REPORT TO THE COMMITTEE ON POST OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Proposed Coordination Between The Medicare And The Federal Employees Health Benefits Programs

Department of Health, Education, and Welfare

Civil Service Commission

HEW and the Commission have submitted to the House Committee a proposal for a new Federal Employees program option which they believe meets the intent of existing laws. GAO has suggested two alternatives to the HEW-Commission proposal that the committee may wish to consider. Both alternatives would require legislation to repeal section 210 of Public Law 92-603. The second alternative would also require authorizing legislation.

MWD-75-99

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164562

The Honorable David N. Henderson
Chairman, Committee on Post Office
and Civil Service
House of Representatives

Dear Mr. Chairman:

This report is in response to your request of March 4, 1975, for information on the coordination of benefits between the Medicare and the Federal Employees Health Benefits programs for persons entitled to benefits under both programs. The report includes information on a Department of Health, Education, and Welfare and Civil Service Commission joint proposal for providing a new option under the Federal Employees program for persons covered by both Medicare Parts A and B. The report also includes a discussion of the current methods used by the Federal Employees Health Benefits plans in providing benefits to Federal enrollees also covered by Medicare.

The report contains a number of matters for consideration by the Committee regarding the joint proposal and two possible alternatives to the joint proposal. Since neither the joint proposal nor the two alternatives fully comply with the requirements of section 210 of Public Law 92-603, the Committee must decide in its evaluation which of these, if any, best meets the intent of section 210. In its deliberations, the Committee should keep in mind that the joint proposal provides special consideration only for those persons age 65 and over who qualify for Medicare Part A, while the two alternatives do not provide special consideration for this group. One alternative would maintain the present system, while the second alternative would provide special consideration to all Federal Employees Health Benefits enrollees age 65 and over.

The report was reviewed by officials of the Civil Service Commission and the Department of Health, Education, and Welfare. Their comments have been incorporated in the report.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
RFEHB	Retired Federal Employees Health Benefits

COMPTROLLER GENERAL'S
REPORT TO THE COMMITTEE ON
POST OFFICE AND CIVIL SERVICE
HOUSE OF REPRESENTATIVES

PROPOSED COORDINATION BETWEEN THE MEDICARE AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAMS

Department of Health, Education, and Welfare
Civil Service Commission

D I G E S T

The Federal Employees Health Benefits program and the Medicare program provide many of the same benefits. However, for enrollees in the Federal Employees program who also qualify for Medicare, the Federal Employees program pays only for covered benefits not paid by Medicare.

These enrollees are eligible for reimbursement of most of their medical care, unlike non-Medicare Federal Employees enrollees who must satisfy any deductible and/or coinsurance requirements. The cost to the FEHB program for enrollees with Medicare Parts A and B is less than the average cost for all FEHB enrollees. However, it is usual in group insurance for some subgroups to receive more value, and some less value, for the same premium, which is based on the average cost for the entire group.

Section 210 of Public Law 92-603 required the Department of Health, Education, and Welfare and the Civil Service Commission to provide, by January 1, 1976, a lower cost option covering only benefits not paid by Medicare (see p. 4.)

Section 210 was enacted because

--enrollees who qualify for Medicare were not deriving full value of their Federal Employees premium and

--the overlapping of benefits of the two programs generally did not make it advantageous for Federal Employees program enrollees to purchase Medicare Part B (see p. 6).

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HEW and the Commission have submitted, to the House Committee on Post Office and Civil Service, a proposal for a new Federal Employees program option which they believe meets the intent of section 210. The option would be available to persons covered by both Parts A and B of Medicare and, at least for the first year, would be financed 100 percent by the Federal Government (see p. 8).

MATTERS FOR CONSIDERATION BY THE COMMITTEE

GAO suggests that the Committee carefully analyze the proposal because it:

--Does not fully comply with the intent of section 210 since it does not (1) make it any more advantageous than it is now for some Federal employees to purchase Medicare Part B or (2) provide an option for Federal Employees program enrollees who have only Part A or only Part B of Medicare (see p. 9.)

--Provides for the Government to pay 100 percent of the premium costs of the new option, at least during the first year, while the Government contribution for all other options is limited. The proposed option covers both enrollees and their dependents. The only cost to the enrollee would be for the Medicare Part B premium (see p. 10).

--Does not substantially increase the health benefits of those currently covered under both programs (see p. 11).

--Results in lower premium rates based on the separate experience of one small group of people (less than 5 percent of the total Federal Employees population) which is contrary to the normal method of establishing one group rate for each option of the total Federal Employees program (see p. 12).

Further, since HEW and the Commission do not know the exact number of enrollees or dependents in the Federal Employees program covered by Medicare and did not consider the costs of including persons in the Retired Federal Employees Health Benefits program, the estimated additional cost to the Government--$48 million for calendar year 1976--of the proposed option may be unreliable. The Committee, therefore, may wish to have more precise cost estimates prepared (see p. 13).

Two alternatives to the HEW-Commission proposal that the Committee may wish to consider are to:

--Maintain the present system of coordinating benefits for those Federal Employees program enrollees also covered by Medicare because (1) there would be no increase in Government costs and (2) according to the Commission, adequate low cost coverage supplemental to Medicare is available through low options presently offered by the Federal Employees plans (see p. 17).

--Introduce a system under which the Government would pay the full cost of Medicare Part B for all eligible Federal Employees enrollees, because it would treat all Federal Employees program enrollees age 65 and over the same and increase their health benefits coverage or reduce their health benefit expenses (see p. 19).

Both alternatives would require legislation to repeal section 210 of Public Law 92-603. The second alternative would also require authorizing legislation.

CHAPTER 1

INTRODUCTION

We reviewed the Civil Service Commission's (CSC's) and Department of Health, Education, and Welfare's (HEW's) proposed method of coordinating benefits under the Federal Employees Health Benefits (FEHB) program and the Medicare program. We made the review in response to a March 4, 1975, request from the Chairman, House Committee on Post Office and Civil Service. (See app. I.)

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The FEHB program was established by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901) and became effective in July 1960. This program was enacted to provide health insurance protection to Government employees and annuitants and to their dependents or survivors. As of June 30, 1974, the program provided health insurance coverage for about 2.2 million employees, 769,000 annuitants, and 6 million dependents. Subscription income for the FEHB program exceeded $1.3 billion in 1973 and is expected to exceed $2.2 billion in 1976.

CSC is responsible for administering the FEHB program and for contracting with and approving the following four types of health plans:

Service Benefit Plan: a Government-wide plan which generally provides benefits through direct payments to physicians and hospitals.

Indemnity Benefit Plan: a Government-wide plan which provides benefits by either reimbursements to the employees or, at their request, payments to doctors and hospitals.

Employee organization plans: plans which are available only to employees who are members of the sponsoring organizations and which provide benefits generally by either reimbursement to the employees or, at their request, payments to physicians and hospitals. For 1975 there are 12 such plans.

Comprehensive medical plans: plans, available only in certain localities, that are either group practice plans providing benefits in the form of medical services by teams of physicians and technicians practicing in their own medical centers or individual practice plans providing benefits in the form of direct payments to physicians with whom the plans have agreements. For 1975 there are 32 such plans.

The cost of the FEHB program is shared by participating employees and annuitants and the Government. The Government's contribution for non-Postal Service employees is 60 percent of the average of the high option rates for the six largest FEHB plans--the two Government-wide plans, the two largest employee organization plans, and the two largest comprehensive medical plans. For Postal Service employees the Government contribution is 65 percent of the average rate for the six largest plans.

For 1975 the standard Government contribution for the FEHB program is $16.55 a month for self-only enrollment and $41.02 a month for family enrollment. For Postal Service employees it is $17.93 and $44.43 a month. The cost to the enrollee is usually the difference between the standard Government contribution and his total premium. The Government's contribution, however, may not exceed 75 percent of the total premium. For Postal Service employees the maximum amount may not exceed 81.25 percent.

MEDICARE PROGRAM

The Medicare program, which is administered by the Social Security Administration, was established by the 1965 amendments to the Social Security Act (42 U.S.C. 1395) to provide health insurance for people age 65 and over.

The Social Security Amendments of 1972 (Public Law 92-603) extended Medicare eligibility to (1) persons under age 65 who have been receiving social security or railroad retirement disability benefits for at least 24 consecutive months and (2) certain individuals or their dependents with chronic kidney failure. The Medicare program consists of

--Part A, which provides inpatient hospital insurance benefits, and

--Part B, which provides supplementary voluntary medical insurance (doctor's services and outpatient hospital benefits).

Medicare Part A is financed through a separate earnings tax paid by employees, employers, and self-employed persons. However, benefits for elderly persons who qualified under a special transitional provision are financed from general Federal revenues. Generally, only those persons entitled to monthly cash benefits under the Social Security or Railroad Retirement programs are eligible for Part A.[1] Part B is available to essentially all persons age 65 and over, at a cost of $6.70 a month with a Government contribution of $7.50 a month. Effective January 1, 1976, the Government contribution for Part B coverage will be at least $8.30 a month.

Federal civilian employees and annuitants generally do not pay social security taxes and, accordingly, are not eligible for Medicare Part A. They can, however, purchase Part B coverage.

