

**THE FEDERAL EMPLOYEES HEALTH BENEFITS
PROGRAM: IS IT A GOOD VALUE FOR FEDERAL
EMPLOYEES?**

HEARING

BEFORE THE
SUBCOMMITTEE ON FEDERAL WORKFORCE,
U.S. POSTAL SERVICE AND THE CENSUS
OF THE
COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES
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THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: IS IT A GOOD VALUE FOR FEDERAL EMPLOYEES?

Thursday, April 11, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON FEDERAL WORKFORCE, U.S. POSTAL
SERVICE AND THE CENSUS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:01 a.m., in Room 2154, Rayburn House Office Building, Hon. Blake Farenthold [chairman of the subcommittee] presiding.

Present: Representatives Farenthold, Walberg, Gowdy, DeSantis, Issa and Norton.

Also Present: Representative Connolly.

Staff Present: Molly Boyd, Majority Parliamentarian; Caitlin Carroll, Majority Deputy Press Secretary; Sharon Casey, Majority Senior Assistant Clerk; Adam P. Fromm, Majority Director of Member Liaison and Floor Operations; Linda Good, Majority Chief Clerk; Jennifer Hemingway, Majority Senior Professional Staff Member; Mark D. Marin, Majority Director of Oversight; James Robertson, Majority Professional Staff Member; Laura L. Rush, Majority Deputy Chief Clerk; Scott Schmidt, Majority Deputy Director of Digital Strategy; Peter Warren, Majority Policy Director; Jaron Bourke, Minority Director of Administration; Lena Chang, Minority Counsel; Kevin Corbin, Minority Professional Staff Member; Yvette Cravins, Minority Counsel; Carla Hultberg, Minority Chief Clerk; Adam Koshkin, Minority Research Assistant; Safiya Simmons, Minority Press Secretary; and Mark Stephenson, Minority Director of Legislation.

Mr. FARENTHOLD. The subcommittee will come to order.

As is our tradition, I would like to begin this hearing by stating the Oversight Committee's mission statement.

We exist to secure two fundamental principles: first, Americans have a right to know the money is taken from them from Washington is well spent and, second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold the Government accountable to taxpayers, because taxpayers have a right to know what they get from their Government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and

bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

At this point I will recognize myself for a brief opening statement.

The Federal Employees Health Benefits Program is the largest employer-based health insurance program in the Country, covering more than 8 million Federal workers, retirees, and their family members through the plans participating in. Since 1960, the plan has offered Federal participants multiple health plan options through private health insurers, a hallmark of the program.

The average health insurance premiums are on the rise. More specifically, the FEHB premium has risen 5.78 percent over the last five years. While this is a pretty small increase compared to what we are seeing in some private sector rates, where rates have risen much more, it is our duty to see how we can continue to save taxpayers' hard-earned dollars and provide the best coverage for our Federal workforce. In these tough times, we must ensure that OPM is providing affordable benefits to FEHB participants in the most cost-effective way and giving them the best benefits that we can afford.

Recently, a study by the CBO, Congressional Budget Office, found that, on the average, the cost of health benefits, including health insurance, was 48 percent higher for Federal civilian workers than for their private sector counterparts, perhaps explaining the lower percentage increase in the premium. But the Federal Government still pays, on average, \$6.00 per hour more for employee benefits than in the private sector. It goes without saying that buying power is also important.

Competition is critical, as well. OPM can leverage enrollees' purchasing power to reduce costs and obtain greater value for Federal workers and their family, as well as for the Federal Government and taxpayers. The OPM must manage today for future increases in costs and projected increases in utilization of health care services.

The President's budget, announced yesterday, has several initiatives intended to improve the value of FEHB. This hearing provides committee members the opportunity to determine the impact these and other proposals will have on provider choice, coverage, and cost. As Government watchdogs, we are always looking for ideas that will lower costs and improve the value of FEHB without unnecessarily restricting consumer choice.

With these broad goals in mind, I would like to thank our witnesses for being here today and for their willingness to testify.

I will now recognize the gentlelady from the District of Columbia, Ms. Norton, for her opening statement.

[Prepared statement of Mr. Farenthold follows:]

Ms. NORTON. Thank you very much, Mr. Chairman. I thank you for bringing together these witnesses to discuss the Federal Employees Health Benefits Program, including the Administration's proposals for what it calls modernizing the program.

FEHBP is, of course, the largest employer-sponsored health insurance program in the Country, covering 8 million individuals. Last year it provided close to \$45 billion in benefits to Federal employees, retirees, and their families. Since its creation in 1959,

FEHBP has been regarded as a model for health insurance reform, and private and public insurance programs such as Medicare. It has also been looked at as a way to expand insurance coverage to the non-Federal community, such as small business employees or the uninsured.

FEHBP has generally performed as well or better than large private employers. Industry experts have rated the benefits offered to enrollees as competitive with other employers. Premium increases are consistently below those of other large employers. For example, according to Barclays U.S. Healthcare, over the last decade, FEHBP premiums have increased 7.7 percent, compared with 9.3 percent in the commercial market.

In 2012, FEHBP premiums increased by 3.8 percent, while the industry surveys show that private sector plans rose by an average of 8.1 percent.

However, this does not mean that FEHBP is a perfect program or that it does not need improvement. For example, coverage for same sex domestic partners, while prevalent in the private sector, is currently not included in FEHBP. Prescription drugs are of a particular concern. One-third, or \$15 billion, of the total FEHBP annual costs were for prescription drugs; and OPM estimates that, for 2013, 25 percent of that, or about \$4 billion, will be spent on specialty drugs. That is a significant increase over 2009, when specialty drugs accounted for only 10 percent.

This hearing provides stakeholders and members with a chance to discuss the pros and cons of the FEHB proposals, including in President Obama's fiscal year 2014 budget that was just issued. While I share the Administration's view that the 50-plus-year-old FEHB Program can be, as the Administration puts it, modernized, but certainly improved, I believe we should approach this cautiously and deliberately to ensure that any changes would improve the health of our Federal employees and retirees, and keep premiums and costs low and affordable.

This is especially important at this juncture because Federal employees are already experiencing pay and benefit cuts, and cannot afford to take more hits. Federal employees are working under a three-year pay freeze. New employees are forced to pay more for their retirement contributions than existing employees, and more Federal workers face furloughs. On top of that, the President has recommended in his budget that Federal workers contribute an additional 1.2 percent more for their pensions and accept a reduced COLA for their annuities based on the changed CPI formula.

I thank you, Mr. Chairman, and appreciate this opportunity to examine the merits of the Administration's proposals, and look forward to hearing from our panel of witnesses and thank them for their testimony.

Mr. FARENTHOLD. Thank you very much, Ms. Norton.

We will now recognize the chairman of the full committee, the gentleman from California, Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman. Thank you for holding this important hearing. And I want to thank Delegate Norton, our ranking member, because, in fact, this is the first and only federal exchange. Eight million Americans depend on this exchange, and

it is the model, at best, for what we intend to make available to those who do not otherwise have employer healthcare providers.

Numerous times during the Affordable Health Care Act drafting and discussion I used the FEHB as the model for perhaps everyone who should have the same fine health care that members of Congress and every Federal employee has. Why not? Let us just simply duplicate this. So when I discover, as the President has discovered, that although a great and longstanding model, it is not a model with as open a process and as much competition as we could have. I look and say, my goodness, if we can't get this 50-year-old system to be optimized, will we in fact deal as well with 50 State systems; some of them run by the States directly, some of them federalized.

So today's hearing is important on all those counts.

I think to every member of Congress who is in that program. It is important. To every staff member now or retired, who depend on this system, getting it right, getting competition, opening it up in a way that is a plus, and not a minus, is important, but I think for all of us who are seeing the testimony today, let's just assume that they are testifying about a national exchange that every American is going to be in. Do we currently have a system that would make the optimum national exchange or should we make it better? And can we do better for the 8 million and the other 316 million Americans?

With that, I thank the chairman and yield back.

Mr. FARENTHOLD. Thank you, Mr. Chairman.

At this point let's introduce our members of the panel.

Before I do that, I do want to say, without objection, all members will have seven days to submit opening statements for the record.

Now we will go to our panel. First up will be Mr. Jonathan Foley. He is the Director of Planning and Policy Analysis at the U.S. Office of Personnel Management.

Next up will be Mr. William A. Breskin. He is the Vice President of Government Affairs at Blue Cross and Blue Shield Association.

Mr. Thomas C. Choate is the Chief Growth Officer at UnitedHealthCare.

Mr. Mark Merritt is President and CEO of the Pharmaceutical Care Management Association.

And Ms. Jacqueline Simon is Public Policy Director for the American Federation of Government Employees.

Pursuant to the rules of the committee, all witnesses will be sworn before they testify. Would the witnesses please rise with me?

If you will raise your right hand, please. Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

Mr. FARENTHOLD. Let the record reflect that all witnesses have answered in the affirmative.

You may be seated.

We have a relatively large panel today. In order that everyone has sufficient amount of time to testify and the members of the subcommittee have sufficient amount of time to ask questions, we would ask that you limit your remarks to five minutes. There is a timer in front of you that will count down with a green light, then

a yellow light, and a red light. When the red light comes on, it will start up and we will know exactly how long you went over.

So we have your entire testimony that you submitted in the record. Hopefully, the members of the committee have already reviewed it. So if you will summarize what you consider to be the salient points in the five minutes, it would be greatly appreciated.

We will start with Mr. Foley. You are recognized for five minutes.

WITNESS STATEMENTS

STATEMENT OF JONATHAN FOLEY

Mr. FOLEY. Thank you, Chairman Farenthold, Ranking Member Norton, and members of the subcommittee. Thank you for the opportunity to appear before you today to discuss the Federal Employees Health Benefits Program.

Established in 1960, the FEHB Program is the largest employer-sponsored health insurance program in the Country, covering approximately 8.2 million Federal employees, retirees, and their dependents. The Office of Personnel Management administers this \$45 billion program through contracts with private insurers.

Currently, there are 95 health plan contracts, with 230 different Government options.

The FEHB Program uses market competition and consumer choice to provide comprehensive benefits at an affordable cost. Average yearly premium increases have declined in each of the last four years, dropping from 7.4 percent in 2010 to 3.4 percent in 2013.

My written testimony addresses the subcommittee's interest regarding the relationship between Medicare and the FEHB Program, and the impact of the Affordable Care Act on the program. I will spend the remainder of my remarks discussing the FEHB Program and its modernization.

The FEHB Program was designed to offer a range of health insurance choices that are reflective of the most competitive options available in the commercial marketplace. As the health insurance market continues to change, OPM has done its best to keep pace. However, there are a number of areas where the original authorizing legislation passed in 1959 constrains OPM from responding to the changed marketplace.

For example, the statute only allows OPM to contract with four plan types. Under the service benefit plan type, Blue Cross Blue Shield offers two government-wide benefit options. The second plan type, indemnity benefit plan was held by Aetna until the late 1980s, but is now vacant. The third plan type consists of employee organization plans. The employee organization plans were grandfathered into the FEHB Program and no new employee organization plans are permitted to join. The final plan type is made up of comprehensive health plans, HMOs, offered at the State level, which have no restrictions in the number of plans participating as long as they meet FEHB qualifying criteria and State licensure laws.

Missing from the current mix are regional plans that are widely available in the commercial market. If these regional plans were

available, FEHB enrollees would benefit from having greater choices that represent best practices in the private sector and more closely resemble product combinations available to private employers and State and local governments.

It is important to emphasize that this proposal would not require that OPM contract with every health plan that applies to participate in the FEHB Program. This proposal would simply provide OPM with the ability to consider additional plan types and contract with plans only when it is in the best interest of the FEHB Program and its enrollees.

Next, OPM proposes increasing its contracting discretion by allowing direct contracting with pharmacy benefit managers. Most FEHB carriers contract with pharmacy benefit managers to purchase prescription drugs and manage pharmacy benefits on behalf of their enrollees. However, current law precludes OPM from contracting directly with PBMs. With the ability to contract directly for PBM services, OPM would obtain better discounts by leveraging the 8.2 million covered lives, providing for more uniform performance across the FEHB, and allowing a more consistent formulary structure and patient care management.

OPM also proposes authorizing the FEHB Program to offer a “self plus one” enrollment option, aligning the program with other large and private employers, as well as State and local governments. Currently, the FEHB Program is only authorized to offer self only and self and family options. By adding the self plus one option, an employee or retiree who does not need a family plan, for example, because they need only to cover a spouse or a child, can choose the self plus one option, rather than the self and family option.

OPM also proposes allowing FEHB enrollees to add a domestic partner to their FEHB enrollment. This proposal would align the FEHB Program with best practices in the private sector, as larger employers competing for talent are increasingly offering domestic partner benefits.

Finally, OPM proposes allowing premium differentials tied to wellness. This proposal provides OPM with the authority to prove a limited adjustment to rates charged to enrollees based on their health status and participation in health and wellness programs. For instance, this proposal would allow OPM to increase the enrollee share of premiums for those who use tobacco products and do not participate in tobacco cessation programs. This proposal aligns the FEHB Program with current trends in the commercial market, increases the use of preventive services, and encourages enrollees to make improvements to their health status, resulting in a reduction or delay of the onset of chronic diseases and associated costs.

Overall, these proposals would result in net mandatory savings of \$8.4 billion over a 10-year period. In addition to cost savings, the proposals directly support OPM’s mission of recruiting, retaining, and honoring a world-class workforce to serve the American people.

Thank you for the opportunity to testify, and I am happy to address any questions you have.

[Prepared statement of Mr. Foley follows:]



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

STATEMENT OF
JONATHAN FOLEY
DIRECTOR, PLANNING AND POLICY ANALYSIS
U.S. OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON FEDERAL WORKFORCE, U.S. POSTAL SERVICE, AND THE
CENSUS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

on

“The Federal Employees Health Benefits Program”

April 11, 2013

Chairman Farenthold, Ranking Member Lynch and Members of the Subcommittee:

Thank you for allowing me the opportunity to appear before you today to discuss the Federal Employees Health Benefits (FEHB) Program.

Background

Established in 1960, the FEHB Program is the largest employer-sponsored health insurance program in the country, providing health insurance for approximately 8.2 million Federal employees, retirees, and their dependents. In 2012, approximately 90 percent of all Federal employees were enrolled and the FEHB Program provided \$45 billion in health care benefits. The Office of Personnel Management (OPM) administers the FEHB Program through contracts with private insurers. On an annual basis, OPM issues a call letter to FEHB carriers soliciting benefit and rate proposals for the next contract term. In addition, new plan applications are

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submitted to OPM each year and plans that meet the requirements specified in the statute and regulations may be accepted for participation. Carrier negotiations are conducted from June through August and OPM provides for an Open Season each November allowing enrollees to change plans.

Currently, there are 95 health plan contracts with 230 different plan choices government-wide. The FEHB Program statute specifies four types of plans: (1) the service benefit plan, which is one government-wide plan that is a fee-for-service plan and pays providers directly for services; (2) indemnity benefit plan; (3) employee organization fee-for-service plans; and (4) comprehensive medical plans. Currently, about 81 percent of total FEHB Program enrollment is concentrated in fee-for-service plans and 19 percent in HMO plans.

Under the statute, all FEHB plans must cover basic hospital, surgical, maternity, physician and emergency care. In addition, plans are required to cover certain special benefits including: prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity between mental health and medical care coverage; and child and adult screenings, preventive care and immunizations. To ensure the benefits provided under the FEHB Program are keeping pace with advances in medicine, OPM reviews treatments to determine if coverage or benefit changes should be implemented. For example, as a result of a recent review, in 2012, OPM concluded there is enough evidence to classify Applied Behavioral Analysis treatment for children with autism as a medical therapy. This reclassification allowed FEHB plans to offer such services where treatment is medically necessary and appropriate providers are available. For the 2013 plan year, 67 FEHB carriers in 22 states are now offering this coverage.

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The FEHB Program uses market competition and consumer choice to provide comprehensive benefits at an affordable cost to both the Federal government and enrollees. FEHB premiums cover enrollees' health care costs, plans' administrative expenses, reserve accounts, and OPM's administrative expenses, which are approximately 0.078 percent of premiums. As set by statute, the government's share of premiums for employees and annuitants is the lesser of 72 percent of the weighted average premium of all participating plans or no more than 75 percent of the total premium for any one plan. However, enrollee premium contributions can be higher than 28 percent if their individual plan's premiums are significantly higher than the average FEHB plan. Average yearly premium increases have declined in each of the last four years, dropping from 7.4 percent in 2010 to 3.4 percent in 2013. In general, yearly changes in premiums reflect trends in the health care marketplace as well as specific policy initiatives negotiated with participating plans.

The remainder of my testimony will address the Subcommittee's interest regarding the relationship between Medicare and the FEHB Program, the impact of the Affordable Care Act (ACA) on the Program, and FEHB modernization.

Medicare and the FEHB Program

Currently, Medicare eligible active or retired Federal employees are not required to enroll in Medicare Part B. If an active or retired Federal employee enrolls in Medicare Part B and maintains coverage in an FEHB plan, Medicare law and regulations determine primary coverage. FEHB plans typically waive copayments, coinsurance, and deductibles for services covered by Medicare Part B. As a result, most annuitants have first dollar coverage. A growing proportion of FEHB enrollees eligible for Medicare Part B do not enroll in Part B. This means that FEHB

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plans are the primary payer for all services that Part B covers, which includes physician services and many outpatient procedures. OPM is encouraging proposals for pilot programs where participating carriers offer a sub-option for Medicare eligible annuitants as an alternate choice. The sub-option may include premium pass-through accounts for plans to use solely to pay some or all of Medicare Part B premiums. Carriers may propose cost sharing changes for enrollees with Medicare Part B that are sufficient to encourage them to participate in the pilot program and also encourage appropriate utilization.

ACA and FEHB Program

After enactment of the ACA, OPM reviewed its contracts and determined that FEHB plans were already in compliance with many of the ACA reforms to the health insurance marketplace. For example, denials of coverage to those with pre-existing conditions were already prohibited within the FEHB Program. However, there were some provisions in the ACA that expanded eligibility and benefits. For instance, effective plan year 2011, OPM extended dependent coverage by allowing adult children up to age 26 to be covered under their parent's FEHB plan. Almost 300,000 young adults between the ages of 22 and 26 now have FEHB coverage as a result of this provision. Another eligibility change included extending FEHB to employees of entitled Tribes, tribal organizations, and urban Indian organizations. Over the past three years, OPM has worked closely with Tribes, tribal organizations, urban Indian organizations, and national organizations to implement this provision of the ACA. As a result, approximately 16,000 tribal employees and dependents in 15 States are now enrolled in the FEHB Program. Additionally, effective with the 2011 plan year, all FEHB plans now cover in-network recommended preventive care, immunizations, and screenings without cost sharing.

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Another provision in the ACA that impacted the FEHB Program was the medical loss ratio (MLR). Beginning in 2011, the ACA required health insurers to use at least a certain percentage of health insurance premiums to pay for medical claims or activities that improve the quality of health care. The ACA set the minimum required MLR at 85% for the large group market and directed health insurers that did not meet the MLR to pay a rebate to their consumers. For FEHB enrollees, by law, rebates are sent to OPM, which serves as the policyholder, and the rebate is used to adjust future premium rates. This method ensures that rebates will be shared between health plan enrollees and the Federal agencies that pay for the FEHB. In 2012, OPM communicated with health insurers and determined that three insurers out of the 91 insurers in the program would provide a rebate to the FEHB Program.

Modernization of the FEHB Program

The FEHB program was designed to offer Federal employees, retirees, and their dependents a range of health insurance choices that are reflective of the most competitive choices available in the commercial marketplace. As the health insurance market continues to change, OPM has done its best to keep pace with change; however, there are a number of areas where the structure of the program as configured by the original authorizing legislation passed in 1959, constrains OPM from responding to the changed marketplace. There are a number of challenges facing the FEHB Program including the need for more competition with more diverse health plan choices; affordability for enrollees; and limited opportunity to use best practices from the private sector. Presently, however, the FEHB Program lacks the flexibility to address these challenges and respond to the continuously changing market. OPM proposes to modernize the FEHB Program in the following ways: allow additional health benefits plan types; increase contracting

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discretion; expand coverage options to include a “self plus one” premium tier and coverage for domestic partners; and allow premium differentials tied to wellness.

OPM proposes to expand its authority to contract with a greater variety of health plan types. The health insurance marketplace has changed significantly since FEHB began and the current contracting structure reflects largely outdated distinctions. As mentioned earlier, the statute only allows four plan types. Under the service benefit plan type, Blue Cross Blue Shield offers two government-wide benefit options (Standard and Basic). The indemnity benefit plan was held by Aetna until the late 1980s. Aetna’s decision to leave as the indemnity benefit plan carrier was due primarily to adverse risk selection, which left Aetna in an uncompetitive situation. The third plan type consists of employee organization plans, which are sponsored by voluntary employee benefit associations or Federal employee unions. There are nine current sponsors and four of these plans are open to only certain Federal employees and retirees. The employee organization plans were grandfathered into the FEHB Program at inception or shortly thereafter and no new employee organization plans are permitted to join. The final plan type is made up of comprehensive health plans (HMOs) offered at the state level, which have no restrictions in the number of plans participating in the FEHB Program as long as they meet FEHB qualifying criteria and state licensure laws.

The FEHB model is built on robust competition and consumer choice that keeps costs affordable for enrollees and offers diverse health plan choices. The ability to contract with strong regional plan types currently available in the private market would enable OPM to increase competition and respond to changes in the health insurance market. FEHB enrollees would benefit from having greater choices that represent best practices in the private sector and more closely

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resemble product combinations available in private industry as well as in state and local government employee programs.

It is important to emphasize that this proposal would not require that OPM contract with every health plan that applies to participate in the FEHB Program under this expanded authority. As with standard contracting procedures, each health plan would still need to meet the qualifying criteria like that currently in place for all plans in the FEHB Program. This proposal would simply provide OPM with the ability to consider additional plan types and contract with plans only when it is in the best interests of the FEHB Program and its enrollees. The introduction of a wider selection of market-driven plans would increase competition within FEHB Program, and thus lead to more choice for enrollees. OPM estimates the expansion of FEHB plan types would result in estimated mandatory cost savings of \$260 million in direct spending over ten years.

Next, OPM proposes increasing its contracting discretion, which would allow us to more efficiently leverage the Federal government's purchasing power for its 8.2 million FEHB enrollees and allow greater flexibility in negotiating benefits by allowing for direct contracting with vendors for pharmacy and other benefits. Many FEHB Program carriers contract with Pharmacy Benefit Managers (PBM) to purchase prescription drugs and manage benefits on behalf of their enrollees. However, current law precludes OPM from directly negotiating with PBM contractors to purchase prescription drugs. With the ability to contract directly for PBM services, OPM would be in a position to obtain better discounts by leveraging the size of the population, providing for more consistent performance across the FEHB, and allowing a more consistent formulary structure and patient care management. Allowing OPM to pursue direct

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negotiations with PBM contractors would result in scored mandatory cost savings of approximately \$1.6 billion over ten years.

OPM also proposes authorizing the FEHB Program to offer a “self plus one” enrollment option. Allowing the FEHB program to offer a "self plus one" enrollment option, places the program in line with other large private employers as well as state and local governments. Currently, the FEHB Program is only authorized to offer self-only enrollment and self and family enrollment. By adding a third tier, the “self plus one” option, an employee or retiree who does not need a family plan - for example, because they need only to cover a spouse or one child - can choose the “self plus one” option rather than the self and family option. OPM also proposes allowing FEHB enrollees to add a domestic partner to their FEHB enrollment. This proposal would align the FEHB Program with best practices in the private sector as larger employers competing for talent are increasingly offering domestic partner benefits. Together, the proposals would result in a savings in mandatory spending of approximately \$5.2 billion over ten years.

Finally, OPM proposes allowing premium differentials tied to wellness. This proposal provides OPM with the authority to approve a limited differential adjustment to rates charged for enrollees based on their health status and participation in health and wellness programs. For instance, this proposal would allow OPM to increase the enrollee share of premiums for those who use tobacco products and do not participate in tobacco cessation programs (which FEHB plans offer tobacco cessation programs at no cost share to enrollees). This proposal aligns the FEHB Program with current trends in the commercial market, increases the use of preventive services, and encourages enrollees to make improvements to their health status resulting in a reduction of long-term

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chronic costs. OPM estimates that this this proposal would result in estimated mandatory cost savings of \$1.3 billion over ten years.

Overall, these proposals would result in net mandatory cost savings of \$8.4 billion to the Federal government over a 10 year period. In addition to cost savings, the proposals would improve efficiency, and directly support OPM's mission of recruiting, retaining, and honoring a world-class workforce to serve the American people.

Conclusion

I want to thank you for this opportunity to testify today and I am happy to address any questions you may have.

Mr. FARENTHOLD. Thank you. I am sure we will be back to you with questions when we finish the panel.

Mr. Breskin, you are now recognized for five minutes.

STATEMENT OF WILLIAM A. BRESKIN

Mr. BRESKIN. Thank you. Mr. Chairman and other members of the subcommittee, good morning. My name is Bill Breskin and I am the Vice President of Government Programs for the Blue Cross and Blue Shield Association. Thank you for this opportunity to discuss the value of the Federal Employee Health Benefits Program. We look forward, with members of the subcommittee, to ensure that Federal employees and retirees continue to have high quality, affordable health care coverage.

The Blue Cross and Blue Shield Association and participating independent local Blue Cross and Blue Shield Plans have jointly administered the government-wide Service Benefit Plan from the very beginning of the program in 1960. Today we provide health insurance to more than 5.2 million active and retired Federal employees and their dependents. Last year, for the second consecutive year, premiums for the most popular option increased by only 2 percent. We are proud of the millions of Federal employees that select Blue Cross Blue Shield for our affordable premiums, our high level of customer satisfaction, low administrative costs, and constant innovation.

With 230 product offerings in the Federal workforce nationwide, and with very high levels of customer satisfaction, the FEHBP is often cited as a model for choice and competition. No matter where they live, Federal enrollees can choose from among a minimum of 13 national products offered by six different carriers, each with a uniform premium nationwide. In fact, 80 percent of Federal employees select these nationwide options.

Combined with local plan options such as HMOs, high deductible health plans, and consumer-directed health plans, Federal enrollees may have as many as 24 different plan choices in some States. No other employer-sponsored health program anywhere offers anything like this level of choice. Indeed, it would be hard to identify any government program having greater competition.

Blue Cross Blue Shield has remained dedicated to FEHBP enrollees, having offered its products for 53 years, every year since the Program's inception. We know that Federal employees and retirees have a broad choice of coverage every year. We also understand the need to reduce; Federal spending has never been greater, and we are leading in care delivery, innovation, and other key strategies that improve health and attack health cost drivers.

We leverage the innovations and provide the relationships used by 85 of the Fortune 100 companies who turn to the Blues for their employee health benefits. Our standard in basic option plans offer more than 25 innovative features, including wellness programs and incentives, online transparency tools, and other management programs to improve the health of Federal employees and the value of their benefits.

The service benefit plan will also offer patient-centered medical homes in every State, plus the District of Columbia, by the end of the year, having already offered PCMH in several States. No one

is more innovative and committed to bringing cutting-edge innovation to the FEHBP than the service benefit plan.

Today I want to offer the Blues perspective on two proposed changes to the FEHBP: first, the addition of regional PPOs in the program and, second, the prescription drug carve-out.

Introducing regional PPOs into the FEHBP will result in higher costs for both the Federal Government and Federal employees, and will jeopardize the most popular nationwide offerings. Instead of offering uniform premiums nationwide, regional PPOs will be allowed to cherry-pick low-cost regions and charge a premium that reflects the cost of that region only. This will lead to higher premiums in the nationwide plans or regions not picked up by the new PPOs, as more enrollees in the low-cost areas choose the regional PPOs. Within a few years, the nationwide plans will become non-competitive and will likely stop offering nationwide coverage altogether.

This would leave certain areas of the Country undeserved or potentially not served at all, and create gross disparities in health insurance coverage for enrollees in different areas. An analogy exists in the Medicare Advantage Program: a national PPO is allowed, but there has never been a nationwide option because nationally priced PPOs cannot coexist with locally rated PPOs, for the same reason that would occur in the FEHBP should regional PPOs be allowed.

Assuming all PPOs were offered on a regional basis, 54 percent of Federal employees and retirees are likely to see their health premiums increase. An analysis of Avalere Health concludes that Federal spending would increase by \$5.7 billion over 10 years if PPOs were offered on a regional basis.

Rather than introducing regional products into the FEHBP and creating an unlevel playing field for competition, we believe a better approach would be to open up the program to any carrier willing to participate on a level playing field nationwide, and to give carriers additional flexibility to offer products and more aggressively incorporate their latest private sector innovations for controlling costs.

Another change that is being proposed is consolidating contracting for prescription drug benefit management in the FEHBP. Proponents of the carve-out approach argue that streamlined purchasing of prescription drugs will save money and lower administrative costs. However, under the pharmacy benefit carve-out, health plans will have limited access to pharmacy claims that would otherwise help identify members who may benefit from case management and coordination of care. This leads to increased costs and poorer health outcomes. Furthermore, prescription drug carve-out will reduce beneficiary choice by limiting prescription drug benefits, preventative effective integrated management of pharmacy and medical benefits, and compromised care management utilization management techniques that help ensure safety and adhere to best practices.

In closing, let me say that the career staff at OPM have done a superb job in managing this program, which is the gold standard of competition and choice, and a model for health care reform. We have identified in our testimony additional innovations that OPM

should consider, including premium discounts, incentives for enrollees to choose high-quality providers, and coverage for new, cutting-edge access for points for health care. Blue Cross Blue Shield is committed to working with OPM and Congress to keep the FEP at the forefront of innovation and make the FEHBP even better, without disrupting the coverage millions of Federal employees have selected today.

I appreciate the opportunity to discuss the value of the FEHBP and I look forward to your questions.

