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FEHBP: OPM'S POLICY GUIDANCE FOR 2001

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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FEHBP: OPM'S POLICY GUIDANCE FOR 2001

TUESDAY, JUNE 13, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2154, Rayburn House Office Building, Hon. Joe Scarborough (chairman of the subcommittee) presiding.

Present: Representatives Scarborough, Morella, Cummings, and Norton.

Staff present: Garry Ewing, staff director; Jennifer Hemingway, deputy staff director; Bethany Jenkins, clerk; Earley Green, minority assistant clerk; and Tania Shand, minority professional staff member.

Mr. SCARBOROUGH. The hearing will come to order.

I welcome everyone to this hearing and thank you for your interest in the Federal Employees Health Benefits Program [FEHBP].

One of the most important duties of this subcommittee is to oversee this critical program. Approximately 9 million Federal employees, retirees, and their families rely on FEHBP for health care coverage. The program has been widely cited as a model employer-sponsored health benefits program and even as a model for reforming Medicare. The key to its success has been the affordable premiums and consumer choice that results from hundreds of health benefits plans competing for the business of individual employees and retirees.

Even though it is an excellent program, the FEHBP, like all health care plans today, faces serious challenges. Premiums have risen dramatically over the past 3 years, and another substantial increase seems imminent for 2001.

The purpose of today's hearing is to examine OPM's administration of this critically important program. We will examine the policies established in OPM's call letter for 2001, as well as several ongoing matters.

I was disappointed to see in this year's call letter no retreat from OPM's practice of continuing to impose mandates on the FEHBP. In previous hearings, we have been warned that mandates drive up premiums. Though each mandate looks reasonable when considered in isolation, their cumulative effect is to increase program costs and deprive consumers and carriers of the flexibility to meet their needs while controlling costs.

And once again, it appears that drug costs are major contributors to rising health care costs. As anyone who reads the newspapers

knows, Congress is very concerned about rising drug costs. This subcommittee is no less concerned. But before either this subcommittee or this Congress rush to propose or approve a solution, I strongly believe we must first develop a complete understanding of the causes of this situation and the impact of possible responses to it. We must follow the Hippocratic oath and, "First do no harm." We should not let short-run pressures lead us to embrace approaches that will do long-term harm to our employees and retirees by degrading the quality of health care coverage under the FEHBP.

I now pass the mic over to my ranking member, Mr. Cummings.

[The prepared statement of Hon. Joe Scarborough follows:]

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OPENING STATEMENT
CHAIRMAN JOE SCARBOROUGH
SUBCOMMITTEE ON THE CIVIL SERVICE
"FEHBP: OPM'S POLICY GUIDANCE FOR 2001"
JUNE 13, 2000

I welcome everyone to this hearing and thank you for interest in the Federal Employees Health Benefits Program (FEHBP).

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Mr. CUMMINGS. Thank you, Mr. Chairman. The subcommittee convened a hearing on the administration policy guidance issue in the Office of Personnel Management call letter. At the hearing for the 2000 call letter, we addressed the impact of President Clinton's executive memorandum mandating FEHBP compliance with the Patient Bill of Rights and the application of cost accounting standards to FEHBP contracts. While there are many new issues to address at this hearing, a few are reoccurring.

This year's call letter reflects President Clinton's directive for mental health and substance abuse treatment parity in the Federal Employees Health Benefits Program and, to the maximum extent possible, a reduction in medical errors and enhanced patient safety in the program.

Specifically, the 2001 call letter calls for health plans' coverage for mental health and substance abuse to be identical to traditional medical care deductibles, coinsurance, co-pays and day and visit limitations. To reduce medical errors and improve the quality of health care, FEHBP plans are required to report to OPM on their patient safety initiative, to educate and inform enrollees about safety, and to work with other health care providers to improve patient safety programs.

