

FEATURE

WITHIN EIGHT YEARS, THE FIRST WAVE OF THE 77 MILLION BABY-BOOM GENERATION WILL START TO RETIRE AND BECOME ELIGIBLE FOR MEDICARE. THIS GENERATION'S RETIREMENT WILL DOUBLE MEDICARE'S ENROLLMENT, DRAMATICALLY INCREASE MEDICARE SPENDING AND COSTS, AND IMPOSE ENORMOUS FINANCIAL PRESSURES ON THE MEDICARE HOSPITALIZATION TRUST FUND, THE GENERAL REVENUE FUND, TAXPAYERS AND MEDICARE BENEFICIARIES ALIKE.

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More important, the retirement of the baby-boom generation will stimulate the greatest demand for medical services in history. This is not only because of the sheer size of the baby-boom generation and the volume of services that such a large retiree population will require, but also because of the rapid changes in medical technology, the fruits of advancing biomedical research, and the expected level of quality of care and service that this next generation of retirees will wish to consume.

Today's \$271 billion Medicare program is a universal, defined benefit program, financed largely by today's taxpayers for today's retirees. This, given America's rapidly changing demographic profile, presents its own formidable financial challenges, as the Medicare trustees, the Congressional Budget Office, and the U.S. General Accounting

be delivered to Medicare patients, Congress and the CMS must price more than 7,000 medical procedures offered by more than 800,000 physicians and other medical professionals; more than 500 hospital procedures; and various medical devices and technologies, skilled nursing and home health care services. In short, Medicare is also governed by a massive system of price regulation.

The central policy question facing Congress and the Administration is whether Medicare, as it exists today, can absorb the demographic shock of the baby-boom generation and continue to deliver high-quality medical care in an economically efficient fashion. I do not think that it can.

Neither Congress nor the Administration can control the popular and growing demand for medical services. For example, in the area of

MAP TO MEDICARE REFORM: BUILDING ON THE FEHBP

by Robert E. Moffit, Ph.D.

Office have already described in significant detail to Congress and the public.

But there is an equally, if not more serious, challenge for the Congress, as well as for doctors, hospitals, nurses, and other medical professionals: How do we assure the cost-effective and efficient delivery of high-quality medical services to this very diverse and rapidly aging population? Under the current system of Medicare governance, medical benefits, treatments, and medical procedures must be authorized by law or approved through the regulatory regime developed and enforced by the Centers for Medicare and Medicaid Services (CMS). In short, Medicare is governed by a system of detailed central planning.

Moreover, beyond the definition and determination of medical benefits, treatments, and procedures, and the conditions under which such services are to

prescription drugs alone, of the 11.8 percent increase in drug spending in 2002, 8 percentage points were attributable to the use of new drugs as well as the expanded use of existing pharmaceuticals for a variety of medical conditions.¹

In the face of an unprecedented demand for modern medical services, there is no question that Congress can control the supply of medical services, and thus the cost of the program itself, simply through tighter controls on reimbursement to doctors, hospitals, and other medical professionals.

The proposition that the government can control the growth in Medicare spending through the imposition of price controls or caps on overall Medicare spending is an intellectually unimpressive one; of course, it can. But, likewise, there is no reason to believe that Congress can impose such controls and cap such spending and simultaneously

accommodate the rising demand for those services without reducing their quantity or compromising their quality.

THE NEED FOR A SUPERIOR MODEL

If Medicare’s current structure of central planning and price regulation is not the best model for Medicare’s future, however, it does not logically follow that conventional private-sector health insurance is a better one.

In the private-sector health insurance market, individuals and families generally do not have portability or security in their coverage. Nor do they exercise control over the terms and conditions of their benefits. Employers, corporate benefits managers, or managed care executives often make all of the key decisions over the terms and conditions of coverage, and therefore can create obstacles to their access to physicians and medical specialists, treatments, and procedures. In most instances, individuals and families, whose coverage is tied to their jobs, cannot “fire” poorly performing health insurance companies in the same way they can dump poorly performing firms in many other areas of insurance coverage or in the provision of all other services in an open market.