[Prepared statement of Mr. Breskin follows:]

Mr. Chairman, Ranking Member Lynch and Members of the Subcommittee:

Good morning. My name is Bill Breskin, and I am Vice President for Government Programs at the Blue Cross and Blue Shield Association. Thank you for this opportunity to discuss the value of the Federal Employees Health Benefits Program (FEHBP) for federal employees. We look forward to working with members of the Subcommittee to ensure federal employees and retirees continue to have high quality, affordable health care coverage.

The Blue Cross and Blue Shield Association and participating independent local Blue Cross and Blue Shield Plans jointly administer the government-wide Service Benefit Plan in the FEHBP. We 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 5.2 million active and retired federal employees and dependents. Last year—for the second consecutive year—premiums for our most popular option increased by only two percent. We are proud that millions of federal employees select Blue Cross Blue Shield for our affordable premiums, high level of customer satisfaction, low administrative costs and constant innovation.

My testimony covers two areas: (1) the value of the FEHBP and Blue Cross and Blue Shield's strong track record in serving federal employees; and (2) our perspective on proposed changes to the program, including the addition of regional PPOs and proposals to consolidate contracting for prescription drug benefit management.

Value of the FEHBP

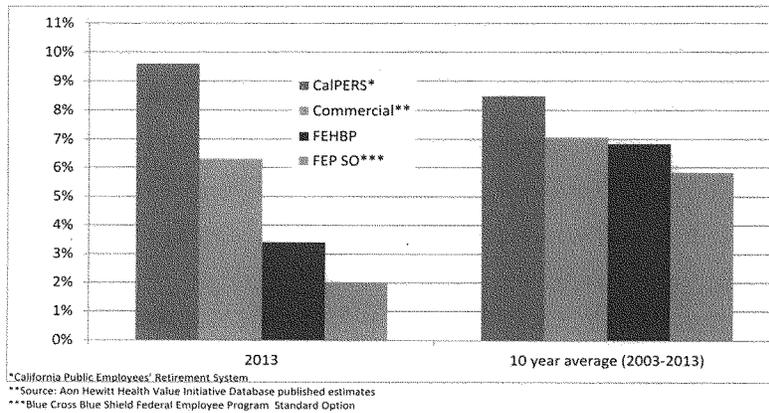
With robust plan offerings and high customer satisfaction, the FEHBP is often cited as a model for choice and competition. The FEHBP offers more plan choices than any other employer in the country. While most employers offer two or three insurance products through one or two carriers, 230 plans participate in the FEHBP—at both the national and local levels. The FEHBP offers active and retired federal employees many plan choices from national

preferred provider organizations (PPOs) to local health maintenance organizations (HMOs), high deductible health plans (HDHPs) and consumer-directed health plans (CDHPs).

The Office of Personnel Management (OPM), which administers the FEHBP, has increased the number of carriers in the program by double digits in the last two years—and more carriers have entered in the last two years than in the last five years. The beauty of the FEHBP is that no matter where they live, federal enrollees can choose from among a minimum of 13 national products offered by six different carriers—each with a uniform premium nationwide. In fact, 80 percent of federal enrollees select these nationwide options. Combined with local plan options, federal enrollees may have as many as 42 plan choices in some states.

The FEHBP has kept premiums affordable for federal employees and retirees while offering comprehensive, integrated benefits. In 2013, FEHBP premiums increased by 3.4 percent, while according to industry surveys, commercial plans rose by an average of 6.3 percent. (See Figure 1).

Figure 1. Premium Growth in CalPERS, Commercial Market, FEHBP and Blue Cross Blue Shield Standard Option, 2013 Benefit Year and 2003-2013



Blue Cross Blue Shield: A Strong Track Record Serving Federal Employees

The Blue Cross and Blue Shield Association and its member Plans are proud to have been dedicated, reliable and consistent participants in the FEHBP since the program's inception 53 years ago. We are committed to the federal market and are focused on serving federal employees, retirees and their families.

The nationwide Blue Cross Blue Shield FEHBP offerings include a Standard and Basic Option—both are popular with federal workers and retirees for their comprehensive benefits, competitive premiums and ongoing innovation. We are proud to have earned the loyalty of federal enrollees and retirees over our five decades in the program.

BCBSA knows that federal employees and retirees have a broad choice in coverage each year. That is why we strive to be the *best* choice for our members and for the FEHBP. We also understand the need to reduce federal spending has never been greater, and we are leading in care delivery innovation and other key strategies that improve health and attack health cost drivers. Blue Cross Blue Shield plans in the FEHBP leverage the innovations and provider relationships used by 85 of the Fortune 100 companies who turn to Blue Cross Blue Shield for their employee health benefits. Our Standard and Basic Option plans offer more than 25 innovative features, including wellness programs and incentives, online transparency tools and other management programs to improve the health of federal enrollees and the value of their benefits.

I want to highlight a few examples of specific Blue innovations that deliver quality, more affordable coverage options in FEHBP.

Patient-centered medical homes in 17 states plus the District of Columbia covered more than 250,000 FEHBP members at the close of 2012. CareFirst BlueCross BlueShield (serving D.C., Maryland and Northern Virginia) operates one of the largest networks of patient-centered medical homes (PCMHs) in the country, which have been available to Blue FEHBP

members since 2011. In a medical home, the patient and primary care practice are at the center of care, and patients have a continuing relationship with a primary care physician and care team that assures care is comprehensive, proactive and coordinated. This reinforces primary care's critical role in helping patients get the care they need, when they need it, with greater efficiency, less redundancy and fewer return trips to the hospital or physician's office—and it encourages teamwork and coordination across all of the clinicians involved in caring for a patient. By the end of this year, Blue Cross Blue Shield FEHBP plans are expected to include PCMHs in all 50 states plus D.C. These care delivery innovations are projected to serve almost 1.2 million federal members by the close of 2014.

Patient safety initiatives, including locally-tailored efforts to prevent medical errors and reduce hospital readmissions, are critical to ensuring our members receive the best possible care. A 2012 pilot with local plans reduced readmissions rates for our federal members in a matter of months, yielding estimated savings of over \$3.5 million. The pilot is now being scaled nationwide.

Chronic disease management programs support BCBSA's FEHBP members with diabetes, congestive heart failure, chronic lung disease, coronary artery disease and/or asthma. In 2012, our 798,000 participating federal members had 11.9 percent fewer inpatient admissions and 8.29 percent fewer emergency room visits than those eligible but not enrolled. These reductions yield tangible savings for OPM and keep federal employees on the job and out of the hospital.

Transparency tools, which include Fepblue.org, MyBlue, and other consumer tools serve our members by helping them save money, make the best health choices and take action on these choices. In 2012, nearly 700,000 federal members signed up for the MyBlue Portal, which helps them to be more active, informed health care consumers. The MyBlue Annual Statement offers a summary of the benefits paid for medical and pharmacy claims for the past year, illustrates annual savings earned for medical and pharmacy services, shows member

utilization of in-network versus out-of-network providers and generic versus brand name medications, and provides information on the incentives available to each member. The MyBlue Treatment Cost Estimator helps members avoid surprises by utilizing the national cost estimation tool prior to receiving services. The National Doctor and Hospital Finder has information to help members assess the quality of the hospitals and physicians. Members can write reviews, read patient satisfaction surveys, and view safety and efficacy ratings for providers. These are only a few of the many consumer tools we employ to make health care transparent for our members.

In sum, no one is more innovative and committed to bringing cutting edge innovation into the FEHBP than Blue Cross Blue Shield.

BCBSA Perspective on Proposed Changes to FEHBP

1. Regional PPOs

While the FEHBP has a long track record of success, some are calling for changes to the program, including the addition of regional PPOs into the FEHBP. We agree that there is always room for improvement, but believe a better approach would be to make statutory changes (if needed) to open up the FEHBP to any carrier willing to participate on a level playing field nationwide.

Adding regional PPOs to the FEHBP is neither innovative nor will lower the overall cost of the FEHBP. In fact, it will result in **higher** costs for both the federal government and federal employees and will jeopardize popular nationwide offerings. Instead of offering a uniform premium nationwide, regional PPOs would be allowed to "cherry pick" low-cost regions and charge a premium that reflects the cost of that region only. Since health care costs vary considerably across the country, regional PPOs will have a strong incentive to select only low-cost areas to offer coverage. This will lead to higher premiums in the nationwide plans or regions not picked up by the new PPOs, as more enrollees in the low-cost areas choose the regional PPOs. Within a few years, the nationwide plans will become non-competitive and will

likely stop offering nationwide coverage all together. This would leave certain areas of the country under-served or potentially not served at all.

Under the current FEHBP, a federal employee who works for a federal agency in California and is enrolled in a national PPO pays the same premium and has the same benefits as an employee working for that agency in New York or in any other state. This is especially important for federal employees and retirees who travel or are transferred to another area of the country. These nationwide plans provide access to in-network providers anywhere in the country, saving the member and the FEHBP money. However, if regional PPOs were allowed into the FEHBP, federal employees would pay different premiums based on the costs of each region. Assuming all PPOs were offered on a regional basis, 54 percent of federal employees and retirees are likely to see their premiums increase. An analysis by Avalere Health concludes that **federal spending would increase by \$5.7 billion over ten years if all PPOs were offered on a regional basis.**

Instead of adding regional PPOs to the program, BCBSA recommends a two-pronged approach for making the FEHBP even better without disrupting the coverage millions of federal enrollees have selected today:

1. *Open up FEHBP to any carrier willing to participate on a level playing field nationwide.* The current statute allows for three categories of nationwide plans: (a) a Service Benefit Plan (BCBS); (b) employee organization or union plans; and (c) an indemnity insurance carrier slot (unfilled). To enhance competition without the negative impacts that regional PPOs would bring, Congress could authorize an unrestricted number of nationwide insurance carriers to offer products government-wide. This would encourage greater competition on a level playing field while preserving the nationwide coverage options overwhelmingly preferred by FEHBP participants. By maintaining the level playing field, the approach could also avoid cost increases expected under the regional PPO model.

2. *Give carriers additional flexibility to offer new products that more aggressively incorporate the latest private sector innovations for controlling costs. Examples include¹:*

- Premium discounts (currently not authorized by statute) that encourage tangible actions to improve health (e.g., smoking cessation or weight loss).
- Incentives for employees to choose high quality providers.
- Coverage of new, technology-supported access points for health care (e.g., e-visits, telemedicine, remote monitoring).

2. Prescription Drug Carve-out

Another change some are proposing is consolidating contracting for prescription drug benefit management in the FEHBP. Proponents of this "carve out" approach argue that streamlined purchasing of prescription drugs for FEHBP enrollees will save money by lowering administrative costs and using the government's purchasing power to secure better pricing than an individual insurance carrier could achieve.

BCBSA opposes any carve out of prescription drug benefit management in the FEHBP. Such an approach would harm enrollees and would not lower costs because it: (1) reduces beneficiary choice by limiting prescription drug benefits; (2) prevents effective integrated management of pharmacy and medical benefits; and (3) compromises care management and utilization management techniques that help ensure safety and adherence to best practices.

The pillars of the FEHBP have long been consumer choice and competition among carriers to offer affordable, high-quality health benefits that best meet the needs of their members. Carving out pharmacy benefit management from the current system would undermine these pillars and increase costs.

¹ Towers Watson and National Business Group on Health. (March 2013). Reshaping Health Care: Best Performers Leading the Way. Available at: <http://www.towerswatson.com/DownloadMedia.aspx?media={BAD5FE64-62FD-492A-8F24-A3C6E5B075B8}>.

For the FEHBP to achieve significant savings, OPM would have to adopt a single, restrictive formulary, which would limit member and provider choice to potentially narrow selection of drugs (as in the Department of Defense [DoD] or Veterans Administration [VA] health programs that use a limited formulary/supply schedule²). The Congressional Budget Office (CBO) has stressed on numerous occasions that similar consolidation of “purchasing power” for Medicare Part D enrollees would not achieve significant savings unless an extremely restrictive formulary was adopted for all beneficiaries.³ In addition, this single prescription drug benefit design is likely to shift costs from pharmacy to medical expenses by preventing the integrated management of medical and prescription drug benefits. Overall program costs would almost certainly increase as a result.

Full integration of medical and pharmacy benefits allows carriers to design products that incentivize members to make safe, appropriate and cost-effective drug choices. Maintaining an integrated medical-pharmacy benefit provides members with better quality health care management as a result of total management and oversight of members across the continuum of care. Studies have found that annual medical expenses for plans with an integrated pharmacy-medical benefit design have been reduced by up to 6.2 percent as compared with plans without integrated designs.⁴

Under a pharmacy benefit carve-out, health plans have limited access to pharmacy claims that would otherwise help identify members who may benefit from case management and coordination of care. This leads to increased costs and poorer health outcomes.

² The VA uses both the FSS and national contracts to purchase drugs. DoD also allows beneficiaries to purchase drugs from retail pharmacies and then negotiates with the manufacturers for additional savings under the FSS. See Government Accountability Office. (June 1997). Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain, Available at: <http://www.gao.gov/assets/230/224182.pdf>.

³ CBO estimates that striking the non-interference provision from the Medicare Modernization Act (*i.e.*, permitting the federal government to negotiate drug prices) would have a negligible effect on federal spending. See Letter from Douglas Holtz-Eakin to Sen. Bill Frist. (January 23, 2004). Available at: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/49xx/doc4986/fristletter.pdf>.

⁴ Culley, E.H., Williams, L.C., & Thomas, L. (2010). Pharmacy Benefit Carve In: The Right Prescription for Cost Savings. *Benefits and Compensation Digest*, 47(2), 22.

In 2011, OPM issued a carrier letter that required FEHBP fee-for-service carriers to alter the way in which they contract with pharmacy benefit managers (PBMs). Specifically, the PBMs must now pass through all drug claims at their actual acquisition cost, and all rebates/discounts must be passed back at 100 percent to the carriers. This has the effect of making certain proposed legislation that would carve out pharmacy benefits unnecessary since carriers are already receiving all the discounts that this legislation hopes to achieve. I would also point out that any savings that have been attributed to a prescription drug carve-out in past budget proposals were predicated on numbers prior to OPM issuing its 2011 carrier letter and are inaccurate.

Integrated medical-pharmacy models allow for more comprehensive and effective management of patients with complex pharmacy needs. The ability to access pharmacy as well as medical claims information also helps decrease the risk of drug abuse and diversion. Prescription drug abuse and diversion is the fastest growing, most widespread substance abuse issue facing our society. Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers. Drug abuse and diversion increases prescription drug costs as well as costs related to provider and emergency room visits, rehabilitation services and other health care needs.

Conclusion

Blue Cross Blue Shield has been in the FEHBP since its inception in 1960, and we are committed to working with OPM and Members of the Subcommittee to make the FEHBP even better without disrupting the coverage millions of federal enrollees have selected today.

Blue Cross and Blue Shield has incorporated a diverse set of innovations in both of our FEHBP plans, Basic Option and Standard Option. Whether it is in care delivery and payment, care management, or member engagement, these innovations leverage the Blues' local presence and nationwide strength to meet the needs of our federal members and our client,

OPM. As the choice of 85 of the Fortune 100 companies, the Blues are constantly innovating and are committed to delivering the best value to our members, whether in the FEHBP or in the commercial marketplace. We focus our services on each member, one at a time, to provide the best products to both the federal workforce and OPM.

I appreciate the opportunity to discuss the value of the FEHBP, and I look forward to your questions.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: William A. Breskin

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.
None.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.
Blue Cross and Blue Shield Association
Vice President, Government Programs

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

(1) The Blue Cross and Blue Shield Service Benefit Plan's contract CS 1039 with the U.S. Office of Personnel Management (OPM) for participation in the Federal Employees Health Benefits Program:

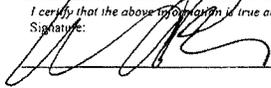
2011 - \$26.7 Billion*
2012 - \$27.7 Billion*
2013 - TBD*

* These numbers represent the premiums attributed to the Service Benefit Plan. BCBSA does not receive the premium dollars; they are deposited in the U.S. Treasury and Blue Plans withdraw funds from a letter of credit account as needed to pay claims and other expenses. These total amounts do not include statutorily required premium loads to defray OPM's administrative costs and to deposit in the Service Benefit Plan's contingency reserve, which is maintained in the U.S. Treasury. It is not possible to calculate the total receipts for 2013 at this time because the total amount attributed to the Service Benefit Plan depends on the number of individuals who enroll in it and the mix of enrollment tiers they choose (self or self and family).

(2) The Blue Cross and Blue Shield FEP BlueVision contracts with OPM for participation in the Federal Employees Dental and Vision Insurance Program:

2011 - \$76.5 Million**
2012 - \$82.9 million**
2013 - TBD**

** These numbers include total premiums. It is not possible to calculate the total receipts for 2013 because the total amount received by FEP BlueVision depends on the number of individuals who enroll in it and the mix of enrollment tiers they choose (self or self and family). In addition to paying for vision and other expenses, a portion of the premiums is also used to defray OPM's expenses in administering the program. (Continued on attached sheet)

I certify that the above information is true and correct.
Signature: 

Date: 4/8/13

(3) Health Insurance for the Aged and Disabled (Medicare Part A Prime contract) from the Centers for Medicare & Medicaid Services:

FY 2011 - \$4,533,100 (contract no. 87-001-1)
FY 2012 - \$4,533,100 (contract no. 87-001-1)
FY 2013 - \$4,533,100 (contract no. 87-001-1)

(4) Resident FTE Assessment Program for the Children's Hospitals Graduate Medical Education (CHGME) Payment Program from the Health Resources and Services Administration:

FY 2011- \$1,262,753 (contract no. HSH230200732003C)
FY 2012 - \$1,313,946 (contract no. HSH230200732003C)
FY 2013 - \$1,141,113 (contract no. HSH250201200006C)

(5) Legal Representation in Arbitration Hearings for the Home Health Third Party Liability Demonstration from the Centers for Medicare & Medicaid Services

FY 2011 and FY 2012 - \$1,363,780 (contract no. HHSM-500-2010-00056C)
FY 2013 Stop Work Order Issued (contract no. HHSM-500-2010-00056C)

(6) Evidence-based Practice Centers (EPC III) (Contract no. HHS 290 2007 100581) with the Agency for Healthcare Research and Quality****

2010 - \$3,684,000
2011 - \$3,396,000
2012 - \$2,477,000

*** Under this contract, which extended from October 2007 to September 2012, receipts actually depend on the number and value of task orders issued to BCBSA. The amounts above represent revenues received from the Agency for Healthcare Research and Quality during that year and include some funds received under a previous contract EPC II.)

(7) Evidence-based Practice Centers (EPC IV) (Contract no. HHS 290 2012 000101) with the Agency for Healthcare Research and Quality*****

***** Under this contract, receipts actually depend on the number and value of task orders on which BCBSA bids successfully. To date, BCBSA has received two task orders, totaling \$245,000.

(8) BCBSA subcontracts with Cahaba Government Benefit Administrators®, LLC, to provide the services of a Hearing Officer, on behalf of Cahaba, to conduct certain intermediary hearings:

Start Date August 3, 2011 - \$70,000 (contract no. CGBA-C-09-0020, Amendment 3)
Start Date August 3, 2012 - \$70,000 (contract no. CGBA-C-09-0020, Amendment 4)

Mr. FARENTHOLD. Thank you very much.
We will now go to Mr. Choate from United. Thank you.

STATEMENT OF THOMAS C. CHOATE

Mr. CHOATE. Thank you, Chairman Farenthold and Congresswoman Norton, for holding this important and timely hearing. I am honored to give UnitedHealth Group's perspective on how increased competition will bring more choices, higher quality and better value to Federal employees in the health benefits program. Reform of the program will better serve the program's sponsors, beneficiaries, and the American taxpayers.

My name is Tom Choate and I am the Chief Growth Officer for UnitedHealthCare, a business segment of UnitedHealth Group. I have worked for many years on our FEHBP business and with the Office of Personnel Management.

United Health Group is a diversified health benefits services company based in Minnetonka, Minnesota. We serve more than 80 million people and have the unique ability to engage in all aspects of the health care delivery system and apply lessons learned at a full-scale in the marketplace. As a result, we view health care delivery and benefit design through multiple lenses.

One thing we know for certain: it is essential for any employer who sponsors health plans to be able to offer choice of affordable, high-quality benefit options to its employees, while ensuring the employer gets the best value for its resources.

Unlike virtually any other employer, the Federal Government can't do this because it is hindered by the law governing the program. That law has not been updated in any meaningful way since President Eisenhower signed it in 1959. The law reflects the way health care was delivered and consumed five decades ago. As a result, competition in the program has eroded.

Since 1995, one plan has more than doubled its market share, from 30 percent to 62 percent of Federal workers. The second largest plan has 7 percent market share. To be clear, that is a 55 point difference between number one and number two competitors. That is clearly not a market in which real competition exists. OPM itself acknowledged last year that "the competitive environment is not as robust as it should be."

The result of this virtual monopoly is exactly what you would expect, it is a system with no real incentives to increase quality, value, and choice for more than 8 million people. It also limits the Federal Government's ability to confront the challenge of rising health care costs.

Lack of competition inevitably leads to the following issues: first, as with any market that becomes more concentrated, consumers pay more. This is clearly an issue with FEHBP.

Last year, a Health Affairs article found that in areas of strong program competitiveness, premiums were more than 10 percent lower than compared to areas of low competition. It also found that real competition in the program only exists in about 15 percent of the Country. That means that in 85 percent of the Country people in this program pay more than they should because competition does not exist in any meaningful way.

Second, with little competition, health plans have fewer incentives and little capacity to innovate and provide better quality. And, third, Government costs continue to rise. This year the program will cost taxpayers \$34 billion. In this age of fiscal challenges, the Federal Government needs the same tools to manage costs that every other large employer has.

The President's 2014 budget, released yesterday, calls for Congress to make several reforms to the program. This includes a proposal that would give OPM the authority to offer new health plans with comprehensive medical benefits. This proposal provides no advantage to any one plan; it merely adjusts the program to reflect the realities of the modern health care system. Plans would still be required to meet all of OPM's existing requirements for participation. OPM would still exercise its oversight authority. In fact, OPM's role in premium design and benefit negotiations would be strengthened by increased competition.

The premise underlying the FEHBP since its inception in 1959 was that competition among health plans results in lower prices and better value. Much has changed since 1959. We have moved from rotary phones to smart phones and from 45s to iTunes. The driving force behind such innovation has been competition, which revolutionized the way we live, including the way many Americans consume health care. Now it is time to update the 1959 law. Federal employees and taxpayers should benefit from the innovation and competition in the market, just as they do in every other market.

In closing, we all know one thing has not changed since 1959: the simple economic principle that consumers benefit from increased competition.

Thank you for the opportunity to testify this morning and for your leadership on this committee.

[Prepared statement of Mr. Choate follows:]

UNITEDHEALTH GROUP®

**United States House Committee on Oversight & Government Reform
Subcommittee on Federal Workforce, U.S. Postal Service & the Census
“The Federal Employees Health Benefit Program: Is It a Good Value for
Federal Employees?”
Testimony of Thomas Choate
UnitedHealth Group Incorporated**

April 11, 2013

Thank you, Chairman Farenthold and Ranking Member Lynch for holding this important and timely hearing. I appreciate the opportunity to share with you UnitedHealth Group’s perspective on how increased competition can bring more health care choices, higher quality and better value to the Federal Employee Health Benefits Program (FEHBP). Reform of the FEHBP would better serve the program’s sponsor, its beneficiaries and the American taxpayers.

My name is Tom Choate and I am the Chief Growth Officer for UnitedHealthcare, a business segment of UnitedHealth Group Incorporated (hereinafter “UnitedHealth Group”), a diversified health and well-being company based in Minnetonka, Minnesota. I am here testifying on behalf of UnitedHealth Group. At UnitedHealth Group, I have been an integral part of our existing FEHBP business and have worked for many years with the Office of Personnel Management (OPM) and our dedicated FEHBP team.

UnitedHealth Group serves more than 80 million people in all 50 states and worldwide through our health benefits and health services businesses. We have the unique ability to participate in all aspects of the health care delivery system and apply lessons learned at full-scale in the marketplace. As a result, we view health care delivery and benefit design through multiple lenses. Our findings are informed by our experience with:

- Direct relationships with 770,000 health professionals, 5,000 hospitals, 154,000 dentists, 67,000 pharmacies, 900 labs, 400 life science organizations, 300 commercial insurance companies and health plans, and 300 government agencies at the Federal, State and local levels;
- 27,000 physicians, nurses, and clinical practitioners in our workforce;
- Managing more than \$300 billion in health care spending annually;
- Processing 82 billion transactions a year, including 750 million transactions through our Web portals and mobility devices; and
- Managing more than 24 million Personal Health Records.

We tailor health benefits, clinical programs and customer service for 3.8 million Medicaid beneficiaries, 9 million Medicare recipients, and more than 26 million Americans through their employer sponsored or individual plans. We have the privilege of managing the health care services for 2.7 million active duty and retired military service members and their families in the 21-State TRICARE West Region.

We strive to foster a health system that is more connected, better informed, and better aligned in its objectives and incentives to continuously improve the effectiveness, quality, and patient focus of the health system. Our approach leverages health data and analytics, technology, shared accountability, cost saving measures, and collaboration among providers, payers and patients across the health care delivery spectrum.

One thing we know for certain: It is essential for any employer who sponsors health plans to be able to offer a choice of affordable, high-quality benefit options to its employees, while also ensuring the employer gets the best value for its resources. This is as true of the Federal Government's options for federal employees, their families and retirees as it is of any employer, including the private sector, and state and local governments.

However, unlike other employers, including the private sector and state and local governments, the Office of Personnel Management needs Congress to act to update the existing statute that governs the Federal Employee Health Benefits Program to enable competition, modernize this outdated health benefits program, and provide its beneficiaries with more choice and coverage options comparable to today's broader marketplace offerings. This kind of reform, importantly, will also confront the ongoing challenges of rising health care costs.

FEHBP beneficiaries deserve this same modernized health care experience, and the Federal Government, like any employer, should benefit from a healthier, more engaged population, better health care value, and lower costs.

History and Background

The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance program in the United States. The \$47 billion Program protects the health of nearly 8 million Federal employees, retirees and their families, including the Congress, the Judiciary, and the US Postal Service. You, your staff, and your families may well be beneficiaries of the program; certainly, many of your constituents are.

The 54-year-old statutory structure of the Program does not reflect the current health care marketplace of today and limits OPM's ability to introduce new health plan choices.

As a result, a growing lack of competition and consumer choice threatens the sustainability of the Program, a problem that OPM has recognized. Without action, this erosion of competition and choice will continue.

However, a simple statutory change authorizing greater health plan participation in the Program will help increase competition, choice and value in the Program.

Competition: A Founding Principle of the FEHBP, in Jeopardy

The premise underlying the FEHBP from its inception in 1959 is that competition among health plans results in lower prices and better value for the Federal Government and Program beneficiaries. A June, 2012 Health Affairs article entitled "*Federal Employees Health Program Experiences Lack Of Competition In Some Areas, Raising Cost Concerns For Exchange Plans,*" demonstrated that in areas of strong FEHBP health plan competitiveness, premiums were more than 10 percent lower compared to areas of low competition.

However, the statute establishing the FEHBP lacks the flexibility to maintain competitiveness and adjust to current and future changes in the employer-sponsored health insurance marketplace. Created during the early years of employer-sponsored health insurance, the law specifically authorized participation by two Government-wide plans, a small number of Employee Organization Plans (largely grandfathered into the Program), and a number of Health Maintenance Organizations serving limited geographic areas.

For nearly three decades, that legislative specificity worked reasonably well. Two Government-wide plans were available, and nearly 400 plans participated in the Program. Competition for participants among many choices was robust, benefits were comprehensive, and plans continually strengthened benefit packages, customer service and administration to attract new participants.

But since the late 1980s, competition and choice in the Program have dramatically decreased. Aetna, one of the two Government-wide plans, left the Program in 1989. More than a dozen of the grandfathered Employee Organization Plans left the Program as well, and the number of participating Health Maintenance Organizations has dropped nearly 50 percent. Incrementally over succeeding years, choices have become fewer and participation in the one remaining Government-wide plan has grown substantially.

In addition to substantially fewer health plans in the Program, these trends are dramatically illustrated by the distribution of individual participants in the program.

Since 1995, the single government-wide plan has more than doubled its market share, from 30 percent of federal workers to more than 60 percent. The next largest plan has 7 percent of the market. That is clearly not a market in which real competition exists, a fact which OPM itself acknowledged in a White Paper it released last year that concluded "the competitive environment is not as robust as it should be."

Without Congress acting and granting OPM the authority to facilitate and enable the entry of new health plan types - which already exist in the broader health insurance marketplace across the United States - into the Program, these plan departures have created a situation where competition and choice in the Program today is largely an illusion. Without action to reinvigorate the competitive nature of the FEHBP, this situation will only worsen in the coming years. As the American health care marketplace continues to modernize, evolve and best serve the health care needs of employers and employees, we should ensure that the FEHBP is equally equipped with the tools and capabilities necessary to achieve these same modern, innovative and effective health care approaches.

Declining Competition Affects Health Care Value, Outcomes, Choice and Cost

Incremental in its effects, the current trend poses undesirable consequences, both now and for the future:

- **Affordability is at risk.** Between 1995 and 2010, 800,000 participants left the Program altogether. While a number of factors can influence enrollment, many can no longer afford health coverage. As participation becomes concentrated in a single insurer, affordability becomes an even more acute issue.
- **Innovation is at risk.** With little competition to spur improvement, health plans have fewer incentives and little capacity to innovate and provide better quality.
- **Individuals face disruption at work and at home.** When their plans leave the FEHBP, beneficiaries often have to choose new doctors and health care facilities, a problematic issue particularly in rural areas. Continuity of care issues present themselves, especially for individuals with chronic illnesses. In addition to its individual effects, disruption also means lower productivity and less commitment in the workplace.
- **Government costs increase.** The Federal Government pays an average of 72% of the premium. This year, the Government's share of the cost for the Program is almost \$34 billion – an amount that in this age of budget restraint and fiscal challenges, the Government must find ways to manage.

