Ethically Economic: The Affordable Care Act's Impact on the Administration of Health Benefits

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Many see the United States' health-care system as unfair. A variety of factors play into this belief, but one that is overlooked is the administration, implementation, and coverage of health benefits and its effect on the health-care system. Without a proper determination of health benefits, the effectiveness and value of a health-care system fails both ethically and economically.

The ethics and economics of the Affordable Care Act (ACA) positively affect the administration, implementation, and coverage of health benefits. This affect can be seen in three areas: essential health benefits, health insurance exchanges, and the qualified health plans administered by the Office of Personnel Management (OPM). Essential health benefits improve the ethics of health benefits by increasing participation and consistency, but must include an array of benefits and

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2. Matthew K. Wynia et al., Improving Fairness in Coverage Decisions: Performance Expectations for Quality Improvement, 4 AM. J. BIOETHICS 87, 88 (2004) ("[D]ifficult health care coverage decisions will always have to be made, and that trust in the legitimacy of these decisions is required for the health care system to be most effective and valuable.").
3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). The article discusses both the ACA and the Federal Employees Health Benefits Program in detail because of the interrelation between the two topics, e.g., Section 1334 of the ACA, and the need to have background knowledge of the FEHBP to understand the argument that the ACA is both economical and ethical.
cost-sharing levels in order to counter potential economic self-interest. Health insurance exchanges improve the ethics of health benefits by providing consistency, by increasing participation to consult with stakeholders, and by being transparent in cost reporting. The exchanges also potentially lower costs, but may be hindered by the self-interest of insurers. The OPM-administered qualified health plans (hereinafter OPM plans) will be created in the likeness of the Federal Employee Health Benefits Program (FEHBP). The FEHBP has its positives and potential pitfalls, but overall having the OPM plans in the exchange will bring stability and lower start-up administrative costs. In the end, these plans will be subject to adverse selection and risk adjustment—much like the FEHBP plans—however, tax credits and potential risk-adjustment models may be used to lessen their impact.

Part I of this Article will discuss how ethics and economics play a vital role in the administration of health benefits; what can happen when political punditry hijacks the administration of health benefits; and what can be done to alleviate these situations. Next, Part II of the Article explores the Affordable Care Act’s impact on health benefits both ethically and economically in terms of “essential health benefits” and the health insurance exchanges. The ACA also requires the OPM to create at least two qualified health plans comparable to the FEHBP. In Part III, the article will discuss the FEHBP, its strengths, and its weaknesses. Finally, Part IV examines the OPM plans looking at additional economical advantages, some potential ethical and economical problems, what OPM can learn from past exchanges’ failures, and recommendations going forward.

I. THE ADMINISTRATION OF HEALTH BENEFITS

The package design for health benefits and the administration of health benefits are vital to health-care delivery. They involve the

4. See infra text accompanying notes 152–68.
6. “Benefits design is the decision-making process that determines what assortment of health care services will be covered under an insurance package.” Id. Package design includes three parts: enumerated benefits, enumerated exclusions, and payer coverage decisions. Lynn Shapiro Snyder, Clayton Nix & Lesley Yeung, The Importance of Stakeholder Participation in the Process to Define the 'Essential Health Benefits Package, BNA HEALTH INSURANCE REPORT, Jan. 5, 2010, at 3. Enumerated benefits are covered benefits if medically necessary. Id. Enumerated exclusions are benefits that are not covered, such as custodial care. Id. Payer coverage decisions are how a health plan decides when to cover or not a procedure or service does not fall into either of the above two categories. Id.
7. “Benefits administration” is the “decision-making process that determines the insurance coverage of specific services for specific individuals within the scope and limitations of the benefits design.” Wynia et
interaction of numerous stakeholders: insurance companies and agents, human resources, health-care providers, and enrollees. In choosing the range of services to be covered, decisions on what benefits to include must be made. These decisions need to be not only fair but also economical. This section explores the ethics and the economics of health benefit administration, what happens when political punditry runs amok with potential benefits, and what can be done to counter the political punditry and to show that ethics and economics are not mutually exclusive in the world of health benefits.

A. Ethics

"Ethics" can have many definitions and meanings. This article uses "ethics" as a guide to moral principles rather than as a moral duty or obligation. While many may wish for the government to have a charity-based model of health care (grounded in moral obligation), it is clearly more based on a social-insurance model (grounded in principles). The American Medical Association’s Ethical Force Program highlights five

al., supra note 2.
8. Id.
9. Id.
10. Id. at 89.
11. Id.
12. Merriam-Webster’s defines "ethic" as "the discipline dealing with what is good and bad and with moral duty and obligation," "a set of moral principles," "a theory or system of moral values," "the principles of conduct governing an individual or a group," "a guiding philosophy," "a consciousness of moral importance," and "a set of moral issues or aspects (as rightness)." Ethics, MERRIAM-WEBSTER ONLINE, http://www.merriam-webster.com/dictionary/ethics?show=0&t-1306623512 (last visited June 11, 2011).
13. A charity model is based on whatever moral obligation the country owes to its citizens. See Richard E. Levy, Of Two Minds: Charitable and Social Insurance Models in the Veterans Benefits System, 13 KAN. J. L. & PUB. POL’Y 303, 303 (2004). “[T]he fulfillment of that responsibility is . . . a voluntary undertaking.” Id. The model is not favored because as “mere gratuities,” these benefits could be revoked at any time because of the lack of legal protections. Id. at 304.
14. A social insurance model involves benefits being in the “form of [a] social contract through which the government uses its taxing and spending powers to spread the costs of old age, disability, unemployment, and poverty.” Id. at 303–04. Prime examples are Medicare, Medicaid, Social Security, and Temporary Assistance for Needy Families. Id. at 303. As “quasi-contractual,” these benefits are not “mere gratuities to be distributed in an ad hoc and discretionary manner.” Id. at 306. Thus, “the distribution of benefits [is] not a discretionary act” and [is] legally protectable. Id.; see also Goldberg v. Kelley, 397 U.S. 254 (1970) (holding that welfare benefits are a protected property interest).
15. The Ethical Force Program is tasked with the “challenge of developing health care system-wide performance measures for ethics. Featuring representatives from groups including patients, practitioners, health plans, purchasers, government and accrediting organizations, this program seeks to develop meaningful solutions that can arise only when a diverse and collaborative group of relevant stakeholders work together.” The Ethical Force Program, AM. MED. ASS’N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program.page (last visited May 28, 2011).
core ethical principles that should be taken into consideration when making the decision on what benefits to cover: (1) transparency, (2) participation, (3) equity and consistency, (4) sensitivity to value, and (5) compassion. These criteria lay an ethical framework upon the administration of benefits and provide a “best practices” for the designing of an ethical benefits program. Although all five are important, this article will briefly discuss three: transparency, participation, and equity and consistency.

First, transparency includes the “importance of being honest” and the “desire to hold both individuals and organization accountable for their decisions.” Individual consumers need access to accurate information about benefit-coverage decisions; otherwise, it is unfair to hold them accountable for decisions based on specific benefit package design. Transparency also involves knowledge of which individuals are involved in any decision-making process and “requires active attention.”

Second, participation is ethical because it allows the consumer ability to participate, which in turn allows the consumer “to recognize and leave poor-quality organizations.” Having strong participation is especially important in the health-care context because the ability to participate can be constrained and it may be impossible to leave a poor-quality benefit plan. In addition, the communication of all stakeholders can help

18. See infra text accompanying notes 29–32.
19. Sensitivity to value involves looking at “net health outcomes of services or technologies . . . and the resources required to achieve these outcomes.” Wynia et al., supra note 2, at 92. In other words, this principle looks to find a health plan that offers more benefits and costs the same as other health plans. Id. The Ethical Force Program calls for a two-step process for analyzing this criteria: (1) “estimat[e] the clinical outcomes associated with the service or technology in question [by] assessing the potential benefits, harms, and risks” and (2) “incorporate[e] information about costs and preferences . . . to determine whether benefits outweigh harms and justify costs for a specific population or patient.” Id. at 92–93. The second step could involve a cost-effective analysis. Id. at 93. Although cost-effective analysis has its advantages, it can be biased, expensive, outdated, and can undervalue “compassion, equity, and equality of opportunity.” Id. at 94. Thus, in order to remain ethical, the second step must allow for benefit-coverage determinations that look towards the individual and not just the population base. Id. at 94–95.
20. Compassion requires that health benefits be “flexible, responsive to individual values and priorities, and attentive to those with critical needs and special vulnerabilities.” Id. at 95.
21. These three principles will be furthered examined and used when discussing essential health benefits, health exchanges, and the OPM-created qualified health plans. See infra Parts II–IV.
22. Wynia et al., supra note 2, at 90.
23. Id.
24. Id. (“All enrollees/beneficiaries should receive a statement explaining the goals of coverage, defining who is included in the covered population, and describing the process used and types of rationales that may be taken into account in making individual coverage decisions.”).
25. Id. at 91.
26. Id. at 91.
"discover alliances" between certain stakeholders who previously did not trust or communicate with each other. Yet, having all of the stakeholders properly represented could "[skew] those already empowered and can leave minority groups susceptible to the effects of majority rule, marginalizing those with significant but unpopular health concerns."28

Third, with consistency, the administration of health benefits should ethically result "in similar decisions under similar circumstances." Benefits administration should not be different due to "rigged, capricious, or otherwise discriminatory" actions.30 So, the coverage of benefits should be concise, clear, and easy to interpret. However, this consistency may "hinder progress" such that innovative, more expensive, and more efficient procedures are not utilized properly.31

An ethical framework for the administration of health benefits will increase quality management and improvement in the health-care system.32 Demonstrating as many of the above five principles as possible in the administration of benefits will lead towards a more ethical approach in health care. Granted, a "business case" can be made on fairness grounds alone by "promot[ing] customer satisfaction,” “reduc[ing] [the] risk of lawsuit,” and “retain[ing] plan members,” but cost and cost control must be considered in order to have a sustainable administration of benefits. The following section discusses the costs and economics of health benefits.