A Public-Private Partnership. If the private-sector experience cannot yield the best model for a better Medicare program, that does not mean we cannot enter into a public-private partnership that can yield solid results for the next generation of senior citizens.

The best serviceable model of a public-private partnership is, in fact, a government program. It is the 43-year-old Federal Employees Health Benefits program (FEHBP), which serves 8.3 million federal employees, retirees, and their families, including more than 172,000 persons who rely on FEHBP as their primary coverage in retirement. Created by an Act of Congress in 1959, the FEHBP is governed under the provisions of Chapter 89 of Title V of the United States Code. It is administered by the United States Office of Personnel Management (OPM) and annually financed through congressional appropriations. Based on choice and competition, it is a government program older than Medicare, Medicaid, or most private managed care arrangements.

BUILDING ON THE FEHBP EXPERIENCE

Building on the FEHBP experience, Congress and the Administration can work together to create a new and improved Medicare program that is characterized by patient choice, including plan choice in rural areas, market competition, and solid consumer information. Other features of the FEHBP model include an openness to change, administrative flexibility, stability in the insurance market, and rationality and predictability in the financing of care. Specifically:

The FEHBP model guarantees enrollees, regardless of where they live, a broad range of health plan choices. The professional literature, including recent surveys of Medicare beneficiaries, proves conclusively that choice of health plans is highly valued and that there is a direct relationship between the choice of a health plan and patient satisfaction.² Not surprisingly, in the FEHBP, enrollee satisfaction is higher than that found among enrollees in the health insurance industry as a whole.³

In any transition to a new program, Medicare patients may wish to remain in conventional Medicare, but they should also have the right to pick and choose from a diversity of options, a variety of health plans, the benefits, the doctors and medical specialists, and the medical treatments they think are better for them at the prices they wish to pay.

The FEHBP is an excellent model for designing a system based on broad personal choice. Every FEHBP enrollee, rural or urban, has a multiple choice of national health plans.⁴ Today, there are 12 national health plan options, mostly fee for service or preferred provider organization (PPO) options, available to all enrollees nationwide. About 70 percent of all enrollees are enrolled in fee for service or PPO plans.⁵

The FEHBP rules governing the participation of health maintenance organizations (HMOs) are very different. HMOs participate at the state level, and the number of participating HMOs, which today cover roughly 30 percent of all FEHBP enrollees, varies from year to year.⁶ There is no reason, of course, why a reform of Medicare could not establish a similar

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structure for national plan options, as well as geographically based HMOs, for future Medicare enrollees.

In assuring choice, and in restructuring the Medicare program, Congress can improve on the experience of the FEHBP in two key areas:

First, it could integrate private retiree health insurance into the new system, creating a seamless continuity of coverage and care. If individuals have had a good experience with a private plan in their active working life, and want to carry that plan with them into retirement as their primary coverage and keep the doctors and specialists that they already have, they should be able to do so and get a government contribution to offset the costs of that plan.

Second, Congress can make sure that the new consumer-driven options are also easily accessible to retirees who want them. Such options include medical savings accounts, flexible spending accounts, health reimbursement accounts, or other forms of health care accounts. In any case, retirees should be able to take accumulated funds from these accounts with them into retirement to use as payment for medical services. Right now there are 1.5 million Americans with such options,⁷ and there are prospects for significant growth.

The FEHBP provides for a benefits package significantly superior to that of Medicare, beyond prescription drug coverage. Beyond the broad range of health care choice, basic FEHBP coverage is typically of greater value than Medicare. According to a recent Congressional Research Service (CRS) analysis, when drug coverage, home health, and skilled nursing care are factored into the comparative equation, FEHBP has a total actuarial value that is 28.8 percent more generous than Medicare.⁸