Why Competition in the FEHBP Continues to Erode

As the administrator of the Program, OPM has recognized these trends and attempted to counteract them. OPM repeatedly invites new HMOs to submit applications for participation, with limited success. Several years ago, the agency unsuccessfully sought a new insurer to replace Aetna as the Government-wide Indemnity Benefit Plan. These and other initiatives by the agency to enhance competition have been helpful, but restrictions in current law limit their effectiveness.

That's because the law governing the FEHBP is far too prescriptive in nature when it describes the types of health plans which may participate in the Program. Current law, as it was enacted in 1959, only authorizes:

- **2 Government-wide Health Plans** - the Service Benefit Plan, which is administered by Blue Cross/Blue Shield, and the Indemnity Benefit Plan, which Aetna administered until its departure from the FEHBP in 1989.
- **Employee Organization Plans** - Only nine of these plans exist today, four of which limit membership to certain classes of participants. This category includes a finite list of organizations. No new employee organization plans may be accepted into the FEHBP.
- **Comprehensive Health Plans** - Now commonly referred to as Health Maintenance Organizations, these plans serve limited geographic areas, largely metropolitan areas in the United States.

For all practical purposes, the only way for an insurer to gain entry to the FEHBP today is in one of two ways. The first is to apply as the Government-wide Indemnity Benefit Plan. That course of action poses substantial insurer risk in today's market, effectively precluding insurer participation. Since one plan currently enjoys more than 60 percent of the market, the new plan would have to undertake an enormous educational and communications effort to move from zero membership to a subscriber base sufficient to recover its initial investment and ongoing operational costs. Furthermore, any new plan would be hampered by a crucial lack of transparency for all carriers except the plan with more than 60 percent market share. That dominant plan has a clear line of sight to its next year's enrollee premium rate contributions since the government contribution is based upon a weighted average of all carrier rates – and that plan accounts for more than 60% of that weight. That means the dominant plan can essentially set its competitive position using this knowledge and its reserve position.

Creating a benefit package available in all 50 states with a competitive premium in the current FEHBP environment would impose a substantial risk for any new plans, with no assurance of a return on investment for a number of years.

The second option is to apply as a Comprehensive Health Plan serving a limited geographic area. While that is possible for some insurers, it does not match up well with the business models of an increasingly large number of innovative insurers in the marketplace today, offering products which represent best practices among large employers, who could provide the Federal Government with the best combination of benefits and value. As OPM notes in its own analysis of the program, “the health insurance market includes other plan types that OPM is precluded from contracting with.”

Solution: Restoring Competition to the FEHBP

The President's FY 2014 Budget Proposal recommends action by the Congress on a number of reforms in the FEHBP, including a proposal that would overcome restrictions on health plan participation in the Program, by adding a provision to the existing statute enabling OPM to receive and consider applications from new health plans that offer comprehensive medical benefits.

Benefits of Increased Competition

Enactment of this provision would be a significant step in enhancing the Program's competitiveness, both now and in the future. It would establish a level playing field, providing no advantage to any insurer or group of insurers. It would merely update and modernize the existing FEHBP statute to reflect the realities of the modern health care system, opening the door to choice, competition and value in the Program and removing artificial and outdated limitations on OPM's ability to accept new health care plans. Plans would still be required to meet all of OPM's existing requirements for participation, and OPM would retain the administrative and regulatory authority to deny or refuse entry to plans that do not meet acceptable standards. Here are some examples of the new types of plans which could apply for participation:

- A Preferred Provider Organization that operates in a single State, region, or nationally;
- A health insurance plan whose territory is confined to a particular region of the United States;
- An Exclusive Provider Organization that offers insurance in a single metropolitan area; and
- A health insurance plan that specializes in the provision of healthcare outside of the United States.

If Congress passes legislation consistent with this proposal, a broad range of potential benefits would accrue to everyone who has a stake in the success of the Federal Employees Health Benefits Program. For instance:

- More than 8 million Federal employees, retirees and family members would benefit from increased plan participation. Health plan choices would likely increase, resulting in quality health care at a competitive price. As previously mentioned, a June, 2012 Health Affairs article demonstrated that in areas of strong FEHBP competitiveness, premiums were more than 10 percent lower compared to areas of low competition. **Crucially, the article also concluded that real competition in the Program only exists in about 15 percent of the country, meaning that in 85 percent of the country, Program beneficiaries – and the Federal Government – are paying more than they should because competition doesn't exist in any meaningful way;**
- Since a variety of new health insurers would be able to enter the Program, many with innovative health delivery mechanisms focused on the quality of individual care and health outcomes, the FEHBP would reap the benefits of innovation and modernization in the larger health care marketplace; and
- OPM's role in benefit design and premium negotiations would be strengthened as a consequence of increased competition for participants among a larger group of health insurers.

What a Modernized FEHBP Would Look Like

A modern FEHBP rooted in competition and value would encourage participating insurers to provide beneficiaries the latest health care advancements and innovations, driving better health outcomes and increasing affordability. These would include:

- Flexible, creative plan offerings that encourage consumer engagement and empowerment;
- Transparency tools that give consumers the information and resources they need to make personally appropriate health care decisions, such as up-to-date, accurate cost estimates for specific services provided by doctors and hospitals;

- Powerful data analytics to help the Government evaluate plan performance, and identify specific opportunities for future cost savings through fully-integrated beneficiary data;
- Tailored programs to improve the health of beneficiaries with chronic, rare, or complex diseases; and
- Modern network-based offerings at a large scale that enhance care coordination, improve health outcomes, and reward providers for outcomes, not volume.

Much has changed since 1959. We've moved from typewriters to lap tops; from rotary dial phones to smart phones; from 45s to iTunes. The driving force behind such innovation has been competition. Innovation and competition have revolutionized the way we live, including the way many Americans consume health care. It's time to update that 1959 law, so federal employees and the Federal Government can also benefit from innovation and competition in the health care marketplace.

After all, one thing hasn't changed since 1959: The simple economic principle that customers and consumers benefit from increased competition.

Thank you for the opportunity to testify this morning, for your leadership on this Committee and for your ongoing commitment to and interest in federal workforce issues.

Committee on Oversight and Government Reform
Witness Disclosure Requirement -- "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Thomas C. Choate

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

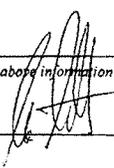
UnitedHealth Group Incorporated

I am Chief Growth Officer at UnitedHealth Group Incorporated.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2009, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None. (UnitedHealth Group Incorporated, on whose behalf I am testifying, receives no Federal grants and does not currently hold any Federal contracts. I am not representing, or responding on behalf of, any of UnitedHealth Group's operating subsidiaries, many of which do hold Federal contracts.)

I certify that the above information is true and correct.
Signature:



Date:

4/9/13

Mr. FARENTHOLD. Thank you, Mr. Choate.

We will now recognize Mr. Mark Merritt, the President and CEO of Pharmaceutical Care Management Association. Mr. Merritt, you are recognized for five minutes.

STATEMENT OF MARK MERRITT

Mr. MERRITT. Good morning, Chairman Farenthold and members of the committee. I am Mark Merritt, President of the Pharmaceutical Care Management Association. PCMA is a national association representing America's pharmacy benefit managers, or PBMs, who administer prescription drug benefits for more than 216 million Americans through Fortune 500 companies, insurers, unions, FEHBP, Medicare Part D, and other State and Federal agencies.

PBMs use a number of sophisticated tools and strategies to modernize pharmacy benefits, reduce cost, and expand access to medications. Specifically, we negotiate discounts from drugstores and drug manufacturers, design formularies that promote generics, create pharmacy networks that offer 90-day mail service, and use health IT like e-prescribing to improve patient safety.

Although no employer or government program is required to use a PBM, almost all choose to do so because of the savings and improvement of benefits involved. Each PBM client has different needs and decides for itself how aggressive to be in terms of cost-cutting, formulary design, drugstore networks, and other areas of pharmacy coverage. In 2003, Congress modeled Medicare Part D on the successful examples of FEHBP and other employers which reduce costs by hiring PBMs to administer benefits and negotiate discounts.

Fortunately, Part D has been a great success. It is not only extraordinarily popular with seniors, but it is the only major entitlement program to come in under budget each year of its operation.

Likewise, in Medicaid, several governors, ranging from Andrew Cuomo of New York to Rick Perry of Texas, have begun to engage PBMs to reduce wasteful pharmacy spending. PBMs helped save New York Medicaid over \$400 million in the first year alone, and this was done without cutting benefits or reducing the number of Medicaid enrollees. On a national scale, a recent report shows that overall U.S. prescription drug spending actually dropped last year.

But there is more PBMs can do to reduce costs for payers across the Nation, including FEHBP. Long recognized as the gold standard for employer-sponsored health benefits, FEHBP, nonetheless, has unique and specific needs. First, unlike some Federal programs which simply deliver health benefits to a fixed set of enrollees, FEHBP uses benefits as part of a broader strategy to recruit and retain Federal workers. This requires generous benefits that offer broad choice, flexibility, and access. Accordingly, FEHBP offers a wide range of options for Federal workers, retirees, and their families. Apparently, the approach is working, because a recent OPM survey showed that enrollees are satisfied with their benefits by a 7 to 1 margin.

Second, many FEHBP retirees are enrolled in Medicare Part A and B, but not Part D. They choose, instead, to maintain their FEHBP drug coverage and allow Medicare to cover their other med-

ical expenses. Lastly, FEHBP's active population is older than that of the typical employer and likely to take more prescription drugs.

PCMA believes OPM has significant running room to innovate and further reduce pharmacy benefit costs. To this end, OPM has suggested in its March Carrier letter the plan's detail how to make better use of PBM tools like tiered cost sharing, prior authorization, and step therapy to promote generics and more affordable brands. OPM also encourages plans to explore mail service and specialty pharmacies, and specifically highlights the potential of preferred pharmacy networks, which can achieve even greater savings on prescription drugs with minimal member disruption.

In closing, we understand and appreciate OPM for seeking new ways to leverage PBM tools to improve prescription drug benefits in FEHBP. We look forward to working with the members of the committee on this and other important issues.

Thank you for having me today and I would be happy to take any questions you might have.

[Prepared statement of Mr. Merritt follows:]



Testimony of Mark Merritt

President & Chief Executive Officer

Pharmaceutical Care Management Association

Before the

**UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON THE FEDERAL WORKFORCE, U.S. POSTAL
SERVICE, AND THE CENSUS**

"The Federal Employees Health Benefit Program:

Is It a Good Value for Federal Employees?"

April 11, 2013

Introduction

The Pharmaceutical Care Management Association (PCMA) appreciates this opportunity to submit our statement for the record of the April 11, 2013 Subcommittee Hearing. PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 216 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP).

PBMs utilize a number of tools and strategies to manage prescription drug benefits that maximize value for health plan enrollees and PBM clients – employers, health plans, federal and state governments, and other payers. A common thread connecting all programs administered by PBMs is that success depends on offering the best overall value in terms of cost, quality, access, and convenience for health plan enrollees and saving PBM clients money. To stay in business, PBMs must deliver high-quality prescription drug benefits at highly competitive prices.

The FEHBP has long been the gold standard for employer-sponsored health benefits and is a model for health insurance reform efforts at the state and national levels. The hallmark of the FEHBP is consumer choice and competition. FEHBP offers a wide range of health insurance options for federal workers, retirees and their families and is extremely popular, with a recent Office of Personnel Management (OPM) survey showing that enrollees are satisfied with their benefits by a 7 to 1 margin. Like any large employer, OPM structures benefits to attract and retain talented employees. Comprehensive prescription drug coverage, widely available at retail and mail-service pharmacies, is a key component of benefit design in the FEHBP. Most plans that participate in the FEHBP competitively bid their drug benefit administration to PBMs.

OPM does not negotiate prescription drug prices or discounts directly with manufacturers or pharmacies, but instead uses its leverage with carriers to negotiate price concessions and reduce wasteful spending on prescription drugs for FEHBP enrollees. OPM's annual carrier letter establishes parameters within which the health plans – and by extension their subcontractors, such as PBMs, dental benefit managers, and mental health benefit managers – must operate. OPM provides additional guidance on specific issues and practices it deems necessary to address. Through this process OPM encourages carriers to innovate and implement

new initiatives to address rising costs and stimulate appropriate use of health care goods and services.

In its most recent carrier letter, OPM encourages plans to innovate by making pharmacy benefits management a “central theme” of their 2014 proposals. The agency suggests that plans detail how they will use PBM tools such as tiered cost sharing, prior authorization, and step therapy to encourage the use of generics and more affordable brands. Likewise, OPM encourages plans to explore how to use preferred pharmacy networks, mail-service pharmacies, and specialty pharmacies to reduce drug costs. OPM specifically highlights the promise of innovative pharmacy networks, saying “We understand that members can achieve even greater savings on prescription drugs with minimal member disruption, through either a narrower pharmacy network or a preferred pharmacy network.”

OPM’s focus on pharmacy networks aligns with a recent PCMA study which found that greater use of preferred and limited pharmacy networks could save the U.S. health system \$115 billion over the next ten years with minimal disruption to beneficiaries. The savings results from competition among the abundance of pharmacies in the United States, including those in big-box stores like Target and Walmart, in grocery stores, independent and chain pharmacies, and mail service pharmacies. Since there are over 60,000 retail pharmacies nationwide -- more than McDonalds, Burger Kings, Pizza Huts, Dunkin Donuts, Wendy’s, Taco Bells, Kentucky Fried Chickens, and Domino’s Pizzas *combined* -- preferred pharmacies can save money without reducing access for patients.

The OPM-established model for pharmacy benefits has allowed PBMs, working with FEHBP carrier clients, to create broad and convenient access to prescription drugs and generate significant savings for health plans and enrollees. Just as they do for private-sector health plans and large employers, PBMs participating in FEHBP plans play a key role in negotiating price discounts from manufacturers and pharmacies in order to lower unit drug prices.

Negotiating price concessions on drugs is just one of the many ways PBMs reduce pharmacy benefits costs. PBMs encourage higher generic utilization, employ more affordable delivery options such as mail-service pharmacy, negotiate discounts from retail pharmacies, and help doctors and patients understand when safer, more affordable options are available. PBMs

understand that the “unit price” of a drug is only one of many different components of prescription drug spending. To ensure added value of these services to payers, PBMs also provide choice of formularies, broad access to medications, convenient pharmacy options, and other benefits for enrollees.

These methods have proven to be successful in lowering the overall costs of drugs. According to the CMS National Health Expenditures Accounts, annual expenditures on outpatient prescription drugs have increased more slowly in the past four years than at any time in the previous four decades. In 2011, expenditures on prescriptions increased just 2.9 percent, well below the 3.9 percent rate of increase in health expenditures overall.

This trend is due in large part to a continued increase in generic dispensing from 67 percent in 2007 to 80 percent in 2011, which was encouraged by PBMs through lower or waived copayments and formulary compliance programs such as step therapy. Generic dispensing rates are generally higher in plans administered by PBMs than in other federal programs, especially Medicaid. This is significant, because every 1 percentage point increase in the generic fill rate can translate into a 1 percentage point reduction in drug costs.

PBMs have been studied by several federal agencies and have received excellent ratings on their performance. In general, the deeper the Federal Trade Commission (FTC) probed into the operations of PBMs and related entities, the more reassuring were the results. This was largely attributed to complex, robust, far-reaching, negotiation-driven competition. Reports from other federal agencies, including three reports from the Congressional Budget Office (CBO 2007a, 2007b, and 2008) and two from the Government Accountability Office (GAO 2003 and 2009), confirm this. The 2003 GAO report, for example, found that FEHBP enrollees paid the lowest prices for 30 prescriptions when purchasing through PBM-owned mail-order pharmacies.

Proposals to Change the Way FEHBP Purchases Pharmacy Benefits

Over the years, alternatives to alter the way OPM purchases and administers pharmacy benefits have been proposed. At the outset, let us note that OPM, through its contracts, already has the capability to implement almost any idea it thinks would improve the quality and value of the program. One proposal included in the President’s budget last year and, we assume, this year

would carve-out pharmacy benefits from all OPM's 230 carriers and put the pharmacy benefit for the entire FEHBP program up for bid to the lowest bidder. PCMA takes a neutral position on this concept as our member companies differ in their views on it.

Other proposals, including Ranking Member Lynch's bill (H.R. 1367), would impose drastic changes on the FEHBP program that would put at risk its ability to continue offering the savings, quality, and choice to which its enrollees have become accustomed. Some FEHBP "reform" proposals substitute federal price controls for market-based competition, while other proposals substitute congressional oversight for that of state boards of pharmacy.

For example, H.R. 1367 would forbid PBMs from paying more than the average manufacturer price for drugs, substituting instead government price controls. This would make the program look more like parts of Medicaid—where price-controls have led states to pay pharmacy dispensing fees which are often double or triple those paid in Medicare Part D and the commercial market. Part D, which, like FEHBP, relies upon competition not price controls, has consistently performed better than CBO projections. Part D is currently more than 40 percent under initial budget projections, has achieved beneficiary satisfaction rates close to 95 percent, and, according to the recent MedPAC report, had a low 2.9 percent annual growth rate in per capita spending from 2006 to 2010.

Such critical changes to FEHBP would normally follow a major report or significant findings that benefits are substandard or services are overpriced compared to other employer payers. But that is not the case. Beneficiaries are overwhelmingly satisfied with FEHBP, by a margin of 83 to 14. FEHBP benefit levels and premiums are comparable to or better than those received by employees in the private sector.

Some have suggested that FEHBP's drug costs are significantly higher than those of private-sector employers, noting that drug benefits are a greater percentage of FEHBP's total spending. But behind the figures are significant differences between FEHBP's insured population and that of most employers. First, the federal workforce is ten years older than that of the average private sector employer, which makes it a heavier user of health care services in general, and prescription drugs in particular, than the average employee population. Second, the FEHBP figures also include expenses for FEHBP's retiree population, including payments for

cost sharing for Medicare-eligibles. Again, retirees are higher users of prescription drugs than working populations. It is unclear whether these numbers also include the costs of the inpatient medications, which are different than outpatient costs. In combination, this largely explains the differences between FEHBP and the average employer expenditure on drug benefits.

Various proposals, including both the carve-out proposal and H.R. 1367, would set in statute contract requirements for PBMs participating in FEHBP. In H.R. 1367, PBMs would be required by statute to disclose proprietary contract terms regarding drug acquisition costs and pharmacy dispensing fees to OPM, carriers, and enrollees, as well as similar information on private-sector contracts outside of FEHBP. The bill would establish drug price controls with reimbursement based on the average price a manufacturer receives from wholesalers for a given drug and require uniform maximum pharmacy dispensing fees determined by OPM. These are functions that are currently subject to negotiation, and indeed, OPM has required through its contracting process that FEHBP carriers require information on drug acquisition costs, obviating the legislation. Further, the bill preempts state laws governing generic drug substitution and therapeutic interchange.

Impact on Patient Safety and Drug Costs of Proposals Limiting Generic Substitution

Pharmacy benefits are carefully designed by FEHBP carriers and their PBMs to give enrollees incentives to use high-value, cost-effective products. Typically this involves promoting generic substitution for branded drugs, within the limits of state law. Pharmacy and physician prescription practices are generally regulated by the States and developed by professional boards with clinical expertise. Some proposals, including H.R. 1367, would place restrictions on drug substitution for FEHBP enrollees. For example, the bill would not allow a drug substitution based on safety if the replacement drug were “higher in cost.” The drug-substitution provisions of H.R. 1367 represent a substantial shift in existing law and could significantly compromise patient safety. Any proposals including such a provision should be carefully weighed for these types of unintended consequences.

H.R. 1367 would also prevent pharmacies from substituting generic drugs without the approval of the prescribing doctor, despite state pharmacy laws *requiring* such substitution.

Generic drugs are widely accepted by patients – indeed, the reason drug costs are not increasing more rapidly is that many brands have lost patent exclusivity and are now competing against generics. The burden on physician offices to respond to pharmacy inquiries would be substantial and would add to physician workflow and overhead costs. In fact, physicians can already write “dispense as written” when they believe a patient would benefit from a specific drug in a therapeutic class. This bill could also cause longer lines at the pharmacy counter. Thus, the extensive patient and physician consultation and approval imposed by this kind of requirement would markedly restrict dispensing of FDA-approved generic versions of brand equivalents and drive drug costs up without improving quality. Generics have proven to be extremely effective at controlling costs and expanding access, which is why many states have implemented mandatory generic substitution laws.

Impact on PBM Competition of Proposals to Debar or Limit Vertically Integrated PBMs

Inexplicably, some proposals would limit the number of PBMs that could participate in the FEHB program. Competition keeps pressure on PBMs to negotiate well and keep costs down, and it makes little sense to limit the field of potential PBM participants, especially if OPM is considering awarding the entire benefit to a single PBM. By way of example, H.R. 1367 would prohibit any drug manufacturer or retail pharmacy from having a controlling interest, defined as 20 percent, in a PBM serving the FEHBP and would prohibit a carrier-controlled PBM from earning a profit, which would appear to include making an operating margin. We do not see how limiting competition would result in the best prices for the program.

Turning to disclosure, PCMA notes that the FTC has said that public disclosure of proprietary pricing information, or “transparency,” leads to higher – not lower – prices. Nonetheless, some proposals would require public release of negotiated rates, by requiring plans to send enrollees, for every prescription, the prices paid to manufacturers for drugs and to pharmacies for dispensing them. These prohibitions and disclosure requirements, combined with an additional requirement that PBMs serving FEHBP disclose specific acquisition costs and other pricing information on their entire book of business, would raise costs and severely limit the number of PBMs willing to participate in FEHBP while driving up drug costs.

PBMs may be unwilling to risk losing the pricing concessions negotiated with manufacturers and pharmacies for non-FEHBP accounts because of the disclosures to enrollees, carriers, and OPM required by the bill. In an ironic twist, reduced competition among PBMs, with the possibility of only a single PBM administering all FEHBP drug benefits, would leave remaining PBMs with little or no incentive to lower costs.

Impact of Proposals for Cost-Plus Pricing Controls

FEHBP relies upon consumer choice and competition rather than price controls to hold down costs and maintain flexible benefits. It is designed to take advantage of price competition among private sector competitors. H.R. 1367 would require carriers to limit payments for drug charges to Average Manufacturer Price (AMP) minus enrollee cost sharing. AMP is the price manufacturers charge wholesalers. The bill also requires PBMs to pay carriers 99 percent of all compensation received from manufacturers. Given that 90 percent of all pharmaceuticals are purchased through drug wholesalers – which to stay in business must charge pharmacies more than the price at which they acquire a drug – requiring reimbursement at AMP would result in PBM reimbursements that are lower than the pharmacy's acquisition cost.

Without accounting for a wholesaler's markup, pharmacies would carry a loss on every prescription, whether the pharmacy served as the PBM's mail-service pharmacy or was a retail pharmacy. Retail pharmacies contested a provision of the Deficit Reduction Act of 2005 (DRA) that imposed requirements regarding use and disclosure of drug acquisition costs based on wholesaler invoices (not manufacturer prices to wholesalers), and provisions in both the House and Senate health care reform bills redefined the AMP, based on manufacturer price to wholesalers, and set a new federal upper payment limit at 175 percent of AMP to address pharmacy concerns.

Even assuming the AMP requirement is adjusted to a different benchmark rate, H.R. 1367 would lead to a cost-plus only pricing policy in FEHBP. Polls show that employers don't want mandates that restrict their choice in this regard. Large employers such as OPM have the option to structure contracts using cost-plus pricing, and many choose not to do so. Although OPM currently encourages its FEHBP health plan to use cost-plus pricing, it could decide to

follow the path taken by other large purchasers which encourage PBMs to negotiate bigger discounts by allowing them to retain a portion of any extra savings.

OPM Already Has the Authority to Impose Standards and Requirements

OPM already has the authority to impose all of H.R. 1367's provisions without seeking any new authority from Congress. OPM routinely uses its existing authority to impose new PBM contract requirements – *when it deems them helpful to the program*. Indeed, OPM has already required FEHBP carriers to insist that PBMs meet rigorous transparency and cost-savings standards – some quite similar to those in the bill. For example, in the 2012 standard contract for experience-rated HMOs, OPM requires contracting PBMs to meet an extensive set of standards, including disclosure, conflict-of-interest, and rebate pass-through requirements. These requirements are outlined in Attachment 1 to this testimony.

Carrier letters, FEHBP guidelines, and the FEHB Carrier Handbook are the appropriate vehicles for OPM to guide and monitor the practices of participating carriers and plans as well as their subcontractors.

Conclusion

FEHBP is successful because it relies on market forces and competition to deliver high quality benefits and services to its enrollees. We urge the Subcommittee to pursue policies that foster and encourage competition to keep drug costs and pharmacy benefits affordable in the FEHBP. We especially urge the Subcommittee to consider carefully the likely harm of proposals, including most of the provisions in H.R. 1367, that would impose federal price controls on drug products and pharmacy services, preempt state laws that assure cost-savings from generic substitution, limit competition, and require sweeping disclosures of pricing and proprietary business practices that could have the unintended effect of driving prices higher and stifling competition. The significant adverse impact of such changes on federal workers, retirees, and dependents who rely on the FEHBP should not be taken lightly.

By using PBMs' management strategies proven in Medicare Part D and the commercial market, FEHBP carriers achieve significant savings for their enrollees in their drug benefits and provided wide access to medications and pharmacies at affordable prices. Additional savings for FEHBP could be obtained if OPM encouraged carriers to adopt even greater use of preferred pharmacy networks, home delivery, formulary tiering, step therapy, prior authorization, and other utilization management tools that facilitate cost-effective medication use.

PCMA looks forward to working with the Subcommittee and Congress to find additional ways to promote savings while continuing to deliver the highest quality, highest value prescription drug benefits for all federal employees.

Attachment 1

**FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM—
STANDARD CONTRACT FOR EXPERIENCE-RATED HEALTH MAINTENANCE
ORGANIZATION CARRIERS
2012**

**SECTION 1.28
STANDARDS FOR PHARMACY BENEFIT MANAGEMENT COMPANY (PBM)
ARRANGEMENTS (JAN 2011)**

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with vendors providing a retail pharmacy network and/or a mail order pharmacy and/or a specialty pharmacy to enrollees and dependents (hereafter "PBM") effective on or after January 1, 2011. Notwithstanding the foregoing, the revisions to Section 1.28(a) in the January 2011 clause shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2013. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

This section does not apply to carrier-owned PBMs, which are already expected to adhere to the FAR and FEHBAR standards and requirements, and the remaining provisions of this contract.

(a) Transparency Standards

(1) The PBM is not majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM agrees to provide pass-through transparent pricing based on the PBM's cost for drugs (as described below) in which the Carrier receives the value of the PBM's negotiated discounts, rebates, credits or other financial benefits.

(i) The PBM shall charge the Carrier no more than the amount it pays the pharmacies in its retail network for brand and generic drugs plus a dispensing fee.

(ii) The PBM shall charge the Carrier the cost of drugs at mail order pharmacies based on the actual cost, plus a dispensing fee. Costs shall not be based on industry benchmarks; for example, Average Acquisition Cost (AAC) or Wholesale Acquisition Cost (WAC).

(iii) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Carrier agrees to credit to the Carrier either as a price reduction or by cash refund the value all Manufacturer Payments properly allocated to the Carrier. Manufacturer Payments are any and all compensation, financial benefits, or remuneration the PBM receives from a pharmaceutical manufacturer, including but not limited to, discounts; credits; rebates, regardless of how categorized; market share incentives, chargebacks, commissions, and administrative or management fees. Manufacturer payments also include any fees received for sales of utilization data to a pharmaceutical manufacturer.

(3) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(4) The PBM's administrative fees, such as dispensing fees, must be clearly identified to retail claims, mail claims and clinical programs, if applicable. The PBM must agree to disclose sources of each administrative fee to the Carrier and OPM.

(5) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a mail order pharmacy, and its retail network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75% of the total cost to the Carrier, whichever is the greater number:

(i) the dollar amount of Total Product Revenue for the reporting period, with respect to the PBM's entire client base. Total Product Revenue is the PBM's net revenue which consists of sales of prescription drugs to clients, either through retail networks or PBM-owned or controlled mail order pharmacies. Net revenue is recognized at the prescription price negotiated with clients and associated administrative fees;

(ii) the dollar amount of total drug expenditures for the Plan;

(iii) the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;

(iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.

(v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers;

(vi) the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(6) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier.

(7) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. A PBM providing information to a Carrier under this subsection may designate that information as confidential commercial information. The Carrier, in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential under 5 C.F.R. § 294.112.

(8) If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.28 shall be deemed to be references to the Underwriter.

(9) The Carrier will require that its PBM contractors:

- (i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;
- (ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and
- (iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(10) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG). The PBM must provide the OPM OIG upon request all PBM records including, but not limited to:

- (i) All PBM contracts with Participating Pharmacies;
- (ii) All PBM contracts with Pharmaceutical Manufacturers;
- (iii) All PBM contracts with third parties purchasing or using claims data;
- (iv) All PBM transmittals in connection with sales of claims data to third parties; and
- (v) All PBM Maximum Allowable Cost (MAC) price lists.

(b) Integrity Standard

The Carrier will require that its PBM contractors agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association (dated October 27, 1994), for their employed pharmacists.

(c) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, telephone customer service, paper claims processing, and other applicable standards set for Carriers at Section 1.9(g)(1), (3), (5) and (6). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

(1) Retail Pharmacy Standards

- (i) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to network pharmacies.
- (ii) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, network pharmacies.

- (iii) Licensing – The PBM verifies the appropriate licensing of its network pharmacies.

(2) Mail Service Pharmacy Standards

- (i) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the physician’s prescription not less than 99.9% of the time.
- (ii) Turnaround time – The PBM promptly dispenses and ships at least 98% on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.

- (3) Prior Approval – if applicable – The PBM promptly reviews and responds to requests for prior approval for specific drugs following receipt of all required information.

