



United States  
General Accounting Office  
Washington, D.C. 20548

160958

Health, Education and Human Services Division

B-280660

August 7, 1998

The Honorable William M. Thomas  
House of Representatives

Subject: Federal Health Programs: Comparison of Medicare, the Federal Employees Health Benefits Program, Medicaid, Veterans' Health Services, Department of Defense Health Services, and Indian Health Services

Dear Mr. Thomas:

About one-third of Americans receive health care that the federal government finances at an aggregate annual cost of over \$300 billion. Major recipients include the elderly; low-income women and children; people with disabilities; federal and military employees, retirees, and their families; veterans; and Native Americans. The federal government finances this care through several programs that pay for private health insurance, reimburse health care services obtained from private providers, or deliver health care services directly. Thus, in some cases, the federal government acts like other large employers that contract with insurance companies and health plans to offer health benefits to employees and their dependents. In other cases, it acts like a large insurance company that pays directly for health care services. In still other cases, it acts like a large staff-model health maintenance organization (HMO) that operates a network of hospitals and employs health care professionals.

To assist the National Bipartisan Commission on the Future of Medicare as it considers changes to the Medicare program, you asked us for information to help compare Medicare with five other federal health programs. These programs are the Federal Employees Health Benefits Program (FEHBP), Medicaid, Department of Veterans' Affairs (VA) health programs, Department of Defense (DOD) health programs (known as TRICARE), and the Indian Health Service (IHS) of the Department of Health and Human Services' (HHS) Public Health Service.

You asked for information that compares key features of these programs, including

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- administrative structures, including the number of pages of legislation and regulation;
- benefit design, including benefits covered and out-of-pocket costs to beneficiaries;
- costs, including per capita costs and growth rates; and
- patient and provider satisfaction.

To obtain this information, we interviewed federal officials responsible for administering these programs and synthesized information obtained from documents produced by the administering agencies and other experts. We conducted our work in June and July of 1998 in accordance with generally accepted government auditing standards.

In summary, the programs' approaches to financing health care for their eligible populations differ markedly. These differences are generally attributable to the programs' serving different eligible populations and the programs' evolving relatively independently. FEHBP serves as an insurance purchaser by contracting with several hundred private health plans to offer health benefits to nearly 9 million federal employees, retirees, spouses, and dependents. FEHBP administrators negotiate premiums and benefits with participating health plans, but the program does not directly reimburse claims or directly provide health care services.

The largest federal health programs, Medicare and Medicaid, have traditionally acted as insurers for their beneficiaries by reimbursing private health care providers for a defined set of health care services. Thus, Medicare and Medicaid administrators directly perform or contract for many of the claims handling and health care provider relations responsibilities that private health plans provide for FEHBP. Both Medicare and Medicaid, however, have increasingly allowed or required their enrollees to choose alternative benefit packages offered by HMOs and other private managed care plans, more closely resembling FEHBP by serving as insurance purchasers for at least a portion of their enrollees.

VA's and IHS' health programs are mainly direct health care providers that own hospitals and other health care facilities and employ or contract directly with physicians and other health care professionals to provide services to eligible beneficiaries. DOD's TRICARE also mainly provides direct health care services but integrates its direct delivery system with private health plans and

providers, thereby also serving as an insurance purchaser. These direct care programs' approach involves the federal government's owning and operating a network of health care facilities and managing health care professionals as employees, a distinctly different approach to financing health care than that used by FEHBP, Medicare, or Medicaid.

In addition, several federal health programs perform a public role beyond financing health care services for their eligible populations. These roles include funding or conducting health care research or graduate medical education (Medicare, VA, and DOD); providing additional funds to hospitals that serve large populations of low-income people (Medicare and Medicaid); establishing physician and hospital payment systems that are adapted by other federal health programs and private health plans (Medicare); and providing public health services (IHS). Following are brief descriptions of each program.

### MEDICARE

Medicare, the nation's largest health insurance program, which enrolled nearly 39 million Americans in 1997, is an entitlement program for those who are 65 or older, disabled, or have end-stage renal disease (ESRD). Administered by HHS' Health Care Financing Administration (HCFA), Medicare is a combination of two insurance programs—hospital insurance (part A) and supplementary medical insurance (part B)—each with its own enrollment, coverage, and financing. Part A covers inpatient care in a hospital or skilled nursing facility, post-institutional home health care, and hospice care; eligible individuals are automatically entitled to coverage. Part B coverage—including physicians' services, outpatient hospital services, nonpost-institutional home health care, and other health care services—is optional, and enrollees must pay a monthly premium that covers about 25 percent of the program's costs.

An increasing share of Medicare enrollees participate in HMO options that operate differently from the traditional fee-for-service Medicare program.<sup>1</sup> In

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<sup>1</sup>An HMO is a prepaid health plan offering comprehensive health services through a network of affiliated hospitals, physicians, and other health care providers. Other managed care arrangements include preferred provider organizations (PPO), which encourage enrollees to use affiliated health care providers through the use of discounts and lower cost-sharing requirements, and point-of-service (POS) plans, which resemble HMOs but allow enrollees to use health care providers not affiliated with the plan by paying higher cost-sharing requirements.

1997, 15 percent of Medicare beneficiaries enrolled in an HMO, and this proportion has grown to 17 percent in 1998. Rather than the federal government's performing insurance functions as it does for traditional Medicare, the government pays private HMOs to provide Medicare covered services to enrollees. In addition, the Balanced Budget Act of 1997 established the Medicare+Choice program, which, beginning in 1999, will provide Medicare enrollees with more private health plan options such as provider-sponsored organizations, private fee-for-service plans, point-of-service (POS) options, and medical savings accounts.

### FEHBP

FEHBP is the nation's largest voluntary employer-sponsored health insurance program and is administered by the Office of Personnel Management. In 1997, FEHBP covered an estimated 8.7 million individuals, including 2.3 million active employees, 1.8 million retirees, and 4.6 million spouses and dependents. Employees and retirees share the costs of health coverage with the federal government, which pays 72 percent of premium costs on average. For 1998, federal employees could select from 10 nationwide plans, 7 plans open to specific groups, or several hundred POS and HMO plans available throughout the nation.