Perhaps even more significant is the ability of FEHBP enrollees to secure value for money. Drug coverage in the FEHBP (all plans have such coverage) provides an excellent case study. According to analyses conducted by the General Accounting Office (GAO), health plans in the FEHBP typically contract with pharmacy benefit managers (PBMs). These PBMs offer “generally non-restrictive drug formularies across a broad range of drugs and

therapeutic categories.”⁹ The GAO found that for 14 selected major brand-name drugs sold in retail pharmacies, enrollees were able to secure discount prices at about 18 percent below what cash-paying customers would otherwise have paid; for four selected generic drugs, the discount prices were 47 percent below prices paid by cash-paying customers.¹⁰ For mail order prescription drug options, the GAO found that the performance was even more impressive.¹¹

The FEHBP has a record of reasonable administrative costs. With a relatively small staff, OPM incurs administrative costs that are 1 percent of the “aggregate cost of plan premiums, but generally are less than that amount.”¹² The administrative costs of the major health insurance carriers, the national fee for service and PPO plans, average about 7 percent.

Parenthetically, it is worth noting that Medicare’s administrative costs are routinely assumed to be much lower, running between 1.5 percent and 2 percent annually. Technically, as a percentage of administration to benefits, this is correct. This widely held assumption, however, neglects the administrative costs that are routinely incurred by doctors and medical practices, hospitals and clinics, home health care and skilled nursing facilities in complying with Medicare’s regulatory regime and paperwork requirements.

A 2001 study conducted by PricewaterhouseCoopers for the American Hospital Association reports that for every hour of care delivered to a Medicare patient in an American hospital, hospital officials typically spend at least a half-hour or more complying with Medicare paperwork. Doctors and other medical professionals bear similar costs in time, energy, and effort. Every dollar spent on complying with the increasingly onerous requirements of Medicare’s growing regulatory regime is a dollar that is not spent on patient care. None of these very real costs, of course, show up in the Medicare budget.

The FEHBP—model allows and encourages innovation in the delivery of health care. In a restructured Medicare program, there should be ample room for plans and providers to innovate and make changes in delivery of medical services, such as the inclusion of new benefit combinations or increasingly

sophisticated coordination of care for persons who are chronically ill. Medicare patients should also be able to take advantage of the latest in cutting edge technology or medical treatments without waiting literally for years for a central agency to make decisions about coverage, or about coding for procedures, or payments for these procedures or technologies.

In this respect, also, the FEHBP provides a solid working model. The program is not, strictly speaking, a pure defined contribution system; nor is it a pure defined benefit system. It is, in effect, a combination of both. While the law defines *categories* of benefits, such as hospitalization or physician services, that must be included in any plan wishing to participate in the FEHBP, the specific medical benefits, treatments, or procedures, including the kind of medical technologies that are available, are largely determined by the health plans themselves and subject to the satisfaction of consumer demand in a competitive market. In other words, the FEHBP provides a structure that accommodates and encourages innovation.

The FEHBP model provides a regulatory system that focuses on consumer protection rather than provider regulation. Under its statutory authority, OPM is to contract with health plans that are licensed in the states; that are reinsured with other companies; that offer detailed statements of benefits with definitions of limitations and exclusions that OPM considers “necessary or desirable”; that charge rates that “reasonably and equitably” reflect the costs of the benefits; and that agree to provide benefits or services to persons entitled, as OPM determines, under the terms of its contract.

OPM enforces fiscal solvency requirements and makes sure that plans can pay claims. The agency is authorized to levy a surcharge on plans of up to 3 percent of premiums to establish a contingency reserve fund for the payment of unforeseen claims.

OPM is also solely responsible for the benefits available to federal employees and retirees. Under Section 8902 of Title 5, the terms of any contract between OPM and a competing plan pre-empt any state or local law governing health insurance or health plans.

There is no reason why a new Medicare administrative agency could not perform the

very same functions as OPM in a restructured Medicare program.

The FEHBP model provides for a stable health insurance market. Adverse selection or risk segmentation is normally a concern with a system based on pluralistic, competing health plans with a variety of benefits packages and voluntary enrollment. The concern is that older and sicker enrollees will congregate in certain plans, drive up the cost of those plans, and drive younger and healthier enrollees out, further driving up costs and premiums with a resultant unraveling of the market.

