open to about 120,000 of the more than 1.5 million military retirees and dependents age 65 and over.[5] It initially included retirees and other eligible beneficiaries in eight geographic areas and expanded in 2001 to include two additional areas.

The law establishing the demonstration (the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999 (NDAA 1999)) directed us to examine a number of topics relating to enrollment and the demonstration's effects on beneficiaries and DOD.[6] Specifically, this report addresses (1) enrollment in the demonstration and the factors that influenced whether military retirees enrolled, (2) the premiums set by FEHBP plans for the demonstration and their strategies for setting premiums, and (3) any effects that the demonstration project had on DOD and beneficiaries—enrollees and nonenrollees.

To address these topics, we, in cooperation with DOD and the Office of Personnel Management (OPM), which administers FEHBP, surveyed between May and August 2000 a representative sample of about 5,600 persons eligible for the demonstration, of whom 85 percent responded. To analyze factors affecting enrollment, we obtained survey information from both enrollees and nonenrollees on health status, insurance coverage, and other factors potentially affecting their enrollment decisions. We also obtained information from DOD on persons eligible for the demonstration and their use of military health care. We obtained information from Quotesmith Inc. on premiums for private Medigap insurance plans that supplement Medicare and are sold directly to individuals. To assess the premiums offered by FEHBP plans, we obtained information from OPM on premiums in the demonstration and in the civilian FEHBP. To obtain information on whether demonstration enrollees were sicker than others, we used Medicare claims on the diagnoses and costs of enrollees, eligible nonenrollees, and civilian FEHBP enrollees age 65 and over who lived near the demonstration sites. To examine the costs of demonstration

[5]In addition, the demonstration was open to approximately 17,000 eligible beneficiaries under age 65.

[6]10 U.S.C. § 1108(k) (2000).

enrollees, we obtained information from OPM and from Medicare claims. We restricted some analyses to retirees age 65 and over for two reasons. First, these retirees constituted 85 percent of all enrollees. Second, cost and diagnostic information was available for these retirees but not for beneficiaries under age 65. We also interviewed representatives of military retiree associations as well as DOD and OPM officials. (See app. I for a discussion of our survey methods and app. II for a discussion of our methods of analyzing health status and factors affecting enrollment, including tests of statistical significance.) We found that the size and design of the demonstration were adequate for us to evaluate its effects and answer the questions that Congress asked. We performed our work in phases from November 1999 through May 2003. In 1999 and 2000, we observed the initial planning and implementation of the demonstration, and in 2000 we conducted the GAO-OPM-DOD survey. At the end of 2002 and in 2003, after the demonstration had ended, we conducted additional analyses. We completed our work in accordance with generally accepted government auditing standards.

Results in Brief

Enrollment in the DOD-FEHBP demonstration peaked at 5.5 percent of potential beneficiaries in 2001 (7,521 enrollees) and then fell to 3.2 percent in 2002, after the introduction of comprehensive health coverage—TRICARE For Life (TFL) and the senior pharmacy benefit—for Medicare-eligible military retirees.[7] Enrollment was considerably greater in Puerto Rico than on the mainland,[8] reaching 30 percent in 2002. Most retirees who knew about the demonstration and did not enroll said they were satisfied with their current coverage—it had better benefits and lower costs than the coverage they could obtain through the demonstration. Many nonenrollees also cited not being able to continue getting prescriptions filled at no charge at MTFs if they enrolled. Among the relatively small proportion of people who did enroll, factors that encouraged their enrollment included their view that the demonstration offered better benefits, such as prescription drugs, than were available to them from other plans, and their lack of existing coverage, such as employer-sponsored insurance or a Medicare managed care plan. These factors also

[7]The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 allowed Medicare-eligible retirees to begin participating in TRICARE in 2001. Pub. L. No. 106-398, § 712, 114 Stat.1645A, 1554A-176 (2000).

[8]The mainland refers to the 48 contiguous states.

help explain the high enrollment in Puerto Rico, where the share of retirees without existing coverage was much greater than on the mainland.

Premiums charged enrollees in the demonstration varied widely—from $65 to $208 monthly for an individual policy in 2000—with those plans that had lower premiums and greater name recognition capturing the largest number of enrollees. In setting premiums, plans had little information about the health and probable cost of military beneficiaries. Plans adopted two different strategies to reduce their financial burden if they attracted sick, costly enrollees. One strategy kept premiums relatively low—at or near premiums in the civilian FEHBP, with the intent of attracting a representative mix of enrollees. The second strategy was to charge higher premiums than in the civilian program, which tended to discourage enrollment and provided a financial cushion in case those beneficiaries who enrolled proved costly. However, plans following the two different strategies attracted about the same proportion of enrollees who were in poor health. In addition, demonstration enrollees were on average less sick and younger than either their counterparts in the civilian program or demonstration nonenrollees. During the first year of the demonstration, enrolled retirees' health care was considerably less expensive per person than the health care for their counterparts in the civilian FEHBP—$3,529 (excluding prescription drugs) compared to $5,313. Premiums for individual policies rose on average in 2001, but they fell in 2002, the first time that a full year's information on enrollees' costs was available when OPM and the plans negotiated premiums.

The demonstration's impact on DOD's budget, MTFs, and military beneficiary access to military health care was small, although its impact on beneficiaries who enrolled was considerable. The limited impact on DOD's budget and MTFs was due in part to the demonstration's small number of potential beneficiaries, relative to the more than 1.5 million military retirees age 65 and over, and in part to the small proportion that actually enrolled. For enrollees, the demonstration substantially expanded their choice of health care options.

In commenting on a draft of this report, DOD said that it concurred with our overall findings but disagreed with our description of the demonstration's impact on DOD's budget as small. DOD's costs for the demonstration relative to its total health care budget were less than 0.1 percent of that budget. DOD provided technical comments that we incorporated as appropriate. OPM declined to comment.

Background

Medicare is generally the primary source of health insurance for people age 65 and over. However, traditional Medicare leaves beneficiaries liable for considerable out-of-pocket costs, and most beneficiaries have supplemental coverage. Military retirees can also obtain some care from MTFs and, since October 1, 2001, DOD has provided comprehensive supplemental coverage to its retirees age 65 and over. Civilian federal retirees and dependents age 65 and over can obtain supplemental coverage from FEHBP. The demonstration tested extending this coverage to military retirees age 65 and over, and their dependents.

Medicare

Medicare, a federally financed health insurance program for persons age 65 and older, some people with disabilities, and people with end-stage kidney disease, is typically the primary source of health insurance for persons age 65 and over. Eligible Medicare beneficiaries are automatically covered by part A, which includes inpatient hospital and hospice care, most skilled nursing facility (SNF) care, and some home health care.[9] They can also pay a monthly premium ($54 in 2002) to join part B, which covers physician and outpatient services as well as those home health services not covered under part A. Outpatient prescription drugs are generally not covered.[10] Under traditional fee-for-service Medicare, beneficiaries choose their own providers and Medicare reimburses those providers on a fee-for-service basis. Beneficiaries who receive care through traditional Medicare are responsible for paying a share of the costs for most services.

The alternative to traditional Medicare, Medicare+Choice, offers beneficiaries the option of enrolling in private managed care plans and other private health plans. In 1999, before the demonstration started, about 16 percent of all Medicare beneficiaries were enrolled in a Medicare+Choice plan; by 2002, the final year of the demonstration, enrollment had fallen to 12 percent. Medicare+Choice plans cover all basic

[9]U.S. citizens and permanent residents are generally eligible for Medicare part A without having to pay a premium if they or their spouse worked for at least 10 years in Medicare-covered employment. Certain other persons with disabilities or end-stage kidney disease are also covered. Work by members of the armed services has been considered Medicare-covered employment since 1966, when Medicare was established.

[10]Medicare generally covers outpatient prescription drugs only if they cannot be self-administered and are related to a physician's services, such as cancer chemotherapy, or are provided in conjunction with covered durable medical equipment, such as inhalation drugs used with a nebulizer. In addition, Medicare covers selected immunizations and certain drugs that can be self-administered, such as blood clotting factors and some oral drugs used in association with cancer treatment and immunosuppressive therapy.

Medicare benefits, and many also offer additional benefits such as prescription drugs, although most plans place a limit on the amount of drug costs they cover. These plans typically do not pay if their members use providers who are not in their plans, and plan members may have to obtain approval from their primary care doctors before they see specialists. Members of Medicare+Choice plans generally pay less out of pocket than they would under traditional Medicare.[11]

Medicare Supplemental Coverage

Medicare's traditional fee-for-service benefit package and cost-sharing requirements leave beneficiaries liable for significant out-of-pocket costs, and most beneficiaries in traditional fee-for-service Medicare have supplemental coverage. This coverage typically pays part of Medicare's deductibles, coinsurance, and copayments, and may also provide benefits that Medicare does not cover—notably, outpatient prescription drugs. Major sources of supplemental coverage include employer-sponsored insurance, the standard Medigap policies sold by private insurers to individuals, and Medicaid.

Employer-sponsored insurance. About one-third of Medicare's beneficiaries have employer-sponsored supplemental coverage. These plans, which typically have cost-sharing requirements, pay for some costs not covered by Medicare, including part of the cost of prescription drugs.[12]

Medigap. About one-quarter of Medicare's beneficiaries have Medigap, the only supplemental coverage option available to all beneficiaries when they initially enroll in Medicare. Prior to 1992, insurers were free to establish the benefits for Medigap policies. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) required that beginning in 1992, Medigap policies be standardized, and OBRA authorized 10 different benefit packages, known as plans A through J, that insurers could offer.[13] The most popular Medigap policy is plan F, which covers Medicare coinsurance and deductibles, but not prescription drugs. It had an average annual premium per person of

[11]See U.S. General Accounting Office, *Medicare+Choice: Selected Program Requirements and Other Entities' Standards for HMOs*, GAO-03-180 (Washington, D.C.: Oct. 31, 2002).

[12]Employer-sponsored health benefits have declined over the last decade and continue to erode. See U.S. General Accounting Office, *Retiree Health Insurance: Gaps in Coverage and Availability*, GAO-02-178T (Washington, D.C.: Nov. 1, 2001).

[13]The Balanced Budget Act of 1997 permitted insurers to offer high deductible versions of existing F and J plans. Pub. L. No. 105-33, § 4032. 111 Stat.251, 359 (1997).

about $1,200 in 1999, although in some cases plan F cost twice that amount. Among the least popular Medigap policies are those offering prescription drug coverage. These policies are the most expensive of the 10 standard policies—they averaged about $1,600 in 1999, and some cost over $5,000. Beneficiaries with these policies pay most of the cost of drugs because the Medigap drug benefit has a deductible and high cost sharing and does not reimburse policyholders for drug expenses above a set limit.[14]

Health Care for Military Retirees

DOD provides health care to active-duty military personnel and retirees, and to eligible dependents and survivors through its TRICARE program.[15] Prior to 2001, retirees lost most of their military health coverage when they turned age 65, although they could still use MTFs when space was available, and they could obtain prescription drugs without charge from MTF pharmacies.[16] In the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (NDAA 2001), Congress established two new benefits to supplement military retirees' Medicare coverage:

- **Pharmacy benefit**. Effective April 1, 2001, military retirees age 65 and over were given access to prescription drugs through TRICARE's National Mail Order Pharmacy (NMOP) and civilian pharmacies. Retirees make lower copayments for prescription drugs purchased through NMOP than at civilian pharmacies. Retirees continue to have access to free prescription drugs at MTF pharmacies.
- **TFL**. Effective October 1, 2001, military retirees age 65 and over who were enrolled in Medicare part B became eligible for TFL. As a result, DOD is now a secondary payer for these retirees' Medicare-covered services, paying all of their required cost sharing. TFL also offers certain benefits not covered by Medicare, including catastrophic coverage. Retirees can continue to use MTFs without charge on a "space available" basis.