B. Economics

Economics, unlike ethics, is fairly definable: "[A] social science concerned chiefly with description and analysis of the production, distribution, and consumption of goods and services." Economically speaking the health-care system is unlike any other: "the health care product is ill-defined, the outcome of care is uncertain, large segments of the industry are dominated by nonprofit providers, and payments are made

27. Id.
28. Id. at 97.
29. Id. at 91.
30. Id.
31. Id.
32. Id. at 97.
33. See id. at 97–98.
34. Id. at 89.
by third parties such as the government and private insurers.\footnote{36} What makes the health-care system unique is the presence and combination of all these factors.\footnote{37} This section looks at the costs of health care, how they are paid for, and how they relate to health benefits; at the ways to control costs via benefits administration; and at economic self-interest.

In 2009, the United States health-care expenditures reached \$2.5 trillion, which is about 17.5% of the Gross National Product or \$8,086 per person.\footnote{38} These costs can be broken down into four major categories: professional services,\footnote{39} retail outlet of medical products,\footnote{40} government administration and net cost of private health insurance,\footnote{41} and hospital investments.\footnote{42} These costs, in turn, are paid for by numerous sources: private health insurance\footnote{43} pays for about 32% of the costs, Medicare pays about 20%, Medicaid pays about 15%, out-of-pocket expenses pays about 12%, and other insurance and third-party payers\footnote{44} pay about 21%.\footnote{45} Both

\begin{itemize}
\item 37. Id.
\item 40. Retail outlets of medical products include prescription drugs, durable medical equipment, and other non-durable medical equipment. NHE Web Tables, supra note 39.
\item 41. Government administration includes the costs of running the multiple federal and state program and any public health activities. Id. The net cost of private health insurance is the “difference between premiums earned by insurers and the claims of losses incurred for which insurers become liable.” Definitions, CTRS. MEDICAID & MEDICARE SERVS., at 4 (2009), http://www.cms.gov/NationalHealthExpendData/downloads/dsm-09.pdf. Combining both public and private expenses makes sense because policies and practices of the public sector affect the cost transfer to the private. Gary T. McIlroy, Health Care Cost Containment in the 1980s, 15 COMP. & BENEFITS REVIEW 15, 16 (1983).
\item 43. In looking at Private Health Insurance in 2009, \$802.1 billion was collected in premiums, which paid for \$712.2 in expenditures. NHE Web Tables, supra note 39. This leaves \$89 billion in “net cost,” which includes “administrative costs, . . . additions to reserves, rate credits and dividends, premium taxes, and plan profits and losses.” Definitions, supra note 41, at 24. While this number may seem like a lot, net cost is down 9.1% from 2008 (or about \$8.9 billion). NHE Web Tables, supra note 39.
\item 44. Some examples of the “others” category includes worker’s compensation, general assistance programs, Children’s Health Insurance Program, and other federal, state, and local programs. Id.
\end{itemize}
public and private health insurances, which pay for over two-thirds of the above costs, administer health benefits. Benefit package design and benefit administration are set up by different payment systems—fee for service, bundled or episode-based, capitated, salary based, and performance-based—that determines what benefits will be paid for or covered.\textsuperscript{46} The amount of what is being paid for is determined by the payment rate.\textsuperscript{47} Generally, payment rate is determined by negotiation in the private sector\textsuperscript{48} and by administration in the public sector.\textsuperscript{49} The relationship between private and public sector payment rates vary widely, especially in geographic terms.\textsuperscript{50}

Controlling costs through benefits administration occurs (1) through benefit package design in general and (2) through incentivizing prevention techniques.\textsuperscript{52}

\begin{itemize}
\item \textsuperscript{45} Id.
\item \textsuperscript{47} Id.
\item \textsuperscript{48} “Payment rates in the private sector are generally set by negotiation [between health plans and providers], reflecting the underlying costs of the services and the relative bargaining power of providers and health plans.” Id. The negotiations may either be explicit, face-to-face bargaining or tacit, where the insurer sets the rates to ensure an adequate pool to spread risk. \textit{Id}.
\item \textsuperscript{49} Government programs, such as Medicare: Generally pay[ ] doctors and hospitals a fixed amount per service or per admission. Although the scope of the payments differs substantially between those two payment systems, the mechanisms for setting payment rates have many similarities. In both cases, a base or average payment amount is multiplied by a factor that is designed to capture differences in the resources needed to provide various services or to treat different types of patients. The base payment amount is updated annually according to statutory formulas, but that update may be—and often is—modified by legislation. \textit{Id}.
\item \textsuperscript{50} Payment rates are generally split up into two sides: physician services and hospital payments. \textit{See id.} The private sector and some state-and-local public-sector insurance programs base their payment rate for physician services on a factor or multiplier of Medicare’s fee schedule. \textit{Id}. On average, Medicare’s payment rates are about 20 percent lower than private sector rates. \textit{Id}. Medicaid’s rates are “about 30 percent lower than Medicare’s rates.” \textit{Id}. (footnote omitted). Hospital care has similar results. \textit{Id}. (“Medicare’s average payment rates for inpatient care were about 30 percent lower than those of private insurers in 2006, and that the payments by Medicaid were about 5 percent lower than those of Medicare.”) (footnote omitted).
\item \textsuperscript{51} Geographically, “Medicare’s rates are established nationally and are adjusted to account for geographic variation in providers’ input costs.” \textit{Id}. Private sector insurers have more negotiating power and leverage where providers are more scarce i.e. rural areas and small cities. \textit{Id}. Private insurance plans pay “30 percent higher than Medicare’s rates in small metro-politan areas and rural areas, 10 percent higher in medium-sized metropolitan areas, and 1 percent higher in large metropolitan areas.” \textit{Id}. (footnote omitted). What makes this outcome exponentially worse is that the “higher spending on health care in certain geographical areas does not correspond to better health outcomes.” \textit{U.S. Health Care Costs, supra note 38}. Individuals are paying more money and receiving the same or worse level of care. Ethically, it’s inconsistent.
\item \textsuperscript{52} Outside the scope of this article are other ways to control costs such as investing in information technology, adjusting provider compensation, and altering tax credits for employer-insured plans. \textit{U.S. Health Care Costs, supra note 38}.
\end{itemize}
First, benefit package design can affect the administration benefits from either the consumer or supplier side. From the consumer side, employers prefer a design that has the ability to share and transfer cost with its employees. By increasing deductibles or implementing higher copayments, it indirectly decreases benefit utilization. If a service is not provided, no cost occurs.

A design, however, that tries to directly control utilization fails. Direct control involves only allowing a certain number of visits a year or rewarding the use of a different type of medical service (e.g., having outpatient surgery rather than inpatient surgery or having a surgery at an ambulatory surgical center rather than at a large, urban hospital). Direct programs fail because the costs for the cheaper second options "gradually rise" to traditional benefit programs. In addition, "[e]mployees do not know how to exercise [these options] adequately." As a patient/consumer, employees rely on the physician's/supplier's advice as to what type of service to use over the employee's financial best interests. Furthermore, the physician may have his or her own financial best interests in mind in either a direct or indirect benefit program. From the supplier side, decreasing the payment rate of a health services generally decreases the amount of service providing in hospitals, home health agencies, and skilled nursing facilities. Physician services have more of a mixed track record, with the majority of studies finding that the decrease in payment rate actually increased the amount of service provided.

Second, preventing illness saves money. A majority of illnesses result from people's health habits and are "controllable and preventable."
Having a benefit program that "identifies the current medical claims cost attributable to specific health habits" can help tailor an employer's wellness program to reduce specific costs. In addition, having a benefits program with financial incentives for prevention visits to the doctor and for workers who engage in a wellness program can help allay costs. A recent example of the benefits of prevention comes from the ACA: Medicare beneficiaries no longer have to pay anything out of pocket for many preventive services, such as mammograms, cancer screenings, smoking and tobacco use cessation counseling, and a new annual wellness visit. In the first two months of 2011, over 150,000 Medicare beneficiaries received a free annual wellness visit. Additionally, Health and Human Services predicts that premiums will now be lower for employers, state Medicaid, and Medigap insurances that previously filled this coverage gap in preventive services in Medicare.

The economic self-interest of these over 150,000 beneficiaries is pretty clear: Being provided a free supply with no cost. Consumers, in general, have a strong self-interest in both their health and their wallet. Market efficiency is achieved when insurers compete for customers based on price and quality of the health plan. Thus, a proper economic model "relies on well-informed consumers making value-based purchasing long periods of time.".

64. McIlroy, supra note 41, at 31
65. See HEALTHCARE.GOV, supra note 62. But see U.S. Health Care Costs, supra note 38 ("[I]t is unclear how much prevention programs will decrease costs, since paradoxically healthier people will likely live—and use the health system—longer.").
66. HEALTHCARE.GOV, supra note 62 ("Includes up to 8 face-to-face visits in a 12-month period but only if the beneficiary is diagnosed with an illness caused or complicated by tobacco use, or takes a medicine that is affected by tobacco.").
67. Id. ("During the annual wellness visit, doctors and beneficiaries can develop and/or update a personalized prevention plan that takes into account medical and family history, detection of any cognitive impairment, potential (risk factors) for depression, and review of the individual's functional ability and level of safety.").
68. Id.
70. HEALTHCARE.GOV, supra note 62.
72. Tai-Seale, supra note 71, at 171–72
decisions when choosing health insurance plans."73 When consumers are well-informed on their plans and other available plans, employees are "more likely to withdraw" from their current plan and switch to plans that better meet their needs.74 Favoring themselves over others, this movement causes adverse selection and the death spiral to some health plans.75

Additionally, insurance companies have their own self interest demonstrated by their contractual language of "medically necessary" procedures and their outright denial of benefits, such as custodial care benefits.76 Health-care providers have their own self-interest too, which can be seen by physicians increasing the rate of billing when benefit reimbursement goes down77 and trade associations' previous ability to manipulate coding language.78 This ability created a body of codes that did not "support evidence-based and consumer-driven benefit plan design, utilization, [or] clinical practice management[.]"79

C. The Gavrilo Princip of Death Panels

This section describes what happens when political punditry comes into play and hijacks morality, which, in turn, trumps both ethics and economics leaving proper benefit payments at the wayside by examining the dreaded "Death Panels" of the Affordable Care Act.

