Medicare and Federal Employees Health Benefits Programs: Their Coordination

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FEDERAL EMPLOYEES and annuitants and their dependents who are aged 65 and over are potential beneficiaries of two Federal health insurance programs—health insurance for the aged (Medicare) and health insurance for active and retired Federal employees. The two programs are in considerable measure duplicatory and most Federal employees and annuitants aged 65 and over are unable to take full advantage of both. A greater degree of coordination between the two programs would be desirable.

More than half of all aged persons have private health insurance coverages that complement or supplement Medicare benefits—that is, to a greater or lesser degree, they meet the deductible or coinsurance payments under Medicare and/or provide additional days of care in a hospital or extended-care facility and other benefits not provided under Medicare.[1] At present, for those Federal employees and annuitants who are covered under both parts of the Medicare program, the coverage they may have under the Federal employee health insurance programs is largely duplicatory. It functions as complementary coverage, but it is not well adapted for this purpose and is often too expensive for the potential benefits.

Probably the major impediment to the development of suitable complementary coverages for active and retired aged Federal employees is that these persons are not all in the same situation with respect to eligibility for hospital benefits under Medicare. (Medicare's supplementary medical insurance (SMI) is open on a voluntary basis to virtually anyone aged 65 or over.) Medicare's hospital benefits were originally made available to all persons aged 65 and over who were eligible for monthly cash benefits under the old-age, survivors, disability, and health insurance program (OASDHI) and the railroad retirement program and, for a transitional period,[2] to all other persons aged 65 and over, with two exceptions. Those in the excepted groups are (a) persons convicted of certain subversive activities or who are members of certain subversive organizations and (b) persons covered by enrollment under the Federal Employees Health Benefits Act (the Act establishing a program of health insurance for Federal employees that covers all active employees and those who retired on an annuity after June 30, 1960) or persons who were so enrolled on February 16, 1965, or who could have enrolled at that time or subsequently.

This exclusion of active Federal employees (and those retired since June 1960) from the hospital benefits of Medicare results primarily from the fact that Federal civil-service employees are not covered under OASDHI (though temporary employees and members of the Armed Forces are). Ever since the passage of the Social Security Act in 1935, spokesmen for Federal civil-service employees have opposed inclusion of Federal employees under the social security program on the grounds that the civil-service retirement system provided superior benefits. These spokesmen feared that coverage under the Social Security Act, with civil-service retirement benefits becoming supplementary to OASDI benefits, would weaken the civil-service system and subject civil-service employees (especially long-term career employees) to higher retirement deductions without sufficiently larger retirement benefits as compensation.

An additional reason for excluding Federal employees and recent annuitants from the hospital benefits of Medicare was that these employees have available to them, through the health insur-

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[1] For a description of the complementary coverages offered by Blue Cross and Blue Shield plans, insurance companies, and other health insurance organizations, see Louis S. Reed and Kathleen Myers, "Health Insurance Coverage Complementary to Medicare," *Social Security Bulletin*, August 1967.

[2] Beginning in 1968, persons reaching age 65 must have a specified number of quarters of coverage to be eligible for hospital benefits under Medicare.

ance program for Federal workers, benefits that are better in most respects than those of Medicare.

Former Federal employees aged 65 and over (and their wives or husbands 65 and over) are eligible under the transitional provision for Medicare's hospital benefits. The situation is further complicated by the fact that some Federal employees and annuitants covered under the health benefits program for Federal employees are eligible for Medicare's hospital benefits by virtue of work in employments covered under the Social Security Act.

FEDERAL EMPLOYEES HEALTH INSURANCE PROGRAMS

The two programs for Federal employees are the Federal employees health benefits (FEHB) plan, which covers active employees and annuitants who retired since July 1, 1960, and the retired Federal employees health benefits (RFEHB) plan, which covers those who retired before July 1, 1960.

Federal Employees Health Benefits Program

The FEHB program enacted in 1959 applies to nearly all active civilian employees of the Federal Government and to former employees who retired on an annuity after July 1, 1960. (The program also covers certain survivors of employees and annuitants.) Under FEHB the Civil Service Commission must make available to eligible employees and annuitants a choice of health insurance plans for themselves and their dependents.

The plans include a Government-Wide Service-Benefit Plan, a Government-Wide Indemnity Plan, plans offered by employee organizations to the members of such organizations, plans providing service through group practice, and plans providing service through individual practice. Each approved plan may offer two levels of benefits (a high and a low option) on a dual rate basis—that is, one rate for the employee or annuitant by himself ("self only") and another rate for the employee or annuitant and his dependents ("self and family").

The legislation sets forth standards, including the types of benefits offered, that plans must meet in order to be approved. The approved plan offers its benefits at specified rates under a contract with the Civil Service Commission. Employees and annuitants are periodically given an opportunity of changing plans or levels of benefits. The Federal Government as employer makes a contribution towards the cost of each plan equal to one-half its charges but not more than $3.64 a month for "self only" and $8.88 for "self and family" coverage.

Currently the program covers more than 7 million persons. About 36 plans are carriers. These include the Government-wide service benefit plan offered by Blue Cross-Blue Shield, the Government-wide indemnity plan offered by a consortium of insurance companies and managed by Aetna Life Insurance Company, 15 plans of employee organizations, 12 local group-practice plans, and seven local individual-practice plans. As of September 30, 1967, 57 percent of the employees and annuitants were enrolled in the Blue Cross-Blue Shield plan, 21 percent in the Aetna plan, 15 percent in employee organization plans, 5 percent in the group-practice plans, and 2 percent in the individual-practice plans.