I look forward to hearing testimony on both of these initiatives. Rising premium and prescription drug costs are of ongoing concern to the subcommittee. Last session I called for hearings on this issue. Federal employees have endured dramatic increases in their health care premiums for 3 straight years. The 9.3 percent FEHBP premium increase for 2000 was preceded by a 9.5 percent increase in 1999 and a 7.2 percent increase in 1998.

The increases in FEHBP premiums reflect what is occurring throughout the health care marketplace which, among other things, can be attributed to an aging population and an ever-increasing prescription drug cost. Forty-one percent of postal and nonpostal FEHBP enrollees are over the age of 61. Given the aging Federal work force and the fact that older Americans are the largest consumers of prescription drugs, the Federal Government has a responsibility to all its employees to explore any and all avenues that may contain premium and prescription drug costs.

Finally, I understand that there is some controversy over the application of cost accounting standards to FEHBP contracts. Cost accounting standards are designed to increase the uniformity and consistency for which cost accounting data is supplied by contractors to the government for the purposes of assisting in either negotiation, pricing, or administration of contracts. CAS are applied to all contractors that performed under negotiated cost-based pricing arrangements with the Federal Government in order to ensure that costs are properly allocated. Blue Cross and Blue Shield continues to raise concerns about the difficulties of implementing cost accounting standards on FEHBP plan contracts.

The American Federation of Government Employees believes that FEHBP contracts should be subject to the standards so agencies can ensure the accuracy of bills submitted by contractors.

I am looking forward to testimony from all the witnesses on all of these issues. I am particularly interested in your views on how to maintain premium and prescription drug costs. Federal employ-

ees are feeling the effects of these increased costs every day. With that, Mr. Chairman, I thank you.

Mr. SCARBOROUGH. Thank you, Mr. Cummings. We have two votes, but I think we have time to hear Mr. Flynn's testimony so let me ask you, Mr. Flynn to come up. Mr. Flynn was appointed as Associate Director for Retirement and Insurance at the Office of Personnel Management in 1994. He directs the Federal retirement systems, and the Federal Employees Health Benefits Program and the group life insurance program, and in 1999 President Clinton recognized Mr. Flynn with a distinguished senior executive award. He has been a frequent witness before this subcommittee and we welcome you back here today.

Let me ask you to rise so we can administer the oath.

[Witness sworn.]

Mr. SCARBOROUGH. Mr. Flynn you may begin your statement.

STATEMENT OF WILLIAM "ED" FLYNN III, DIRECTOR, RETIREMENT AND INSURANCE SERVICE, OFFICE OF PERSONNEL MANAGEMENT

Mr. FLYNN. Good morning, Mr. Chairman and Mr. Cummings. I want to thank you for your invitation to be here today to discuss our policy guidance to health plans participating in the Federal Employees Health Benefits Program. We are pleased to report that the Federal Employee Program continues to be a model employer-based health benefits program that owes its success to market competition and informed consumer choice. We remain committed to providing access to high-quality, affordable health coverage for Federal employees and retirees and members of their families.

Our approach each year concentrates on desired outcomes, leaving as much flexibility as possible for individual plans to make specific proposals that will best serve their members.

Today I would like to discuss our major initiatives for next year: mental health and substance abuse parity and reducing medical errors and improving patient safety. At the White House Conference on Mental Health last June, the President directed OPM to achieve benefit parity for mental health and substance abuse treatment in the Federal Employees Health Benefits Program. Next year all plans will provide coverage for clinically proven treatments for mental illness and substance abuse in a manner identical to coverage for other medical conditions. Deductibles, coinsurance, copayments and day and visit limitations will parallel one another under parity.

Based on research by the National Institute of Mental Health and others, indicating a growing consensus on treatment protocols and the effectiveness of managed care delivery systems, we concluded that it is possible to expand access to care in an affordable way.

A preliminary review of proposals for next year indicates that plans will use networks of providers extensively to deliver the parity benefit. Now, the degree of management within those networks will vary from plan to plan, as is typically the case. Most analysts familiar with the Federal Employees Health Benefits Program assume that parity might increase costs somewhere between 1 and 3 percent of the total premium. We will know that with certainty

when our negotiations are concluded later this summer, but all of the evidence suggests that we will be well under the upper level of that range.