### MEDICAID

Medicaid, a joint federal-state program, provided health care services to 36 million low-income individuals, including children, their adult caretakers, the elderly, and the disabled, in fiscal year 1996. Within limits established by federal standards, states have discretion in determining specific age and income eligibility thresholds, specific covered benefits, and whether to offer or require enrollment in HMOs or other managed care alternatives. By meeting the minimum federal standards, states qualify for federal matching payments covering at least 50 percent and as much as 83 percent of Medicaid program costs, depending on a state's per capita income. In 1996, 22 percent of Medicaid recipients were enrolled in an HMO or similar prepaid managed care program. Medicaid is also the primary public payer for nursing home and in-home long-term care services for elderly and disabled individuals.

### VETERANS' HEALTH CARE PROGRAMS

In 1997, VA operated 172 hospitals, 439 ambulatory clinics, 131 nursing homes, and other health care facilities that provided direct health care services to about 3 million veterans. Veterans are classified into one of seven priority

groups on the basis of factors including their military service and any related health conditions as well as income. These groups receive available health services within budget limits as established by direct government appropriations and some insurance payments.

DOD HEALTH CARE (TRICARE)

The DOD health program, TRICARE, covers more than 8 million active and retired members of the uniformed military services and their dependents. TRICARE is a direct care system consisting of 115 hospitals, 471 clinics, and nearly 150,000 personnel operated by the military and supplemented by health care purchased to cover health care services not available through its facilities. The majority of care provided by TRICARE is done so through military facilities. TRICARE has three options for its beneficiaries: TRICARE Standard (a fee-for-service option), TRICARE Extra (similar to a PPO), and TRICARE Prime (similar to an HMO). Active-duty personnel must enroll in TRICARE Prime; retirees and dependents may pay an annual fee to select one of these options.

IHS

IHS is the principal federal health care provider for federally recognized Native Americans and in 1997 provided health care services to over 1 million people. IHS provides a health services delivery system as well as funds to assist Native American communities and tribes to develop and manage health care programs. Eligible individuals may receive direct health care services through hospitals and clinics operated by the IHS or through contract organizations. In some cases, contracts are established with tribes, and the tribes assume responsibility for providing these health care services. IHS also provides public health services such as health education, environmental health, and sanitation.

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Enclosures 1 through 6 provide side-by-side comparisons of these six federal health care programs on basic program characteristics, administrative structure and costs, benefits covered, out-of-pocket costs, per capita and other program costs, and enrollee/patient and provider satisfaction.

If you have any further questions about this letter, please call me at (202) 512-7114. The information presented in this letter was developed by N. Rotimi

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Adebonojo, Senior Evaluator, and Mark Vinkenes, Senior Social Science Analyst, under the direction of John Dicken, Assistant Director.

Sincerely yours,

A handwritten signature in cursive script that reads "William J. Scanlon". The signature is written in black ink and is positioned above the printed name.

William J. Scanlon  
Director, Health Financing and  
Systems Issues

Enclosures - 6

BASIC PROGRAM CHARACTERISTICSTYPE OF PROGRAM

**Insurance purchasers** (FEHBP and parts of Medicare, Medicaid, and DOD) contract with private health plans that reimburse or prepay for health care services.

**Public insurers** (traditional Medicare and Medicaid programs) pay claims for services that enrollees' obtain from private health care professionals and facilities.

**Direct care providers** (VA health, DOD, and IHS) deliver health care services through hospitals and other health care facilities that the programs own and health care professionals that the programs employ.

MANAGED CARE

**Medicare** 15 percent of beneficiaries enrolled in HMOs

Medicare+Choice will expand managed care options to include PPOs, POS plans, and medical savings accounts.

**FEHBP** 29 percent enrolled in HMOs

Most other enrollees have PPO and POS options

**Medicaid** 22 percent enrolled in HMOs in 1996

**DOD** Managed care options through nonmilitary providers are used only if military providers are unavailable.

40 percent enrolled in TRICARE Prime (similar to an HMO)

DUAL ELIGIBILITY

Medicare is the primary payer for about 14 percent of FEHBP enrollees, 14 percent of Medicaid recipients, 39 percent of VA health users, and 17 percent of DOD users.

Table 1.1: Basic Program Characteristics

|   | Medicare   | FEHBP   | Medicaid   | VA  | DOD  | IHS   |
|---|--|---|--|---|--|---|
| <b>General information</b>                    |  |   |  |   |  |   |
| Type of program                               | Insurer/ insurance purchaser   | Insurance purchaser                               | Insurer/ insurance purchaser                               | Direct care provider  | Direct care provider/ insurance purchaser                        | Direct care provider  |
| Organization and delivery of care             | Primarily fee-for-service with managed care option <sup>a</sup>            | Fee-for-service and managed care options          | Fee-for-service or managed care depending on state         | Primarily direct care with some contract health care services     | Primarily direct care, fee-for-service, and managed care options | Primarily direct care with some contract health care services |
| Eligible population                           | People 65 years or older, disabled, or with end-stage renal disease (ESRD) | Federal employees, retirees, and their dependents | Certain low-income families, aged, or disabled individuals | Veterans honorably discharged, plus some nonveterans <sup>b</sup> | Members of uniformed services, retirees, and their dependents    | Members/ descendants of federally recognized Indian tribes    |
| <b>Size of program</b>                        |  |   |  |   |  |   |
| Population (in millions)                      | 38.6 enrollees <sup>c</sup>  | 8.7 enrollees <sup>d</sup>                        | 36.1 users <sup>e</sup>                                    | 3.0 users <sup>b</sup>  | 8.2 enrollees <sup>f</sup>                                       | 1.3 users <sup>d</sup>  |
| Program expenditures (in billions)            | \$210.5 <sup>h</sup>   | \$15.4  | \$160.0 <sup>i</sup>                                       | \$17.1  | \$15.6 <sup>j</sup>  | \$2.1   |
| <b>Managed care</b>                           |  |   |  |   |  |   |
| HMO enrollees <sup>k</sup>                    | 15%  | 29% <sup>l</sup>                                  | 22% <sup>m</sup>   | Not applicable  | 40% <sup>n</sup>   | Not applicable  |
| Other managed care options <sup>k</sup>       | None <sup>a</sup>  | PPO<br>POS  | Primary care case managers                                 | Not applicable  | PPO  | Not applicable  |
| <b>Dual eligibility</b>                       |  |   |  |   |  |   |
| Medicare dual eligible enrollees <sup>o</sup> | Not applicable   | 14%   | 14%  | 39% <sup>p</sup>  | 17% <sup>q</sup>   | Not available   |

Note: Beneficiary and expenditure data are for 1997 unless otherwise noted.