As Medicare began, the Civil Service Commission estimated that about 125,000 of the employees or annuitants covered under FEHB were aged 65 and over. Some 60 percent of these persons, the Commission estimated, were not eligible for Medicare's hospital benefits; the other 40 percent were eligible because they had worked at some time in employments covered under OASDHI. All could enroll in Medicare's SMI program.

Retired Federal Employees Health Benefits Program

The RFEHB program enacted in 1960 provided for health insurance coverage for Federal employee annuitants who retired before July 1, 1960, as an immediate annuity for disability or after 12 years' service. The coverage includes their dependents and survivor annuitants. Under this program, eligible annuitants have a choice between a so-called uniform plan, which is underwritten by an insurance company, and any qualified private health insurance plan they elect (a Blue Cross-Blue Shield plan or an insurance company or other health insurance plan). To-

wards the cost of the plan selected, the Government contributes $3.50 a month for a person enrolling for self only and $7.00 a month for a person enrolling for self and family.

Under the uniform plan, for which Aetna is the carrier, enrollees are offered a choice of three contracts: Basic coverage only, major medical coverage only, and basic coverage plus major medical coverage. The basic and major medical coverages are not duplicatory—that is, the major medical coverage is so written that it excludes as eligible expense any payments that could be made under the basic coverage.

On the eve of Medicare, some 215,000 annuitants were enrolled for RFEHB, and coverage of their dependents brought the total number under the program to 300,000 persons. About 75 percent of those covered were aged 65 and over and were thus eligible for Medicare's hospital benefits and could enroll in its SMI program. Of the 215,000 annuitants in the RFEHB program approximately 55 percent were enrolled in the uniform plan. The majority of the rest, who were enrolled in "private plans," had coverage with local Blue Cross and Blue Shield plans.

As of mid-1967, 188,765 annuitants were enrolled under the RFEHB program. All told, some 281,000 persons including dependents were covered, and most of them were aged 65 and over. Of the total number of annuitants enrolled, 87,730 had the uniform plan and 101,035 were enrolled in private plans—63,750 with Blue Cross-Blue Shield plans, 25,980 with employee organization plans, 7,550 with insurance companies, and 3,755 with other plans. (The number covered under the RFEHB program will gradually decline to zero as this group dies off.)

BENEFITS AND SUBSCRIPTION COSTS UNDER MEDICARE AND SELECTED PLANS

The accompanying table presents comparable data on the benefits and the monthly subscription cost to covered persons (1) under Medicare, (2) under the high options of four plans of the FEHB program—the Government-wide service benefit plan, the Government-wide indemnity plan, the National Association of Letter Carriers health benefits plan, and the group-practice plan of the Group Health Association of Washington, D.C. (the majority of whose members are Federal employees), and (3) under the basic coverage and major medical coverage of the uniform plan of the RFEHB program. Each of the four selected plans under the FEHB program also offers a low option at a lower cost, as do most of the plans under this program.

It will be seen that the high options of the four FEHB plans generally provide coverage that is on the whole more comprehensive than that of Medicare but less comprehensive in some respects. More comprehensive coverage of hospital care is usually provided under these plans, and coverage of physician service as good as or better than Medicare's—as well as some coverage of drugs and private-duty nursing, which are not covered at all by Medicare. On the other hand, none gives any coverage of care in nursing homes or extended-care facilities—a type of coverage provided by Medicare that is especially important for older people.

Medicare benefits and the benefits under the various Federal employee plans are duplicatory to a great extent and, in general, a person covered under both Medicare and a Federal employee plan could not obtain the full benefits of both. The Civil Service Commission has contracted with approved plans that they are not to pay for benefits provided by Medicare and that in settling claims for persons entitled to Medicare benefits, they are to pay expenses not covered by Medicare up to the limits of their benefit coverage but not more than 100 percent of covered expense—that is, a covered person could in no case be reimbursed for more than 100 percent of illness charges incurred for covered services.

Clauses contained in the enrollment brochures of the various Federal employee plans may clarify the situation. The brochure for the Government-wide service benefit plan describes the conditions of the Medicare relationship as follows:

> MEDICARE—If a subscriber is entitled to benefits from Health Insurance for the Aged under Social Security ("Medicare"), benefits under this plan will always be reduced by the amount of the benefits payable by Medicare for the same service. However, the amount of such reductions shall be available (with respect to the same service for which the reduction was incurred) to cover "deductibles" and "coinsurance" under Medicare and under this Plan.

The Government-wide indemnity plan brochure contains this statement:

> Double Coverage—The double coverage limitation is intended to prevent payment of benefits which exceed expenses. It applies when a person covered by this plan is also covered by Health Insurance for the Aged under Social Security ("Medicare") or by some other plan for which any employer of the enrollee or any person in his family makes either (a) contributions towards premium or (b) deductions from pay or annuity. When double coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. The Indemnity Benefit Plan will always pay its benefits in full or a reduced amount which, when added to the benefits payable by the other plan, will equal 100 percent of allowable expense.

The brochure of the National Association of Letter Carriers plan states:

> Double Coverage—If a person is eligible for benefits under any other plan provided by law, including Health Insurance for the Aged under Social Security ("Medicare"), or any plan for which an employer makes either (a) contributions towards the premium, or (b) deductions from pay or annuity, his benefits under this plan will be limited. In such a case, this plan will pay benefits for covered expenses in accordance with its provisions up to an amount which, when added to the benefits available from the other plan, will not exceed the total charges incurred. In no case will benefits be paid in excess of the Plan's liability under its provisions.