(4) Quality of Drug Therapy - The quality assurance program implemented by a Carrier’s PBM contractor must include a process to measure the quality of its drug therapy provided to enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(d) Alternative Drug Options

The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitution:

- (i) The PBM must treat the prescribing physician, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.
- (ii) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other physician’s office staff member as authorized by the Prescriber.
- (iii) The PBM must memorialize in appropriate detail all conversations with patients and physicians in connection with drug interchanging requests, including the identity of the contact person at the physician’s office and the basis for his or her authority.
- (iv) The PBM will only interchange a patient’s drug from a lower priced drug to a higher priced drug to patient or Plan when authorized by the Carrier or the Plan.
- (v) The PBM will permit pharmacists to express their professional judgment to both the PBM and physicians on the impact of drug interchanges and to answer

physicians' questions about dosing. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to physicians for drug interchanges that in their professional judgment should not be made.

- (vi) The PBM will offer to disclose, and if requested, will disclose to physicians, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(e) Patient Safety Standard - The Carrier will require that its PBM contractors establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

- (i) A system for identifying and communicating drug and consumer safety issues at point-of-service; and
- (ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.

(f) Safety and Accessibility for Consumers - The Carrier will require that its PBM contractors meet the following standards related to pharmacy network management and consumer access to medications.

(1) The Carrier will require that its PBM contractor define the scope of its services with respect to:

- (i) The distribution channels offered (e.g. pharmacy network, mail order pharmacies, or specialty pharmacies);
- (ii) The types of pharmacy services offered within each distribution channel; and
- (iii) The geographic area served by each distribution channel.

(2) The Carrier will require that for each distribution channel provided by its PBM contractor, the PBM contractor:

- (i) Establishes criteria and measures actual performance in comparison to those criteria; and
- (ii) Makes improvements where necessary to maintain the pharmacy network and meet contractual requirements.

(3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:

- (i) Quality and safety of drug distribution; and
- (ii) Quality of service

(g) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Mark Merritt

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

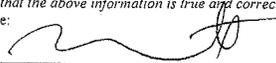
None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

PCMA, CEO

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None

I certify that the above information is true and correct.
Signature: 

Date: 4/8/13

Mr. FARENTHOLD. Thank you, Mr. Merritt.
We will now recognize Ms. Jacqueline Simon, Public Policy Director for the AFGE.

STATEMENT OF JACQUELINE SIMON

Ms. SIMON. Chairman Farenthold, Ranking Member Norton, and members of the subcommittee, thank you for the opportunity to testify today on behalf of the more than 650,000 Federal workers in 65 agencies that AFGE represents.

Health insurance benefits are extremely important to AFGE's members. We have been very frustrated by our inability to have much of a voice when it comes to FEHBP. Because the program is statutory, we are unable to use the collective bargaining process to make our priorities and preferences known, and OPM has, in the past four years, adopted a culture of extreme secrecy regarding FEHBP, leaving us almost completely in the dark about the program and the changes they have contemplated.

In particular, our request for information about the likely impact on enrollees of changes being considered today were refused until the last minute, when OPM realized we intended to complain about the withholding of information at today's hearing. In fact, all we had received prior to preparation of our testimony was a large font 10 screen PowerPoint presentation from last December that raised many questions, but answered none.

We ultimately received another document last week that revealed what was in the Administration's budget release yesterday; that the proposals amount to a multi-billion dollar cost-shifting that will ultimately cause great financial harm to many of our members.

Federal employees currently pay an average of 30 percent of FEHBP premiums, in addition to sometimes substantial out-of-pocket deductibles and co-payments. In some plans, the employees' share of premiums is 64 percent. Yet, we get almost no information or any input in decisions about changes in benefits, administration, or structure. We are apparently supposed to just keep quiet and keep paying.

After a three-year pay freeze, massive increases in employee costs for FERS and furloughs of up to 14 days, Federal employees can hardly afford to keep quiet. And like every other middle-class American, no Federal employee can afford to pay any more than absolutely necessary for health insurance.

We believe the changes in FEHBP that OPM is proposing will have some winners and losers, but that overall they will shift costs for the program away from the Government and onto the backs of Federal workers.

The proposal described as giving discounts for wellness would charge more to those with the misfortune of being ill or aged or overweight. The proposal to expand plan types is a proposal that will bring in plans with inferior benefit packages and will worsen the program's already risk segmentation. It will also mean charging employees in high health care cost cities more for their health care. These are not necessarily cities where salaries are higher.

The proposal to carve out prescription drugs may become a proposal to transform the prescription drug coverage into either a

voucher or, worse, an employee pay all pseudo benefit. The proposal to add “self plus one” is a proposal to charge families with more than two persons more for their benefits.

Interestingly, when the PowerPoint was shown to AFGE last December, there was a slide with an OPM proposal to eliminate the statutory provision that prevents the Government from paying more than 75 percent of any FEHBP premium. It was presumably the spoonful of sugar to help the medicine go down. All the other proposals take benefits away. This one would have helped many low paid and uninsured Federal workers gain some coverage. But this proposal has been eliminated from the PowerPoint document that now circulates. Word is that OPM approved the cuts and nixed the one thing that would have provided a benefit.

So AFGE is in a difficult position. We believe strongly that FEHBP is in need of reform, but all the rhetoric about the benefits of competition, how it will lower costs, ring hollow when there is no standard benefits package and the program is structured to maximize risk segmentation. Without a standard benefits package, competition doesn't lower prices, it just divides up the market. OPM's proposals divide up the market further, geographically in terms of risk and in terms of health status.

As for regional PPOs, we know the most expensive and least accountable plans in the program are the regional HMOs. They are in and out of the program, merge with one another, drop providers, add providers. They are generally unstable. We often hear from our members that these regional plans charge the Government far more than they charge local employers. But again OPM has not made the case on the merits of this proposal; we are just told that it is a best practice in the private sector, a sector not known for best practices in the area of health insurance.

We believe strongly that in light of the extremely large share of FEHBP costs that Federal employees shoulder, we deserve an opportunity to have input on the benefit structure and administration of this program; not a PowerPoint once in a blue moon, but a regular exchange of information and concerns, and opportunity to have questions answered and employees' perspectives given serious consideration. We have such opportunities in the thrift savings plan, we have it with the Federal Salary Council for workers on the general schedule, and in the Federal Prevailing Rate Advisory Council for blue collar Federal workers. All these advisory councils are statutory and all work extremely well.

We urge the subcommittee to consider establishing an FEHBP advisory committee so that Federal employees have a regular opportunity to learn more about their health insurance program and know that their interests, views, and concerns are receiving the attention they deserve. Thank you.

[Prepared statement of Ms. Simon follows:]

Introduction

My name is Jacqueline Simon, and I am the Public Policy Director of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the 650,000 federal employees AFGE represents, I thank you for the opportunity to testify today. The Federal Employees Health Benefits Program (FEHBP), which covers more than eight million federal employees, retirees, and their dependents, is the nation's largest employer-sponsored health insurance program. FEHBP is affected by the Patient Protection and Affordable Care Act, and FEHBP is also a target of those who would force federal employees to forfeit their earned benefits to finance deficit reduction. The President's failed deficit commission, led by Morgan Stanley Director Erskine Bowles and former Republican Senator Alan Simpson recommended dismantling FEHBP and turning it into a voucher program. Within the next few years, when the tax provisions of Obamacare take effect, some FEHBP plans will be passing to enrollees the full amount of their new excise tax liabilities (40% of the premium that exceeds the law's threshold amounts), causing premiums to increase substantially. And now the Office of Personnel Management (OPM) is floating several highly controversial initiatives that would have a harmful effect on many of the most vulnerable enrollees.

OPM has provided stakeholders next to nothing in terms of analysis or justification for these proposed changes. That is one reason why we are asking lawmakers to withhold approval for any of the OPM initiatives. It is massively unwise to give OPM the authority it seeks to make enormous and consequential changes to FEHBP without requiring them to demonstrate the impacts of these changes on enrollees. In that context, we are also asking Congress to establish a statutory advisory council for FEHBP, modeled on the Employee Thrift Advisory Council and the Federal Salary Council, so that organizations representing federal employees and retirees will have a formal opportunity to gain access to information about FEHBP policies and administration.

With federal pay frozen for three straight years, a massive tax increase on FERS employees via increased retirement contributions, and furloughs of up to 14 days that may be repeated each year for the next decade, federal employees cannot withstand any more reductions in their compensation. Meanwhile, in spite of the freeze and the shift of retirement system costs that lower new employees' take home pay by an additional 2.3 percent in perpetuity; federal employees have had to pay more each year for health insurance. No federal employee can afford to pay any more than is absolutely necessary for health insurance, and there is certainly no justification for any more cost-shifting to federal employees. Unfortunately, all of OPM's proposals, except perhaps for one, would shift costs to enrollees without improving the program or lowering its overall costs at all.

We understand that the changes in FEHBP that OPM is proposing will produce both winners and losers, but that overall, they will shift costs for the program away from the government and onto the backs of federal workers. There are obviously numerous ways for the government to reduce deficits, but the worst possible way is to impose further cuts in benefits on its own workforce. As with the pay freeze and the retirement system cost shifting, the administration couches its proposals in the notion that it is following private sector practice, or "modernizing." But the end result is the same: lower compensation for federal employees through cost-shifting. Thus, AFGE urges lawmakers to reject all proposals from OPM that would lead to higher costs or lower benefits for federal workers.

Our members currently pay an average of 30% of FEHBP premiums, in addition to sometimes substantial out-of-pocket deductibles and copayments. In some plans (New Jersey's and Delaware's Aetna Open Access Plans), the employee's share of the premium is 64%. Yet despite shouldering this tremendous financial burden, we have neither access to information nor input into any decisions about expansions or contractions of benefits, changes in administration, or changes in program structure. We're in the unenviable position of being expected to keep quiet and keep paying. That is another reason why we are so grateful for this opportunity to testify today. Hearings like this have become our sole opportunity to voice concerns about FEHBP and the direction OPM would like to take it.

OPM's FEHBP Proposals

Discounts for Wellness

We first consider the proposal described as giving "discounts for wellness." This Orwellian label barely masks its true purpose -- to impose surcharges on those deemed "unwell." The unwell have relatively higher health insurance claims than those identified as "well." Would OPM also propose lower salaries for those deemed "unwell"? Would OPM propose to charge those in "wellness programs" more for their retirement benefits on the belief that those with good health are likely to live longer, and therefore cost the retirement system more? Would it all come out even in the end? Lower pay and benefits now for the obese, but since they die earlier, they will be charged less for retirement?

The latest medical research strongly suggests that obesity is as much a function of genetics as is height. But illness is a misfortune, not a moral defect. Genetic traits do not respond to financial incentives. According to the latest data from the Centers for Disease Control, obesity rates vary tremendously by race and ethnicity, with 58.5% of non-Hispanic black women and 41.4% of Hispanic women classified as obese, while just 32.2% of non-Hispanic white women were labeled as such. The legal definition of discrimination involves disparate treatment on the basis of immutable characteristics, and one protected class has to do with physical disability. There

are numerous conditions that are physical disabilities that might make a federal employee ineligible for the “wellness discounts” related to obesity, rendering the initiative discriminatory. We understand that this form of discrimination is legal under ERISA and other laws, but it remains offensive to our sense of fairness. As such, AFGE urges members of the subcommittee to reject the so-called “premium differentials tied to “wellness”” initiative.

As an alternative, we propose requiring all FEHBP plans to cover up to \$750 per year for gym memberships, fitness classes, or fitness devices. This would provide a positive incentive to pursue fitness, and it is a practice that is far superior to penalizing those with obesity or other conditions that render them ineligible for preferred rates. This is the practice that AFGE uses for its employee health insurance program. For many of AFGE’s employees, this subsidy has been instrumental in the decision to pursue fitness classes that would otherwise have been unaffordable.

Adding a new Premium Tier: Self plus one

OPM has also proposed a “self plus one” category of premiums. This change would increase costs for families, and perhaps, contrary to the plan, might also increase costs for those who choose the “self plus one.” Self plus one would include many retirees or older couples, but it would also include some single parents of just one child. Those who currently choose family coverage include hundreds of thousands of parents and children under 26. Children under age 26 are the least expensive group to insure: the bulk of their health care costs come from primary care office visits, immunizations, and preventive care, which adds up to about \$900 per child per year. Other than that, their costs generally come from emergency room visits, and prescription drugs. Thus, families that include one or more children generally cost less to insure than two adults. That is why, currently, in FEHBP, among those with family coverage, those with more than one child subsidize the two-adult family. But all that could change with self plus one, to the detriment of both kinds of families.

FEHBP’s most serious structural problem is risk segmentation. FEHBP encourages those with similar risk to congregate in the same plans. Risk segmentation can occur when a program lets participants choose from plans that vary widely in terms of benefits, and when the program lets participants choose the number and age of individuals covered. Risk segmentation robs a large group of the benefits of minimizing average risk, and since premiums are based on average risk, risk segmentation produces higher aggregate health care costs for FEHBP than would occur if everyone were in the same pool. The “self plus one” proposal would exacerbate FEHBP’s risk segmentation problem, creating new disadvantaged groups of self-plus ones with similar risk profiles. Older or sicker couples would pay more, but so would those with larger families. Overall, the plan would have even more risk segmentation, which in turn raises aggregate costs and costs for some enrollees.

Interestingly, President Obama's Affordable Care Act went to great lengths to avoid the adverse consequences of risk segmentation. The rules for exchanges attempt to standardize benefits by allowing them to include no more than four benefits packages (60,70,80, and 90 percent of projected cost of "essential health benefits"), limiting the differentials plans can charge by age, and prohibiting differentials by gender altogether. Initially, Obamacare would have prohibited self plus one, but bowing to pressure from the states and insurance industry, state exchanges will have the option of charging by the number of individuals (up to a maximum individualized charge per family for three children).

The sole rationale offered by OPM for the self plus one premium tier is that they consider it a "best practice" in the private sector. Although business buzzwords like "best practices" should always be approached cautiously, there is a clear sense of what one means by the term, and it is important to note that what private firms consider "best practice" is not necessarily desirable public policy. A private sector "best practice" is one that maximizes profits, and in the context of compensating employees, that increasingly means minimizing employer costs for health insurance by shifting costs on to employees, eliminating defined benefit pensions altogether and providing only nominal employer funding of defined contribution plans. Further, empirical evidence shows that the private sector does not have the "best" practices when it comes to health insurance; the public sector's practices are far superior. A 2011 Congressional Budget Office (CBO) analysis of Representative Paul Ryan's budget found that "average spending in traditional Medicare will be 89 percent of (that is 11 percent less than) the spending that would occur if that same package of benefits was purchased from a private insurer." (http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf)

An OPM document estimated that establishing self plus one in FEHBP would save the government \$6 billion over ten years. The proposal would shift some or all of this \$6 billion on to federal employees and retirees. Again, it is incumbent upon OPM to evaluate the impact that this change would have on plans and enrollees. OPM simply says premiums would not change ("there would be no overall impact on premiums"), but \$6 billion would be saved. What kind of assumptions did OPM use to produce that statement and the savings estimate? For many years, OPM's actuaries have told us that self plus one premiums would likely exceed family premiums in FEHBP, and that allowing this category would send family coverage premiums much higher. If past OPM actuarial estimates were so wrong, can OPM explain why they were wrong? Does OPM expect that all plans would offer this option, or would offering it be voluntary? The \$6 billion would be a massive compensation cut on top of the pay freezes, retirement cuts, and furloughs if it derives from cost shifting, as we suspect. Thus, AFGE urges the committee to reject this proposal as well.

Regional PPOs

The next idea from OPM for FEHBP is one its proponents call “expansion of FEHBP plan types.” In practice, this means allowing regional Preferred Provider Organizations (PPOs) to compete against the national PPOs such as Blue Cross/Blue Shield (BCBS) standard and basic options. The “Blues” are FEHBP’s most popular plans, and currently cover more than 60 percent of enrollees. Like other proposals that claim to lower costs by increasing competition, this one will deliver much less than promised by OPM. First, OPM has a miserable track record when it comes to “arms-length” negotiations with health insurance carriers. Indeed, the carriers are regularly referred to as OPM’s “partners” while we, the enrollees on whom OPM wants to shift more and more costs, are more like lepers. What OPM never seems to understand is that as a purchaser, they have a different set of interests from the carriers and it is not their role to follow and accommodate and approve any and all demands by the carriers. Thus their assurance that they would pursue a “negotiations” strategy “not only advantageous to the FEHBP Program but to carriers as well” does not bode well for enrollees, and neither does the \$600 million they think they will save from this initiative. Health care costs (prices and utilization) are not going down; if the government is saving \$600 million here and \$6 billion there in FEHBP, it can only mean that enrollees are paying the difference.

Like all of OPM’s proposals, this one would have both winners and losers. One question is who the winners would be and who would be the losers. Another is whether there are more losers than winners; the \$600 million savings estimate begins to answer that question in the affirmative. There is also the question of whether the amount of savings for the winners exceeds the losses of the losers. In short, what will be the impact on FEHBP? How many will migrate out of other plans into these regional PPO’s? How many will shift out of other plans that are affected by the migration to regional PPO’s? What will be the impact on premiums and benefits? *OPM has not answered any of these questions.*

OPM suggests that BCBS plans have too much market power, and that a dose of competition from regional PPOs will lower costs for both. But we know from experience that is not how things go in FEHBP. What will likely happen is that BCBS will end its national plan and the various state BCBS organizations will compete against the regional PPO’s, depriving federal employees of the most popular national plan. More risk segmentation will plague FEHBP. There may be less competition, not more, as a result of this change.

If there is one thing FEHBP carriers oppose more than anything, it is the reform long championed by AFGE: one standard benefits package that would require plans to compete on the basis of cost and quality, rather than compete by segmenting the market. Without the national BCBS plans, the regional plans will construct dissimilar benefits packages designed to cherry pick, and the ensuing increase in risk segmentation will worsen FEHBP’s existing flaws.

We have surveyed our members who choose a BCBS plan and they report that they like the stability of BCBS, they like the large provider network, and they like the benefits package relative to other plans. In short, they like the fact that the Blues offer comprehensive benefits. They do not like the premiums, of course, or the fact that their rise seems inexorable. But they do like the idea and the reality of one national plan. They understand that purchasing power is maximized in a large group, and that average costs and therefore premiums are lowest in a diverse risk pool. The Blues are as close as FEHBP gets to having one big, diverse federal government plan with a standard benefits package. They know that the other regional plans try to lure away those with a particular need or preference, and are thus a worse deal. That is how BCBS became the biggest FEHBP plan, and that is why there is no appetite for yet additional breakaway plans that will further segment the market, and further dilute the purchasing power of the federal employee and retiree group.

Direct Contracting with one Pharmacy Benefit Manager

Another OPM initiative, put forth under the heading of “increasing contracting discretion” would involve carving out prescription drug benefits and allowing OPM to negotiate directly with one Pharmacy Benefit Manager (PBM). The logic behind this is identical to AFGE’s arguments in favor of reducing the number of carriers in order to consolidate buying power and encourage the kind of competition that drives down costs, rather than that which merely segments the market and shifts costs. AFGE would be supportive of this proposal if OPM had not let slip that it contemplated this in the context of full “voucherization” of FEHBP, as recommended by Messrs. Simpson and Bowles, but not endorsed by the commission they led. The notion that the carve out would mean a voucher to purchase prescription drugs, and would, eventually, be part of a fully-voucherized cafeteria-type structure for all of FEHBP makes AFGE extremely wary of OPM’s initiative.

In addition, since it seeks to save \$1.8 billion over ten years, it is not clear whether OPM’s strategy would lead to the adoption of a formulary (i.e. a list of covered drugs) that would leave out a particular drug or brand of drug that a patient needs. It is also far from clear that OPM would be successful in choosing a PBM that would provide the best prices. There is an almost inevitable trade-off between the restrictiveness of the formulary and the overall cost of the prescription drug benefit. Further, plans such as Blue Cross/Blue Shield may have more buying power than OPM, as they cover more than eight million when their non-federal customers are counted. It remains for OPM to demonstrate how it intends to lower its costs without a cost-shifting voucher or problematic restrictions on the formulary.

Alternatively, AFGE strongly supports H.R. 1367, introduced by Representative Stephen Lynch (D-MA), the *FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act*. The bill is meant to lower FEHBP’s prescription drug costs by putting restrictions on the activities of

PBMs, the entities that negotiate with drug manufacturers and supply prescription drug benefits to health insurance plans of all types. The legislation prohibited PBMs from switching a person's prescription without prior approval from the prescribing doctor (currently PBMs do so if switching to a different drug is more profitable for them). It also required a PBM to return to insurance plans almost all rebates and incentive payments they receive from manufacturers, and creates disclosure requirements for information about such rebates and incentive payments.

Domestic Partner Benefits

Finally, OPM has indicated a willingness to allow domestic partners to be added to a federal employee's FEHBP enrollment. However, tax laws will require the government to include in the employee's taxable income the value of FEHBP benefits provided to a domestic partner and/or the child of a domestic partner unless they qualify as the employee's "dependents" for federal income tax purposes. In cases where the domestic partner and/or his or her children do qualify as dependents for federal income tax purposes, the value of the insurance under FEHBP will not be taxable to the employee. AFGE strongly supports the full coverage for domestic partners of both same- and opposite-sex couples and their children under FEHBP, as well as other law changes that would not impose a tax penalty on same-sex families.

Federal Employees Need an Advisory Council for the FEHBP Program

Federal employees and retirees pay at least 25% and as much as 64% of the premiums for health insurance under FEHBP. Yet in spite of this heavy financial obligation and the fact that FEHBP is the sole source of health insurance for many of its eight million participants, there is no formal mechanism for enrollees to have any input into any aspect of the program. We must rely upon OPM to negotiate contracts, set policy, and to decide what, if any, benefits beyond those specified in statute will be included or excluded. And we are forced to rely upon OPM to provide information, almost always after the fact, of what it has decided to do with this program. There is no formal mechanism for sharing of information prior to decision making. There is no formal mechanism for having federal employees' questions about FEHBP answered by OPM staff. In short, after paying, in the aggregate, 30% of the program's cost, there is no formal mechanism or opportunity for federal employees to have any involvement in its administration.

Federal employees have opportunity for input into administrative decisions involving the General Schedule pay system with the Federal Salary Council (FSC), a Presidentially-appointed advisory council required by law. The FSC includes outside experts in pay as well as representatives of the largest federal unions. Federal employees have an opportunity for input into administrative decisions involving the Federal Wage System with the Federal Prevailing

Rate Advisory Committee (FPRAC), an advisory council whose director is appointed by the Director of OPM and whose members include both management and labor representatives. And federal employees have the Employee Thrift Advisory Council (ETAC) which gives federal and postal employees and retirees and members of the uniformed services, all of whom participate in the Thrift Savings Plan (TSP), a chance to have input into administrative decisions involving the program. All of these bodies are established in statute, and all function well as avenues for dialogue and exchange of information, concerns, and advice. FEHBP would benefit greatly from the establishment of a similar statutorily required employee advisory council. AFGE will be seeking a sponsor for legislation to establish such an advisory committee.

Coverage of Applied Behavioral Therapy for Autism in FEHBP

After years of pressure from AFGE and organizations representing the families of those with autism spectrum disorders, OPM finally agreed to allow FEHBP plans to cover the most widely used and most effective treatment for autism, Applied Behavior Analysis (ABA). Thirty-seven states require health insurance plans operating in their state to cover autism treatments and interventions. OPM's action still falls far short of this standard, because it only permits and does not require FEHBP plans to cover treatments such as ABA. Nevertheless, starting in January 2013, 67 of FEHBP's 230 participating plans offered ABA. In 19 states, coverage will be offered in some regions. All state-specific plans in Arkansas, Minnesota, and New Mexico will provide the coverage.

Neither of the largest FEHBP plans, Blue Cross/Blue Shield Standard Option or Basic Option, will cover ABA in 2013. These nationwide plans cover 62% of all FEHBP participants, and the regional plans that cover ABA do not begin to include the remaining 37%. Thus, if OPM is at all serious about providing coverage for the most effective and widely used intervention for autism, it must require plans to cover ABA. AFGE will continue to press OPM to require this coverage in every FEHBP plan.

Obamacare and FEHBP

The enactment of the Affordable Care Act in 2010 has not yet solved all of our nation's problems associated with health care cost and insurance coverage, as 50 million Americans remain uninsured and we still spend almost twice as much per capita as other advanced industrialized countries with nationalized health care. This is true despite the fact that almost half of all American health care spending is funded by the US government through Medicare and Medicaid which are *not* drivers of cost. (Indeed, OPM should look to these government programs and the Veterans Health Care system for best practices). The country's problems with prices and coverage derive from the other "half" of health care spending, the portion controlled

by private insurers and pharmaceutical companies and where policies and rates are set by the private sector rather than government regulation.

The phase-in of benefits from Obamacare began in 2011 with extension of coverage to dependents up to age 26, no copayments for preventive care, and smoking cessation benefits, again without charging any copayments. Several other provisions of Obamacare affect federal employees and retirees who participate in FEHBP. Three will have a direct cost impact. The most promising is the rule on medical loss ratio limitations. Insurers will have to spend at least 80 percent of premiums on medical care or functions that improve the quality of care. For those covered by large group policies, insurers must spend an even higher amount -- 85 percent. Insurers who fail to meet this standard must provide policyholders with a rebate instead of pocketing the extra premiums as profit.

Those covered by Medicare and an FEHBP plan pay nothing for one annual well patient visit to a doctor, and can request a personalized illness prevention plan at no cost. Medicare beneficiaries are also able to get immunizations and screenings for cancer and diabetes without any copayments. Those who participate in Medicare Part D are eligible for a 50 percent discount on brand-name drugs and a seven percent discount on generic drugs if the plan has a coverage gap (also known as a "donut hole"). These discounts will increase each year until the donut hole is completely eliminated by 2020.

Beginning in 2018, the income-based government subsidies for individuals to purchase health insurance from state-run "exchanges" will become available. Unfortunately, because the incomes of hundreds of thousands of federal employees are so low, and FEHBP premiums are so high, the number of federal employees eligible for subsidized purchase through the exchange will be large. The numbers will be larger than originally anticipated because while FEHBP premiums continue to climb, the three-year pay freeze has impoverished growing numbers. The subsidies will be calculated partially to limit the share of family income paid out in premiums, and partially on the basis of family size.

2014 will also see the introduction of rules to prevent insurance companies from discriminating against those with a pre-existing or existing health problem. In addition, insurance companies will be prohibited from placing lifetime limits on the amount they will pay for benefits for a patient (the law raises the limit and eventually eliminates it). Restrictions on insurance companies' ability to cancel coverage when an enrollee falls ill also come into effect in 2014.

However, Obamacare also includes a time bomb provision, set to go off in 2018, that is likely to be very damaging to federal employees. The most punitive will be the 40 percent excise tax on "high cost" or "Cadillac" plans that will make FEHBP far less affordable for many federal employees and retirees than it already is. Most disturbing is the fact that this tax will fall on

many FEHBP plans whose high costs are not at all a reflection of a rich benefit package. In fact, the highest cost plans in FEHBP are not those with the most comprehensive benefits. The highest cost plans are those that exploit FEHBP's structural weaknesses by encouraging those with the highest health risks to congregate, and thus their costs reflect the risk group rather than the actuarial value of the benefits offered. Additionally, some FEHBP plans become high cost because of their political power and the Office of Personnel Management's long history of exempting them from cost accounting standards, and acceding to their demands for large annual premium increases.

FEHBP contracts are fixed price re-determinable type contracts with retrospective price redetermination. This means that even as the insurance companies receive only a fixed amount per contract year per "covered life", they are allowed to track their costs internally until the end of the year. The following year, they can claim these costs and recoup any amount they say exceeded their projections from the previous year. They are guaranteed a minimum, fixed profit each year regardless of their performance or the amount of claims they pay. The cost "estimates" on which they base their premium demands are a combination of what they report as the prior year experience plus projections for the coming year plus their minimum guaranteed profit. Clearly, there is no ability for federal employees to alter the "high cost" of these plans. It is in the FEHBP's insurance companies' interests to keep costs and profits high, and benefits low. And to subject the result of this inefficient system, one that propels FEHBP premiums ever-upward without regard to affordability or without any meaningful expansion of benefits to a "Cadillac" tax just adds insult to injury.

The excise tax is a heavily regressive tax on federal workers, especially those whose incomes are too high to be eligible for the exchange subsidies but are too low to afford employee premiums in excess of \$3,000 per year. While the 40 percent tax is levied on the insurance company and is paid on incremental costs over \$10,200 for individuals and \$27,500 for families, there are FEHBP HMOs whose rates already meet the 2018 thresholds.

The 2011 Deficit Commission's Proposal to Dismantle FEHBP

The recommendations of the co-chairs of the President's National Commission on Fiscal Responsibility called for "transforming the Federal Employees Health Benefits Program (FEHBP) into a defined contribution premium support plan that offers federal employees a fixed subsidy that grows by no more than GDP plus 1 percent each year." Although the commission failed to achieve the supermajority vote necessary to send its recommendations to Congress for fast track consideration, the recommendations remain alive in current attempts to reduce the deficit on the backs of federal employees.

The voucher plan would change FEHBP by having the government provide a fixed amount of cash each year that employees could use to buy insurance on their own, instead of paying a percentage of average premiums charged by the insurance companies, as is currently the case. Under the existing statutory system, if premiums go up by 10 percent, the government's contribution goes up by around 10 percent. The FEHBP financing formula requires the government to pay 72 percent of the weighted average premium, but no more than 75 percent of any given plan's premium. Under the Commission proposal, the government's "defined contribution" or voucher would go up by an amount totally unrelated to the rise in premiums. For example, between 2011 and 2013, FEHBP premiums went up by an average of 3.5 percent (3.4% for 2013), and so did the government's contribution. If the voucher proposal would have been in effect, the government's "contribution" or voucher would have gone up by GDP + 1%. The annual growth rate of GDP in 2011 is estimated to have been 2% (through the third quarter, the most recently available data). Adding an additional percentage point to that and the voucher would have risen by 3%, not enough to cover the average rise in premiums.