<sup>a</sup>Under the Balanced Budget Act of 1997, an expanded range of choices will be available, including HMOs, provider-sponsored organizations, private fee-for-service plans, and medical savings accounts. Existing Medicare HMOs may include a POS option, but these options will be expanded under the new law.

<sup>b</sup>An eligible veteran's priority for receiving a uniform inpatient and outpatient benefit package depends on factors such as the presence and extent of the service-connected disability, income, and period or conditions of military service.

<sup>c</sup>38.6 million individuals were enrolled in part A, part B, or both; 38 million individuals were enrolled in part A (87.4 percent aged and 12.6 percent disabled); 36.4 million individuals were enrolled in part B (88.2 percent aged and 11.8 percent disabled).

<sup>d</sup>Of the estimated 8.7 million enrollees, 2.3 million were active employees, 1.8 million were retirees, and an estimated 4.6 million were dependents and spouses.

<sup>e</sup>Medicaid data are for 1996. Total enrollment for Medicaid was 41.2 million.

<sup>f</sup>DOD does not require eligible beneficiaries to be enrolled before using military health care facilities.

<sup>g</sup>THS users include patients who received care during the past 3 years.

<sup>h</sup>Does not include health care services provided to Medicare beneficiaries paid by Medicaid or private supplemental health insurance.

<sup>i</sup>Includes \$91 billion in federal expenditures and \$69 billion in state expenditures in 1996.

<sup>j</sup>Also includes costs of maintaining wartime health care delivery readiness.

<sup>k</sup>An HMO is generally a prepaid health plan offering comprehensive coverage exclusively through a network of contracted providers. The HMO receives a predetermined fixed capitation payment for providing services. Other managed care plans include PPOs that provide financial incentives for enrollees to use affiliated providers and POS plans that resemble HMOs but allow enrollees to opt out of using network providers at a higher cost.

<sup>l</sup>Percentage is based upon active employees and retired enrollees (not including dependents).

<sup>m</sup>Medicaid HMO enrollment data are for 1996.

<sup>n</sup>The majority of DOD's health care services are provided directly by a military hospital or clinic. However, fee-for-service, PPO, and HMO plans supplement direct care capacity with civilian providers. In 1998, about 40 percent of TRICARE enrollees (including all active-duty personnel) are in TRICARE Prime—an HMO plan.

<sup>o</sup>Low-income Medicare beneficiaries may also receive coverage from Medicaid. For some dually eligible individuals, Medicare is supplemented by services available under their state's Medicaid program; however, the extent of this Medicaid coverage may vary by basis of eligibility. Some dually eligible individuals receive Medicaid assistance for Medicare premiums, cost sharing, and services not covered by Medicare, such as prescription drugs; other dually eligible beneficiaries receive assistance for Medicare premiums or cost sharing. Medicare is considered the primary payer for dually eligible individuals, with Medicare making

ENCLOSURE 1

ENCLOSURE 1

payments before any payments are made by Medicaid. Moreover, some Medicare- or Medicaid-eligible people may also be eligible for services through either FEHBP, VA, DOD, or IHS.

<sup>8</sup>VA officials estimated the number of dual eligibles (1.2 million) on the basis of a 1992 National Survey of Veterans and VA workload data.

<sup>9</sup>Based on users.

**ADMINISTRATIVE STRUCTURE AND COSTS**

The six programs vary considerably in the breadth and intensity of their administrative activities and the extent to which they directly perform or delegate their administrative activities to other federal agencies, states, and private organizations.

**Medicare** HCFA performs administrative activities as an insurer and insurance purchaser. It directly performs many of these activities but also relies heavily on the Social Security Administration (SSA) to determine eligibility and on administrative contractors (fiscal intermediaries and carriers) to process and pay claims, identify and deter fraud and abuse, and provide assistance to beneficiaries and providers.

**FEHBP** Operating a large employer insurance purchasing program, the Office of Personnel Management (OPM) establishes and monitors contracts with health plans. Health plans, however, determine conditions of provider participation, approve providers for participation, establish provider rates, pay claims, deliver health care services, collect payments for these services, and monitor the delivery of these services. Each federal agency determines eligibility for its employees and their dependents and collects their premiums. OPM performs these functions for retirees and their dependents.

**Medicaid** States are the primary operational administrators, performing (or contracting out) most enrollment, claims processing, enrollee/provider assistance, and quality monitoring responsibilities. HCFA ensures that states receive federal funds and monitors their implementation of the program.

**VA** VA is responsible for those activities needed to administer a nationwide health care delivery system, which includes establishing and maintaining health care facilities, hiring and supervising providers, contracting for selected services, and monitoring the quality of service delivery.

**DOD** DOD is responsible for administering an extensive health care delivery system; DOD also purchases insurance to complement the direct care services for its beneficiaries.

**IHS** IHS, a component of HHS' Public Health Service (PHS), is responsible for administering a health care delivery system throughout the nation.