The Group Health Association brochure has the following statement:

> Medicare—If you are entitled to Health Insurance for the Aged under Social Security ("Medicare"), this plan will continue to provide its benefits in full, but is entitled to receive payment for the services

Comparison of benefits and subscription charges under Medicare, under four plans of the Federal employees health benefits program (FEHB), and under the uniform plan of the retired Federal employees health benefits program (RFEHB), as of January 1, 1968

Benefit	Medicare	FEHB program (high options of plans)[1]				Uniform plan of RFEHB	
		Government-wide service-benefit plan	Government-wide indemnity plan	National Association of Letter Carriers plan	Group Health Association, Washington, D.C.	Basic coverage	Major medical coverage
Hospital care: Inpatient	90 days in semi-private accommodations with deductible of $40, with patient paying $10 per day, 61st-90th day; plus lifetime reserve of additional 60 days with patient paying $20 a day. Reasonable charges for X-ray and laboratory examinations paid in full.	365 days in semi-private accommodations. All charges covered in full.	100% of first $1,000 of semiprivate room and board charges, plus 80% of balance. All other hospital expense, 80% after deductible of $25.	Up to 365 days per confinement, pays first $3,000 of room and board and first $1,000 of other expenses, plus 80% of additional charges	365 days in semi-private accommodations. All charges covered in full.	Up to 31 days in any calendar year, pays $15 a day for room and board; up to $150 in any year for ancillary services.	For 32d to 122d day, pays $12 a day for room and board; 75% of ancillary charges above $150 and general deductible of $100 for single person and $150 for a family.
Outpatient	See physician service.	Care for surgery, accidental injuries and medical emergencies, X-ray and laboratory tests, and radiation therapy.	80% of expense after deductible of $25.	Covered for minor surgery and accidental injury up to $50.	Covered in full.	For surgery and care of accidental injuries, pays for ancillary services as above.	Pays 75 percent of charges after general deductible.
Physician service	80% of reasonable charges for all physician services and all hospital outpatient services, after general deductible of $50. (Check-ups and immunizations not covered).	Under basic benefits, provides service or indemnity benefits for surgery, in-hospital visits, X-ray and laboratory services, and care for medical emergencies wherever performed. Under supplementary benefits, pays 80% of all charges, after general deductible of $100, not met by basic benefits. Check-ups and immunizations not covered.	80% of reasonable charges for all physician service after general deductible of $50 ("other" hospital expenses count against this deductible). Check-ups and immunizations not covered.	For surgery, pays actual charges up to allowances in $400 schedule and, after patient pays $200, 80% of reasonable charges. For other medical services, 80% of charges after general deductible of $50. Check-ups and immunizations not covered.	Covered completely, including annual check-ups and immunizations; member pays $5 for first home call in each illness.	Surgical expense reimbursed in accordance with schedule paying $240 for most expensive operation. Medical service not covered.	Pays 75% of charges above amounts payable under basic coverage and general deductible.

See footnotes at end of table.

and supplies provided, to the extent they are reimbursed by Medicare.

For Federal employees and annuitants entitled to Medicare benefits, any coverage they have under a Federal employee plan functions as complementary coverage to Medicare. This is because Medicare provides its benefits irrespective of any other coverage and is thus always the primary carrier.

As noted earlier, the Federal Employees Health Benefits Act authorizes the Civil Service Commission to permit each approved plan to offer only two levels of benefits, each on a dual rate basis. The Commission therefore cannot permit approved plans to offer special complementary coverage to aged persons with Medicare coverage.

Because of the lack of coordination of the two programs, many Federal employees and annuitants aged 65 and over have faced or in the future must face difficult decisions as to whether they should enroll in Medicare's SMI program, keep their Federal employee health plan, or drop it. Their decision will be influenced by whether or not they are eligible for Medicare's hospital benefits, whether or not they have dependents under age 65 for whom they wish to maintain health insurance protection, and other factors.

Comparison of benefits and subscription charges under Medicare, under four plans of the Federal employees health benefits program (FEHB), and under the uniform plan of the retired Federal employees health benefits program (RFEHB), as of January 1, 1968—*Continued*

Benefit	Medicare	FEHB program (high options of plans)[1]				Uniform plan of RFEHB	
		Government-wide service-benefit plan	Government-wide indemnity plan	National Association of Letter Carriers plan	Group Health Association, Washington, D.C.	Basic coverage	Major medical coverage
Extended-care facilities.	100 days, with patient paying $5 per day, 21st–100th day.	Not covered	Not covered	Not covered	Not covered	Not covered	Up to 31 days after hospitalization for at least 5 days, pays $6 a day.
Home health services.	100 visits after hospitalization at no charge and 100 visits irrespective of hospitalization, with patient paying 20% of cost after general deductible of $50.	80% of visiting-nurse service charges covered after general deductible of $100.	80% of visiting-nurse service charges covered after general deductible of $50.	80% of visiting-nurse service charges covered after general deductible of $50.	Not covered	Not covered	See private-duty nursing.
Drugs	Not covered	80% after general deductible of $100.	80% after general deductible of $50.	80% after general deductible of $50.	80% after $50 in any one year.	Not covered	75% after general deductible.
Appliances, braces, rental of durable equipment.	80% after general deductible of $50.	80% after general deductible of $100.	80% after general deductible of $50.	80% after general deductible of $50.	Not covered	Not covered	75% after general deductible.
Private-duty nursing.	Not covered	80% after general deductible of $100.	80% after general deductible of $50.	80% after general deductible of $50.	Covered but only in hospital and when approved by GHA physician.	Not covered	75% of charges after general deductible up to $16 a day for 31 days.
Care outside U.S.	Not covered	Covered	Covered	Covered	Covered	Covered	Covered.
Maximum benefits payable.	None specified	Basic benefits plus $50,000.	$40,000	$15,000 for all charges other than for hospital care and surgery.	None specified	None specified	Maximum lifetime, $5,000.
Monthly subscription charge.	$3 for medical insurance program; increased to $4 effective Apr. 1, 1968.	Self, $8.43; self and family, $20.58.[2]	Self, $8.06; self and family, $20.15.[2]	Self, $4.94; self and family, $17.29.[2]	Self, $13.02; self and family, $33.54.[2]	Self, $2; self and family, $4.[3]	Self, $1.50; self and family, $3.[3]

[1] Benefits and costs of the low options of these plans are as follows:

(1) The Government-wide service-benefit plan provides up to 30 days for each hospital confinement, lower allowances for surgery (accepted as full payment by physicians in some areas for low-income patients), in-hospital medical care for only 30 days and at lower allowances, and reimbursement of 75 percent of other charges after a deductible of $150; the subscription cost, after the Government contribution is $3.64 a month for self only and $8.88 for self and family.

