

**UP, UP, AND AWAY! GROWTH TRENDS IN  
HEALTH CARE PREMIUMS FOR ACTIVE AND  
RETIRED FEDERAL EMPLOYEES**

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**HEARING**

BEFORE THE

OVERSIGHT OF GOVERNMENT MANAGEMENT,  
THE FEDERAL WORKFORCE, AND THE  
DISTRICT OF COLUMBIA SUBCOMMITTEE

OF THE

COMMITTEE ON  
HOMELAND SECURITY AND  
GOVERNMENTAL AFFAIRS  
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# **UP, UP, AND AWAY! GROWTH TRENDS IN HEALTH CARE PREMIUMS FOR ACTIVE AND RETIRED FEDERAL EMPLOYEES**

FRIDAY, MAY 18, 2007

U.S. SENATE,  
SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT  
MANAGEMENT, THE FEDERAL WORKFORCE,  
AND THE DISTRICT OF COLUMBIA,  
OF THE COMMITTEE ON HOMELAND SECURITY  
AND GOVERNMENTAL AFFAIRS,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 10:32 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Subcommittee, presiding.

Present: Senators Akaka, Voinovich, and Warner.

## **OPENING STATEMENT OF CHAIRMAN AKAKA**

Chairman AKAKA. Good morning and aloha. The Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia will come to order.

Today, the Subcommittee meets to consider the average growth rate of health care premiums for active and retired Federal employees and their families. The Federal Employee Health Benefits (FEHB) Program is the Nation's largest employer-sponsored health care program in the country. Boasting a hefty 8 million participants, it is regarded as a model program for the public sector and Medicare.

This is something we can all be very proud of. I believe that as we look to the future of the Federal workforce, it is critical that the FEHB Program continue to provide quality care choices at the lowest possible cost to employees and retirees. It is critical to attracting and retaining top-flight talent.

Without any doubt, the FEHB Program is competitive with the private sector and other areas of the public sector. Federal employees and retirees have roughly 280 health care plans to choose from. Every year OPM uses its leverage as the Nation's largest employer-sponsored health benefit plan to keep premiums as low as possible for our enrollees and their families, while maintaining high-quality care services.

From 1998 to 2005, premiums rose on average more than 7 percent a year. From 2001 to 2003, average premiums grew by double digits. While this was mostly in line with overall premium growth

in the marketplace, active and retired employees still felt the impact on their wallets.

After years of growing premiums, OPM used reserve funds to reduce the average premium growth rate by 7 percent. Over the last 2 years, the premium increases were kept lower. This was especially helpful to retirees on fixed incomes who did not get to choose what prescription drugs or services they need. However, premium growth is still a problem because it consistently outpaces the cost-of-living adjustments and average annual pay raise.

What really concerns me is that premiums fell not because OPM negotiated better rates or market forces drove down health care costs, but because they dipped into reserve funds. Premiums would have been lower if OPM had applied the drug subsidy. OPM has a good story to tell. They would have had a better story and Federal workers and retirees would have paid less if OPM had used all of the resources available to them.

Last year, I requested that GAO conduct a review of the trends in FEHB Program premiums. The report, "Federal Employee Health Benefits Program Premium Growth Has Slowed and Varies among Participating Plans," was released in December 2006. Today's testimony will review the results of the GAO report and discuss the impact of FEHB Program premiums on administrators, providers, and enrollees.

I disagree with OPM's decision not to apply the Medicare subsidy. Also I was disappointed that OPM denied the Postal Service, an independent agency which does not receive appropriated funds, the subsidy as well. I believe we all have a common goal: To offer a range of comprehensive health care plans and ensure that the lowest possible premiums are there. So, I thank you again for being here today.

Senator Voinovich, please proceed with your statement.

#### **OPENING STATEMENT OF SENATOR VOINOVICH**

Senator VOINOVICH. Good morning, Mr. Chairman, and thank you for holding this hearing this morning to examine the Federal Employees Health Benefit Program. I share your concerns about the rising cost of health care, not just for approximately 8 million people in the FEHB Program, but for all individuals in my home State of Ohio and across the Nation.

My remarks this morning, Mr. Chairman, are really more geared toward the big picture, and you have done a really good job of narrowing it down to the report by the GAO. But I think everyone should recognize that spending on health care in the United States has reached \$1.9 trillion, almost 16.5 percent of the GDP, the largest share ever. And despite all that spending, 47 million Americans, or 15 percent of the population, have no health care coverage. For those with access to insurance, the costs continue to rise, and that is what we are concerned about. Within the FEHB Program, premiums have increased every year since 1998. However, the Office of Personnel Management has demonstrated its ability to keep premium increases at or below the national average.

In managing the FEHB Program, OPM has a difficult job. The FEHB Program is recognized as a model health insurance program. Isn't it interesting that it is always referred to as an example of

quality coverage. We have got to provide all citizens with access to the same quality health care that the Federal employees have. The expectations of the Executive Branch, of Congress, and of the Federal employees are that plans will provide comprehensive coverage across the Nation, both in rural and in urban environments, at reasonable prices for all Federal employees.

In the private sector employer-sponsored health insurance markets, it is even harder to keep the cost of coverage affordable. Individuals who receive their insurance from private employers were faced with an average premium increase of 7.7 percent between the spring of 2005 and the spring of 2006. Fortunately, that was a lower growth rate than the 9.2-percent increase in 2005 and the 11.2-percent increase in 2004.

Yet, despite the slowdown, premiums continue to increase much faster than overall inflation, 3.5 percent, and wage increases, 3.8 percent. Premiums for family coverage have increased by 87 percent since 2000. These statistics are startling, and it is beyond time that we do something about them.

Now, for too many years, I have listened to my colleagues on both sides of the aisle talk about the rising cost of health care and the growing number of uninsured Americans without much progress at the Federal level to come up with an innovative solution to the Nation's problems regarding access to quality, affordable health care. That is why, Mr. Chairman, Senator Bingaman and I have introduced a bipartisan bill that presents innovative solutions called the Health Partnership Act. It was introduced in the House by Tammy Baldwin, Democrat from Wisconsin, and Dr. Tom Price, Republican from Georgia. The House version has more than 65 co-sponsors. The bill would support State-based efforts to reduce the uninsured, reduce costs, improve quality, improve access to care, and expand information technology.

Over a 5-year period, Congress would then evaluate whether the States are meeting the goals of the Act and evaluate whether various State's approaches do not work in order to make recommendations for Federal health care reform. I know that Secretary Leavitt, the National Governors Association, the Heritage Foundation, and The Brookings Institution, are all supportive of this legislation.

While I continue to work to advance the Health Partnership Act, I also plan to introduce legislation next week with Senator Carper to establish and maintain an electronic personal health records system for individuals and family members enrolled in the FEHB Program. Our legislation was the result of a Subcommittee hearing earlier this year, which examined the use of health information technologies. Experts agree that a widespread adoption of health information technologies, such as electronic health care records will revolutionize the health care profession. In fact, the Institute of Medicine, the National Committee on Vital and Health Statistics, and other expert panels have identified information technology as one of the most powerful tools in reducing medical errors and improving the quality of care. Not only can EHRs save lives and improve the quality of health care, they also have the potential to reduce the cost of delivering of health care.

According to the Rand Corporation, the health care delivery system in the United States could save approximately \$160 billion an-

nually with the widespread use of electronic medical records, and that is why, Mr. Chairman, I would like to see us get legislation that would require our health system to do this. We would set the example for the rest of the country.

So I look forward to hearing what the witnesses have to say today and, again, thank you for holding this hearing.

Chairman AKAKA. Thank you very much, Senator Voinovich.

Senator Voinovich and I have worked closely together. He has been a leader in these areas, and I would tell you that he has set the pace for this Subcommittee as we continue to work on issues that we need to, to try to flesh out problems and to try to improve those conditions as well.

We are so happy that we have been able to have you as witnesses, and as you know, our Subcommittee has rules that require that all witnesses testify under oath, and, therefore, I ask our witnesses to please rise and raise your right hand. Do you solemnly swear that the testimony you are about to give this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. KICHAK. I do.

Mr. DICKEN. I do.

Chairman AKAKA. Thank you very much. Let the record note that the witnesses responded in the affirmative.

We have two witnesses before us today. First is Nancy Kichak, Associate Director and Chief Actuary, Strategic Human Resources Policy Division, U.S. Office of Personnel Management; and John Dicken, Director of the Health Care Team, U.S. Government Accountability Office. Good to have you, and may I ask you, Ms. Kichak, to begin with your statement.

**TESTIMONY OF NANCY KICHAK,<sup>1</sup> ASSOCIATE DIRECTOR, STRATEGIC HUMAN RESOURCES POLICY DIVISION, AND CHIEF ACTUARY, U.S. OFFICE OF PERSONNEL MANAGEMENT (OPM)**

Ms. KICHAK. Thank you, and thank you for inviting me here today to represent the Office of Personnel Management and to discuss the recent premium trends within the Federal Employees Health Benefits Program (FEHB), as well as the initiatives OPM and the health insurers who participate in the program use to provide top-quality health care at a reasonable cost to approximately 8 million Federal employees, retirees, and their families.

The FEHB Program offers competitive health benefits products to Federal workers, like other large employer purchasers, by contracting with private sector health plans. For 5 consecutive years, rate increases in the FEHB Program have declined. In fact, for 2007, the rates increased only 1.8 percent. The result: Approximately 63 percent of FEHB Program enrollees incurred no premium increase, while another 15 percent saw increases of less than 5 percent. For the past 5 years, the rate increases were lower than industry averages.

We believe these low increases are the result of the continued efforts by OPM and the Administration and our carriers to provide FEHB Program enrollees with health care choices that meet their

<sup>1</sup>The prepared statement of Ms. Kichak appears in the Appendix on page 27.

respective individual and family health care needs at affordable prices. Among those efforts, OPM has taken steps to further promote market-based competition by providing a range of quality health care options that include high-deductible health plans and consumer-driven plans. We have also introduced flexible spending accounts and new dental and vision programs.

Under authority provided by law, OPM has provided guidance to agencies to allow them to pay the full cost of premiums for Federal employee reservists for up to 24 months, while they are deployed in harm's way. Agencies have shown their support for our reservists by accepting this responsibility.

Over the past several years, OPM's annual guidance for benefit proposals in the FEHB Program has encouraged carriers to add benefits to their respective coverage options. Those benefits have included coverage for a variety of preventive services such as screenings for osteoporosis, colorectal cancer, abdominal aortic aneurysm, and cholesterol, as well as a variety of immunizations. In addition, we have consistently encouraged carriers to place emphasis on care management programs and practices to address the complex health care needs of enrollees with chronic conditions.

As part of the annual rate negotiation process, OPM makes use of its authority to use excess reserves to mitigate premium increases. As OPM stated during the past year's Open Season rollout period, we negotiate with FEHB Program plans to exercise this option. The recent Government Accountability Office (GAO) report on premiums confirms OPM's ability to use reserves in this manner and to generally mitigate fluctuations in premiums from year to year. This is the third time in the last 5 years our bilateral negotiations with insurance carriers have resulted in some planned reduction in reserves.

Regarding the use of the Medicare Part D employer subsidy to assist with offsetting premiums in the program, the intent of the subsidy is to encourage employers to continue providing prescription drug coverage to their Medicare-eligible retirees. As part of the fiscal year 2006 budget process, the potential use of the subsidy was evaluated by the Federal Government. This review found no good rationale for the Federal Government to pay itself to continue providing prescription drug coverage to Federal retirees, especially since OPM has no plans to eliminate this coverage. As OPM moves forward, we will continue to seek innovative benefit proposals from FEHB Program carriers that provide quality, value, and affordable health care options.

We are proud of our record in administering the program and believe it offers Federal employees and retirees a wide variety of options from which to select the health benefits and premiums that best meet their needs.

I appreciate the opportunity to testify and will be glad to answer any questions. Thank you.

Chairman AKAKA. Thank you very much, Ms. Kichak. Mr. Dicken.

**TESTIMONY OF JOHN E. DICKEN,<sup>1</sup> DIRECTOR, HEALTH CARE TEAM, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (GAO)**

Mr. DICKEN. Mr. Chairman and Senator Voinovich, I am pleased to be here today to discuss the findings from our December 2006 report entitled “Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed and Varies among Participating Plans.” About 8 million Federal employees, retirees, and their dependents receive health coverage through more than 280 plans participating in the FEHB Program. As you noted, Mr. Chairman, this makes the FEHB Program the largest employer-sponsored health insurance program in the country. Federal employees’ health insurance premiums have increased on average each year since 1997. These increases posed higher costs for the Federal Government and for enrollees who combined will pay about \$35 billion in premiums in 2007.

My remarks today, based on our December report, will focus on three areas: One, recent FEHB Program premium growth trends compared to those of plans offered by other purchasers; two, the factors that contributed to average premium growth trends across all FEHB Program plans; and, three, the factors that contributed to differing premium growth among selected FEHB Program plans.

In summary, the average annual growth in FEHB Program premiums has slowed each year since 2002. From 2003 through 2007, the FEHB Program premium growth was generally lower than the growth for other purchasers. The key factors driving most of the growth in premiums were increases in the cost and utilization of health care services and prescription drugs. However, the premium growth for 2006 and 2007 was moderated by projected withdrawals from reserve funds.

To elaborate, growth in average FEHB Program premiums peaked at 12.9 percent for 2002 and has slowed to 1.8 percent for 2007. This represents the lowest average growth in FEHB Program premiums since 1997. The average annual growth rate in FEHB Program premiums from 2003 through 2007, 7.3 percent, has been slower than that of other purchasers. For example, premiums for the Nation’s second largest public employee health benefits program, the California Public Employees’ Retirement System, grew at 14.2 percent on average during this period. Similarly, premiums for employers surveyed annually by the Kaiser Family Foundation grew at 10.5 percent on average during this period.

Projected increases in the cost and utilization of health care services and prescription drugs accounted for most of the average annual premium growth across all FEHB Program plans for 2000 through 2007. Absent projected decreases in the costs of other factors, these increases will have raised 2007 average premiums by about 9 percent—6 percent due to higher cost and utilization of services and 3 percent due to higher prescription drug costs. Enrollee demographics, particularly the aging of the enrollee population, were projected to have less of an effect on premium growth.

At the same time, projected withdrawals from reserves offset average premium growth in the past 2 years, particularly for 2007. Officials from several plans stated that OPM monitored their plans’

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<sup>1</sup>The prepared statement of Mr. Dicken appears in the Appendix on page 33.

reserve levels and worked closely with them to build up or draw down reserve levels gradually to avoid wide fluctuations in premiums from year to year. Projected additions to reserves nominally contributed to average premium growth by less than 1 percentage point for 2000 through 2005. However, projected withdrawals from reserves offset average premium growth by about 2 percentage points for 2006 and 5 percentage points for 2007. Other factors, including benefit changes that resulted in less generous coverage and enrollees choosing lower-cost plans, slightly offset average premium growth for 2000 through 2007.

Premium growth varied among plans. Premium growth rates for the 10 largest plans by enrollment, accounting for about three-quarters of total enrollment, ranged from 0 to 15.5 percent for 2007. The variation was even wider across the smaller plans. Officials from several plans cited two key drivers of this higher than average premium growth: Higher than average increases in the actual costs and utilization of services and increasing shares of elderly enrollees.

In closing, FEHB Program premiums are driven in large part by plans' actual costs and utilization of health care services in prior years, projecting for future changes in benefits, enrollment, and health care expenditures. While for the last 2 years anticipated withdrawals from reserves have moderated FEHB Program premium growth, this strategy cannot be sustained indefinitely. As costs and utilization of prescription drugs and other health care services continue to increase, the FEHB Program, like other employer plans, will continue to face premium pressures in the future.

Mr. Chairman, this concludes my statement. I would be happy to answer questions that you or Members of the Subcommittee may have.