Table 2.1: Administrative Entities, Expenditures, and Pages of Statute and Regulation

|   | Medicare  | FEHBP  | Medicaid  | VA                              | DOD                             | IHS  |
|---|---|--|---|---------------------------------|---------------------------------|--|
| <b>Administrative entities</b>  |   |  |   |                                 |                                 |  |
| Primary federal administrative entity   | HHS-HCFA  | OPM  | HHS-HCFA  | VA                              | DOD                             | HHS-PHS-IHS  |
| Other key administrative entities   | Admin. contractors, health plans, state survey agencies, PROs <sup>a</sup>        | Federal agencies and health plans                            | States, <sup>b</sup> health plans, and PROs                                       | Not applicable <sup>c</sup>     | Health plans <sup>d</sup>       | Tribes, admin. and provider contractors, PROs          |
| <b>Administrative expenditures</b>  |   |  |   |                                 |                                 |  |
| Federal entities' administrative expenditures (percentage of total expenditures) (\$ in billions)   | 0.1% (\$0.24)   | 0.1% (\$0.02)  | 0.1% (\$0.09) <sup>e</sup>  | 12.9% (\$2.2) <sup>f</sup>      | Not available                   | 2.4% (\$0.05)  |
| Other key entities' administrative expenditures (percentage of total expenditures) (\$ in billions) | Admin. contractors: 0.6% (\$1.3)<br><br>Health plans and providers: Not available | Federal agencies, health plans, and providers: Not available | States 4.2% (\$6.7) <sup>e</sup><br><br>Health plans and providers: Not available | Not applicable                  | Health plans: Not available     | Tribes, admin. and provider contractors: Not available |
| <b>Pages of statute and regulation<sup>g</sup></b>  |   |  |   |                                 |                                 |  |
| Statutory (U.S.C.) pages <sup>h</sup>   | 586 (42 U.S.C. 1395 to 1395ggg)   | 30 (5 U.S.C. 8901 to 8914)                                   | 279 (42 U.S.C. 1396 to 1396v)   | 54 (38 U.S.C. 1701 to 1774)     | 56 (10 U.S.C. 1071 to 1107)     | 131 (25 U.S.C. 1601 to 1683)                           |
| Regulatory (C.F.R.) pages <sup>h</sup>  | 1,084 (42 C.F.R. 400.200 to 424.352)  | 93 (5 C.F.R. 890.101 to 891.502)                             | 1,344 (42 C.F.R. 430.0 to 498.103)  | 186 (38 C.F.R. 17.30 to 17.805) | 366 (32 C.F.R. 199.1 to 199.22) | 68 (42 C.F.R. 36.1 to 36.374)                          |

Note: Data are for 1997 unless otherwise noted.

<sup>a</sup>Administrative contractors assist beneficiaries and providers, process and pay claims, and perform activities related to ensuring program integrity and payment safeguards, including conducting medical reviews and auditing cost reports. Part A contractors are called intermediaries; part B contractors are called carriers. Peer review organizations (PRO) are private not-for-profit organizations that provide program integrity and quality improvement services for Medicare, state Medicaid programs, and other health programs.

<sup>b</sup>Although Medicaid is a joint federal-state program, states are the primary administrative entity. HCFA's main administrative functions are to ensure that states have sufficient funding and technical assistance and that their programs are administered according to federal law and regulation.

<sup>c</sup>Beginning in 1999, the VA will implement or contract for certain administrative functions as it transitions to an enrollment-based eligibility system established by the Veterans Healthcare Eligibility Reform Act of 1996 (P.L. 104-262).

<sup>d</sup>TRICARE supplements care in military treatment facilities with contract service providers.

<sup>e</sup>These are 1996 data. Of the \$6.7 billion in state administrative costs for Medicaid, \$3.6 billion were federal matching funds. Costs for state survey and certification activities, Medicaid fraud control units, and vaccines for children are excluded from these data.

<sup>f</sup>Administrative costs include activities associated with administering and operating health care facilities, which entail a broader scope of activities than those associated with programs that serve as insurers or insurance purchasers for beneficiaries. However, these exclude certain administrative costs not associated with the direct provision of health care such as those associated with engineering, housekeeping, and instructors for residents.

<sup>g</sup>In addition to statute and regulation, the programs also provide other guidance, such as manuals, contracts, and memoranda, to contractors, health plans, and others. Programs operating as direct care providers supervise health care providers directly; programs operating as insurers provide detailed guidance to health care providers; and those operating as insurance purchasers rely on health plans to oversee and provide guidance to health care providers. In addition, administrative contractors, health plans, providers, and others rely on proposed rules and explanatory material published in the Federal Register, which can be much more extensive than the final regulations consolidated in the Code of Federal Regulations (C.F.R.).

<sup>h</sup>To estimate the number of pages, we located portions of the United States Code (U.S.C.) and the Code of Federal Regulations (C.F.R.) specifically identified with each federal health program. The number of pages of statute and regulation were estimated on the basis of the number of lines identified by computerized searches. The page count for the U.S.C. is current as of May 11, 1998, including federal laws enacted through P.L. 105-175. The searches included all statutory language and captions but did not include public law citations, historical and statutory notes, cross references, and other supplementary material generally not enacted into law. The page count for the C.F.R. is current as of June 16, 1998, including regulations published through volume 63, page 32955 of the Federal Register. The page counts include program-specific statutes and regulations (as cited in the table) but do not include other statutes and regulations that may also affect the programs.

Table 2.2: Major Administrative Functions and Primary Administrative Entities

| Administrative functions                                  | Medicare   | FEHBP                               | Medicaid                                    | VA                          | DOD                            | IHS                            |
|---|--|-------------------------------------|---|-----------------------------|--------------------------------|--------------------------------|
| Distribute materials on benefits and services             | HCFA, Social Security Administration (SSA), and admin. contractors | OPM, federal agencies, health plans | States, health plans, contractors           | VA                          | DOD, health plans <sup>a</sup> | IHS, tribes                    |
| Determine beneficiary eligibility                         | SSA  | Federal agencies <sup>b</sup>       | States                                      | VA                          | DOD                            | IHS, tribes                    |
| Collect premiums/enrollment fees                          | SSA, HCFA  | Federal agencies, OPM               | Not applicable <sup>c</sup>                 | VA                          | Health plans <sup>a</sup>      | Not applicable                 |
| Establish requirements for plans                          | HCFA   | OPM                                 | States                                      | Not applicable <sup>d</sup> | DOD                            | Not applicable                 |
| Approve plans   | HCFA   | OPM <sup>e</sup>                    | States                                      | Not applicable <sup>d</sup> | DOD                            | Not applicable                 |
| Negotiate benefits/premiums with health plans             | Not applicable <sup>f</sup>  | OPM                                 | States                                      | Not applicable <sup>d</sup> | DOD                            | Not applicable                 |
| Manage contracts with plans                               | HCFA   | OPM                                 | States                                      | Not applicable <sup>d</sup> | DOD                            | Not applicable                 |
| Determine conditions of provider participation/employment | Statute, HCFA, health plans <sup>g</sup>                           | Health plans                        | Statute, states, health plans <sup>g</sup>  | VA                          | DOD, health plans <sup>g</sup> | IHS, tribes                    |
| Approve providers   | HCFA, state survey agencies, health plans                          | Health plans                        | States, state survey agencies, health plans | VA                          | DOD, health plans <sup>g</sup> | IHS, tribes                    |
| Establish provider rates                                  | Statute, HCFA, health plans  | Health plans                        | Statute, states, health plans               | VA                          | DOD                            | IHS through admin. contractors |