(2) The Government-wide indemnity plan pays 100 percent of the first $500 of allowable expense for hospital room and board, plus 75 percet of any balance, and 75 percent of other hospital expenses and surgical and medical expenses above $50 in each calendar year up to a maximum of $15,000 (not more than $25 of $50 deductible will be charged against hospital expenses); the subscription cost is $3.16 a month for self only and $7.58 for self and family.

(3) The NALC plan pays, for 365 days in each confinement, the first $500 of hospital room and board charges and the first $300 of other hospital expenses, plus 75 percent of charges over these amounts; actual charges up to scheduled amounts in a schedule with a maximum fee of $300 and, after the patient pays the next $200, 75 percent of remaining reasonable charges, plus 75 percent of other charges after the general deductible of $50, up to a maximum of $5,000 in any one year; the subscription cost is $2.99 a month for self only and $8.65 for self and family.

(4) The Group Health Association plan pays all necessary hospital charges except 50 percent of the first $150; it provides all doctor services except that the patient pays $2 for each office visit, $5 for the first home call in each illness, and charges ranging from $1 to $5 for injections, laboratory, X-ray and other diagnostic tests, and physical therapy treatments; out-of-hospital drugs are not covered; the subscription cost is $8.00 for self only and $21.28 for self and family.

[2] Government contribution (additional) is $3.64 for self and $8.88 for self and family.

[3] Amount that the enrollee pays after the government contribution of $3.50 for self only and $7.00 for self and family. The government contribution remains the same if the annuitant takes both coverages. Hence for both coverages the annuitant pays $7.00 a month for self only and $14.00 for self and family.

SITUATION FOR DIFFERENT GROUPS OF EMPLOYEES AND ANNUITANTS

Consideration of the situation of different groups of employees and annuitants who are aged 65 and over, with respect to taking advantage of Medicare and their Federal employee health program, will help to make clear the problems involved.

Active Federal employee or annuitant enrolled in FEHB plan and not eligible for Medicare's hospital benefits.—Such an employee or annuitant probably does not wish to cancel his FEHB plan because he would then have no hospital insurance protection. If, on the other hand, he keeps his FEHB plan, he may well question the worth of enrolling for Medicare's SMI program since those benefits would largely duplicate the benefits under his FEHB plan. In part, his decision might depend on the particular plan and option he had. The more extensive the benefits under his FEHB plan, the less the return he could expect from SMI.

For example, an employee or annuitant enrolled in the high option of the Government-wide service-benefit plan is entitled, under this plan's basic benefit provisions, to benefits for surgical service, in-hospital physician visits, and out-of-hospital X-ray and laboratory examinations and radiation therapy that meet all or most of physician charges for these services.[3] Under this plan's supplemental benefit provisions, the individual is entitled to reimbursement of 80 percent of the physician's reasonable and customary charges for office and home visits and other services, to the extent not paid under basic benefits, above $100 in any one year. Virtually the only benefit to be derived from enrolling under SMI (to which his physician service coverage under the FEHB plan would then be supplemental) is full or partial reimbursement of (a) those physician charges for surgery and in-hospital visits not met by the basic or supplemental benefits of the service-benefit plan, and (b) those charges above $100 for physician office and home visits and for appliances not met by the supplemental benefits of that plan.

The matter is complicated and requires illustration. Take the case of an employee who incurs $1,000 of physician charges in a year—$400 for surgery, $100 for X-ray and laboratory examinations (out of hospital), and $200 for office and home visits. Without SMI his service-benefit plan (high option) might pay the charges shown below:

Type of service	Total charges [1]	Paid by—			
		Basic benefits	Supplemental benefits or by patient	Supplemental benefits	Patient
Total	$1,000	$700	$300	[2] $160	$140
Surgery	400	[3] 350	50	(4)	(4)
X-ray and laboratory (out-of-hospital)	100	100	.....	(4)	(4)
In-hospital visits (43 visits)	300	[3] 250	50	(4)	(4)
Office and home visits	200	.....	200	(4)	(4)

[1] Assumes all charges are "reasonable and customary."
[2] 80 percent of charges in excess of $100.
[3] Assumes person is in an area where plan provides indemnity allowances (for a person of his income level) and that these payments fall short of meeting total charges as indicated.
[4] Because of the deductible, only the total can be divided between what plan pays and what patient pays.

The SMI program, if all physician charges were adjudged reasonable, would have met 80 percent of all the charges above $50 or $760, leaving the patient to pay $240. With the service-benefit plan complementary to SMI (and with SMI's deductible met, in effect, by the first $50 for office and home calls), then the situation would be as follows: Since the service-benefit plan, in the absence of SMI, would have met $350 of the charges for surgery, it would meet all of the $80 charges for surgery not met by SMI. (SMI would have paid 80 percent of $400 or $320). The same situation would hold for X-ray and laboratory examinations and in-hospital visits. Since the service-benefit plan under its supplemental provisions would have paid a total of $160 of physicians' charges, it would pick up all $80 of the charges for office and home visits not met by SMI (SMI would have met, in effect, 80 percent of the $200 of such charges less $50, or $120). Therefore, SMI and the service-benefit plan between them would pay 100 percent of the charges for physicians' services.