Originally a part of the ACA,80 "Advanced Care Planning Consultation"81 would financially incentivize physicians to voluntarily

73. Id. at 171.
74. Id. at 182 (This research article evaluated the amount of information received from OPM to federal employees regarding health plans. It measured the years 1994 and 1995.) These years matter because in 1995 OPM freely disseminated report cards to all employees as opposed to just benefit managers and some employees. Id. at 173. In relation to ethics, allowing a consumer ability to participate allows the consumer "to recognize and leave poor-quality organizations." Wynia, supra note 2.
75. See infra text accompany notes 217–24 for a description and application of adverse selection to the FEHBP.
77. CBO.GOV, supra note 46 ("An analysis of Medicare payments conducted by CBO in 2007 . . . found that physicians responded to recent reductions . . . by increasing the reported volume and intensity of the services they deliver. In particular, that study concluded that the response of physicians offsets about a quarter of the reduction in spending that would otherwise occur.") (emphasis added) (footnote omitted).
78. Synthia L. Molina, ABC Codes: An Essential Tool for Health Benefit Cost Management and Consumer-Driven Health Plans, 36 COMP. & BENEFITS REVIEW 71, 72 (2004). At one point "coding was largely overseen by medical and dental trade associations predisposed to restrict access and payment to competing practitioners[,]" such as chiropractors and acupuncturists. Id. The only data available "to support the financing, administration, and delivery of care [was] directed by physicians[.]" Health plans avoided offering these alternative medicine, nursing, and other integrative health care interventions." Id.
79. Id. at 73.
discuss end-of-life options with patients by creating a Medicare reimbursement code for a consultation. It would have involved explaining advance directives, living wills, durable power of attorney, health-care proxies, and the continuum of services offered at the end-of-life from full resuscitation to palliative care. The consultation code never made it to President Obama for his signature because it became “politically toxic and widely misunderstood as creating bureaucratically-administered government death panels.”

The powder keg of political punditry was filled by Betsy McCaughey on Fred Thompson’s radio show, Rush Limbaugh, John Boehner, and Virginia Foxx. On August 7, 2009, Republican nominee for Vice President, Sarah Palin, lit the fuse by posting a note on Facebook:

The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s “death panel” so his bureaucrats can decide, based on a subjective judgment of their “level of productivity in society,”

83. See generally H.R. 3200, §1233.
84. Perry, supra note 82, at 410-11.
85. On July 16, 2009, Ms. McCaughey, former lieutenant governor of New York, stated that the health care reform bill “would make it mandatory — absolutely require — that every five years people in Medicare have a required counseling session that will tell them how to end their life sooner.” McCaughey claims end-of-life counseling will be required for Medicare patients, POLITIFACT, July 23, 2009, http://www.politifact.com/truth-o-meter/statements/2009/jul/23/betsy-mccaughey/mccaughey-claims-end-life-counseling-will-be-req/ . Politifact gave Ms. McCaughey a “Pants on Fire” rating for her statement. Id.
86. On July 21, 2009, Rush Limbaugh stated:
Mandatory counseling for all seniors at a minimum of every five years, more often if the seasoned citizen is sick or in a nursing home. . . . That's an invasion of the right to privacy. We can't have counseling for mothers who are thinking of terminating their pregnancy, but we can go in there and counsel people about to die. I'm sure you could get some counselors from the Hemlock Society to go in and do this. Kevorkian might want to come back to life and handle this. End-of-life counselors, end-of-life treatment for senior citizens, mandatory.

whether they are worth of health care. Such a system is downright evil.89

Thirty percent of individuals polled about a week after that Palin’s statement thought that the new health-care reform included a provision for death panels.90 Forty-seven percent of the Republicans and forty-five percent of individuals who watched Fox News thought that the new reform included death panels.91 By mid-October the provision was dropped by House Democrats92 because “death panels” became “emotionally charged rhetoric” of “political posturing and moral sloganeering.”93 Additionally, the strong moral belief that “money should not matter when life and death are on the line” and that “any form of health care ‘rationing’ may convey a disrespect for human life” played a heavy role in the demise of the consultation code.94

This punditry left behind the ethics and economics of administration of health benefits. By allowing reimbursement to physicians for these end-of-life discussions, quality of life can be improved and costs can be lowered.

Ethically, end-of-life care can be invasive.95 Participation from the patient and communication between the patient and physician are important.96 Unfortunately, communication in the health-care system is undervalued and underfunded.97 When physicians and patients had end-of-life communications, the patients received more passive care (e.g., hospice

91. Id.
92. Perry, supra note 82, at 412.
93. Id. at 419, 421.
94. Id. at 425 (citations omitted).
95. Id.; Alexi I. Wright, et al., Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Analysis, 300 JAMA 1665, 1665 (2008); Baohui Zhang, et al., Health Care Costs in the Last Week of Life: Associations with End-of-Life Conversations, 169 ARCHIVES INTERNAL MED. 480, 480 (2009) (citing aggressive end-of-life procedure such as mechanical ventilator use and full-code resuscitation).
96. Perry, supra note 82, at 423–24; Wright et al., supra note 95, at 1670 (finding that patients who did not have end-of-life discussions with their physicians “received significantly more aggressive medical care . . . with worse patient quality at the end of life” and worse bereavement adjustment for caregivers); see also Wynia et al., supra note 2, at 91.
97. Perry, supra note 82, at 424. When Medicare beneficiaries were given a chance to have a free wellness consultation, over 150,000 beneficiaries participated in two months. HEALTHCARE.GOV, supra notes 65–70.
or respite care) and an increase in patient quality of life. Economically, end-of-life care is costly. Having end-of-life discussions decreases those end-of-life costs by thirty-five percent because the discussions lead to less invasive and less costly procedures. When you economically incentivize communication, ethical participation can occur between physicians and patients, and economic costs can be cut.

In the future, to avoid this type of hijacking of morality—especially when both ethics and economics coincide—politicians need to strike a balance on how individuals frame health care. Viewing health care as a market commodity is inconsistent with the efforts to use legislation and regulations to extend health care to all. Specifically, portraying death panels as a market commodity—i.e., as a cost-cutting measure—portrays the government as a harsh, disciplinarian punisher. Liberals needed to evoke values of cooperation and mutual aid, a morality of empathy for others and responsibility for oneself and others.

Overall, health insurance and the administration of benefits should be framed as providing "a mechanism for pooling our premium dollars so that health care will be available when we need it because no one has the private resources to fund a lifetime of health care on their own." Thus, "[c]reating and maintaining a first-class health care system requires us all to contribute, as we are able, to the costs of health care." This type of framing will appeal more to the Sarah Palins of the world because it identifies with a broader base of moral judgments, namely, loyalty and

98. Wright et al., supra note 95, at 1670.
99. Approximately five percent of Medicare patients die every year. A.E. Bamato et al., Trends in Inpatient Treatment Intensity Among Medicare Beneficiaries at the End of Life, 39 HEALTH SERVS. RESEARCH 363, 364 (2004). Moreover, in the final year of life, about a third of medical costs are expended in the last thirty days with seventy-eight percent of those costs relating to acute care. Ezekiel J. Emanuel et al., Managed Care, Hospice Use, Site of Death, and Medical Expenditures in the Last Year of Life 162 ARCHIVES INTERNAL MED. 1722, 1725 (2002).
100. Zhang, et al., supra note 95, at 482. In addition, those who had higher medical costs in the final week of life had more physical distress. Id. at 482, 484.
101. See generally Perry, supra note 82, at 421-25.
104. Watson, supra note 102; Reinhardt, supra note 103.
105. Id.
106. Id.
107. Id.
II. AFFORDABLE CARE ACT

ACA was passed in March of 2010 with both great fanfare and disgust. Of the over 1,000 pages of the Act, this section only discusses two parts: “essential health benefits” and “health insurance exchanges” with a focus on ethical and economic issues.

A. Essential Health Benefits

Section 1302 of the ACA requires that the state health insurance exchanges meet a baseline of “essential health benefits” found in a typical employer plan. The definition of essential health benefits is at the discretion of the Department of Health and Human Services, but broadly, it must have ten listed categories. These categories are a “fundamental change” in benefit coverage in the United States because the government has never “mandated such a comprehensive set of insurance benefits be included in insurance coverage.” Defining these categories will be one of the “most consequential” provisions and will have a “great[ ] impact on consumers.” It will also involve a balancing between ethics and economics.

113. Id.
115. See Aston, supra note 112 (quoting John Ball, MD, chair of the Institute of Medicine committee in charge of helping HHS define EHB: “Part of what we’re looking at is how do you bring appropriate balance to generosity [ethics] and affordability [economics].”).
1. Ethics

Ethically, participation and consistency are the most important principles. Participation is important for “all of the stakeholders of health reform.” Therefore, the process, i.e., notice and comment rulemaking, in defining essential health benefits must be “inclusive, transparent, and efficient.” Public comment should be meaningful in response to any proposed rule and should also include “open forums and public hearings.” Having a full, open process could help “avoid replacing the political maelstrom of Congress with an executive branch maelstrom.”