There are FEHB program enrollees and their dependents who are entitled to benefits from both the Medicare and the FEHB programs. When the Medicare program was enacted it was intended that Medicare benefits would be paid without regard to any other benefits that might be payable under other health insurance plans. As a result, when health care expenses are incurred and covered under both Medicare and an FEHB plan, Medicare pays its benefits first. The FEHB plans have antiduplication provisions in their contracts with CSC to prevent benefit payments which exceed expenses. The plans' method of paying benefits for persons

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[1]The phrase "eligible for Part A," as used in this report, refers to having accumulated sufficient quarters under the Social Security program or to otherwise having qualified for Part A benefits at no cost to the recipient. Effective July 1973, persons who have an insufficient number of quarters and are enrolled in Part B can purchase Part A coverage--which cost $36 a month for fiscal year 1975.

covered under Medicare results in the plans paying up to 100 percent of the remaining covered expenses.

CSC does not know the exact number of FEHB program enrollees currently eligible for Part A; however, CSC estimates that by June 1976 about 258,000 FEHB program enrollees, or 50 percent of the enrollees age 65 and over, and 150,000 dependents will be covered by Part A.

REASONS FOR PROPOSED COORDINATION CHANGE

Section 210 of Public Law 92-603 (42 U.S.C. 1395y) was enacted on October 30, 1972. It required CSC to provide health insurance plans under the FEHB program which would supplement Medicare benefits. The intent was to provide Federal employees and annuitants, covered by both the FEHB and Medicare programs, an option under the FEHB program which would (1) provide better coordination for benefits not paid in full by Medicare and (2) reduce their premiums for the FEHB program.

Section 210 provided that, effective January 1, 1975, the Medicare program, both Parts A and B, would not pay for any covered service if such service was also covered under the FEHB plan in which the beneficiary was enrolled. This provision was not to go into effect, however, if the Secretary of Health, Education, and Welfare certified that the FEHB program had been modified to assure that (1) there was available to Federal employees or annuitants one or more Federal health benefit plans which offered protection for benefits not covered, or not paid in full, under Part A, Part B, or Parts A and B of Medicare and (2) the Government was making a contribution toward the health insurance of such employees or annuitants in an amount at least equal to the contribution it makes for any employee or annuitant enrolled for high option coverage under the Government-wide plans. This contribution could be in the form of a payment toward the Medicare supplement; a payment to, or on behalf of, the individual to offset the cost to him of his coverage; or a combination of such payments.

On October 26, 1974, Public Law 93-480 was enacted and deferred the effective date of section 210 until January 1, 1976. It also required CSC and HEW to submit

a progress report to the Congress by March 1, 1975, on the proposed coordination of the FEHB program and Medicare, or section 210 would become effective on July 1, 1975. CSC and HEW submitted a proposed plan to the Congress on February 26, 1975.

SCOPE OF REVIEW

We made our review at CSC and HEW headquarters, Washington, D.C. Our principal objective was to compare the existing method of coordinating FEHB and Medicare program benefits with the proposed method.

We reviewed the legislative history of section 210 of Public Law 92-603. In addition, we obtained the views of CSC and HEW personnel knowledgeable of, and responsible for, the coordination of the programs. Also, to obtain an understanding of how the present system works, we reviewed a limited number of FEHB program claims for persons covered under Medicare and also covered by one of the following FEHB plans:

--The Service Benefit Plan.

--Indemnity Benefit Plan.

--American Postal Workers Union.

--The Group Health Association, Inc.

CHAPTER 2

EFFECTS OF PROPOSED CHANGE IN COORDINATING PROGRAM BENEFITS

The HEW-CSC proposed change in coordinating program benefits provides for a new FEHB program option for persons covered by both Medicare Parts A and B which would be financed 100 percent by the Government, at least during the first year. The proposed change is intended to implement, in part, section 210 of Public Law 92-603 and thereby eliminate problems with the present system of coordination.

In our opinion the Committee should analyze the proposed coordination change carefully because it (1) does not fully comply with the intent of section 210 and (2) contains several features which may be undesirable. Also, since CSC does not know the number of enrollees in the FEHB program covered by Medicare or did not consider the cost of including those persons in the Retired Federal Employees Health Benefits (RFEHB)[1] program, the estimated additional cost to the Government--$48 million for calendar year 1976--for implementing the new FEHB option may be unreliable.

PRESENT SYSTEM

The problems in the present method of coordinating benefits were highlighted in a September 1972 report by the Senate Committee on Finance (S. Rept. 92-1230). The major problems identified were:

--FEHB plans cover many of the same health care benefits covered under Medicare.

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[1]The RFEHB program was established by the Retired Federal Employees Health Benefits Act (74 Stat. 849) and became effective July 1, 1961. This program was established to provide health benefits for Government employees who had retired before July 1, 1960, and were therefore not eligible for the benefits provided under the Federal Employees Health Benefits Act of 1959. (See p. 13.)

--Federal employees or annuitants do not derive the full value of their premiums under the FEHB program because of the antiduplication provision.

--Federal employees and annuitants generally do not find it advantageous to enroll in Medicare Part B because of the overlapping of Part B benefits with FEHB program benefits and therefore do not receive the benefit of the Federal general revenue contribution which is available to all persons who enroll in Part B.

For each option under the FEHB plans, a single premium rate has been established on the basis of the average cost of benefits for all enrollees in the option. Consequently, some categories of enrollees normally derive less benefits than other categories in the same option although all pay the same premium. This is the usual situation in group insurance where all enrollees pay the average rate but some subgroups receive more, and some less, than the average value of the premium. For example, although the cost of benefits would normally be less for a young married couple with no children than for the middle-aged couple with children, both would pay the same premium for the same self and family option.

We reviewed the methods used by several FEHB plans--the Service Benefit Plan, the Indemnity Benefit Plan, one employee organization plan, and one comprehensive medical plan--in coordinating benefits with Medicare for enrollees entitled to benefits under both programs. The methods varied as to the application of FEHB program benefits; however, the coordination of benefits by the FEHB plans usually resulted in an individual covered under both programs receiving payment for most of his medical costs. This is commonly referred to as "wrap-around" coverage. (Appendix II contains a description of various wrap-around methods of coordination used by the FEHB plans.)

According to CSC, the present system also results in savings to the FEHB program. These savings are described as the difference between the amount the FEHB plans paid for benefits and the amount the plans would have paid if Medicare had not paid its benefits first. CSC estimated that the FEHB program saved over $300 million during 1967-73, as a result of persons being covered under both Medicare

and the FEHB program, and estimated that such savings will be $236 million in 1976.

Calendar year	FEHB program savings (millions)
1967	$ 15.9
1968	22.7
1969	32.7
1970	40.0
1971	48.2
1972	58.2
1973	85.0
Total	$302.7

HEW-CSC JOINT PROPOSAL

The HEW-CSC proposed option will result in reduced costs to FEHB program enrollees with both Medicare Part A and Part B. The features of the proposal which the Committee should carefully consider are:

--It does not make it any more advantageous for some Federal employees to purchase Medicare Part B because it excludes FEHB program enrollees not eligible for Part A.

--It results in the Government paying 100 percent of the cost of the premiums (at least during the first year, since the cost has been estimated to be less than the standard Government contribution) for persons covered by both Medicare Parts A and B. All other options are limited to the 75 or 81.25 percent maximum Government contribution. Also, it provides coverage not only to individuals covered by Medicare but also provides free high option coverage to their family members.

--It does not substantially increase the health benefits of those individuals covered under both programs.

--It will result in lower premium rates, based on the separate experience of one small group of people (less than 5 percent of the total FEHB population), which is contrary to the normal method of establishing one group rate for each option of the total FEHB program.

The Committee should also consider the fact that the estimated cost of implementing the new option has been made without (1) knowing the exact number of enrollees in the FEHB program eligible for Medicare Part A and (2) estimating the cost implication of enrollees in the RFEHB program who might switch to the new option.

Not advantageous for eligible enrollees to purchase Part B

One of the problems identified in the Senate Committee on Finance's September 1972 report was that Federal employees and annuitants enrolled in the FEHB program generally did not find it advantageous to enroll in Medicare Part B because of the overlapping of benefits. Therefore, these persons were not receiving the Government's general revenue contribution, toward the cost of Part B, which is available to virtually all other persons age 65 and over.

Contrary to the intent of section 210, the proposed HEW-CSC option still does not make it advantageous for those FEHB program enrollees not eligible for Part A of Medicare to purchase Part B. The HEW-CSC proposal will benefit only those FEHB program enrollees who have Medicare Part A or whose spouse or dependent child has Medicare Part A. Also, to qualify for the proposed HEW-CSC option, enrollees must purchase Part B, which costs $6.70 a month.

Accordingly, the proposed option excludes FEHB program enrollees age 65 and over who have worked only in the Government and whose spouse or dependents are not eligible for social security benefits. Not only will these people be excluded from the proposed option, but their health insurance premiums will increase (along with the premiums

of everyone else enrolled in the FEHB program) to cover the estimated increased cost to the FEHB program resulting from the new option.

Government pays cost of new option

Another feature of the HEW-CSC option is that the Government is to pay 100 percent of the cost of the new option, at least in the first year. All other options in the FEHB program are limited to a maximum Government contribution of 75 or 81.25 percent.

Since the beginning of the FEHB program, there has been a limit on the amount the Government would pay toward an enrollee's premium. For non-Postal Service enrollees the maximum Government contribution was 50 percent from 1971 until January 1, 1974, when it was increased to 75 percent (Public Law 93-246). Low option enrollees and some high option enrollees now receive less than the standard Government contribution because of the 75 percent limit. For 1975 about 17 percent of the FEHB program enrollees are receiving less than the standard Government contribution.

In commenting on this report, HEW officials stated that it would be possible to amend the HEW-CSC proposal to apply the present 75 or 81.25 percent limitation, but that it would seem anomalous for the Government to pay less toward the health insurance protection of these Medicare-FEHB enrollees than it pays toward the health insurance protection of younger workers.