[14]See U.S. General Accounting Office, *Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives*, GAO-02-533T (Washington, D.C.: Mar. 14, 2002) and *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs*, GAO-01-941 (Washington, D.C.: July 31, 2001).

[15]DOD also provides health care to retired reserve service members and their families as well as Medal of Honor recipients and their families.

[16]Retirees could obtain prescription drugs from an MTF only if the drugs were stocked by the MTF. In addition, over 400,000 beneficiaries age 65 and over were eligible for the mail order and retail pharmacy benefit as a result of the Base Realignment and Closure (BRAC) actions.

In fiscal year 1999, before TFL was established, DOD's annual appropriations for health care were about $16 billion, of which over $1 billion funded the care of military retirees age 65 and over. In fiscal year 2002, DOD's annual health care appropriations totaled about $24 billion, of which over $5 billion funded the care of retirees age 65 and over who used TFL, the pharmacy benefit, and MTF care.

In addition to their DOD coverage, military retirees—but generally not their dependents—can use Department of Veterans Affairs (VA) facilities. There are 163 VA medical centers throughout the country that provide inpatient and outpatient care as well as over 850 outpatient clinics. VA care is free to veterans with certain service-connected disabilities or low incomes;[17] other veterans are eligible for care but have lower priority than those with service-connected disabilities or low incomes and are required to make copayments.

FEHBP

FEHBP, the health insurance program administered by OPM for federal civilian employees and retirees, covered about 8.3 million people in 2002. Civilian employees become eligible for FEHBP when hired by the federal government. Employees and retirees can purchase health insurance from a variety of private plans, including both managed care and fee-for-service plans, that offer a broad range of benefits, including prescription drugs. Insurers offer both self-only plans and family plans, which also cover the policyholders' dependents. Some plans also offer two levels of benefits: a standard option and a high option, which has more benefits, less cost sharing, or both.[18] For retirees age 65 and over, FEHBP supplements Medicare, paying beneficiaries' Medicare deductibles and coinsurance in addition to paying some costs not covered by Medicare, such as part of the cost of prescription drugs.[19]

[17]Veterans with a service-connected disability rating of 50 percent or more qualify for free health care in VA facilities. Their treatment may be for conditions unrelated to military service. The disability rating is based on an evaluation that represents the average loss in earning capacity associated with the severity of physical and mental conditions. Individuals' ratings range from 0 percent to 100 percent.

[18]Some plans refer to the two options as the basic option and the standard option.

[19]See U.S. General Accounting Office, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits*, GAO-03-236 (Washington, D.C.: Dec. 31, 2002).

Over two-thirds of FEHBP policyholders are in national plans; the remainder are in local plans. National plans include plans that are available to all civilian employees and retirees as well as plans that are available only to particular groups, for example, foreign service employees. In the FEHBP, the largest national plan is Blue Cross Blue Shield, accounting for about 45 percent of those insured by an FEHBP plan.[20] Other national plans account for about 24 percent of insured individuals. The national plans are all preferred provider organizations (PPO) in which enrollees use doctors, hospitals, and other providers that belong to the plan's network, but are allowed to use providers outside of the network for an additional cost. Local plans, which operate in selected geographic areas and are mostly managed care, cover the remaining 32 percent of people insured by the FEHBP.

Civilian employees who enroll in FEHBP can change plans during an annual enrollment period. During this period, which runs from mid-November to mid-December, beneficiaries eligible for FEHBP can select new plans for the forthcoming calendar year. To assist these beneficiaries in selecting plans, OPM provides general information on FEHBP through brochures and its Web site. Also, as part of this information campaign, plans' representatives may visit government agencies to participate in health fairs, where they provide detailed information about their specific health plans to government employees.

The premiums charged by these plans, which are negotiated annually between OPM and the plans, depend on the benefits offered by the plan, the type of plan—fee-for-service or managed care—and the plan's out-of-pocket costs for the enrollee. Plans may propose changes to benefits as well as changes in out-of-pocket payments by enrollees. OPM and the plans negotiate these changes and take them into account when negotiating premiums. Fee-for-service plans must base their rates on the claims experience of their FEHBP enrollees, while adjusting for changes in benefits and out-of-pocket payments, and must provide OPM with data to justify their proposed rates. Managed care plans must give FEHBP the best rate that they offer to groups of similar size in the private sector under similar conditions, with adjustments to account for differences in the demographic characteristics of FEHBP enrollees and the benefits

[20]Blue Cross Blue Shield is a consortium of local Blue Cross Blue Shield plans across the country. It charges the same premium in all locations and distributes that premium to its local plans, without any adjustment for local variations in health care costs.

provided.[21] The government pays a maximum of 72 percent of the weighted average premium of all plans and no more than 75 percent of any plan's premium. Unlike most other plans, including employer-sponsored insurance and Medigap, FEHBP plans charge the same premium to all enrollees, regardless of age. As a result, persons over age 65, for whom the FEHBP plan supplements Medicare, pay the same rate as those under age 65, for whom the FEHBP plan is the primary insurer.

The FEHBP Demonstration

The FEHBP demonstration allowed eligible beneficiaries in the demonstration sites to enroll in an FEHBP plan. The demonstration ran for 3 years, from January 1, 2000, through December 31, 2002. The law that established the demonstration capped enrollment at 66,000 beneficiaries and specified that DOD and OPM should jointly select from 6 to 10 sites. Initially, the agencies selected 8 sites that had about 69,000 eligible beneficiaries according to DOD's calculation for 2000.[22] (See table 1.) Four sites had MTFs, and 1 site—Dover—also participated in the subvention demonstration.[23] Two other sites, which had about 57,000 eligible beneficiaries, were added in 2001. Demonstration enrollees received the same benefits as civilian FEHBP enrollees, but could no longer use MTFs or MTF pharmacies.

[21]These private sector groups are referred to as similarly sized subscriber groups.

[22]More recent DOD data indicate that the number of eligible beneficiaries was approximately 80,000 in the 8 original sites. (See app. III.) This substantial increase in eligible beneficiaries, compared to the initial figure, resulted from corrections that DOD made to its eligibility and enrollment database. We used the lower figure in implementing the sampling strategy for our survey because it was the only information available at the time of the survey. To maintain consistency, all analyses for 2000 use the original (lower) DOD figure.

[23]The law establishing the FEHBP demonstration required that at least one site contain an MTF, one site not contain an MTF, one site be a participant in the DOD Medicare subvention demonstration, and no TRICARE region have more than one FEHBP demonstration site. 10 U.S.C. § 1108(C) (2000).

Table 1: Number of Eligible Beneficiaries by DOD-FEHBP Demonstration Site, 2000-2002

Site	2000	2001	2002
With MTF:			
Camp Pendleton, Calif.	24,907	27,328	27,287
Dover, Del.[a]	4,384	4,868	4,867
Fort Knox, Ky.	7,757	9,121	9,113
Puerto Rico	6,907	9,401	9,453
No MTF:			
Dallas, Tex.	13,607	16,159	16,133
Greensboro, N.C.	3,278	4,033	4,024
Humboldt County, Calif.	2,919	3,461	3,454
New Orleans, La.	5,083	6,095	6,085
Adair County, Iowa		29,584	29,530
Coffee County, Ga.		27,329	27,284
Total—initial 8 sites[b]	68,842		
Total—10 sites		137,379	137,230

Source: DOD.

Note: The 2000 data are as of January 1, 2000, 2001 data are as of March 14, 2001, and 2002 data are as of February 21, 2002.

[a]Dover also participated in the DOD Medicare subvention demonstration.

[b]DOD initially calculated that there were 68,842 beneficiaries in the original 8 sites. Based on this figure, the demonstration including the two new sites had approximately 126,000 eligible beneficiaries. The higher numbers in 2001 and 2002 resulted from corrections that DOD made to its eligibility and enrollment database.

Military retirees age 65 and over and their dependents age 65 and over were permitted to enroll in either self-only or family FEHBP plans. Dependents who were under age 65 could be covered only if the eligible retiree chose a family plan. Several other groups were permitted to enroll including:

- unremarried former spouses of a member or former member of the armed forces entitled to military retiree health care,
- dependents of a deceased member or former member of the armed forces entitled to military retiree health care, and
- dependents of a member of the armed services who died while on active duty for more than 30 days.

About 13 percent of those eligible for the demonstration were under age 65.[24]

DOD, with assistance from OPM, was responsible for providing eligible beneficiaries information on the demonstration. A description of this information campaign is in appendix IV.

The demonstration guaranteed enrollees who dropped their Medigap policies the right to resume their coverage under 4 of the 10 standard Medigap policies—plans A, B, C, and F—at the end of the demonstration. However, demonstration enrollees who held any other standard Medigap policies, or Medigap policies obtained before the standard plans were established, were not given the right to regain the policies. Enrollees who dropped their employer-sponsored retiree health coverage had no guarantee that they could regain it.

Each plan was required by OPM to offer the same package of benefits to demonstration enrollees that it offered in the civilian FEHBP, and plans operating in the demonstration sites were generally required to participate in the demonstration. Fee-for-service plans that limit enrollment to specific groups, such as foreign service employees, did not participate. In addition, health maintenance organizations (HMO) and point-of-service (POS) plans were not required to participate if their civilian FEHBP enrollment was less than 300 or their service area overlapped only a small part of the demonstration site.[25] Thirty-one local plans participated in the demonstration in 2000; for another 14 local plans participation was optional, and none of these participated.

The law established a separate risk pool for the demonstration, so any losses from the demonstration were not covered at the expense of persons insured under the civilian FEHBP.[26] As a result, plans had to establish separate reserves for the demonstration and were allowed to charge

[24]Persons eligible for the civilian FEHBP were not eligible for the demonstration.

[25]HMOs are comprehensive medical plans that coordinate health care through a network of physicians and hospitals. A POS option provides enrollees with a choice of using the plan's health care providers or paying higher fees to see providers outside of the plan's network.

[26]A risk pool is the group of people with respect to whom the premium is set. In the FEHBP, premiums depend upon the expected claims or costs of those enrolled. The FEHBP demonstration required that expected costs for the demonstration enrollees and for civilian FEHBP enrollees be calculated separately. 10 U.S.C. § 1108(h) (2000).

different premiums in the demonstration than they charged in the civilian program.

Enrollment Was Low, Largely Due to Beneficiaries' Satisfaction with Existing Coverage

Enrollment in the demonstration was low, although enrollment in Puerto Rico was substantially higher than on the U.S. mainland. Among eligible beneficiaries who knew about the demonstration yet chose not to enroll, most were satisfied with their existing health care coverage and preferred it to the demonstration's benefits. Lack of knowledge about the demonstration accounted for only a small part of the low enrollment. Although most eligible retirees did not enroll in a demonstration plan, several factors encouraged enrollment. Some retirees took the view that the demonstration plans' benefits, notably prescription drug coverage, were better than available alternatives. Other retirees mentioned lack of satisfactory alternative coverage. In particular, retirees who were not covered by an existing Medicare+Choice or employer-sponsored health plan were much more likely to enroll. The higher enrollment in Puerto Rico reflected a higher proportion of retirees there who considered the demonstration's benefits—ranging from drug coverage to choice of doctors—better than what they had. The higher enrollment in Puerto Rico also reflected in part Puerto Rico's greater share of retirees without existing coverage, such as an employer-sponsored plan.