The FEHBP, however, offers a working model to alleviate this concern. Extensive research on the issue of adverse selection in the FEHBP shows that, in fact, the program is remarkably stable.¹³ In the FEHBP, there is no risk-adjustment mechanism to deal with the problem of adverse selection, yet it is characterized by features that should gravely aggravate problems of adverse selection: There is no standardized benefits package; premiums are governed by a crude form of community rating (older persons pay the same rates as younger ones); and all plans are required to enroll persons without regard to their health status.

Professor Kenneth Thorpe of Emory University found, however, that while more than half of regular active workers and older, Medicare-eligible workers are enrolled in low-cost health plans, the age distribution is roughly the same across all competing health plans in the FEHBP: low-cost, medium-cost, and high-cost plans. The research indicates that the generosity of the subsidy, a government contribution up to 75 percent of the cost of the health plan, is enough to encourage younger and healthier persons to pay extra for the attractive benefits in higher priced health plans.¹⁴

The FEHBP experience, therefore, has positive implications for Medicare reform, where proposed Medicare contribution formulas for competing health plans would likely be more generous than those in the FEHBP.

The FEHBP model provides for a regulatory environment that is light and flexible and that does not demoralize doctors and other medical professionals. The FEHBP provides a solid working model

of regulatory flexibility. Under Section 8902 of Title 5 of the U.S. Code, OPM “may prescribe reasonable minimum standards” for health benefits plans and for carriers. As the CRS observed in its comprehensive 1989 analysis of the FEHBP, the legislative language authorizing the FEHBP gave OPM “broad powers” to administer the FEHBP, and OPM has thus had “wide latitude to institute changes it felt were needed....”¹⁵

Under Section 890.201 of the Code of Federal Regulations,¹⁶ OPM has set forth rules to admit and negotiate with health plans that comply with the provisions of law. Under OPM rules, there are no mandatory government fee schedules or price controls and no flawed formulas governing reimbursement updates for the services of doctors, hospitals, or medical professionals.

Medical professionals should not have to wrestle with literally tens of thousands of pages of incomprehensible rules, regulations, guidelines, and related paperwork governing virtually every aspect of their operations. They should also be paid on the basis of real market conditions, reflecting real consumer demand and provider supply, rather than the current system of administrative pricing which, because it often bears little or no relationship to existing real market conditions, often results in taxpayers and patients either overpaying or underpaying for medical services or benefits. In short, health plans and providers should be able to operate in a system governed by a small bureaucracy and minimal regulation. The FEHBP provides a model for designing such a system.

The FEHBP regulatory system is a model that provides a level playing field for competing health plans. As noted, OPM rules focus primarily on consumer protection, but they also enforce a level playing field for private health plans. For example, all competing health plans have to accept enrollment of employees and retirees without discriminating against them on such grounds as age, race, sex, pre-existing physical or mental conditions, or health status. Health plans must also provide health benefits to enrollees “wherever they may be” and guarantee their right to renew coverage.

Plans are also required to have a standard rate structure for individuals and family coverage and to maintain statistical records for the plan

covering federal employees separate from their other insurance business. In order to insure their ability to pay claims, health plans must have “a special reserve fund” for operations and reinvest any fund income in the fund. Health plans must also provide for continued enrollment of persons during the contract period and ensure enrollment without a waiting period for covered persons.

The FEHBP model gives enrollees the ability to act on solid information in selecting plans, as well as doctors, hospitals, and medical treatments. In the 21st century, information technology will accelerate and become a vehicle for increasingly sophisticated personal decision-making. As of September 2001, according to a U.S. Department of Commerce study, 143 million Americans, or more than half of the U.S. population, were using the Internet with a growth rate of roughly 2 million new Internet users per month.¹⁷ About 70 percent of Americans in the workforce during their prime years, from their 20s into their 50s, use computers; and as the same study notes, Americans who used the computers when they were younger “will likely continue to do so as they age.”¹⁸

Already, 35 percent of Americans are going on-line to secure health information.¹⁹ By the time the baby-boom generation starts to retire, information technology will almost certainly play an increasingly important role in decision-making among doctors and patients alike. They should have routine access to the best possible information from authoritative sources on plans, benefits, treatments, and procedures. Information on quality, price, and benefits should characterize plan choice for the next generation of Medicare patients, and that information should be provided not simply by health plans themselves, but also by various consumer and retiree organizations, union and employee organizations, and ethnic, fraternal, and even medical and religious organizations.