Chairman AKAKA. Thank you very much, Mr. Dicken. I want both of you to know that your full statements will be placed in the record.

To both of our witnesses, according to GAO, one of the reasons the premium rate slowed over the past 4 years was due to "less generous coverage." OPM disagreed with GAO's characterization. While we all want lower premium increases, we do not want to see a loss of service.

What services do you each consider to be generous types of services? Let me ask first Ms. Kichak and then Mr. Dicken. Ms. Kichak.

Ms. KICHAK. We believe that in recent years we have done a very good job in improving coverage for preventive services. We are covering more screenings than ever before. We are covering more immunizations. Although there have been some changes in our prescription drug programs in recent years, we feel we have been able to maintain the value of the drug programs by good management of pharmacy benefit programs and substitutions of generics which are the same quality drug at a lesser price.

We have increased our preventative services and maintained some of our most costly services by good management of the benefits.

Chairman AKAKA. Thank you. Mr. Dicken.

Mr. DICKEN. Certainly the plans offered by the FEHB Program offer comprehensive benefits and, like other large employers, OPM has been looking at those benefits. The plans have made some changes which in some recent years have had a modest effect on reducing the premiums. As Ms. Kichak noted, a number of those changes are in the area of prescription drugs where a number of plans have made changes in their cost sharing to enrollees, in some cases increasing that cost sharing or else restructuring the cost sharing to try to encourage the use of generic drugs or other cost-effective drugs.

Chairman AKAKA. Ms. Kichak, after Congress authorized employees to apply for a Medicare Part D drug subsidy, the Postal Service took advantage of the program and spent hundreds of thousands of dollars to apply for the employer supplement. OPM denied the application as the administrator of the FEHB Program. However, GAO found that had the Postal Service's application been approved, retirees would have saved money on their premiums.

Doesn't OPM look at whether or not retirees would reduce their premium costs in deciding on a course of action? And if not, why don't they?

Ms. KICHAK. I think OPM is extremely concerned with the cost of health care, which is why we work so hard to have a competitive program open to all different kinds of coverages so that folks have a choice and can find what they want.

As far as the Medicare subsidy is concerned, the Federal Government pays a significant portion of the premium, in the same way that the government subsidizes a part of Medicare Part D. The government was paying for this coverage anyway for the Part D drug. The particular legislation that authorized the application only said that employers, including the FEHB Program, could apply. But it did not specify that went to reduced premiums. Other employers have used that money to offset their total costs, which enables them to continue to provide the coverage. Likewise, the FEHB Program, had they applied, could have used that money to offset the cost of their contribution for annuitants.

So, really, when we looked at it, it was a question of was the government going to spend the money through the Medicare program or through the FEHB Program. We felt that it made no sense to go through the complex application process for the subsidy to move money from the Medicare program to the FEHB Program or vice versa.

Chairman AKAKA. Ms. Kichak, one of the stated reasons OPM said it did not apply for the subsidy was that it would be "the government paying itself." However, the Postal Service does not receive appropriated funds from Congress. Did OPM expect the Postal Service to receive other Federal funds to supplement premium coverage and is that the reason they chose to deny the Postal Service the subsidy?

Ms. KICHAK. The Postal Service is part of the FEHB Program, and their annuitants, when they retire, are paid out of the Civil Service Retirement and Disability Fund, and they are part of the same group. When their claims are filed, they are identified as civil service annuitants, not postal annuitants, and they are treated like everyone else. In fact, this is an instance where, when they are an

employee, they get a different subsidy from the Postal Service than other Federal employees, but when they retire, they become paid the same as anyone else.

So, first of all, in our data pool that we would need to refer to to apply for the subsidy, it would be hard for our carriers to distinguish the costs of postal annuitants as opposed to non-postal annuitants. So they are part of our system. We are not going to reduce the drug benefits, so we do not need the subsidy to protect the drug program in the FEHB Program. And so it was just difficult to treat them differently than the rest of the Federal Government.

Chairman AKAKA. You said in your testimony the Federal Government evaluated participation in the Medicare subsidy. Who specifically reviewed this?

Ms. KICHAK. OPM looked very carefully at all of the options under the Medicare program. We consulted with CMS to make sure we understood the options. Remember, this was a new program. It had a lot of options. It was not quite clear. Everything was not known on day one when the legislation passed it. They provided us some assistance in evaluating our level of drugs versus their level of drugs. And then we consulted throughout the Administration.

Chairman AKAKA. Thank you for your responses. Senator Voinovich.

Senator VOINOVICH. Thank you. I was one that was very supportive of the Medicare retirees subsidy to other retirement systems in the country, both public and private, to encourage them to stay in the program. Many of us were concerned that if we did not provide the subsidy, some employers like General Motors and others would just drop their prescription drug coverage and tell their retirees to enroll in Medicare. I have been pleased with the way it has worked out because most retiree and retirement systems have stuck with the program, and it has made a difference.

In the case of the Federal Government, your calculation was—and correct me if I am wrong—that if you applied for that subsidy, the money would have come in and it would have been coming from the Federal Government. It would have increased the cost of Medicare, the Part D program, because you would have got the money.

Ms. KICHAK. Right.

Senator VOINOVICH. Now, one would argue that if you had done that, that would have given you more money so that you could have reduced your overall costs to the program and perhaps passed that on to your participants who pay a percentage of the cost. What is it, about 28 percent average?

Ms. KICHAK. About 28 percent.

Senator VOINOVICH. So I would like you to respond to that issue. That is my first question.

Second is, from what I understand some of the folks from the Postal Service claim that they fund their retirement system or benefit programs similar to a State program, like California or Ohio, where you have retirees in it, and that because of the fact that you did not apply for that, you put them at a disadvantage so they were not able to get the benefit of this additional money.

Could you just clarify that for me on that rationale again?

Ms. KICHAK. First of all, you are absolutely right. Had we applied for the subsidy, it would have cost the Medicare program

more. And the FEHB Program also relies on general revenues from the Federal Government to pay the government's share of the health insurance for the non-postal retirees.

Senator VOINOVICH. OK. So your logic is that the general fund comes up with the money for Medicare. It also provides money to you, for you to do the job, but it would just be taking money out of one pot and putting it into another.

Ms. KICHAK. Yes.

Senator VOINOVICH. OK.

Ms. KICHAK. If you look at how the private sector uses the subsidy—and we do not have good statistics—but they were getting the subsidy to help defray their costs so they would continue to provide the coverage. So the money goes back to the employer, and it is not specified how the employer uses it other than the employer cannot cancel the coverage. That is the point of the subsidy.

So, yes, applying it to premiums would have been one option, but it was not a requirement. The money could have all come directly back into the general fund and then used to defray rate increases.

Now, the Postal Service is a separate issue because they do fund differently. But it is very hard in the FEHB Program with 8 million enrollees and 4 million enrollments and 285 plans to identify those drug costs for postal versus non-postal. One of the reasons the FEHB Program is cost efficient is we have extremely low administrative expenses, and it would have been a very difficult process to try to identify the drug costs.

The application process with CMS is not simple. It would have placed a great burden on our enrollees to try to identify that money for a relatively small group of folks, not the entire program.

Senator VOINOVICH. Are you saying the Postal Service, in terms of their retirement system, is separate and is funded by premiums that the folks in the Postal Service pay for their health care benefits?

Ms. KICHAK. For their retirees, they pay—

Senator VOINOVICH. No. For their active employees. Is the premium about the same as retiree's pay for their health care.

Ms. KICHAK. Well, the postal employees are in the same risk pool, so the total premium is the same. One of the hallmarks of the FEHB Program is the premium is the same whether you are a postal employee, a non-postal employee, or a retiree. Everybody is in the same risk pool.

Senator VOINOVICH. So the Postal Service is in the FEHB Program?

Ms. KICHAK. They are in the FEHB Program. The Postal Service has historically paid a higher portion of the total premium for employees, higher than the 72 percent. That ceases when the person retires, and then when they become a postal retiree in our civil service system, then the contribution of their health insurance is based on the 72 percent formula.

Senator VOINOVICH. All right. So if the Postal Service would have applied for the 28 percent subsidy, both retired and active workers premiums would have been reduced.

Ms. KICHAK. It could have helped them reduce their costs, yes.

Senator VOINOVICH. And you distinguish that, or do not distinguish that from—you are not going after it?

Ms. KICHAK. For one segment of the population, yes.

Senator VOINOVICH. Well, for a lot of them, it is fairly confusing. The other problem that we have heard about is the problem of providing health care in rural areas of our State. It is becoming more difficult, and I understand it is not just Ohio but a national problem. What are you doing about that in terms of people who live in rural areas that are Federal employees to make sure that they have got access to health care?

Ms. KICHAK. There are a couple things. First of all, we have national plans. Blue Cross, who is going to be on the next panel, serves the Nation governmentwide, and we look to make sure that their preferred provider networks are comprehensive, as there are other plans in the program that are nationwide—GEHA, Mail Handlers, NALC, APWU—and, I am sure I am forgetting someone.

In addition, this year, for 2008 in our Call Letter we are trying to do some things to encourage more HMOs to participate. We have many. It has been said before that we have 285 plans. We have had some problems with pricing of HMOs because we have not previously allowed them to offer benefit packages unless they were already in place, which meant if an HMO wanted to do something different, we would not accept it until it had a proven track record. Now we are going to be looking at some different packages in HMOs. Maybe this will be a way to get more HMOs to come in and expand that provision of care also.

Senator VOINOVICH. On another subject, have you seen more of your retirees go into Medicare Advantage as a result of the 4D program?

Ms. KICHAK. Yes, we have.

Senator VOINOVICH. Do you know what percentage it is?

Ms. KICHAK. No. We do not have the data on that, but it is a program that they are starting to move into.

Senator VOINOVICH. I would like to find out the percent, if you could.

Ms. KICHAK. Well, we will get you—

Senator VOINOVICH. I would also be interested to know why they are moving to the Medicare Advantage program. There is a budget controversy about that right now. There are some that say that the costs are too high and more than what they would be if they were not in Medicare Advantage. But from my perspective, as I have traveled around Ohio and talked to many people—people like it because they get a little better deal. Also they feel more comfortable because they have been able to establish a relationship with a health care provider on a regular basis, rather than the fee-for-service that you get under the other program.

Ms. KICHAK. One of the things that we see even in the FEHB Program, in our HMOs, is if folks have been with them as employees, they like to stay with them when they retire because of that doctor-patient relationship. So, I will find out anything I can about our participation and get that for the record.

#### INFORMATION SUBMITTED FOR THE RECORD

About 2.5 percent of retirees (49,200) are in Medicare Advantage.

Senator VOINOVICH. Yes, because that is going to be from your perspective. I would like to see it because we are going to have some debate about this issue. Could you try to look at our mandated costs for the Federal Government, particularly in the Medicare area?

Ms. KICHAK. Yes. Thank you.

Senator VOINOVICH. Thank you.

Chairman AKAKA. Thank you very much. I will start a second round of questions here.

To both of you, as you know, the Office of Personnel Management is responsible for negotiating the terms of service, such as what the premium rates will be and the services provided for those premiums. I am concerned OPM lacks sufficient negotiating authority to address specific problems such as prescription drug costs.

Do you believe that OPM has enough negotiating authority, or are there areas that OPM could do a better job of negotiating for lower premiums if they had that authority? Ms. Kichak.

Ms. KICHAK. First of all, I would like to point out that we negotiate with our carriers, but it is our carriers who negotiate with the doctors, the providers, the drug companies, etc. Having said that, it appears to me that we have sufficient authority. What we seem to be getting are very good prices for the drugs we have. I understand that drugs are expensive, but when we introduced the PBMs in the program, we were able to increase benefits for people who used those pharmacies through the savings we and our carriers achieved on our behalf from those drug companies. So, in my mind, it seems to be working.

Also, OPM has the authority to negotiate a level of benefits to ask the carriers to go out and agree with the providers at a certain level of benefits, and we exercise it. I think we deliver a good product. So, I am not looking for any more authority. Thank you.

Chairman AKAKA. Mr. Dicken.

Mr. DICKEN. As Ms. Kichak indicated, as OPM is negotiating with about 200 different plan options, they will be looking at the differences among those plans and they are keeping all the plans that meet minimum standards. FEHB Program, as contrasted to some other large employers, will be negotiating with a large group of plans that meet their minimum standards. Other employers may negotiate with one or fewer plans and be able to select only those that have the best value for their options.

Certainly OPM has indicated that in the past they have been able to negotiate down from the initial bids that come in during the Call Letter process. And also as Ms. Kichak noted, a key part of this is the plans themselves, often working with pharmacy benefit managers, negotiating the most effective prescription drug costs and ensuring that some of those savings are passed on to FEHB Program and its enrollees.

Chairman AKAKA. As we all know, there are many plans, approximately 280. And so, OPM negotiates with the large, medium, and small health care providers to offer a significant range of options for employees. Hopefully this competition helps keep the costs down.

To both of you, do you think the fact that OPM negotiates with so many plans impedes OPM's ability to negotiate each plan's premium rates?

Ms. KICHAK. Well, it is a lot of plans, but we have been able to manage it, I think very well. We put our most experienced folks on the plans that cover the most enrollees. Therefore, we are able to focus our efforts where it is most important that we do.

But we look at every plan in the program, and innovation can come from any corner. We work very hard with each and every carrier to get their best ideas, and then I know in a competitive model like we have, the other carriers are looking to see what their competition is doing. And this is how we get new ideas into the program. But we are definitely able to negotiate with every plan.

Chairman AKAKA. Mr. Dicken.

Mr. DICKEN. Here is where FEHB Program is unique in having 8 million enrollees in all parts of the country, they require a large number of plans so that there can be both the national options as well as regional options that are available locally. OPM is relying on its competitive model to have a number of plans that will allow enrollees to choose the benefits that are available in their area and at their cost. Other employers may choose other ways, employers like GM and CalPERS that may instead select a small number of plans. It is just two different approaches for how to negotiate.

Chairman AKAKA. Ms. Kichak, wellness and preventive care can do a lot to keep people healthy and reduce the costs of more serious illnesses, like heart disease. In the 2008 Call Letter, you asked carriers to address preventive care in their proposals. How do you make wellness and preventive care a priority in FEHB Program plans?

Ms. KICHAK. We ask for it every year. I think if you look at our history of Call Letters, you will see something almost every year in the preventive area. I do not know exactly when cholesterol screening was added, but it was very recent.

We rely on the accrediting bodies that determine when the best time is for mammograms, immunizations, and things like that. We make sure that our carriers are aware of what those schedules of preventive services are and that they comply with them so that we are in step with what the medical community and the providers are telling the Nation is the best kind of preventive care to offer.

Chairman AKAKA. My last question before I call on Senator Voinovich is to Ms. Kichak. According to OPM's 2007 numbers, the President's HealthierFeds Initiative has almost 39,000 employees and retirees enrolled, but only 20 percent have completed the challenge. What else is OPM really doing to encourage participation in the HealthierFeds program beyond advertising it on the website?

Ms. KICHAK. We have a very active network, e-mail network, of HealthierFeds coordinators in the agency. So, the website itself was not the major part of that campaign. We had a webcast from the Department of Health and Human Services when we kicked it off. We have worked with the President's Council on Physical Fitness and have had leaders from that area work with us. But there is somebody in virtually every agency trying to get that agency to get healthier.

Even though our HealthierFeds challenge has ended, during Public Service Recognition Week we had HealthierFeds walks at lunchtime throughout the entire week. So, we are keeping that campaign going even though those numbers were very discouraging.

Chairman AKAKA. Thank you very much. Senator Voinovich.

Senator VOINOVICH. On the same thing, I would suspect that all of the companies that cover folks are also encouraging them to be as fit as possible and setting up programs to try and deal with the whole issue of wellness.

Ms. KICHAK. Very definitely.