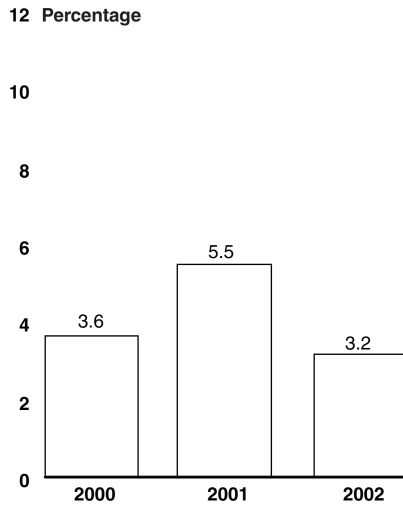
Enrollment Rate Low on U.S. Mainland, Far Greater in Puerto Rico

While some military retiree organizations as well as a large FEHBP plan predicted at the start of the demonstration that enrollment would reach 25 percent or more of eligible beneficiaries, demonstration-wide enrollment was 3.6 percent in 2000 and 5.5 percent in 2001.[27] In 2002, following the introduction of the senior pharmacy benefit and TFL the previous year, demonstration-wide enrollment fell to 3.2 percent. (See fig. 1.) The demonstration's enrollment peaked at 7,521 beneficiaries, and by 2002 had declined to 4,367 of the 137,230 eligible beneficiaries.[28]

[27]Enrollment as a percentage of eligible beneficiaries in 2000 is based on DOD's initial figure of 68,842 eligible beneficiaries.

[28]Enrollment for 2000 was as of January 1, 2000, enrollment for 2001 was as of March 14, 2001, and enrollment for 2002 was as of February 21, 2002.

Figure 1: DOD-FEHBP Demonstration-wide Enrollment, 2000-2002



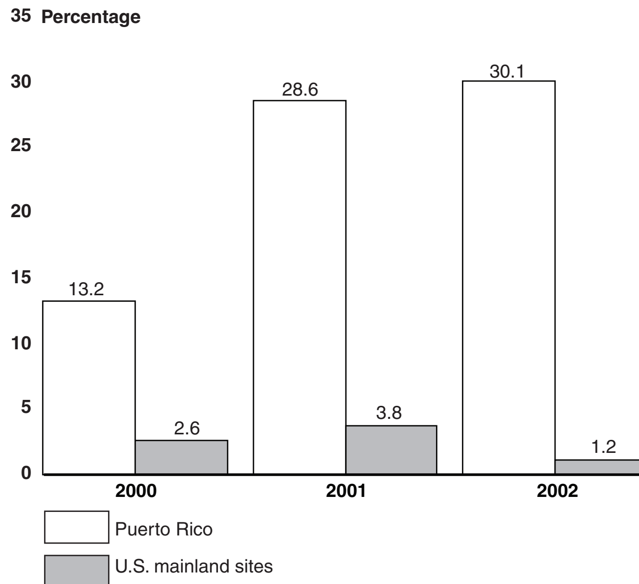
Source: DOD.

Note: GAO analysis of DOD data. Enrollment is expressed as a percentage of eligible beneficiaries.

These low demonstration-wide enrollment rates masked a sizeable difference in enrollment between the mainland sites and Puerto Rico. In 2000, enrollment in Puerto Rico was 13.2 percent of eligible beneficiaries—about five times the rate on the mainland. By 2001, Puerto Rico's enrollment had climbed to 28.6 percent. Unlike 2002 enrollment on the mainland, which declined, enrollment in Puerto Rico that year rose slightly, to 30 percent. (See fig. 2.) Among the mainland sites, there were also sizeable differences in enrollment, ranging from 1.3 percent in Dover, Delaware, in 2001, to 8.8 percent in Humboldt County, California, that year. Enrollment at all mainland sites declined in 2002.[29]

[29]See app. III for enrollment by site.

Figure 2: DOD-FEHBP Demonstration Enrollment on the Mainland and in Puerto Rico, 2000-2002



Source: DOD.

Note: GAO analysis of DOD data. Enrollment is expressed as a percentage of eligible beneficiaries.

Nonenrollees Emphasized Better Benefits and Lower Costs of Existing Coverage

Retirees who knew about the demonstration and did not enroll cited many reasons for their decision, notably that their existing coverage's benefits—in particular its prescription drug benefit—and costs were more attractive than those of the demonstration.[30] In addition, nonenrollees expressed several concerns, including uncertainty about whether they could regain their Medicare supplemental coverage after the demonstration ended.

- **Benefits of existing coverage**. Almost two-thirds of nonenrollees who knew about the demonstration reported that they were satisfied with their existing employer-sponsored or other health coverage.[31] For the majority

[30]Only nonenrollees who knew about the demonstration (44 percent of eligible beneficiaries) were asked to give their reasons for not enrolling. Because respondents to our survey gave multiple reasons for not enrolling, percentages reported concerning benefits, prescription drugs, and other reasons add to more than 100 percent.

[31]Satisfaction with existing coverage was a much less important reason for not enrolling in Puerto Rico than on the mainland. In Puerto Rico, 28 percent of nonenrollees were satisfied with their existing coverage, compared to 66 percent of nonenrollees on the mainland.

of nonenrollees with private employer-sponsored coverage, the demonstration's benefits were no better than those offered by their current plan.

- **Costs of existing coverage**. Nearly 30 percent of nonenrollees who knew about the demonstration stated that its plans were too costly.[32] This was likely a significant concern for retirees interested in a managed care plan, such as a Medicare+Choice plan, whose premiums were generally lower than demonstration plans.
- **Prescription drugs and availability of doctors**. In explaining their decision not to enroll, many eligible beneficiaries who knew about the demonstration focused on limitations of specific features of the benefits package that they said were less attractive than similar features of their existing coverage. More than one-quarter of nonenrollees cited not being able to continue getting prescriptions filled without charge at MTF pharmacies if they enrolled. More than one-quarter also said their decision at least partly reflected not being able to keep their current doctors if they enrolled. These nonenrollees may have been considering joining one of the demonstration's managed care plans, which generally limit the number of doctors included in their provider networks. Otherwise, they would have been able to keep their doctors, because PPOs, while encouraging the use of network doctors, permit individuals to select their own doctors at an additional cost.
- **Uncertainty**. About one-fourth of nonenrollees said they were uncertain about the viability of the demonstration and wanted to wait to see how it worked out. In addition, more than 20 percent of nonenrollees were concerned that the demonstration was temporary and would end in 3 years. Furthermore, some nonenrollees who looked beyond the demonstration period expressed uncertainty about what their coverage would be after the demonstration ended: Roughly one-quarter expressed concern that joining a demonstration plan meant risking the future loss of other coverage—either Medigap or employer-sponsored insurance. Finally, about one-quarter of nonenrollees were uncertain about how the demonstration would mesh with Medicare.

Lack of Knowledge about Demonstration Accounted for Only Small Part of Low Enrollment

Lack of knowledge—although common among eligible retirees—was only a small factor in explaining low enrollment. If everyone eligible for the demonstration had known about it, enrollment might have doubled, but would still have been low. DOD undertook an extensive information campaign, intended to inform all eligible beneficiaries about the

[32]See app. V for a complete list of reasons given.

demonstration, but nearly 54 percent of those eligible for the demonstration did not know about it at the time of our survey (May through August 2000). Of those who knew about the demonstration, only 7.4 percent enrolled. Those who did not know about the demonstration were different in several respects from those who did: They were more likely to be single, female, African American, older than age 75, to have annual income of $40,000 or less, to live an hour or more from an MTF, not covered by employer-sponsored health insurance, not officers, not to belong to military retiree organizations and to live in the demonstration areas of Camp Pendleton, California, Dallas, Texas, and Fort Knox, Kentucky.

Accounting for the different characteristics of those retirees who knew about the demonstration and those who did not, we found that roughly 7 percent of those who did not know about the demonstration would have enrolled in 2000 if they had known about it. As a result, we estimate that demonstration-wide enrollment would have been about 7 percent if all eligible retirees knew about the demonstration. (See app. II.)

Comparison of enrollment in Puerto Rico and the mainland sites also suggests that, among the factors that led to low enrollment, knowledge about the demonstration was not decisive. In 2000, fewer people in Puerto Rico reported knowing about the demonstration than on the mainland (35 percent versus 47 percent). Nonetheless, enrollment in Puerto Rico was much higher.

Factors Spurring Enrollment Included Favorable Assessment of FEHBP and Lack of Existing Coverage

In making the decision to enroll, retirees were attracted to an FEHBP plan if it had better benefits—particularly prescription drug coverage—or lower costs than their current coverage or other available coverage. Among those who knew about the demonstration, retirees who enrolled were typically positive about one or both of the following:

- **Better FEHBP benefits**. Two-thirds of enrollees cited their demonstration plan's benefits package as a reason to enroll, with just over half saying the benefits package was better than other coverage available to them. Nearly two-thirds of enrollees mentioned the better coverage of prescription drugs offered by their demonstration plan. Furthermore, the inclusiveness of FEHBP plans' networks of providers mattered to a majority of enrollees: More than three-fifths mentioned as a reason for enrolling that they could keep their current doctors under the demonstration.

- **Lower demonstration plan costs**. Among enrollees, about 62 percent said that their demonstration FEHBP plan was less costly than other coverage they could buy.

  Beneficiaries' favorable assessments of FEHBP—and their enrollment in the demonstration—were related to whether they lacked alternative coverage to traditional Medicare and, if they had such coverage, to the type of coverage. In 2000, among those who lacked employer-sponsored coverage or a Medicare+Choice plan, or lived more than an hour's travel time from an MTF, about 15 percent enrolled. By contrast, among those who had such coverage, or had MTF access, 4 percent enrolled.

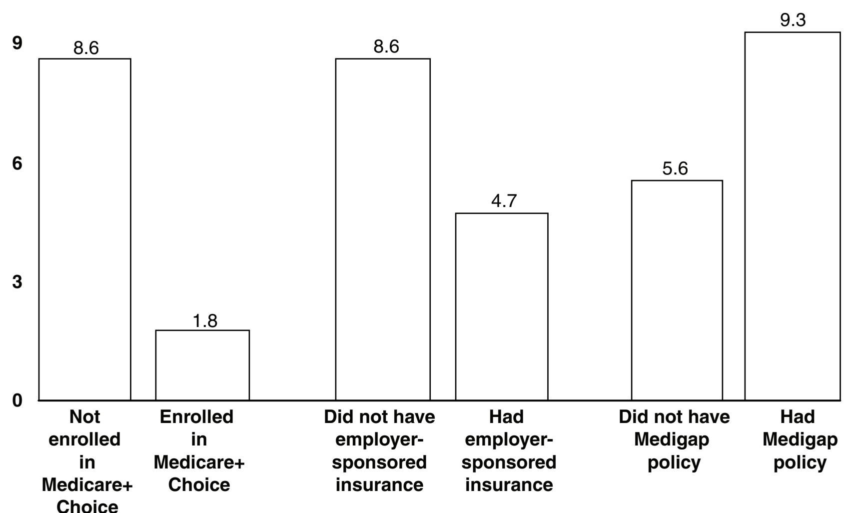
  In particular, enrollment in an FEHBP plan was more likely for retirees who lacked either Medicare+Choice or employer-sponsored coverage.