CSC has estimated that the Government contribution will be sufficient to cover the premium for the Medicare option at least in the first year. However, under the provisions of the new option, if experience shows that the cost of this option is more than the standard Government contribution the FEHB program enrollee would have to pay the difference in subsequent years.

During the first year the only cost to the enrollee or his family would be the premium for Medicare Part B--$6.70 a month. CSC has estimated that benefits for a self-only enrollee in the proposed option, with both Parts A and B of Medicare, will cost about 55 percent of the average high option premium of $27.58. The standard Government

contribution for a self-only enrollee is $16.55 a month--60 percent of the average high option premium. CSC also estimated that the benefit cost for a husband and wife, both covered by Parts A and B, would be 45 to 50 percent of the total premium and that the benefit costs for a husband and wife with only one covered by both Parts A and B would be 75 to 80 percent of the high option premium. The standard Government contribution for self and family enrollees is $41.02 a month--60 percent of the average high option premium of $68.37.

CSC did not offer separate options for FEHB program enrollees with only Part A or only Part B, as required by section 210. CSC's estimates indicated that such options would cost as much or more than the high option premiums the enrollees are currently paying. CSC's actuary estimated that the average benefit cost for an enrollee covered by Part B only would be 150 percent of the total high option premium, and for an enrollee covered only by Part A the cost would be 100 percent of the total high option premium or the same premium the enrollee is now paying.

It should also be recognized that the present method of coordination provides wrap-around coverage only to those individuals who actually have Medicare. In contrast the HEW-CSC proposal not only provides wrap-around coverage to these individuals but also provides high option coverage to their family members. CSC stated this was done to retain the FEHB family coverage provision.

For example, if an FEHB program enrollee has sufficient credits for work under the social security system, his entire family would be eligible for free high option coverage under the proposal. Also, if an enrollee does not have sufficient credits under social security he, and his family, may still be eligible for the new option if his spouse or dependent qualifies for Medicare Part A.

No substantial increase in benefits

The HEW-CSC proposal provides for a Medicare option that will have the same benefit structure and wrap-around method of coordination as the present high option coverage. Accordingly, those persons covered under both programs who are presently enrolled in an FEHB high option plan will not

realize any change in benefits. Also, because the FEHB low option coverage appears to be an adequate supplement to Medicare, those persons enrolled in Medicare and a low option FEHB plan will not receive a substantial increase in benefits except for raising the lifetime maximum benefits available. The only substantial increase in benefits will be for those family members not covered by Medicare who are now in low option FEHB plans. They will receive high option coverage under the new option.

Separate experience-rating

CSC intends to separately experience-rate the proposed HEW-CSC option. The FEHB program currently realizes a savings (see p. 8) for individuals covered under Medicare and also enrolled in an FEHB plan because Medicare pays first. These savings, estimated to be $235 million in 1976, will be applied only to the individuals included under the proposal.

Separately experience-rating this group appears to be contrary to the general practice of establishing FEHB program group health insurance rates. The FEHB program establishes subscription rates based on average net premiums--the average health costs for all enrollees in a group--instead of premiums for different groups based only on their health costs. CSC believes that this group should be included as part of the regular FEHB program but believes that separate experience-rating is mandated by section 210.

It would seem that other groups could benefit from separate experience-rating; however, this has not been done because of the general practice of establishing group health rates. For example, health benefits costs vary for persons depending on their age and sex categories. This was illustrated in our May 22, 1972, report (B-164562) on the Indemnity Benefit Plan, which showed the annual health costs in 1969 by age group for all employees and annuitants covered under the high option plan.

Indemnity Benefit Plan
1969 Health Costs for All
Enrollees Having High Option Coverage

Active employees			Annuitants	
Age group	Male	Female	Age group	Male and female
15 to 19	$ 49.65	$ 83.10	Under 50	$ 226.98
20 to 24	53.79	85.07	50 to 54	230.79
25 to 29	57.43	87.37	55 to 59	233.35
30 to 34	61.73	90.19	60 to 64	230.07
35 to 39	68.68	110.63	[a]65 to 69	225.62
40 to 44	85.58	139.69	[a]70 to 74	223.74
45 to 49	116.20	180.44	[a]75 and over	287.10
50 to 54	160.72	173.09		
55 to 59	218.95	176.58		
60 to 64	302.56	258.44		
[a]65 to 69	276.99	222.71		

[a]Decrease in health costs in these age groups attributable to Medicare coverage.

In commenting on our report, HEW officials stated that the FEHB premiums take into account the fact that Medicare pays a large part of the benefit costs which results in lower FEHB premiums, so that non-Medicare FEHB enrollees actually pay a lower premium for their FEHB protection than it is worth. The officials also stated that any costs incurred as a result of the implementation of section 210 would be a reduction in savings and can be considered costs which the FEHB program should have borne since the beginning of the Medicare program.

CSC, in commenting on our report, stated that there was nothing wrong with the single-premium rate concept in group insurance; rather, it is true of all group health benefits plans that the young subsidize the old, the healthy subsidize the sick, and people with small families subsidize those with large families.

Cost estimates of proposed option unreliable

According to CSC estimates, the new option will result in a redistribution of costs to the FEHB program of $52

million--$39 million being paid by the Government and $13 million by non-Medicare enrollees. In addition, the Government's general revenue contribution for Part B will increase by $9 million as a result of additional FEHB program enrollees and dependents purchasing Part B.

There is some uncertainty as to the accuracy of these estimates. CSC has estimated that in June 1976 about 258,000 enrollees (50 percent of the enrollees age 65 and over) and 150,000 dependents will be eligible for Medicare Part A. No statistics are available on the number of FEHB program enrollees currently eligible for Part A or enrolled in Part B. However, the information provided to CSC by the Indemnity Benefit Plan for 1972 showed that 68 percent of the persons over age 65 filing claims were eligible for Part A. Also, a CSC study for 1972 showed that 58 percent of civil service retirees over age 65 were receiving social security cash benefits and would, therefore, be eligible for Part A.

In addition, enrollees covered under the RFEHB program were not considered in preparing the cost estimates for the HEW-CSC proposal. Although enrollees under this program were not covered under section 210 or included in the joint HEW-CSC proposal, Public Law 93-246, enacted January 31, 1974, gave CSC the authority to allow enrollees to switch from the RFEHB program to the FEHB program. CSC officials said that CSC would have an open season as soon as the proposed Medicare option was available to enable the RFEHB program enrollees to switch to a regular FEHB plan and obtain the free Medicare option. It would be advantageous for RFEHB enrollees to enroll in the Medicare option because it would provide them greater coverage at less cost.

According to CSC, over 90 percent of the RFEHB enrollees are already covered by Part A because of special legislation enacted in 1965 (42 U.S.C. 426a). The 1975 monthly Government contribution for persons covered under the RFEHB program is $3.50 for self-only and $7.00 for self and family, while the 1975 standard Government contribution for the FEHB programs is $16.55 a month for self-only and $41.02 a month for family enrollment. As of June 1974 there were 190,427 enrollees in the RFEHB program--137,441 covered under self-only and 52,986 under self and family coverage. Therefore, it appears that a substantial switch in enrollees

from the RFEHB program to the FEHB program could considerably increase Government expenditures.

In commenting on our report, CSC stated that these estimates are in accordance with common actuarial practice. It said the effort required to obtain more reliable data on these enrollees would be time consuming, costly, and would not necessarily result in more accurate estimates. CSC also stated that it saw no need to further complicate the proposal by assuming that persons in the RFEHB program eventually would be brought under it.

While the usual actuarial practice is to make an estimate of the probable cost of a new program and adjust it later as experience may indicate, the estimate should be carefully made so that a large adjustment will not be necessary when experience becomes available. Because of the delay in issuing reports of the enrollment activity and claim payment information, the earliest period for which experience can be calculated will be the third or fourth calendar year of the new program. If the initial data used for the estimates are not sufficient and all cost elements are not included, the reliability of the estimate is questionable and any inaccuracy is carried forward at least 2 years.

Also, we believe that persons in the RFEHB program should be considered in the cost estimates because of the potential significant cost effect if a substantial number of RFEHB enrollees switch to the new option.

MATTERS FOR CONSIDERATION BY THE COMMITTEE

GAO believes that, in its deliberations on the proposed option, the Committee should consider whether it is desirable to adopt an option which:

--Will not make it any more advantageous for Federal employees and annuitants not eligible for Medicare Part A to obtain the Federal contribution for Part B of Medicare, which apparently was one of the objectives of section 210.

--Does not provide separate options for persons covered by Part A only or Part B only, as required by section 210.

--Will increase the cost of health insurance to Federal employees and annuitants over age 65 who have worked only in Government and whose spouse or dependents are not eligible for social security benefits.

--Will, at least during the first year, be financed 100 percent by the Government although all other options in the FEHB program will be limited to the 75 or 81.25 percent maximum Government contribution.

--Gives special consideration--the free high option coverage--to families of persons with Medicare Parts A and B.

--Will not substantially increase the health benefits received by individuals currently covered under both the FEHB and Medicare programs, except for raising the lifetime maximum benefits available for those persons currently enrolled in low option.

--Would experience-rate one group of enrollees in the FEHB program because their premiums are greater than the benefits received, even though there are several other groups within the FEHB program that would also benefit from separate experience-rating.