Senator VOINOVICH. In other words, you are doing it as a system? The companies within the system, I am sure, are doing everything they can, I have met with some of the major insurance companies. They say, "We are really trying to get the people we cover to do some things differently to keep the costs down."

Ms. KICHAK. HealthierFeds is a workplace initiative. Yes, the carriers are doing a lot and they have a very good story to tell. They are identifying chronic diseases and working with individuals to manage those chronic diseases, so that if there is an individual who has something like diabetes and is not keeping up with their medication program, they are in contact with them.

We are always working with new programs in that area. In my house, we get lots of mail from the health plan that my husband has selected telling him what he needs to do. I am glad I do not have to make those directives to him. And it is very encouraging to see the health plans reach out to the enrollees and try to encourage good health.

Senator VOINOVICH. Are you familiar with the legislation that Senator Carper and I have introduced in terms of health information technology, specifically the personal health care records, in the FEHB Program?

Ms. KICHAK. No, I am not familiar with your specific piece of legislation.

Senator VOINOVICH. Have you ever looked at the issue of the Federal Government negotiating directly with the pharmaceutical companies? Under the current Medicare FEHB Program structure, that compete for business, they compete against each other to try and deal with as large a formulary as possible and also as reasonable a cost as possible. Have you ever looked at the option of eliminating the PBM's role and requiring the government to negotiate directly with any companies.

Ms. KICHAK. We have definitely looked at that option. I believe there was a legislative proposal along those lines. I have been with OPM a long time. Probably that legislative proposal could have been as long ago as 10 years ago. It did not receive very strong support.

We also have conducted a couple of studies about how our carriers are doing in negotiating with PBMs, and one of the studies showed that they were doing very well. So we have not continued to push that option because of our consideration of how we think our carriers are doing.

Senator VOINOVICH. OK. So it is the carriers that negotiate with the PBMs.

Ms. KICHAK. The PBMs, yes.

Senator VOINOVICH. At this stage of the game, no one is looking to do it differently because you feel that the smorgasbord of options in terms of the formulary and the costs seem to be OK because of the fact you have got competition among the plans.

Ms. KICHAK. They seem to be working, and our Inspector General is providing increased oversight of the carriers' agreements with the PBMs. And that is providing us some assurance that we are getting money back through those arrangements.

Senator VOINOVICH. Mr. Chairman, I have no other questions.

Chairman AKAKA. Thank you very much, Senator Voinovich.

I want to thank both of you for your testimony and your responses to our questions. I want you to know that we may have other questions for you to respond to, and we will keep the record open for one week for other Members to do that.

Again, thank you so much. You have been helpful, and we look forward to seeing you again at another hearing. Thank you.

Chairman AKAKA. I would like to call forward our second panel: Stephen Gammarino, Senior Vice President, National Programs, Blue Cross Blue Shield Association; and Alan Lopatin, Legislative Counsel, National Active and Retired Federal Employees Association.

I want to welcome both of you and to tell you that we have a requirement that we swear in witnesses before this Subcommittee. Would you please rise? Do you solemnly swear that the testimony you are about to give this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. GAMMARINO. I do.

Mr. LOPATIN. I do.

Chairman AKAKA. Thank you very much. Let the record note that the witnesses responded in the affirmative.

I want to thank you again for coming and before I call on Mr. Gammarino, I just noticed that our good friend and colleague, Senator Warner, has arrived, and I want to ask him for any statement or comment he has before your testimony.

Senator WARNER. Thank you, Mr. Chairman. I would just simply ask that my prepared opening statement appear following the Chairman's and the Ranking Member's opening statements in the record. I thank you.

Chairman AKAKA. Thank you very much, Senator Warner. It will be included in the record.

[The prepared opening statement of Senator Warner follows:]

#### PREPARED OPENING STATEMENT OF SENATOR WARNER

Chairman Akaka and Senator Voinovich, I thank you for holding this important hearing today to examine the growth trends in health care insurance premiums for active and retired Federal employees, an issue that impacts a number of my constituents in the Commonwealth of Virginia.

Access to affordable health care is a critical issue for everyone. While Federal employees enjoy the ability to choose among a wide variety of health plans to best suit their needs, substantial increases in Federal Employee Health Benefits Program (FEHBP) premiums could unfortunately threaten to make health insurance coverage cost prohibitive for many Federal employees, their dependents, and Federal retirees.

To address the escalating cost of health insurance, a Presidential directive issued in 2000 extended the concept of premium conversion, the ability to pay health insurance premiums with pre-tax dollars, to active Federal employees who participate in FEHBP. This benefit is already available to many private sector employees and

State and local government employees. While premium conversion does not directly affect the amount of the FEHBP premium, it helps to offset some of the cost by reducing an individual's Federal tax liability.

Regrettably, our retired civil servants, who pay the same premiums as Federal employees, do not have this same opportunity. In the Senate, for the last several Congresses, I have introduced legislation to extend premium conversion to our retired Federal employees, many of who are fixed incomes. This benefit is estimated to result in average savings of \$820 per year for annuitants.

I look forward to hearing from the distinguished witnesses, and their examination of the issue and suggestions on ways to ensure that FEHBP continues to be one of the leading health insurance plans in terms of its coverage and cost effectiveness. Thank you.

Chairman AKAKA. Mr. Gammarino, would you please proceed with your statement?

**TESTIMONY OF STEPHEN W. GAMMARINO,<sup>1</sup> SENIOR VICE  
PRESIDENT, NATIONAL PROGRAMS, BLUE CROSS BLUE  
SHIELD ASSOCIATION**

Mr. GAMMARINO. Good morning. Thank you for this opportunity to discuss premiums in the Federal Employees Health Benefits Program. We appreciate your interest in this program and look forward to working with you and the Subcommittee to address this and other issues that are so important to Federal employees and retirees.

The Blue Cross and Blue Shield system is proud to have offered the Service Benefit Plan from the beginning of the program in 1960. Today, we provide health insurance to more than 4.7 million active and retired Federal employees and dependents. We believe we have been successful because, in large part, Federal employees and retirees recognize our commitment to offer high-quality, affordable health care coverage. Our goal is to ensure that the right person gets the right treatment at the right time, and we work hard to do that while maintaining competitive rates.

One factor benefiting Federal employees and retirees is the very structure of this market-oriented, employer-sponsored program in which risk-bearing carriers compete with one another for an individual's business. This retail competition and the fact that all the competitors are at risk compel carriers to develop actuarially sound products that offer attractive benefits at competitive prices. Through their choices, enrollees help to keep premiums in check.

Federal employees and retirees have also benefited from the OPM's sound stewardship and its focus as the employer on maintaining this as an attractive employment benefit to assist in recruitment and retention of a well-qualified workforce. This has contributed significantly to this program's reputation as a model employer-sponsored health benefits program. Congress has also played an important role in the success of the program through its diligent oversight.

The FEHB Program is, of course, integrally tied to the private health care industry. Federal employees and retirees see the same doctors and hospitals as their neighbors who work for private employers. Accordingly, the program is also affected by the same forces at work in health care in general. These forces include increased usage of prescription drugs and provider services, advances

<sup>1</sup>The prepared statement of Mr. Gammarino appears in the Appendix on page 46.

in medical technology and drug therapies, national demographic trends, and, of course, customer expectations.

This program is also affected by the demographics of the Federal population. Retirees make up over 46.1 percent of the FEHB Program and 47 percent of our program. In 2006, the average age of contract holders in the Service Benefit Plan's Standard Option—that is our largest program—was almost 61 percent and Basic Option was over 45 percent. I am, however, very pleased that this year, for the third consecutive year, there was no change in premiums for our Basic Option. Additionally, the individual's share of the premiums for our Standard Option, which covers almost 4 million people, actually declined slightly, while the premium increased by only 1 percent.

I am even more pleased that we accomplished this while making enhancements to our benefits. As the Members of this Subcommittee know, the act expressly provides that funds in a carrier's contingency reserve may be used to stabilize premiums. We were able to use our reserves to that effect in 2007.

I would also like to review for the Subcommittee three relatively new initiatives designed to improve the quality of health care that our enrollees receive.

Working closely with OPM, we are developing a member-centric program called Care Coordination. Care Coordination applies health information technology to an integrated database in order to improve our members' ability to receive higher quality of care. It specifically focuses on members with chronic conditions, such as diabetes, who would benefit from our disease or case management initiatives.

The second initiative is called Blue Distinction. This is a nationwide program of Blue Cross Blue Shield that helps foster the development of a more consumer-centered, knowledge-driven health care system. Blue Distinction is an important step toward providing health care consumers with cost and quality information similar to what they expect when they buy other types of goods and services. Consumers will have access to the information necessary for sound decisionmaking through Blue Distinction's:

Special care centers for bariatric surgery, cardiac care, and transplant services. These centers must meet clinically valid standards and deliver better outcomes;

Nationwide hospital measurement program and improvement program;

And, last through demonstration of various transparency projects. We believe Blue Distinction will lead to healthier lives and, over time, lower health care costs as doctors and patients improve their interaction.

Third, the Blue Cross Blue Shield Association has recently proposed a legislative initiative to create a new independent institute to support clinical research comparing the effectiveness of medical procedures, drugs, devices, and biologics. The institute would disseminate its findings to providers and in reader-friendly form to consumers. We believe this approach would ultimately be the best path to assuring affordability by reducing ineffective, inappropriate, or redundant care while maximizing the quality of care.

In conclusion, let me assure the Subcommittee that we are committed to providing Federal employees, retirees, and their families affordable coverage so they may obtain high-quality health care. We look forward to working with OPM and Congress in order to achieve that objective.

This concludes my prepared remarks, and I would be very pleased to answer any questions you may have.

Chairman AKAKA. Thank you very much. Mr. Lopatin.

**TESTIMONY OF ALAN G. LOPATIN,<sup>1</sup> LEGISLATIVE COUNSEL,  
NATIONAL ACTIVE AND RETIRED FEDERAL EMPLOYEES AS-  
SOCIATION**

Mr. LOPATIN. Thank you, Mr. Chairman and Senator Warner. On behalf of our Nation's 4.6 million Federal employees, retirees, and survivors, I appreciate the opportunity to express the views of the National Active and Retired Federal Employees Association on FEHB Program premiums.

Chairman Akaka, NARFE commends you for requesting the GAO report we are considering today and for your leadership on trying to help Federal employees and annuitants shoulder higher health care costs. We were pleased that you specifically asked the non-partisan GAO to determine how FEHB Program premiums would have been affected had OPM applied for a payment provided under the Medicare Modernization Act of 2003.

The MMA provides that all employers who furnish drug coverage to their retirees age 65 and older, at least as generous as the new Medicare Part D, are eligible to receive a subsidy of 28 percent of the per enrollee cost for drug coverage—an average of \$670 per Medicare beneficiary, according to CMS. GAO found that premium growth in one of the largest FEHB Program plans with a high share of older enrollees could have been 3.5 to 4 percent lower in 2006 and 2 percent lower across all the FEHB Program plans had the payment been accessed.

NARFE has long held that the FEHB Program is the best group health insurance plan in America today and should serve, as we have all said, as a model for others. Even in years of double-digit rate hikes, we have said that OPM does a better job negotiating premium increases than any other employer. But we are bewildered by the action—or, more appropriately, inaction—of the Federal Government in not taking advantage of a \$1 billion subsidy to which its health plan is entitled. It just does not make street sense.

The goals of the Federal Government as an employer should be to attract and retain the best and the brightest to serve this country. OPM, as the chief steward of the civil service, must keep its focus on that goal in decisions affecting our competitive edge.

This decision also denied the U.S. Postal Service access to a payment that would benefit its competitive status and its ratepayers, including you and me. OPM has cited two reasons for the Administration's decision to forego the payment. First, they said they did not need to take advantage of the payment since they had no plans to change the drug coverage of Federal annuitants age 65 and older. Yet other public and private employers with no intention of

<sup>1</sup>The prepared statement of Mr. Lopatin appears in the Appendix on page 52.

reducing their retiree drug benefits decided to apply for the payment anyway.

Second, OPM claims that they do not believe it is appropriate for the Federal Government to be paying itself for this purpose. Such intragovernmental transfers are not unusual. In fact, the Federal Government pays itself for future retirement obligations when Federal agencies make contributions from annual appropriations to the retirement trust on behalf of their employees.

In response to several years of quickly rising premiums, the demand for lower-cost FEHB Program plans has increased. This has been helpful to some enrollees who want to cut costs. Lower-wage and younger workers naturally gravitate to lower-cost plans. In many instances, the higher-cost plans have more comprehensive coverage and better provider access than lower-cost options. As a result, individuals with greater health care needs tend to remain in higher-cost plans, and the opposite is true for healthier persons. With fewer healthier enrollees, greater claim experience with the higher-cost plans contributes to even higher premiums.

The GAO report confirms NARFE's fear that this migration could mean a race to the bottom where workers and annuitants are limited to plans with less coverage, smaller provider networks, and greater out-of-pocket costs. As it is, the shift of enrollees combined with the weighted average formula for government fair share contributions result in disproportionately higher enrollee premiums in the most popular plans for retirees.

No option has more potential for separating the risk pool than the combination of a health savings account and a high-deductible health plan. Healthier enrollees tend to be attracted to HSAs because, as low health care utilizers, they can be rewarded with unspent balances or credits at the end of each year. Less healthy enrollees avoid HSAs because they could end up paying thousands of dollars in out-of-pocket costs. Without precautions against HSA-inspired risk selection, the introduction of these new plans could ultimately be the death knell for fee-for-service and many traditional HMO options.

The Administration's fiscal year 2008 budget would give lackluster enrollment in HSAs a jump start by allowing Blue Cross to offer the controversial option. Blue Cross plans are the largest and most popular in the FEHB Program, and as a result, the insurance carrier's brand loyalty and considerable marketing resources could significantly increase HSA enrollment if Blue Cross was allowed and decided to offer such an option. NARFE opposes further expansion of HSAs because of their potential adverse effect on comprehensive plans.

The higher utilization of health care by older enrollees is a well-documented reality of what happens to us as we age. Most annuitants started their careers in Federal service when they were younger and healthier and paid more into health insurance than they got out of it. Now that they have retired, some of them get more out of health insurance than they pay into it. This contract between generations has been a fundamental principle of group health insurance for decades. NARFE strongly believes that the cost of providing health care to older enrollees could be mitigated if: First, the Administration agreed to apply for and accept the

Medicare employer payment; and, second, if FEHB Program plans were allowed to buy prescription drugs for their enrollees at the discount mandated by the Federal supply schedule. Given substantial congressional support for allowing Medicare to directly negotiate drug prices, it is time for this Subcommittee to revisit using the same leverage to make prescription drugs less expensive in FEHB Program.

Finally, Mr. Chairman, I would be remiss were I not to put in a plug for NARFE's top legislative agenda in this arena, especially at this moment—namely, the enactment of premium conversion legislation introduced by Senator Warner as S. 773, a matter referred to the Senate Finance Committee. The measure would allow Federal annuitants and military personnel to pay for their health insurance premium with pre-tax dollars in the same manner as current employees are allowed. This modest step would make health insurance premiums more affordable.

For 47 years, the FEHB Program has minimized costs and provided a wide choice of comprehensive health insurance plans to nearly 9 million Federal employees, retirees, and their families. NARFE stands ready to work with this panel, with others in Congress, OPM, and insurance carriers to find the ways and means to contain out-of-control health care costs without sacrificing quality, and to ensure that the Federal family has access and coverage, without resorting to proposals that only shift costs to enrollees, or circumvent risk sharing in our group health plan.

Thank you so much.

Chairman AKAKA. Thank you very much.

It is always a pleasure to have Senator Warner here. I am going to ask Senator Warner to proceed with his comments or questions. Senator Warner.

#### **OPENING STATEMENT OF SENATOR WARNER**

Senator WARNER. Thank you, Mr. Chairman. I have to leave to go to Arlington for a soldier from Virginia who was lost in Iraq.