Late last year, the Institute of Medicine report on medical errors riveted our attention on this topic. The President set a goal for the Nation to reduce preventable medical errors by 50 percent over 5 years. We believe patient safety is a vital issue demanding priority attention from all of us. We are not imposing any unique requirements on health plans. We are, however, requiring their support of effective strategies that promote health care quality.

These efforts will not result in any cost increases this year. We will require plans to advise us on error reduction strategies they currently have in place and to describe their future plans to strengthen their safety program and will publicize this information to our members this fall. We have asked plans to designate a person or an office to manage their patient safety initiatives.

We are also encouraging plans to consider error reduction strategies endorsed by others such as the Business Roundtable's Leapfrog Group.

We stress the importance of working with providers and others to implement systems that ensure patients receive appropriate services in optimal settings and that providers who employ sound practices are noted and rewarded.

Finally, in 2002 we will require all plans to begin seeking accreditation from a nationally recognized organization that has incorporated patient safety standards into its accreditation requirements.

Now, the call letter also provided guidance on several other issues, including sections on prescription drug benefits, and coverage for high-dose chemotherapy and autologous bone marrow transplants. The statement I have submitted for the record covers each of these topics and several others and I will be happy to answer any questions you may have about them.

Finally, the budget for next year assumes an average premium increase of 8.7 percent. While useful for budget planning purposes, the actual amount will not be known until our negotiations have been completed at the end of the summer. The trends that we described last year continue to affect our program and those of other employers. While the summer's negotiations will yield the final result, I am not optimistic about the trends we continue to see. Last fall Director Lachance said these premium increases were unacceptable—she continues to feel that way—and that she intended to seek amendments to the current law to counteract them.

We want the ability to set standards for health plan participation that will promote health care quality and cost effectiveness and we want authority to achieve economies and efficiencies of scale by contracting directly for selected benefits. A draft proposal to accomplish these objectives is currently under development within the administration, and when the internal clearance process is completed, we expect to transmit it to the Congress for their consideration.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions that you may have.

Mr. SCARBOROUGH. Thank you, Mr. Flynn.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
OFFICE OF PERSONNEL MANAGEMENT

at an oversight hearing of the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

on

FEHBP: OPM'S POLICY GUIDANCE FOR 2001

June 13, 2000

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR CONVENING THIS HEARING TO REVIEW OFFICE OF PERSONNEL MANAGEMENT (OPM) POLICY GUIDANCE FOR UPCOMING CONTRACT NEGOTIATIONS WITH HEALTH PLANS ELIGIBLE TO PARTICIPATE IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) DURING THE YEAR 2001.

WE ARE PLEASED TO REPORT THAT THE FEDERAL EMPLOYEE PROGRAM CONTINUES TO BE A MODEL EMPLOYER-BASED HEALTH BENEFITS PROGRAM THAT OWES ITS SUCCESS TO MARKET COMPETITION AND INFORMED CONSUMER CHOICE. WE REMAIN COMMITTED TO PROVIDING ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH CARE COVERAGE FOR FEDERAL EMPLOYEES AND RETIREES.

AT THE SAME TIME, AS ADMINISTRATOR OF THE NATION'S LARGEST GROUP HEALTH PROGRAM, WE KNOW THAT WE ARE IN A UNIQUE POSITION TO PROVIDE PROGRESSIVE LEADERSHIP IN HELPING TO IMPROVE GENERAL ACCESS TO ESSENTIAL HEALTH SERVICES AND EFFECTIVELY PROMOTING NATIONAL HEALTH CARE PRIORITIES.