Historically, enrollees in the FEHBP have had regular access to clear, comparative health information from both government and private-sector sources. OPM annually publishes a Guide to FEHBP plans. This is a simple, detailed, and plain-English comparison of health plans, rates, and benefits.

MEDICAL PROFESSIONALS SHOULD NOT HAVE TO WRESTLE WITH LITERALLY TENS OF THOUSANDS OF PAGES OF INCOMPREHENSIBLE RULES, REGULATIONS, GUIDELINES, AND RELATED PAPERWORK GOVERNING VIRTUALLY EVERY ASPECT OF THEIR OPERATIONS.

THERE IS NO REASON WHY 21ST CENTURY RETIREES, PARTICULARLY THE BABY-BOOM GENERATION, SHOULD NOT BE ABLE TO TAKE ADVANTAGE OF RAPIDLY ADVANCING INFORMATION TECHNOLOGY FOR PERIODIC HEALTH PLAN COMPARISONS, AND EVEN MORE DETAILED COMPARATIVE INFORMATION ON QUALITY, SERVICE, OUTCOMES, AND THE AVAILABILITY OF EVIDENCE-BASED MEDICINE AMONG PROVIDERS.

Prominent private-sector organizations publish comparative information on health plans. The National Association of Retired Federal Employees (NARFE) publishes *Federal Health Benefits and Open Season Guide*, which is oriented specifically to federal retirees and rates plans on benefit packages. The Washington Consumers Checkbook publishes *Checkbook's Guide to Health Insurance Plans for Federal Plans for Federal Employees*. Written in plain English, both of these guides provide excellent comparative information on price, benefits, and service. Beyond the published guides, FEHBP enrollees are now getting comparative information on the Internet. As a matter of policy, OPM is accelerating the provision of on-line information, particularly for retirees.

There is no reason why 21st century retirees, particularly the baby-boom generation, should not be able to take advantage of rapidly advancing information technology for periodic health plan comparisons, and even more detailed comparative information on quality, service, outcomes, and the availability of evidence-based medicine among providers.

The FEHBP model provides for a financially stable program. The FEHBP trust fund is unified, and its administration is comparatively simple. Both the government contribution and all beneficiary premium payments are combined and deposited in the Federal Employee Health Benefits Trust Fund.

For federal retirees, OPM administers their enrollment, provides for an automatic deduction of their portion of the premium from their monthly federal retirement checks, adds the applicable government contribution, and deposits that money in the FEHBP trust fund. Congress appropriates projected amounts for the FEHBP trust fund for federal retirees as part of the annual Treasury and Postal Appropriations process.

While the FEHBP trust fund is administered by OPM, it is formally a part of the United States Treasury. The Secretary of the Treasury, in consultation with OPM, has the legal authority to invest the assets of the trust fund in federal government securities, and interest income from these government securities is also credited to the trust fund. During the contract year, payments to health insurance plans or carriers are made directly

from the U.S. Treasury and charged to the FEHBP trust fund. OPM's administrative expenses are also charged to the FEHBP trust fund.

Premium income and disbursements in the FEHBP trust fund are easily tracked. The fund's income is routinely subject to congressional action and oversight. If, for any reason, there is a need for a supplemental appropriation for the FEHBP trust fund, Congress can and does provide for it. In this respect, the FEHBP trust fund model is superior as a mechanism for monitoring the solvency and ensuring the financial stability of a modernized Medicare system.

CONCLUSION

The FEHBP is 43 years old. It is older than Medicare, Medicaid, and most private employment-based managed care arrangements. We know a great deal about it, both its strengths and its weaknesses. While the program is by no means perfect, there is little doubt that it is a government program with a solid record of success. This success is evident in its ability over time to deliver high-quality health care within a pluralistic framework of consumer choice and market competition.