I would like to go back to S. 773 that you referred to, Mr. Lopatin. Do you feel that as it is drawn up, it largely addresses a considerable segment of this problem?

Mr. LOPATIN. It would certainly help to alleviate the increase in premiums if Federal retirees could use pre-tax dollars much as employees do right now. They find sticker shock when they go from employment to retirement and notice that they are not getting that same subsidy, if you will, or at least tax advantage. And I think it would help greatly.

Senator WARNER. Within your organization, is it well received?

Mr. LOPATIN. NARFE is a thousand percent supportive, and every one of our members is pushing—

Senator WARNER. Given that you are working on this 24 hours a day, 7 days a week—

Mr. LOPATIN. Twenty-five hours on some days.

Senator WARNER. How do you feel this legislation is being received by other Members of Congress?

Mr. LOPATIN. I only wish it were before this Subcommittee instead of the Senate Finance Committee, just because we have so many friends here. But it is being well received. We have got a

good number of cosponsors working with your office on both sides of the Hill, and Congressman Davis' bill in the House. We are hopeful, but we are trying to do whatever we can to also help mitigate the cost so that we can move the legislation forward.

Senator WARNER. Well, you have got a marvelous organization, and I am delighted to be associated and to work with it, and I thank you very much.

Mr. LOPATIN. We appreciate your leadership.

Senator WARNER. I thank the Chairman and Ranking Member.

Chairman AKAKA. Thank you very much, Senator Warner.

I want to pursue questions about wellness and preventive care, as I did with the first panel. Mr. Gammarino, as a provider, what is your policy on covering wellness services like gym memberships and preventive care?

Mr. GAMMARINO. First of all, we have very comprehensive benefits with what I call our core health insurance program relative to preventive services. The types of services that you just mentioned—gym memberships, other types of what we call “affinity programs”—are not in our core product, not associated with the actual cost as it relates to the premium. We do actively have these affinity programs, and we offer what we call discounted nationwide programs that allow our members, if they sign up through our affinity programs, various discounts for joining those types of entities.

Chairman AKAKA. Mr. Lopatin, as an association representing the interests of active and retired employees, how are you promoting those issues in your membership?

Mr. LOPATIN. Well, NARFE is 100 percent behind active retirees, not just in the legislative arena but to get out, get exercise, get help behind them and in front of them. We have encouraged it through our federation conventions. Our President, Margaret Baptiste, is on the road right now or would otherwise be here. Our members come out to these meetings, and the type of social networking that they are able to do helps to keep them healthy by exchanging information about what is available out there, especially for seniors. We are foursquare behind civic engagement. NARFE members, as you can imagine, are dedicated civil servants with a lifetime of experience and are trying to contribute that experience back to their communities by staying active and keeping healthy that way.

Chairman AKAKA. Because of the size of your organization and the active participation, the retirees feel the burden of health care costs more than most as a result of being on fixed incomes. What do you see retirees doing to deal with the growing premium rates?

Mr. LOPATIN. Unfortunately, retirees every day, and not just Federal retirees, are faced with making tough decisions between affording prescription drugs, putting food on the table, and the other everyday costs of living. Often, Federal retirees have seen their premiums outpace their cost-of-living adjustments, and they are lucky to have those cost-of-living adjustments which we hope to retain and that we do not expect to expand. But it still is hard to make ends meet.

We find that Federal retirees in a very generous or at least a reasonably generous and competitive retirement program keep Federal retirees in a place where they are in a bit of a better place

than some other retirees. But it is a tough time, especially with spiraling health care costs, especially for prescription drugs, notwithstanding Medicare.

Chairman AKAKA. I would like to ask both of you about the impact of health savings accounts. OPM continues to promote the use of health savings accounts as an alternative to traditional health care options. Some feared that HSAs would increase the premiums for traditional coverage.

What do you believe the impact of health savings accounts has been on active and retired employees' health care premiums? Mr. Gammarino.

Mr. GAMMARINO. When this particular plan was first introduced, there was a lot of concern among a number of different groups that somehow these new products would take the better risk from the older, well-established insurance programs, like Blue Cross Blue Shield. I know at the time the agency was very focused on ensuring when they did introduce it, they introduced it in a way that it would reduce that type of impact. And I think they succeeded. I think today you would say those products are in the market. Blue Cross Blue Shield very much encourages choice and availability of different choices within the market. We think that is a good thing. We think the way they were introduced was appropriate, and materially, they have not affected the program as a whole, and they have not specifically affected Blue Cross Blue Shield in their ability to ensure affordable health care products.

Mr. LOPATIN. Mr. Chairman, if I could also add to that, luckily the small uptake in the HSAs available in the current FEHB Program have had a negligible effect. But time and again we are seeing, as lower-income employees, as younger and healthier employees migrate to more attractive plans and the incentives behind HSAs of having balances available to you at the end of the year can only have a deleterious effect on the premiums for the plans where retirees want to have the continued relationship with their doctor, want to get that preventive care, have the right incentives. We are concerned that if HSAs were to blossom, we would see more risk selection going on as a consequence, potentially see the undermining of all other FEHB Program plans.

Chairman AKAKA. Let me ask each of you, how have HSAs affected the overall premium market? Mr. Lopatin.

Mr. LOPATIN. I believe in FEHB Program, again, the effect has been negligible, only because of the small enrollment numbers in HSAs. We are just concerned that would not last.

Chairman AKAKA. Mr. Gammarino.

Mr. GAMMARINO. In terms of Blue Cross Blue Shield, we serve 98 million people nationwide. It is a growing segment of our market, particularly as it relates to what I would call small groups and individual markets. We do see that it provides an opportunity in some cases for affordable health care products where one did not exist. So we do see some small groups that are enrolling that were not enrolling before because of the cost of health care.

So we think it is a good option to have out there, and it is a growing option relative to the private market.

Chairman AKAKA. We will have a second round. Now, Senator Voinovich.

Senator VOINOVICH. Ninety-eight million people?

Mr. GAMMARINO. Yes, sir.

Senator VOINOVICH. That is a lot of people.

Mr. GAMMARINO. We are very proud of that. Almost 100 million. We are looking forward to that day, too.

Senator VOINOVICH. We just talked about HSAs. Do you see any marked movement from people that are in regular plans to HSAs? Or as you just said, is it mostly in areas where they do not have access to that, that HSAs have become an option for folks that heretofore might not have insurance coverage?

Mr. GAMMARINO. Yes, it is basically what I referred to before and what I would call the small and individual group market.

Senator VOINOVICH. And Mr. Lopatin basically said he is worried about some of the people moving off from more comprehensive coverage to HSA plans.

Mr. LOPATIN. From the large group health environment.

Senator VOINOVICH. They are already covered and saying they are in good health and so they choose lower cost HSAs. And then you pull them out of the larger risk pool, and then what is left are the people that are more sick, and as a result of that, premiums rise for every one else. Is that what you are saying?

Mr. LOPATIN. We have already seen it in the risk segmentation that has gone on because of new moves to consumer-driven plans.

Mr. GAMMARINO. On the private sector, there are other large employers that are pretty much doing the same thing that OPM is, meaning they have a cafeteria of products. They are introducing this newer product as one of many choices, and the uptake is—it can vary depending upon how the employer decides to incent this. But, bottom line there is always that issue of new product introductions and cascading of poorer risk relative to better risk. It is something that we, the Blues, have seen over our 40 years. It is not necessarily only focused on this particular product. You can have this evidence in other products as well.

Senator VOINOVICH. To what do you attribute the lower rate of increase in premiums? Well, let's put it this way: Taking our Federal program and comparing it with lots of other programs in the country, why is it that our premiums have stayed pretty competitive compared to, say, some of the other places?

Mr. GAMMARINO. That is a great question, because it is something that we are very sensitive to, and I think we are very proud to be part of what I would call a great competitive choice model that is probably the most effective that is out there in terms of allowing a competitive environment to drive the best value for the members. And it is not just price. It is also what we provide that makes, what we think, this program very valuable to Federal employees and retirees.

Senator VOINOVICH. Is the coverage available under this program pretty much the same as what it is around the country?

Mr. GAMMARINO. Relatively to large employers, yes. It is a very comprehensive program, but it is similar to any of what I would call the Fortune 500 relative to the comprehensive set of benefits.

Senator VOINOVICH. So the thing is you cover 8 million people and have various providers competing for their business. And as a

result of that, competition providers are required to offer good coverage and lower costs to keep the folks that you have.

Mr. GAMMARINO. Right. What does distinguish the FEHB Program is—there was some concern on the other panel that there was a large number of health plans and does that hurt. We think it helps. We actually think the large choice and then the only way you can succeed long term in this program is to be very focused on this population, be very sensitive to the needs, and provide a price point that is reasonable with a set of benefits. And if you cannot do that, you will not last long in this program.

It is something unique, something that I think other people should certainly try to emulate. It works.

Senator VOINOVICH. Of the people in the program, how many of them are retirees?

Mr. GAMMARINO. In our program, 47 percent are retirees. In the entirety of the FEHB Program, I believe it is 46.1 percent are retirees, so that is a very large percentage.

Senator VOINOVICH. I asked the question of the Advantage program. Do you see people moving more toward Advantage or are they pretty well staying with what they have?

Mr. GAMMARINO. I have not seen any significant movement. Most of our members are long-term members. They are going to need a significant reason to leave our program, and given our value proposition, that does not occur very frequently.

Senator VOINOVICH. Mr. Lopatin, in terms of retirees, if you compare the cost of health care by retirees with, say, a large system like California, what is the participation and the percentage that the retiree contributes to the plan?

Mr. LOPATIN. In CalPERS?

Senator VOINOVICH. Yes.

Mr. LOPATIN. I do not know offhand.

Senator VOINOVICH. In other words, the percentage that our retirees contribute is about 28 percent. Is that basically—

Mr. LOPATIN. On average, yes, under the fair share formula. But we find that retirees and enrollees are having a larger premium increase because of the weighted average as more folk move to lower-cost plans. This is true because of the way the Federal Government contributes—putting in 72 percent of the cost of health insurance in the aggregate. As you move to lower-cost plans, that aggregate number becomes lower and shifts those costs especially to retirees who do not move from the plan.

Senator VOINOVICH. But nationally that is what is happening?

Mr. LOPATIN. Correct.

Senator VOINOVICH. I am familiar with some of the public retirement systems, and they are all feeling the pinch of it and they are raising the costs to their retirees because that is what they have to do.

Mr. LOPATIN. We are more concerned with keeping the FEHB Program healthy because it has been successful for almost five decades.

Senator VOINOVICH. And the people in the program, one of the things that I think that is an attractive aspect of the Federal program is the fact that if you are in it, once you retire you can continue to remain in the program; whereas, some other retirement

systems, particularly now we are seeing in the private sector, they are whacking them out, and they are without—

Mr. LOPATIN. And I myself personally am a deferred annuitant and do not have access to the FEHB Program. I will talk to your staff about how we might be able to remedy that in time. [Laughter.]

But, when the day comes, I hope to come back and work for the Federal Government and finish out my retirement and go out as an immediate annuitant, a benefit that I sorely miss.

Senator VOINOVICH. That is a big deal, isn't it?

Mr. LOPATIN. Huge.

Senator VOINOVICH. Yes.

Mr. LOPATIN. Because what I buy in a Blue Cross plan on the private market is not nearly as generous as what you get through the Federal Government plan.

Senator VOINOVICH. Yes. Well, I know that you are promoting the concept that they should be able to pay for it with pre-tax dollars. But I have to say to you that if we did that for Federal retirees, you know very well that everybody else would be then asking for—

Mr. LOPATIN. We are happy to endorse your legislation opening it to everybody else. [Laughter.]

Senator VOINOVICH. Well, to be candid with you, it butts up against this whole issue of entitlements and where we are going as a country in terms of dealing with it, though I understand that you have a reason to be promoting it.

But I would say, Mr. Chairman, that overall, God bless the FEHB Program. It is one of the great benefits of people who work for the Federal Government. Thank you.

Chairman AKAKA. Well, thank you very much, Senator Voinovich. Let me conclude before we adjourn. As a provider, Mr. Gammarino, you are the gatekeeper for employees, retirees, and their families' access to health care. This care is important for all enrollees, but, in particular, to families with children and also the retired.

How can you improve the customer service for those in your plan?

Mr. GAMMARINO. Well, we are working at it every day, Senator. I would like to talk a little bit about what we are doing to try to work with employees to provide even greater value, which I know you strongly support. With an aging population, one of the things that we are focused on is providing services to enrollees. We have various patient advocate programs today that actually reach out to members. We have a very rich database. We can pinpoint people that may need some help navigating the health care system, and we focus on that today to try to reach out and, through a voluntary approach, allow people to help provide that gatekeeper approach for members as they navigate this system and get the care they need and make sure that we maintain an affordable product.

So we are working at that day in and day out, from just general customer service, now we are entering a new phase of what I would call this patient advocate, where we are reaching out to members, providing the service they need to get better health care.

Chairman AKAKA. Mr. Lopatin, from your perspective, what do you think carriers can do to be more customer friendly to the participants and their programs?

Mr. LOPATIN. To the extent they can have efficient customer service phones that get answered, reasonableness in reviewing accounts and claims, and a consumer-friendly and a health-friendly workplace so that we can maintain not only the relationship that we have with doctors but with our health plans. NARFE members are very satisfied with the plans that they have. We would hope that the best thing that most of these plans could do is keep up the good work. Certainly the lion's share of our members are Blue Cross members as well, and we continue to hope and pray that we will have that service there year in, year out.

Chairman AKAKA. Well, thank you very much, both of you, for your testimony and your responses.

The hearing record will remain open for 1 week from today for Members of this Subcommittee to submit additional statements or questions.

You have been very helpful to this Subcommittee, and I just want you to know that we are doing this to try to find better ways of providing the best service to our people.

So, with that, I want to thank you very much. The hearing is adjourned.

[Whereupon, at 12:02 p.m., the Subcommittee was adjourned.]

# A P P E N D I X

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**STATEMENT OF  
NANCY H. KICHAK  
ASSOCIATE DIRECTOR FOR  
STRATEGIC HUMAN RESOURCES POLICY  
AND CHIEF ACTUARY  
OFFICE OF PERSONNEL MANAGEMENT**

**before the**

**SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT  
MANAGEMENT, THE FEDERAL WORKFORCE, AND THE  
DISTRICT OF COLUMBIA  
COMMITTEE ON HOMELAND SECURITY AND  
GOVERNMENTAL AFFAIRS  
UNITED STATES SENATE**

**on**

***Growth Trends in Health Care Premiums for Active and Retired Federal  
Employees***

**May 18, 2007**

Mr. Chairman and Members of the Subcommittee:

I am here today on behalf of Linda M. Springer, Director of the Office of Personnel Management (OPM), to discuss the recent premium trends within the Federal Employees Health Benefits (FEHB) Program, as well as the initiatives of OPM and the health insurers who participate in the FEHB Program to provide Federal employees, retirees, and their families with top quality health care at reasonable cost.

**Administering the Federal Employees Health Benefits Program**

OPM administers the FEHB Program, which covers approximately 8 million Federal employees, retirees, and their dependents. The FEHB offers competitive health benefits products for Federal workers, much like other large employer purchasers, by contracting with private sector health plans.

For five consecutive years, rate increases in the FEHB Program have declined. In fact, for 2007, rates increased only 1.8 percent. The result – approximately 63 percent of FEHB enrollees incurred no premium increase, while another 15 percent saw increases of less than 5 percent. For the past five years, the rate increases were lower than industry averages with the last three years being remarkably lower.