- **Lack of Medicare+Choice**. Controlling for other factors affecting enrollment, those who did not use Medicare+Choice were much more likely to enroll in a demonstration plan than those who did. (See fig. 3.) Several reasons may account for this. First, in contrast to fee-for-service Medicare, Medicare+Choice plans are often less costly out-of-pocket, typically requiring no deductibles and lower cost sharing for physician visits and other outpatient services. Second, unlike fee-for-service Medicare, many Medicare+Choice plans offered a prescription drug benefit. Third, while Medicare+Choice plan benefits were similar to those offered by demonstration FEHBP plans, Medicare+Choice premiums were typically less than those charged by the more popular demonstration plans, including Blue Cross Blue Shield, the most popular demonstration plan on the mainland.
- **Lack of employer-sponsored coverage**. Retirees who did not have employer-sponsored health coverage were also more likely to join a demonstration plan. Of those who did not have employer-sponsored coverage, 8.6 percent enrolled in the demonstration, compared to 4.7 percent of those who had such coverage. Since benefits in employer-sponsored health plans often resemble FEHBP benefits, retirees with employer-sponsored coverage would have been less likely to find FEHBP plans attractive.[33]

[33]Like retirees' employer-sponsored coverage, those with Medicare+Choice coverage were significantly less likely to enroll, while retirees covered by Medicare part B were significantly more likely to enroll. (See app. IV.) Part B coverage of enrollees and nonenrollees differed slightly: 94.7 percent for enrollees and 92.1 percent for nonenrollees.

Retirees with another type of alternative coverage, Medigap, responded differently to the demonstration. Unlike the pattern with other types of insurance coverage, more of those with a Medigap plan enrolled (9.3 percent) than did those without Medigap (5.6 percent). Medigap plans generally offered fewer benefits than a demonstration FEHBP plan, but at the same or higher cost to the retiree. Seven of the 10 types of Medigap plans available to those eligible for the demonstration do not cover prescription drugs. As a result of these differences, retirees who were covered by Medigap policies would have had an incentive to enroll instead in a demonstration FEHBP plan, which offered drug coverage and other benefits at a lower premium cost than the most popular Medigap plan.

Figure 3: DOD-FEHBP Demonstration Enrollment by Type of Previous Health Coverage, 2000



Source: CMS and GAO-DOD-OPM survey.

Note: GAO analysis of CMS and GAO-DOD-OPM survey data. Enrollment is expressed, for employer-sponsored coverage, as a percentage of eligible beneficiaries who knew about the demonstration and, for Medicare+Choice enrollment and Medigap coverage, as a percentage of eligible retirees who knew about the demonstration. An eligible beneficiary or retiree may have more than one type of coverage.

Like the lack of Medicare+Choice or employer-sponsored coverage, lack of nearby MTF care stimulated enrollment. While living more than an hour from an MTF was associated with higher demonstration enrollment, MTF care may have served some retirees as a satisfactory supplement to

Medicare-covered care, making demonstration FEHBP plans less attractive to them. Of eligible retirees who knew of the demonstration and lived within 1 hour of an MTF, 3.7 percent enrolled, compared to 11.1 percent of those who lived more than 1 hour away.

Higher Enrollment in Puerto Rico Associated with Greater Lack of Satisfactory Alternative Coverage

Higher enrollment in Puerto Rico than on the mainland reflected in part the more widespread lack of satisfactory alternative health coverage in Puerto Rico compared to the mainland. In Puerto Rico, of those who knew of the demonstration, the share of eligible retirees with employer-sponsored health coverage (14 percent) was about half that on the mainland (27 percent). In addition, before September 2001, no Medicare+Choice plan was available in Puerto Rico. By contrast, in mainland sites where Medicare+Choice plans were available, their attractive cost sharing and other benefits discouraged retirees from enrolling in demonstration plans. Other factors associated with Puerto Rico's high enrollment and cited by enrollees there included the demonstration plan's better benefits package—especially prescription drug coverage—compared to many retirees' alternatives, the demonstration plan's broader choice of doctors, and the plan's reputation for quality of care.[34]

Premiums Varied Widely, Reflecting Plans' Different Assessments of Demonstration Risk

The premiums charged by the demonstration plans varied widely, reflecting differences in how they dealt with the concern that the demonstration would attract a disproportionate number of sick, high-cost enrollees. To address these concerns, plans generally followed one of two strategies. Most plans charged higher premiums than those they charged to their civilian FEHBP enrollees—a strategy that could have provided a financial cushion and possibly discouraged enrollment. A small number of plans set premiums at or near their premiums for the civilian FEHBP with the aim of attracting a mix of enrollees who would not be disproportionately sick. Plans' underlying concern that they would attract a sicker population was not borne out. In the first year of the demonstration, for example, on average health care for demonstration retirees was 50 percent less expensive per enrollee than the care for their civilian FEHBP counterparts.

[34]There was only one local plan in the demonstration in Puerto Rico: Triple-S.

Plans' Premiums Varied Widely, and Plans with Lower Premiums Attracted the Most Enrollees

Demonstration plans charged widely varying premiums to enrollees, with the most popular plans offering some of the lowest premiums. In 2000, national plans' monthly premiums for individual coverage ranged from $65 for Blue Cross Blue Shield to $208 for the Alliance Health Plans. Among local plans—most of which were managed care—monthly premiums for individual coverage ranged from $43 for NYLCare Health Plans of the Southwest to $280 for Aetna U.S. Healthcare. Not surprisingly, few enrollees selected the more expensive plans.[35] The two most popular plans were Blue Cross Blue Shield and Triple-S; the latter offered a POS in Puerto Rico. Both plans had relatively low monthly premiums—the Triple-S premium charged to individuals was $54 in the demonstration's first year. Average premiums for national plans were about $20 higher than for local plans, which were largely managed care plans. (See table 2.)

Table 2: Monthly Premiums Charged to Enrollees for Individual Policies in the DOD-FEHBP Demonstration, 2000

Type of plan	Plan or group of plans	Enrollee share of premium
National plans		
	Blue Cross Blue Shield	$65
	GEHA Benefit Plan	99
	Other national plans—average	142
National plan average		125
Local plans		
	Triple-S	54
	Other fee-for-service plans—average	78
	Managed care plans—average	107
Local plan average		103
Average of all plans		$107

Source: OPM.

Note: GAO analysis of OPM premium data. Premiums are for a standard option individual policy unless only one option was available.

Some plans in the demonstration were well known in their market areas, while others—especially those open only to government employees—likely had much lower name recognition. Before the demonstration started, OPM officials told us that they expected beneficiaries to be unfamiliar with many of the plans included in the demonstration. These

[35]For example, the 10 percent of plans with the highest premiums attracted 0.1 percent of enrollees.

officials said that beneficiaries were likely to have only experience with or knowledge of Blue Cross Blue Shield and, possibly, some local HMOs. The success of Blue Cross Blue Shield relative to other national plans in attracting enrollees appears to support their view, as does Triple-S's success in Puerto Rico, where it is one of the island's largest insurers. In 2000, Blue Cross Blue Shield was the most popular plan in the demonstration, with 42 percent of demonstration-wide enrollment and 68 percent of enrollment on the mainland. Among national plans, the GEHA Benefit Plan (known as GEHA) was a distant second with 4 percent of enrollment. The other five national plans together captured less than 1 percent of all demonstration enrollment. Among local plans, Triple-S was most successful, capturing 96 percent of enrollment in Puerto Rico and 38 percent of enrollment demonstration-wide. The other local plans, taken together, accounted for about 14 percent of demonstration-wide enrollment.

Plans' Premium Strategies Diverged despite Common Concerns about Attracting Sicker Enrollees

Several factors contributed to plans' concern that they would attract sicker—and therefore more costly—enrollees in the demonstration. Plans did not have the information that they usually use to set premiums—claims history for fee-for-service plans and premiums charged to comparable private sector groups for managed care plans. Moreover, according to officials, some plans were reluctant to assume that demonstration enrollees would be similar to their counterparts in the civilian FEHBP. A representative from one of the large plans noted that the small size of the demonstration was also a concern. The number of people eligible for the demonstration (approaching 140,000, when the demonstration was expanded in 2001) was quite small compared to the number of people in the civilian program (8.5 million in 2001). If only a small number of people enrolled in a plan, one costly case could result in losses, because claims could exceed premiums.

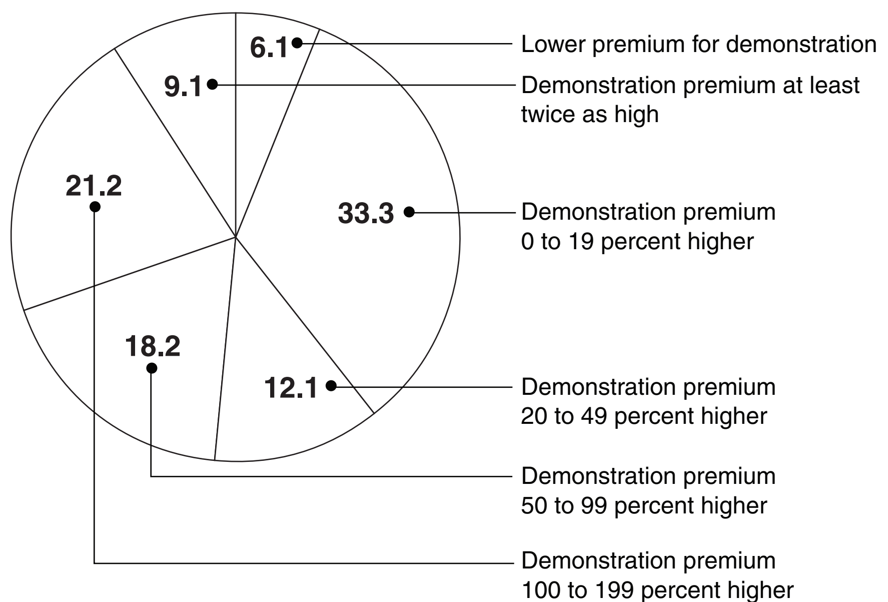
In response to the concern that the demonstration might attract a disproportionate number of sick enrollees, plans developed two different strategies for setting premiums. Plans in one group, including Blue Cross Blue Shield and GEHA, kept their demonstration premiums at or near those they charged in the civilian FEHBP. Representatives of one plan explained that it could have priced high, but they believed that would have resulted in low enrollment and might have attracted a disproportionate number of sick—and therefore costly—enrollees. Instead, by keeping their premium at the same level as in the civilian program, these plan officials hoped to make their plan attractive to those who were in good health as

well as to those who were not. Such a balanced mix of enrollees would increase the likelihood that a plan's revenues would exceed its costs.

By contrast, some plans charged higher premiums in the demonstration—in some cases, 100 percent higher—than in the civilian FEHBP. Setting higher premiums might provide plans with a financial cushion to deal with potential high-cost enrollees. While higher premiums might have discouraged enrollment and reduced plans' exposure to high-cost patients, this strategy carried the risk that those beneficiaries willing to pay very high premiums might be sick, high-cost patients.

More than four-fifths of plans chose the second strategy, charging higher premiums in the demonstration than in the civilian FEHBP. In 2000, only two plans—both local plans—charged enrollees less in the demonstration than in the civilian program for individual, standard option policies; these represented about 6 percent of all plans. By contrast, three plans—about 9 percent of all plans—set premiums at least twice as high as premiums in the civilian FEHBP. (See fig. 4.)

Figure 4: Comparison of Premiums for the DOD-FEHBP Demonstration with Civilian FEHBP Premiums, 2000



Source: OPM.

Note: GAO analysis of OPM premium data. Premiums are for a standard option individual policy unless only one option was available.

Military Retirees Who Enrolled in Demonstration Not as Sick as Other Retirees

The demonstration did not attract sicker, more costly enrollees—instead, military retirees who enrolled were less sick on average than eligible nonenrollees.[36] We found that, as scored by a standard method to assess patients' health, older retirees who enrolled in the demonstration were an estimated 13 percent less sick than eligible nonenrollees. At each site enrollees were, on average, less sick than nonenrollees. In the GAO-DOD-OPM survey, fewer enrollees on the U.S. mainland (33 percent) reported that they or their spouses were in fair or poor health compared to nonenrollees (40 percent). Retirees who enrolled in demonstration plans had scores that indicated they were, on average, 19 percent less sick than civilian FEHBP enrollees in these plans.