Consistency concerns exist because the definition of essential health benefits “does not specify the degree to which benefits must be uniform between the basic levels of coverage, or even within a basic level of coverage.” Potentially, individuals in the same circumstance could be treated in different ways. In addition, decisions will also need to made as to when to cover a “group’s need to have [a] new or traditionally noncovered procedures paid for by insurance.”

2. Economics

Economically, self-interest is playing a large role in defining the scope of “essential health benefits” for consumers, health-care providers, and employers. Consumers want the most coverage and the cheapest price, but covering rare procedures that have high costs will not meet the “majority’s need to keep premiums affordable.”

Medical associations, such as the American Academy of Pediatrics and the American Society of Plastic Surgery, testified at hearings that essential health benefits should cover their procedures. These specific

117. Id.; Transparency is also one of the Ethical Force Programs’ principles. Supra notes 22-24 & accompany text.
118. Snyder, Nix & Yeung, supra note 5, at 2.
119. Id.
120. Oechsner & Schaler-Haynes, supra note 114, at 290; see, e.g., Rachel L. Garfield et al., Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services, 61 PSYCHIATRIC SERVS. 1081, 1084 (2010) (“If behavioral health benefits available under qualified health plans are set at those currently available in typical private plans, some services needed by individuals with mental disorders . . . will be excluded from coverage.”).
121. For example, two people are enrolled into two different health plans that have the same actuarial value. One plan may offer a longer period of coverage for an inpatient stay, but in order to maintain the same actuarial value offer less prescription drug coverage. Thus, if both people are prescribed the same drug, one person would get better coverage than the other.
122. Aston, supra note 112.
123. Id.
124. Id.
medical associations want a strict, bright-line definition of essential health benefits, while the American Medical Association recommends that "HHS strike a balance." by using a current example: the Federal Employees Health Benefits Program. Although FEHBP does not have a standard or minimum benefit package, the plan does "cover[s] hospital, physician, medical and surgical care." Moreover, health plans under the FEHBP have to cover childhood immunizations, mental-health services, and must use "evidence-based guidelines for preventive care." Employers and health insurance companies are worried about providing too many benefits because it will cost more for enrollees, and according to the ACA, once an individual’s insurance cost exceeds eight percent of their gross income, the individual mandate no longer applies. Thus, individuals are priced out of the requirement to have insurance, which defeats a primary purpose of the ACA: covering the over thirty-two million uninsured.

In order to promote both ethics and economics, the definition of essential health benefits must have an assortment of health plan options with an array of benefits and cost-sharing levels that allow for adequate consumer choice. This solution addresses ethical concerns by allowing for consumer choice amongst an array of provided benefits. The array is especially important because the definition of essential health benefits is only one part of a package design of benefits: enumerated benefits. A key component of enumerated benefits—medical necessity—is still, at this point, determined by the health plan. Thus, an array of benefits is

125. The AMA is not really striking much of a balance because the FEHBP is an employer-sponsored health-insurance program; thus, this balance tips in favor of the employers and health insurance companies. For more on the drawbacks of the FEHBP, see infra notes 209–27 & accompanying text.
126. Aston, supra note 112.
127. Id. (quoting Gerald E. Harmon, MD., a member of the AMA Council of Medical Service).
128. Id.
129. Id. ("The big issue that came out is the more generous you make the benefits, the more expensive it will be, and if it's mere expensive, perhaps access to insurance will be less," said John Ball, MD, chair of the IOM committee.); Id. ("It would be a mistake to curtail flexibility for the consumer and employers by requiring all plans to cover a soup-to-nuts benefit package when many employers and consumers prefer a more bare-bones plan and the moderate price it affords.") (quoting Jerry Malooly, Director of Benefit Programs and Health Policy for the Indiana Personnel Dept., on behalf of the U.S. Chamber of Commerce).
130. Patient Protection and Affordable Care Act, § 5000A(e)(1)(A), Pub. L. No. 111-148, 124 Stat. 119 (2010). The individual mandate requires most individuals who are not on a public insurance program to either have private health insurance of pay a penalty. Id. § 1501.
132. Aston, supra note 112.
133. Snyder, Nix & Yeung, supra note 3, at 5.
134. Ann essential health benefit may still be denied if not medically necessary. Aston, supra note 112.
necessary because an inflexible definition will lead to consistency issues. The solution addresses economic concerns by allowing for cost-sharing and an assortment of health plans. This permits insurers to spread risk amongst plans, which helps keep both premiums and costs down.  

**B. Health Insurance Exchanges**

All health plans that are part of the health insurance exchanges must meet the definition of essential health benefits. The section explores these exchanges. Section 1311 of the ACA requires that each state establish an “American Health Benefit Exchange” and a “Small Business Health Options Program Exchange” to facilitate the purchase of “qualified health plans” by eligible individuals and small businesses. In other words, the exchanges are “web-based clearinghouses that will allow eligible consumers to shop for and purchase ‘qualified health plans’ from private and no-profit insurers.” Section 1311 also lays out the many requirements and functions that an exchange must meet to qualify.

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135. Id.; see also Snyder, Nix & Yeung, supra note 5, at 3. Moreover, health plans still must design enumerated exclusions and coverage determinations. Id.

136. A “Qualified Health Plan” is a health plan that meets criteria for certification by HHS, provides essential health benefits, and is offered by an insurer that is “licensed and in good standing,” offers a health plan at the silver and at the gold level, “charges the same premium rate for each qualified health plan,” and generally complies with all regulations. Patient Protection and Affordable Care Act, § 1301, Pub. L. No. 111-148, 124 Stat. 119 (2010).

137. The requirements include offering qualified health plans, additional rules for any benefits beyond essential health benefits offered, functions, limitations on funding, consultation with stakeholders, and publication of costs. Patient Protection and Affordable Care Act, § 1311(d).

138. The functions include: Certification, recertification and decertification of plans; [c]ertification of individuals exempt from the individual responsibility requirement; [p]resentation of information on certain individuals and to employers; and [e]stablishment of a Navigator program that provides grants to entities assisting consumers.
This section explores the ethics and economics of the exchanges.

1. Ethics

Ethically, the health insurance exchanges reflect the ethical principles of consistency, participation, and transparency. First, consistency is reflected in these Exchanges because, overall, the exchanges provide the opportunity that all Americans are treated in the same manner in regards to receiving health care especially employers who have economically poor employees. They help overcome “nonfinancial barriers” in getting benefits coverage by not allowing state insurance laws to exclude “individuals with preexisting conditions or high medical costs.” Second, participation is one of the requirements that exchanges must have in order to be qualified. The statute requires an exchange to “consult with stakeholders.” The requirement of “advocates for enrolling hard to reach populations” is important because this specific stakeholder can help counter the skewing of decisions to the majority of beneficiaries.

Third, the exchanges are also on the right track as far as the ethical principle of transparency. The exchanges are required to publish their administrative costs (e.g., licensing and regulatory fees) and their losses due to waste, fraud, and abuse. Additionally, the publication must be

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141. See generally supra Part I.a.
142. Health Insurance Exchange: Implementation and Data Considerations for States and Existing Models for Comparison, ROBERT WOOD JOHNSON FOUND. 1 (2010) (stating that the exchanges help achieve the goal of “increasing access to and facilitating the purchase of affordable health insurance”).
143. More Money, Fewer Problems, AM. MED. NEWS, Apr. 4, 2009, http://www.ama-assn.org/amednews/2009/04/06/gvcaO4O6.htm (“It is much easier for wealthier Americans to get employer-sponsored health insurance. . . . [O]nly 69% of workers earning less than 400% of the federal poverty level are offered coverage through their employer, while 93% of those at 400% or more are.”) (citing U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-09-252, STATE CHILDREN’S HEALTH INSURANCE PROGRAM: CMS SHOULD IMPROVE EFFORTS TO ACCESS WHETHER SCHIP IS SUBSTITUTING FOR PRIVATE INSURANCE (2009)).
146. Id. The list of required stakeholders include individuals who are enrolled in qualified health plans, individuals and entities who are experienced in “facilitating enrollment in qualified health plans[,]” “representatives of small businesses and self-employed individuals; State Medicaid offices; and advocates for enrolling hard to reach populations.” Id.
147. Wynia et al., supra note 2, at 97; Merlis, supra note 144.
148. Id. at 90.
149. Patient Protection and Affordable Care Act, § 1311(d)(7).
online and must “educate consumers on such costs.” The cost reporting, however, does not include coverage decisions or how new services should be covered. In other words, it does not address the ethical concerns regarding benefit administration.

2. Economics

The biggest potential benefit from economics is its ability to “facilitate[e] comparison shopping for coverage” and “to create an organized and fair market to attract and retain customers.” Moreover, the exchanges will “increase flexibility, portability, and transparency, and lower cost by enhancing competition” which will “lower costs for consumers.”

The exchanges will lower costs for all the stakeholders by increasing competition among insurers through comparison shopping and informed consumers, and by providing leverage to small businesses through the pooling of individuals. The Congressional Budget Office estimates that the exchanges will lower administrative overhead by four to five percent. In addition to lowering administrative costs, premiums have been estimated to decrease by $2,000 per family by 2019 and employer-based insurance could see a decrease of $3,000 per employee by 2019. Specifically, if all of the provisions of the ACA were implemented in 2010, small businesses (i.e., less than 100 employees) would see an overall decrease of $9.3 billion in employer costs for health insurance.