We believe that these low increases are the result of the continued efforts by OPM and the Administration to provide FEHB enrollees with choices of quality health care that meet their respective individual and family health care needs at affordable prices. Among those efforts, OPM has taken steps to further promote market-based competition by providing a range of quality health care options that include High Deductible Health Plans and Consumer-Driven Health Plans linked to Health Savings Accounts, as authorized by Congress and signed into law by President

George W. Bush in the Medicare Modernization Act of 2003. In addition, for 2007, we took steps to enable enrollees to make pre-tax contributions to their Health Savings Accounts through payroll allotment. We have also added other health-related benefits such as stand-alone dental and vision benefits as well as Flexible Spending Accounts.

And, under Public Law 108-375, *The National Defense Authorization Act for 2005*, OPM continues to encourage agencies to assist Federal employee reservists by paying the Government's share and the employee's share of the FEHB premium for up to 24 months while those individuals are deployed in harm's way, in accordance with the guidelines specified in the law. We are pleased to say that about all Executive branch agencies have chosen to waive premiums for these individuals.

Each year, OPM issues its FEHB "Call Letter" to provide guidance and negotiation objectives for benefit proposals from FEHB Program plans for the next contract term. Over the past several years the Call Letter has asked carriers to add benefits to their respective coverage options. Those benefits have included coverage for a variety of preventive services such as screenings for osteoporosis, colorectal cancer, abdominal aortic aneurysm, and cholesterol as well as a variety of adult and childhood immunizations. In addition, we have consistently encouraged carriers to place emphasis on

care management programs and practices to address the complex health care needs of FEHB enrollees with chronic conditions.

As part of the annual premium rate negotiation process, OPM makes use of its authority to use excess reserves to mitigate premium increases. As OPM stated during the past year's Open Season rollout period, we allowed FEHB plans to exercise this option to reduce premiums. The Government Accountability Office, in its December 2006 report, titled "Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies Among Participating Plans," confirms OPM's ability to use the reserves in this manner and to generally mitigate fluctuations in premiums from year to year. Usually, better than expected claims experience creates excess reserves and leads individual health plans to propose drawing down reserves in future years. In fact, this is the third time in the last five years our bilateral negotiations with insurance carriers have resulted in some planned reduction in reserves.

Regarding the use of the Medicare Part D employer subsidy to assist with offsetting premiums in the FEHB Program, the intent of the subsidy is to encourage employers to continue providing prescription drug coverage to their Medicare eligible retirees. As part of the Fiscal Year 2006 Budget process, the potential use of the subsidy was evaluated by the Federal

Government. This review found no good rationale for the Federal Government to pay itself to continue providing prescription drug coverage to Federal retirees, especially since OPM has no plans to eliminate this coverage.

As OPM moves forward, we will continue to seek innovative benefit proposals from FEHB carriers that provide for quality, value and affordable health care options. OPM has encouraged proposals from plans that would allow for lower cost HMO options that are offered in the marketplace but not actually offered to Federal enrollees. We strongly encourage plans to offer chronic care and disease management programs including flexible benefit options for chronically ill patients. OPM also asked plans to compare their current preventive care benefits against those endorsed by the U.S. Preventive Services Task Force under the U.S. Department of Health and Human Services which are built on evidence-based medicine. Like many other employers, the Federal Government, under the leadership of President Bush, Secretary Leavitt, and Director Springer, has been committed to promoting a healthier workforce through preventive care. We believe these health promotion efforts are responsive to the needs of enrollees and add value to their health care coverage. It is also important that enrollees have the ability to make informed decisions that result in improved lifestyle

choices and health care outcomes. We know the Federal workforce is well informed, and we encourage FEHB carriers to reach out to their enrollees to avail themselves of the positive effect that preventive care services can have on their health.

OPM is proud of its record in administering the FEHB Program and believes it offers Federal employees and retirees a wide variety of options from which to select the health benefits and the premiums that best meet their needs. We were also pleased that about 60 percent of employees who replied to our 2006 Federal Human Capital Survey (FHCS) responded positive in reference to their satisfaction with our Federal health insurance benefits.

Mr. Chairman, I appreciate this opportunity to testify before the Subcommittee on this very important issue. I will be glad to answer any questions you or other Members may have.

United States Government Accountability Office

**GAO**

**Testimony**

Before the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Homeland Security and Governmental Affairs, U.S. Senate

For Release on Delivery  
Expected at 10:30 a.m. EDT  
Friday, May 18, 2007

**FEDERAL EMPLOYEES  
HEALTH BENEFITS  
PROGRAM**

**Premiums Continue to Rise,  
but Rate of Growth Has  
Recently Slowed**

Statement of John E. Dicken  
Director, Health Care



May 18, 2007



Highlights of GAO-07-873T, a testimony before the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Homeland Security and Governmental Affairs, U.S. Senate

## FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

### Premiums Continue to Rise, but Rate of Growth Has Recently Slowed

#### Why GAO Did This Study

Average health insurance premiums for plans participating in the Federal Employees Health Benefits Program (FEHBP) have risen each year since 1997. These growing premiums result in higher costs to the federal government and plan enrollees. The Office of Personnel Management (OPM) oversees FEHBP, negotiating benefits and premiums and administering reserve accounts that may be used to cover plans' unanticipated spending increases.

GAO was asked to discuss its December 22, 2006 report, entitled *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies Among Participating Plans* (GAO-07-141). In this report, GAO reviewed (1) FEHBP premium trends compared with those of other purchasers, (2) factors contributing to average premium growth across all FEHBP plans, and (3) factors contributing to differing trends among selected FEHBP plans. GAO reviewed data provided by OPM relating to FEHBP premiums and factors contributing to premium growth. For comparison purposes, GAO examined premium data from the California Public Employees' Retirement System (CalPERS) and surveys of other public and private employers. GAO also interviewed officials from OPM and eight FEHBP plans with premium growth that was higher than average and six FEHBP plans with premium growth that was lower than average.

[www.gao.gov/cgi-bin/getrpt?GAO-07-873T](http://www.gao.gov/cgi-bin/getrpt?GAO-07-873T).

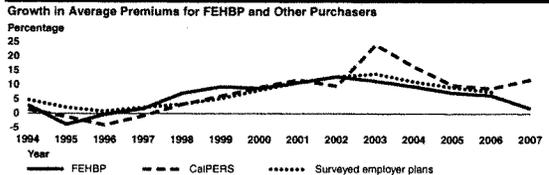
To view the full product, including the scope and methodology, click on the link above. For more information, contact John E. Dicken at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

#### What GAO Found

Growth in FEHBP premiums recently slowed, from a peak of 12.9 percent for 2002 to 1.8 percent for 2007. Starting in 2003, FEHBP premium growth was generally slower than for other purchasers. Premium growth rates for the 10 largest FEHBP plans by enrollment—accounting for about three-quarters of total enrollment—ranged from 0 percent to 15.5 percent for 2007.

Projected increases in the cost and utilization of health care services and in the cost of prescription drugs accounted for most of the average annual FEHBP premium growth for 2000 through 2007. Absent other factors, these increases would have raised 2007 average premiums by 9 percent. Other projected factors, including benefit changes resulting in less generous coverage and enrollee migration to lower-cost plans, slightly offset average premium growth. In 2006 and 2007, projected withdrawals from reserves helped offset average premium growth—by 2 percentage points for 2006 and 5 percentage points for 2007.

To explain the factors associated with premium growth, officials GAO interviewed from most of the FEHBP plans with higher-than-average premium growth cited increases in the cost and utilization of services as well as a high share of elderly enrollees and early retirees. Officials GAO interviewed from most plans with lower-than-average premium growth cited adjustments made for previously overestimated projections of cost growth, and some officials cited benefit changes that resulted in less generous coverage for prescription drugs. The plans with lower-than-average premium growth also experienced a decline of 0.5 years in the average age of their enrollees compared with an increase of 0.5 years in the average age of all FEHBP enrollees.



Sources: OPM, CalPERS, and Kaiser Family Foundation/Health Research and Educational Trust.  
 Note: The 2007 average premium growth rate for employer plans in the Kaiser/HRET surveys was not available at the time we completed our work for this testimony.

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the findings from our December 2006 report entitled *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies among Participating Plans*.<sup>1</sup> For this report, we were asked to examine the nature and extent of premium increases in the Federal Employees Health Benefits Program (FEHBP) and the potential effect on premium growth of the Medicare retiree drug subsidy, had OPM applied for the subsidy and used it to offset premium growth.<sup>2</sup> Federal employees' health insurance premiums have increased each year since the late 1990s, and these increases pose higher costs for the federal government and plan enrollees.<sup>3</sup> About 8 million federal employees, retirees, and their dependents receive health coverage through plans participating in the FEHBP, the largest employer-sponsored health insurance program in the country. The Office of Personnel Management (OPM) administers the program by contracting with multiple health insurance carriers to offer health plans through the program and negotiates benefits and premium rates with each carrier. OPM also administers reserve accounts for each plan that may be used to cover plans' unanticipated spending increases.<sup>4</sup>

My remarks today will focus on (1) recent FEHBP premium growth trends compared to those of plans offered by other purchasers, (2) the factors that contributed to average premium growth trends across all FEHBP plans as well as the effect the Medicare retiree drug subsidy would have had on premium growth, and (3) the factors that contributed to differing premium growth among selected FEHBP plans. These remarks are based on information contained in our December 2006 report.

In conducting our work, we analyzed historic and recent premium trend data from 1994 through 2007 from OPM for all FEHBP plans and compared

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<sup>1</sup>GAO-07-141 (Washington, D.C.: Dec. 22, 2006).

<sup>2</sup>As of January 1, 2006, employers offering prescription drug coverage to Medicare-eligible retirees enrolled in their plans could apply for a tax-exempt government subsidy. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2125 (2003). OPM has chosen not to apply for the subsidy.

<sup>3</sup>GAO previously reported on federal employees' health insurance premium trends through 2003. See GAO, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits*, GAO-03-236 (Washington, D.C.: Dec. 31, 2002).

<sup>4</sup>Pursuant to 5 U.S.C. § 8909.

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them with premium data from the California Public Employees' Retirement System (CalPERS)—the second largest public purchaser of employee health benefits—and surveys of multiple employer-sponsored health plans from Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET).<sup>3</sup> To identify factors contributing to average FEHBP premium growth trends across all FEHBP plans, we analyzed OPM summary reports assessing the effect of projected changes in various factors, including the cost and utilization of services, enrollee demographics, and use of reserves, on premium growth trends from 2000 through 2007.<sup>4</sup> We also examined aggregate data on the actual growth in per-enrollee expenditures from 2003 through 2005 for 5 large FEHBP plans.<sup>5</sup> We explored with officials from OPM and 14 selected FEHBP plans the potential effect on premium growth of the retiree drug subsidy if OPM had applied for the subsidy and used it to mitigate premium growth. The 14 plans were selected because of size (at least 5,000 enrollees) and length of participation in the FEHBP (at least 3 years). To examine the reasons for differing premium growth trends among FEHBP plans, we conducted interviews with officials from these 14 plans. Eight of the plans had higher-than-average premium growth, and six of the plans had lower-than-average premium growth for either (a) 2006 or (b) the 3-year period from 2004 through 2006. A detailed explanation of our scope and methodology is contained in appendix I of the December 2006 report. We conducted our work for that report from January 2006 through December 2006 in accordance with generally accepted government auditing standards.

In summary, we found that growth in average FEHBP premiums recently slowed from a peak of 12.9 percent for 2002 to 1.8 percent for 2007. This

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<sup>3</sup>Kaiser/HRET has conducted surveys of employer-sponsored health benefits since 1989. These surveys capture data from employers ranging in size from 3 to 300,000 or more workers. KPMG Peat Marwick conducted the surveys before 1999. We analyzed premium growth trends for CalPERS from 1994 through 2007. We analyzed premium growth trends for Kaiser/HRET surveyed employers from 1994 through 2006, because the Kaiser/HRET survey data available when we prepared our December 2006 report did not include growth rates for 2007.

<sup>4</sup>Premium rates for each year are prospectively set by individual FEHBP plans based on their projections of growth for various factors. OPM calculates the average premium growth across all FEHBP plans and estimates the composite projected growth in each of these factors across all FEHBP plans based on the plans' projections. Actual growth for each factor may differ from these projections.

<sup>5</sup>OPM was not able to provide these data for all FEHBP plans for 2005. These 5 plans accounted for about 90 percent of fee-for-service enrollment and about 67 percent of total FEHBP enrollment.

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was lower than growth for other purchasers from 2003 through 2007. Premium growth rates for the 10 largest FEHBP plans by enrollment, accounting for about three-quarters of total enrollment, ranged from 0 to 15.5 percent for 2007, but varied more widely across the smaller FEHBP plans.

Projected increases in the cost and utilization of health care services and in the cost of prescription drugs accounted for most of the average annual premium growth across all FEHBP plans for 2000 through 2007. Absent projected decreases in the costs of other factors, these increases would have raised 2007 average premiums by about 9 percent, rather than the 1.8 percent actual increase for that year. During this same period, projected decreases in the costs associated with certain other factors, including benefit changes that resulted in less generous coverage and enrollee migration to lower-cost plans, generally helped offset premium growth to a small extent. In 2006 and 2007, projected withdrawals from reserves particularly helped offset average premium growth by about 2 percentage points for 2006 and about 5 percentage points for 2007. Regarding the potential effect of the retiree drug subsidy, most plan officials we interviewed stated that the subsidy would have had a small effect on premium growth for 2006 had OPM applied for the subsidy and used it to mitigate premium growth. Officials from two large plans with higher-than-average shares of retirees, however, stated that the subsidy would have lowered their plans' premium growth—officials from one plan said by at least 3.5 to 4 percentage points for their plan. We estimated that the subsidy would have lowered premium growth across all FEHBP plans for 2006 by more than 2 percentage points on average, from the 6.4 percent average growth rate for 2006 to about 4 percent. OPM officials said that OPM did not apply for the subsidy because the intent of the subsidy was to encourage employers to continue offering prescription drug coverage to Medicare-eligible enrollees, and FEHBP plans were already doing so.

To explain the factors associated with premium growth, officials we interviewed from most of the plans with higher-than-average premium growth cited increases in the cost and utilization of services as well as a high share of elderly enrollees and early retirees. Officials we interviewed from most plans with lower-than-average premium growth cited adjustments made for previously overestimated projections of cost growth, and some officials cited benefit changes that resulted in less generous coverage for prescription drugs. The plans with lower-than-average premium growth also experienced a decline of 0.5 years in the average age of their enrollees compared with an increase of 0.5 years in the average age of all FEHBP enrollees.

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## Background

The FEHBP is the largest employer-sponsored health insurance program in the country, providing health insurance coverage for about 8 million federal employees, retirees, and their dependents through contracts with private insurance plans. All currently employed and retired federal employees and their dependents are eligible to enroll in FEHBP plans, and about 85 percent of eligible workers and retirees are enrolled in the program. For 2007, FEHBP offered 284 plans, with 14 fee-for-service (FFS) plans, 209 health maintenance organization (HMO) plans, and 61 consumer-directed health plans (CDHP). About 75 percent of total FEHBP enrollment was concentrated in FFS plans, about 25 percent in HMO plans, and less than 1 percent in CDHPs.

Total FEHBP health insurance premiums paid by the government and enrollees were about \$31 billion in fiscal year 2005. As set by statute, the government pays 72 percent of the average premium across all FEHBP plans but no more than 75 percent of any particular plan's premium.<sup>8</sup> The premiums are intended to cover enrollees' health care costs, plans' administrative expenses, reserve accounts specified by law, and OPM's administrative costs. Unlike some other large purchasers, FEHBP offers the same plan choices to currently employed enrollees and retirees, including Medicare-eligible retirees who opt to receive coverage through FEHBP plans rather than through the Medicare program. The plans include benefits for medical services and prescription drugs.