| Administrative functions                             | Medicare  | FEHBP                   | Medicaid  | VA | DOD                            | IHS                                    |
|--|---|-------------------------|---|----|--------------------------------|--|
| Pay claims   | Admin. contractors, health plans                                    | Health plans            | States, health plans                                    | VA | Health plans <sup>a</sup>      | IHS through admin. contractors         |
| Monitor delivery and quality of health care services | HCFA, PROs, state survey agencies, admin. contractors, health plans | OPM, health plans       | States, HCFA, PROs, state survey agencies, health plans | VA | DOD, health plans <sup>a</sup> | IHS and PROs                           |
| Monitor abuse or fraud <sup>b</sup>                  | HCFA, admin. contractors  | Health plans            | States  | VA | DOD                            | IHS                                    |
| Deliver health care services                         | Health plans, providers   | Health plans, providers | Health plans, providers                                 | VA | DOD, health plans <sup>a</sup> | IHS, tribes, care provider contractors |
| Collect payments/reimbursements from users/insurers  | Health plans, providers   | Health plans, providers | Health plans, providers                                 | VA | DOD, health plans <sup>a</sup> | IHS, tribes, admin. contractors        |

<sup>a</sup>In each of 12 regions, DOD contracts with a health plan to provide health care services and administration as part of the TRICARE system.

<sup>b</sup>OPM determines beneficiary eligibility for retirees.

<sup>c</sup>Medicaid generally does not require premiums, but states may require nominal copayments from certain individuals for certain services. Premiums can be charged for some optional populations in some state programs.

<sup>d</sup>According to agency officials, beginning in 1999, VA may implement or contract for these administrative functions as it transitions to an enrollment-based eligibility system established by the Veterans Healthcare Eligibility Reform Act of 1996 (P.L. 104-262).

<sup>e</sup>OPM reviews plans' applications to determine that they meet FEHBP's criteria for participation.

<sup>f</sup>No negotiation takes place between HCFA and health plans because premiums to participating HMOs are defined by a formula established in statute.

<sup>g</sup>Health plans determine the criteria for providers participating in their networks; Medicare, Medicaid, or DOD conditions of provider participation also apply.

<sup>h</sup>The relevant agencies' inspectors general also monitor fraud and abuse for each program.

BENEFITSBENEFIT DESIGN

- Medicare** Benefits are defined by statute for traditional Medicare. Participating HMOs may offer additional benefits.
- FEHBP** All plans cover most major benefits but have flexibility in designing cost-sharing requirements and specific limitations as negotiated by OPM.
- Medicaid** Federal statute defines mandatory benefits and allows states to receive federal matching funds for optional services.
- VA** Provides health care services for eligible individuals within prioritized categories that depend on availability of appropriated funds and collections from third parties.
- DOD** Provides health care services for eligible individuals that depend on availability of appropriated funds and collections from third parties.
- IHS** Provides health care services for eligible individuals that depend on availability of appropriated funds and collections from third parties.

MAJOR EXCLUSIONS OR ADDITIONAL BENEFITS

- Medicare** Does not cover outpatient prescription drugs, long-term care, or clinical trials (with limited exceptions). Eighty-six percent of traditional Medicare enrollees have supplemental coverage through private policies, their employer, or Medicaid that covers certain of these excluded services. Medicare HMOs must cover statutory services and generally also offer additional optional benefits, especially prescription drugs.
- Medicaid** Provides nursing home and in-home long-term care services.
- VA** Provides nursing home long-term care services.
- IHS** Also provides public health services in Native American communities.

Table 3.1: Summary of Major Benefits

|  | Medicare <sup>a</sup> | FEHBP                | Medicaid                   | VA               | DOD                   | IHS                  |
|--|-----------------------|----------------------|----------------------------|------------------|-----------------------|----------------------|
| Inpatient/outpatient hospital and emergency services   | Yes                   | Yes <sup>b</sup>     | Yes                        | Yes <sup>c</sup> | Yes                   | Yes                  |
| Physician services                                     | Yes                   | Yes <sup>b</sup>     | Yes                        | Yes              | Yes                   | Yes                  |
| Immunization and preventive services (e.g., physicals) | Limited               | Yes <sup>b</sup>     | Yes <sup>d</sup>           | Yes              | Yes                   | Yes                  |
| Prescription drugs (outpatient)                        | Very limited          | Yes <sup>b</sup>     | Optional (56) <sup>e</sup> | Yes              | Yes                   | Yes                  |
| Durable medical equipment and supplies                 | Yes                   | Limited <sup>b</sup> | Yes                        | Yes              | Yes                   | Yes                  |
| Dental   | Limited <sup>f</sup>  | Yes <sup>b</sup>     | Optional (46) <sup>d</sup> | Yes              | Optional <sup>g</sup> | Yes                  |
| Mental health (inpatient and outpatient)               | Yes                   | Yes <sup>b</sup>     | Yes <sup>h</sup>           | Yes              | Yes                   | Limited <sup>i</sup> |
| Alcohol/substance abuse (inpatient and outpatient)     | Yes                   | Yes <sup>b</sup>     | Yes <sup>h</sup>           | Yes              | Yes                   | Limited <sup>j</sup> |
| Therapy and other related health services <sup>k</sup> | Yes                   | Yes <sup>b</sup>     | Optional <sup>l</sup>      | Yes              | Yes                   | Yes                  |
| Skilled nursing facility care                          | Yes                   | Yes <sup>b</sup>     | Yes                        | Yes              | Yes                   | No                   |
| Home health  | Yes                   | Yes <sup>b</sup>     | Yes                        | Yes              | Yes                   | No                   |
| Long-term nursing facility/home care                   | No                    | No                   | Yes                        | Yes              | No                    | Demo only            |
| Hospice care   | Yes                   | Yes <sup>b</sup>     | Optional (38) <sup>d</sup> | Yes              | Yes                   | No                   |
| Clinical trials, experimental therapies/treatments     | Limited <sup>m</sup>  | Limited <sup>b</sup> | No                         | Yes <sup>n</sup> | Limited               | No                   |