150. Id.; see also Timothy S. Jost, Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues, THE COMMONWEALTH FUND, at 7, (Sept. 2010), http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_healthins_exchanges_ACA_eight_difficult_issues_v2.pdf (“Exchanges should develop rating systems that permit accurate comparison of the value of competing health plans, and satisfaction-survey programs that pay particular attention to the opinions of plan members who have serious health problems or financial problems related to their health needs.”).
151. Wynia, supra note 2, at 90.
152. Health Insurance Exchange, supra note 142.
153. Id.
156. Karen Davis et al., Starting on the Path to a High Performance Health System: Analysis of the Payment and System Reform Provisions in the Patient Protection and Affordable Care Act of 2011, at ix (2010). Administrative costs make up about 6.6% of the total expenditures in the United States’ health-care system. NHE Web Tables, supra note 39.
157. Davis, supra note 156, at 35.
158. Id. (internal citations omitted).
159. Employer costs includes premium contribution, employer subsidies, assessments, and vouchers. Bowen Garrett & Matthew Buettgens, Employer-Sponsored Insurance Under Health Reform: Reports of Its
Exchanges will lower costs, but self-interest will always loom.

Insurers, in their own economic self-interest, may "compete on their ability to select the healthiest enrollees, rather than on efficiency or quality" in a process called "cream-skimming." Exchanges also put insurers into "direct head-to-head competition for [a] standardized product[,]" giving consumers the ability to switch to a "different health plan during every open enrollment period." Not many insurers would like to be in this situation. In addition, insurers are already selling on an individual market with their economies of scale already in place. Thus, adding health plans for the exchanges will have high administrative and marketing costs. Furthermore, insurance agents make money off of commissions and may refuse to promote Exchanges or direct clients to a plan on the individual market to increase their own fees.

The ACA does not include a public option in the exchanges. It does, however, require the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits Program (FEHBP), to contract with private insurers to offer at least two multi-state plans in each exchange, including at least one offered by a non-profit entity.

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Demise are Premature, ROBERT WOOD JOHNSON FOUND., Jan. 2011, at 4, http://www.urban.org/uploadedpdf/4122295-Employer-Sponsored-Insurance.pdf Assessments, under the ACA, occur when "workers independently buy[ ] subsidized insurance through nongroup exchanges." Id. at 1. These assessments would hit medium firms, those that have 100 to 1,000 employees, especially hard, with costs actually increasing. Id. at 3.

160. Id. at 4. The decrease is "largely due to the introduction of health insurance exchanges for [small-business] employers." Id.

161. Merlis, supra note 144; see also Wicks et al., Barriers to Small-Group Purchasing Cooperatives, ECON. & SOC. RES. INST., at 10 (2000) ("Health plans particularly do not like [health exchanges]' employee-choice feature because they do not get the whole group, with its range of high- and low-risk individuals, they fear they will get just the less healthy individuals.").

162. Cream-skimming occurs when insurers are "able to 'rig' the incentive structure so as to encourage selectively the patronage of certain kinds of 'desirable' insureds (e.g., the healthiest or lowest risks)." Peter Siegelman, Adverse Selection in Insurance Markets: An Exaggerated Threat, 113 YALE L.J. 1223, 1253 (2004).

163. Wicks et al., supra note 161.


165. Id. (stating that health plans are hostile to these types of arrangements because it "gives their customers bargaining clout"); Wicks et al., supra note 161.

166. See Wicks et al., supra note 161; Wicks, supra note 164, at 2, 4 (discussing how private insurers prefer to get and retain an entire employee group outside the exchange).

167. Merlis, supra note 144. Plans will incur extra costs because "they have to change their administrative systems to accommodate the administrative structure of the [exchange]." Wicks, supra note 161.

168. See Wicks et al., supra note 161, at 11 (discussing the downfall of state Exchanges being due in part to "indifferent or hostile" insurance agents).

III. FEHBP

This section explores the FEHBP including its history, its constant flirtation with health care reform, and its positives and negatives.

A. Background

The FEHBP is the largest employer-sponsored health-insurance program in the world. It covers over nine million individuals including “[f]ederal employees, retirees, former employees, family members, and former spouses.” The Program was created by Public Law 86-382, which was enacted on September 28, 1959, and currently, is governed by chapter 89 of title 5 of the United States Code. The statute allows the OPM to promulgate any regulations necessary to carry out the Act. These regulations are found in two places in the Code of Federal Regulations: part 890 of title 5 and chapter 16 of title 48. The FEHBP has over 90 health plans with two types of enrollment: Self Only and Self and Family. Federal employees can change their health plan during the “open season,” which occurs annually during the later part of the calendar year.

In short, OPM negotiates and enters into contracts with various private health insurance carriers (e.g., Blue Cross and Blue Shield) including Health Maintenance Organizations (HMOs) to provide coverage of health benefits. Then, federal employees get to choose which health plan best suites them and/or their family. This choice depends on the cost

170. OFFICE OF PERSONNEL MGMT., FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM HANDBOOK 1 (2010).
171. Id.
173. OFFICE OF PERSONNEL MGMT., supra note 170; see also 5 U.S.C. §§ 8901–8914.
174. 5 U.S.C. § 8913. The statute and regulations gives OPM “enormous discretion” to run the FEHBP with the “power to negotiate benefits packages and premiums annually with plans” and “suggest ways for plans to contain costs as the craft their proposals and premium requirements.” Madhu Chugh, Executive Authority to Reform Health: Options and Limitations, O'NEILL INST. PAPERS, at 14, n.102 (2009), http://scholarship.law.georgetown.edu/ois_papers/22.
176. For comparisons sake, back in September 1967, CSC/OPM offered thirty-six plans to more than seven million individuals. Louis S. Reed, Medicare and Federal Employees Health Benefits Programs: Their Coordination from Social Security Bulletin, 31 SOC. SECURITY BULL. 1, 4 (Sept. 1968), available at http://www.ssa.gov/policy/docs/ssb/v31n9/v31n9p3.pdf. In addition, premium rates were capped at $3.64 per month for single-only and $8.88 for self-and-family coverage. Id.
177. OFFICE OF PERSONNEL MGMT., supra note 170, at 3.
178. Id.
of premiums, coverage of certain benefits or prescription drugs, what doctors are in-network, etc. Each insurance carrier charges a different premium amount, and payment of this premium is split in between the government, who generally covers around seventy-five percent, and the employee, who covers the rest. OPM withholds approximately four percent of all premiums paid. This amount serves the purpose of being a reserve that can be used for a variety of purposes: to "offset a plan’s losses [when] medical claims spending exceeds projections," "to reduce an otherwise unusually large annual increase," or to "avoid benefits [from being] cut."

In regards to the administration of health benefits, OPM and carriers negotiate in a bilateral process, which is equivalent to private sector negotiation. Both must approve the final contract, which includes agreeing upon what benefits are covered. Additionally, OPM and carriers prepare a brochure that is "intended to be a complete statement of benefits available to the enrollee, including the plan’s benefits, limitations, and exclusions." The benefit packages vary due to being developed by

179. Premiums are established either by experience rating or community rating. Mark Merlis, The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform, KAISER FAMILY FOUND., 5 (2003) [hereinafter Merlis KFF]. The premium rate for experience rating is "based on the individual plan’s projected costs for serving FEHBP enrollees in the coming year[ ] plus a ‘service charge’ . . . from .5 percent to 1 percent." Id; see also Merlis, supra note 144, at 6. This projection is based off of "past cost experience" and takes into effect "inflation, benefit changes, and other factors expected to affect costs." Merlis KFF, supra. On the other hand, the premium rate for community rating is based off the two HMOs whose “enrollment is closest in size to the plan’s FEHBP enrollment.” The community rate is “then adjusted for expected use of medical resources of the FEHBP group.” Id. at 5 (internal quotations omitted); see also Merlis, supra note 144, at 6. “Prices across FEHBP plans are driven by the mix of enrollees attracted, the precise benefits and provider networks offered, cost-sharing requirement, and other provisions. Between premiums and cost sharing, enrollee costs can be substantial.” Randall R. Bovbjerg, Lessons for Health Reform From the Federal Employees Health Benefits Programs, ROBERT WOOD JOHNSON FOUND. 2 (2009). In general, a “plan’s premium negatively affects satisfaction” among federal employees. Tai-Seale, supra note 71, at 179.

180. OFFICE OF PERSONNEL MGMT., supra note 170, at 3, 10. This premium split is called the “Fair Share” formula:

For most employees and annuitants, the Government contribution equals the lesser of: (1) 72 % of amounts OPM determines are program-wide weighted average of premiums in effect each year, for self only and for self and family enrollments, respectively, or (2) 75 % of the total premium for the particular plan an enrollee selects. Id. at 10.

181. Bovbjerg, supra note 179; Merlis, supra note 144, at 6.

182. Bovbjerg, supra note 179.

183. Id.

184. Merlis, supra note 1449, at 6.

185. OFFICE OF PERSONNEL MGMT., supra note 170, at 3.

186. See supra note 48 & accompanying text.

187. OFFICE OF PERSONNEL MGMT., supra note 170, at 3.

188. Id. at 3-4.
the carriers who are "each seeking to attract enrollees."\textsuperscript{189} Still, OPM requires a baseline of services for all plans,\textsuperscript{190} it requires particular benefits, and has "eliminated plans [which] provided substandard coverage."\textsuperscript{191} Furthermore, any health plan that is a part of the FEHBP cannot have any waiting periods or exclusions for preexisting conditions.\textsuperscript{192}

Overall, FEHBP has been seen as "successful," with the ability to modernize benefit design while curbing premium increases.\textsuperscript{193} This section explores why the FEHBP is a success, why this success makes politicians constantly flirt with the FEHBP as a solution to all health care’s problems, and why the FEHBP may not be quite the success as perceived. In addition, this section examines the future OPM plans in the health insurance exchanges, the positives, the previous state exchange failures, and how to overcome these failures in the new exchanges.