By statute, OPM can negotiate contracts with health plans without regard to competitive bidding requirements.<sup>9</sup> Plans meeting the minimum requirements specified in the statute and regulations may participate in the

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<sup>8</sup>The Balanced Budget Act of 1997 established the government's current share of the premiums beginning in the 1999 contract year. Pub. L. No. 105-33, §7002, 111 Stat. 251, 662 (amending 5 U.S.C. §8906). OPM determines separate averages for individual plans and for family plans. Although the average enrollee premium contribution is 25 percent of the average premium for all plans, enrollee premium contributions can be higher than 28 percent for plans with premiums significantly higher than the average FEHBP plan. For example, the 2006 monthly premium for a particular FEHBP plan was \$642, compared with the average premium of \$415. Because the government's share is \$299 (72 percent of \$415), the enrollee premium contribution for this particular plan was \$343 (\$642 minus \$299), or about 53 percent of the plan's premium.

<sup>9</sup>5 U.S.C. §8902.

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program, and plan contracts may be renewed automatically each year. OPM may terminate contracts if the minimum standards are not met.<sup>10</sup>

OPM administers a reserve account within the U.S. Treasury for each FEHBP plan, pursuant to federal regulations. Reserves are funded by a surcharge of up to 3 percent of a plan's premium.<sup>11</sup> Funds in the reserves above certain minimum balances may be used, under OPM's guidance, to defray future premium increases, enhance plan benefits, reduce government and enrollee premium contributions, or cover unexpected shortfalls from higher-than-anticipated claims.

On January 1, 2006, Medicare began offering prescription drug coverage (also known as Part D) to Medicare-eligible beneficiaries.<sup>12</sup> Employers offering prescription drug coverage to Medicare-eligible retirees enrolled in their plans could, among other options, offer their retirees drug coverage that was actuarially equivalent to standard coverage under Part D and receive a tax-exempt government subsidy to encourage them to retain and enhance their prescription drug coverage.<sup>13</sup> The subsidy provides payments equal to 28 percent of each qualified beneficiary's prescription drug costs that fall within a certain threshold and is estimated to average about \$670 per beneficiary per year. OPM opted not to apply for the retiree drug subsidy.

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<sup>10</sup>OPM can terminate a plan's contract at the end of the contract term if fewer than 300 federal employees and retirees were enrolled during the two preceding contract terms. In addition, if a plan fails to meet minimum standards, OPM can withdraw its approval after giving the plan notice and providing an opportunity for a hearing.

<sup>11</sup>5 U.S.C. §8909. Reserves may also be credited with any unused portions of funds set aside for OPM's administrative expenses and income from investment of the reserves. In the case of FFS plans, reserves may also be credited with portions of excess premiums that may remain after claims and the plan's administrative costs and other financial obligations have been met. These excess premiums may not be transferred into reserve accounts for most HMO plans.

<sup>12</sup>For more information on Medicare Part D, see GAO, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act*, GAO-05-205 (Washington, D.C.: Feb. 14, 2005).

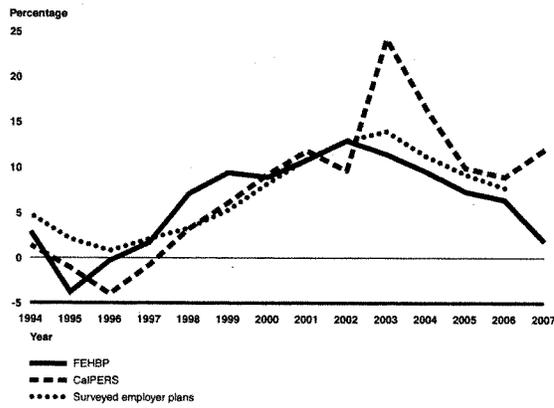
<sup>13</sup>In general, according to the Centers for Medicare & Medicaid Services, actuarial equivalence measures whether the expected amount of paid claims under the employers' prescription drug coverage is at least equal to the expected amount of paid claims under the standard prescription drug coverage under Medicare Part D. The conference committee report for the legislation authorizing this subsidy indicated a belief by the committee that the subsidy would help employers retain and enhance their prescription drug coverage in the face of increasing pressure to drop or scale back such coverage. H.R. Conf. Rep. No. 108-391, at 484 (2003).

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**Growth in Average  
FEHBP Premiums  
Has Recently Slowed  
and Was Lower Than  
That of Other  
Purchasers**

The average annual growth in FEHBP premiums has slowed since 2002—declining each year from 2003 through 2007—and was generally lower than the growth for other purchasers since 2003. After a period of decreases in 1995 and 1996, FEHBP premiums began to increase for 1997, to a peak increase of 12.9 percent for 2002. The growth in average FEHBP premiums began slowing in 2003 and reached a low of 1.8 percent for 2007. The average annual growth in FEHBP premiums was faster than that of CalPERS and surveyed employers from 1997 through 2002—8.5 percent compared with 6.5 percent and 7.1 percent, respectively. However, beginning in 2003, the average annual growth rate in FEHBP premiums was slower than that of CalPERS and surveyed employers—7.3 percent compared with 14.2 percent and 10.5 percent, respectively. (See fig. 1).

Figure 1: Growth in Average Premiums for FEHBP and Other Purchasers, 1994 through 2007



Sources: OPM, CalPERS, and Kaiser/HRET.

Note: The 2007 average premium growth rate for employer plans in the Kaiser/HRET surveys was not available at the time we completed our work for this testimony.

The premium growth rates for the 10 largest FEHBP plans by enrollment—accounting for about three-quarters of total FEHBP enrollment—ranged from 0 percent to 15.5 percent for 2007. Premium growth rates across the smaller FEHBP plans varied more widely.

Regarding enrollee premiums—the share of total premiums paid by enrollees—the growth in average enrollee premiums generally paralleled total premium growth from 1994 through 2007. In 2006, average monthly FEHBP premiums were \$415 for individual plans and \$942 for family plans in total. The enrollee premium contributions were \$123 for individual plans and \$278 for family plans.

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**Projected Growth in  
Several Factors  
Contributed to  
Average FEHBP  
Premium Growth**

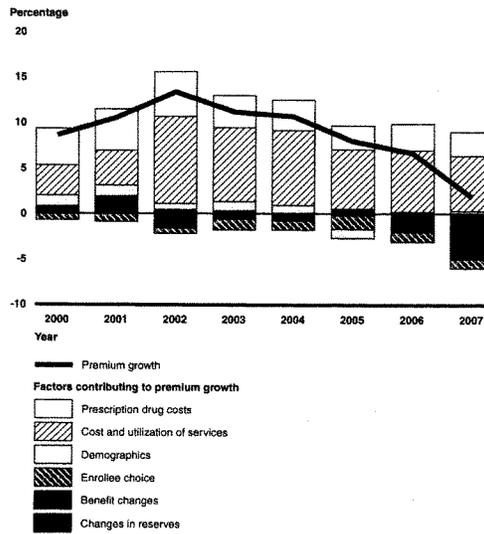
Projected increases in the cost and utilization of services and in the cost of prescription drugs accounted for most of the average annual premium growth across FEHBP plans for the period from 2000 through 2007, although projected withdrawals from reserves offset much of this growth for 2006 and 2007. Absent projected changes associated with other factors, projected increases in the cost and utilization of services and the cost of prescription drugs would have accounted for a 9 percent increase in average premiums for 2007. Projected increases in the cost of and utilization of services alone would have accounted for about a 6 percent increase in average premiums for 2007, down from a peak of about 10 percent for 2002. Projected increases in the cost of prescription drugs alone would have accounted for about a 3 percent increase in premiums for 2007, down from a peak of about 5 percent for 2002. Enrollee demographics—particularly the aging of the enrollee population—were projected to have less of an effect on premium growth. Projected decreases in the costs associated with certain other factors, including benefit changes that resulted in less generous coverage and enrollee choice of plans—typically the migration to lower-cost plans—generally helped offset average premium growth for 2000 through 2007 to a small extent.

Projected withdrawals from reserves offset average premium growth for 2006 and 2007. Officials we interviewed from most of the plans stated that OPM monitored their plans' reserve levels and worked closely with them to build up or draw down reserve funds gradually to avoid wide fluctuations in premium growth from year to year. Projected additions to reserves nominally contributed to average premium growth—by less than 1 percentage point—for 2000 through 2005. However, projected withdrawals from reserves offset average premium growth by about 2 percentage points for 2006 and 5 percentage points for 2007.<sup>14</sup> (See fig. 2.)

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<sup>14</sup>OPM officials said that reserves had a larger effect in mitigating average premium growth for 2007 for FFS plans compared with HMO plans, because FFS plans had larger accumulated reserves upon which they could draw. According to OPM officials, increases in the actual cost and utilization of services in 2006 were lower than projected for that year, and therefore the projected withdrawals from reserves were not made in 2006. Because of the resulting higher reserve balances, plans and OPM projected even larger reserve withdrawals for 2007.

**Figure 2: Projected Changes in Various Factors Affecting FEHBP Premium Growth, 2000 through 2007**



Source: OPM.

We also reviewed detailed data available for five large FEHBP plans on claims actually incurred from 2003 through 2005. These data showed that most of the increase in total expenditures per enrollee was explained by expenditures on prescription drugs (34 percent) and on hospital outpatient services (26 percent).

Officials we interviewed from several FEHBP plans stated that the retiree drug subsidy would have had a small effect on premium growth had OPM applied for the subsidy and used it to offset premiums. First, drug costs for Medicare beneficiaries enrolled in these plans accounted for a small

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proportion of total expenses for all enrollees, and the subsidy would have helped offset less than one-third of these expenses. Second, because the same plans offered to currently employed enrollees were offered to retirees, the effect of the subsidy would have been diluted when spread across all enrollees. However, officials we interviewed from two large plans with high shares of elderly enrollees stated that the subsidy would have lowered premium growth for their plans. Officials from one of these plans estimated that 2006 premium growth could have been 3.5 to 4 percentage points lower.

Our analysis of the potential effect of the retiree drug subsidy on all plans in FEHBP showed that had OPM applied for the subsidy and used it to offset premium growth, the subsidy would have lowered the 2006 premium growth by 2.6 percentage points from 6.4 percent to about 4 percent.<sup>15</sup> The reduction in premium growth would have been a onetime reduction for 2006.<sup>16</sup> Absent the drug subsidy, FEHBP premiums in the future would likely be more sensitive to drug cost increases than would be premiums of other large plans that received the retiree drug subsidy for Medicare beneficiaries.

OPM officials explained that there was no need to apply for the subsidy because the intent of the subsidy was to encourage employers to continue offering prescription drug coverage to Medicare-eligible enrollees, and FEHBP plans were already doing so. The potential effect of the subsidy on premium growth would also have been uncertain because the statute did not require employers to use the subsidy to mitigate premium growth.

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<sup>15</sup>We used the nationwide average subsidy estimated by the Centers for Medicare & Medicaid Services to be about \$670 per Medicare-eligible retiree. The actual subsidy for Medicare-eligible retirees in FEHBP may have varied from this average. Officials from CalPERS stated that the subsidy, which they had received but had not decided how to use as of August 2006, amounted to 13 to 17 percent of the total premium for Medicare-eligible enrollees in 2006. They stated that the subsidy would have a greater effect on premiums for CalPERS enrollees because, unlike FEHBP, CalPERS offers separate plans for employed enrollees and retirees (including Medicare beneficiaries), and the subsidy would thus be applied exclusively to premiums for retirees.

<sup>16</sup>Continued use of the subsidy in subsequent years would affect actual FEHBP premiums but not their rate of increase.

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**Changes in the Cost and Utilization of Services and Enrollee Demographics Accounted for Differing Premium Growth Among FEHBP Plans**

Officials we interviewed from most of the FEHBP plans with higher-than-average premium growth in 2006 cited increases in the actual cost and utilization of services and high shares of elderly enrollees and early retirees as key drivers of premium growth. Our analysis of financial data provided by six of these plans showed that the average increase in total expenditures per enrollee from 2003 through 2005 was about 40 percent—compared with the average of 25 percent for five large FEHBP plans that represented about two-thirds of total FEHBP enrollment. From 2001 through 2005, the average age of enrollees across all eight plans with higher-than-average premium growth increased by 2.7 years—compared with an average increase of 0.5 years across all FEHBP plans.

Officials we interviewed from most of the FEHBP plans with lower-than-average premium growth in 2006 cited adjustments for previously overestimated projections of cost growth and benefit changes that resulted in less generous coverage for prescription drugs as factors that limited premium growth. Our analysis of financial data provided by two plans showed that per-enrollee expenditures for prescription drugs increased by 3 percent for one plan and 13 percent for the other from 2003 through 2005—compared with 30 percent for the average of the five large FEHBP plans. Also, from 2001 through 2005, the average age of enrollees across all six of these plans decreased by 0.5 years—compared with an average increase of 0.5 years across all FEHBP plans.

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Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members of the subcommittee may have.

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**Contacts and Acknowledgements**

For future contacts regarding this testimony, please contact John E. Dicken at (202) 512-7119 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Randy Dirosa, Assistant Director; Iola D'Souza; and Timothy Walker made key contributions to this testimony.



**BlueCross BlueShield  
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**TESTIMONY OF**

**Blue Cross & Blue Shield Association**

An Association of Independent  
Blue Cross & Blue Shield Plans

**Before the**

**Subcommittee on Oversight of Government Management,  
the Federal Workforce, and the District of Columbia  
Committee on Homeland Security and Governmental Affairs  
United States Senate**

**On**

**“Up, Up, and Away! Growth Trends in Health Care Premiums for Active and  
Retired Federal Employees”**

**Presented by:**

**Stephen W. Gammarino  
Senior Vice President, National Programs**

**Friday, May 18, 2007**

Mr. Chairman and Members of the Subcommittee:

Good morning. Chairman Akaka, Ranking Member Voinovich, and Members of the Subcommittee, I am Stephen Gammarino, Senior Vice President, National Programs, of the Blue Cross and Blue Shield Association. Thank you for this opportunity to discuss premiums in the Federal Health Benefits Program with the members of the Subcommittee. We appreciate your interest in the FEHBP and look forward to working with you and the Subcommittee to address this and other issues that are so important to the federal employees and retirees who rely on the FEHBP for their health care coverage.

The Blue Cross and Blue Shield Association and participating independent state and local Blue Cross and Blue Shield Plans jointly administer the government-wide Service Benefit Plan in the FEHBP. We are proud to have offered the Service Benefit Plan from the very beginning of the FEHBP in 1960. Today, the Service Benefit Plan provides health insurance to more than 4.7 million active and retired federal employees and dependents. By their choice to enroll in one of the options we offer, the Service Benefit Plan has become the largest plan in the Program.

We believe we have been so successful in this program because, in large part, federal employees and retirees recognize our commitment to offering high-quality, affordable health care coverage. Our goal is to ensure that the right person gets the right treatment at the right time, and we work hard to do that while maintaining competitive rates.

#### **Factors Affecting Premiums**

There are a number of factors that affect FEHBP premiums. One factor benefiting federal employees and retirees is the very structure of this market-oriented, employer-sponsored program in which risk-bearing carriers compete with one another for each individual employee's or retiree's business. This retail competition and the fact that all of the competitors are at risk compel carriers to develop actuarially sound products that offer attractive benefits at competitive prices. Through their own choices, enrollees help to keep premiums in check.

Federal employees and retirees have also benefited from the Office of Personnel Management's responsible management of the Program. OPM's sound stewardship and its focus, as the employer's agent, on maintaining the FEHBP as an attractive employment benefit to assist the federal government in recruiting and retaining a well-qualified workforce, have contributed significantly to the FEHBP's reputation as a model employer-sponsored health benefits program.

Congress has also played an important role in the success of the FEHBP through its oversight role. I especially commend Congress for largely, and wisely, refraining from imposing too many mandates on the FEHBP. Each mandate

looks attractive when viewed in isolation. But as a whole, mandates deprive OPM and carriers of the flexibility they need to keep pace with the dynamic health care market and to deploy their resources in ways that most effectively respond to our customers' values and needs.