ANNUAL CONTRACTING FOR THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM CUSTOMARILY BEGINS WITH A CALL LETTER LIKE THE ONE WE ISSUED TO HEALTH PLANS ON APRIL 11, 2000. THE LETTER PROVIDES OUR POLICY GUIDANCE ON PLAN BENEFITS, PERFORMANCE AND ADMINISTRATION TO ENSURE THAT THE APPROXIMATELY 9 MILLION ELIGIBLE BENEFICIARIES WHO DEPEND ON THE PROGRAM HAVE ACCESS TO THE HEALTH SERVICES THEY NEED AT AN AFFORDABLE COST. OUR APPROACH IN THE CALL LETTER IS TO CONCENTRATE ON DESIRED OUTCOMES, RATHER THAN THE PROCESSES FOR ACHIEVING THEM. OUR GUIDANCE LEAVES AS MUCH FLEXIBILITY AS POSSIBLE FOR INDIVIDUAL PLANS TO PROPOSE ACCEPTABLE BENEFIT PACKAGES THAT WILL BEST SERVE THEIR PLAN MEMBERS.

EACH PLAN'S BENEFITS AND RATES ULTIMATELY ARE THE PRODUCT OF BILATERAL NEGOTIATIONS. WE VALUE THE OPPORTUNITY THIS AFFORDS TO PARTNER WITH HEALTH PLANS AND OFFER A RANGE OF HIGH-QUALITY CHOICES. IN FACT, THIS YEAR'S CALL LETTER BEGAN BY ACKNOWLEDGING

AND THANKING THE PLANS FOR THEIR COOPERATION IN SUCCESSFULLY IMPLEMENTING MANY IMPORTANT PROGRAM INITIATIVES IN RECENT YEARS AS A RESULT OF THIS COLLABORATION, THE IMPROVEMENTS WE HAVE ADVANCED OVER THE YEARS HAVE BEEN ACHIEVED WITH MINIMAL IMPACT ON PREMIUMS.

TODAY, I WOULD LIKE TO DISCUSS OUR MAJOR INITIATIVES FOR CONTRACT YEAR 2001 - MENTAL HEALTH AND SUBSTANCE ABUSE PARITY, AND REDUCING MEDICAL ERRORS AND IMPROVING PATIENT SAFETY.

MENTAL HEALTH AND SUBSTANCE ABUSE PARITY

AT THE WHITE HOUSE CONFERENCE ON MENTAL HEALTH HELD ON JUNE 7, 1999, THE PRESIDENT DIRECTED OPM TO ACHIEVE BENEFIT PARITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM BY CONTRACT YEAR 2001.

OUR PARITY INITIATIVE WILL EXPAND THE RANGE OF BENEFITS OFFERED WHILE MANAGING THEM EFFECTIVELY. THIS MEANS THAT ALL HEALTH PLANS WILL PROVIDE COVERAGE FOR CLINICALLY-PROVEN TREATMENTS FOR MENTAL ILLNESS AND SUBSTANCE ABUSE IN A MANNER IDENTICAL TO COVERAGE FOR OTHER MEDICAL CONDITIONS. DEDUCTIBLES, COINSURANCE,

COPAYMENTS, AND DAY AND VISIT LIMITATIONS WILL PARALLEL ONE ANOTHER UNDER PARITY.

IN DEVELOPING OUR PARITY STRATEGY, WE REVIEWED A GROWING BODY OF RESEARCH AND ACTUAL INDUSTRY EXPERIENCE THAT INDICATES THAT PARITY CAN BE IMPLEMENTED WITHOUT SUBSTANTIALLY INCREASING PREMIUMS AS LONG AS IT IS COUPLED WITH CARE MANAGEMENT TO ENSURE THAT ONLY APPROPRIATE AND EFFECTIVE TREATMENT IS AUTHORIZED. WE ALSO LEARNED THAT CARE MANAGEMENT CAN BE IMPLEMENTED IN DIFFERENT WAYS. MANY HEALTH PLANS HIRE SPECIALIZED MANAGED BEHAVIORAL HEALTH CARE COMPANIES TO PROVIDE MENTAL HEALTH SERVICES FOR PLAN MEMBERS, OR TO MANAGE SERVICES AVAILABLE FROM THE HEALTH PLAN'S EXISTING NETWORK PROVIDERS. OTHERS SUCCESSFULLY MANAGE SERVICE DELIVERY THEMSELVES.