Under the low option and with the same charges

[3] In most areas, benefits are on a service basis for those under specified income levels—generally $4,000–$6,000 for a single person and $6,000–$8,000 for a family; for those above these income levels, benefits are on an indemnity basis. In some areas benefits are on an indemnity basis and in others on a full-service basis regardless of income.

the service-benefit plan would perform as follows, in the absence of SMI:

Type of service	Total charges	Paid by—			
		Basic benefits	Supplemental benefits or by patient	Supplemental benefits	Patient
Total	$1,000	$472	$528	[1]$283.50	$244.50
Surgery	400	250	150	[2]	[2]
X-ray and laboratory (out-of-hospital)	100	90	10	[2]	[2]
In-hospital visits (43 visits)	300	132	168	[2]	[2]
Office and home visits	200		200	[2]	[2]

[1] 75 percent of charges in excess of $150.
[2] Because of the deductible, only the total can e divided between what plan pays and what patient pays.

If the employee has SMI, then the low option of the service-benefit plan would pay all the charges for surgery, X-ray and laboratory examination, and in-hospital visits not met by SMI and all of the $80 charges for office and home visits not met by SMI. In short, the low option will perform as well as the high option in meeting these charges for physician services.

In the case under consideration it would obviously have been to the employee's or annuitant's advantage to have been enrolled in SMI. In return for his outlay of $48 (after April 1, 1968), that program would have paid the $140 in physician charges the individual would have had to pay out of pocket under the high option and the $244.50 he would have had to pay out of pocket under the low options.

A case in which an aged person incurs $1,000 of physician charges in a year is not a usual one. Consider what happens in a more nearly typical case in which an aged person incurs $150 in charges for office and home visits in a year and has no surgery or hospital admission (fewer than 1 in 5 persons aged 65 and over have a hospital admission in any given year). Without SMI, the high option of the service-benefit plan would pay $40 of these charges (80 percent of the $50 after discharge of the $100 deductible), and the low option (with its deductible of $150) would pay nothing. If the employee or annuitant had SMI, that program would pay $80 of the $150 of incurred charges and the patient would pay $70. The high option of the service-benefit plan would pay $40 of this $70, and the low option would pay nothing. In this instance, the high option would perform better than the low option but, at a cost of $48 a year, SMI would not have been a worthwhile purchase in either case.

Consider the situation under the Aetna plan, assuming the same physician charges. Without SMI, the high option would pay $760 of the physician charges (80 percent of $1,000 less $50), leaving $240 to be paid by the patient. If the employee or annuitant has SMI, that program would pay the same amount of the physician charges; the Aetna high option, functioning as complementary coverage, would then pay in full the $240 not paid by SMI. In the absence of SMI, the low option of Aetna would pay $712.50 of the physician charges (75 percent after the deductible of $50); with SMI coverage, it also would pay in full all the charges not met by that program.

For the employee who has $150 in charges for physician services and no surgery or hospitalization, the Aetna plan in the absence of SMI would pay $80 under its high option and $75 under its low option. The SMI program would pay $80 (80 percent of $150 less $50), leaving $70 unpaid, and either option of Aetna would pay all of this amount. In both cases, the low option would perform as well as the high option, and enrollment in SMI would have been advantageous.

The National Association of Letter Carriers plan under its high option, in the absence of SMI, would pay $790 of the $1,000 in physician charges in the first hypothetical case, and the patient would pay $210. Under the low option, the plan would pay $662.50 of the physician charges and the patient would pay $337.50. If the patient had SMI, that program would pay all but $240 of the physician charges, and either option would pay the balance. In the second hypothetical case—the patient with $150 in physician charges for office and home visits—the situation would be the same as that under the Aetna plan.

An employee enrolled in Group Health Association's high option plan obtains all physician services needed without direct cost, except that he pays $5 for the first home call in an illness. The only benefit he could expect to receive by enrolling under SMI would be payment of 80 percent of charges above $50 for appliances and home health services (visiting-nurse service, principally). The SMI premiums of $48 a year (after April 1, 1968)

would be a high price to pay for such limited benefits, and few people with GHA coverage would enroll in SMI unless the SMI premiums were refunded to them by the plan. The Social Security Amendments of 1967 included a provision to permit such refunds.[4]

Active Federal employee or annuitant entitled to Medicare's hospital benefits because of previous covered employment.—If such a person has dependents for whom he wishes to maintain health insurance protection, he will undoubtedly wish to keep his FEHB plan but may well question whether he should sign up for SMI. If he has no dependents or has only a dependent wife who is aged 65 or over and entitled to Medicare's hospital benefits, then he may find it hard to decide whether to keep his FEHB plan alone, drop it and sign up for SMI at $4 a month ($8 for himself and his wife), or keep his FEHB plan—perhaps shifting to a low option—and sign up for SMI. His choice may depend upon what plan and option he has.

If he has the high option of a plan giving broad coverage, he can substantially reduce his outlay for health insurance by dropping his FEHB plan and taking SMI, but he will then end up with inferior coverage.

The employee who has the high option of the Government-wide service-benefit plan has superlative coverage of hospital care, better coverage than Medicare's for surgery, in-hospital visits, and X-ray and laboratory examination, but not as good coverage as Medicare's for physician office and home visits. The service-benefit plan also covers drugs, private-duty nursing, and services outside the country, none of which are covered under Medicare. The cost is $8.43 for self only and $20.58 a month for self and family.