The FEHBP is, of course, integrally tied to our private health care industry. Federal employees and retirees see the same doctors and hospitals as their neighbors who work for private employers. Accordingly, the FEHBP is also affected by the same forces at work in health care in general.

These forces include increased utilization of prescription drugs and provider services, advances in medical technology and drug therapies, national demographic trends, and customer expectations.

One feature of the FEHBP that we should also keep in mind is that the nationwide fee-for-service plans, such as the Service Benefit Plan, offer uniform rates across the country. Any federal employee or retiree can enroll in any FEHBP plan and can switch to any other carrier during annual open seasons. All enrollees in a plan pay the same rates and receive the same benefits. The Service Benefit Plan also is required to be the insurer of last resort in the FEHBP.

The FEHBP is also affected by the demographics of the federal population. Retirees make up 46.1 percent of the FEHBP, and 47 percent of the Service Benefit Plan. In 2006, the average age of contract holders in the Service Benefit Plan's Standard Option, our largest plan, was almost 61, and Basic Option was over 45.

#### **The Rate Setting Process**

Each year OPM issues a call letter to all competing carriers in which the agency lays out its policies and expectations for the FEHBP in the coming year. Each carrier then develops its own proposals for rates and benefits. (In fact, we will be submitting our rate and benefit proposals at the end of this month.) In formulating those proposals, carriers will take into account the policies and expectations announced in the call letter, the values of its members, and its own projections for the costs of providing the benefits it is proposing. Carriers' projections are informed by its own analysis of historical utilization and costs, but carrier actuaries must also factor in assumptions about future prices of various health care services and expected utilization.

The carrier will also factor in its reserve position. In addition, of course, each carrier must keep a wary eye on the competitive landscape that it faces.

OPM will analyze those proposals, and then the carrier and the agency will negotiate the final benefit package and premium rates. A carrier's final rates also include statutorily required contributions to the contingency reserve maintained in

the U.S. Treasury for that carrier and to defray expenses OPM will incur in administering the FEHBP.

**2007 Rates for the Service Benefit Plan**

I am very pleased that this year, for the third consecutive year, there was no change in the premiums for our Basic Option. Additionally, the individual's share of the premiums for our Standard Option, which covers almost 4 million people, actually declined slightly, and the total premium increased by only 1 percent.

I am even more pleased that we accomplished this while maintaining generous benefits. In fact, we have added significant enhancements to our benefits. For Standard Option, these include better coverage for chiropractic services and acupuncture, more generous ambulance coverage, and improved coverage for routine physicals and cancer screenings. For Basic Option, we have eliminated \$40 co-payments for diagnostic or psychological testing related to mental illness or substance abuse and diagnostic tests at outpatient hospital or surgical centers, and we improved maternity benefits.

As the members of this subcommittee know, the FEHBP Act expressly provides that funds in a carrier's contingency reserve may be used to stabilize premiums. We were able to use our reserves to stabilize our premiums for 2007.

**Quality Initiatives**

I would also like to review for the Subcommittee several initiatives designed to improve the quality of health care our members receive.

**Care Coordination**

Working closely with OPM, we are developing a member-centric program, called Care Coordination. Care Coordination applies health information technology to an integrated database in order to improve our members' ability to receive higher quality health care.

Care Coordination focuses on those with chronic conditions, diabetics for example. Under it, we will use claims data, including prescription drug information, and information from enrollment forms to identify those members who would benefit from our Plans' disease or case management programs. We will then work with our local Plans to educate those members about the benefits of such programs and, we hope, persuade them to take advantage of the appropriate program.

We anticipate that all Plans will be part of the Care Coordination program by 2008. Our objective for this program is to enhance the health care received by

those who need it most by strengthening their ability to manage their medical conditions.

### **Blue Distinction<sup>SM</sup>**

Blue Distinction is a nationwide program of the Blue Cross and Blue Shield companies to help foster the development of a more consumer-centered, knowledge-driven health care system. Blue Distinction is an important step toward providing health care consumers with cost and quality information similar to what they expect before buying most other goods and services.

By encouraging a much deeper level of transparency, Blue Distinction intends to (1) encourage and empower consumers to make more informed decisions about their health care; and (2) collaborate with providers to make health care more affordable and enable members and providers together to improve quality outcomes.

Consumers will have access to the information necessary for sound decision making through Blue Distinction's:

- special care centers (bariatric surgery, cardiac care, and transplant services), which are leading institutions identified in collaboration with providers across the country that meet clinically valid standards and deliver better outcomes;
- nationwide hospital measurement and improvement program, which draws together data from the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality on common conditions such as heart attacks, heart failure, and pneumonia; and
- transparency demonstrations in which Blue Plans work with hospitals, physicians, and medical groups to test the most effective ways of bringing information on health care quality and costs to consumers.

Blue Distinction, we believe, will lead to healthier lives and, over time, lower healthcare costs as patients and doctors interact with one another.

### **Comparative Effectiveness**

One of the most fundamental drivers of cost increases is the fact that almost 30 percent of expenditures in our current health care system is for ineffective, inappropriate or redundant care. The dearth of evidence based medicine results in patients receiving suboptimal care -- and paying more for it. Only about 54

percent of acute care delivered and 56 percent of chronic care delivered by physicians follows guidelines from medical literature.

BCBSA believes this root problem is causing many of the headliner issues of today: increasing uninsured levels and decreasing affordability for those with insurance. To address these core problems, BCBSA has proposed a legislative initiative to create a new independent institute to support clinical research comparing the effectiveness of medical procedures, drugs, devices, and biologics. The institute would disseminate its findings to providers, and in reader-friendly form to consumers. Providers that follow the institute's findings would receive special malpractice protections. BCBSA believes this approach would ultimately be the best path to assuring that affordability returns to health care while maximizing quality of care. We believe the institute should be funded by both public payers – like Medicare and Medicaid – as well as private payers.

**Conclusion**

Let me assure the Subcommittee that we are committed to providing federal employees, retirees, and their families affordable coverage so they may obtain high-quality healthcare. We look forward to working with OPM and Congress in order to achieve that goal.

This concludes my prepared remarks. I would be pleased to answer any questions you may have.

**STATEMENT BY  
ALAN G. LOPATIN  
LEGISLATIVE COUNSEL  
NATIONAL ACTIVE AND RETIRED FEDERAL  
EMPLOYEES ASSOCIATION**

**TO THE SUBCOMMITTEE ON OVERSIGHT OF  
GOVERNMENT MANAGEMENT,  
THE FEDERAL WORKFORCE AND THE DISTRICT OF  
COLUMBIA  
COMMITTEE ON HOMELAND SECURITY AND  
GOVERNMENTAL AFFAIRS  
UNITED STATES SENATE**

**HEARING ON  
FEDERAL EMPLOYEES HEALTH BENEFITS  
PROGRAM (FEHBP) PREMIUMS**

**MAY 18, 2007**

Mr. Chairman on behalf of our nation's 4.6 million federal employees, retirees and survivors, I appreciate the opportunity to express the views of the National Active and Retired Federal Employees Association (NARFE) on Federal Employees Health Benefits Program (FEHBP) premiums.

Chairman Akaka, NARFE commends you for requesting the Governmental Accountability Office (GAO) report we are considering today and for your leadership on trying to help federal employees and annuitants shoulder higher health care costs. Indeed, we were pleased that you specifically asked the nonpartisan GAO to determine how FEHBP premiums would have been affected had the Office of Personnel Management (OPM) applied for a payment provided under the Medicare Modernization Act of 2003 (MMA).

Section 1860D-22 of the Medicare Modernization Act provides that all employers who provide drug coverage to their retirees age 65 and older, at least as generous as the new Medicare Part D prescription drug plan, are eligible to receive a subsidy of 28 percent of the per enrollee cost for drug coverage.

GAO found that premium growth in one of the largest FEHBP plans with a high share of older enrollees could have been 3.5 to 4 percent lower in 2006 had the payment been accessed. Additionally, the payment would have lowered the growth in premiums across all FEHBP plans for 2006 by more than 2 percentage points on average, from 6.4 percent to about 4 percent. GAO also wrote that, "Absent the drug subsidy, FEHBP premiums in the future would likely be more sensitive to drug cost increases than would be premiums of other large plans [state and

local government and private employers] that receive the retiree drug subsidy for Medicare beneficiaries.” The report said that prescription drug costs accounted for 34 percent of the increase in total expenditures per enrollee for the five largest FEHBP plans – the single largest cost driver between 2003 and 2005.

NARFE has long held that FEHBP is the best group health insurance plan in America today and should serve as a model for others. Even in years of double digit rate hikes, we have said that OPM – on behalf of the government as an employer-- does a better job negotiating premium increases than any other employer. The GAO report affirms this fact. But we can't say that everything is being done to contain premium growth if more than \$1 billion is left on the table every year.

We are bewildered by the action (or, more appropriately, inaction) of the Federal Government as an employer not to take advantage of a \$1 BILLION subsidy to which its health plan is entitled.

Are we to let politics trump sound public policy and practice – policy that was likely advocated by civil service career professionals charged with administering the Plan?

NARFE understands all too well “budget parlance”. Our members, including your active and retired colleagues, have long been “parlanced” through the loss of benefits -- delayed and eliminated COLAs, pay absorption, and alternative pay plans.

The goals of the Federal Government as an employer should be to attract and retain the best and the brightest to serve this country. In doing so, we must be a competitive employer. OPM, as the chief steward of the civil service must keep its focus on that goal in decisions affecting our competitive edge.

You, as leaders, have the power to promote the integrity of our civil service and our capacity to recruit and retain the workforce needed to inspect our ports, protect our food, air, and water, and support our seniors, our children, and our working families.

Most NARFE members, by tradition, are retirees. Our time in direct service to the nation has passed. Certainly, we will always be vigilant in our efforts to protect our earned benefits from our time of employment and to seek equity with our colleagues, retirees, and active civilian and military personnel.

But our responsibility, as yours, lies in the ability of our government to follow in our footsteps of not just competent, but superlative, support of our citizens and our government. Any and all actions should be taken with that mission in mind. We owe it to our legacy and we owe it to the American taxpayer.

Recognize that this decision also was denied the United States Postal Service, acting as a business with a quasi-governmental mission, access to the payment which would benefit its competitive status and its ratepayers, including you and me.

The government's action in this regard, repeated, does not support sound business practice. And we ALL suffer.

Federal workers, retirees and survivor annuitants, who often struggle to pay their steadily increasing premiums, cannot understand why the federal government has failed to do what so many other employers have done to reduce this burden, especially when state and local governments do not think twice about accepting the payment.

The Administration's Objections

OPM has cited two reasons for the Administration's decision to forgo the payment.

First, they have said they did not need to take advantage of the payment since they had no plans to significantly change the drug coverage of federal annuitants age 65 and older. It is fair to say that other public and private employers who had no intention of reducing or ending their retiree drug benefits decided to apply for the payment anyway. Certainly, the Centers for Medicare and Medicaid Services (CMS) does not withhold the payment based on what they think an employer's behavior will be in response to the Medicare drug benefit and the employer payment. Stockholders and employees would be understandably furious if their company did not avail themselves of anything that could contain health care costs without sacrificing coverage.

Second, OPM claims that they do not believe it is appropriate for the federal government to be paying itself for this purpose. Nonetheless, what they do not say is that payments to OPM,

unlike other employers, would not result in a spending “outlay” under federal budget rules, since they remain within the government. Such “intragovernmental transfers” are not unusual. In fact, the federal government pays itself for the future retirement obligations when federal agencies make contributions from their appropriated salary and expense accounts to the on-budget retirement trust on behalf of their employees.

We also wonder why the Administration chose not to object to the payment much earlier in this process. NARFE announced on June 17, 2003 that we would oppose the version of the Medicare Prescription Drug bill that was about to go to the House floor because of concerns that employers, including the federal government, might dump retiree drug coverage in response to the creation of a Medicare drug benefit. Then-Ways and Means Committee Chairman Bill Thomas and Health Subcommittee Chairwoman Nancy Johnson responded by clarifying in the House-passed legislation that the federal government, as an employer, would be eligible for the prescription drug subsidy payment. Their change not only survived the legislative process, it was enhanced when state and local government also were made eligible for the payment.

At no point during the consideration of MMA did the Administration oppose including the federal government among the eligible employers. Indeed, OPM and CMS staff met in 2004 to discuss how OPM would receive the employer subsidy and made arrangements to ensure that payments to OPM would be considered an intragovernmental transfer. That is why OPM’s announcement in the 2005 FEHBP “call letter,” that the Office would not apply for the payment came as a surprise and disappointment to us.

OPM has also said that the payment is unnecessary since FEHBP is already “heavily subsidized”.

NARFE objects to this characterization because it implies that the benefits federal employees and retirees earn is really welfare. The “government contribution,” which is the statutory term used to describe the FEHBP employer premium share, is no different from any other form of earned compensation, like wages and retirement benefits. Moreover, we think that the government would want to exercise the option of lowering the worker share of health premiums to help attract a talented and skilled workforce, particularly as we respond to the human capital shortage precipitated by a growing wave of federal retirements.

NARFE is also concerned that the Administration’s decision to forgo the payment further stacks the deck against federal workers whose jobs are considered for contracting out to the private sector. Contracting out decisions are based on an assessment of the cost of having the government continue to perform a specific function against moving that work to the private sector. For that reason, private contractors who use the Medicare employer payment to lower their health insurance costs have an advantage in such competitions over federal agencies, who by Administration policy, are barred from doing the same.

#### FEHBP “Fair Share” Premium Formula

Mr. Chairman, the GAO report you requested also attempted to evaluate the performance of the FEHBP “Fair Share” formula, developed by OPM, Congress and NARFE in 1996 and 1997.

Fair Share was intended to maintain a consistent level of government contributions as a percentage of total program costs, regardless of which health plan enrollees elect. For that reason, we have been concerned whenever the percentage increase in the enrollee premium share is disproportionately higher than the government contribution. For instance, in 2006 the enrollee share of a family Blue Cross/Blue Shield standard option premium increased by 14.85 percent while the government/employer contribution grew by only 5.76 percent. The formula should minimize the proportionate cost hikes between what enrollees and the government pays.

Under Fair Share, 72 percent of the program-wide weighted average of all 284 plan premiums determines the government contribution. The government as employer pays a larger percentage of any FEHBP plan (up to a 75 percent cap) with lower premiums and it pays a smaller percentage of plans with a higher rate.

In response to several years of double digit increases, the demand for lower cost FEHBP plans has increased. This has been helpful to some workers and annuitants who want to cut costs. Lower wage and younger workers naturally gravitate to lower cost plans. However, since the government/employer contribution is set by a "weighted average" of all premiums, large enrollment shifts to less expensive plans could lower the overall amount the government pays and increase the percentage share which enrollees pay in moderate to high cost plans.

In many instances, the higher cost plans have more comprehensive coverage and better provider access than lower cost options. As a result, individuals with greater health care needs tend to remain in higher cost plans and the opposite is true for healthier persons. With fewer healthier

enrollees, consequently, greater claim experience with the higher cost plans contributes to higher premiums. In fact, carriers have withdrawn some "high option" plans when their premiums became too expensive. With the departure of high option, we fear that "standard option" (and with it, consumer choice) may suffer the same fate. While NARFE understands why more efficiency is necessary, we are troubled such a focus on cost consciousness could mean "a race to the bottom" where workers and annuitants are limited to plans with less coverage, smaller provider networks, and greater cost sharing in terms of more and more out-of-pocket costs in addition to plan premiums.

This situation would deteriorate more rapidly if the present 75 percent limit on the FEHBP government contribution were eliminated. Under Fair Share, enrollees pay at least 25 percent of their health plan premiums. Absent this cap, the enrollee share of FEHBP premiums could be zero if enrollees select the lowest cost plans -- giving enrollees a "premium-free" option. That could have a significant effect on the rest of the program. The availability of a no-cost plan would serve as an even stronger incentive to younger, healthier employees and would lead more enrollees to congregate in the no-cost plans. Consequently, adverse selection costs would be shifted to enrollees in all other plans, increasing enrollee costs and effectively limiting consumer choice.