Before deciding whether to adopt the proposed option, the Committee may wish to require HEW and CSC to develop more precise cost estimates by determining (1) the number of enrollees eligible for Medicare Part A, (2) the number of dependents who would qualify for the proposed option, and (3) the costs of including enrollees under the RFEHB program.

CHAPTER 3

POSSIBLE ALTERNATIVES FOR CONSIDERATION BY THE COMMITTEE

The Committee may wish to consider the following alternatives to the HEW-CSC proposed option:

--Maintain the present system.

--Introduce a system under which the Government would pay all of the cost for Part B coverage for eligible FEHB program enrollees.

Both of these alternatives would require legislation to repeal section 210 of Public Law 92-603. In addition, the second alternative would require authorizing legislation.

MAINTAIN PRESENT SYSTEM

According to the Director of CSC's Bureau of Retirement, Insurance, and Occupational Health, CSC prefers the present system and the HEW-CSC proposal was developed only to comply with the intent of section 210.

CSC has sent to annuitants during open seasons a notice stating:

> "All plans under the Federal Employees Health Benefits Program adjust their benefits so that they supplement, rather than duplicate, Medicare benefits. Both Government-wide plans and most employee organization plans have a low option which will, in most cases, adequately supplement both parts of Medicare at less cost to you than the high option. If your Medicare card(s) show that both you and your spouse have Part A hospital insurance and Part B medical insurance and you are in the high option of a plan (or in a plan with only one option), you may wish to consider the advisability of changing to a less expensive low option in the same or a different plan." (Underscoring supplied.)

According to CSC estimates, in June 1976 about 28 percent of enrollees age 65 and over covered by both Medicare Parts A and B will be enrolled under a low option plan. The HEW-CSC proposal would increase health benefits mainly for family members not covered by Medicare who are now in low option FEHB plans because they would then receive high option coverage.

If the present system is maintained, CSC could prepare a publication showing how certain low option plans adjust their benefits to supplement Medicare and compare this with how high option plans adjust their benefits. This publication could show how most medical costs are paid with little out-of-pocket expense for an enrollee who also qualifies for Medicare Parts A and B. This could encourage more FEHB program enrollees age 65 and over with Medicare to switch to the less expensive low option plans. The high and low option monthly withholding rates for the two Government-wide plans are shown in the following table.

Service Benefit Plan	1975 monthly enrollee cost
Self-only high option	$ 11.70
Self-only low option	2.21
Self and family high option	27.90
Self and family low option	5.41
Indemnity Benefit Plan	
Self-only high option	8.41
Self-only low option	3.44
Self and family high option	21.16
Self and family low option	8.52

It appears that the major difference between the high and low option plans of the two Government-wide plans for people covered by both parts of Medicare is the maximum lifetime limitation. (Included in appendix II is a description of how the high and low options of the various plans provide wrap-around benefits for persons covered by Medicare.)

The major advantages of maintaining the present system are that (1) it would not increase the Government's costs

and (2) according to CSC, low option coverage of most FEHB plans appears to be an adequate supplement to Medicare.

The major disadvantage of this system is that FEHB enrollees who are also covered by Medicare do not derive full value of their FEHB premium. However, other groups in the FEHB program, who do not have Medicare, also do not receive full value for their FEHB premium (see p. 12).

PART B PREMIUM COSTS

The advantages of introducing a system in which the Government would pay for FEHB program enrollees' Part B premium for Medicare are that

--it would give FEHB program enrollees who have worked only in Government the opportunity to take advantage of the Medicare Part B program and, accordingly, the wrap-around coverage provided by the FEHB plans for Medicare Part B and

--it would treat all FEHB program enrollees age 65 and over the same, while, at the same time, either increasing their health benefits coverage or reducing their health benefits expenses.

According to CSC estimates, by June 1976 there will be 516,000 FEHB program enrollees age 65 and over, of which 258,000 will not elect to purchase Medicare Part B. Using these estimates, payment of the FEHB program enrollees' share of the Part B premium would result in an additional Government expense of about $41 million annually. In addition, the increased general revenue contribution by the Government for those enrollees who would not have elected to purchase Part B would result in an additional expense of about $26 million--a total additional annual expense of about $67 million.

One-half of the payment for the enrollees' share of the Part B premium, $20.5 million, would directly benefit those 258,000 FEHB program enrollees who were paying for Part B but who would not pay for it under this alternative. Estimating on the basis of the average monthly cost for

administration expenses of $1.48 for each person enrolled in Medicare, the alternative would also increase Medicare's administrative expenses by about $4.5 million.

The remaining $42 million ($67 million less $20.5 million and $4.5 million) would result in (1) increased health benefits to FEHB program enrollees as a result of their Part B coverage and (2) reduced costs to the FEHB program--because Medicare would pay for Part B-type coverage first--which would be shared by the Government (60 percent) and the FEHB program enrollees (40 percent). There is no information available, however, to determine what proportion of the $42 million would go to either the FEHB program enrollees or to the FEHB program.

In commenting on our report, HEW officials stated that they believed the alternative of the Government paying for the enrollees' Part B premium would not provide supplementary protection for those who have Part A of Medicare. They stated that under this alternative an FEHB enrollee entitled to Medicare Part A would not get the full value of his Part A and FEHB protection. They expressed concern that under either of GAO's alternatives an FEHB enrollee entitled to Part A would not receive special consideration because he would get no more protection than an enrollee not entitled to Part A.

Since Medicare pays first without regard to any other insurance, an FEHB enrollee entitled to Medicare Part A would always receive the full benefit of his Part A coverage. While it is true that under either of our alternatives FEHB enrollees who qualify for Part A do not receive special consideration, this is a matter which we believe the Committee should decide in its evaluation of the proposed HEW-CSC option and our alternatives.

MATTERS FOR CONSIDERATION BY THE COMMITTEE

In considering these alternatives the Committee should recognize that, like the HEW-CSC proposal, neither of these alternatives meets the intent of section 210 of Public Law

92-603. The advantages of maintaining the present system are

--there would be no increased Government costs and

--according to CSC, low option coverage of most FEHB plans appears to be an adequate supplement to Medicare.

The advantages of the Government paying the enrollees' Part B premium are

--all FEHB program enrollees would be able to take advantage of the Medicare Part B program and

--all FEHB program enrollees age 65 and over would be treated the same and would have their health benefits coverage increased or their health benefits expenses decreased.

APPENDIX I

U.S. House of Representatives
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
207 CANNON HOUSE OFFICE BUILDING
Washington, D.C. 20515

March 4, 1975

B-164562

Honorable Elmer B. Staats
Comptroller General
General Accounting Office
Washington, D. C. 20548

Dear Mr. Comptroller General:

On February 25, 1975, we received a statement of facts prepared by your staff which addressed the background regarding the coordination of benefits between the Federal Employees Health Benefits Program and Medicare. Since that date our Committee has received a progress report prepared jointly by the U.S. Civil Service Commission and the Department of Health, Education, and Welfare on their proposed plan for improving coordination between Medicare and the Federal Employees Health Benefits Program. This report was required under Section 4 of Public Law 93-480 which also deferred the effective date of Section 1862(c) of the Social Security Act. Section 1862(c) had required the Commission to offer an option for supplemental benefits for persons in the Federal employees program who had Medicare by January 1, 1975. Public Law 93-480 deferred this requirement until January 1, 1976.

The proposed plan recommends legislative changes which the Subcommittee must review if the plan is to be implemented by January 1, 1976. In this regard, we would now like the General Accounting Office to do additional work on the current method the Commission uses for coordinating benefits for the Federal employees program and Medicare and to identify the inequities of this system. In addition, we would like your Office to review the proposed plan set forth in the progress report and to identify any problem areas or inequities in this plan. We also would like you to compare the

APPENDIX I

B-164562

two systems, current and proposed, to determine the overall cost implications to the Federal Employees Health Benefits Program and to the Government. This information is needed to evaluate the extensive legislative changes that will be required to implement the proposed plan. Accordingly, we request that you provide us with this information as soon as possible.

Sincerely yours,

David N. Henderson
Chairman

DNH:bjl

METHODS OF COORDINATING BENEFITS BETWEEN THE FEHB AND MEDICARE PROGRAMS

The present methods for coordinating benefits for persons covered under both the Medicare and FEHB programs vary among the FEHB plans. For persons covered under both programs, Medicare receives the bill initially, determines a reasonable charge for the services, applies deductible and coinsurance provisions,[1] and provides payment for covered services.

After Medicare has processed the bill, the FEHB plans apply their benefit payments. Because of the antiduplication provision in FEHB contracts, the plans will not pay for a service if the payment would exceed the total charge for that service. Therefore, when Medicare provides benefits for a service covered under an FEHB plan, the FEHB plan pays its benefits in a reduced amount which, when added to the Medicare benefits for that service, will generally cover most of the charge. The plans use a "wrap-around" method of payment whereby they pay for covered services that have not been fully paid by Medicare--up to the amount the FEHB plans would have paid if the person was not covered by Medicare. The plans' payment includes Medicare deductible and coinsurance provisions and certain charges not allowed under Medicare.

The methods used by the FEHB plans for applying benefits to the charges remaining after Medicare has made its payment are described below.

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[1] Under Part A the beneficiary must pay the first $84 of costs for covered services during each benefit period. After this deductible is met, Medicare pays for covered services in full for up to 60 days and costs in excess of $21 per day through the 90th day. Under Part B the deductible is the first $60 of costs for covered services each calendar year. Under its coinsurance provision, Medicare then pays 80 percent of the reasonable charges for any additional covered services.