<sup>a</sup>Benefits listed are for traditional fee-for-service Medicare. Most Medicare managed care plans offer non-Medicare covered benefits such as prescription drugs, preventive care, dental services, eye exams, and glasses.

<sup>b</sup>Plans have flexibility in designing specific benefit usage limitations and cost-sharing requirements.

<sup>c</sup>VA offers limited emergency services.

<sup>d</sup>Immunizations are a mandatory service for children but an optional service for adults.

<sup>e</sup>The number in parentheses is the number of states offering this optional benefit, including the District of Columbia, American Samoa, Guam, N. Mariana Islands, Virgin Islands, and Puerto Rico. States may place certain limits on the coverage of all services, such as a limit on the number of hospital days or physicians' visits. However, each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. Durable medical equipment and supplies are covered under the home health benefit.

<sup>f</sup>Dental coverage in the Medicare fee-for-service system is limited to inpatient dental.

<sup>g</sup>Except for active-duty personnel, dental benefits are optional and financed and provided outside of TRICARE.

<sup>h</sup>Psychiatrists' services are covered as physicians' services; however, psychologists' services and those of other mental health providers are optional. Inpatient services within an "institution for mental diseases" are optional for those under 21 years of age; however, these services are not available for individuals aged 22 to 64.

<sup>i</sup>Outpatient mental health services only.

<sup>j</sup>Inpatient alcohol and substance abuse services for youths only.

<sup>k</sup>Includes occupational and physical therapy and speech and hearing services.

<sup>l</sup>Occupational therapy is available in 36 states; physical therapy is available in 45 states; and speech and hearing services are available in 42 states.

<sup>m</sup>Medicare does not generally reimburse routine patient care cost for beneficiaries enrolled in a clinical trial that has not demonstrated medical effectiveness with some limited exceptions. For example, HCFA and the National Institute of Health are collaborating on a randomized clinical study on the effectiveness of lung volume reduction surgery, with Medicare paying the inpatient care costs for participating beneficiaries.

<sup>n</sup>Clinical research is conducted in VA hospitals and affiliated medical schools.

OUT-OF-POCKET COSTS

Table 4.1: Out-of-Pocket Costs

| Cost sharing   | Medicare <sup>a</sup>  | FEHBP   | Medicaid   | VA   | DOD   | IHS               |
|--|--|---|--|--|---|-------------------|
| Patient cost sharing                                 | Yes  | Yes/<br>varies by plan <sup>b</sup>                           | Limited/<br>varies <sup>c</sup>                                | Varies by<br>priority<br>group <sup>d</sup>  | Varies by<br>eligibility<br>category<br>status <sup>e</sup>   | None              |
| Premium/<br>enrollment fee                           | Part B: \$43.80<br>per month   | \$40 to<br>\$248 per<br>month <sup>b</sup>                    | None <sup>c</sup>  | None   | \$0 to \$460<br>per year <sup>e</sup>                         | None              |
| Deductibles  | Part A: \$764<br>for inpatient<br>hospital<br>Part B: \$100 <sup>f</sup> | \$0 to \$600<br>for<br>inpatient<br>hospital <sup>b</sup>     | None <sup>c</sup>  | None   | \$0 to \$300<br>per year <sup>e</sup>                         | None              |
| Copayment/<br>coinsurance                            | Part A: 0% to<br>25% <sup>f</sup><br>Part B: 20% for<br>most services    | 0 to 30%<br>for<br>hospital<br>and<br>outpatient <sup>b</sup> | Limited/<br>varies by<br>state and<br>beneficiary <sup>c</sup> | None or<br>\$48.50 for<br>outpatient<br>None or<br>\$764 for<br>inpatient<br>hospital<br>care <sup>f</sup> | 0% to<br>25% <sup>e</sup>                                     | None              |
| Annual<br>maximum<br>benefit limits                  | Limits based<br>on benefit<br>periods <sup>f</sup>                       | None <sup>h</sup>   | Varies by<br>state <sup>i</sup>                                | None   | Substance<br>abuse<br>limits<br>based on<br>benefit<br>period | None              |
| Lifetime<br>maximum<br>benefit limits                | For inpatient<br>psychiatric<br>care only <sup>f</sup>                   | None  | None   | None   | For<br>substance<br>abuse<br>only                             | None              |
| Catastrophic<br>protection/<br>limits on<br>expenses | None   | \$1,000 to<br>\$6,700 <sup>b</sup> per<br>year                | Not<br>applicable  | Yes  | \$1,000 to<br>\$7,500 per<br>year <sup>e</sup>                | Not<br>applicable |
| Average annual<br>cost-sharing<br>liability          | \$757/enrollee <sup>j</sup>  | Not<br>available  | Minimal  | Minimal <sup>k</sup>   | Not<br>available  | None              |

<sup>3</sup>The table reflects cost sharing for Medicare's fee-for-service program. Out-of-pocket costs for managed care plans differ (typically, HMOs do not require deductibles but may require copayments) and may require additional premiums for additional benefits.