Plans' divergent strategies for setting premiums resulted in similar mixes of enrollees. Blue Cross Blue Shield and GEHA, both of which did not increase premiums, attracted about the same proportion of individuals in poor health as plans on the mainland that raised premiums.

Demonstration Enrollees Less Expensive than Eligible Nonenrollees and Much Less Expensive than Their Civilian FEHBP Counterparts, Leading to Reduced Premiums for Most Plans in Final Year of Demonstration

During 2000, the first year of the demonstration, enrolled retirees' health care was 28 percent less expensive—as measured by Medicare claims—than that of eligible nonenrolled retirees and one-third less expensive than that of their FEHBP counterparts.[37] (See table 3.) The demonstration enrollees' average age (71.8 years) was lower than eligible nonenrollees' average age (73.1 years), which in turn was lower than the average age of civilian FEHBP retirees (75.2 years) in the demonstration areas. OPM has obtained from the three largest plans claims information that includes the cost of drugs and other services not covered by Medicare. These claims show a similar pattern: Demonstration enrollees were considerably less expensive than enrollees in the civilian FEHBP.

[36] We assessed enrollees' health prior to the demonstration, using the Principal Inpatient Diagnostic Cost Group, (PIP-DCG), which relies on diagnoses from inpatient hospital stays and other patient characteristics. See app. II for discussion of the method and our results.

[37] "Their FEHBP counterparts" refers to civilian retirees who were Medicare-eligible and enrolled in FEHBP plans.

Table 3: Average Spending on Medicare-covered Services for Retirees Eligible for the DOD-FEHBP Demonstration—by Enrollment Status, 2000

Spending	Demonstration enrollees	Eligible nonenrollees	Civilian FEHBP retirees
Medicare	$3,174	$4,412	$4,785
Coinsurance	213	315	344
Deductible	142	169	184
Total	**$3,529**	**$4,896**	**$5,313**

Sources: CMS, DOD, and OPM.

Note: GAO analysis of CMS Medicare claims data, DOD enrollment data, and OPM enrollment data. As of January 1, 2000, the average age of demonstration enrollees was 71.8 years; of eligible nonenrollees, 73.1 years; and of civilian FEHBP retirees, 75.2 years.

Although demonstration enrollees' costs were lower than those of their FEHBP counterparts in the first year, demonstration premiums generally remained higher than premiums for the civilian FEHBP. In 2001, the second year of the demonstration, only a limited portion of the first year's claims was available when OPM and the plans negotiated the premiums, so the lower demonstration costs had no effect on setting 2001 premiums. Demonstration premiums in 2001 increased more rapidly than the civilian premium charged by the same plans: a 30 percent average increase in the demonstration for individual policies compared to a 9 percent increase for civilians in the same plans. In 2002, the third year, when both the plans and OPM were able to examine a complete set of claims for the first year before setting premiums, the pattern was reversed: On average, the demonstration premiums for individual policies fell more than 2 percent while the civilian premiums rose by 13 percent. However, on average, 2002 premiums remained higher in the demonstration than in the civilian FEHBP. Blue Cross Blue Shield was an exception, charging a higher monthly premium for an individual policy to civilian enrollees ($89) in 2000 than to demonstration enrollees ($74).

Impact of Demonstration on DOD Was Limited Due to Small Size and Low Enrollment, but Impact on Enrollees Was Greater

Because the demonstration was open to only a small number of military retirees—and only a small fraction of those enrolled—the demonstration had little impact on DOD, nonenrollees, and MTFs. However, the impact on enrolled retirees was greater. If the FEHBP option were made permanent, the impact on DOD, nonenrollees, and MTFs would depend on the number of enrollees.

DOD Little Affected by Demonstration, Due Primarily to Its Size, but Enrollees More Affected

Because of its small size, the demonstration had little impact on DOD's budget. About 140,000 of the more than 8 million people served by the DOD health system were eligible for the demonstration in its last 2 years. Enrollment at its highest was 7,521—about 5.5 percent of eligible beneficiaries. DOD's expenditures on enrollees' premiums that year totaled about $17 million—roughly 0.1 percent of its total health care budget.[38] Under the demonstration, DOD was responsible for about 71 percent of each individual's premium, whereas under TFL it is responsible for the entire cost of roughly similar Medicare supplemental coverage.[39]

Probably because of its small size, the demonstration had no observable impact on either the ability of MTFs to assist in the training and readiness[40] of military health care personnel or on nonenrollees' access to MTF care. Officials at the four MTFs in demonstration sites told us that they had seen no impact from the demonstration on either MTFs or nonenrollees' access to care.

[38]We were not able to adjust DOD expenditures to account for any reductions in the cost of prescription drugs and MTF care due to the demonstration. While some military retirees who enrolled were diverted from military to civilian care, the numbers were small and any reductions in MTF costs could not be separated from other factors affecting DOD expenditures. In addition, according to DOD, its costs for the demonstration were $28 million for FEHBP premiums and $11 million for administration, when measured over 3 years. These costs averaged less than 0.1 percent of the DOD health care budget over the life of the demonstration.

[39]TFL pays for Medicare-covered services not paid for by Medicare, as well as certain other services.

[40]Readiness refers to the capability of the military health system to provide medical support of military deployments, from small humanitarian engagements to major military actions.

Since enrollees were typically attracted to the demonstration by both its benefits and its relatively low costs, the impact on those who enrolled was necessarily substantial. In the first 2 years, the demonstration provided enrollees with better supplemental coverage, which was less costly or had better benefits, or both. In the third year of the demonstration, after TFL and the retirees' pharmacy benefit were introduced and enrollment declined, the number of beneficiaries affected by the demonstration decreased. TFL entitled military retirees to low-cost, comprehensive coverage, making the more expensive FEHBP unattractive. The average enrollee premium for an individual policy in the demonstration's third year was $109 per month. In comparison, to obtain similar coverage under the the combined TFL-pharmacy benefit, the only requirement was to pay the monthly Medicare part B premium of $54. Further, pharmacy out-of-pocket costs under TFL are less than those in the most popular FEHBP plan.

Impact of Permanent FEHBP Option Would Depend on Enrollment

The impact on DOD of a permanent FEHBP option for military retirees nationwide would depend on the number of retirees who enrolled. For example, if the same percentage of eligible retirees who enrolled in 2002—after TFL and the retirees' pharmacy benefit were introduced—enrolled in FEHBP, enrollment would be roughly 20,000 of the more than 1.5 million military retirees. As retirees' experience with TFL grows, their interest in an FEHBP alternative may decline further. As long as enrollment in a permanent FEHBP option remains small, the impact on DOD's ability to provide care at MTFs and on MTF readiness would also likely be small.

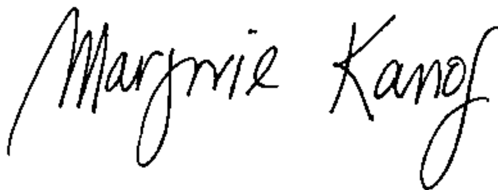
Agency Comments

We provided DOD and OPM with the opportunity to comment on a draft of this report. In its written comments DOD stated that, overall, it concurred with our findings. However, DOD differed with our description of the demonstration's impact on DOD's budget as small. In contrast, DOD described these costs of the 3-year demonstration–$28 million for FEHBP premiums and $11 million for administration—as substantial. While we do not disagree with these dollar-cost figures and have included them in this report, we consider them to be small when compared to DOD's health care budget, which ranged from about $18 billion in fiscal year 2000 to about $24 billion in fiscal year 2002. For example, as we report, DOD's premium costs for the demonstration during 2001, when enrollment peaked, were about $17 million—less than 0.1 percent of DOD's health care budget. Although DOD's cost per enrollee in the demonstration was substantial, the number of enrollees was small, resulting in the demonstration's total cost to DOD being small. DOD's comments appear in appendix VI. DOD

also provided technical comments, which we incorporated as appropriate. OPM declined to comment.

We are sending copies of this report to the Secretary of Defense and the Director of the Office of Personnel Management. We will make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staffs have questions about this report, please contact me at (202) 512-7101. Other GAO contacts and staff acknowledgments are listed in appendix VII.



Marjorie E. Kanof
Director, Health Care—Clinical
and Military Health Care Issues

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Appendix I: GAO-DOD-OPM Survey of Military Retirees and Others Eligible for the DOD-FEHBP Demonstration

To determine why those eligible for the Federal Employees Health Benefits Program (FEHBP) demonstration enrolled or did not enroll in an FEHBP plan, we co-sponsored with the Department of Defense (DOD) and the Office of Personnel Management (OPM) a mail survey of eligible beneficiaries—military retirees and others eligible to participate in the demonstration. The survey was fielded during the first year of the demonstration, from May to August 2000, and was sent to a sample of eligible beneficiaries, both those who enrolled and those who did not enroll, at each of the eight demonstration sites operating at that time. The survey was designed to be statistically representative of eligible beneficiaries, enrollees, nonenrollees, and sites, and to facilitate valid comparisons between enrollees and nonenrollees.

Questionnaire Design

In constructing the questionnaire, we developed questions pertaining to individuals' previous use of health care services, access to and satisfaction with care, health status, knowledge of the demonstration, reasons for enrolling or not enrolling in the demonstration, and other topics. Because eligible beneficiaries could choose FEHBP plans that also covered their family members, we included questions about spouses and dependent children. DOD and OPM officials and staff members from Westat, the DOD subcontractor with responsibility for administering the survey, provided input on the questionnaire's content and format. After pretesting the questionnaire with a group of military retirees and their family members, the final questionnaire included the topic areas shown in table 4. We also produced a Spanish version of the questionnaire that was mailed to beneficiaries living in Puerto Rico.

Table 4: Major Survey Sections and Topics Covered

Section	Topics covered
Use of Health Care Services in 1999	Health care use, source and use of prescription drugs, use of military treatment facility (MTF) care, ease of access to MTF care, and satisfaction with MTF care.
Health Status	Current health status, health status compared to 1 year ago, and need help with personal care needs.
Family	Marital status, spouse's health care use, spouse's use and source of prescription drugs, spouse's health status, dependent children, and dependent children's health status.
Knowledge of the Demonstration and Impact of the Demonstration Information Campaign	Knowledge of the demonstration, source of knowledge of the demonstration, whether demonstration information materials were received, usefulness of the information materials, use of the toll-free telephone service, source of information received about individual demonstration plans, usefulness of plans' information, problems with making the enrollment decision, reasons for joining the demonstration, and reasons for not joining the demonstration.
Other Insurance Coverage	Medicare supplemental insurance of self and spouse, other insurance coverage, cost of insurance coverage, out-of-pocket costs for medical services, and prescription drugs.
Personal Information	Zip code, date of birth, sex, membership in a military retiree organization, travel time to nearest military hospital, rank at retirement, race and ethnicity, educational attainment, income, and home ownership.

Source: GAO-DOD-OPM survey.

Sample Design

Working with DOD, OPM, and Westat, we defined the survey population as all persons living in the initial eight demonstration sites who were eligible to enroll in the demonstration. The population included military retirees, their spouses and dependents, and other eligible beneficiaries, such as unremarried former spouses, designated by law. We drew the survey sample from a database provided by DOD that listed all persons eligible for the demonstration as of April 1999.