#### Health Savings Accounts

Although traditional lower cost managed care insurance could drive up the enrollee premium share, no option has more potential for separating healthy from sick enrollees than the

combination of a Health Savings Account and High Deductible Health Plan (HSA/HDHP).

Healthier enrollees tend to be attracted to HSAs and other consumer-driven financing schemes because, as low health care users, they can be rewarded with unspent balances or credits at the end of each year.

Less healthy enrollees avoid HSAs and consumer-driven plans because they could pay thousands of dollars in out-of-pocket costs. As a result, higher volume health care users are more likely to stay in traditional comprehensive plans. This phenomenon, called “adverse selection,” forces traditional insurance plan carriers to raise premiums, cut benefits or both. NARFE’s concerns about HSAs were confirmed by a January 2006 GAO report, which found that HSAs tended to attract younger and wealthier FEHBP enrollees.

In addition, the nonpartisan Employee Benefit Research Institute (EBRI) December 2005 report found that individuals with HSAs are “significantly more likely to spend a larger share of their income on out-of-pocket health care expenses than those in comprehensive plans” and that they were “significantly more likely to avoid, skip or delay health care because of cost than those with more comprehensive health insurance.”

In 2006, only 0.2 percent of FEHBP participants were enrolled in an HSA or similar plan. If HSA enrollment continues to be low, the controversial options will have minimal effect on comprehensive plans. However, without precautions against HSA-inspired “risk selection,” the new plans could result in higher premiums and less benefits for the FEHBP’s comprehensive

insurance if larger numbers of healthier enrollees migrate to HSAs. Ultimately, this would be the death knell for fee-for-service plans and many traditional HMO plan products.

The Administration's FY 2008 budget would give lackluster enrollment in HSAs a jump start by allowing Blue Cross/Blue Shield (BC/BS) to offer the controversial option in FEHBP.

In fact, the federal law which authorizes the FEHBP stipulates that one government-wide "Service Benefit Plan" offers two levels of benefits. BC/BS is the Service Benefit Plan. The budget recommends that the FEHBP law be amended to allow the Service Benefit Plan to offer three, instead of two, benefit levels which would enable BC/BS to offer a government-wide HSA/HDHP.

BC/BS's current health plans are the largest and most popular in the FEHBP. As a result, the insurance carrier's brand loyalty and considerable marketing resources could significantly increase HSA enrollment in FEHBP if they decided, and were allowed, to offer such an option.

What is new about this recycled proposal is that, in addition to BC/BS, the Administration says that the "Indemnity Benefit Plan" should provide HSAs as a system-wide option.

Despite being named in the law which authorizes FEHBP, the Indemnity plan has not been available since the Aetna left the FEHBP in 1990. Legislation would be necessary to enable the long dormant plan to offer HSAs.

The entry of a second large insurance carrier with an HSA option available to most enrollees could also boost participation in HSAs.

NARFE opposes further expansion of HSAs because they could increase premiums for comprehensive plans since relatively healthy enrollees with higher incomes would be siphoned off into HSAs.

#### Mature and Older Enrollees

While GAO found that prescription drug cost and utilization of services were the highest cost contributors in all FEHBP plans, they reported that demographics had a greater effect on higher cost plans than less expensive options. We believe that trend is true for two reasons.

First, as individuals age and use more health care, they have a greater need for access to the physicians of their choice and comprehensive coverage than younger enrollees. That means they tend to enroll in fee-for-service plans which usually cost more than managed care options.

Second, some annuitants age 65 and older join a higher cost plan, even when a more moderately priced option is available which would provide the same level of benefits when their FEHBP plan is coordinated with Medicare coverage. For example, some retirees stayed in what used to be Blue Cross/Blue Shield “high option” despite the fact, that when it was combined with Medicare Parts A and B, high option offered no added value over the less expensive “standard option”. That is why for years NARFE has helped Medicare-participating annuitants determine whether their level of coverage is appropriate.

Age is rarely a determining factor regarding whether individuals make the best decisions about their health plan choices. Indeed, the turnover rate in FEHBP plans continues to remain about two percent a year. Some enrollees remain in plans even though they might be able to find other options with lower premiums and equivalent coverage and provider access.

In any event, the higher utilization of health care by older enrollees is a well-documented reality of what happens to us as we age. Most annuitants started their careers in federal service when they were younger and healthier and paid more into health insurance than they got out of it. Now that they have retired, some of them get more out of health insurance than they pay into it. This “contract between generations” has been a fundamental principle of group health insurance for decades. For that reason, we must accept the reality that an aging workforce and 2.3 million annuitants will have a definite impact on premiums. And, we honor this obligation because it was, and is, earned by federal workers who served their country.

NARFE strongly believes that the cost of providing health care to older enrollees could be mitigated if: (A) the Administration agreed to apply and accept the Medicare employer payment and (B) FEHBP plans were finally allowed to buy prescription drugs for their enrollees at the discount mandated by the federal supply schedule (FSS).

Indeed, OPM proposed in 2000 that the Special Agents Mutual Benefit Association (SAMBA), an employee organization FEHBP plan, be allowed to buy drugs off the Federal Supply Schedule for their participants, as part of a two year demonstration program to determine if the

arrangement was feasible for other FEHBP carriers. The agency cancelled the pilot project, not long after it was announced, due to the pharmaceutical industry's refusal to participate. Drug companies argued they did not have to provide SAMBA drugs at the Federal Supply Schedule discount because, unlike Department of Defense and the Department of Veteran's Affairs, the employee organization plan, while part of FEHBP, was not a government agency.

Given substantial congressional support for allowing Medicare to directly negotiate drug prices, it is time for this committee to revisit using the same leverage to make prescription drugs less expensive in the FEHBP.

#### Conclusion

For 47 years the FEHBP has minimized costs and provided a wide choice of comprehensive health insurance plans to nearly nine million federal employees, retirees and their families. OPM's ability to minimize expenses continues to be challenged by persistently higher health care costs. I can assure this committee that adequate, affordable health care coverage is of paramount importance to workers and retirees. NARFE stands ready to work with this panel, others in Congress, the OPM and the FEHBP insurance carriers to find the ways and means to contain out-of-control health care costs without sacrificing quality, and to ensure that the federal family has access and coverage, without resorting to proposals that only shift costs to enrollees, or circumvent risk sharing in our group plan environment.

**BACKGROUND  
UP, UP, AND AWAY!  
GROWTH TRENDES IN HEALTH CARE PREMIUMS FOR ACTIVE AND  
RETIRED FEDERAL EMPLOYEES  
May 18, 2007**

**Background**

The Federal Employee Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance plan in the nation. Established in 1960, roughly 8 million federal employees, retirees and their families participate. The Office of Personnel Management (OPM) oversees the management of the FEHBP and is responsible for the annual negotiation of benefits and premium costs. It is considered by many analysts to be a model for Medicare and other public employer-sponsored health care plans.

Enrollees have roughly 280 health plan choices available to them, and, according to OPM, the FEHBP provides \$31.5 billion annual in health care benefits. Employees have 30 days to enroll in the FEHBP after their start date. Every year they have an opportunity to change their enrollment during the Open Season, which usually runs from mid-November through mid-December. An employee or retiree may elect individual coverage or self plus family coverage. There are three different options for employees: a fee-for-service plan, a health maintenance organization plan, or a point of service plan, which has features of both.

OPM projects the annual cost of premiums to the Federal government to administer the benefits to employees and retirees. As that is an estimate, OPM has reserve funds available to them to help offset any potential increase. The following is a table of the yearly amount OPM used from the reserve funds and the average percentage impact that had on premium growth rates as prepared by the Government Accountability Office (GAO).

	2000	2001	2002	2003	2004	2005	2006	2007
Changes in reserve funds	0.8%	0.6%	0.4%	0.3%	-0.2%	0.5%	-1.8%	-5.0%
Enrollee Choice	-0.7%	-0.9%	-0.6%	-1.2%	-1.0%	-1.5%	-1.1%	-1.0%
Benefit Changes	0.0%	1.3%	-1.6%	-0.6%	-0.6%	-0.2%	-0.2%	0.0%
Demographics	1.2%	1.2%	0.7%	1.0%	0.9%	-1.0%	0.2%	0.3%
Drug Costs	4.0%	4.5%	4.9%	3.5%	3.3%	2.6%	2.9%	2.6%
Cost and utilization of services	3.3%	3.8%	9.5%	8.1%	8.2%	6.5%	6.7%	6.0%
<b>Premium growth</b>	<b>8.6%</b>	<b>10.5%</b>	<b>13.3%</b>	<b>11.1%</b>	<b>10.6%</b>	<b>6.9%</b>	<b>6.6%</b>	<b>1.8%</b>

Since 2002, the average growth of health care premiums for enrollees in the FEHBP has slowed significantly from a peak of 12.9 percent in 2002 to 1.8 percent in 2007. This downward trend came after five years of consistent growth of average premiums from

1997 to 2002. However, as can be seen from the above table, the significant decrease in the average premium growth rate is due in large part to OPM dipping into reserve funds.

The average growth and decline of the premiums over the past ten years tends to be less than private sector employer plans and in line with the market. According to OPM, the total average premium cost was \$135.61 for an individual and \$309 for an individual plus family. Of that cost, the Government's average obligation was \$97.68 for an individual and \$223.41.

The following chart shows the average growth rate for the past thirteen years as compared to the California Public Employees Retirement System and a Kaiser Family Foundation/Health Research and Education Trust survey of private employer sponsored health care plans as prepared by GAO:

	A	B	C	D	E	F	G
1	<b>Growth in Average Premiums for FEHBP and Other Purchasers 1994 - 2007</b>						
2	<b>Year</b>	<b>FEHBP</b>	<b>CalPERS</b>	<b>Kaiser - all employer sizes</b>			
3	1994	2.9%	1.4%	4.8%			
4	1995	-3.8%	-1.1%	2.1%			
5	1996	-0.3%	-4.0%	0.8%			
6	1997	1.7%	-0.8%	2.1%			
7	1998	7.1%	3.2%	3.3%			
8	1999	9.4%	6.1%	5.3%			
9	2000	8.9%	9.2%	8.2%			
10	2001	10.8%	11.8%	10.9%			
11	2002	12.9%	9.6%	12.9%			
12	2003	11.4%	24.1%	13.9%			
13	2004	9.5%	16.4%	11.2%			
14	2005	7.3%	9.9%	9.2%			
15	2006	6.4%	8.9%	7.7%			
16	2007	1.8%	11.9%	N/A			
17							
18	Source: OPM, Kaiser Family Foundation/Health Research and Education Trust (HRET) surveys, and CalPERS.						

### **GAO's Report**

At the request of Senator Akaka, the Government Accountability Office conducted a review of the health care premium trends for the FEHBP and OPM's role in negotiating benefits. The GAO report, *Federal Employee Health Benefits Program, Premium Growth has Slowed, and Varies among Participating Plans*, evaluated (1) FEHBP premium trends compared with those of other purchasers, (2) factors contributing to average premium growth across all FEHBP plans, and (3) factors contributing to the

differing trends among selected FEHBP plans. GAO was not asked to make any further recommendations.

As the title of the report indicates, the premium growth over the past five years has been less significant than in the five years between 1997 and 2002. However, it is an average rating and not completely reflective of the individual changes in premiums and service coverage for large, medium and small options within those respective plans. The last time the average health care premiums fell for FEHBP enrollees in 1995. The report also noted one explanation to the slowed growth in premiums was from “less generous coverage,” especially in prescription drug coverage and “enrollee migration to lower cost plans.”

An additional key finding of the report is that should OPM have applied for the Medicare Part D subsidy, it would have had a “small effect on premium growth.” According to the report, “officials from two large plans with higher-than-average shares of retirees stated that the subsidy would have lowered their plans’ premium growth - officials from one plan claimed by at least 3.5 to 4 percentage points for their plan. We estimate that the subsidy would have lowered the growth in premiums across all FEHBP plans for 2006 by more than 2 percentage points on average, from 6.4 percent to about 4 percent.”

#### **Medicare Part D Subsidy**

In 2003 Congress approved the employer Medicare Part D subsidy to encourage employees to maintain prescription drug services. While all Federal retirees, as with all Americans, are eligible for Medicare at the age of 65, their benefits coverage does not change once they reach 65. They can opt either for the Medicare Part D or stay with the FEHBP option that includes prescription drug coverage.

According to the Centers for Medicare and Medicaid Services, the final regulation reflects CMS’ four objectives:

- maximizing the number of retirees benefiting from the special retiree drug subsidy;
- assuring that the plan sponsors contribute to retiree drug coverage at least what Medicare pays on retirees behalf;
- minimizing administrative burden while maximizing flexibility for employers and unions; and
- remaining within budget estimates.

The U.S. Postal Service applied for the Medicare Part D employer subsidy in 2005. OPM decided not to apply for the subsidy arguing it amounted to the government paying itself. Furthermore, since the prescription drug coverage offered by the FEHBP plans was not changing significantly, OPM concluded there was no justification to apply for the subsidy. The Postal Service, however, argued that its pool of funds originated from revenue generated by stamp sales and that it does not receive any appropriated funds. Therefore, the same pool of money is not paying for the health care premiums. Ultimately, OPM denied the Postal Service's request.

#### **OPM Call Letter**

OPM releases an annual Call Letter to health care service providers requesting benefits and rate information based on specific requirements. The letter includes any key policy initiatives, priorities, or changes and starts the process by which OPM negotiates the premium rates for the following year. OPM determines the new rates by August of each year. Last year, after passage of the dental and vision care bill, service providers were allowed to submit proposals for expanding their service benefits to dental and vision care for which employees and retirees would pay 100 percent of the premiums.

The 2008 Call Letter went out to health care providers on March 7, 2007 and requires a response by May 31, 2007. The 2008 benefits policy in the call letter continues OPM's priorities to improve the transparency through Health Information Technology, promote high deductible health care plans, enhanced dental and vision care benefits, children and newborn care, and preventive care. The Senate Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia held a hearing on Health Information Technology earlier this year on February 1, 2007.

#### **Legislation**

H.R. 1256 – a bill to amend Title 5 of the U.S. Code to increase the level of Government contributions under the Federal employees health benefits program. Under current law, the Federal government pays on average 72 percent of the total cost of premiums for FEHBP enrollees, but the government can pay no more than 75 percent of the total cost of premiums. Mr. Hoyer introduces similar legislation every Congress to increase the government's share of health care premiums to 80 percent and increase the cap to 83 percent.

S. 773, introduced by Senator Warner, and H.R. 1110, introduced by Mr. Tom Davis – bills to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums. In October 2000 President Bill Clinton issued Executive Order number 13150 automatically enrolling all active duty executive branch employees in premium conversion where their health care premiums would be taken out of pre-tax dollars. The same benefit was extended to legislative branch employees in January 2001. The President's authority

did not permit him to extend the same benefit to retired Federal employees. As such, legislation has been introduced in every Congress since the 107<sup>th</sup> to allow premium conversion for retired enrollees of the FEHBP.

**Additional Information**

Congressional Research Service report, *Federal Employee Health Benefits Program: Available Health Insurance Options*, order code RS21974, January 5, 2007.

Congressional Research Service report, *Federal Employees Dental and Vision Insurance Program*, RS22535, November 21, 2006.

Government Accountability Office report, *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies among Participating Plans*, GAO-07-141, December 2006.

Government Accountability Office report, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits*, GAO-03-236, December 2002.

Office of Personnel Management, Federal Employees Health Benefits Program  
Web site, [[www.opm.gov/insure/health](http://www.opm.gov/insure/health)]