<sup>4</sup>Reflects cost sharing for managed fee-for-service plans that are open to all FEHBP enrollees. The data represent the range in cost sharing for self-only coverage; family coverage typically has higher premiums. Premiums and cost-sharing requirements vary depending on health plan selected. HMOs typically do not have deductibles but may impose copayments. POSs may require higher cost sharing if out-of-network providers are used.

<sup>5</sup>Pregnant women, children under 18, hospital and nursing home patients, and categorically needy recipients enrolled in HMOs have no cost-sharing requirement. Different requirements may apply in state Medicaid programs operating under a demonstration or waiver authority.

<sup>6</sup>Cost-sharing requirements depend on one's enrollment priority, which is based on factors such as income and whether health care conditions are service related.

<sup>7</sup>Cost-sharing requirements for TRICARE vary by eligibility category and TRICARE plan option. Outpatient care in military treatment facilities has no cost-sharing requirements. Active-duty personnel generally have no or limited cost-sharing requirements. TRICARE Prime has a \$12 or \$30 charge for civilian outpatient visits or emergency care. TRICARE Extra requires enrollees to pay 20% of negotiated fees for civilian outpatient visits or emergency care. TRICARE Standard requires enrollees to pay 25% of allowable charges for civilian outpatient visits or emergency care. Catastrophic limits on expenses per year are \$1,000 for active-duty family members, \$3,000 for retirees in TRICARE Prime, and \$7,500 for retirees not enrolled in TRICARE Prime.

<sup>8</sup>In 1998, part A: For hospitalization, beneficiaries are charged a \$764 deductible for each 90-day benefit period. Benefit periods are renewed after the patient has been out of the hospital for 60 consecutive days. Thus, for each new benefit period, a deductible is required, but the patient is entitled to 90 days of inpatient hospital coverage. Within a benefit period, no coinsurance must be paid for the first 60 days; however, coinsurance of 25 percent of the inpatient hospital deductible applies for each of the 61st to 90th days. Medicare also has 60 lifetime reserve days that may be applied to care beyond the 90-day benefit period. The coinsurance amount for each of these reserve days is 50 percent of the hospital deductible. For skilled nursing care, the benefit period is 100 days with no coinsurance for the first 20 days but \$95.50 a day for the 21st to 100th days. No lifetime reserve days exist for skilled nursing care. No coinsurance is required for post-institutional home health care. Inpatient psychiatric hospital care has a lifetime maximum benefit of 190 days.

Part B: For medical expenses, a \$100 annual deductible and coinsurance of 20 percent of the approved amount is required; beneficiaries may be required to pay additional charges of up to 15 percent of the approved amount when they see a nonparticipating physician. Coinsurance is 50 percent for most outpatient mental health services and 20 percent of the first \$900 for each independent physical and occupational therapy visit and all charges thereafter each year. Home health care requires no coinsurance except 20 percent of the approved amounts for durable medical equipment. For outpatient hospital services, coinsurance is 20 percent of the hospital charges.

<sup>9</sup>A \$764 inpatient copayment is charged for each 90-day inpatient benefit period for certain veterans. For outpatient care, coinsurance is \$48.50 per visit for certain veterans. In addition, a \$2 copayment per prescription drug applies to all veterans, with certain exceptions.

<sup>b</sup>Some specific benefits, such as dental services or durable medical equipment, may have limits on annual maximum benefits.

<sup>i</sup>States may limit the coverage of services, such as a limit on hospital days or physician visits; however, each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

<sup>j</sup>For Medicare-covered services only in calendar year 1995. Including noncovered services, part B premiums, private health insurance (Medigap) premiums, and balance billing, average out-of-pocket cost in 1996 was \$2,605 or 21% of household income of the elderly overall. Data are for noninstitutionalized beneficiaries.

<sup>k</sup>An unofficial estimate for average annual cost sharing of \$26 was provided by VA officials. This estimate is based on cost recoveries and the total number of users in 1997.

PER CAPITA AND OTHER PROGRAM COSTSPER CAPITA COSTS

Differences in per capita costs are largely attributable to differences in the age and health status of the population served by the programs:

- Medicare's per enrollee cost of \$5,450 represents the costs of providing health care for a high-utilizing population, including the elderly, disabled, and end-stage renal disease (ESRD) patients.
- FEHBP's expenditures of \$1,768 per enrollee and DOD's expenditures of \$1,863 per user reflect their coverage of employed people, retirees, and dependents, similar to other large employers providing coverage to active workers and retirees.
- Medicaid's cost of \$4,807 per enrollee person-year includes the costs of providing long-term care services to elderly individuals who consume about one-third of Medicaid costs but account for only 13 percent of beneficiaries.
- VA's per user expenditures of \$4,798 include the costs of covering many disabled and older individuals.
- IHS' costs per user of \$1,578 reflect that many recipients may also receive health care paid benefits from other payers.

**Table 5.1: Comparison of Federal Health Programs' Average Annual per Capita Costs and Estimates of Error, Fraud, and Abuse**

|                                    | Medicare                               | FEHBP                | Medicaid                             | VA                            | DOD                           | IHS              |
|------------------------------------|--|----------------------|--------------------------------------|-------------------------------|-------------------------------|------------------|
| Expenditures per capita            | \$5,450 per enrollee <sup>a</sup>      | \$1,768 per enrollee | \$4,807 per person-year <sup>b</sup> | \$4,798 per user <sup>c</sup> | \$1,863 per user <sup>d</sup> | \$1,578 per user |
| Dollars in error, fraud, and abuse | Estimated at \$20 billion <sup>e</sup> | Unknown              | Unknown                              | Unknown                       | Unknown                       | Unknown          |

Note: Data for 1997 unless otherwise noted.

<sup>a</sup>For 1995, Medicare expenditures averaged \$4,489 for aged enrollees; \$3,975 for disabled enrollees; and \$37,611 for ESRD enrollees.