This proposal originated in a Heritage Foundation "backgrounder," published in 2001 which criticizes FEHBP's "artificial restrictions on plan options, including less expensive plans" and recommends getting rid of all legally "mandated benefits," removing the 75 percent cap on the government's contribution to a plan, and allowing rollovers of any unspent funds. To make matters worse, Heritage recommended allowing plans selling to federal employees to charge different premiums to different individuals, based upon age or health risk. Differential premiums combined with the voucher approach would spell disaster for federal employees, no matter what their age or health status.

Why did co-chairmen Bowles and Simpson propose this drastic change? The proposal was presented as a "pilot program" in health care vouchering. The co-chairs planned to use federal employees as guinea pigs to see what happens if you de-link the government's financing of health care from actual health care costs. If they liked what happened to federal employees under the voucher plan, they said they would advocate extending the same approach for Medicare. Following the description of turning FEHBP into a voucher, they say many on the commission wanted to "offer seniors a fixed subsidy, adjusted by geographic area and by individual health risk to purchase health coverage from competing insurers." They went on to say that "if this type of premium support model successfully holds down costs without hindering quality of care in FEHBP," they would apply it to Medicare.

House Budget Committee Chairman Paul Ryan (R-WI) and the House Republicans who voted for his budget did not wait for the FEHBP pilot, and voted to voucherize Medicare. Of course, the voucher plan only holds down costs for the government, shifting the burden to federal workers

or the elderly. Clearly the objective is to reduce government spending and impoverish workers and retirees.

Conclusion

During the three year pay freeze, federal employees' health insurance contributions have grown by more than thirteen percent. The cost to employees of participating in FEHBP continues to rise by more than either the general rate of inflation or the rate of growth of their ability to pay (i.e. cola growth for retirees or pay adjustment rates). While the consumer protections included in Obamacare have allowed all Americans to enjoy some of the positive elements of the FEHBP, federal employees' main benefit has been the extension of coverage to dependents up to age 26. AFGE supports efforts to lower FEHBP's prescription drug prices, but will closely monitor any sense that efforts to do so are part of a voucherization project or would negatively affect the formulary. Finally, AFGE will seek to protect federal employees from the new taxes Obamacare will impose starting in 2018, because they punish enrollees for the failure of OPM to negotiate premiums that are a fair reflection of the benefits contained in FEHBP's plans.

The establishment of an FEHBP Advisory Council, similar to the FSC, FPRAC, or ETAC, would allow representatives of federal employees the opportunity to voice their many concerns about the adequacy of the program to OPM, the federal agency with the responsibility of administering the program fairly.

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**Committee on Oversight and Government Reform
Witness Disclosure Requirement - "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)**

Name: Jacqueline Simon

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

None.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

I am the Public Policy Director of the American Federation of Government Employees, AFL-CIO.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None.

I certify that the above information is true and correct
Signature:

Date:

Mr. FARENTHOLD. Thank you, Ms. Simon. We appreciate your testimony and I certainly do have some questions for you when the time comes.

Pursuant to an agreement with the minority, Mr. Walberg, who has another hearing or something to attend, we are going to go out of the normal order of questioning. Mr. Walberg has quite a few questions, so we have agreed to allow Mr. Walberg 10 minutes for questioning, and then Ms. Norton 10 minutes of questioning, then we will come back to myself and Mr. Gowdy for the usual five minutes of questioning, and any other members who may show up in the meantime.

So at this point I will recognize Mr. Walberg for 10 minutes.

Mr. WALBERG. Well, I thank the chairman. Being subcommittee chairman and my subcommittee going on right now, you understand why I would like to get back as soon as possible, so that they don't realize they can do it better without me.

First, I would like to thank you and I would like to thank Chairman Issa for holding this important hearing. I certainly, had I been here when the witnesses were welcomed, would want to welcome them as well and thank them for appearing across the board.

Today we take a look at the Federal Employee Health Benefits Program and consider changes that can strengthen the program going forward. I have reviewed each of the witnesses' testimony and concluded that the FEHBP has been a valuable and well-administered program, but also one that is seriously hampered in responding to the present challenges and opportunities in the health care marketplace.

Unfortunately, the FEHBP and its administrator, the U.S. Office of Personnel Management, OPM, are hamstrung by a 50-plus-year-old statute which locks OPM into a delivery structure that reflected the health care industry in 1959, but not now. Most reforms, such as those outlined in the President's budget, which was released yesterday, can provide the statutory changes necessary to allow the FEHBP to access the myriad products and services that comprise today's health care marketplace.

The hallmarks of a model health care program are healthy competition, consumer choice, and high-quality care at a reasonable cost. The FEHBP, through most of its existence, has included these vital components. However, due to the lack of authority for OPM to entertain scores of new and different insurance products, the program has stagnated. There are roughly 50 percent fewer carriers participating in the program today than in 1990. Many Federal employees and retirees, depending on where they live, have limited options to choose from. Many of the latest plan designs and innovations in health care management are not available to either OPM, as the administrator of the plan, or Federal employees and retirees as participants in the plan.

For all these reasons, opening up the FEHBP to greater competition and, therefore, greater choice will serve the Federal Government, Federal employees, and retirees and taxpayers well. OPM will retain all of its regulatory and negotiating authority to ensure the prospective new plan entrants will strengthen the overall program and provide greater value to the participants.

I am particularly pleased that there is interest in addressing this issue by both the legislature and the executive branch. As such, Mr. Chairman, I would like to submit for the record OPM's white paper on the subject, as well as a letter from three providers, Aetna, Humana, and UnitedHealthcare.

Mr. FARENTHOLD. Without objection, so ordered.

Mr. WALBERG. Let me ask my first question, Mr. Breskin. Thank you for being here. The assumptions that your commissioned Avalere report made about the introduction of new plans appears, at least to me, wholly speculative. Wouldn't you agree it more likely that new plans would enter in a gradual manner, reflect a variety of health plan types, and that OPM would exercise its authority to ensure that the program operates in the best interests of the Government and its participants?

Mr. BRESKIN. Thank you for the question. My reaction is I don't know how it would play out. I certainly know this: there is quite a bit of interest, at least in one carrier, in getting into the program on a regional basis, and there have been no assurances whatsoever that when they get in on a regional basis that they are planning to serve the interests of all employees, all of the Federal workforce throughout the Country. The point we have raised and the point that the Avalere study is focused on is the concern about cherry-picking, the idea that if there are regional PPOs, that regional PPOs can choose low-cost areas, come in, offer their products at a much lower rate than the national carriers have to because the national carriers are offering a single rate across the Country, and it will cause actually a noncompetitive situation.

It is important, when we talk about competition, not just to talk about the idea of more people starting into the program, but also the effect on competition between having an unlevel playing field between national PPOs and regional PPOs. And the effect that will have is the national PPOs will not be able to offer, because they have a single national rate, a competitive product in those lower cost areas and will eventually be forced to go regional as well. So what you will end up with, actually, is fewer choices for Federal employees, particularly in higher cost areas, and possibly no choices for Federal employees in those high cost areas.

So Avalere's premise, I think it is a valid one, I do not think it is speculative at all; I think it reflects the concerns we have and the concerns about the cherry-picking that would likely occur if someone was able to come in regionally.

Mr. WALBERG. Well, I appreciate that and I think that really establishes and sets the framework of understanding here, and I would continue to say there are a lot of assumptions, especially with OPM and the responsibility that they have shown and how they are undertaken.

I guess I would turn to you, Mr. Foley. Do you agree with both its assumptions, the Avalere report commissioned by Blue Cross Blue Shield, and the conclusions in that report? If not, could you tell us why not?

Mr. FOLEY. No, I don't agree with the assumptions and with the conclusions. To start off, in terms of the cherry-picking concern, OPM has that concern now with the current marketplace, and we manage that issue by negotiating with our local health plans and

with our national health plans to make sure that the local plans are not just choosing areas that are advantageous to them and undercut other health plans. So we do that now in our current market, and we would do that when we have regional PPOs. We would look to make sure that a regional PPO is in the best interest of the enrollees and of the program overall, and does not undercut markets. We would make sure that they are responsible programs in that regard.

The Avalere study assumes a very high rate of switching of enrollees based, apparently, on price. So they have elasticity assumptions that don't jive with our current experience or experience over the past 50 years in terms of how employees and retirees respond to price signals when the FEHB Program.

Choosing a health plan is a complex decision. Often it is about the providers that you have or the brand name of the insurer, and a lot of other factors. So price is only one factor. So the elasticity assumptions I just couldn't agree with.

Mr. WALBERG. Well, if you could go into a little more detail in explaining how the agency would evaluate and accept new plan types in the program.

Mr. FOLEY. Sure. We would look to, first of all, our normal process, where a health plan submits an application, and often it is the case that a new health plan requires two or three tries before they actually are accepted in the program because we have concerns about customer service or the benefits that are offered, or some of the competitive concerns that have been raised earlier. So all of those things would enter into play, so it might take a period of time before a new entrant would actually come into the market.

When they do come into the market, we would look to make sure that the region that is described is several contiguous States, that doesn't pick any one market, doesn't undercut in any one market, but is a blend of markets so that it doesn't have the effect of some of the concerns that have been raised to date. We would go through our normal process in terms of making sure that the plan is financially sound, that it has good customer service, and all the other criteria that we apply normally to health plans would be applied to those plans.

So we view this as an extension and an expansion of how we look at new entrants into the FEHB Program now.

Mr. WALBERG. Okay, thank you.

Mr. Breskin, just to be clear, are you telling the committee today that Blue Cross Blue Shield would withdraw its participation as a service benefit plan if Congress gave OPM the authority to accept a broad range of new health plan types?

Mr. BRESKIN. No, I am not.

Mr. WALBERG. Well, the report seems to indicate that.

Mr. BRESKIN. Well, let me make things clear. First of all, our 53 year association in the FEHBP, I think, speaks for itself. It certainly speaks to our commitment to this program. We have been in it through thick and thin. We got down to a single day of reserve and we figured out a way to stay in the program back in 1982. So we are certainly not suggesting exiting. What we are suggesting, however, is that if we are put in a position where we cannot compete on a national basis with a national PPO in a competitive way,

we would have no other choice but to continue our participation in the FEHBP in a way that would allow us to be competitive, which would have to be regional.

A perfect analogy is on the Medicare Advantage Program, where regional PPOs were originally started in the Medicare Advantage Program and, in fact, back in 2003 there was an attempt to try to put in a national PPO product or national PPO products in the Medicare Advantage Program and, in fact, an incentive of 3 percent was given to any carrier that was willing to offer a national PPO product; and nobody did it. Nobody is doing it at this point, and the reason is you can't have two different sets of rules.

So to answer your question, no, we are committed to this program for the long haul. But we obviously can't be put in a position where we can't compete in a position where we can't compete on a level playing field, and we would have to find that level playing field and compete in that way.

Mr. WALBERG. If I could ask one more question.

Mr. FARENTHOLD. Without objection.

Mr. WALBERG. Mr. Foley, if no changes are made to the structure of the program, where do you see the FEHBP in 5 years, 10 years, 20 years?

Mr. FOLEY. Sure. As we look at it right now, the FEHB, if you look at it as a marketplace, is more concentrated than the commercial marketplace overall, so without changes, without additional authorities, we see a continuation of that concentration. And our concern is that that undercuts some of the competition that exists in the program and the choice of health plans. So it is difficult to say exactly where it will be 5, 10 years from now, but we have seen a continuing trend from the mid-1980s to a very high concentrated market, more highly concentrated than insurance markets commercially, and we see a continuation of that trend and the problems that are associated with it.

Mr. WALBERG. Less effective, less of an ability to provide comprehensive coverage, new plans, new programs, new ideas?

Mr. FOLEY. Yes.

Mr. WALBERG. Thank you.

Mr. Chairman, thank you for your efforts.

Mr. FARENTHOLD. Thank you, Mr. Walberg. We will let you get back to your subcommittee as well.

We will now recognize the gentlelady from the District of Columbia for 12 minutes.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Foley, my great problem with government has generally been that it doesn't innovate, so I am always open to innovation in government. I find I can't bear how hard it is to change one little thing in government. But I have to tell you the burden is really on you, especially when you use the word modernize when it comes to FEHB fix. Essentially what you are proposing to do is to fix what everybody believes, I think even you at this table do not believe, is broken. The chairman, the big chairman here, indicated, I think, quite factually that FEHBP has been a model for what this Administration is trying to do with their Affordable Health Care Act.

You have a lot of chutzpah because you have in place the model and all we understand about what is happening with this Adminis-

tration with the Affordable Health Care Act comes close to chaos. So at least you have one model that you can look to. Of course, it should be looked to as a model for what to do and what not to do. And as you do the Affordable Health Act, you could learn from that experience, because that is a true nationwide pool.

So, in looking at your proposal, my concern would be capsulized in one word: price. You know, the word competition means nothing unless you are going to reduce the price for the average person on FEHBP. Remember, in most parts of the world there is only one payor; and I guess you figured out why. And that is what I want to first get back to. The reason that even Singapore has one payor is that the first rule of insurance is get the biggest pool you can. That is what you have managed to do. Moreover, you have the Post Office, you have members of Congress and all this great, big pool, the biggest pool in the Country. Do you think that pool, the size of that pool tells us anything about OPM's success in keeping premium costs lower than the private sector?

Mr. FOLEY. First of all, thank you for your description of the program; it is a model program and it is one that we are proposing to modernize, but really these are changes that will occur over periods of years and really are in the spirit of the basic model, which is a competitive model and one that is based on choice. The large pool that we have, the 8.2 million covered lives, is an advantage to the program.

Ms. NORTON. If you had a smaller pool, the way the average employer apparently has, wouldn't that mean that the price for the average Federal worker would go up?

Mr. FOLEY. It would decrease our negotiating power, and I think, with reference to the proposal about contracting authority, we are proposing to use that size, that large pool to negotiate lower prices in the pharmacy area.

Ms. NORTON. On the one hand you are trying to use that large pool, in the pharmacy area; in the other hand, with respect to the rest of health care, you are breaking up the pool.

Mr. FOLEY. Well, the reason is different, and there are two different markets. So you have a pharmacy benefit manager share market, which has a few large players that are capable of handling the business that we would bring to them. You do not have that same situation in the health insurance base; you have many local plans, you have many national plans. And our strategy to increase competition in that space makes a lot of sense to us, given the market that is there.

Ms. NORTON. So you think the regional pools, for example, which are a smaller number of employees?

Mr. FOLEY. We are not proposing regional pools. The regional plans would participate in the overall FEHB; they would be part of the same pool. So we are not carving up the pool in any way. And, in and of itself, that should decrease price, it shouldn't increase price.

Ms. NORTON. Well, wait a minute. The point is price. What is the point, then? If these pools do not lower the price, then why not stick with the pool that you have, since you already have the price coming down?

Mr. FOLEY. Regional plans, not pools, regional plans will increase competition in the regions that they are serving, and we believe that that will lower price because it will lead to more competition; and that is what we are seeing in the commercial market, so we would like to bring that benefit to the FEHB market.

Ms. NORTON. So you are telling me that the pool would not be as Mr. Breskin says when he keeps his OPM cherry-picking; you are saying do not bother, we can manage anything, where they would cherry-pick the low-cost regions and charge a premium that reflects that region, shifting some costs to the larger FEHBP pool? I do not see how that can fail to happen.

Mr. FOLEY. Again, our actuaries have looked at this in the way that the Avalere people looked at the circumstances, and they estimate modest savings for this over a 10-year window, so there are obviously different assumptions being used about the efficiency of the regional plan, about the propensity for Federal employees and retirees to switch plans.

Ms. NORTON. Well, let's get to switching plans. First of all, I think you have an obligation, as you come before us, to tell the members of Congress and their staffs who are sitting here is our Federal employees going to be on the exchange, so that all of this is essentially moot? I mean, we were told, when we passed the Affordable Health Care Act, that everyone would "go on the exchange." What does that mean in terms of this? First of all, what does that mean? Are Federal employees no longer going to be a part of their own plan, as, I might add, other employers would continue to have, but are all a part of the exchange and therefore would go on the exchange to find the best deal, rather than be part of something called the FEHBP? I mean, I am confused as to where all of this starts in the first place, and here you are talking about changing it. No one has told members of Congress whether they are going to be part of the FEHBP or whether they should all be prepared to go into the exchange.

Mr. FOLEY. Federal employees and retirees have employer-sponsored coverage, it is credible coverage, and they will not be going on exchanges. There is a provision, as you have referenced, that affects members of Congress and their staff. That is something that we are writing regulation on.

Ms. NORTON. Well, let's straighten that out. Are you saying to me that members of Congress and their staff will no longer be a part of the FEHBP?

Mr. FOLEY. That is, right now, a subject of regulation. It would be inappropriate for me to comment.

Ms. NORTON. So we are certainly losing part of that pool.

Let me go on. How would you manage what would otherwise be seen to be to the advantage of a regional plan to go to regions, lower cost regions, rather than have what every other employer has? Every other employer in the United States will have one or two, of course. We have this wonderful galaxy. How would you manage to keep the cherry-picking from transferring costs to the larger pool that is not in these regional pools?

Mr. FOLEY. We would do it similar to the way we do it with local plans who come in and propose areas, and if we feel that the local plan is just picking the good risk or picking an area to undercut

a competitor, and not in the best interest of enrollees and of the program overall, we negotiate a larger region or a different region. An analogy might be in the Pacific Northwest. If a regional plan came in and said that they wanted to offer products in Washington and Oregon, and we needed another plan in Alaska, we would negotiate that they take Alaska as well. And that is the power that we have as a negotiator and that is, I think, one of the strengths of this model, is our ability to act on behalf of enrollees, and I think that is why we have experienced the success we have over the 50 years we have had the program.

Ms. NORTON. I will leave that on the table and ask Mr. Breskin, in fact, I will ask Mr. Foley, perhaps both of you can explain this. This rendition that Mr. Choate's testimony gives of how the FEHBP started with many more plans and over the decades these plans dropped out; some were grandfathered in, most of them dropped out. Even the health maintenance organization dropped out. So part of the reason why one or two plans, and the first plan that has 60 percent, which on its face doesn't look very competitive, part of the reason may be that these others dropped out. Well, if you have been managing so well, how come all of these plans dropped out? Why didn't you keep a competitive FEHBP?

Mr. FOLEY. We have over 230 plan options available.

Ms. NORTON. No, my question is not how many do you have now. My question is you grandfathered in plans, more than 400 participated in the program. It looks like, by attrition, some plans have gotten dominance, rather than by competition. Why didn't FEHBP manage to have more national plans in the program so that it would not be caught with a model that now gives one carrier 60 percent of the pool?

Mr. FOLEY. Ms. Norton, our statute limits the number of plan types that we can have.

Ms. NORTON. So when did the others drop out?

Mr. FOLEY. The dropping out has occurred mainly among local HMOs. If you recall, in the 1990s there was a large and robust HMO market.

Ms. NORTON. Did 400 plans initially participate in government-wide and nationwide plans?

Mr. FOLEY. No. That 400 figure is probably sort of a high point, again, when there was a lot of HMO presence in the 1990s; and the FEHBP reflects a commercial market, to a large degree, so if there are a lot of HMOs locally, they tend to join the FEHB program. So we have 230 plan options and we have increased each of the last two years the number of plan options, and we work very hard to increase those options to increase competition. So we are doing what we can administratively, but the law restricts us in terms of adding national plans or adding regional plans, for that matter.

Ms. NORTON. Thank you, Mr. Chairman. I see my time is up.

Mr. FARENTHOLD. Thank you very much, Ms. Holmes. I was going to go next, but I do see the chairman of the full committee is here, and out of deference to the value of his time, I will go ahead and recognize him as our next majority member for five minutes.

Mr. ISSA. I will gladly pay you Tuesday for a hamburger today. I owe you, chairman.

Mr. FOLEY, I want to be for the President's budget in this area, but let us go through a few things. First of all, standing behind an obsolete law is a bad excuse for why you can or can't do anything. Wouldn't you agree that you are in the business of saying to Congress, change the law? I have the opportunity to be in the business of changing laws. So, first of all, would you say that it is time to lift the cap on this four different—in other words, eliminate many of the brush that have become obsolete in the 1960 law?

Mr. FOLEY. We think it is appropriate to add additional plan types and to allow the FEHBP to—

Mr. ISSA. No, no, I understand what you are proposing doing, but I just want to get to the core of it. Let's scrap some of the limitations of the original law as a premise going forward. Aetna dropped out I think before I got in Congress, okay? It is time to say that is over with.

Now, wouldn't you agree that the legacy of my own postal carrier and other organizational ones does, to a certain extent, already divide up the whole process, doesn't it? In other words, the postmaster has proposed leaving your system because he says he can save money. I know your organization doesn't agree, but you have two very large groups. As a matter of fact, he represents your largest single element, current and retired postal workers, and he says scrap it, I am leaving you and I am going to go bid for one big entity. Isn't that true?

Mr. FOLEY. Yes, he has proposed—

Mr. ISSA. Okay, so one of the processes should be for us to create a situation in which numbers-based, numbers-and service-based competitive responses should be able to be the primary determinant of changes in this program, isn't that true?

Mr. FOLEY. Yes, we believe that that increases choice.

Mr. ISSA. Because Delegate Norton I think did a good job of questioning whether cherry-picking regions would make you save money in one region for which you would like to score, but then the national programs would have a tendency to say, in the next rebid, you have cherry-picked a lot of things, it is going to change how we work nationally, isn't that true? Inevitably that you can't score as you typically do, you score that there will be no change at the two dominant carriers in front of you, and then you take the savings. That is just the way savings tends to get scored, isn't it?

Mr. FOLEY. No, we don't agree.

Mr. ISSA. But do you score an increase from Blue Cross as a result of going to regional cherry-picking? Because you have asked for the ability not to regionally bid come one, come all. You have asked for the ability to cherry-pick when it works to your benefit, isn't that true?

Mr. FOLEY. No. Our actuaries, as I said, have modeled this and they come up with a modest savings. This is an incremental change to the program.

Mr. ISSA. I appreciate it is an incremental change, but I do believe that Delegate Norton is right that we have to be very cautious about—I have no problem with the regions, I really don't, but I think it has to be numbers-based.

Another area is although you call for domestic partner benefits, and I share with you that the Government has to be competitive with the private sector, and if that includes those benefits, so be it. Now, you are limiting it to gay couples only, same sex couples; you are not allowing domestic partner benefits for heterosexual couples, which makes the score smaller, but it doesn't make you equal to the private sector, does it? In other words, the private sector is recognizing a domestic benefit of either gender, very often. So you are only doing part of it there, is that correct?

Mr. FOLEY. No, that is not correct. The President's budget reflects the inclusion of opposite sex and same sex couples.

Mr. ISSA. Okay. Then the \$240 million previous CBO would be dwarfed; you would probably in the multi-billion dollars per year, isn't that true?

Mr. FOLEY. It is approximately \$600 million over 10 years to add that benefit.

Mr. ISSA. I hear you. I find that is believable as the estimates what Obama Care was going to cost. So it is now doubled what was estimated.

You also want to give these benefits to retirees, isn't that true, in other words, add it to their entitlement?

Mr. FOLEY. To new retirees, yes.

Mr. ISSA. To new retirees. Not to anyone retired as of today?

Mr. FOLEY. That is the way we have modeled the benefit.

Mr. ISSA. Okay. I want to make sure that was scored that way, because we all understand that the incentive to recruit and retain a workforce has nothing to do with those already retired.

I would quickly like to go a couple more items. Obama Care included a rather esoteric provision, which is the men and women on this dais, the men and women behind there are currently going to lose their participation in the Federal Employee Health Care Benefit as of the end of this year, right?

Mr. FOLEY. We are in the process of writing regulations in response to the law. I can't comment, or it would be inappropriate for me to comment.

Mr. ISSA. Oh, no, it is very appropriate and you will comment, if you don't mind. It is important not that you issue an opinion on the law at this point, although we have had discussions between OPM on what it might mean or not mean. Is there any economic benefit to pulling us out and putting us into exchanges not yet formed from an administrative overhead? In other words, somebody still has to administer these people going into Maryland, D.C., and Virginia plans, and some Pennsylvania; us going into plans in all 50 States in the Union, and our district offices going into plans in all 50 States in the Union, which would be regional exchanges. Is there any benefit to that administratively, or is that a burdensome cost, by definition, to have a few thousand people pulled out of the plan and then administered all over the Country, to the Federal Government, who has to absorb this overhead?

Mr. FOLEY. I am not prepared to comment on that.

Mr. ISSA. I would request that you go back and have OPM comment on it, because the Speaker just went through sequestration; everyone went through an 8 to 10 percent cut, depending upon which part of the budgets they were cutting. The fact is the admin-

istrative costs would have to be borne within legislative or executive costs.

Mr. Chairman, I would ask to have just an additional one minute.

Mr. FARENTHOLD. Without objection.

Mr. ISSA. Thank you.

Again, I said I want to be with you, and I really do. The proposal itself inherently is good. Let's open up the process. Let's recognize that artificial historic definitions need to be gone. I do believe that although I am willing to support a law change that would create a regional opportunity, and certainly a law change that would create a greater opportunity for nationals to come in, I believe that, as you go back today with the proposals from us, that you need to answer the question of are you willing to go through a process that says you can only do any of these if there is a finding scored by CBO or found by GAO to be an actual savings. In other words, let's not agree to a change that you then go through and based on a prediction that may not be true. Are you willing to take that back today to the Administration? Because I want to work with you. I want to open up and change very aggressively the law, but only to the extent that Ms. Norton and I can come to an agreement that we have been prudent in making sure that the proof is in the pudding before we begin significant changes with incumbent carriers.

Mr. FOLEY. We are asking for the authority to contract with regional plan types. We wouldn't do that if it weren't in the best interest of the program. So we are approaching this in a very deliberate and incremental way. And as I described earlier, we would go through all the normal processes in terms of vetting the proposal and the insurers.

Mr. ISSA. Mr. Foley, I am exceeding even my borrowed time. History has been please trust us, we will be prudent. The history in this committee is that ain't so. So in rewriting the law to give that kind of authority, I must admit if the Administration, Vice President and the President, want to have, and obviously OPM, want to have our buy-in, and you will have it, it is going to have to be based not on we give you the authority, trust us, but based on a much more limited, perhaps a pilot program, certainly a bidding process that is open to review and independent third party.

I must admit that today, discovering that Obama Care is going to cost us double, discovering that most States don't want to form exchanges, and that, contrary to the law as passed, we are going to be subsidizing non-State exchanges, which was clearly prohibited in the law, that puts us in a situation in which we cannot deal with 8 million Americans, current and retired, in a way that would endanger the cost and benefit to those individuals.

So I opened with I want to be with you. I strongly want to be with you. I believe in competition. I share with Delegate Norton and Mr. Walberg and others, the chairman, that we want to be with you, but we want to work on this not from a budget proposal, but from a change in law proposal, and I look forward to doing that.

Mr. Chairman, ranking member, I appreciate the excessive indulgence. I yield back.

Mr. FARENTHOLD. Thank you very much.

We now have the member of the full committee, Mr. Connolly, who is requesting to participate. Without objection, I will allow Mr. Connolly to participate and recognize him for five minutes.

Mr. CONNOLLY. Thank you, Mr. Chairman. And, before my five minutes, I just want to thank you for your graciousness. Because of the limitation of the space on the subcommittee, I could not join the subcommittee. I was on it last year. But I do represent the third largest number of Federal employees, so I have a direct and vital interest in the subject, and I thank you so much.

Mr. FARENTHOLD. You are welcome. Any time.

Mr. CONNOLLY. As well as the chairman of the full committee and, of course, my friend and ranking member, Eleanor Holmes Norton. And I would ask my five minutes start over. That was all gracious, thank you.

[Laughter.]

Mr. ISSA. Mr. Chairman, could you give him an extra minute or two to say thank you, but we will start over?

Mr. CONNOLLY. I thank my colleague.

I wanted, Mr. Foley, to focus on a proposal that came out of the postmaster general, which was to pull the Postal Service employees out of FEHBP.

In fact, Mr. Chairman, I would ask unanimous consent to insert in the record the testimony of Walt Francis before this committee last year to refresh our memories as to his analysis of the consequences of such an action.

Mr. FARENTHOLD. Without objection.

Mr. CONNOLLY. Without objection. I thank the chair.

Mr. Foley, have you all looked at the possible ramifications of such a move?

Mr. FOLEY. Yes, we have, and we have discussed with the Postal Service their proposals. Essentially, the proposal to pull out postal employees and retirees would amount to about a quarter of the population that is in the program right now. We believe, in aggregate, for the program as a whole, it doesn't have a very significant price impact in the sense of disrupting the market; however, on an individual plan basis it has a very significant impact, looking at the 23 plans that have 50 percent or more of their enrollees that are postal employees, retirees. That would have a significant impact on several of those plans. So overall, as I said, the impact is not great, but there are also unintended consequences.

Mr. CONNOLLY. Well, you say it is not great. We had testimony when we had that hearing that, in aggregate, to maintain current benefits with the diminished pool, short pool of remaining Federal employees could cost \$1 billion more annually. Does that ring a bell with you?

Mr. FOLEY. I don't recall a specific figure.

Mr. CONNOLLY. I would ask, then, that you get back to us for the record as to whether your analysis concurs with that. It also said cost for retirees could rise rather substantially for a retired couple.

Mr. FOLEY. Right. And that really is dependent on the plan that they are in, as I mentioned.

Mr. CONNOLLY. On the plan.

Mr. FOLEY. Certain plans are very affected by this change and some, quite frankly, wouldn't stay in business, I don't think, and

some would experience increases; and it really depends on the mix of enrollees.

Mr. CONNOLLY. In fact, we also had some testimony that some widows, for example, might not be covered by Medicare, given the employment of their spouse, and they would have to find a way to try to compensate for that if the Postal Service were to pull out of FEHBP.

There is also, is there not, a question of viability of some of the existing postal plans? For example, the mail handlers standard plan has 150,000 participants, only 10,000 of whom are postal employees. So if you were to separate the two, in theory, that plan could go away because it is not viable with a risk pool of 10,000 remaining. Would that be a fair statement?