Service Benefit Plan

This is a Government-wide plan administered by CSC under a contract with the Blue Cross Association and The National Association of Blue Shield Plans. Its method for coordinating benefits with Medicare varies depending on whether the person has high or low option coverage.

Under high option coverage the plan pays the Medicare deductible and coinsurance costs for covered hospital charges and all covered hospital costs beyond the 90th day of confinement.

For covered surgical-medical charges, the plan subtracts the Medicare payment and pays up to the usual, customary, and reasonable charge[1] level for that service.

Under low option coverage the plan pays the Medicare deductible and coinsurance amounts for covered hospital services up to the 90th day of confinement. After the 90th day, supplemental benefits are applied. For covered surgical-medical services, the plan determines its reasonable allowance according to its low option schedule of allowances, subtracts any Medicare payment, and pays up to 100 percent of the reasonable allowance.

Supplemental benefits under this plan provide coverage for usual, customary, and reasonable charges for expenses for covered services that are not provided by basic hospital and surgical-medical benefits. Under low option coverage supplemental benefits can be used to cover any difference

[1] The usual, customary, and reasonable charge is determined by the plan. The fee charged is usual if it is the fee most often charged by that provider for that service. It is customary if it is within the range of fees for that service charged by providers in that area. It is a reasonable charge when it is usual and customary or is determined by the carrier to be justified because of unusual circumstances.

between the usual, customary, and reasonable charge and the low option schedule of allowances. Supplemental benefits are also paid for some services, such as physician office visits, that are not covered by basic benefits, and some services, such as prescription drugs, not covered by Medicare. Supplemental benefits are subject to

--a lifetime maximum limit of $250,000 for high option and $150,000 for low option,

--a deductible of $100 for high option and $150 for low option, and

--a coinsurance rate of 80 percent for high option and 75 percent for low option.

A person enrolled in Medicare Part B is not required to satisfy the deductible and is not subject to the plan's coinsurance rate for supplemental benefits.

Indemnity Benefit Plan

This is a Government-wide plan administered by CSC under a contract with the Aetna Life Insurance Company. The plan's general method of payment requires that itemized bills be submitted with each claim. The plan determines a reasonable charge for any covered procedure and applies a deductible--$50 for high option and $75 for low option for expenses other than hospital room and board--and pays either 80 percent for high option or 75 percent for low option of the remaining charges. The lifetime maximum benefits available under the plan are $250,000 for high option and $100,000 for low option.

For persons insured under both the Indemnity Benefit Plan and Medicare, Medicare pays its benefits first and a copy of the original bill and an explanation of Medicare's payment is sent to the plan. The plan determines what it would have paid if the person had no Medicare coverage; deducts the Medicare payment; and pays the remaining charges, including Medicare's deductible and coinsurance amounts up to the amount it would have paid if the person had no Medicare coverage. If the plan's actual payment is less than what it would have paid, the difference is set aside

as a Medicare credit for that person for the remainder of that calendar year. This credit can be applied to subsequent bills for covered services for the plan's and Medicare's coinsurance and deductible amounts and for charges disallowed by Medicare. Credit built up from Part A type charges can be applied to Part B charges and vice versa.

Employee organization plans

These plans' general methods of payment are similar to the Indemnity Benefit Plan. The plans receive itemized bills, determine a reasonable charge for covered services, apply any deductible and coinsurance rates, and pay the remaining amount. There are slight variations among plans as to the services covered, the reasonable charges allowed, and the amounts and applicability of deductibles and coinsurance rates.

The employee organization plans' methods for coordinating benefits for persons with Medicare coverage are also similar to the Indemnity Benefit Plan. After Medicare's payment the plans receive copies of the original bills and an explanation of the Medicare benefits. The plans determine the reasonable allowances for charges, apply any applicable deductible and coinsurance rates, and determine the amount of payment allowed for those charges. The Medicare payment is deducted from the original bill and the remaining amount is paid by the plan--up to the amount that would have been paid if the person had no Medicare coverage.

All plans set up a Medicare credit which represents the difference between the payment allowed by the plan and the amount actually paid after Medicare payments. The Medicare credit is available to that person for the remainder of the calendar year and can be applied to subsequent bills for deductible and coinsurance rates. Some plans use the Medicare credit to pay deductible and coinsurance charges for services, such as prescription drugs, covered by the FEHB plans but not covered by Medicare.

Comprehensive medical plans

The comprehensive medical plans are only available to employees who live in the geographic area where the plans

are located. These plans offer health services on a prepaid basis. There are two types of comprehensive plans--group-practice prepayment plans and individual-practice prepayment plans. The individual-practice plans pay benefits directly to individual physicians who have agreements with the plans. According to CSC officials, these plans coordinate benefits with Medicare in the same way the Service Benefit Plan does.

The group-practice prepayment plans provide benefits on a prepayment basis for services provided by physicians practicing as a group in a common center or centers. Because of the prepaid nature of the group-practice plans, the wrap-around method of coordination used by other types of FEHB plans is not applicable. The plans have made special arrangements with Medicare for reimbursement of covered services for their enrollees who are covered under Medicare.

APPENDIX III

Joint DHEW-CSC Report

on

Improved Coordination Between Medicare

and the Federal Employee Health Benefits Program

to the

Committee on Post Office and Civil Service

and the

Committee on Ways and Means

of the

House of Representatives

and to the

Committee on Post Office and Civil Service

and the

Committee on Finance

of the

Senate

Required by Public Law 93-480

To Effectuate Section 1862(c) of the Social Security Act

on January 1, 1976 Rather Than July 1, 1975

APPENDIX III

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REPORT ON PLANS FOR IMPROVED COORDINATION BETWEEN MEDICARE AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHB)

I. Legislative Background

Section 4 of Public Law 93-480 (approved October 26, 1974) requires that a joint DHEW-CSC report on the steps being taken to better coordinate the FEHB and Medicare programs by adjusting Federal employee health benefit plans so that they complement the protection provided under Medicare be submitted to Congress by 3/1/75, in order to retain the 1/1/76 effective date of section 1862(c) of the Social Security Act (42 U.S.C. 1395y.(c)). If the report is not submitted by 3/1/75, the effective date is moved up to July 1, 1975.

Section 1862(c) (as amended by P.L. 93-480) reads as follows:

> " (c) No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual on or after January 1, 1976, if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which such item or service is so furnished the Secretary shall have determined and certified that such plan or the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that --
>
> "(1) there is available to each Federal employee or annuitant enrolled in such plan, upon becoming entitled to benefits under Part A or B, or both Parts A and B of this title, in addition to the health benefits plans available before he becomes so entitled, one or more health benefits plans which offer protection supplementing the protection he has under this title, and
>
> "(2) the Government or such plan will make available to such Federal employee or annuitant a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans established under chapter 89 of such title 5, with such contribution being in the form of (A) a contribution toward the supplementary protection referred to in paragraph (1), (B) a payment to or on behalf of such employee or annuitant to offset the cost to him of his coverage under this title, or (C) a combination of such contribution and such payment."

The intent of section 1862(c) as expressed by the Committee on Ways and Means of the House and concurred with by the Committee on Finance of the Senate was: ". . . to assure a better coordinated relationship between the FEHB program and Medicare and to assure that Federal employees and retirees age

65 and over will eventually have the full value of the protection offered under Medicare and FEHB. . . ."1/

II. Present Method of Coordinating Medicare and FEHB Benefits

While FEHB plans and Medicare duplicate some types of covered expenses, duplicate benefits are not paid. Instead, FEHB benefits supplement those paid by Medicare. For Federal employees and annuitants who have hospital insurance (Part A) and/or supplementary medical insurance (Part B) of Medicare as well as a FEHB plan, supplementation has, since the start of the Medicare program, been achieved through an antiduplication provision in the FEHB plan, i.e., typically, the plan pays its benefits in full or in a reduced amount which, when added to the benefits paid by Medicare, reimburses up to 100 percent of allowable expenses. Thus, the FEHB benefits "wrap around" Medicare benefits.

Because, by law, Medicare pays its benefits without regard to other insurance (i.e., Medicare is primarily liable),2/the "wrap around" supplementation operates with relative simplicity: No determination as to whether a person has Medicare is required until a claim for benefits is filed. At that time, the claimant indicates whether he has Parts A and/or B of Medicare; and if he does, supplementary benefits are paid under the FEHB plan up to 100 percent of allowable expenses.

Since FEHB plans' benefits are reduced by the amount of Medicare benefits that are also payable, there is a substantial savings to the FEHB program. For 1976, it is estimated that these savings will be about $235,000,000 or about 10.4 percent of the total FEHB premium. As time passes, the dollar amount of these savings would become larger as the number of FEHB people entitled to Medicare increases, and the cost of health care goes up.

The savings effected by a FEHB plan because of its nonduplication of Medicare benefits result in a lower standard premium for all employees and annuitants enrolled in that plan and for the Government.

III. Problems With Present Method of Coordination

While this arrangement for coordinating Medicare and FEHB benefits has the advantage of simplicity, the equity of the system has come into question.

1/Excerpt from House Report No. 91-1096 Social Security Amendments of 1970, Report of the Committee on Ways and Means on H.R. 17550, p.25.

2/The one exception to this rule is payment made under a workmen's compensation plan (see section 1862(b) of the SSA).

Although FEHB benefits are not paid to the extent that Medicare benefits are paid for the same services, FEHB annuitants and employees who are covered by Medicare pay the same FEHB premium as those who do not have Medicare coverage. Thus, although such employees and annuitants pay the full premium that is charged for comprehensive FEHB coverage, these employees and annuitants receive only complementary benefits.