B. Successful and Flirtatious

FEHBP is seen as a success because of its ability to spread risk over a large population of individuals\textsuperscript{194} without having its premiums risk-adjusted.\textsuperscript{195} Insurers who participate in the FEHBP "can’t turn anyone down,"\textsuperscript{196} have to "structure benefit packages with extreme precision to attract the widest possible mix of ages and conditions,"\textsuperscript{197} and are "limited in how much profit they can make under the program."\textsuperscript{198} Federal employees receive good benefits with a wide choice of plans.\textsuperscript{199} They do

\textsuperscript{189} Bovbjerg, supra note 179; see also Chugh, supra note 174. FEHBP’s benefits must include “both for costs associated with care in a general hospital and for other health services of a catastrophic nature.” 5 U.S.C. § 8904(a) (2011).
\textsuperscript{190} Chugh, supra note 1749.
\textsuperscript{191} Merlis, supra note 144, at 16.
\textsuperscript{192} Bovbjerg, supra note 179.
\textsuperscript{195} Merlis KFF, supra note 179, at 6. Premiums are not risk-adjusted when “the premiums paid to a plan do not vary by enrollee characteristics, such as age, sex, or health risk.” Id. The national plans meet the Ethical Force Program’s definition of consistency because they “do not vary according to where an enrollee is located either.” Id.
\textsuperscript{197} Murray, supra note 196.
\textsuperscript{198} Abelson, supra note 194. “[A]nything above those amounts is put in reserves used to keep average premium increases lower than they would otherwise be.” Id.
\textsuperscript{199} Bovbjerg, supra note 179, at 1.
not have to fear being rejected or treated differently based on their health status or age.\textsuperscript{200} Furthermore, these plans are portable to any federal job and into retirement.\textsuperscript{201}

FEHBP is also a success because OPM has great negotiating power.\textsuperscript{202} In addition, OPM, with over fifty years of experience, consists of subject-matter experts in the field with the ability to manage excess costs, to insure control over each carrier, and to identify problems.\textsuperscript{203} Furthermore, the statutes and regulations that administer the FEHBP are more generous than other insurance laws, including preemption from state benefit rules.\textsuperscript{204} Taken as a whole, the FEHBP transforms the health-care system into a consumer’s market and “promotes consumer-friendly competition,”\textsuperscript{205} neither of which are seen in the health-care market.\textsuperscript{206}

Because of this success, politicians have flirted with the FEHBP as the solution to the United States’ health-care problems and as the minimum benefit package every American should have\textsuperscript{207} because it has appealing characteristics to both parties. “Conservatives like the program’s reliance on private health plans and market competition. Liberals like the prospect of expanding to everyone the FEHBP’s large-
employer-style benefits, community rating, and close oversight of insurer pricing.

C. Or is It Successful?

To start off, the FEHBP has been misperceived. The general impression of the FEHBP as such a generous system with great benefits is "colored by years of news about presidential and congressional care at military hospitals or the Congressional health clinic." This care received by these politicians is not paid for by the FEHBP; it is separately funded. Furthermore, the FEHBP does not have any public purchasing power; "[i]t simply helps enrollees buy private insurance and is thus quite different from public coverage."

The benefits provided by the FEHBP fall short of "large private plans in actuarial value." Also, in comparing premiums, FEHBP enrollees often have a higher share than employees of large private plans. This higher premium amount can be seen by the 100,000 federal workers, about five percent of the active workforce, who do not have a FEHBP plan

208. Bovbjerg, supra note 179. Even if the FEHBP was implemented on an open, national market, it still would not address the nation's runaway medical costs. Abelson, supra note 194. In addition, the Program would "play such a big role in the insurance market" that it would "become less flexible and require greater regulation than it does now." Id.; see also Murray, supra note 196.

209. See infra text accompanying notes 210-227.

210. Bovbjerg, supra note 179, at 5.

211. Id.; Phil Scott, What Kinds of Benefits Does Really Get?, AARP BULL., Dec. 15, 2010, http://www.aarp.org/work/employee-benefits/info-12-2010/benefits_what_does_congress_really_get.html ("For an annual payment of $503, members can receive routine care from the Office of the Attending Physician, which has facilities in the Capitol . . . and include[s] physicals and other examinations, on-site X-rays and lab work, physical therapy and referrals to medical specialists. In addition, current members (but not their dependents) can receive medical and emergency dental care at military hospitals and clinics. Inpatient care is covered by FEHBP insurance, but outpatient care is free if it's performed at facilities in the national capital region, such as Bethesda Naval Hospital in Maryland or Walter Reed Army Medical Center in the District of Columbia.").

212. Bovbjerg, supra note 179, at 6 (italics omitted). Thus, the enrollees of the FEHBP run into the same issues any other enrollee of a private health insurance plan; for example, the denial of benefits because services are not covered or the services do not meet contractual definitions. Burgin v. OPM, 120 F.3d 494 (4th Cir. 1997) (exclusion in the Plan for "'custodial care, rest cures, domiciliary or convalescent care.'); Colicchio v. OPM, 2011 U.S. Dist. LEXIS 10918 (D. Md. Feb. 3, 2011) (denying allograft surgery for not being medically necessary); Murray, supra note 196 ("Rep. Jim McDermott, Washington State, had a friend whose wife had cancer and the recommended treatment wasn't covered under his friends plan for the policy in the region, but 'it was covered in other parts of the country.'").

213. Bovbjerg, supra note 179, at 3. Benefit levels do "exceed those of most small employer groups or individuals buying on their own." Id. Actuarial value is "the percentage of the total covered expenses that the plan would, on average, cover. For example, a plan with a 70% actuarial value means that consumers would on average pay 30% of the cost of health care expenses through features like deductibles and coinsurance." Frequently Asked Questions, KAISER FAMILY FOUND., http://healthreform.kff.org/SubsidyCalculator/Faq.aspx (last visited June 5, 2011).

214. Bovbjerg, supra note 179, at 3.
because even the cheapest option is still not affordable. Moreover, the federal health benefits "have evolved to serve a population that is older and has substantially higher incomes than the uninsured."

The main drawback of the FEHBP is adverse selection. Adverse selection describes the process by which enrollees "utilize private knowledge of their own riskiness when deciding to buy or forgo insurance." The economic self-interest of each individual trumps the ethical principle of consistency and creates not so similar decisions in similar circumstances. For example, if an enrollee knows that they are going to have knee surgery next year, during FEHBP’s open season, that individual would choose a health plan that offers better coverage for that surgery and the corresponding physical therapy. Theoretically, as these and other individuals leave a health plan, the quality of enrollees falls, prices rise, and the dreaded “death spiral” occurs where no one is covered. This process has occurred with some of the FEHBP’s health plans. For example, in the 1980s, a significant amount of enrollees all went to the Blue Cross High Option, which provided the best coverage for mental health services, from the Blue Cross Standard Option. Blue

216. Bovbjerg, supra note 179, at 6.
218. Wynia, supra note 2, at 90.
219. See Bovbjerg, supra note 179, at 4 ("Under any multiple-choice system, one or more plans may disproportionately attract people who are older or sicker than average—for example, by offering easier access to specialists or other difference in benefits. Then such a plan must charge above-average premiums, which in turn encourages people whose premiums are not below average to leave, thus raising premiums for the remaining people, which drives away yet more people.").
220. Siegelman, supra note 162, at 1223–24; Bovbjerg, supra note 179, at 4 (discussing how adverse selection “make[s] the plan unsustainable, whether or not it provides better or more efficient care, given the particular mix of health risks within its enrolled population”); Merlis, supra note 144, at 11 (“In time, the exchange could fall into a ‘death spiral,’ serving a dwindling pool of high-risk enrollees with very high premium rates.”).
221. Norman Carleton, A Note on the Federal Employees Health Benefits Program – A Model for Medicare?, WASH. OUTSIDE (Apr. 19, 2011, 11:18 AM), http://washingtonoutside.blogspot.com/2011/04/note-on-federal-employee-health-benefit.html (“In the 1980s, Blue Cross offered a high and low option plan under the FEHBP. Over time, the risk profile of the group covered by the high option plan became much worse than those in the low option plan. Blue Cross had to increase the premiums for the high option plan rather dramatically at times because of this. The increase in premiums caused a further migration from the high to the low option plan, thus exacerbating the difference in the risk characteristics of the two populations. Eventually, the risk profile of the high option plan became so bad and costs escalated so much that Blue Cross dropped it.”); Stuart M. Butler & Robert E. Moffit, The FEHBP as a Model for a New Medicare Program, 14 HEALTH AFF. 47, 51 (1995) (describing adverse selection as being an “irritant” to the FEHBP).
222. NORTHROP GRUMMAN INFORMATION TECHNOLOGY, INC. ET AL., supra note 217 ("For example, in
Cross dropped the option and enrollees incurred a distorted premium contribution. However, enrollees in the FEHBP will receive coverage on a different plan.

Another interesting characteristic of the FEHBP is how the large population of individuals covered by the FEHBP is divided into different tranches of risk; i.e., "separate risk pools, with different characteristics." While not necessarily a negative, it can create disproportionate amount in premiums with the "young choosing cheap HMO's [and] the older individuals choosing more expensive plans to provide better benefits." If there is enough migration from one tranche to another, it can cause one or more plans to become too expensive to maintain.

IV. THE OPM PLANS

If these issues exist now, how should the OPM plans for the Exchanges address these concerns and what can be learned from other state exchange failures? This section explores these issues, addresses other issues, and makes recommendations going forward.