We stratified the sample by the eight demonstration sites and by enrollment status—enrollees and nonenrollees. Specifically, we used a stratified two-stage design in which households were selected within each

of the 16 strata and one eligible person was selected from each household. For the enrollee sample, we selected all enrollees who were the sole enrollee in their households. In households with multiple enrollees, we randomly selected one enrollee to participate. For the nonenrollee sample, first we randomly selected a sample of households from all nonenrollee households and then randomly selected a single person from each those households. We used a modified equal allocation approach, increasing the size of the nonenrollee sample in steps, bringing it successively closer to the sample size that would be obtained through proportional allocation. This modified approach produced the best balance in statistical terms between the gain from the equal allocation approach and the gain from the proportional allocation approach.[1] If both an enrollee and a nonenrollee were selected from the same household, the nonenrollee was dropped from the sample and a different nonenrollee was selected. We adjusted the nonenrollee sample size to take account of expected nonresponse. Our final sample included 1,676 out of 2,507 enrollees and 3,971 out of 66,335 nonenrollees.

Response Rates

Starting with an overall sample of 5,647 beneficiaries, we obtained usable questionnaires from 4,787 people—an overall response rate of 85 percent.[2] (See table 5.) Response rates varied across sites, from 76 percent to 85 percent among nonenrollees, and from 92 percent to 98 percent among

[1] We considered (1) a proportional (to the population size) allocation across the sites that would provide the greatest precision for population estimates, (2) an equal allocation across the sites that would provide the greatest power to detect differences among the eight sites, and (3) a matched allocation, in which the same number of enrollees and nonenrollees would be selected, and which would provide the greatest power to detect differences between enrollees and nonenrollees. We also examined two blended strategies: one that blended proportional allocation with equal allocation, and another that blended proportional allocation with matched allocation. We conducted a simulation to compare the gain in precision and power—increasing the size of the nonenrollee sample under each blended strategy. Assessing the gains from the two strategies, we determined that the modified equal allocation approach was preferable. We specified the size of the nonenrollee sample that would maximize the probability, at the 5 percent significance level, of detecting a 5 percentage point difference in proportions between enrollees and nonenrollees and a 10 percentage point difference between enrollees and nonenrollees at a given site.

[2] Westat, which fielded the survey, sent initial survey packages to all beneficiaries starting in May 2000. Nonrespondents were sent follow-up reminder postcards as well as additional survey packages as needed. Participants with questions could call toll-free numbers and speak with English- or Spanish-speaking survey staff.

enrollees. (See table 6.) At each site, enrollees responded at higher rates than nonenrollees.

Each of the 16 strata was weighted separately to reflect its population. The enrollee strata were given smaller sampling weights, reflecting enrollees' higher response rates and the fact that they were sampled at a higher rate than nonenrollees. The weights were also adjusted to reflect the variation in response rates across sites. Finally, the sampling weights were further adjusted to reflect differences in response rates between male and female participants in 8 strata.

Table 5: Survey Responses and Nonresponses

Sample size	**5,647**
Response	4,787
Nonresponse	860
Overall response rate	85%
Reason for nonresponse	
Deceased	27
Refusal	36
Ineligible	11
Other nonresponse	786
Total not completed	860

Source: GAO-DOD-OPM survey.

Note: Westat analysis of GAO-DOD-OPM survey.

Table 6: Population, Sample Size, and Response Rate, by DOD-FEHBP Demonstration Site and Enrollee Status, 2000

Site and enrollee status	Population	Sample size	Number of respondents	Response rate (percentage)
Camp Pendleton, Calif.				
Enrollee	303	197	187	95
Nonenrollee	24,604	752	609	81
Dallas, Tex.				
Enrollee	520	350	323	92
Nonenrollee	13,087	731	618	85
Dover, Del.				
Enrollee	35	26	24	92
Nonenrollee	4,349	388	310	80
Fort Knox, Ky.				
Enrollee	134	98	90	92
Nonenrollee	7,623	676	535	79
Greensboro, N.C.				
Enrollee	285	187	183	98
Nonenrollee	2,993	268	228	85
Humboldt County, Calif.				
Enrollee	221	150	143	95
Nonenrollee	2,698	232	193	83
New Orleans, La.				
Enrollee	96	71	65	92
Nonenrollee	4,987	419	318	76
Puerto Rico				
Enrollee	913	597	561	94
Nonenrollee	5,994	505	400	79
All sites				
Enrollee	2,507	1,676	1,576	94
Nonenrollee	66,335	3,971	3,211	81
Total	**68,842**	**5,647**	**4,787**	**85**

Sources: DOD, OPM, and GAO-DOD-OPM survey.

Note: GAO analysis of DOD and OPM data, and Westat analysis of GAO-DOD-OPM survey.

Appendix II: Data, Methods, and Models Used in Analyzing Factors Affecting DOD-FEHBP Demonstration Enrollment

In this appendix, we describe the data, methods, and models used to (1) analyze the factors explaining how beneficiaries knew about the demonstration and why they enrolled in it, (2) assess the health of beneficiaries and civilian FEHBP enrollees, and (3) obtain the premiums of Medigap insurance in the demonstration areas.

Analysis of Factors Affecting Knowledge about the Demonstration and Enrollment

Our approach to analyzing eligible beneficiaries' behavior involved two steps: first, analyzing the factors related to whether eligible beneficiaries knew about the demonstration, and second, analyzing the factors related to whether those who knew about the demonstration decided to enroll.

Knowledge about the demonstration. To account for differences in beneficiaries' knowledge about the demonstration, we used individual-level variables as well as variables corresponding to individual sites.[1] These individual-level categories were demographic and economic variables, such as age and income; health status; other sources of health coverage, such as having employer-sponsored health insurance; and military-related factors. The inclusion of site variables allowed the model to take account of differences across the different sites in beneficiaries' knowledge about the demonstration.

We analyzed the extent to which these variables influenced beneficiaries' knowledge about the demonstration using a logistic regression—a standard statistical method of analyzing an either/or (binary) variable. This method yields an estimate of each factor's effect, controlling for the effects of all other factors in the regression. In our analysis, either a retiree knew about the demonstration or did not. The logistic regression predicts the probability that a beneficiary knew about the demonstration, given information about the person's traits—for example, over age 75, had employer-sponsored health insurance, and so on. The coefficient on each variable measures its effect on beneficiaries' knowledge.[2] These coefficients pertain to the entire demonstration population, not just those beneficiaries in our survey sample. To make the estimates generalizable to

[1]Individual sites were represented by binary or dummy variables; for example, Humboldt County, California had a value of one when a beneficiary lived in that site, and a value of zero when the beneficiary lived in another site.

[2]To avoid statistical problems with analyzing the probability directly, logistic regression analyzes a related dependent variable—a function of the probability, P, divided by (1-P). However, the estimated probability, P, can be calculated from the logistic regression. In our analysis, P refers to each retiree's probability of knowing about the demonstration.

the entire eligible population, we applied sample weights to all observations.

In view of the large difference in enrollment between the mainland sites and Puerto Rico, we tested whether the same set of coefficient estimates was appropriate for the mainland sites and the Puerto Rico site. Our results showed that the coefficient estimates for the mainland and for Puerto Rico were not significantly different (at the 5 percent level), so it was appropriate to estimate a single logistic regression model for all sites.

Table 7 shows for each variable its estimated effect on knowledge, as measured by the variable's coefficient and odds ratio. The odds ratio expresses how much more likely—or less likely—it is that a person with a particular characteristic knows about the demonstration, compared to a person without that characteristic. The odds ratio is based on the coefficient, which indicates each explanatory variable's estimated effect on the dependent variable, holding other variables constant. For the mainland sites, retirees were more likely to know about the demonstration if they were male, were married, were officers, were covered by employer-sponsored health insurance, lived less than an hour from a military treatment facility (MTF), or belonged to military retiree organizations. Retirees were less likely to know about the demonstration if they were African American; were older than age 75; or lived in Camp Pendleton, California, Dallas, Texas, or Fort Knox, Kentucky.

Table 7: Estimated Effects of Selected Factors on Whether Eligible Retirees Knew about the DOD-FEHBP Demonstration

		Odds ratio	Coefficient
Demographic and economic factors	African American	0.67	-0.40[a]
	Higher income (over $40,000)	1.29	0.26[a]
	Hispanic	0.61	-0.49[b]
	Male	1.38	0.32[c]
	Married	1.43	0.36[c]
	Officer	1.49	0.40[c]
	Older than age 75	0.71	-0.35[c]
Health status	Self or spouse in fair or poor health	0.85	-0.16
Health insurance coverage	Covered by a Medigap policy	1.10	0.09
	Covered by employer-sponsored health insurance	1.39	0.33[c]
	Enrolled in a Medicare+Choice plan in 1999	0.97	-0.03
	Enrolled in Medicare part B on January 1, 2000	1.12	0.11
Military-related factors	Less than 1 hour from an MTF	1.46	0.38[c]
	Member of military retiree organization	1.70	0.53[c]
	Used VA care during fiscal years 1998 or 1999	0.81	-0.21
Site effects[d]	Camp Pendleton, Calif.	0.58	-0.55[c]
	Dallas, Tex.	0.65	-0.43[c]
	Dover, Del.	0.72	-0.33
	Fort Knox, Ky.	0.59	-0.52[a]
	Greensboro, N.C.	1.18	0.16
	Humboldt County, Calif.	0.93	-0.07
	Puerto Rico	0.77	-0.26
	Constant		-0.73[c]
	Observations		3,504

Sources: GAO-DOD-OPM survey, CMS, and VA.

Note: GAO analysis of GAO-DOD-OPM survey data, CMS enrollment data and VA enrollment data. The odds ratio expresses how much more likely—or less likely—it is that a person with a particular characteristic knows about the demonstration, compared to a person without that characteristic. The coefficient indicates each explanatory variable's estimated effect on the dependent variable, holding other variables constant.

[a]Significant at the 5 percent level.

[b]Significant at the 10 percent level.

[c]Significant at the 1 percent level.

[d]The site effects consisted of a dummy variable for each site; the comparison site is New Orleans, La., selected at random from the eight sites. The mainland site effects were jointly significant at the 5 percent level.

Decision to enroll in the demonstration. To account for a retiree's decision to enroll or not to enroll, we considered four categories of individual-level variables similar to those in the "knowledge of the demonstration" regressions, and a site-level variable for Puerto Rico. We also introduced a set of health insurance factors pertaining to the area in which the retiree lived—the premium for a Medigap policy and the proportion of Medicare beneficiaries in a retiree's county of residence enrolled in a Medicare+Choice plan.

In our logistic regression analysis of enrollment, we included only those people who knew about the demonstration. Despite the large enrollment differences between the mainland sites and Puerto Rico, our statistical tests determined that the mainland sites and the Puerto Rico site could be combined into a single logistic regression of enrollment. We included a variable for persons in the Puerto Rico site. (See table 8.)

Table 8: Estimated Effects of Selected Factors on Whether Eligible Retirees Enrolled in an FEHBP Plan

		Odds ratio	Coefficient
Demographic and economic factors	African American	0.51	-0.68[a]
	Hispanic	1.19	0.17
	Higher income (over $40,000)	1.35	0.30[b]
	Male	0.74	-0.31[c]
	Married	5.06	1.62[c]
	Officer	1.46	0.38[a]
	Older than age 75	1.32	0.28
Health status	Self or spouse in fair or poor health	0.93	-0.07
Health insurance coverage	Covered by a Medigap policy	1.32	0.28[b]
	Covered by employer-sponsored health insurance	0.40	-0.92[a]
	Enrolled in a Medicare+Choice plan in 1999	0.53	-0.64[a]
	Enrolled in Medicare part B on January 1, 2000	2.01	0.70[a]
Military-related factors	Less than 1 hour from an MTF	0.36	-1.01[a]
	Member of a military retiree organization	1.49	0.40[a]
	Used VA care during fiscal years 1998 or 1999	1.00	0.00
Geographic effects	Medicare+Choice enrollment in county[d]	--[e]	-0.01[a]
	Medigap price for county and age category	--[e]	-0.38[a]
	Puerto Rico site	2.96	1.09[a]
	Constant		-2.69[a]
	Observations		1,913

Sources: GAO-DOD-OPM survey, Quotesmith Inc., CMS, and VA.