BASED ON RESEARCH BY THE NATIONAL INSTITUTE OF MENTAL HEALTH AND OTHERS INDICATING A GROWING CONSENSUS ON TREATMENT PROTOCOLS AND THE EFFECTIVENESS OF MANAGED CARE DELIVERY SYSTEMS, WE CONCLUDED THAT IT IS POSSIBLE TO EXPAND ACCESS TO CARE IN AN AFFORDABLE WAY.

THE PRESIDENT'S DIRECTIVE TO ACHIEVE FULL PARITY CULMINATED

COLLABORATIVE EFFORTS ALREADY UNDERWAY BY OPM AND THE HEALTH PLANS TO IMPROVE MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE IN THE PROGRAM. FOR EXAMPLE, IN 1995, PRIOR TO THE FEDERAL MENTAL HEALTH PARITY ACT OF 1996, OUR PROGRAM ABOLISHED LIFETIME BENEFIT MAXIMUMS ON MENTAL HEALTH BENEFITS. IN 1999, ALL FEDERAL EMPLOYEE PLANS BEGAN PROVIDING THE SAME COVERAGE FOR OFFICE VISITS AND DIAGNOSTIC TESTING FOR MANAGING DRUG TREATMENT FOR MENTAL CONDITIONS AS FOR ANY OTHER MEDICAL CONDITION.

AT OUR 1998 AND 1999 CONFERENCES WITH HEALTH PLANS , WE FEATURED PRESENTATIONS BY PANELS OF EXPERTS WHO DISCUSSED THE DESIRABILITY AND FEASIBILITY OF OFFERING EXPANDED AND AFFORDABLE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS. FOLLOWING THE 1999 CONFERENCE, WE MET WITH OUR LARGER HEALTH PLANS, HEALTH NETWORK MANAGERS, AND HEALTH INDUSTRY ASSOCIATIONS TO ADDRESS THE INITIATIVE. TO HELP US IN DEVELOPING SPECIFIC GUIDANCE FOR IMPLEMENTATION OF FULL PARITY, WE CONTRACTED WITH THE WASHINGTON BUSINESS GROUP ON HEALTH FOR A REPORT ON THE EXPERIENCES OF OTHER LARGE EMPLOYERS WHO CURRENTLY PROVIDE PARITY OR NEAR PARITY BENEFITS, WITH RECOMMENDATIONS ON BEST PRACTICES AND POTENTIAL PITFALLS. THE REPORT IS AVAILABLE ON OUR WEB SITE [WWW.OPM.GOV/INSURE].

IN KEEPING WITH OUR WELL-ESTABLISHED PRACTICE OF COLLABORATING WITH HEATH PLANS ON ATTAINING PROGRAM GOALS, THE 2000 CALL LETTER BROADLY OUTLINES WHAT WE CONSIDER THE ESSENTIAL COMPONENTS OF PARITY. FOR EXAMPLE, COVERED SERVICES MUST INCLUDE TREATMENT FOR ALL CATEGORIES OF MENTAL HEALTH AND SUBSTANCE ABUSE CONDITIONS LISTED IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TO THE EXTENT THAT THE SERVICES FOR THESE CONDITIONS ARE INCLUDED IN AUTHORIZED TREATMENT PLANS. THE EXTENT OF COVERAGE IN ANY PARTICULAR CASE WILL DEPEND ON GENERALLY-ACCEPTED PROTOCOLS FOR TREATING THE PARTICULAR CONDITION AND EACH HEALTH PLAN'S BENEFIT DESIGN FEATURES. WE ALSO EMPHASIZE THE IMPORTANCE OF DEVELOPING EFFECTIVE STRATEGIES FOR EDUCATING PLAN MEMBERS AND MEDICAL PROVIDERS ABOUT MENTAL HEALTH AND SUBSTANCE ABUSE NETWORK ENTRY AND REFERRAL PROCEDURES.