Section 1334 of the ACA requires that OPM create at least two multi-state qualified health plans for each Exchange. The health plans must be administered "in a manner similar to the manner in which the Director [of OPM] implements the contracting provisions with respect to carriers under the early 1980s, the use of mental health services was two to three times higher in the FEHB Program's Blue Cross High Option plan than its standard option, even though only minor differences existed in the actuarial value of benefits in the two options." (internal citations omitted); Roger Feldman, Brian Dowd & Robert Coulam, The Federal Employee Health Benefits Plan: Implications on Medicare Reform, 36 INQUIRY 188, 188 (1999) ("[T]he FEHBP has experienced some selection problems, but not enough to prevent it from offering a wide variety of choices without standardized benefits or direct risk adjustment.").

223. Merlis, supra note 144, at 17.
224. See Butler & Moffit, supra note 221 ("[Adverse selection] has not undermined the program. Indeed, after exhaustive analysis of the strengths and weaknesses of the FEHBP, the Congressional Research Service (CSR) concluded that the program is structurally sound. According to the CRS, 'That FEHBP has continued to "work" over the years, despite major changes in the environment in which it has operated, reflects on the soundness of its basic design.' ") (internal citations omitted); Roger Feldman, Brian Dowd & Robert Coulam, The Federal Employee Health Benefits Plan: Implications on Medicare Reform, 36 INQUIRY 188, 188 (1999) ("[T]he FEHBP has experienced some selection problems, but not enough to prevent it from offering a wide variety of choices without standardized benefits or direct risk adjustment.").
225. Carleton, supra note 221; see also Mark A. Hall, Risk Adjustment Under the Affordable Care Act: A Guide for Federal and State Regulators, COMMONWEALTH FUND, at 5 (2011) ("Uneven risk distribution can happen randomly, through natural consumer preferences, or via strategic insurer behavior.").
226. Carleton, supra note 221.
227. See Siegelman, supra note 162, at 1257. Professor Siegelman discusses Harvard University's health plans, where due to a contribution change to the health plans, "younger, lower-risk employees" switched to HMOs over to a Preferred Provider Organization (PPO). Id. The enrollment for the PPO fell by seventy-five percent in three years and premiums increased fivefold. Id. The PPO had to be "withdrawn altogether." Id. With the FEHBP, an inverse to the Harvard situation happened with HMOs in the late 1990s. Murray, supra note 196. HMOs where priced out by fee-for-service plans with more than 100 programs leaving. Id.
Additionally, the benefit package for any plan in these exchanges must be "uniform in each State and consists of the essential [health] benefits." Ethically, these OPM plans meet the general consistency and participation goals that are required of essential health benefits. Economically, the OPM plans will have the general benefits of being a part of an Exchange. This section examines the additional positive impact these plans have on the economics of the administration of health benefits; discusses the potential problems these plans face both ethically and economically; briefly explores past state exchange failures and what can be learned from them; and makes recommendations as to how to handle some of the bigger issues.

A. Positives

Economically, the OPM plans will help lower administrative costs to individuals and employers. Small businesses do not have to pay the start-up costs of having an enrollment program. The economy of scale involved in implementing a benefit administration program is greatly reduced because these exchanges and OPM's FEHBP already has electronic documentation. In addition, the start-up costs of the enrollment process, of communicating with carriers, and with managing the benefits billing process will be reduced because OPM will be administering these qualified health plans.

With over fifty years experience, OPM already has subject-matter experience built into its health plans. Thus, the OPM plans will already have this experience so issues such as "needing to improve the current way of monitoring the evidence of insurability process, over-age dependents, domestic partner requirements" are already handled or resolved before an individual or small business employee participates in the exchange. Employers do not have to have an "active role in managing costs and services," including the "management of medical benefit financing" and

229. Id. § 1334(a)(4)
230. Id. § 1334(c)(1)(a)
231. Supra notes 116–21 & accompanying text.
232. Supra notes 152–68 & accompanying text.
233. See Valerie Gieseke, Key Considerations in Automating health and Welfare Benefits Administration, 37 COMPENSATION & BENEFITS REV. 56, 57 (2005).
234. See id. at 57–58.
235. See supra note 203 & accompanying text.
236. Gieseke, supra note 233, at 58.
the "negotiation with providers to eliminate excess costs and services[.]"  

B. Problems

A potential ethical problem involves the distribution of information to, and the counseling of, individuals and small businesses about the OPM plans. Although OPM administers the FEHBP, each specific agency has the "responsibility to provide health insurance information and counseling to its employees[,]" i.e., transparency. In addition, any employee question about the FEHB has to be directed to an agency-specific benefits officer, i.e., participation. Additionally, agency specific responsibilities include "develop[ing] contacts with carrier representative to assist their employees," providing information to employees about their "rights and responsibilities," determining eligibility of employees and family members, and processing health benefits actions. Furthermore, each employing agency has, as a part of their agency budget, costs for these personnel operations. In other words, OPM pays the start-up costs, while each agency pays the administrative managing costs.

With the OPM plans, who is going to take on the specific agency responsibilities? The individual themselves or the employer will have to take on this responsibility to provide transparent coverage and an ability to participate. Employers will have to "communicat[e] techniques and incentives to educate employees to choose quality cost-effective providers, to understand the medical cost consequences of their lifestyles, and to position cost sharing in a positive framework." Furthermore, decentralized organizations, like some small-businesses (as compared to the federal government), "often struggle with timely and accurate termination reporting" and can have difficulty with employees who

237. See McIlroy, supra note 41, at 17.
238. OFFICE OF PERSONNEL MGMT., supra note 170, at 6.
239. See supra text accompanying notes 22–24.
240. OFFICE OF PERSONNEL MGMT., supra note 170, at 8.
242. OFFICE OF PERSONNEL MGMT., supra note 170, at 6-7. Other responsibilities include "processing new enrollments and enrollment changes and collecting and transmitting employee and employer premium contributions." Merlis, supra note 144, at 7.
243. Id.
244. This statement assumes that OPM will not be taking on these additional responsibilities like the state of Connecticut has with their small-business exchange. Health Insurance Exchange, supra note 142, at 4 ("The Connecticut Business and Industry Association's Health Connections Exchange reduces the administrative burden for small employers by offering them full-service human resources services, which has been particularly successful in the less than 25 employee small group market.").
245. McIlroy, supra note 41, at 17.
246. Gieseke, supra note 233, at 58.
don’t complete the forms properly, on time, or both.”

Thus, although OPM will defray the start-up costs of administering a health plan, small-business employers and individuals will have to incur the day-to-day administrative costs.

Economically, many individuals point to the exchanges, and in effect the health plans offered, as having the ability to lower premiums and reduce costs. A qualified health plan administered by OPM may not be the solution. This fact is especially true when only ten percent of 545 employers stated that they would pay $200 a month per employee, while the other ninety percent would either pay less or nothing at all. Looking at the 2011 FEHBP’s non-postal premium rates, the minimum the government—as an employer—pays for a month of coverage is $252 for a self-only Aetna consumer-driven health plan and tops out at $391 for a variety of high coverage, self-only plans. In regards to self-and-family plans, the government contribution ranges from $568, for Aetna’s consumer-drive plan, to $875, for high coverage, family plans. The contribution to an employee’s health plan by the government is higher than what 90% of employers are willing to pay. Thus, even with reduced costs, the health plans offered by OPM may not attract employers to the Exchanges.

247. Id.
248. See supra notes 152–60 & accompanying text.
252. OFFICE OF PERSONNEL MGMT., supra note 250.
253. Id.
254. See Wicks, supra note 164, at 5 (“Even if [Exchanges] could offer lower premiums, they could not substantially reduce the number of uninsured because the premium reductions would not be big enough to induce large numbers of uninsured employers and uninsured workers to opt for coverage.”); Wicks et al., supra note 161, at 2 (“There is no convincing evidence that [Exchanges] have had a major impact on
C. Past Failures

States have implemented health insurance exchanges mostly for small businesses.\textsuperscript{255} Examining these exchanges is important because comparisons and dissimilarities can be drawn between past failures and the future OPM plans. This section will broadly describe why such exchanges failed and why the OPM plans may help alleviate future exchange failures.

Generally, state exchanges have failed because of an inability to gain market share\textsuperscript{256} which causes the exchanges to not achieve the necessary “economies of scale or gain[ ] the bargaining power that would allow them to offer lower-cost coverage.”\textsuperscript{257} Without this power, exchanges cannot attract or retain health plans.\textsuperscript{258} In addition, with no mandate of parity on the insurers’ side, state exchanges failed because insurers would “cherry pick” the healthiest individuals by offering them cheaper plans outside of the exchange,\textsuperscript{259} while dumping high-risk or -cost individuals into the exchange; thus, creating ever-rising premiums.\textsuperscript{260} With rising premiums, the health plans are no longer a bargain, employers start backing away, and soon, insurers will follow.\textsuperscript{261}

The OPM plans and the ACA will help alleviate these concerns and may be able to keep exchanges afloat as they gain market share. Health insurers are familiar with OPM-administered FEHBP plans and have dealt reducing the number on uninsured.”\textsuperscript{255}


\textsuperscript{256} See generally Wicks et al., supra note 161. Enrollment has been large in some state exchanges, California at 150,000 and Florida at 92,000, but this great influx caused a rapid drop in enrollment. \textit{Id.} at 2. Yet, the Connecticut Business and Industry Association’s Health Connections is still going strong with its 75,000 members as of 2010. \textit{Health Insurance Exchange, supra note 142} at 8, tbl. 1.

\textsuperscript{257} State Health Insurance Purchasing Alliances and Cooperatives, Nat’l Conference of State Legislatures, http://www.ncsl.org/default.aspx?tabid=18905 (last updated May 2011) (stating that Exchanges have “insignificant market penetration due to the inability to offer health insurance at lower price than offered in the broader small group market”).