Also, it is generally not advantageous for employees and annuitants under FEHB plans to enroll for Part B of Medicare because many of the same health care expenses that would be covered under Part B already are covered under the FEHB plans. Those persons who do not enroll do not get the benefit of the Federal general revenue contribution which is available to all persons who enroll in Part B. Effective January 1, 1976, for each Part B enrollee the Federal contribution will be at least $8.30 per month.

In recognition of these problems, a recommendation that Federal workers be covered under Medicare (with present Federal retirees being deemed insured with the cost being met by the Government, as employer) and the FEHB program provide its annuitants who are also eligible for Medicare with health insurance coverage which complements Medicare was included in the 1969 report by SSA to the House Committee on Ways and Means and Senate Committee on Finance entitled "Relating Social Security Protection to the Federal Civil Service."

IV. Problems With Implementing Section 1862(c)

Based on an analysis of the feasibility and effect of modifying the FEHB program in accordance with the specifications in section 1862(c), DHEW and CSC conclude that on balance the modification described in that section of the law would be disadvantageous not only to Federal employees and annuitants, but also to the Government. Some of the reasons for this conclusion are as follows:

A. The Civil Service Commission actuarial estimates are that if, as section 1862(c) implies, the premiums for the supplemental plans were based solely on the health experience of the aged and disabled who are entitled to Medicare, rather than on the health experience of all FEHB enrollees, a FEHB option to supplement Part B alone would offer the same benefits as now for a higher premium. An option to supplement Part A alone would offer the same benefits for about the same premium. Stated differently, an option to supplement when an individual has only Part A appears unnecessary, while an option to supplement when an individual has only Part B would disadvantage those FEHB enrollees who subscribed to it.

B. Section 1862(c) requires that the Government's full standard contribution to FEHB coverage (as calculated annually under 5 U.S.C. 8906) be applied to pay the beneficiary's premium for the supplemental FEHB option,

his Part B premiums or both, but does not provide for crediting any portion of the Government FEHB contribution toward the premium of the employee's or annuitant's spouse (or child) who may be covered under a FEHB family enrollment but not under Medicare.

C. Twelve additional options would be needed under each of the 46 plans participating in the FEHB program to supplement (a) Part A of Medicare, (b) Part B of Medicare, and (c) Parts A and B of Medicare, each for four family groupings: (1) for self only enrollees, (2) families where all family members are covered by Medicare, (3) families where only the enrollee is covered by Medicare, and (4) families where only the dependents are covered by Medicare--making over 500 additional options. Thus, the FEHB program would be greatly complicated.

V. Results if the 1862(c) Exclusion Goes Into Effect

One possible response to the difficulties of instituting the FEHB options as specified in section 1862(c) is to take no action to make complementary coverage available under the FEHB program. If this were to occur, then on January 1, 1976, Federal employees and annuitants covered by the FEHB program will be excluded from Medicare coverage which duplicates that provided by FEHB. SSA has determined, based on advice from its Office of the General Counsel, that the exclusionary language of section 1862(c) relates to coverage, not payments, and thus, would prohibit Medicare from making any payment for items and services covered under a FEHB plan in which the beneficiary is also enrolled, even though FEHB would not pay for such items and services. This occurs primarily when deductibles and coinsurance are involved.

From the standpoint of the FEHB plans, this alternative would be relatively simple to administer. A FEHB plan would pay its benefits in full (subject, of course, to any deductibles and coinsurance) without regard to whether the beneficiary is also covered by Medicare; and Medicare would not make any payment for items and services covered under the beneficiary's FEHB plan even though the employee or annuitant did not receive payment for such items or services by reason of such deductibles and coinsurance.

This result would not only frustrate the intent of the Congress in enacting section 1862(c), but it would also result in a serious disadvantage to dually entitled beneficiaries by depriving them of a substantial part of their Medicare protection. In addition, beneficiaries would have larger out-of-pocket expenses as they would have to pay FEHB deductible and coinsurance amounts. Furthermore, it would also cause serious administrative problems for the Medicare program. For example: (1) many inquiries would be received from Medicare beneficiaries injured by the denial of Medicare benefits for FEHB covered services, for which no payment or only partial payment was received under the latter program, (2) it would be necessary

for SSA to develop and apply policies for implementing the FEHB exclusion, i.e., for determining whether items and services are covered under the particular beneficiary's FEHB plan, and (3) the Medicare carriers and intermediaries would have to stay abreast of the benefits offered by 114 or more FEHB plan options in order to avoid paying for FEHB covered services.

The elimination of Medicare coverage for dually entitled individuals would result in increased premiums for all FEHB employees and annuitants, and the Government. The Government contribution to FEHB coverage for 1976 would be increased by $127,000,000 and enrollees would have to pay an additional $108,000,000. These increases would be offset to some extent by corresponding decreases in costs to the Medicare program and to beneficiaries who would cancel their Part B enrollment and thus save the Part B monthly premium.

Those options which contain the greatest proportion of enrollees who are individuals covered by Medicare would require the largest rate increases. Therefore, those individuals who are intended to be helped by section 1862(c) would be hit with the highest proportionate rate increase. In addition, persons who currently have Medicare and a low option FEHB plan, which together generally pay 100 percent of covered expenses, would need to consider changing to a high option in order to get relatively similar, although lesser, protection. (Whether or not such persons switched to a high option plan, they might also want to cancel their enrollment in Part B of Medicare, since they would generally derive very little benefit from such coverage.) This accounts for the additional cost to the Government and enrollees in the event section 1862(c) goes into effect.

VI. Joint DHEW-CSC Recommendation to Provide Supplementary FEHB Coverage

Both DHEW and the CSC believe that the modification of FEHB program in accordance with section 1862(c) would not be in the best interests of dually entitled FEHB Medicare beneficiaries, and would create expensive and unnecessary administrative problems. Therefore, the two agencies are developing a legislative proposal to amend section 1862(c) that would (1) permit the desired coordination between Medicare and the FEHB program; (2) provide supplemental FEHB coverage at no cost to employees, annuitants, and their families as long as the premiums for such coverage do not exceed the maximum dollar amount the Federal Government may contribute to the health insurance premiums for high option self and family enrollees; and (3) eliminate or minimize administrative complexity. Such an approach would best serve the interests of all parties.

Specifically, the proposal would require the following legislative changes:

A. Federal Employees Health Benefit Act

(1) Section 8903 of title 5 U.S. Code should be amended to permit any plan participating in the FEHB program, and require all Government-wide FEHB plans, to offer "Medicare Supplement" health insurance options

which would provide coverage for all employees, annuitants, and members of their families, where the employee or annuitant or a member of the family is also entitled to Parts A and B of Medicare.

(2) Section 8906 of title 5 U.S. Code should be amended to provide that for purposes of this proposal, the 75 percent limitation on the Federal Government contribution shall be removed; and further provide that the Federal Government shall pay 100 percent of the premium for the Medicare supplement plan where an employee, annuitant, and/or member of the family is enrolled in Medicare Parts A and B, subject however to the maximum dollar amount the Federal Government may contribute to the health insurance premiums for all employees and annuitants.

B. Medicare Benefits Under the Social Security Act

(1) Title XVIII of the Social Security Act should be amended to provide for employees and annuitants who are presently entitled to Part A of Medicare a special one-time enrollment period to enroll in Part B of Medicare. During this special enrollment period the two-time Part B enrollment limitation and the 10 percent premium increase required for each full 12 months elapsing between the time this individual could first have enrolled and actually does enroll shall not apply.

(2) Section 1862(c) of the Social Security Act should be amended to permit approval of the "Medicare Supplement" option for FEHB employees and annuitants by the Secretary of Health, Education, and Welfare.

C. Effective Date for Legislation Described in Both A and B

The first January that begins no less than 6 calendar months after the month of enactment.

D. Timing of Enactment

Legislation should be enacted by the Congress before July 1, 1975, in order to permit implementation of the CSC-DHEW recommended substitute provision by January 1, 1976. However, if this cannot be accomplished, it is recommended that section 1862(c) be amended to postpone its effective implementation date from January 1, 1976 until January 1, 1977.

VII. Explanation of Recommendations

A. Federal Employees Health Benefits Program

The FEHB program (chapter 83 of title 5, United States Code) would be amended to offer a new "Medicare Supplement" option, in addition to the option or options it already offers, and require the removal of the 75 percent limit on the Government's contribution to premiums for the new supplement. As long as the premium for the "Medicare Supplement" option does not exceed the dollar amount the Government contributed to high option premiums, removal of the 75 percent limit would require the Government to pay the full premium for this option, with no cost to the enrollee.

Current CSC actuarial estimates indicate that the Federal Government's standard (now 60 percent of the average high option premium of the 6 largest FEHB plans) contribution to premium would be more than sufficient

to pay the full premium of a "Medicare Supplement" option both for self-only enrollees who have Parts A and B of Medicare, and family enrollees who have Parts A and B of Medicare or whose family members have Parts A and B. However, if experience proves that the cost of this complementary coverage is greater than the amount that can be contributed by the Government, the beneficiary would pay a small amount toward the premium in future years. At least for the first year the only premium such an enrollee would have to pay for himself and/or his family would be the prevailing rate for Part B of Medicare.

This option would permit self-only and family enrollments. It would be open for enrollment only to a person who had Parts A and B of Medicare or whose spouse or child had Parts A and B. Under a family enrollment, all eligible family members, including those without Medicare, would be covered by the option.