In designing a superior program for retirees, the challenge is to match the FEHBP in its performance. Specifically, the challenge is to match it in the breadth of choice available to enrollees, the flexibility of its administration, the ease with which benefits are added or modified, and the comparative absence of bureaucracy and red tape in its operations. In these areas, the FEHBP provides an excellent model for designing major improvements in the way in which we can finance and deliver medical benefits to America's senior citizens, particularly the first wave of the baby-boom generation set to retire in just eight years.

Robert E. Moffit is Director of the Center for Health Policy Studies at The Heritage Foundation. This article is excerpted from testimony before the Senate Special Committee on Aging, May 6, 2003.

FOOTNOTES

[1]“Rx Spending Growth Slows to Lowest Level in Six Years,” Pharmaceutical Research and Manufacturers of America, Spring 2003.

[2]For an overview of the recent surveys and the professional literature, see Derek Hunter, “Just the Facts: Health Care Choice and Patient Satisfaction,” Heritage Foundation *Web Memo* No. 259, April, 17, 2003, at <http://www.heritage.org/Research/HealthCare/wm259.cfm>.

[3]*Ibid.*

[4]For a discussion of coverage in rural as well as urban areas, see Nina Owcharenko, “Giving Rural Seniors a Choice of Health Plans: The FEHBP Model for Medicare Reform,” Heritage Foundation *Web Memo* No. 258, April 17, 2003, at <http://www.heritage.org/Research/HealthCare/wm258.cfm>.

[5]U.S. General Accounting Office, *Federal Employees’ Health Plans: Premium Growth and OPM’s Role in Negotiating Benefits*, Report to the Subcommittee on International Security, Proliferation and Federal Services, Committee on Governmental Affairs, U.S. Senate, GAO-03-236, December 2002, p. 6.

[6]*Ibid.*, p.7.

[7]See Jon R. Gabel *et al.*, “Consumer Driven Health Plans: Are They More than Talk Now?” *Health Affairs* Web Exclusive, at http://www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_112002.htm.

[8]Derek Hunter, “Just the Facts: The Disparity in Value Between FEHBP and Medicare Coverage,” Heritage Foundation *Web Memo* No. 262, April 23, 2003, at <http://www.heritage.org/Research/HealthCare/wm262.cfm>.

[9]David M. Walker, Comptroller General of the United States, “Medicare: Observations on Program Sustainability and Strategies to Control Spending on Any Proposed Drug Benefit,” testimony before the Committee on Ways and Means, U.S. House of Representatives, GAO-03-650T, April 9, 2003, p. 20.

[10]*Ibid.*, p. 19.

[11]*Ibid.*, p.20. The GAO analysis revealed that for mail order prescription drug options in the FEHBP, the prices were 27 percent

lower for the selected brand-name drugs and 53 percent lower for the selected generic drugs.

[12]“These sums pay the personnel costs of OPM actuaries and employees who negotiate with carriers, monitor plans, and generally oversee all aspects of program administration. OPM adds a charge to each plan’s premium to cover these administrative costs.” Carolyn L. Merck, *The Medicare Program and The Federal Employees Health Benefits Program: Purpose, Design and Operations*, May 26, 1999, p. 34.

[13]Curtis S. Florence and Kenneth E. Thorpe, “How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?” *Health Affairs*, Vol. 22, No. 2 (Spring 2003), pp. 211–218.

[14]*Ibid.*

[15]*The Federal Employees Health Benefits Program: Possible Strategies for Reform*, A Report prepared by the Congressional Research Service for the Committee on Post Office and Civil Service, U.S. House of Representatives, 101st Cong., 1st Sess., Committee Print 101–5, May 24, 1989, p. 238.

[16]Code of Federal Regulations, Title 5, Volume 2, Parts 700 to 1199, revised as of January 1, 2001, pp. 410–412.

[17]See *A Nation On-Line: How Americans Are Expanding Their Use of the Internet*, U.S. Department of Commerce, National Telecommunications and Information, Economics and Statistics Administration, February 2002, p. 1.

[18]*Ibid.*, p. 14.

[19]*Ibid.*, p. 2.