The active employee or annuitant entitled to hospital benefits under Medicare because of some earlier covered employment can cut his monthly health insurance outlay substantially by taking the SMI and dropping the FEHB plan. The saving may be attractive to a retired person living on a reduced income. But it will be achieved by downgrading his health coverage at a time in life when he needs the best health insurance coverage he can get.

Consider the case of a person with a comprehensive group-practice plan—Group Health Association, for example—who now pays $13.02 a month for self only and $33.54 for self and wife. If he drops this plan and relies only on Medicare's hospital and medical benefits at a cost of $4 ($8 for self and wife), his health insurance costs will obviously be substantially lower, but he will end up with coverage much inferior to what he had before.

Only 15 percent of all employees and annuitants have the low options, but the proportion among those aged 65 and over is probably higher. In many plans, persons with the low options would find it less expensive to retain their low-option FEHB plan than to take out SMI, and their coverage would be about as good, perhaps better, than that of SMI. If an employee now has the low option of the Government-wide indemnity plan, for example, he pays $3.16 a month for self, $7.58 for self and wife. This coverage is probably a better buy than SMI at $4.00 for himself alone or $8.00 for himself and wife, since it provides valuable hospital benefits to supplement those under Medicare.

Similarly the employee or annuitant with the low option of the Government-wide service-benefit plan, for which he pays $3.64 a month for himself and $8.88 for self and family, would probably do better to keep this coverage than to drop it in favor of SMI at $4.00 and $8.00, respectively.

(In comparing the cost of Medicare's SMI and the cost of the FEHB coverages for an aged person, it should be borne in mind that aged subscribers to the FEHB plans are heavily subsidized by the younger employees. These same coverages, if the aged employees had to pay the full cost, would cost two to three times more.)

[4] Most GHA members are Federal employees. It was to the plan's advantage that members aged 65 and over (whether or not eligible for Medicare's hospital benefits) should enroll in SMI since the plan would be paid its costs in providing covered services to those entitled to Medicare benefits. Members aged 65 and over could hardly be expected to enroll under SMI when it would provide practically no benefits beyond those already available to them. The GHA plan therefore offered, as an inducement to enroll, to refund the amount of the SMI premium. When the Civil Service Commission refused to sanction this because it would be an illegal rebate of premiums, the plan successfully pressed for an amendment to the Social Security Act that would permit such refund.

The employee or annuitant who wishes to obtain a very good, broad health insurance coverage will take out Medicare's SMI and then, in effect, complement or supplement his Medicare coverage with a FEHB plan. Considered as complementary coverages, the group-practice plans are prohibitively expensive. The high options of the two Government-wide plans and the employee organization plans are also very expensive for their potential benefits. The low options of these plans, however, frequently provide excellent complementary coverages at prices that are reasonable in comparison with nongroup complementary coverages available in today's market.

The Civil Service Commission in its brochure issued to Federal employees, *Information About Plan Charges Effective January 1968*, recognizes that when the low options are complementary to Medicare they perform as well or practically as well as the high options. The Commission encourages Federal employees and annuitants eligible for Medicare to take the low options. Under the heading, "Medicare," the brochure advises:

> A recent change in regulations provides a new opportunity to change enrollment: Employees and annuitants who are eligible for Medicare may now change from high to low option in the same plan at any time. All plans in the Federal Employees Health Benefits Program adjust their benefits so that they supplement, rather than duplicate, Medicare benefits. Most low options will adequately supplement Medicare at less cost than the high options. If you (and your wife or husband) have full Medicare coverage (Hospital Insurance and Medical Insurance) and you are enrolled in the high option of a plan which has two options, you should consider the advisability of changing to the less expensive low option. A request to change should be made to your employing office (or to your retirement system if you are an annuitant).

For most Blue Cross nongroup contracts complementary to hospital insurance under Medicare, the cost as of January 1, 1967, was between $2 and $3 a month. For most Blue Shield nongroup contracts complementary to supplementary medical insurance under Medicare the cost was $1–$4 a month. Most Joint Blue Cross-Blue Shield nongroup contracts complementing both parts of Medicare had a price of $4–$6 a month.[5]

Most of these nongroup coverages would not give as good complementary coverage as that provided by the low options of the two Government-wide plans or by the low options of the employee organization plans and would cost more than these low-option plans after the Government contribution. (Thus the low option of the Government-wide service-benefit plan has a total cost of $7.28 for self only and $17.76 for self and family, but after the Government contribution the cost to the employee is $3.64 and $8.88, respectively.) Blue Cross-Blue Shield group rates for complementary coverage would be lower than the nongroup rates. If it were considered desirable to do so, it would probably be possible to devise group complementary coverages for Federal employees and annuitants that would cost less than the present rates for many low-option plans.

Annuitant (eligible for Medicare's hospital benefits) enrolled in the uniform plan under the RFEHB program.—Some of the major factors such a person would weigh in deciding whether to enroll in Medicare's SMI program and, if so, whether to cancel or retain his uniform plan coverage, are the same as those for the FEHB enrollee eligible for Medicare's hospital benefits.

Together the basic coverage and the major medical coverage of the uniform plan give coverage of physician charges that in some respects is better than that of Medicare's SMI but in other respects is inferior. The uniform plan's coverage of drugs is also a factor in its favor, as is the allowance for hospital care that will complement Medicare's hospital benefits.

The cost (to the annuitant) for both coverages together is $7 for self alone and $14 for self and family. On the whole, it seems that the Medicare's SMI at $4 a month is much better.[6] The situation is completely altered, of course, if the annuitant has a spouse or other dependents under age 65 for whom he wishes to retain coverage.