For an individual who has Medicare, the option would supplement Parts A and B, up to 100 percent of expenses for covered services, as heretofore, i.e., the option would reimburse for all regular high option benefits of the plan which are not provided by the Medicare program. For an individual (enrollee, spouse, or child) without Medicare, the option would provide regular high option benefits of the plan.

This Supplemental Plan would be consistent with congressional intent in passing section 1862(c), and provide additional advantages to employees, annuitants, and family members because it (1) recognizes and retains FEHB's family coverage provisions, (2) results in a lower premium cost (for the first year at least, an enrollee would pay only Part B premiums), and (3) eliminates the need for each FEHB plan to develop a myriad of options.

Under this proposal, the new "Medicare Supplement" would not be available to persons enrolled in only one part--Part A or Part B--of Medicare, as is currently required by section 1862(c). (See section IV A for a discussion of the reasons for not providing such coverage.) An individual covered by Medicare under Part A or Part B only would, as at present, have available to him insurance coverage in one of the regular options of the plan subject to the plan's antiduplication provision, resulting in most cases in the person receiving 100 percent reimbursement for covered services with Medicare being the primary insurer.

The new "Medicare Supplement" option would be experience-rated separately from the other regular options in the Plan. Experience-rating the Medicare-subsidized group of enrollees separately results in redistributing $52,000,000 which would have been paid by enrollees in the new "Medicare Supplement" option in the absence of such a rating process: $39,000,000 would be paid by the Government and $13,000,000 would be paid by non-Medicare enrollees, in the form of higher insurance premiums.

B. Medicare Benefits Under the Social Security Act

(1) A special enrollment period is necessary for FEHB employees and annuitants because these individuals either did not enroll for or cancelled their Part B insurance as retaining this coverage was not advantageous when they did not have the opportunity to obtain supplemental and nonduplicative FEHB coverage.

(2) Authorizing the Secretary of HEW to approve the FEHB Medicare supplement would perpetuate congressional intent as now incorporated in section 1862(c) to assure effective coordination between the FEHB plans and Medicare.

C. Effective Date

It is clear that CSC and DHEW would need time, once enacted, to implement the proposed legislation. In recognition of this implementation time, the DHEW and CSC recommend an effective date which would be on the first January that begins no less than 6 calendar months after the month of enactment. This would allow CSC and DHEW time to notify all eligible employees and annuitants of the new supplement and to allow for an enrollment period in the FEHB "Medicare Supplement" and in Medicare Part B.

VIII. Recommendation

The Civil Service Commission and Department of Health, Education, and Welfare jointly recommend the substitute provision described in item VI of this report as being an effective way to coordinate FEHB and Medicare.

Estimated Impact of FEHB/Medicare Coordination Options

(Calendar 1976 incurred costs, $ in millions)

Federal Costs

	FEHB	Medicare net of SMI premium	Total
1. Section 1862(c) coordination	$ 49	$ 9	$ 58
2. FEHB primary to Medicare	$127	$-264	$-137
3. HEW/CSC proposal	$ 39	$ 9	$ 48

Enrollee Premiums

FEHB enrollees

	Without Medicare	With Medicare	Total	Medicare SMI Enrollees	FEHB Rebate	Total
1. Section 1862(c) coordination	$ 13	$-52	$-39	$ 7	$-10	$-42
(Percent change)	(1.6%)	(-100%)	(-4.5%)			
2. FEHB primary to Medicare	$100	$ 8	$108	$-33	--	$ 75
(Percent change)	(12.3%)	(15.4%)	(12.5%)			
3. HEW/CSC proposal	$ 13	$-52	$-39	$ 7	--	$-32
(Percent change)	(1.6%)	(-100%)	(-4.5%)			

GAO note: Supplementary medical insurance (SMI)--Federal general revenue contribution for Part B costs.

UNITED STATES GOVERNMENT

Memorandum

U.S. CIVIL SERVICE COMMISSION

Subject: GAO Draft Report on "Proposed Coordination of Benefits Between the Medicare and the Federal Employees Health Benefits Program"

Date: JUN 2 8 1975

In Reply Refer To: RL:INS:I

Your Reference:

From: Thomas A. Tinsley, Director
Bureau of Retirement, Insurance, and Occupational Health

To: Gregory J. Ahart, Director
Manpower and Welfare Division
U.S. General Accounting Office
Washington, D. C. 20548

The following comments on the Draft Comptroller General's Report are in the main suggestions for clarifying certain words and phrases used in the Report to describe the CSC-HEW proposal and its effect. As regards the alternative proposal suggested by the GAO, our only observation is that although it could be considered to be in the spirit of section 1862(c) of the Social Security Act (referred to in the GAO report as section 210 of Public Law 92-603), as we believe ours also is, it clearly does not meet the specific intent of section 1862(c), anymore than ours does. This observation could be, but is not, repeated throughout the report. Both proposals would require repeal or amendment of section 1862(c).

[See GAO note.]

On page 4, the sentence beginning, "as a result," in the second full paragraph could be taken to imply that the private sector is treated differently. This of course is not the case. Also, in the last sentence of this paragraph, insert "covered" before "expenses". And in the last paragraph, it would be more precise to begin: "CSC does not know the exact number of FEHB enrollees currently eligible for part A; however, based on available data, the Office of the Actuary's best estimate is that by June 1976 . . . ."

[See GAO note.]

On page 7, we see no need to further complicate the proposal with an assumption that persons in the RFEHB program eventually would be brought under it. There is a more important need now not to confuse the RFEHB program with the regular FEHB program, which bringing it up at this date can only do.

GAO note: Deleted material concerns matters in the draft report which have been revised in the final report.

APPENDIX IV

SUBJECT: GAO Report

On page 8, the third statement is not entirely true. Deductibles and coinsurance for both low and high option Service Benefit (the Blues) Plan Supplemental Benefits are waived in these cases. The low and high option Indemnity Benefit (Aetna) Plan also makes some adjustment to take account of part B coverage. For example, if such a person has $200 covered medical expenses, Medicare would pay $112 following its $60 deductible and 20% coinsurance on the balance, leaving $88 unpaid. Under the current law and the proposal, the Blues would waive its $100 deductible and 20% coinsurance on the balance and pay the remaining $88 in full. Aetna would figure what its regular payment would be after a $50 deductible and 20% coinsurance on the balance -- $120; then it would pay the $88 balance due under its customary formula, and credit the difference between $120 and $88 -- $32 to the enrollee's account. If subsequently the same person had $200 of expenses covered only under FEHB (e.g., prescription drugs) the Blues would waive its own deductibles and coinsurance and pay the bill in full. Aetna would, under its formula, pay $120 plus the credit of $32 saved by Medicare being primarily liable for the medical bill, for a total of $152 of the $200 drug bill.

Also on page 8, the first full paragraph describes the single-premium-rate concept as if something were wrong with it. There is nothing wrong with this in group insurance; rather it is true of all group health benefits plans that the young subsidize the old, the healthy subsidize the sick, and people with small families subsidize those with large families. Who is to say who does or does not get full value for their premiums? No one can expect to remain young and healthy all their lives, and if they were not expected to help foot the bill while they were, there would be no one to do so when they were not.

On page 10, the first statement is questionable. Family members of an employee or annuitant with full Medicare coverage are also eligible for benefits under the proposal whether or not they are eligible for part A. And, as noted in the comments at the top of page 8 of the GAO draft report, there can be advantages of purchasing part B alone.

The results described in the second statement are either mandated by section 1862(c) of the Social Security Act, as well as under the CSC-HEW proposal, or recognize the family coverage under FEHB.

If the 100 percent saving in out-of-pocket FEHB cost of health benefits is itself a benefit, the third statement is not correct; this is particularly true for people who would now get high option coverage rather than low.

The fourth statement is true, but it is a requirement of section 1862(c) of the Social Security Act.

With respect to the last full paragraph on page 10, we repeat our earlier comments on page 4 of the GAO report, that estimates are based on the best data available. Precise data will not be available until after a year's experience; no amount of effort will get it any sooner. This is standard practice in estimating premium rates for new groups.

And, as also stated earlier, we see no need to get involved with the RFEHB program just yet; the recent option to transfer from RFEHB to FEHB has expired under our current regulations, and a new option will be considered once we get more experience with this new program.

On page 11, the first full paragraph does not recognize that people eligible for part B only can be covered as members of a family, nor that the premium rate for them as a group as compared with people with part A only as a group is higher because the cost of hospitalization, which they have no protection against, is the most significant cost of health insurance.

At the bottom of page 11, the title and first sentence are exaggerations since no notice is taken of the dollar limit equal to 60 percent of the average high option premium of the 6 largest plans under the program. Although the dollar amount provided under the 60 percent limit is expected to be sufficient to pay the full cost, there is no guarantee that it will, and if it does not the health benefits plans will need to pay the additional cost the first year. The "100 percent of cost" is the outside limit that would be paid in the event it is less than the regular 60 percent Government contribution to high option plan premiums.

With respect to page 13, we already have explained why the proposal is not limited to individuals. (FEHB covers families, not individuals, under any particular family option.)

Once again, on page 14, we run into the problem of rating Medicare-covered enrollees separately from others in the group. This is a problem with the requirements of section 1862(c) of the Social Security Act. We can't have it both ways; whether we treat Medicare enrollees as part of the group (which we agree is the correct procedure) or we don't (which is mandated by section 1862(c)), we can go in but one direction at a time.

Also, on page 15 we come across the same situation we commented upon at pages 4 and 10 (the last full paragraph). Assume those comments repeated here.

And on page 16, we again find the misleading introduction of RFEHB (see comments on pages 7 and 10).