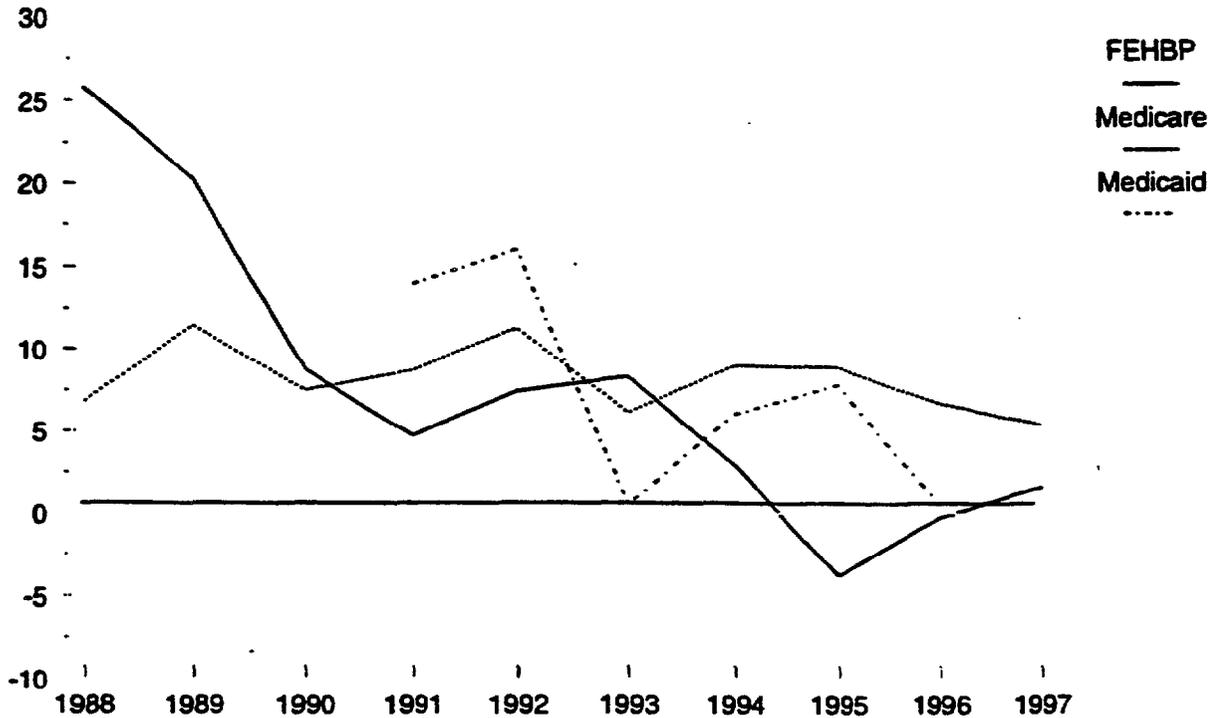
<sup>b</sup>Data are for 1996. For 1996, the Urban Institute estimated costs to be \$10,338 per elderly enrollee; \$8,450 per blind and disabled enrollee; \$1,838 per adult enrollee; and \$1,143 per child enrollee.

<sup>c</sup>The range in average expenditures per user is large for VA health users, with extended care and chronic care patients having average costs of \$36,020.

<sup>d</sup>Expenditures per user are adjusted to exclude military readiness costs. DOD expenditures are based on a simple average of expenditures per eligible user for each of the armed services.

<sup>e</sup>In fiscal year 1997, the HHS Inspector General estimated \$20.3 billion in inappropriate payments; the portion attributable to fraud is unknown.

Figure 5.1: Growth Rates in Medicare, FEHBP, and Medicaid Costs per Capita, 1988 to 1997



Note: Medicaid cost growth rates are calculated on the basis of person-year enrollment equivalents for fiscal years 1991 to 1996. Medicaid data are not presented for 1988 to 1990 and 1997 because they are not comparable. Medicare costs per enrollee and Medicaid costs per person-year include disproportionate share hospital payments. Both Medicare and FEHBP costs are based on calendar years 1988 to 1997.

ENROLLEE/PATIENT AND PROVIDER SATISFACTION

**Medicare** Among respondents to the 1996 Medicare Current Beneficiary Survey, a random survey of more than 16,000 beneficiaries found—

Care received: 30% very satisfied  
4% very dissatisfied

Costs of care: 17% very satisfied  
13% very dissatisfied

Medicare has begun using the Consumer Assessment of Health Plans Study (CAHPS) survey to collect additional enrollee satisfaction information.

**FEHBP** Annually surveys a sample of enrollees to determine satisfaction with health plans, including coverage, access, choice, and quality of care. Summary information is provided to eligible individuals at open enrollment periods.

Among respondents in 1997, the following enrollees rated the health plan as good, very good, or excellent:

87% of fee-for-service enrollees  
84% of HMO enrollees  
85% of POS enrollees

FEHBP will begin using CAHPS to report enrollee satisfaction information in 1999.

**VA** Among veterans surveyed in 1997—

Inpatient care (overall quality): 65% excellent/very good  
Outpatient care (overall quality): 63% excellent/very good

**Table 6.1: Enrollee/Patient and Provider Satisfaction Information**

| Criteria  | Medicare             | FEHBP           | Medicaid | VA               | DOD     | IHS |
|---|----------------------|-----------------|----------|------------------|---------|-----|
| <b>Does the program systematically collect enrollee/patient satisfaction information?</b> |                      |                 |          |                  |         |     |
| Enrollee/patient satisfaction with health plan  | Limited <sup>a</sup> | Yes             | No       | Not applicable   | Limited | No  |
| Enrollee/patient satisfaction with provider   | Limited <sup>a</sup> | No <sup>b</sup> | No       | Yes              | Limited | No  |
| <b>Does the program systematically collect provider satisfaction information?</b>         |                      |                 |          |                  |         |     |
| Provider satisfaction with health plan or program   | No                   | No              | No       | Yes <sup>c</sup> | No      | No  |

<sup>a</sup>HCFA is significantly expanding the systematic collection of patient satisfaction data. This expansion will involve collecting consumer satisfaction data for all health plans and will also include questions about satisfaction with providers.

<sup>b</sup>A summary statistic is reported for each health plan, which is, in part, determined by enrollees' perceptions of their ability to find doctors with whom they are satisfied.

<sup>c</sup>VA conducts employee surveys that include questions on satisfaction.

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