If the annuitant enrolls in Medicare's SMI then

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[5] Louis S. Reed and Kathleen Myers, *op. cit.*

[6] In 1966 and up to October 1, 1967, the cost of coverage under the uniform plan for self only was $7.50 for the basic coverage, $7.00 for the major medical coverage, and $14.50 for both, with the cost for self and family double in all instances. After Medicare began, benefit expense under the uniform plan dropped markedly since this plan was now in effect providing complementary coverage to Medicare and much of the annuitant's expenses formerly borne by this plan were now met by Medicare. As of October 1, 1967, the Civil Service Commission reduced the plan rates to those now in effect.

he will need to decide whether to retain his uniform plan coverage, switch to a private plan (that is, complementary coverage of his local Blue Cross-Blue Shield plan or of some other carrier), or cancel his RFEHB enrollment entirely. If he cancels he loses the benefit of the Government contribution of $3.50 a month. The basic coverage only (at $1.50 a month after the Government contribution) is cheap and gives some supplementation of Medicare's hospital benefits (as good as the complementary coverage of most Blue Cross plans), as well as allowances for surgical service that pay the deductible and all or most of the 20-percent coinsurance amount on surgery charges.

With both basic and major medical coverage (at a cost of $7 a month) the annuitant will have good supplementation of Medicare's benefits. In most areas, however, the complementary coverages of Blue Cross-Blue Shield, available at a total cost of $4–$7 (after the Government contribution, a net cost to the annuitant of 50 cents to $3.50) might well be a better choice. The same may also be true of the complementary coverage offered by other carriers.

Annuitant (eligible for Medicare's hospital benefits) enrolled in private plan under RFEHB program.—Since the annuitant is entitled to Medicare's hospital benefits it would be to his advantage to enroll for Medicare's SMI and either cancel his private plan (in which case he loses the advantage of the Government contribution) or change his present coverage to a complementary one. The situation may be different if his spouse is under age 65.

CONCLUSIONS OF THE ANALYSIS

The major conclusions of this analysis are:

1. Medicare and the two Federal employee health insurance programs are poorly coordinated. The one was designed to provide health insurance to aged persons, the other to provide health insurance to Federal employees and annuitants. The Federal employee or annuitant who is aged 65 or over is unable in most cases to take full advantage of both programs. If he is eligible for Medicare's hospital benefits and enrolls in Medicare's supplementary medical insurance program, he may cancel his FEHB coverage as unduly expensive, in which case he ends up with a poorer health insurance coverage than he had before. If he is not eligible for Medicare's hospital benefits, he will wish to keep his FEHB plan but may not find it worthwhile to enroll in SMI. If he has dependents under age 65, he will wish to keep his FEHB plan to protect them but cannot reap the full advantages of Medicare. Considered as complementary coverage to Medicare, many FEHB plans are prohibitively expensive for the potential benefits involved.

2. In some important respects the existing situation is inequitable for Federal employees and annuitants. All aged persons, whether or not they had coverage under the Social Security Act, were transitionally blanketed-in for Medicare's hospital benefit, except Federal employees and annuitants covered under the FEHB. It is true that Federal employees under most FEHB plans have overall a better hospital coverage (except for Medicare's benefits in extended-care facilities—benefits important for the aged). Nevertheless, they must pay substantial amounts for it. Other persons aged 65 and over receive Medicare's hospital coverage without cost. All aged persons may enroll for Medicare's medical insurance program. In many cases, however, it is not to the Federal employee's advantage to do so because he cannot drop his FEHB plan without forgoing coverage of his dependents or lowering the quality of his health insurance coverage. In effect, he loses the benefit of the Government's SMI contribution.

3. The existing situation encourages Federal employees and annuitants eligible for Medicare's hospital benefits to downgrade their health insurance coverage (by relying solely on Medicare and cancelling their FEHB plan) just when they need the best health insurance coverage they can get.

4. The existing situation does not permit aged Federal employees and annuitants who wish to enroll or keep their enrollment in group-practice plans to derive any significant benefits from either part of Medicare. Thus such plans tend to be unduly expensive, in comparison with others. Consequently, the situation discourages enrollment in group-practice plans at the same time that the Government is endeavoring to encourage the growth of group medical practice and of

prepayment plans that provide group protection.[7]

5. Though the Federal Government is greatly concerned about high and rising medical costs, the present situation tends in some degree to foster unnecessary utilization of services and, possibly, escalation of physicians' fees. When an employee has both SMI and some FEHB plan, he can frequently receive 100-percent reimbursement of charges for all physician office and home visits. This situation, in the absence of effective arrangements for review and control of utilization of physicians' office and home visits, is likely to encourage abuse by patients and doctors. Neither Medicare nor most of the FEHB plans that pay doctors on a fee-for-service basis have effective arrangements for controlling the utilization of physicians' office and home visits. Both programs have relied on the built-in deductible and coinsurance features. The removal, in effect, of these features when there are no substitute devices for controlling utilization of or charges for services may well result in excessive insurance costs. (The same cautions are probably not needed with respect to surgery and in-hospital visits since patients are generally reluctant to undergo surgery or to stay in hospitals longer than necessary. In any case, controls on hospital utilization also tend to control the utilization of physicians' in-hospital visits.)

6. Although the Federal Government would like as many of the aged as possible to enroll in SMI, as an employer it pursues policies that deter enrollment of some aged Federal employees and annuitants in that program.

APPROACHES TO A SOLUTION

It seems clear that there can be no effective coordination of Medicare and the Federal Government's health insurance programs for its employees unless all Federal employees and annuitants stand in the same position with respect to eligibility for Medicare's hospital insurance benefits. In other words, an effective solution seems to call for ending the present exclusion of certain Federal employees and annuitants from Medicare's hospital benefits.