Note: GAO analysis of GAO-DOD-OPM survey, DOD enrollment data, CMS enrollment data, VA enrollment data, and Quotesmith Inc. Medigap premium data.

[a]Significant at the 1 percent level.

[b]Significant at the 5 percent level.

[c]Significant at the 10 percent level.

[d]The proportion of Medicare beneficiaries in a retiree's county of residence enrolled in a Medicare+Choice plan.

[e]Odds ratios are not reported for continuous variables, such as the number of enrollees and the price in dollars, because, unlike binary variables, the choice of values to make a comparison is arbitrary.

We found that retirees were less likely to enroll in the demonstration if they were African American, enrolled in Medicare+Choice plans, had employer-sponsored health insurance, lived in areas with a high proportion of Medicare beneficiaries enrolled in a Medicare+Choice plan, lived in areas where Medigap was more expensive, or lived less than an hour from an MTF. Retirees who had higher incomes, were officers, were members of a military retiree organization, were enrolled in Medicare part B, lived in Puerto Rico, or were covered by a Medigap policy were more likely to enroll.

Calculating the Impact on Enrollment if Those Eligible Had Known about the Demonstration

We estimated what the demonstration's enrollment rate would have been in 2000 if everyone eligible for the demonstration had known about it. For the 54 percent of retirees who did not know about the demonstration, we calculated their individual probabilities of enrollment, using their characteristics (such as age) and the coefficient estimates from the enrollment regression.[3] Aggregating these individual estimated enrollment probabilities, we found that if all eligible retirees had known about the demonstration, enrollment in 2000 would have been 7.2 percent of eligible beneficiaries, compared with actual enrollment of 3.6 percent.[4]

Estimating Health Status Based on PIP-DCG Scores

To measure the health status of retired enrollees and nonenrollees, as well as of civilian FEHBP enrollees, we calculated scores for individuals using the Principal Inpatient Diagnostic Cost Group (PIP-DCG) method. This method—used by the Centers for Medicare & Medicaid Services (CMS) in adjusting Medicare+Choice payment rates—yielded a proxy for the healthiness of military and civilian retirees as of 1999, the year before the demonstration. The method relates individuals' diagnoses to their annual Medicare expenditures. For example, a PIP-DCG score of 1.20 indicates that the individual is 20 percent more costly than the average Medicare beneficiary. In our analysis, we used Medicare claims and other administrative data from 1999 to calculate PIP-DCG scores for eligible military retirees and their counterparts in the civilian FEHBP in the demonstration sites.

Using Medicare part A claims for 1999, we calculated PIP-DCG scores for Medicare beneficiaries who were eligible for the demonstration. We used a

[3]In these calculations, we used only the characteristics from the model to simulate enrollment, which means we assumed the people who did not know about the demonstration would have behaved the same with respect to their decision to enroll, given their characteristics, as those who knew. We also adjusted for the difference between the enrollment rate in the demonstration as a whole and the enrollment rate of those included in the logistic regression analysis for whom there were no missing data.

[4]Retirees who reported that they did not know about the demonstration before the survey may have included some retirees who had known about it at one time. About 9 months elapsed between DOD's final mailing to beneficiaries about the demonstration and the end of our survey. Our logistic regression for enrollment considered only people who responded in the survey that they knew about the demonstration. We excluded people from the enrollment regression who were enrolled but responded that they did not know about the demonstration. This did not affect our results because nearly all (more than 99 percent) of those who said they did not know about the demonstration did not enroll.

DOD database to identify enrollees as well as those who were eligible for the demonstration but did not enroll.

We also calculated PIP-DCG scores based on 1999 Medicare claims for each Medicare-eligible person enrolled in the civilian FEHBP. We obtained from OPM data on enrollees in the civilian FEHBP and on the plans in which they were enrolled. We restricted our analysis to those Medicare-eligible civilian FEHBP enrollees who lived in a demonstration site.

Results of PIP-DCG calculations. We compared the PIP-DCG scores of demonstration enrollees with those of eligible retirees who did not enroll. In every site, the average PIP-DCG score was significantly less[5] for demonstration enrollees than for those who did not enroll. We also compared the PIP-DCG scores of those enrolled in the demonstration with those enrolled in the civilian FEHBP: For every site, these scores were significantly less for demonstration enrollees than for their counterparts in the civilian FEHBP.[6] (See table 9.)

[5]The scores were significantly less at the 5 percent level.

[6]The scores were significantly less at the 5 percent level.

Table 9: Health Status Comparisons of DOD-FEHBP Demonstration Enrollees with Eligible Retirees Who Did Not Enroll and with Civilian FEHBP Retirees, Based on PIP-DCG Scores

	Ratio of PIP-DCG scores of enrollees in a demonstration plan	
Site	Compared to eligible military retirees who did not enroll	Compared to civilian retirees in FEHBP
All sites	0.87	0.81
Camp Pendleton, Calif.	0.88	0.83
Dallas, Tex.	0.82	0.75
Dover, Del.	0.76	0.71
Humboldt County, Calif.	0.91	0.86
Fort Knox, Ky.	0.79	0.73
Greensboro, N.C.	0.84	0.77
New Orleans, La.	0.78	0.73
Puerto Rico	0.94	0.93

Source: CMS, DOD, and OPM.

Note: GAO analysis of CMS claims data, DOD enrollment data, and OPM enrollment data. Comparisons used 1999 claims data and measured enrollment status as of September 2000. The difference between the PIP-DCG scores for the enrollees in the demonstration and the scores of military retirees who did not enroll was statistically significant at the 5 percent level for each demonstration site. The difference between the PIP-DCG scores for the enrollees in the demonstration and the scores of civilian retirees in FEHBP was statistically significant at the 5 percent level for each demonstration site.

Medigap Premiums

We compiled data from Quotesmith Inc. to obtain a premium price for Medigap plan F in each of the counties in the eight demonstration sites.[7] We collected the lowest premium quote for a Medigap plan F policy for each sex at 5-year intervals: ages 65, 70, 75, 80, 85, and over 89. A person age 65 to 69 was assigned the 65-year-old's premium, a person age 70 to 74 was assigned the 70-year-old's premium, and so on. Using these data, we assigned a Medigap plan F premium to each survey respondent age 65 and over, according to the person's age, sex, and location.

[7]Quotesmith.com, Inc. *Instant Medicare Supplemental Insurance Quotes* (Darien, Ill.: June 2000), http://www.quotesmith.com/index.html#medsup (downloaded on June 27, 2000).

Appendix III: Enrollment in the DOD-FEHBP Demonstration

Tables 10, 11, and 12 show enrollment rates by site and for the U.S. mainland sites as a whole for each year of the demonstration, 2000 through 2002.

Table 10: Enrollment in the DOD-FEHBP Demonstration, 2000

		Enrollees	Eligible beneficiaries	Percentage enrolled
Mainland sites	Camp Pendleton, Calif.	303	24,907	1.2
	Dallas, Tex.	520	13,607	3.8
	Dover, Del.	35	4,384	0.8
	Fort Knox, Ky.	134	7,757	1.7
	Greensboro, N.C.	285	3,278	8.7
	Humboldt County, Calif.	221	2,919	7.6
	New Orleans, La.	96	5,083	1.9
Total for mainland sites		**1,594**	**61,935**	**2.6**
Other site	Puerto Rico	913	6,907	13.2
Total		**2,507**	**68,842**	**3.6**

Source: DOD.

Note: Data are as of January 1, 2000.

Table 11: Enrollment in the DOD-FEHBP Demonstration, 2001

		Enrollees	Eligible beneficiaries	Percentage enrolled
Mainland sites	Adair County, Iowa	1,564	29,584	5.3
	Camp Pendleton, Calif.	421	27,328	1.5
	Coffee County, Ga.	867	27,329	3.2
	Dallas, Tex.	949	16,159	5.9
	Dover, Del.	64	4,868	1.3
	Fort Knox, Ky.	188	9,121	2.1
	Greensboro, N.C.	334	4,033	8.3
	Humboldt County, Calif.	305	3,461	8.8
	New Orleans, La.	142	6,095	2.3
Total for mainland sites		**4,834**	**127,978**	**3.8**
Other site	Puerto Rico	2,687	9,401	28.6
Total		**7,521**	**137,379**	**5.5**

Source: DOD.

Note: Data are as of March 14, 2001.

Table 12: Enrollment in the DOD-FEHBP Demonstration, 2002

		Enrollees	Eligible beneficiaries	Percentage enrolled
Mainland sites	Adair County, Iowa	484	29,530	1.6
	Camp Pendleton, Calif.	145	27,287	0.5
	Coffee County, Ga.	212	27,284	0.8
	Dallas, Tex.	354	16,133	2.2
	Dover, Del.	36	4,867	0.7
	Fort Knox, Ky.	70	9,113	0.8
	Greensboro, N.C.	85	4,024	2.1
	Humboldt County, Calif.	65	3,454	1.9
	New Orleans, La.	74	6,085	1.2
Total for mainland sites		**1,525**	**127,777**	**1.2**
Other site	Puerto Rico	2,842	9,453	30.1
Total		**4,367**	**137,230**	**3.2**

Source: DOD.

Note: Data are as of February 21, 2002.

Appendix IV: DOD's Approach to Informing Beneficiaries about the DOD-FEHBP Demonstration

The program for informing and educating eligible beneficiaries about the demonstration was modeled on OPM's approach to informing eligible civilian beneficiaries about FEHBP. Elements of OPM's approach include making available a comparison of FEHBP plans and holding health fairs sponsored by individual federal agencies. DOD expanded upon the OPM approach–for example, by sending postcards to inform eligible beneficiaries about the demonstration because they, unlike civilian federal employees and retirees, were unlikely to have any prior knowledge of FEHBP. In addition, DOD established a bilingual toll-free number. During the first year's enrollment period, DOD adjusted its information and education effort, for example, by changing the education format from health fairs to town meetings designed specifically for demonstration beneficiaries. In the second year of the demonstration, DOD continued with its revised approach. In the third year, after TRICARE For Life (TFL) began, DOD significantly reduced its information program but continued to mail information to all eligible beneficiaries. It limited town meetings to Puerto Rico, the only site where enrollment remained significant during the third year.

Mailings

DOD sent a series of mailings to all eligible beneficiaries. These included

- a postcard announcing the demonstration, mailed in August 1999,[1] that alerted beneficiaries to the demonstration–the returned postcards allowed DOD to identify incorrect mailing addresses and to target follow-up mailings to beneficiaries with correct addresses;
- an OPM-produced booklet, *The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DOD/FEHBP Demonstration Project*, received by all eligible retirees from November 3 through 5, 1999, that contained information on participating FEHBP plans, including coverage and consumer satisfaction;
- a trifold brochure describing the demonstration, which was mailed on September 1 and 4, 1999; and
- a list of Frequently Asked Questions (FAQ) explaining how Medicare and FEHBP work together.

At the time of our survey, after the first year's information campaign, over half of eligible beneficiaries were unaware of the demonstration. Among those who knew about it, more recalled receiving the postcard than

[1]Dates for this and subsequent mailings refer to the first year of the demonstration.

recalled receiving any of the later materials—although the FAQ was cited more often as being useful. (See table 13.)

Table 13: Beneficiaries Who Recalled Receiving DOD-FEHBP Demonstration Mailings and Who Found Them Useful

	Percentages	
	Beneficiaries who recalled receiving materials[a]	Beneficiaries who found materials useful[b]
Postcard announcing the DOD-FEHBP demonstration	31	61
Booklet entitled, *The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DOD/FEHBP Demonstration Project*	27	67
Trifold brochure describing the demonstration	17	69
FAQ about coordination of Medicare and FEHBP benefits	17	72

Source: GAO-DOD-OPM survey.