Mr. FOLEY. Well, if those employees were pulled out and part of a postal plan of whatever formation that would be, the remainder in the FEHB may or may not be a viable plan option. I guess our concern is much greater about the plans that have a much higher concentration of postal employees and retirees.

Mr. CONNOLLY. I just think we have to pay attention to this proposal and we have to, without emotion, without bias, hopefully, we need honest analytical work. What are the consequences both for the postal employees who are being pulled out and for the remaining FEHB programs? Ms. Norton was correctly citing some concerns she has about competitiveness and entry and the number of options available. I want to know, and I am sure my colleagues do, could this precipitative move in fact have an unintended consequence of actually killing some options for all employees, maybe with the best of intentions?

And the other thing I am really interested in is, at the end of the day, net, does it in fact save money.

My final point, Mr. Chairman, I was so glad to hear of the concern of the chairman of the full committee about members of Congress and their staff being pulled out of the FEHBP, and the fact that that actually could have attendant unforeseen administrative costs, and I certainly agree with him and would remind him that that was a Republican amendment to Obama Care in the Senate led by Senator Chuck Grassley of Iowa. I just want to get that in the record.

Thank you, Mr. Chairman.

Mr. FARENTHOLD. Thank you.

At long last it is my turn to ask some questions. I will probably go down in history as one of the most generous chairman with time.

Mr. CONNOLLY. You have my vote.

Mr. FARENTHOLD. So I am going to start out with Mr. Foley. Mr. Foley, I think we can kind of summarize your proposals in three big areas that we are talking about right now: that is, opening up the program to more regionalized care to increase competition; you guys taking over and doing prescription drugs in-house; and then, finally, adding in some alternative coverages, be it the "plus one" coverage, as well as some incentives for wellness. We are going to kind of focus on those issues broadly.

My first question, let's talk a little bit about the regions. It has been mentioned that cherry-picking, I understand in the much less

stressful environment of South Texas than Washington, D.C., we would probably get some lower rates. The chairman pointed out we really don't have a firm score on doing that yet, is that correct?

Mr. FOLEY. We have estimated that the expanding the plan types would save approximately \$240 million over 10 years.

Mr. FARENTHOLD. I am going to go to Mr. Breskin, who has the vast majority. You think that number is reasonable and will hold?

Mr. BRESKIN. I don't, and I think it doesn't take into account what we have described as the phenomena that will likely occur. Of course, the Avalere study indicated it would be more like \$6 billion increase over the 10-year period.

Mr. FARENTHOLD. All right. I would imagine Mr. Choate is going to have a different opinion of that as well.

Mr. CHOATE. Historically, obviously, as we have seen competition increase, we are not endorsing one specific type of plan designed to be added; we are simply asking for OPM to have the capability of being able to offer local, national, regional, any type of plan that any commercial market would be able to offer today, and at their discretion be able to offer those.

Mr. FARENTHOLD. Okay. Let's get back to Mr. Foley here. So you guys want the power to do your own prescription drug program. Would you cover all prescription drugs, are you guys going to cherry-pick, or how are you going to choose which ones you do or don't cover yourself, and then do you dump the dogs to Mr. Merritt?

Mr. FOLEY. The way we would approach the pharmacy benefit manager option would be that we would first look at it and look at the market and the kinds of bids we get in. We are not entering into this if it is not good value for enrollees and for the program as a whole. We think it is good value; otherwise, we wouldn't propose that we go down this path.

Mr. FARENTHOLD. So you are asking us to trust you with no numbers.

Mr. FOLEY. No. We estimate that it would save \$1.6 billion in mandatory savings over a 10-year period.

Mr. FARENTHOLD. But just to get back to my original question, you all aren't talking about taking over all of them, just the more common drugs that you see the highest use of?

Mr. FOLEY. We would see that we would, pharmacy is a complex market and we would see that we would want to look at specialty drugs, for example, separately and consider whether that makes sense to have as part of a single PBM purchase; and we would want to make sure that the benefit design is consistent with the plans that we have, being able to transmit information in real-time to have as good or better coordination with the medical benefit.

Mr. FARENTHOLD. Now, having dealt with Mr. Merritt's group in trying to get some specialty drugs that my doctor wants my wife and myself to be on, I can guarantee you are doing a good job trying to save the Government money. There are an awful lot of hoops that we have to jump through to do that. Would cherry-picking off some of the prescriptions from your program run up your costs significantly? How would it affect your members?

Mr. MERRITT. Well, it depends. I mean, we don't believe that price controls generally save money, they more shift cost to other programs. And one challenge would be if there is direct negotiation

in the form of price controls, that most likely that would probably shift higher costs into the exchange and other programs. When you add 8 million lives into that program, probably the response a manufacturer is going to have are to raise prices across the board. So we see a number of ways you can save money without that, and, as with most employers, there is a lot more you can do to save money as people get more comfortable, in terms of preferred pharmacy networks, more generic utilization, and things like that.

Mr. FARENTHOLD. A little bit off the subject, but just something of personal interest to me, having grown up at the soda fountain of my pharmacy, I am really kind of seeing a shift pushing to the big Walgreens, CVSes, and a lot of pressure on those small family-owned pharmacies. What can we do about that, or is that just an inevitable force of the marketplace?

Mr. MERRITT. Well, some of that is a little bit of an urban myth in the sense that small pharmacies continue to grow; they are very profitable. As you were saying, let's see the score on how much is really going on. The reality is that PBMs are there in the marketplace to save money for consumers and employers and government programs, and some folks would rather we just go away, like it was 20 years ago, but people can't afford to do that. They want better benefits and, frankly, we move a lot of business to the most efficient drugstores, those who offer the best prices, and certainly those in rural areas where there aren't many options have a lot of negotiating power and do very well.

Mr. FARENTHOLD. All right.

Ms. Norton, I gave everybody else a little bit of time. Would you object to me taking another minute and a half?

Ms. NORTON. Unanimously.

Mr. FARENTHOLD. All right, thank you.

I wanted to get to Ms. Simon for a minute. Now, you haven't gotten a lot of questions, but you raised some real concerns on the part of the Government workforce. You pointed out that there might be a problem with bringing in a wellness program, and to me that just seems counterintuitive. Why would you not want to have incentives for the workers that you represent to, for instance, quit smoking?

Ms. SIMON. Well, part of the Affordable Care Act already provides coverage for smoking cessation; it was a requirement. But we, of course, want every incentive for Federal employees to be able to pursue wellness. What we don't want is price discrimination against those who have the misfortune of being ill or obese.

Mr. FARENTHOLD. Well, isn't there a difference between the misfortune of being ill and choosing to smoke? I have the misfortune of being overweight. I might be subject to one of those.

Ms. SIMON. Well, in my written testimony I suggest an alternative, which is what AFGE does as an employer.

Mr. FARENTHOLD. Incentive?

Ms. SIMON. It doesn't penalize those who have an illness or who are older but provides money for fitness classes and gym membership, and that sort of thing.

Mr. FARENTHOLD. And you also expressed a little bit of concern about a "plus one" program. To me, this seems like since the employees pick up a share of their health care, giving those married

couples, or in this case we are even talking about expanding it into same sex couples of opposite sex domestic partners. To me, this seems like a cost savings for some of your members that mirrors what is almost universally done in the private sector.

Ms. SIMON. Well, thank you for bringing that up, Chairman Farenthold. Here is the awkward thing, and this hearing has felt rather gratifying to me because I am listening to the members of the subcommittee ask all the same questions we have been trying to ask of OPM, and we haven't been able to get any answers beyond trust us, either. For many, many years, as long as I have been involved with advocating for Federal employees regarding FEHBP, OPM's actuaries have told us that "self plus one" would be actually more expensive than a family, families of more than two persons.

And now, suddenly, we are getting different numbers, but we are only getting the bottom line, and we have not been able to see what kinds of assumptions OPM has used in its calculations for saying this will cost this or this will cost that; this will save this amount of money. We really do want to know exactly how they arrived at their estimates for changes in premiums to family coverage, what the premiums would be for "self plus one," and we have been denied that information.

We can't really say, one way or another, whether this would be good, who would be the winners and who would be the losers, until we see how those numbers were constructed.

Mr. FARENTHOLD. All right. Well, thank you very much.

Did anybody on this side have any additional questions?

Ms. NORTON. Just for the record, Mr. Chairman, first, there are a couple questions from Representative Danny Davis that he would like answered for the record. That is number one.

Mr. FARENTHOLD. And he will get this into the record. We will send this to you guys, and if you would respond in writing, it would be greatly appreciated.

Ms. NORTON. And I wonder if Mr. Foley would respond in writing as well to the suggestion of Ms. Simon for the AFGÉ based on what the Federal Government does in other areas. Apparently in the thrift savings bond area we have a thrift advisory council. Even with salaries we have a federal salary council.

Mr. Foley, what bothers me most about your proposal is that there is no constituent. Those who use the plan apparently have not had an opportunity to look at it and to advise you on it. Now, their views are not determinative, but they are part of the market. I would like to have Mr. Foley respond to the chairman on whether he believes that the model from these other areas would also perhaps advise an employee advisory council for this area as well.

Mr. FARENTHOLD. And I will just speak from personal experience in listening to folks, in our case it is constituents, but in your case it would be customers, is always a valuable experience. I would join with Ms. Norton in encouraging you to take a look at that.

Ms. NORTON. And one more thing for the record. Mr. Foley indicated what the savings would be for the negotiations for pharmaceuticals. I think he said \$1.6 billion over a 10-year period. But he never gave us what the savings would be if we went to the larger plan with regional plans he is proposing. So I would ask that you

provide for the chairman what the marginal savings, I believe that is your word, would be if we switched to the plan that OPM is recommending today.

Mr. FARENTHOLD. All right, with that, I would like to thank the witnesses and the members of the panel for participating today.

The subcommittee will stand adjourned.

[Whereupon, at 11:35 a.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Committee on Oversight and Government Reform
Subcommittee on Federal Workforce, U.S. Postal Service, and the Census
Opening Statement of Chairman Blake Farenthold
“The Federal Employees Health Benefits Program:
Is it a Good Value for Federal Employees?”
April 11, 2013

The federal government provides health insurance coverage for more than 8 million federal workers, retirees, and their family members through health plans participating in the Federal Employees Health Benefits Program (FEHBP), the largest employer-based health insurance program in the country. Since 1960, the FEHBP has offered federal participants a choice of multiple health plans through private health insurers – a hallmark of the program.

Examining the value of the FEHBP is a balance of many factors, including provider choice, coverage, and cost. In these tough times, we must ensure OPM is providing affordable benefits to FEHBP participants in a cost-effective manner. Effective competition is critical, with OPM leveraging enrollees’ purchasing power to reduce costs and obtain greater value for federal workers and their families, as well as for the federal government as the employer. OPM must manage today for future projected increases in the cost and utilization of health care services.

A recent study by the Congressional Budget Office found that on average, the cost of benefits, including health insurance, was 48 percent higher for federal civilian workers than for their private sector peers. Put another way, the federal government pays on average \$6 more per hour per employee for fringe benefits. The value of the FEHBP increases as federal workers near retirement, since they retain coverage in retirement with no change in premium.

Average health insurance premiums continue to rise, 5.78 percent within the FEHBP over the last five years. Growing premiums result in higher costs to the federal worker as well as the taxpayer, who funds approximately 70 percent of the insurance premium on behalf of the federal government.

The President’s budget proposes several initiatives intended to improve the value of the FEHBP. This hearing provides Committee members the opportunity to determine the impact these and other proposals would have on provider choice, coverage, and cost. I remain open to proposals that will lower cost and improve the value of the FEHBP without unnecessarily restricting consumer choice, and thank our witnesses for their willingness to testify.

DARRELL E. ISSA, CALIFORNIA
CHAIRMAN

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Opening Statement
Rep. Eleanor Holmes Norton

Subcommittee on Federal Workforce, U.S. Postal Service and the Census
Hearing on "The Federal Employees Health Benefits Program: Is It a Good Value for
Federal Employees"

April 11, 2013

Thank you, Chairman Farenthold, for bringing together these witnesses to discuss the Federal Employees Health Benefits Program (FEHBP), including the Administration's proposals for modernizing the program.

FEHBP is the largest employer-sponsored health insurance program in the country, covering 8 million individuals. Last year, it provided close to \$45 billion in benefits to federal employees, retirees and their families. Since its creation in 1959, FEHBP has been regarded as a model for health insurance reform and private and public health insurance programs, such as Medicare. It has also been looked at as a way to expand insurance coverage to the non-federal community, such as small business employees or the uninsured.

FEHBP has generally performed as well or better than large private employers. Industry experts have rated the benefits offered to enrollees as competitive with other employers. Premium increases are consistently below those of other large employers. For example, according to Barclay's U.S. Healthcare, over the last decade, FEHBP premiums have increased 7.7% annually compared to 9.3% in the commercial market. In 2012, FEHBP premiums increased by 3.8%, while industry surveys show that private sector plans rose by an average of 8.1%.

However, this does not mean that FEHBP is a perfect program or that it does not need improvement. For, example, coverage for same-sex domestic partners while prevalent in the private sector is currently not included in FEHBP. Prescription drug costs also are a concern. One-third or \$15 billion of the total FEHBP annual costs were for prescription drugs. And, OPM estimates that for 2013, 25% of that or about \$4 billion will be spent on specialty drugs. That is a significant increase over 2009, when specialty drugs accounted for only 10% of total drug spending.

This hearing provides stakeholders and members with the chance to discuss the pros and cons of the FEHBP proposals included in President Obama's fiscal year 2014 budget that was just issued.

While I share the Administration's view that the 50 plus year old FEHBP can be modernized and improved, I believe that we should approach this cautiously and deliberately to ensure that any changes would improve the health of our federal employees and retirees and keep premiums and costs low and affordable.

This is especially important at this juncture because federal employees are already experiencing pay and benefit cuts and cannot afford to take more hits. Federal employees are working under a 3 year pay freeze, new employees are forced to pay more for their retirement contributions than existing employees, and some federal workers face furloughs. On top of that, the President has recommended in his budget that federal workers contribute an additional 1.2% more for their pensions and accept a reduced COLA for their annuities based on the chained CPI formula.

Thank you, Chairman. I appreciate this opportunity to examine the merits of the Administration's proposals and look forward to hearing from our panel members.

Contact: Jennifer Hoffman, Press Secretary, (202) 226-5181.

Health Plan Competition in the FEHB Program

The purpose of this paper is to describe the current competitive environment among health plans in the Federal Employees Health Benefits (FEHB) program and the impact of expanding the types of plans that are eligible to participate in the program.

Background

The FEHB program provides health insurance coverage for approximately 8 million people (federal employees, annuitants, and their families) through private health insurance plans. FEHB operates as a type of health insurance exchange where health plans propose a set of benefits and premiums, which are negotiated with the Office of Personnel Management. The total cost of the program in 2011 was \$43 billion, of which approximately 70 percent was paid by the government and 30 percent by enrollees.

The premise underlying the FEHB program since its inception in 1959 is that competition among health plans will result in lower prices and better value for the government and enrollees. Generally, the model has performed well: the benefits offered to enrollees have been rated as competitive with other employers by external analysts¹ and annual premium increases are at or below those of other large employers (though considerably above CPI).

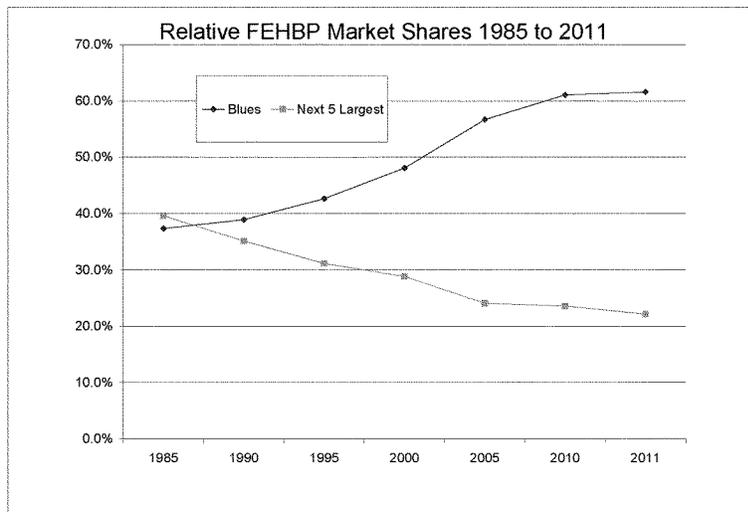
While the FEHB model has withstood the test of time and influenced the direction of health reform, the competitive environment is not as robust as it could be. The health insurance market has changed dramatically over the last fifty years, but, due to the way that Title V is constructed, the FEHB program lacks the flexibility to adjust in response to the changing market. The following sections provide evidence of problems, specifically the growing concentration of the FEHB market in a dominant insurer (Blue Cross Blue Shield) and the departure or diminished role of certain health plans in the FEHB market.

Growing Concentration in the FEHB Market

Blue Cross Blue Shield (BCBS) has been a major player in the FEHB program since it began. BCBS fills the role of “service benefit plan” (as defined in Title 5, Section 8903(1)), one of four plan types described in the original legislation. As the service benefit plan, BCBS offers two government-wide benefit options (Standard and Basic). There are currently 2,521,816 contract holders with BCBS; 1,810,849 with BCBS Standard and 710,967 with BCBS Basic. Combined, these two benefit options cover 61.6% of the FEHB market.

The chart below shows the evolution of BCBS’s market dominance. In 1987, BCBS covered approximately 37% of FEHB enrollees, whereas the next five largest health plans covered about the same percentage of enrollees. In 2011, the next five largest health plans covered 22.1% of the FEHB market.

¹ Deloitte compared the most popular FEHB plans with other private health plans and other public sector plans in 2010. They determined that the FEHB plans were ‘market competitive’ with plans offered by large private employers.



What has occurred to enable BCBS to occupy such a dominant position in the FEHB market? One contributor to BCBS's growth is the exit of Aetna from FEHB in the late 1980s. Aetna filled the second plan type, government-wide indemnity insurer²(as defined in Title 5, Section 8903(2)). Aetna's demise was due primarily to adverse risk selection: too many high risk/high cost enrollees were in Aetna, driving up the cost of Aetna premiums relative to other health plan premiums. Low risk/low cost enrollees selected other health plans, leaving Aetna in an uncompetitive situation.

The third plan type defined in Title 5, Section 8903 (3) and 8903a is employee organization (EO) plans. Employee organization plans are either sponsored by voluntary employee benefit associations (VEBAs) or federal employee unions. The nine current sponsors of EO plans include the Government Employees Health Association, American Postal Workers Union, National Rural Letter Carriers' Association, National Association of Letter Carriers, and Special Agent Mutual Benefit Association. Four of these EOs are open to only certain federal employees and retirees. These plans were grandfathered into FEHB at its inception or shortly thereafter but no new EO plans are permitted to join the program. Since 1959, more than a dozen (e.g., Postmasters Benefit Plan and Benefit Association of Congressional Employees) have dropped from the program and the collective market share of EOs in 2011 is 17%.

Another contributor to BCBS's market dominance is the introduction of BCBS Basic in 2002. BCBS Basic is an Exclusive Provider Organization (EPO), meaning that enrollees are restricted

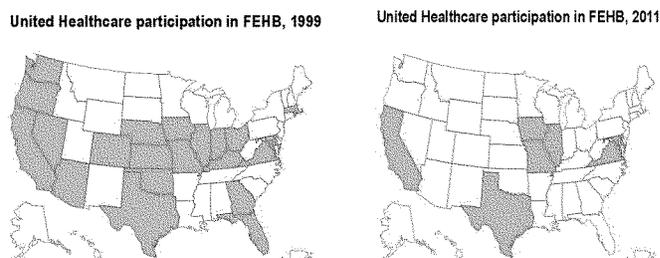
² Indemnity Benefit Plan — One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904 (2) of this title.

to a defined provider network and out of network care is covered in very limited circumstances. The EPO model operates much like an HMO by controlling the range of providers available to enrollees. HMOs (comprehensive health plans in FEHB parlance) are the fourth plan type defined in Title 5, Section 8903 (4). There is no restriction in the number of HMOs participating in the FEHB program as long as they meet FEHB qualifying criteria and state licensure laws.

Premiums for BCBS Basic are considerably lower than BCBS Standard and competitive with other lower cost programs. BCBS Basic has grown to 17% FEHB Market share in only 10 years. BCBS Basic has attracted many of its enrollees from BCBS Standard, but also has drawn from other plans. Over time, the profile of BCBS Basic enrollees is becoming somewhat higher risk/higher cost and premiums have risen accordingly.

Exiting of other large insurers

Over the last 25 years, the role of other large insurance companies in FEHB has diminished. As the charts below display, United Healthcare operated in 21 states in 1999, 16 states in 2007, and only 7 states in 2010. Similar enrollment patterns could be shown for Aetna, Humana, Cigna, and Coventry.



It is well documented that health insurance markets are becoming increasingly concentrated³ and that this concentration is contributing to premiums rising faster than inflation.

Is the FEHB more or less concentrated than the overall commercial market? As the table in Attachment 1 shows, BCBS market share in FEHB is greater than its market share among all products in 46 of the 51 markets shown. In contrast, Aetna has less of a market presence in FEHB than overall in 29 of the 32 markets where a comparison was possible. Similarly, Humana had greater market share in the overall commercial market than the FEHB market in 20 of the 21 states where a comparison could be made. In all 45 states where United Healthcare operates, its FEHB market share is less than its overall market share.

Proposed change

³ J.C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," Health Affairs, Vol 23, Number 6, Nov/Dec, 2004.

As described above, OPM is allowed to contract for health insurance services from four health plan types: 1) service benefit plan; 2) indemnity insurance plan; 3) employee association plans; and 4) comprehensive health plans. However, the health insurance market includes other plan types that OPM is precluded from contracting with. The largest examples are regional preferred provider organizations such as those operated by Humana, Aetna, Cigna, and United Healthcare. These health insurers participate in the FEHB program through HMOs in limited service areas; however, they do not participate nearly to the extent that they could, given their presence in the overall market in these states. Allowing OPM to negotiate with these organizations as regional entities will enable them to participate in the most efficient and effective way while at the same time providing FEHB enrollees with greater choice.

The addition of other plan types would enable the FEHB to respond to future changes in the dynamic health insurance market. With the implementation of health reform, there is the possibility that new health plan types may emerge; for example, accountable care organizations may become health insurers in their own right. OPM cannot be responsive to enrollee needs if it must seek a law change every time a new opportunity emerges.

It is important to emphasize that OPM is not obligated to contract with every health plan that applies to participate in the program; each health plan must meet qualifying criteria and OPM must determine if the introduction of the plan is in the best interests of the program. Examples of qualifying criteria include the availability of financial reserves sufficient to withstand significant changes in enrollment or the marketplace, having marketing materials that are clear and transparent, compliance with prompt payment rules, and having adequate provider networks to ensure enrollee access.

OPM exercises discretion in approving plans to ensure that they do not unnecessarily disrupt the FEHB market and disadvantage enrollees. For example, when high deductible options were introduced, OPM required that the plans establish and contribute to individual health savings accounts to protect enrollees in case of unforeseen illness and to retain the actuarial value of the benefit. High deductible plans remain an option in the program but their collective enrollment is less than 2%. We do not expect that expanding the number of plan types will result in more high deductible options.

The following language had been proposed by OPM in 2007 to enable more plan types to participate in the program:

Section 8903 of title 5, United States Code, is amended, by adding the following after 8903(4)(C) – “(5) ADDITIONAL HEALTH PLAN TYPES.— Plans that offer health benefits of the types named under section 8904(a)(1) or (2), or both, through physicians, hospitals, and other health care providers.”

This language would enable the FEHB to contract with contemporary health plan types that are currently major players in the private sector market, such as regional PPOs, and allow OPM to add plans in the future that would advantage plan participants. Nothing in the proposed language would restrict current insurance carriers from also offering additional plans under the new

paragraph (5), and it is reasonable to expect that new carriers would participate once invited into the program.

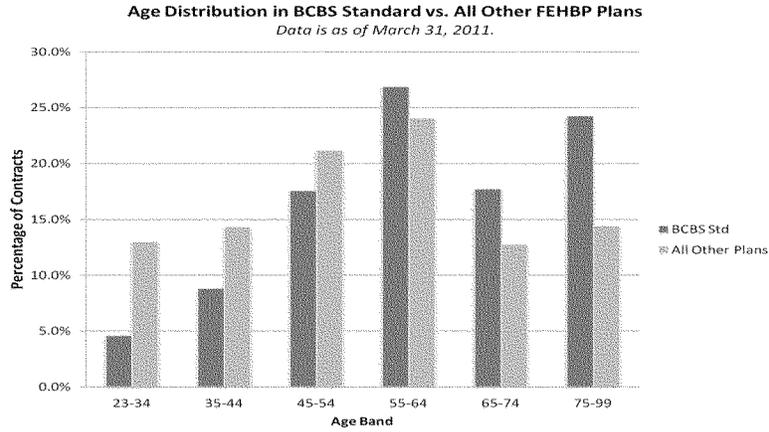
Moreover, to be clear, we do not interpret the language of the proposed section 8903(5) as allowing OPM to contract with entities that only provide one service, such as pharmacy benefits. The proposed language is modeled after existing FEHB language, specifically appearing in section 8903(1), (2), and (3). As with those other sections, each additional health plan added through the new section 8903(5) would be required to offer “benefits of the type” described in Section 8904 (a)(1) or (2). Thus, consistent with our long-standing interpretation of this language, the proposed section 8903(5) would not authorize OPM to contract with an entity, unless that entity provides the array of health services listed in 8904(a)(1) or (2), as is required of other health plan types listed in section 8903. For example, Pharmacy Benefit Managers (PBM) do not provide the array of services identified in sections 8904(a)(1) or (2), but instead act as agents for health plans in the purchasing of drugs from manufacturers and the supply of drugs to retail pharmacies and by mail order. Section 8903(5), therefore, would not authorize OPM to “carve out” pharmacy benefits by contracting directly with PBMs for this purpose. As stated in the President’s budget proposal, we remain very interested in obtaining legal authority that would allow us to contract directly for pharmacy benefits.

Impact of Expanding Plan Types

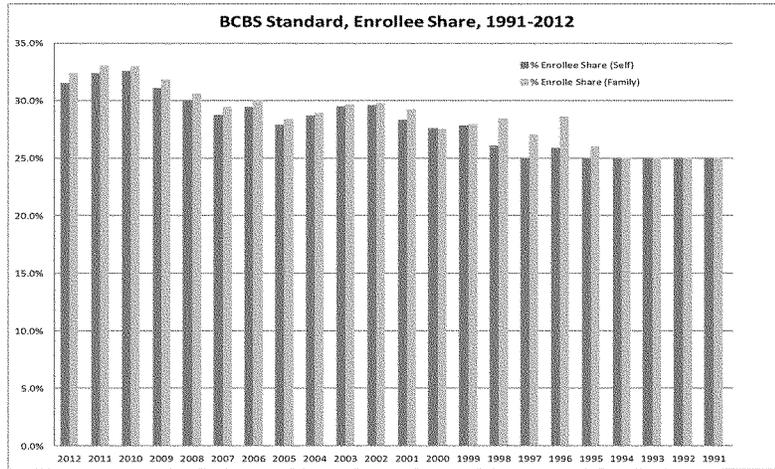
Insurance markets are difficult to enter, in part, because enrollees tend to stay with health plans. On average, between 3 and 5 percent of FEHB enrollees change health plans each year. Additionally, the resources and effort required to develop a health insurance product and bring it to market are significant and cannot be mustered quickly. For these reasons, we do not expect many new health plans to enter or expand their presence in the FEHB market, nor do we expect a sudden growth in plans. The most likely occurrence would be those regional insurers already in the FEHB would to seek to expand their presence in the program. We expect that this will evolve over a number of years.

Another possibility is that plans that participate in the BCBS Federal Employees Plan (FEP), the national aggregation of BCBS local plans with whom OPM contracts, will opt to contract separately with FEHB while maintaining their existing relationship through BCBS FEP. Wellpoint and Anthem, for example, are large regional PPOs within FEP that could seek this option.

Concerns have been raised about the impact of this change on BCBS Standard, which includes 44% of FEHB enrollees. We do not believe that this change in and of itself will have a destabilizing impact on BCBS Standard. BCBS Standard has attracted and retained an older population on average. As the chart below indicates, Standard option already has a greater proportion of age 55 and over relative to other plans in the FEHB.



In addition, BCBS Standard has been losing enrollment (mainly to BCBS Basic) in recent years and has experienced a greater concentration of higher cost enrollees. As a consequence, the enrollee share of premium has grown steadily (see chart below).



Hence, BCBS Standard will need to adjust to the market regardless of the addition of plan types. In fact, having viable regional health plans available to take higher risk enrollees should make this transition easier.

There are other changes that FEHB has made or could make to increase competition. FEHB is in the process of changing the way community rating is done such that value of premiums for community-rated plans (locally-based HMOs) will be assessed based on the plan's ability to achieve a medical loss ratio (MLR) threshold instead of the similarly sized subscriber group methodology currently in place. The MLR-based rating methodology provides a more predictable and more transparent way of rating HMOs; this change should lead to more plans staying with the program and some new plans entering the program.

Another change would be to price all plans on a state basis. Currently, the ten national plan options (BCBS and EOs) have national premiums for self and self plus family, whereas, the remaining plans have premiums based on local market conditions. The effect of the national premiums is to distort local markets: undercutting community-rated prices in high cost markets, but disadvantaging national plans in low cost markets. In Massachusetts, a high cost state that includes several strong managed care organizations, BCBS enjoys 88% market share in FEHB, but only 48% market share in the overall commercial market.