APPENDIX IV

SUBJECT: GAO Report

Finally, on pages 17 and 18, we already have in this memorandum commented on each point listed. With respect to the recommendation to require more precise cost estimates, we can only add to what has been said before that to do so would be too time consuming and too costly, and we doubt that it would produce any more reliable data than we have now.

APPENDIX V

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUL 2 8 1975

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report to the Chairman, House Committee on Post Office and Civil Service entitled, "Proposed Coordination of Benefits Between Medicare and the Federal Employees Health Benefits Program." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON GAO DRAFT REPORT ENTITLED "PROPOSED COORDINATION OF BENEFITS BETWEEN MEDICARE AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM"

GAO's draft report to the Chairman, House Committee on Post Office and Civil Service, contains several criticisms of the proposed plan set forth in the "Joint DHEW-CSC Report on Improved Coordination Between Medicare and the Federal Employees Health Benefits Program," together with two GAO-devised alternatives to the plan for the Committee's consideration.

The following comments deal with those features of the DHEW-CSC proposed plan which GAO thinks may be undesirable, and present our views on GAO's suggested alternatives.

GAO Finding

The DHEW-CSC proposed plan does not fully comply with the intent of Section 210 of Public Law 92-603 because it does not (1) make it advantageous for some Federal employees to purchase Medicare Part B and (2) provide an option for FEHB enrollees who have only Part A or only Part B of Medicare.

SSA Comments

As the joint DHEW-CSC report points out, to comply fully with the provisions of Section 210 of P.L. 92-603 would require the CSC to offer 12 additional options under each of the 46 plans participating in the FEHB program--making over 500 additional options. Such a proliferation of plans is not practicable. Nor is it practicable to offer an option which would encourage Federal employees and annuitants who are not covered under Part A of Medicare to enroll in Part B, or a separate option to FEHB enrollees who have only Part A. CSC actuaries have estimated that an option to supplement the benefits of those who have Part A only would cost about the same as the present FEHB plans, and an option to supplement the benefits of those who have only Part B would cost about 50 percent more than the present plans. Thus an option to supplement the benefits of an individual who has only Part A appears unnecessary, while an option to supplement the benefits of an individual who has only Part B would disadvantage FEHB enrollees who subscribed to it.

GAO Finding

The DHEW-CSC proposed plan provides for the Government to pay 100 percent of the premium costs of the new option at least during the first year

while the Government contribution for all other options is limited. The proposed option covers both enrollees and their dependents.

SSA Comments

Under the proposed DHEW-CSC option the Government would pay 100 percent of the premium cost for the first year. This is because the benefit cost of the option is less than the maximum allowable Government contribution--60 percent of the average high-option premium for the six largest FEHB plans. The benefit cost for a self-only enrollee would be about 55 percent of the high-option premium. The benefit cost for a husband and wife would be 45 percent to 50 percent of premium and the cost for a husband and wife if only one is covered by Parts A and B would be 75 percent to 80 percent of premium. Combining the latter two cases results in a premium of about 55 percent of the high-option self-and-family rate. Since the standard contribution is 60 percent of the average high-option premium, both the self-option and self-and-family option can be offered free to enrollees initially. If experience proves that the cost of the supplementary coverage is greater than the amount that can be contributed by the Government, the enrollee would pay the difference between the Government contribution and the actual cost of the plan.

It would of course be possible to amend the proposal to apply the present 75- or 81.25-percent limitation on the Government contribution to the individual premium and to require the enrollee to pay the remainder. However, this alternative would result in the Government paying less toward the FEHB protection of employees and annuitants entitled to Medicare than it pays toward the FEHB protection provided most other FEHB enrollees. Under the present arrangements, low-option enrollees and some few high-option enrollees--only 17 percent of all FEHB enrollees--receive less than the standard Government contribution toward their FEHB protection. It would seem anomalous for the Government to pay less toward the health insurance protection of these Medicare-FEHB enrollees, who are for the most part retired workers living on limited incomes, than it pays toward the health insurance protection of younger workers. Also, these enrollees will not get health insurance protection free of charge under the proposal. Each eligible enrollee must enroll in Part B of Medicare and will be required to pay the Part B monthly premium--currently $6.70.

GAO Finding

The DHEW-CSC proposed plan does not significantly increase the health benefits of those currently covered under both programs.

SSA Comments

The report correctly states that the DHEW-CSC proposal does not significantly increase the health benefits of those currently covered under both programs. It is not clear to us why GAO characterizes this as "undesirable" or even thinks it necessary to make this point, since an expansion of coverage was not the intent of the joint proposal nor of the Congress in enacting the legislation. Rather, it was intended that the FEHB program be adjusted to assure a better coordinated relationship between it and the Medicare program and to assure that Federal employees, retirees, and annuitants who are enrolled in the FEHB program and are also entitled to Medicare protection would get FEHB protection worth the full value of the premiums they pay or which are paid on their behalf.

GAO Finding

The DHEW-CSC proposed plan results in premium rates based on separately experience rating one group of people which is contrary to the normal method of establishing rates for the FEHB program.

SSA Comments

The proposal does result in premium rates which are based on separately experience rating one group of people contrary to the normal method of establishing rates for the FEHB program--it is our understanding that proper insurance underwriting procedure requires rating any group separately when that group is removed from a larger rating population. However, since the cost estimates were made by the actuaries of the Civil Service Commission, we defer to the CSC for their comments on this point.

SSA Comments on Other Issues Raised by GAO

The GAO report also expresses concern that the premiums paid by non-Medicare FEHB enrollees and the Government contribution would increase under the plan. (CSC estimates that under the DHEW-CSC proposal the premiums for non-Medicare enrollees and the Government contribution would increase by $13 million and $39 million, respectively, in calendar year 1976.) Under the present system, FEHB premiums are based on the experience of the whole covered group, which includes Federal workers, retirees, and annuitants. The premiums are set to take into account the fact that Medicare pays a large part of the benefit

APPENDIX V

cost for those who are also Medicare beneficiaries. This of course results in lower FEHB premiums for all enrollees, so that non-Medicare FEHB enrollees actually pay a lower premium for their FEHB protection than it is worth. The difference is made up by workers engaged in covered social security employment who are subsidizing, through the payment of Medicare's hospital insurance contributions, the FEHB program for Federal workers and for Federal retirees and annuitants.

The savings which accrued to the FEHB program as a result of FEHB benefit payments being reduced by Medicare benefits have amounted to over $300 million from 1967 through 1973 and are estimated at $235 million for 1976. These savings will become larger in the future as the number of FEHB enrollees entitled to Medicare increases and as the cost of health care increases. Viewed from this perspective, any costs to the FEHB program incurred as a result of the implementation of Section 210 would be a reduction in savings and can be considered costs which the FEHB program should have borne since the beginning of the Medicare program.

GAO Alternatives to the DHEW-CSC Proposed Plan

The GAO report proposes two alternatives to the DHEW-CSC proposal. The first alternative is to repeal Section 210 of Public Law 92-603; the second alternative is to introduce a system under which the Government would pay the full cost of Medicare Part B for all eligible FEHB enrollees.

The first alternative would maintain the present system with the inequities the DHEW-CSC proposal and congressional legislation is designed to correct.

The second alternative would treat all FEHB employees and annuitants age 65 and over equally. This alternative would meet the congressional objective of encouraging Federal employees and annuitants age 65 and over to enroll in the Part B program. However, it would not provide supplementary protection for those who have Part A of Medicare. Thus a FEHB enrollee who is entitled to Part A of Medicare would not get the full value of his Part A and FEHB protection. We believe it is important that an individual get the full value of his Part A protection. This protection is earned during an individual's working years through a separate tax on his covered earnings; no payments are made after his earnings have stopped due to retirement at age 65 or severe disability. Thus when an individual reaches age 65 and becomes entitled to monthly social security benefits (or has been entitled to disability benefits for 2 consecutive years), he automatically becomes entitled to Part A of Medicare. He receives this protection as an

earned right, having paid toward his Part A protection through contributions on his earnings. The Part B program, on the other hand, is a voluntary program and is financed through the contributions paid by those who have enrolled in the program and by the Federal Government.

Although we do not favor the second GAO alternative, in the event that the proposal is given serious consideration, we suggest that it be revised to provide for special enrollment periods (as is provided for in the DHEW-CSC proposal) for Federal employees and annuitants who would be eligible for Part B. Many FEHB enrollees do not now have Part B insurance, as this coverage is not to their advantage when they do not have the opportunity to obtain supplemental and nonduplicative FEHB coverage. We also suggest that for these individuals the alternative provide for waiver of the existing 2-time limitation on Part B enrollment and waiver of the Part B premium increase for late enrollment. Under present Medicare law, an individual may enroll in Part B only twice and must pay an additional 10-percent premium for each full 12 months elapsing between the time he could first have enrolled in Part B and actually does enroll.

We believe that the joint DHEW-CSC recommendation more closely conforms with congressional intent as expressed in Section 210 of Public Law 92-603 than does the GAO proposal. We are particularly concerned that under either GAO alternative, a Federal employee or annuitant entitled to FEHB who is also covered under the Part A program (approximately 50 percent of age-65-and-over FEHB annuitants) would get no more protection than the employee or annuitant who does not have Medicare hospital insurance protection. The beneficiary entitled to Part A and FEHB would continue to get less than the full value of his Medicare and FEHB protection. The non-Medicare FEHB enrollee would continue to pay a lower premium for his FEHB protection than it is worth and, in addition, get a windfall benefit in that the Government would pay the total cost of his Part B protection.