One way of achieving this goal would be to end the exclusion of Federal civil-service employees from the social security system—that is, to bring all Federal employees under that system, with civil-service pensions, like State and local governments retirement benefits and private pensions, becoming supplementary to OASDI benefits. If this step were taken, then Federal employees and annuitants would, of course, also become eligible for Medicare's hospital benefits on reaching age 65. There would, presumably, be transitional provisions to give entitlement to benefits for those already aged 65 or nearing that age without sufficient quarters of covered employment.

Then the Federal Government as an employer would presumably wish to consider what changes should be made with respect to continued coverage of employees and annuitants aged 65 and over under the Federal employee health benefit programs. Coverage of those aged 65 and over might be discontinued, for example, and the Government might then pay all or most of the monthly premium for Medicare's SMI and at the same time authorize approved FEHB plans to offer complementary-to-Medicare coverage for employees and annuitants entitled to benefits under both parts of Medicare.

The Cabinet Committee on Federal Staff Retirement Systems in 1966 made recommendations that would provide another approach to a solution of the problems dealt with here. In its report of February 15, 1966, the Committee recommended "that all future civilian appointees to the Federal Service and all present employees who desire such coverage should be covered under the Social Security Health Insurance Program, and should be provided with optional complementary coverage with government sharing the cost." [8]

In more detail it was recommended that:

> Federal employees covered only by a staff retirement system should have health insurance protection after they reach age 65 on the same basis as other workers. This should be accomplished by covering under the health insurance provisions of social security all

[7] See Department of Health, Education, and Welfare, *A Report to the President on Medical Care Prices*, 1967, pages 4–5; *Private Health Insurance and Medical Care: Conference Papers* (from the National Conference on Private Health Insurance), Social Security Administration, 1968; and *Promoting the Group Practice of Medicine*, Report of the National Conference on Group Practice (Public Health Service Publication No. 1750), 1967.

[8] See *Federal Staff Retirement Systems*, Appendix to the Report to the President of the United States by the Cabinet Committee on Federal Staff Retirement Systems (S. Doc. 14, 90th Cong., 1st sess.).

such present Federal employees and annuitants who desire the coverage, and all persons who in the future enter or re-enter Federal employment that is covered only by a staff retirement system.

For employees and annuitants who become eligible for social security health insurance and who desire broader protection than they obtain under social security, the Federal Government should make available complementary health insurance designed to maintain protection at approximately the level afforded by the Government-wide high-option plans, with the cost being shared by the Government and the participants. Coverage under present plans authorized by the Federal Employees Health Benefits Act of 1959 should be terminated for future entrants who will, of course, qualify for Social Security Health Insurance protection.

Under this proposal all present Federal employees if they desired would be covered under Medicare—that is, made eligible for hospital benefits—and would pay the employee contribution under that program. All Federal civil-service annuitants aged 65 and over and their aged dependents would become eligible for hospital benefits, and it is probable that all active Federal employees aged 65 and over would choose to be covered under Medicare and be eligible for its hospital benefits. All new employees would be covered under Medicare, like persons in private employment, with the Federal Government paying the employer's tax. The report goes on to say:

For those employees who become eligible for social security health insurance protection and wish to maintain the level of comprehensive protection they had under the Federal Employees Health Benefits Program, the Federal Government should arrange for, and perhaps share the cost of, as it does with respect to the present programs for retired employees, complementary group insurance provided by private carriers . . . Once such complementary coverage is made available, eligibility for social security health insurance should, of course, terminate coverage under the health plans now provided under the Federal Employees Health Benefits Act of 1959 for future entrants into the Federal service.

In other words, each approved FEHB plan would provide, together with Medicare, at least as good coverage as that now provided under the high options of the Government-wide service benefit and indemnity plans. The employee or annuitant could elect such coverage for self only or for self and spouse also aged 65 or over. Some combination of regular and complementary coverages would need to be made available for employees aged 65 and over with spouse under age 65 or for employee and spouse who both have reached age 65 but with dependent children now covered under an FEHB plan. The Federal Government would pay all or part of the $4 charge to the enrollee for SMI.

A modification of this approach would be to place all present Federal employees and annuitants under Medicare and make all Federal employees subject to contributions for hospital insurance under the Social Security Act. Some transitional provisions would be needed to give eligibility for hospital benefits to those nearing age 65 who would not have sufficient quarters of OASDHI coverage to qualify for benefits.

If all Federal employees and annuitants aged 65 and over were made eligible for Medicare's hospital benefits or were assured of becoming eligible on reaching age 65, then it would seem desirable for the Federal Government as an employer to follow the example of many other employers and encourage employees and annuitants aged 65 and over to enroll in SMI by paying all or most of the monthly premium for them.

With all aged Federal employees and annuitants enrolled in both parts of Medicare it would then be possible for the Civil Service Commission to authorize approved FEHB plans to offer to employees and annuitants who have reached age 65 an additional option that would provide benefits to complement Medicare benefits suitably. It would also be necessary to change the FEHB program in order to permit employees aged 65 and over to continue FEHB coverage for a spouse under age 65 and for dependent children.

Such complementary coverage could be similar in nature to what is offered by the various types of health insurance organizations to persons aged 65 and over who are not Federal employees. They would in general aim to provide to Federal employees and annuitants a level of health benefits as good in all respects as that provided under their present high options to all covered employees and better in those respects in which Medicare benefits were currently superior. The costs would depend upon the level of benefits written.

The approaches outlined seem to offer a means of assuring to all active Federal employees aged 65 and over and to all annuitants who retired after July 1, 1960, an adequate level of health insurance protection at moderate costs.