Attachment 1
MarketShare FEHB vs. All Products

State	Aetna		BCBS		Humana		United	
	FEHB	All Products	FEHB	All Products	FEHB	All Products	FEHB	All Products
ALABAMA	0%	2%	89%	82%	0%	3%	0%	8%
ALASKA	3%	13%	79%	70%	0%	n/a	0%	n/a
ARIZONA	9%	20%	59%	26%	0%	n/a	0%	21%
ARKANSAS	0%	n/a	74%	66%	0%	6%	0%	10%
CALIFORNIA	2%	6%	40%	28%	0%	n/a	5%	n/a
COLORADO	3%	8%	53%	29%	0%	n/a	0%	24%
CONNECTICUT	2%	6%	78%	35%	0%	n/a	0%	18%
D.C.	11%	4%	58%	63%	0%	n/a	7%	23%
DELAWARE	3%	17%	80%	51%	0%	n/a	1%	5%
FLORIDA	1%	9%	74%	20%	2%	n/a	0%	22%
GEORGIA	4%	8%	63%	45%	1%	n/a	0%	11%
HAWAII	0%	n/a	78%	58%	0%	n/a	0%	12%
IDAHO	1%	5%	72%	58%	0%	5%	0%	6%
ILLINOIS	2%	5%	69%	72%	7%	5%	2%	7%
INDIANA	1%	5%	74%	53%	0%	6%	0%	10%
IOWA	0%	2%	67%	69%	0%	5%	3%	10%
KANSAS	1%	n/a	71%	48%	2%	7%	0%	n/a
KENTUCKY	1%	n/a	78%	50%	1%	24%	0%	5%
LOUISIANA	1%	6%	72%	54%	0%	15%	0%	10%
MAINE	1%	9%	83%	58%	0%	n/a	0%	7%
MARYLAND	8%	11%	63%	44%	0%	n/a	9%	20%
MASSACHUSETTS	1%	n/a	88%	48%	0%	n/a	0%	4%
MICHIGAN	1%	4%	68%	59%	0%	n/a	0%	6%
MINNESOTA	1%	n/a	72%	45%	0%	n/a	0%	n/a
MISSISSIPPI	1%	4%	76%	67%	0%	8%	0%	10%
MISSOURI	1%	n/a	59%	32%	3%	n/a	5%	16%
MONTANA	0%	n/a	70%	58%	0%	10%	0%	6%
NEBRASKA	1%	3%	76%	36%	0%	6%	0%	15%
NEVADA	2%	5%	51%	18%	0%	n/a	0%	53%
NEW HAMPSHIRE	1%	3%	81%	61%	0%	n/a	0%	6%
NEW JERSEY	12%	19%	67%	43%	0%	n/a	0%	22%
NEW MEXICO	1%	n/a	49%	23%	0%	n/a	0%	22%
NEW YORK	7%	4%	56%	24%	0%	n/a	0%	25%
NORTH CAROLINA	1%	5%	75%	56%	0%	4%	0%	19%
NORTH DAKOTA	0%	n/a	83%	85%	0%	7%	0%	2%
OHIO	3%	7%	63%	28%	0%	n/a	0%	12%
OKLAHOMA	1%	12%	79%	45%	0%	n/a	0%	17%
OREGON	1%	n/a	54%	27%	0%	n/a	0%	8%
PENNSYLVANIA	0%	8%	72%	60%	0%	n/a	0%	n/a
RHODE ISLAND	1%	n/a	90%	51%	0%	2%	0%	35%
SOUTH CAROLINA	1%	n/a	74%	50%	0%	n/a	0%	15%
SOUTH DAKOTA	0%	n/a	76%	57%	0%	7%	0%	n/a
TENNESSEE	5%	5%	71%	38%	0%	7%	0%	28%
TEXAS	2%	17%	69%	28%	3%	6%	0%	20%
UTAH	1%	n/a	57%	24%	0%	n/a	0%	8%
VERMONT	1%	n/a	83%	48%	0%	3%	0%	7%
VIRGINIA	5%	7%	66%	56%	0%	n/a	4%	8%
WASHINGTON	2%	6%	48%	51%	0%	n/a	0%	10%
WEST VIRGINIA	1%	n/a	80%	37%	0%	n/a	1%	7%
WISCONSIN	1%	n/a	61%	23%	0%	11%	0%	28%
WYOMING	0%	n/a	81%	45%	0%	7%	0%	10%

Markets to compare	32	51	21	45
All Products > FEHB	29	5	20	45

Sources : 1) FEHB Semi-Annual Headcount, March 2011; 2) NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2010.

**CAN A USPS-RUN HEALTH PLAN HELP SOLVE ITS FINANCIAL
CRISIS?**

Testimony of Walton Francis

Independent Consultant and Principal Author of
CHECKBOOK's Guide To Health Plans For Federal Employees

Before the Subcommittee on Federal Workforce, Postal Service, and Labor Policy

Committee on Oversight and Government Reform

U.S. House of Representatives

March 27, 2012

Mr. Chairman, and members of the Subcommittee:

I am pleased to testify before you today concerning the current status and performance of the Federal Employees Health Benefits Program (FEHBP) as it relates to the United States Postal Service (USPS) and USPS solvency problems. I am testifying in my personal capacity, not as the principal author of *CHECKBOOK's Guide to Health Plans for Federal Employees*, and not as a consultant to the Centers for Medicare and Medicaid Services. All views expressed are my own.

Let me start by saying that I have a great deal of sympathy for the USPS, which finds itself in a predicament that is primarily the result of a (1) flawed statute that enables the Congress of the United States to micromanage what should be business decisions, of (2) bizarre accounting and budget scoring rules that fail to recognize fiscal realities, (3) of an Internet business threat whose severity few if any could have fully foreseen as recently as a decade ago, and of (4) essential reforms to the Medicare/FEHBP interface that are long overdue and that were never seriously considered by the Congress over the last decade, under the stewardship of either party or either branch of government. For these reasons alone, the Congress should give the USPS fiscal relief to the tune of billions of dollars a year.

But the problem is also one of fiscal and bargaining mistakes by the USPS, and nowhere have these mistakes been as important as in its (5) decisions on health insurance subsidies for its employees. The USPS has for decades provided unnecessary subsidies to its employees' health insurance costs and, despite some recent reductions, still pays a higher share of premiums by far than is standard among American corporations or consistent with its fiscal condition.

I will address each of these issues in turn, and then address (6) the health insurance reforms that I think the USPS and the Congress should make. In fact, I regard the current postal fiscal crisis as a wonderful opportunity to make changes that would protect and preserve the FEHBP for decades to come, to the benefit of all employees and retirees, both postal and non-postal.

Dismantling the FEHBP

The USPS proposals would massively disrupt or destroy the FEHBP, the single most successful health insurance program ever operated by the United States government. In destroying the FEHBP, the USPS would disrupt the health insurance of 8 million Americans, and breach statutory entitlement promises made to millions of Federal retirees. In a world where the House of Representatives' own Budget Resolution, voted just a few days ago, is routinely dismissed as "radical" or "ideological," these proposals certainly exceed in immediate harm anything the Congress has previously endorsed or voted for other Medicare recipients or retirees. No one, for example, has previously proposed radical reductions in the statutory retirement benefits of existing Medicare retirees. Yet the USPS proposal does just that.

It would pull out almost one fourth of current Federal employee enrollees, and a like percentage of Federal annuitant enrollees. Plans that currently enroll half or more postal employees, such as the National Association of Letter Carriers (NALC) plan, and the Rural Postmaster plan, would be decimated. It is hard to see how the FEHBP could survive with any similarity to its current design. For example, there are 18 plan options available nationally to Federal employees and retirees. Of these plans, 15 are open to all employees. If all of the postal union plans (all but one of which are open to all Federal employees) went under, the total number of national plans would drop to 11, and those open to all would drop to 8. HMOs aside, plan choices would be cut

in half for almost all employees and retirees. And many HMOs would leave the program as well, as their enrollment dropped in cities and towns all over America.

The numbers of employees and retirees affected would be staggering. For example, the Mail Handlers Standard option plan enrolls about 150,000 employees and retirees. Only about 10,000 of these are postal employees. If this plan went under, all 150,000 Federal employees and retirees would be forced to change plans. Likewise, the NALC plan enrolls about 120,000 employees and retirees. About 30,000 of these are postal employees. If this plan went under about 120,000 employees and retirees would be forced to change plans. In both cases all postal annuitants over the age of 65 would be forced not only to change plans but also to leave the FEHBP.

President Obama has been criticized for promising that under Health Reform all Americans would be able to stay in their existing health plans. To whatever degree this promise was exaggerated, the USPS plan, if adopted by the Congress, would make it look like solid gold.

The FEHBP as a Model for Insurance Reform

In my scholarly book, *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, I concluded that over the last 50 years the FEHBP has outperformed Medicare in cost control, in service, in benefit generosity, in fraud prevention, and in protecting enrollees from catastrophically high health care expenses.

I was not the first to reach these conclusions. Every major Medicare reform proposal of the last decade, enacted or not, has been based on the FEHBP model. In 1995 the Heritage Foundation published "The FEHBP as a Model for Medicare Reform." During the Clinton Administration the National Bipartisan Commission on the Future of Medicare, otherwise known as the "Breaux/Thomas Commission," in 1999 endorsed the FEHBP model of consumer choice among competing plans by a majority vote, just short of a super-majority vote. During the recent Bush Administration the Republican-controlled Congress enacted the Medicare Modernization Act in 2003, explicitly modeling both the Medicare Advantage program and the Medicare Prescription Drug Program (Part D) on the FEHBP. In fact, the MMA requires that in administering these programs the Centers for Medicare and Medicaid Services (CMS) use the policies and methods of the FEHBP.

All of the recent reform proposals for Medicare, including the first Ryan plan, the Ryan/Rivlin plan, the Rivlin/Domeneci plan, the Burr/Coburn plan, the Lieberman/Coburn plan, and the Ryan/Wyden plan (among others), have attempted to follow even more closely the FEHBP model under which all plans (including original Medicare plans) compete on an equal footing to attract enrollees, holding down costs through competition among plans.

The Rand/Graham/Lee/Demint plan introduced last week, which would enroll all Medicare beneficiaries in the FEHBP, would not only follow the FEHBP model, but would explicitly rely on the FEHBP plans to enroll 50 million Medicare beneficiaries in the same risk pool as Federal employees and retirees. Whatever one's view of this scheme, the USPS proposal would destroy it as an option.

In the present charged political environment, with arguments before the Supreme Court on the individual mandate even today, I hesitate to mention this, but the Obama Administration's health reform law follows the model of the FEHBP in promoting competition among health plans in a

health insurance exchange. And what, one might ask, are the major differences between the FEHBP statute and the legal challenge before the Supreme Court? One answer is that unlike health reform, the FEHBP does not impose an individual mandate.

It hardly seems inappropriate to ask how, of all those insurance experts of both parties and both houses of Congress who have looked to the FEHBP as a model, only the USPS sees it as an albatross to be abolished.

Follow the Money

The USPS has no professional or historical competence in insurance design or in analysis of health insurance reform models, and probably no real desire to gain these. The USPS is clearly looking for a solution that would allow it to obtain a taxpayer subsidy in the billions of dollars. It would do so by claiming that its new plan would enable it to eliminate or vastly reduce the contributions to FEHBP reserves for retirees that it is forced to make under present law. The motives for this are perfectly clear and transparent. Indeed, in some sense the logic of the USPS proposal is impeccable. If a debt is onerous, make whatever changes are needed to write it off.

It is not my intention to analyze the actuarial or legal rationale through which the USPS seeks to reduce, most notably, the \$5 billion a year it is currently required to pay to “pre-fund” its retiree health benefits. But I will make the following observations, which can readily be confirmed by the Congressional Budget Office or any fiscal expert.

Under current law, the Federal government maintains a number of trust funds, including the Federal retiree health benefits trust fund, the Medicare Part A trust fund, and the Social Security trust fund, that are intended to somehow segregate and preserve funds to meet future obligations. Under the fiction that the USPS is a true business (a principal supposedly established in the 1970 Postal Reorganization Act, and reaffirmed in the 2006 Postal Accountability and Enhancement Act), the USPS is supposed to prefund its retiree obligations on the same basis as private corporations. But the 2006 Act in particular was an exercise in science fiction. It gave the Federal government a budget windfall in the arcane “scoring” rules that govern Congressional score keeping on budget matters.

But all these trust funds are “let’s pretend.” You may recall the debates late in the Clinton Administration over placing the Social Security trust fund in a “lock box.” The only thing more surreal than those debates was the underlying reality: all of these trust funds are EMPTY in fact if not in accounting. The money has been spent. The only things remaining are accounting pretenses. Put another way, every dollar that the USPS does not contribute to deficit reduction through charges to its patrons or reductions in employee benefits is a dollar that the taxpayers will have to borrow now and repay in the future. The issue before the Congress is not whether or how to fund real obligations with monies placed in real trust funds, but how to apportion USPS insolvency among future taxpayers, postal patrons, and postal employees.

In February, the HayGroup consulting firm presented a purportedly sound analysis of the USPS proposals whose “starting point” was the measurement of trust fund obligations prepared by the OPM Office of the Actuary. But all estimates by that Office are based on the accounting fiction that the trust funds actually exist as dedicated funds unavailable to fund the government’s current account deficit. The HayGroup report on “United States Postal Service Retiree Health Benefits” made clear in its key assumption on “Funding Method” that “the funding forecast assumes the

USPS retains the PSRHBFB assets” (page 2). These assets do not exist except as a legal and accounting fiction. The money has been spent.

(As an aside, the HayGroup report was dated February 10, 2012, and assumes that all annuitants over age 65 “enroll in Medicare Parts A and B with no penalty” (page 4). Meanwhile, a USPS PowerPoint presentation entitled “USPS Health Care Program,” apparently also prepared in February of 2012, says that “growing nonparticipation in Medicare increases costs for USPS and for participants” (page 3). Apparently the USPS and its consulting firm are not on the same page.)

This fiscal legerdemain then raises the obvious question: why dismantle the FEHBP to preserve accounting fictions that no responsible and informed adult believes to be true? Why not just eliminate the prepayment obligations by the stroke of a pen, and leave this valuable program to continue to provide high value for money? Is the Federal government really so incompetent that it would abolish one of its most cost-effective programs to maintain the pretense that it is fiscally responsible?

The USPS Substantive Proposals on the Merits

The USPS has changed its proposals in recent months. Originally, for example, it claimed that a major part of its savings would arise from paying new Postal employees a lower health insurance subsidy. This claim suffered from the obvious problem that the USPS won’t be hiring any consequential number of new employees for decades as it downsizes—savings zero.

Then and now the USPS claims that FEHBP plan designs are somehow obsolete and do not match “best practices” in the private sector or align “cost to value.” This naturally raises the question as to how all those Congressional leaders and experts of both parties could have been so badly fooled all these years. How is it that only the USPS has been able to detect that the FEHBP plans fail to provide health promotion and wellness benefits, and chronic condition and disease management programs? And of course the truth is that the FEHBP provides all these things and many more. It is more than passingly ironic that a USPS system facing ever more devastating competition, include parcel carriers and the Internet, fails to understand that competition among competing health plans drives down costs while improving service.

Nonetheless, the FEHBP is no longer the best model of effective competition among health plans. Medicare Advantage and Medicare Part D share that blue ribbon prize. After all, Part D has held its costs to a level roughly forty percent below that predicted by both CMS and CBO actuaries and experts, a record the FEHBP cannot match. But the FEHBP is no slouch, and has outperformed the “one size fits all” traditional Medicare for almost the entire history of both programs in controlling costs. As a point of comparison, the mis-designed TRICARE system makes even traditional Medicare look like a miracle of modern management.

The current “discussion draft” USPS proposal proudly proclaims that it will provide a reform that will “especially benefit annuitants who cover only self and spouse” (as opposed to larger families). The truth of this claim is easily tested. According to the U.S. government’s Medical Expenditure Panel Survey (MEPS), the annual cost of health care at age 55 to 65 is about \$8,000 per person. So the cost of health care for a retired couple is approximately \$16,000. The annual cost for an adult under age 35 is about \$2,000, and for a child is about \$1,500, according to MEPS. So the annual cost of a premium for a retired couple would be about \$16,000 (less cost-

sharing) and for a young family of four about \$7,000 (less cost sharing). In other words, this wonderful reform would, other things equal, charge retired couples more than double the premium amount charged young families.

The falsity of this pipe dream about the alleged benefits of a “couples” premium has been described for decades by the OPM actuaries and by advice given through *CHECKBOOK’s Guide to Health Plans for Federal Employees*. But the postal bureaucrats who designed these “reforms” are not health insurance experts and would not be expected to know such things.

Interestingly, the February 2012 USPS discussion draft, in describing the “key features” of the “proposed USPS plan” demonstrates an either unintended or deliberate decision to drastically reduce insurance benefits. This contradicts previous USPS promises that it would maintain or improve those benefits.

Under the discussion draft proposal, Blue Cross Standard option is described as charging 15 percent in network coinsurance for most services. This is false. This plan charges no coinsurance for inpatient hospital services and \$20 or \$30 copays for most outpatient services. The document then goes on say that the Blue Cross plan has a \$5,000 out of pocket limit and no limit for prescription drugs, even though drugs are included in the plan’s \$5,000 OOP limit. These features are proudly contrasted with a USPS “High Option” that charges 10 percent coinsurance for all hospital stays and all physician visits, and that has an OOP limit of \$7,500 for medical and drug expenses combined. If the best USPS plan is so inferior to Blue Cross Standard option, one hesitates to describe the “Middle” and “Value” USPS options. Suffice it to say that not one single FEHBP plan has benefits as poor as the “Value Option,” and only one has benefits as poor as the “middle” USPS option. So the truth is revealed: in sharp contrast to earlier promises, the USPS now proposes a massive reduction in health insurance benefits to current employees in the name of modernization and value purchasing.

To its seeming credit, the USPS plan includes a consumer-driven high deductible option in its so-called “Value Option.” This plan would have a \$4,000 deductible. But there is something missing. Unlike all the consumer-driven plans in the FEHBP, there is no Health Savings Account or comparable reimbursable arrangement. In the FEHBP plans, this account is typically about \$1,500 to \$2,000 for a family. In the USPS scheme, it got left on the cutting table.

It is not an easy task to design a sensible health insurance reform, and there is an important and essentially insurmountable problem facing the USPS proposal. The FEHBP operates as a single risk pool. An agency with a disproportionate number of older and more costly enrollees has its premium costs subsidized by agencies with a disproportionate number of younger and less costly enrollees. Younger and older enrollees pay the same premiums. Experts and ethicists differ on the merits of such a system. But whatever its overall merits, it is the reality of the FEHBP and of the system the USPS proposes to leave. What do current data tell us about the problems created by a pullout? Quite a lot! The following table shows the consequences to the USPS of a pullout from the FEHBP, using 2009 data:

Age:	Under 35	35-44	45-54	55-64	Over 65	Total
Ave Cost at that age (MEPS)	\$2,000	\$4,000	\$6,000	\$8,000	\$11,000	
Number of postal self-only enrollments	15,000	25,000	69,000	62,000	7,000	178,000
Total Cost (M)	\$30,000	\$100,000	\$414,000	\$496,000	\$77,000	\$1,117,000
Average cost per postal employee						\$6,275
Number of non-postal self-only enrollments	161,000	109,000	191,000	179,000	25,000	665,000
Total Cost (\$M)	\$322,000	\$436,000	\$1,146,000	\$1,432,000	\$275,000	\$3,611,000
Average cost per non-postal employee						\$5,430

As these numbers show, the USPS has an employee pool that is substantially more costly than that of non-postal employees, simply because it is older. To provide the identical benefits and premium levels to USPS employees that nonpostal employees receive will cost about one sixth more per employee, or about one tenth of the all-employee average. Put another way, just to break even the USPS will have to reduce benefits or increase premiums by about one tenth. Considering that USPS employees number about 500,000, and that average premium costs per enrollee in the program (self-only averaged with self and family) are about \$11,000, the costs of a pullout to the USPS will exceed one billion dollars annually just to maintain current levels of benefits and premiums. And over time, as the postal work forced ages further, the costs will rise sharply.

Put another way, the FEHBP is a giant insurance pool. All workers and retirees pay either a self-only or self and family premium, regardless of their age. Younger workers subsidize older workers. Retirees with Medicare subsidize all the rest, because Medicare is “primary” and pays about three fourths of health care costs (more, for the few Federal retirees who get prescription drug coverage from Medicare). Within this pool, postal employees benefit because they are older and more costly than average. Were the USPS to pull out, its premiums would increase to maintain equivalent benefits, while those of other GS and other non-postal workers would decrease.

The USPS Record in Health Insurance Cost Control

Unlike almost all other agencies, the USPS has substantial discretion over insurance benefits. While the USPS was not given the authority to override OPM in plan participation and benefit design decisions, it was given the authority to decide on premium subsidy levels.

That authority, exercised through collective bargaining, has led to multi-billion dollar spending decisions. This year the USPS pays up to 83.5 percent of plan premiums, whereas for GS and other non-postal employees the maximum payment is 75 percent of plan premiums. And the USPS pays this rate up to 80 percent of the costs of the average plan, compared to a ceiling of 72 percent for nonpostal employees and all retirees. The result of this generous contribution formula is that on average the USPS pays about \$1,000 more for family premiums, and about \$500 more for self-only premiums, than the rest of the government. This is a rate negotiated through collective bargaining, and in prior years the difference was even larger, but for an organization that is essentially insolvent, and has known for years that insolvency loomed, that seems rather oddly generous. Considering that about two thirds of postal workers have family policies, the net cost of this differential in 2012 exceeds \$400 million. Over the last five years, the cost of this differential has been close to \$3 billion.

Incidentally, according to the Kaiser Family Foundation data on employer insurance, the average percentage of premium paid by large employers is around 70 percent. So it is the USPS, not the nonpostal work force, which is out of line with modern employer practice.

What is worse, the USPS initiated what is arguably the single worst mistake in the history of the FEHBP. “Premium conversion” is a system in which the employee share of premiums is tax-sheltered (this is on top of the tax-free status of the employer share). It is routinely used by corporate America because it shifts costs to Federal taxpayers. However, it makes no sense for the Federal government itself, because it takes from one pocket to put into the other. From an insurance design standpoint, in a competitive system like the FEHBP premium conversion is a disaster, because it attenuates the already weak incentives for enrollees to choose more frugal plans. Assuming that the marginal tax rate of a postal worker is about one third on average (this includes OASDI taxes and State income tax), the 16.5 percent employee share of premium becomes more like 10 percent.

Unfortunately, the Office of Personnel Management copied this mistake several years after the USPS led the way. It is hard to estimate with any precision the effects of this policy over the years, but it is likely that it has led to average premium increases, compared to what they would otherwise have been, of close to half a percent a year, or even more. Total FEHBP costs are likely several billion dollars a year higher than they would have been without premium conversion. There is dramatic confirmation of the relatively weak current incentives in today’s

FEHBP in the failure of the several consumer-driven and high deductible plans—almost all of which are excellent buys—to attract more than about one percent of total FEHBP enrollment.

What the USPS Could Do Under Current Law

As the discussion above suggests, the FEHBP could generate much larger savings than it does now. Several years ago I developed a table to show Federal agencies how much they could save if they make *CHECKBOOK's Guide to Health Plans for Federal Employees* available online to their employees, and effectively encouraged its use during Open Season. The key point is that as much as 75 percent of each enrollee's premium is paid by the employing agency, through its Salaries and Expenses account. While the table is slightly dated, and understates potential USPS savings (where the contribution rate is now as high as 83.5 percent), the potential savings are rather substantial, to say the least. As the table shows, for every employee who switches from one of the dozen highest cost plans to one of the dozen lowest cost plans, the average saving is roughly \$2,000. Assuming enrollment choices are stable, which they are in the FEHBP, this is not a one time saving to the agency, but one that continues year after year.

Agency Savings Potential 2010

Biweekly Govt Contribution		Biweekly Saving from Switch		Annual Saving from Switch	
Self Premium	Family Premium	Self Saving	Family Saving	Self Saving	Family Saving

Govt Contribution for 12 Highest Cost Plans in DC Area (Maximum Govt Contr)

\$167.61 \$376.04

Government Contribution & Savings Under 12 Lowest Cost Plans in the DC Area:

Mail Handlers Value Option	\$82.68	\$197.12	\$84.93	\$178.92	\$2,210	\$4,650
Kaiser Standard	\$100.49	\$231.13	\$67.12	\$144.91	\$1,750	\$3,770
Aetna Healthfund HDHP	\$103.51	\$226.68	\$64.10	\$149.36	\$1,670	\$3,880
Mail Handlers HDHP	\$107.60	\$243.81	\$60.01	\$132.23	\$1,560	\$3,440
GEHA St	\$111.08	\$252.41	\$56.53	\$123.63	\$1,470	\$3,210
United Healthcare HDHP	\$113.38	\$253.29	\$54.23	\$122.75	\$1,410	\$3,190
APWU CDHP	\$116.55	\$262.20	\$51.06	\$113.84	\$1,330	\$2,960
GEHA HDHP	\$131.82	\$301.08	\$35.79	\$74.96	\$930	\$1,950
United Healthcare CDHP	\$135.45	\$299.84	\$32.16	\$76.20	\$840	\$1,980
Blue Cross Basic	\$139.52	\$326.75	\$28.09	\$49.29	\$730	\$1,280
Aetna Open Access Basic	\$145.62	\$340.79	\$21.99	\$35.25	\$570	\$920
Aetna Healthfund CDHP	\$145.73	\$347.75	\$21.88	\$28.29	\$570	\$740

Average government savings under these 12 plans:

\$1,250 \$2,660

Average for Self and Family Combined:

\$1,960

I haven't had time to make these calculations more precise for the USPS, or to reflect current postal employee plan enrollments, but a ballpark estimate would be that if one half of postal

employees could be persuaded to switch from one of the higher cost plans (over one third are in Blue Cross Standard option, for example) to one of the lower cost plans, 250,000 employees times a USPS saving in excess of \$2,000 each would bring in \$500 million in savings in the first year alone. And this saving would put employees in good plans, not the stripped down versions the USPS is now proposing.

Here is a simple suggestion: The USPS could offer a two hundred dollar year-end bonus, perhaps as a Health Savings Account, to every employee who made such a switch in the next Open Season.

This is but one option under current law. There are others. For example, the USPS and the postal unions could collaborate on a premium contribution reform similar to the one I recommended in *Putting Medicare Consumers in Charge: Lessons from the FEHBP*. The basic idea is that the government contribution could be 100 of the cost of a lower benchmark, such as 70 percent of the average of all plans' total premium cost. This would actually reduce the employee share of premium for the most frugal plan choices. But it would raise premiums for those in the higher cost plans. Postal workers themselves would decide which plan to choose, from among the wide set of choices offered today (almost two dozen plan options throughout America, not just in the DC area). Over time, workers would gravitate to lower cost plans and the USPS would save a great deal of money.

The Good News About the USPS Retirement Proposal

The one good thing that I see emerging from the USPS proposal is its focus on the growing problem of Medicare/FEHBP premium and benefit coordination.

Medicare was created over 40 years ago, and the FEHBP over 50 years ago. The design of each has not significantly changed since its inception, with the major exception that Medicare has added private plan alternatives and a system of choice based on the FEHBP model in Medicare Advantage, as well as a prescription drug benefit. Original Medicare remains frozen in the time warp of vintage 1960 insurance patterns (e.g., the nonsensical bifurcation between hospital and physician costs, and the failure to use networks to control costs). The FEHBP has aged far more gracefully, with a market driven structure that readily adopts the latest and best insurance practices. But neither program has made any sensible accommodation to the existence of the other.

Absent legislative reform, OPM and the plans have struggled to create some kind of coordination. Unfortunately, the one they chose creates a major problem. All but one of the national fee-for-service plans in the FEHBP offer age-65 enrollees a seemingly wonderful benefit enhancement. The plans promise that if the enrollee has both Medicare Parts A (hospital) and B (physician), all hospital and physician care will be free—no deductibles, no coinsurance, and no copayments. Not only that, all this medical care will be free whether or not the enrollee uses preferred providers—network constraints go away. What could be wrong with this wonderful benefit enhancement? Indeed, the great majority of retirees elect to pay the Medicare Part B premium at age 65, and enroll in one of the national fee for service plans.

This wonderful coverage comes, however, at a high price. In 2012, the total premium cost for the most popular choice in combination with Medicare, Blue Cross Standard Option, will cost a retired couple over \$7,500 in premium. This is a “for sure” expense, whether or not they ever see

a doctor (of course, total cost is far higher, with most hidden in the government premium subsidies).

This same couple was most likely enrolled in Blue Cross until age 65, and was satisfied with its good benefits and reasonable premium. What changed upon turning age 65 that impelled them to pay an extra \$2,400 a year for two Part B premiums? They do get that reduced cost sharing, and the ability to leave the network without penalty. However, *CHECKBOOK's Guide* estimates that in 2012 the net effect of joining Part B is to cost the average retired couple in Blue Cross Standard option more than \$1,000, on average. The answer is that this decision is rational for that couple only because existing law is irrational.

Of greater importance to the program and to the United States Treasury, this decision is expensive. That retired couple has no incentive to be frugal in any way in making decisions about any kind of health care other than prescription drugs and dental care. Unlimited provider visits are free. The most expensive provider in the nation is free. The most discretionary surgical procedure is free. Durable medical equipment is free. Every conceivable medical test is free. Thousand dollar MRI and CAT scans are free. If an additional scan would show progress, the price is right for the second.

Based on robust research findings on the effects of cost sharing incentives, each person enrolled in a wraparound FEHBP plan and Medicare Parts A and B costs the Federal government somewhere on the order of 15 percent or more, or \$1,500 or more, in unnecessary medical care utilization (for the source of this conservative estimate, see Jeff Lemieux *et al.*, "Medigap Coverage and Medicare Spending: A Second Look," in *Health Affairs* Volume 27, Number 2, March/April 2008). With approximately 1.5 million Medicare enrollees (both single and couples), the Federal government loses more than \$2 billion a year in increased utilization under the current system. Most of this cost falls on Medicare (which pays first) but as much as a half billion dollars a year falls on the FEHBP. And it falls disproportionately on plans like Blue Cross Standard Option, because they attract a disproportionate number of Medicare enrollees.