\textsuperscript{258} Wicks, \textit{supra} note 164, at 3-4.

\textsuperscript{259} North Carolina’s exchange failed, in part, because “healthy groups purchased less expensive policies outside the exchange.” Richardson, \textit{supra note 154}, at 12. The exchange also had too small of enrollment, had low insurer participation, had choice problems among health plans for employees, and did not have any quality comparison measures. \textit{State Health Insurance, supra note 257}.

\textsuperscript{260} Micciche, \textit{supra note} 255. This cherry picking was a significant factor in the downfall of Texas’s state exchange. Cappy McGarr, Opinion, \textit{A Texas-Sized Health Care Failure}, N.Y. TIMES, Oct. 5, 2009, http://www.nytimes.com/2009/10/06/opinion/06mcgarr.html?ref=opinion. (“Private insurance companies, which could offer small-business policies both inside and outside the exchange, cherry-picked relentlessly, signing up all the small businesses with generally healthy employees and offloading the bad risks — companies with older or sicker employees — onto the exchange.”). California’s state exchange failed, in part, because it was voluntary and not the exclusive source of coverage. Richardson, \textit{supra note} 154, at 11; \textit{State Health Insurance, supra note} 257.

\textsuperscript{261} McGarr, \textit{supra note} 260.
with OPM in contract negotiations. OPM will bring similar bargaining power to the table with the qualified health plans and know what insurers will generally cover and for what price. This still may not allow lower-cost coverage, but will give the exchanges stability and insurers comfort that there will be at least two qualified health plans administered from a reputable source in the exchange market. In other words, the OPM plans bring credibility to the exchanges.

D. Recommendations

Although the FEHBP has been successful, some individual health plans, as a part of the FEHBP, have been discontinued due to adverse selection and improper risk adjustment. This section addresses these concerns and makes recommendations for the OPM plans.

Adverse selection has occurred in the FEHBP health plans.\textsuperscript{262} It will also occur in the OPM plans because OPM is directed to administer theses plans “in a manner similar” to the FEHBP.\textsuperscript{263} In order to avoid rising premiums,\textsuperscript{264} creating a high-risk pool exchange,\textsuperscript{265} and motivating younger individuals to opt for insurance outside of the exchange,\textsuperscript{266} tax subsidies or credits need to be provided.\textsuperscript{267}

The United States tax system provides subsidies on health care.\textsuperscript{268} Tax subsidies and credits can reduce adverse selection by “encouraging

\begin{footnotes}
\item[262] See supra notes 217–224 and accompanying text.
\item[264] Bovbjerg, supra note 179, at 4.
\item[265] Merlis, supra note 144, at 11.
\item[266] Bovbjerg, supra note 179, at 4.
\item[267] Another recommendation that could potentially lower the impact of adverse selection would be to have a qualified health plan be a consumer-driven health plan (CDHP). “The introduction of new benefits in the form of consumer-directed, high-deductible plans seems to be changing the age distribution of enrollees selecting different plans.” Id. at 5. Yet, CDHPs still have their own issues including lower satisfaction that preferred-provider-organization plans, higher out-of-pocket costs, more missed visits to physicians, and low levels of trust in the plan itself. Fronstin & Collins, supra note 251, at 1. In addition, individuals who are uninsured will have difficulty paying the high deductibles. Andrews, supra note 251. If OPM decides to implement more than the two required qualified health plans, it should consider a CDHP because of its proven track record to attract younger and healthier individuals. See U.S. Gov’t Accountability Office, GAO-10-616, Consumer-Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements 1 (2010) (finding that eighteen of twenty-one studies reviewed showed that CDHPs enrollees were healthier based on utilization of healthcare services).
\end{footnotes}
low-risk individuals to participate and seek greater insurance coverage.” Moreover, subsidies can “offset the price effects of adverse selection” and help compete with non-exchange plans. The tax subsidy or credit provided in the exchange must be available only for an exchange. This point should not be overlooked because providing a sub-set of an insurance market group with a subsidy can lead to individuals purchasing insurance in that sub-set and to purchasing more insurance coverage, especially the larger the subsidy.

The ACA provides such a tax credit for individuals, but not employer-sponsored plans, which purchase insurance through an Exchange and meet certain income requirement guidelines. The tax credit will flow directly to the insurer on the individual’s behalf and will be “based on a maximum amount that recipients will be required to spend for their monthly premium.” The credit, by only effecting exchange-based plans, will help fight the problems of adverse selection by keeping cost lows and by incentivizing exchange-based health plans, a sub-set of the insurance market, over non-exchange plans.

A second potential issue involves having different risk profiles and attempting to risk adjust certain plans in order to prevent their implosion. The plans in the exchanges will have different risk

271. Merlis, supra note 144, at 12. But see generally 5.4 at 2–3 (“If insurance leads to modest wasteful spending, then the optimal subsidy drops significantly.”).
272. Bovbjerg, supra note 179, at 4; Merlis, supra note 144, at 12.
273. See generally Cherukupalli, supra note 269; Gruber & Poterba, supra note 268.
274. Micciche & Gillespie, supra note 137, at 2. The credits will be available to “those earning between 133 percent to 400 percent of the Federal Poverty Level,” which is approximately $22,500 for a family of four. Id. at 2, n.3.
275. Id. at 2. “The maximum is set on a sliding scale starting at [three] percent of ‘modified adjusted gross income.’ For those earning 133 percent [of the Federal Poverty Line] and increasing gradually to 9.5 percent for those between 300 percent to 400 percent [of the Federal Poverty Line].” Id.
276. See Gruber & Poterba, supra note 268, at 701 (finding that a one percent increase in cost of insurance reduced the probability that a self-employed individual will have insurance by 1.8 percentage points).
277. See Cherukupalli, supra note 269.
278. Risk adjustment is a “method of adjusting capitation payments to health plans, either higher or lower, to account for the difference in expected costs of individuals.” Gregory C. Pope et al., Evaluation of the CMS-HCC Risk Adjustment Model, RESEARCH TRIANGLE INSTITUTE INTERNATIONAL 4 (2011), at https://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011. The ACA already has some risk-adjustment mechanisms including requiring a base-level of health benefits and requiring insurers to pay the same rate both in and out of the exchanges for individuals and small-group subscribers. Hall, supra note 225, at 3.
279. See supra notes 225–27 & accompanying text.
profiles. With the distortion of price competition, e.g., healthier individuals in some plans, sicker individuals in other plans, premium differences would reflect the "characteristics of their enrolled population" rather than "relative efficiency." In order to have OPM's qualified health plans reflect their relative efficiency, something akin to Medicare Advantage should be implemented.

Medicare Advantage, also known as Part C of Medicare, is a Medicare health plan that is offered by private insurance companies, which are approved by Centers of Medicaid and Medicare Services. The plan provides coverage for hospital and physician services like standard Medicare and may offer additional coverage. Medicare Advantage plans are paid for by a fixed amount from Medicare and by out-of-pocket costs that differ according to the benefits provided. Normally, these plans would have distortion of price competition; however, "[e]nrollee characteristics that may predict future costs and utilization are compared across plans." Medicare pays the plans with healthier, low-risk populations less than those with sicker, high-risk populations. The rates that enrollees see are of a "typical" participant when making a health plan choice; "[t]he adjustments are invisible to consumers." Furthermore, by using this risk-adjustment method, private plans have less of an incentive to "risk select" healthy enrollees and plans that provide care for sicker enrollees are not penalized.

Although the benefits to this model are immense and proven, medical conditions and need for services change over time. No one can perfectly predict the level of risk and the consumer will always have their own self-interest to look out for. Additionally, another problem is that

280. Merlis, supra note 144, at 17.
281. Id.
283. Id. Additional coverage may include "vision, hearing, dental, and/or health and wellness programs" and Medicare Part D for prescription drug coverage. Id.
284. Id.
285. Id. supra note 144, at 18. The current risk-adjustment model used by CMS is the Hierarchal Condition Categories. For more information on this model, see Pope et al., supra note 278, at 4–22. This model is based off of diagnostic codes rather than demographic measures, which better predicts risks. Hall, supra note 225, at 1, 6–7.
286. Merlis, supra note 144, at 18; Pope et al., supra note 278, at 2, 5.
287. Merlis, supra note 144, at 18.
288. Pope et al., supra note 278, at 5.
289. See generally Pope et al., supra note 278.
290. Merlis, supra note 144, at 18.
291. Id.
Medicare, i.e., the government, is controlling the paying mechanism with Medicare Advantage, while OPM only controls part of the paying mechanism of the FEHBP and none of the OPM plans. This point is to not to say that government should not direct tax credits or subsidies by a risk-adjustment method, just that it will be a logistical nightmare and out of OPM’s control.  

V. Conclusion

The Affordable Care Act (ACA) helps the administration of health benefits achieve ethical and economic goals through three provisions: the definition of “essential health benefits,” the implementation of health insurance exchanges, and the participation of the OPM plans in the exchanges. Ethically, these three provisions increase transparency, participation, and consistency by either providing or requiring the reporting of cost information, the presence of certain stakeholders, and the ability for more individuals to receive coverage. Economically, the provisions will attempt to lower cost, to provide stability and credibility to reform mechanisms, and to alleviate stakeholder’s economic self-interest. Overall, the ACA improves the ethics and economics of the administration of health benefits, but attention needs to be placed on potential roadblocks like political punditry, adverse selection, and risk allocation.

Many view the health-care system as unfair. Yet, through an ethical and economic administration of health benefits, the effectiveness and value of health care are improved.

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292. See Micciche & Gillespie, supra note 137, at 3 (describing how the tax credits for the future exchanges do not have an “aggregation of premium payments” which will lead to “distinct operational challenges, disadvantages in attracting insurers, and potential complications for purchases”).