Note: These materials were mailed in 1999 for the 2000 enrollment period.

[a]The question was asked only of those who knew that, as part of the new demonstration, they could join an FEHBP health plan.

[b]Entries are percentages of beneficiaries who recalled receiving them.

Health Fairs and Town Meetings

Initially, the health fairs that DOD sponsored for military bases' civilian employees were its main effort—other than the mailings—to provide information about the demonstration to eligible beneficiaries. At these health fairs, plans set up tables at which their representatives distributed brochures and answered questions. At one site, the military base refused to allow the demonstration representatives to participate in its health fair because of concern about an influx of large numbers of demonstration beneficiaries. At another site, the turnout exceeded the capacity of the plan representatives to deal with questions and DOD officials told us that they accommodated more people by giving another presentation at a different facility or at the same facility 1 month later.

A DOD official discovered, however, that it was difficult to convey information about the demonstration to large numbers of individuals at the health fairs. DOD officials determined that the health fairs were not working well, so by January 2000, DOD replaced them with 2-hour briefings, which officials called town meetings. In these meetings, a DOD representative explained the demonstration during the first hour and then

answered questions from the audience. A DOD official told us that these town meetings were more effective than the health fairs.[2]

For the first year of the demonstration, just under 6 percent of those eligible attended either a health fair or a town meeting. The number of eligible beneficiaries who reported attending these meetings varied considerably by site—from about 3 percent in New Orleans and Camp Pendleton to 4 percent in Fort Knox and 18 percent in Humboldt County. Roughly 11 percent of beneficiaries reported attending in Puerto Rico, the site with the highest enrollment.

DOD's Call Center and Web Site

DOD also established a call center and a Web site to inform eligible beneficiaries about the demonstration. The call center, which was staffed by Spanish and English speakers, answered questions and sent out printed materials on request. In the GAO-DOD-OPM survey, about 18 percent of those who knew about the demonstration reported calling the center's toll-free number. The proportion that called the toll-free number was much higher among subsequent enrollees (77 percent) than among nonenrollees who knew about the demonstration (13 percent). The Web site was another source of information about the demonstration.

Beneficiaries' Sources of Information

Although less than half of eligible beneficiaries knew about the demonstration, most of those who did know said they obtained their information from DOD's mailings. Other important sources of information included military retiree and military family organizations and FEHBP plans. (See table 14.)

[2]In Puerto Rico, the town hall meetings were conducted in Spanish, which, according to one DOD official, was very effective in conveying the information to the eligible beneficiaries at that site.

Table 14: Beneficiaries' Sources of Information about the DOD-FEHBP Demonstration

	Percentages		
Source of information	**All beneficiaries**	**Enrollees**	**Nonenrollees**
Received information mailed by DOD	81.8	78.1	82.1
Received information from a military retiree or family organization	33.1	43.3	32.3
Received information from one of the FEHBP plans	25.0	37.3	24.0
Heard about demonstration from family or friends	7.0	10.0	6.8
Attended a health fair or town meeting	5.9	25.6	4.3
Heard about it from office of Member of Congress	2.1	5.5	1.8
Read article about the demonstration in the newspaper	7.6	9.7	7.4
Saw newspaper advertisements by one or more FEHBP plans	1.9	2.2	1.8
Heard about demonstration on radio or television	1.7	1.7	1.7
Other[a]	6.7	10.4	6.3

Source: GAO-DOD-OPM survey.

Note: The source of information is given only for those who knew before receiving the survey that, as a part of the new demonstration, they could join an FEHBP health plan. Percentages add to more than 100 because respondents could select more than one reason. Respondents reported information gained relating to 2000 enrollment.

[a]"Other" refers to answers that could not be classified.

Nearly all of enrollees (93 percent) and more than half of nonenrollees who said they considered enrolling in an FEHBP health plan (55 percent) reported that they had enough information about specific plans to make an informed decision about enrolling in one of them. More than three-fifths of these beneficiaries who enrolled or considered enrolling in an FEHBP plan said they used *The 2000 Guide to FEHBP Plans Participating in the DOD/FEHBP Demonstration Project* as a source of information. Other major sources of information were the plans' brochures and DOD's health fairs and town meetings. More than 18 percent of those who considered joining did not obtain information about any specific plan. (See table 15.)

Table 15: Sources of Information for Eligible Beneficiaries about Specific FEHBP Plans

Source of Information	Percentages Enrollees	Nonenrollees	Total
Reading *The 2000 Guide to FEHBP Plans*	75.1	59.7	**63.5**
Reading one or more plans' brochures	46.5	26.0	**31.1**
Health fair or town meeting	35.2	12.5	**18.1**
Calling one or more plans	27.2	9.9	**14.2**
Friends or family	14.3	8.6	**10.0**
Internet	10.3	3.8	**5.4**
Advertising in a newspaper or other publication	1.6	3.0	**2.7**
Other[a]	10.1	6.8	**7.6**
I did not get information about any specific FEHBP plans	1.2	24.3	**18.6**

Source: GAO-DOD-OPM survey.

Note: Entries are percentages of respondents who considered joining an FEHBP plan. Percentages add to more than 100 because respondents could select more than one reason. Respondents reported information gained relating to 2000 enrollment.

[a]"Other" refers to answers that could not be classified.

Appendix V: Enrollees' and Nonenrollees' Reasons for Joining or Not Joining a DOD-FEHBP Demonstration Plan

Table 16 shows reasons cited by enrollees for enrolling in a DOD-FEHBP health plan in 2000, and table 17 shows reasons cited by nonenrollees for not enrolling.

Table 16: Survey Responses by Enrollees to the Question "Why Did You Join a DOD-FEHBP Health Plan?"

	Percentages		
		Location	
	All respondents	Mainland	Puerto Rico
The plan's benefits package meets my needs (and those of my family)	66.7	66.1	68.2
I needed better coverage for prescriptions	64.3	60.0	74.7
My current doctors are among those I can select under the plan	62.5	63.0	61.3
It costs less than other coverage that I could buy	62.1	58.8	69.9
The plan's benefits package is better than other coverage I could get	50.8	47.2	59.2
It costs less than my previous coverage (insurance or health plan)	49.8	48.9	51.8
The plan has a good reputation for quality of care	44.6	39.6	56.6
My spouse joined the plan, and it is more convenient if we're both in the same plan	34.6	28.6	48.7
I can't count on getting space-available care	27.1	33.1	13.1
It gives me a broader choice of doctors than I had before	26.5	21.8	37.5
I don't want to use military care	22.2	25.9	13.4
Many civilian doctors don't accept CHAMPUS/TRICARE[a]	20.4	17.2	28.2
My friends or relatives recommended that I join the plan	14.2	9.4	25.3
Other[b]	10.0	10.9	7.8

Source: GAO-DOD-OPM survey.

Note: This question was asked only of people who knew about the demonstration at the time of the survey. Beneficiaries were given a list of possible answers as well as an "Other" option for which they could write their own answers.

[a]CHAMPUS is the name given to the military health care program that preceded TRICARE.

[b]Answers that could not be classified.

Table 17: Survey Responses by Nonenrollees to the Question "Why Didn't You Join a DOD-FEHBP Health Plan?"

	Percentages		
		Location	
	All respondents	Mainland	Puerto Rico
I was satisfied with my current coverage	64.1	65.9	28.4
It would cost too much	29.4	29.9	17.6
The program is new, and I'm waiting to see how it works	26.6	26.4	30.2
I wasn't sure how it would work with Medicare	26.2	25.7	36.2
I wouldn't be able to use military pharmacies anymore	26.1	26.4	20.8
I couldn't keep my current doctors	25.5	26.3	8.1
The demonstration will end in 3 years	22.0	22.3	16.5
I was afraid I wouldn't be able to get my Medicare supplemental policy back after the demonstration ended	20.2	20.6	12.1
I can get care at military health care facilities when I need it	14.4	13.6	30.7
I heard about the demonstration, but did not have enough information to make a decision	13.9	13.3	27.5
I was afraid I wouldn't be able to get my retiree health insurance back after the demonstration ended	11.1	11.1	11.0
I can get care at the VA when I need it	10.2	9.1	31.4
I couldn't decide which plan to join	9.5	9.0	20.8
My spouse didn't want to join so I decided not to	5.7	5.5	9.2
My friends and relatives recommend against it	5.0	5.2	0.0
I was not eligible	4.5	4.7	1.1
I didn't know about the demonstration project	3.5	3.4	4.4
None of the plans available to me had a good reputation	3.0	3.1	1.1
Other[a]	15.8	15.9	13.2

Source: GAO-DOD-OPM survey.

Note: This question was asked only of people who knew about the demonstration at the time of the survey. Beneficiaries were given a list of possible answers as well as an "Other" option for which they could write their own answers. Answers relate to enrollment in 2000. Because beneficiaries could select multiple reasons, the percentages total more than 100.

[a]Answers that could not be classified.

Appendix VI: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAY 2 2 2003

Ms. Marjorie E. Kanof
Director, Health Care-Clinical and Military Health Care Issues
U.S. General Accounting Office
441 G Street, N.W., Washington, D.C. 20548.

Dear Ms. Kanof:

This is the Department of Defense (DoD) response to the GAO Draft Report, GAO 03-547 "MILITARY RETIREE HEALTH BENEFITS: Enrollment Low in Federal Employee Health Plans Under DOD Demonstration," dated April 30, 2003 (GAO Code 290026 formerly 804635)."

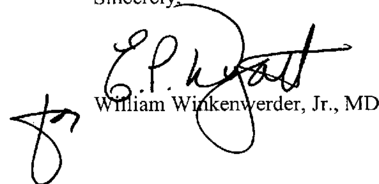
Thank you for the opportunity to review and comment on this report. Overall, the Department concurs with the findings contained in the Draft Report. However, DoD is concerned about the report's suggestion that the demonstration project had limited impact on its budget. This is an inaccurate conclusion. It is important to note that despite the extremely low enrollment in the demonstration project, DoD's costs associated with operationalizing the demonstration were significant. DoD's total contribution to the beneficiaries' premiums was over $28 million. Additionally, the administrative costs to operate the demonstration project exceeded over $11 million. These high costs associated with operationalizing this demonstration had a substantial impact on DoD's budget.

As the report accurately points out, DoD and OPM launched a vigorous marketing campaign to create awareness and promote enrollment in the FEHBP demonstration project. Efforts included mass mailings, a toll-free call center with bilingual services, and health fairs conducted at every demonstration site. Despite the extensive marketing of the demonstration project, total enrollment remained extremely low.

In conclusion, it is extremely important to recognize there were substantial costs associated with the demonstration project and it had considerable impact on DoD's budget. This demonstration project illustrates that the number of beneficiaries enrolled in the project did not equate with lower costs because there were additional administrative costs associated with operating the demonstration.

Please feel free to address any questions to my project officers on this matter, Mr. Pradeep G. Gidwani (functional) at (703) 681-3636 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-3492.

Sincerely,



William Winkenwerder, Jr., MD

Enclosure:
As stated

Appendix VII: GAO Contacts and Staff Acknowledgments

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Acknowledgments

Major contributors to this work were Michael Kendix, Robin Burke, Jessica Farb, Martha Kelly, Dae Park, and Michael Rose.

Related GAO Products

Defense Health Care: Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weaknesses. GAO-03-592T. Washington, D.C.: March 27, 2003.

Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies. GAO-03-196. Washington, D.C.: January 10, 2003.

Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits. GAO-03-236. Washington, D.C.: December 31, 2002.

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(290026)

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