Meanwhile, it appears that increasing numbers of age-65 retirees are deciding not to sign up for Medicare Part B. They calculate, correctly, that they will save substantially in most years by not having to pay two sets of premiums. There are alternatives, such as suspending FEHBP enrollment, paying only one set of premiums, and enrolling in a Medicare Advantage plan. Today, all Medicare Advantage plans offer very good value (for example, they all have good catastrophic protection), and paying one premium is far better than paying two premiums. But very few even know this option exists, and even fewer choose it.

The trend of few retirees signing up for Part B will accelerate as more and more higher income retirees face the Medicare income-tested Part B premium penalty (almost all GS-15 or higher-graded retirees who are single will pay the higher income-tested premium if they enroll in Part B). Every such decision actually saves the Federal government money by reducing incentives for wasteful overutilization, but those savings accrue primarily to Medicare, not the FEHBP. The effect on the FEHBP is to raise premiums overall, and especially in those plans that disproportionately attract retirees (e.g., Blue Cross Standard Option and NALC).

FEHBP plans individually and the program as a whole would benefit if many more Medicare-eligible enrollees sign up for Part B. Most of this saving would, however, be offset by wasteful overutilization if current benefit design remains unchanged.

There is a major alternative. Instead of enriching benefits so far as to eliminate all hospital and physician cost sharing, in a decreasingly successful effort to induce Medicare participation, plans could instead directly subsidize Medicare Part B premiums. Ideally (from a government-wide and taxpayer perspective) plans would be strongly discouraged or even prohibited from improving physician and other ambulatory cost sharing, but instead encouraged to add benefits that are not covered by Medicare Parts A and B, such as better prescription drug coverage, vision care, dental care, and improved hearing aid coverage. (That the government's no-cost standalone dental plans would lose business, and that OPM's longstanding policy of discouraging dental benefits would be reversed, should be of no concern whatsoever since hundreds of millions of dollars in actual real savings to both enrollees and the taxpayer would be involved. Alternatively, the dental subsidy could be directed towards "free" enrollment in those plans.)

Viewed from a beneficiary perspective, the ideal result would be no-cost Part B coverage, no change in cost sharing for hospital, medical, and drug benefits based on Medicare coverage (that is, most benefits would be identical pre- and post-65, and modest additional benefits (such as a dental fund or premium subsidy of several hundred dollars) not available pre-Medicare. Take-up would be near 100 percent (why would anyone decline a free benefit?), and all enrollees would directly gain more than they do under the current wrap-around scheme, as well as retaining the ability to go out of network should they so choose, using the Medicare Part B benefit.

Under such a reform, there would have to be a one-time amnesty from the Medicare penalty for delayed enrollment or, better yet, Medicare would adopt the Part D innovation of allowing penalty-free late enrollment for anyone who had been enrolled in comparable or better "creditable coverage." (This last innovation would benefit Medicare in all situations where employers such as State or local governments had rich benefits post-65, as many do.)

Among the other benefits of such a reform, it would encourage retirees to remain in HMO plans, since there would no longer be an advantage for enrolling in national fee-for-service plans. As a result, the FEHBP would benefit from the superior cost control exercised by HMO plans. (At present, about one third of employees enroll in HMOs, but most older retirees migrate to the "free" care of the national plans and less than one tenth of annuitants are enrolled in HMOs.)

Such a program could and should be voluntary. Compulsion is not needed if incentives are properly aligned. Almost any version would be easy for plans to administer, as they currently serve large numbers of retirees both under and over age 65, with every conceivable combination of Medicare coverage, including even a few retirees and survivors in their 80s and 90s who have no Medicare coverage at all.

And if this change were made for the FEHBP program as a whole, the currently required USPS contribution for unfunded retiree health care costs would decrease substantially, thereby directly benefiting the solvency of the USPS without massively disrupting either the FEHBP and its 8 million enrollees and dependents, or renegeing on retirement promises made in law to current postal retirees.

Conclusion

If Medicare/FEHBP benefit and premium coordination are not reformed, the FEHBP is likely to see costs surge over time. I urge the Congress to think "out of the box" in assessing the current state of the FEHBP and possible reform options like these. There is plenty of practical and

analytic help to be found in the CBO, OMB, GAO, and OPM itself. I wish you success in making needed reforms to this vital program. It is not aging well, and the USPS proposal, while badly flawed, demonstrates the importance of reform for the program as a whole.

It is clear that the main goal of the USPS is to reduce its costs of financing retiree health costs, and the USPS is apparently even willing to take on the substantial financial burden of an aging and increasingly expensive work force to get that relief. But it is neither necessary nor sensible to do anything remotely so drastic as dismantling the FEHBP to achieve the savings it needs, and possibly even higher savings.

Thank you for the opportunity to testify today.

Questions for
Mr. Jonathan Foley
Director, Planning and Policy Analysis
U.S. Office of Personnel Management

Chairman Blake Farenthold
Subcommittee on Federal Workforce, U.S. Postal Service and the Census
Committee on Oversight and Government Reform

Hearing: "The Federal Employees Health Benefits Program:
Is it a Good Value for Federal Employees?"

1. Is the FEHBP is of sufficient quality to recruit and retain the best and brightest civilian workforce?

The FEHB Program is the largest employer-sponsored health insurance program in the country. With low administrative costs and over 230 different plans, the FEHB Program is an efficiently administered program which offers many choices to Federal employees. However, over the years, the health insurance marketplace has changed and the law, as currently written, prevents the FEHB Program from implementing many of the changes that have occurred in the commercial marketplace. OPM's legislative proposals would align the FEHB Program with best practices offered in the private sector; thus ensuring that the Federal government can continue to compete with the private sector in order to recruit and retain the best and brightest civilian workforce.

2. AFGE's testimony suggests that the President's proposals would "have a harmful effect on many of the most vulnerable enrollees" and would "shift costs to enrollees without improving the program or lowering its overall costs at all." What is OPM's response to this criticism?

OPM respectfully disagrees with that assessment. We believe the changes we are proposing, if enacted, will keep the program on a path to long-term financial viability while offering a choice of health care coverage that will meet the needs of Federal employees, retirees, and their dependents. We believe we can keep health care cost growth as low as possible through good stewardship of the program with prudent legislative changes when necessary.

Questions for
Mr. Jonathan Foley
Director, Planning and Policy Analysis
U.S. Office of Personnel Management

3. What are OPM's short- and long-term projected changes in the factors affecting premium growth? Absent legislative change, how is OPM preparing to mitigate these factors?

For both short and long term, the factor affecting premium growth is health care cost trend, which OPM projects to be between 5 and 6 percent. Absent legislative changes, OPM will continue to:

- *work with carriers to effectively manage costs by, for example, encouraging contracting with effective delivery system models such as Patient Centered Medical Homes;*
- *set goals for carriers to achieve drug trends low by encouraging the use of generic drugs and by managing specialty drug trend;*
- *work with carriers to increase participation in wellness programs and other programs to help individuals better manage chronic conditions; and,*
- *incentivize carriers to improve the quality of care provided to Federal employees, retirees, and their dependents by taking steps such as reducing preventable complications, reducing the use of commonly overused tests and procedures, and by encouraging the Meaningful Use of health information technology.*

4. The President's Budget includes a proposal allowing OPM to contract for additional health plan types, producing mandatory cost savings of \$260 million in direct spending over ten years.

- a) If the proposal were enacted, how many enrollees will migrate from existing plans to additional health plan types?

Until benefits and premiums are negotiated, the migration from existing plans is difficult to project. We anticipate that the migration will be gradual because enrollees do not shift from their current plans readily and the development of new health plans will occur over time depending on local or regional market conditions.

- b) How will OPM guard against risk segmentation with respect to additional health plan types?

OPM manages risk segmentation through the negotiation of benefits and rates with carriers. As discussed below, OPM currently negotiates with health plans to ensure that the benefit design and areas served are balanced and in the best interests of the FEHB program.

Questions for
Mr. Jonathan Foley
 Director, Planning and Policy Analysis
 U.S. Office of Personnel Management

- c) What impact would a new plan's selection of certain geographic markets have on national plan premiums?

There has always been a risk of cherry picking geographic areas within the FEHB program given that there are more than 200 local health plan options competing with national carriers each of whom has a single national price. OPM has addressed this risk through negotiating balanced service areas with local plans. Plans may propose to serve the most profitable area, but, through negotiation, OPM expands the plan's service area to serve enrollees in less profitable areas. OPM would employ a similar negotiation strategy with new regional plans.

Overall, OPM believes that the impact of the expansion of FEHB plan types will occur over a number of years and will not have a dramatic impact on markets. Establishing a new health plan takes time in part because enrollees do not change plans frequently and because developing the infrastructure to support a plan takes time and money. Expansion of FEHB plan types is a modest reform that should improve competition amongst plans without radically altering the number or quality of health plan choices.

5. What percentage of plans are meeting OPM's goal of issuing 80 percent of drugs in generic form? What contingencies has OPM considered if carriers' existing efforts do not achieve this goal?

Based on data supplied by the carriers, in 2012, 65 percent of health plans with 26 percent of the FEHBP population are achieving this target. OPM will work with plans that do not expect to meet the generic dispensing goal to make changes to their benefits or administrative programs to help them achieve the 80 percent goal in 2014. The OPM goal for 2013 was 75 percent generic dispensing rate. Based on data supplied by the carriers, we expect that 94 percent of plans will achieve that goal this year. Plans will continue to increase their generic dispensing rate as more drugs come off patent.

6. How is OPM meeting its goal of maintaining the specialty drug trend at 22 percent of less? What is the cost trend for the last three years? How will OPM contain future growth in spending on specialty drugs?

Recent cost trend for specialty drugs in the FEHBP is displayed below:

*2013 (projected) – 16%
 2012 (estimated) – 17%
 2011 – 19%
 2010 – 22%*

OPM will work with carriers to administer benefit changes or program changes that will encourage the better management of specialty drug trend. Some of the programs that carriers are using include: the use of specialty drug pharmacies; step therapy, to assure that first-line therapies are

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tried first, before newer and more expensive therapies, when appropriate; and prior authorization, to assure that specialty drugs are used only for conditions in which their safety and efficacy has been demonstrated. Specialty pharmacies achieve savings by negotiating deeper savings with the manufacturers as well as providing an increased level of customer service to members using these drugs.

7. In its 2013 Call Letter, OPM notes that enrollees can achieve even greater savings on prescription drugs with minimal disruption through either a narrower pharmacy network or preferred pharmacy network. Is this proposal likely to produce savings for the enrollee? How does this proposal compare with private sector practice?

Based on information from Pharmacy Benefits Managers (PBMs), OPM believes savings will accrue to the program through narrower or preferred pharmacy networks. If enrollees' cost sharing is calculated through coinsurance, enrollees will directly experience savings in their retail prescription drug purchases. Enrollees may also experience savings through their premiums because the cost of prescription drugs is a significant portion (approximately 30 percent) of the total premium. Large employers are reducing their networks in order to help them control their health care costs. If a carrier proposes to contract with a PBM for a narrower network, OPM requires that the carrier demonstrate how reasonable access to pharmacy services will be maintained for enrollees.

8. Given that many FEHBP participants purchase prescription drugs through a Pharmacy Benefits Manager in their existing plans, how would simply changing the PBM relationship produce savings? How much of the projected savings come from a more restrictive formulary?

Each carrier in the FEHBP negotiates their PBM contract for their population only. OPM can achieve savings by contracting with a single PBM through:

- *economies of scale by negotiating on behalf of all Federal employees, retirees and dependents;*
- *administrative savings resulting from one contractual relationship (OPM/PBM) versus many (100 carriers/numerous PBMs); and,*
- *consistent strategies across the program to reduce costs and improve quality.*

The projected savings were not based on adding a more restrictive formulary.

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9. In the last decade, the average annual growth in FEHBP premiums has been generally lower than the growth for other health care purchasers. Please explain the extent to which OPM used the FEHBP reserve accounts to offset premium increases for the last ten years, by year.

All plans in the FEHB use reserves to mitigate future premium increases. Historically reserves have held level in relative terms though there are fluctuations both up and down as the result of program experience (e.g., lower/higher utilization than anticipated). When reserves rise, we can anticipate lower future premium increases, while low reserve levels indicate higher future premium increases. In general, OPM actuaries negotiate rates to hold three to four months reserve.

The following table shows the historical unobligated reserve levels for all plans in the program as of the end of the calendar year.

Year	Months of Unobligated Reserves
2011	4.97
2010	4.36
2009	4.06
2008	4.10
2007	4.54
2006	4.92
2005	4.36
2004	3.78
2003	3.42
2002	2.85

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10. The FEHBP has two premium tiers, individual and family. OPM is proposing a third premium tier of "self plus one." OPM estimates this proposal, combined with coverage for domestic partners, would result in mandatory savings of \$5.2 billion over ten years. Please provide the assumptions used as the basis for this estimate.

Key Assumptions for Self Plus One coverage:

- *Self plus one coverage is estimated to draw 1,159,000 enrollments from existing self and family coverage program wide*
 - *337K from Non-Postal Actives*
 - *111K from Postal Actives*
 - *711K from Annuitants*

11. What, if any, impact would the addition of Self Plus One as an enrollment category have on the Self and Family premium?

As a result of the introduction of the self plus one option, we expect each carrier to make adjustments to their self only and self and family enrollment options. Adjustments will vary by carrier depending on their mix of enrollees, but we expect the overall adjustment to self and family options to be about 7-8%.

12. The FEHBP requires agencies to report to carriers on a quarterly basis the names of enrollees, and carriers to resolve any enrollment discrepancies. OPM's 2013 call letter states that carriers "must ensure they have programs in place for prevention and prompt collection of improper payments.

a) How does OPM ensure enrollees and their dependents are eligible for health benefits?

The Federal agencies, not OPM, are responsible for making decisions about whether an employee's family member is eligible for coverage. Each agency has the authority to request whatever documentation it believes is necessary to determine a family member's eligibility. OPM expects the agencies to take reasonable actions.

The Standard Form (SF) 2809 (Health Benefits Election Form) warns employees that any intentionally false statement or willful misrepresentation (such as listing ineligible individuals as family members) is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 10 years. Electronic enrollment systems contain similar warnings.

If an agency suspects that a person listed is not an eligible family member, the agency may request documentation such as a marriage license or birth certificate. If the employee refuses to provide documentation, the agency may refer the case to their Inspector General for investigation.

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Foster children are covered if the employee certifies that certain requirements are met. If an agency has concerns over whether the requirements have been met, it may request documentation from the employee.

OPM allows the FEHB plans to add new family members to existing self and family enrollments. The plans are allowed to request documentation proving the person is an eligible family member. OPM encourages plans to request the documentation.

- b) How much is lost each year to these improper payments?

There is no evidence to support a substantial rate of improper payments due to ineligible dependent coverage. However, OPM is working to reduce the number of ineligible employees, annuitants and family members in the FEHB Program.

- c) What steps is OPM taking to reduce improper payments through eligibility verification?

OPM has made an extensive effort to ensure that only eligible employees, annuitants and family members are covered under the FEHB Program.

The FEHB Centralized Electronic Enrollment Reconciliation Clearinghouse (CLER) went operational on June 1, 2002. CLER is a computer match program that compares the FEHB enrollment records of federal agencies against enrollment records of FEHB Program carriers. CLER identifies discrepancies in the records and posts discrepancies on a web site for the agencies and carriers to use in resolving enrollment discrepancies.

- In June 2002 the error rate (calculated by dividing the number of records where a discrepancy has been identified by the number of records submitted) for the carriers was 15%. Currently the error rate for the carriers is 2%.*
- In June 2002 the carriers had approximately 140,000 more enrollment records than did the payroll offices. Currently that number is down to approximately 25,000.*

We continue to work with both the agencies and the carriers to lower the error rate and the number of excess enrollment records.

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13. The OPM Inspector General has long recommended ending the exemption of the FEHBP from the Anti-Kickback Statute, characterizing it as "the single most valuable measure that can be taken to combat fraud and abuse against the FEHBP by health care providers."

- a) Did OPM consider the Inspector General's recommendation in developing its legislative proposal to modernize the FEHBP?

The Administration's proposal to modernize the FEHBP is focused on providing OPM the flexibility to keep pace with the changing health insurance marketplace through more competition with more diverse health plan choices, affordability for enrollees, and opportunity to use best practices from the private sector. Changing the law to apply the Anti-Kickback Statute to the FEHBP is not included in this proposal.

- b) How would implementation of this recommendation improve the integrity of the FEHBP?

In the October 1, 2011, - March 31, 2012, Semi-annual report to Congress, the Inspector General addressed this issue. The Inspector General's message noted that the FEHBP was specifically excluded from the Anti-Kickback Statute and that activities that constitute criminal behavior when committed under other Federal health care programs are not punishable if they occur in the FEHBP. The impact on the integrity of the FEHBP is that prosecutors pursuing cases under the Anti-Kickback Statute are often reluctant to expand their cases to include similar False Claims Act violations against the FEHBP by the same providers. Thus, we are rendered less able to protect the FEHBP against violations by providers.

14. AFGE's testimony discusses the 40 percent excise tax the Affordable Care Act imposes on certain high cost health plans, describing it as a "regressive tax on federal workers."

- a) How will OPM manage this tax within the FEHBP?

This tax is not expected to take effect until the 2018 plan year. OPM will work with FEHB participating plans to ensure that they meet the requirements of the Affordable Care Act. The Internal Revenue Service has not issued guidance on the tax and plans will need to review such guidance to ensure compliance.

- b) Will this tax be passed along to employees in the form of higher premiums?

Once the Internal Revenue Service issues final guidance on the tax, we will work with the plans to determine the impact on the FEHB Program.

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15. What percentage of federal workers and retirees decline FEHBP coverage because of affordability concerns? Would raising the premium cap help address this concern? How would such a proposal potentially increase more competition among low cost plans?

For 2008, 6.6 percent of Federal employees were uninsured despite being eligible for FEHB coverage. While we can't determine the various reasons for this choice, we know that this population of uninsured Federal employees has a higher concentration of lower income employees than those employees in higher income brackets. Raising the cap on the government contribution (currently 75% of premium) should benefit those who choose low cost plans and potentially attract more low cost plans to participate in the FEHB.

16. OPM has stated that it would use data to recognize plans that are quality leaders on its website. Medicare uses similar data in several ways, including letting consumers compare hospital quality and developing 5-star rankings for Medicare Advantage plans. Does OPM intend to use this quality data to develop similar comparison or ranking tools?

OPM's program for quality measurement is described in Carrier Letter 2012-25 (available at <http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-25.pdf>). All Federal Employees Health Benefits Program Carriers collect and report a set of quality measures which assess health plan performance in key areas such as cancer screening, diabetes care, cardiovascular risk management, prenatal care, and prompt follow up after mental health hospitalization. Results are scored in comparison to national benchmarks for commercial PPO and HMO plans. OPM has included plan HEDIS scores on our website since 2006 for HMOs and since 2009 for fee-for-service plans. Beginning in the fall of 2013, carriers attaining top scores will be recognized by OPM as "Exemplary" and those improving by 20% or more between years will be designated "most improved."

Federal employees can consider plan performance in their choice of plans at Open Season. Healthcare Effectiveness Data and Information Set (HEDIS) metrics by plan are displayed at <http://www.opm.gov/healthcare-insurance/healthcare/quality-healthcare/hedis/2012/index.aspx>

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17. OPM wants insurance carriers to reduce hospital readmissions by 20 percent and cut preventable "hospital acquired conditions," such as falls, by 40 percent. Medicare has developed value-based payment systems that penalize providers for failing to meet similar goals. Does OPM intend to develop a similar program?

Beginning in 2009, OPM encouraged proven strategies to reduce preventable medical errors and allowed FEHB carriers to deny payment for provider claims for the preventable Hospital-Acquired Conditions as long as members were held harmless. OPM does not impose any other penalties for this purpose.

OPM's current approach to reducing readmissions, preventable harms, and prematurity is detailed in Carrier Letter 2012-17 (available at <http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-17.pdf>). In 2012, plans provided data on readmission rates, Neonatal Intensive Care Unit days, and preventable harm rates and, in 2013, plans will add Plan All-Cause Readmission rates to the required quality metrics. Plan performance will be benchmarked and recognized as described in the response to question 16. This year, we also asked carriers to consider hospital performance on measures used by CMS of hospital acquired conditions and early elective delivery as important factors in the choice of network facilities.

18. AFGE's testimony recommends Congress establish a statutory advisory council for the FEHBP, modeled on existing advisory councils for the Thrift Savings Plan and the Federal Salary Council. Would an advisory council impose additional costs on the FEHBP? How would a statutory advisory council improve the value of the FEHBP?

During meetings held at the end of 2012 and beginning of 2013 to discuss the FEHB modernization proposals, OPM and employee organization and union representatives discussed the creation of an FEHBP advisory committee. In particular, OPM personnel inquired about the need for such a committee, the composition of the committee, and frequency of meetings. Both the employee organizations and unions expressed an interest in the creation of such a committee. As a result, OPM has created an FEHB Program Advisory Group and the first meeting is scheduled in May 2013.

The FEHB Program Advisory Group will meet on a semi-annual basis to share information and ideas about the FEHB Program. Although not a decision-making body, the establishment of this Group will improve the flow of information between OPM and FEHB enrollees. Representatives from unions/employee organizations will provide feedback on OPM's FEHB initiatives based on the preferences of their respective members. Membership in this group will be open to any representative of a union/employee organization whose members are Federal employees or annuitants. OPM does not believe that an advisory group of the type described above will impose additional cost on the agency.

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Delegate Eleanor Holmes Norton
Subcommittee on Federal Workforce, U.S. Postal Service and the Census
Committee on Oversight and Government Reform

Hearing: "The Federal Employees Health Benefits Program:
Is it a Good Value for Federal Employees?"

The American Federation of Government Employees (AFGE) has suggested allowing federal employees the opportunity to provide input on the policies of the Federal Employees Health Benefits Program (FEHBP). AFGE suggested a statutory advisory council for FEHBP, based on the model of the Employee Thrift Advisory Council that advises the Federal Retirement Thrift Investment Board on the Thrift Savings Plan and the Federal Salary Council that advises the Administration on federal pay issues.

1. In light of these precedents in comparable federal programs, would OPM object to such an entity or would it recommend such an entity? Please also state the reasons for your position.

During meetings held at the end of 2012 and beginning of 2013 to discuss the FEHB modernization proposals, OPM and employee organizations and unions representatives discussed the creation of an FEHBP advisory committee. In particular, OPM personnel inquired about the need for such a committee, the composition of the committee, and frequency of meetings. Both the employee organizations and unions expressed an interest in the creation of such a committee. As a result, OPM has created an FEHB Program Advisory Group and the first meeting is scheduled in May 2013.

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OPM does not believe that an advisory group of the type described above will impose additional cost on the agency.

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Representative Danny K. Davis
Member of the Committee on Oversight and Government Reform

Hearing: "The Federal Employees Health Benefits Program:
Is it a Good Value for Federal Employees?"

The Federal Employees Health Benefits Program (FEHBP), administered by the Office of Personnel Management (OPM), is the largest employer-sponsored health insurance program in the country and insures approximately eight million people. Since the federal government and FEHBP enrollees share the cost of the program's premiums -with the government and enrollees generally paying about 70% and 30% of premiums, respectively- it is critical to safeguard the program from fraud, waste, and abuse.

1. Does OPM have estimates for the past 3 years of the amount and percentage (compared to total premiums paid or benefits provided) of money that is lost each year due to fraud, waste and abuse in the FEHBP? If so, please provide.

OPM does not have comprehensive estimates of Fraud, Waste and Abuse in the FEHBP; however, the agency's Improper Payments Reporting for FEHBP includes amounts identified and recovered as a result of Investigative settlements and litigation, which are the combined efforts of the OIG, Department of Justice, other law enforcement, FEHB Carriers, and OPM Contracting Officers.

Investigative recoveries are often the result of research, negotiation and/or negotiations that have taken place over several years, but are reported in the year the recoveries were made.

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The below table reflects Investigative recoveries for the last 5 years as a percentage of FEHB Premiums during the same period.

Improper Health Care Overpayments			
Year	Premiums (M)	Invest. Recovered (M)	% of Premium
2012	\$42,558.5	\$167.0	0.39%
2011	\$40,493.0	\$46.8	0.12%
2010	\$38,778.8	\$23.1	0.06%
2009	\$37,093.9	\$38.7	0.10%
2008	\$35,323.5	\$19.9	0.06%

2. Please describe the typical or common situations in which fraud, waste, and abuse may occur in the program.

Health care fraud cases are often time-consuming and complex, and may involve several health care providers, members or plans. Occasionally, multiple health insurance plans are being defrauded and, where appropriate, OPM's Inspector general coordinates investigations with other Federal agencies. OIG criminal investigations are critical to protecting Federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP. Instances of fraud can vary widely to include such activities as the submission of false claims, double-billing, pharmaceutical marketing/irregularities, prescription fraud and more. Of concern are the growth of medical identity theft and organized crime in health care fraud, which has affected the FEHBP.

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3. What efforts have been taken by OPM to reduce the fraud, waste, and abuse in the FEHBP?

OPM exercises continuous oversight of carriers in the FEHBP. Carriers are required to develop programs to assess their vulnerability to fraud and abuse and must have systems designed to detect and eliminate fraud and abuse internally by carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. The program must specify provisions in place for cost avoidance as well as fraud detection, along with criteria for follow-up actions. Carriers must submit an annual analysis of the costs and benefits of its fraud and abuse program to OPM. Carriers report on such items as: cases opened, dollars identified as lost and recovered, savings and prevented loss, referrals to law enforcement, cases referred to the Office of the Inspector General, and number of arrests and criminal convictions. OPM's OIG supports our endeavors to ensure compliance through its audit program in support of the notification, reporting, and other requirements outlined in the contract and other guidance to FEHBP carriers.

OPM's administration of the FEHBP includes substantial controls, providing the framework for effective development, implementation, audit, reporting and oversight of Plans' Fraud and Abuse Programs. OPM/ Healthcare & Insurance exercises continuous oversight of carriers in the FEHBP and, as an employer-purchaser on behalf of the entire Federal community, OPM encourages carriers to adopt and aggressively follow, at minimum, the following industry standards in their fraud and abuse programs:

1. *Anti-Fraud Policy Statement*
 2. *Written Plan and Procedures*
 3. *Formal Employee Training*
 4. *Fraud Hotlines*
 5. *Enrollee Education*
 6. *Fraud Protection Software*
 7. *Security to Protect Claims, Member, and Provider Information*
 8. *Patient Safety*

Currently, the OPM Office of Inspector General (OIG) Suspension and Debarment Team disciplines FEHB participating health care providers who have lost professional licenses, been convicted of a crime related to delivery of or payment for health care services, violated provisions of a Federal program, or are debarred by another Federal agency. These sanctions help assure that FEHB funds will not be paid, either directly or indirectly, to such providers.

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4. Does OPM have estimates for the past 3 years of the amount and percentage (compared to total premiums paid or benefits provided) of money that is recovered each year from OPM's efforts to reduce fraud, waste, and abuse? If so, please provide.

As noted earlier, the fraud and abuse program is based on effective oversight of OPM / Healthcare and Insurance's Contracting Officers. The focus is on plan administration of a program that is comprehensive, effective, and leverages proven components of both the public and private sectors. The presence of strong controls to prevent fraud before it occurs to save funds before they are paid are at least as valuable as funds recovered, which may not indicate the existence of a comprehensive, effective program. That said, in our efforts to evaluate and upgrade FEHBP carrier oversight, including fraud and abuse, we have identified opportunities to enhance the reporting requirements that plans use as the basis to provide fraud and abuse performance metrics to OPM and are working to update plan guidance in this regard.

I support OPM's efforts to expand eligibility for FEHBP coverage to employee's adult children up to the age of 26 and to employees of Tribes, tribal organizations, and urban Indian organizations and their dependents. However, in order to ensure that taxpayer dollars are wisely spent, I believe that OPM's efforts to reduce fraud, waste, and abuse in the FEHBP should include verifying the eligibility of dependents to receive FEHBP coverage.

1. Please explain how OPM verifies the eligibility of dependents to receive FEHBP coverage.

The Federal agencies, not OPM, are responsible for making decisions about whether an employee's family member is eligible for coverage. Each agency has the authority to request whatever documentation it believes is necessary to determine a family member's eligibility. OPM expects the agencies to take reasonable actions.

The Standard Form (SF) 2809 (Health Benefits Election Form) warns employees that any intentionally false statement or willful misrepresentation (such as listing ineligible individuals as family members) is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 10 years. Electronic enrollment systems contain similar warnings. If an agency suspects that a person listed is not an eligible family member, the agency may request documentation such as a marriage license or birth certificate. If the employee refuses to provide documentation, the agency may refer the case to their Inspector General for investigation.

Foster children are covered if the employee certifies that certain requirements are met. If an agency has concerns over whether the requirements have been met, it may request documentation from the employee.

OPM allows the FEHB plans to add new family members to existing self and family enrollments.

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The plans are allowed to request documentation proving the person is an eligible family member. OPM encourages plans to request the documentation.

2. How does OPM prevent waste, fraud, and abuse with respect to dependent eligibility for FEHBP coverage?

OPM has made an extensive effort to ensure that only eligible employees, annuitants and family members are covered under the FEHB Program.

The FEHB Centralized Electronic Enrollment Reconciliation Clearinghouse (CLER) went operational on June 1, 2002. CLER is a computer match program that compares the FEHB enrollment records of federal agencies against enrollment records of FEHB Program carriers. CLER identifies discrepancies in the records and posts discrepancies on a web site for the agencies and carriers to use in resolving enrollment discrepancies.

- *In June 2002 the error rate (calculated by dividing the number of records where a discrepancy has been identified by the number of records submitted) for the carriers was 15%. Currently the error rate for the carriers is 2%.*
- *In June 2002 the carriers had approximately 140,000 more enrollment records than did the payroll offices. Currently that number is down to approximately 25,000.*

We continue to work with both the agencies and the carriers to lower the error rate and the number of excess enrollment records.