A PRELIMINARY REVIEW OF PROPOSALS FOR 2001 INDICATES THAT PLANS WILL USE NETWORKS OF PROVIDERS EXTENSIVELY TO DELIVER PARITY BENEFITS. HOWEVER, THE DEGREE OF MANAGEMENT WITHIN THOSE NETWORKS WILL VARY FROM PLAN TO PLAN.

FINALLY, WE ARE COLLABORATING WITH THE DEPARTMENT OF HEALTH AND

HUMAN SERVICES IN CONTRACTING FOR A MULTI-YEAR EVALUATION OF IMPLEMENTATION AND OPERATION OF THE FEDERAL EMPLOYEES MENTAL HEALTH PARITY INITIATIVE, AND AN ANALYSIS OF THE IMPLICATIONS OF PARITY FOR OTHER EMPLOYERS, HEALTH PLANS, AND PLAN PARTICIPANTS. WE ALSO WILL ENCOURAGE COOPERATIVE EFFORTS BETWEEN HEALTH PLANS AND NATIONAL INDEPENDENT ACCREDITING ORGANIZATIONS TO DEVELOP STANDARDS AND MEASURES TO ASSIST PURCHASERS IN EVALUATING THE DELIVERY OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

A NATIONAL ADVISORY MENTAL HEALTH COUNCIL STUDY INDICATES THAT ACTUAL INDUSTRY EXPERIENCE HAS SHOWN A 30-50 PERCENT COST SAVINGS ON MENTAL HEALTH BENEFITS WHEN INTRODUCED WITH MANAGED CARE TECHNIQUES IN MARKETS WITH LITTLE PRIOR MANAGED CARE EXPERIENCE. IN MARKETS ALREADY UTILIZING MANAGED CARE TECHNIQUES PRIOR TO THE INTRODUCTION OF PARITY, TOTAL HEALTH PLAN PREMIUMS INCREASED BY LESS THAN 1 PERCENT.

AT THE END OF THIS SUMMER'S CONTRACT NEGOTIATIONS WE WILL KNOW MORE DEFINITIVELY WHAT EFFECT MENTAL HEALTH PARITY WILL HAVE ON PREMIUMS, BUT ALL OF THE EVIDENCE TO DATE SUGGESTS THAT THESE MEASURES WILL BE QUITE AFFORDABLE.

REDUCING MEDICAL ERRORS AND IMPROVING PATIENT SAFETY

IN NOVEMBER 1999, THE INSTITUTE OF MEDICINE (IOM) REPORT, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, FOCUSED ATTENTION ON MEDICAL ERRORS AND PATIENT SAFETY. THIS REPORT EMPHASIZED THAT MOST MEDICAL ERRORS ARE SYSTEMS RELATED, RATHER THAN ATTRIBUTABLE TO INDIVIDUAL NEGLIGENCE OR MISCONDUCT. IT CONCLUDED THERE ARE PRACTICAL STEPS THAT ORGANIZATIONS. INCLUDING HEALTH PLANS, CAN TAKE TO ENCOURAGE IMPROVEMENTS THAT WILL REDUCE ERRORS AND PROMOTE HEALTH CARE QUALITY. ON DECEMBER 7, 1999, THE PRESIDENT DIRECTED THE QUALITY INTERAGENCY COORDINATION (QuIC) TASK FORCE TO EVALUATE THE RECOMMENDATIONS IN THE IOM REPORT AND TO FORMULATE A FEDERAL RESPONSE. THE WHITE HOUSE RELEASED THE QuIC REPORT, DOING WHAT COUNTS FOR PATIENT SAFETY: FEDERAL ACTIONS TO REDUCE MEDICAL ERRORS AND THEIR IMPACT, ON FEBRUARY 22. OPM WAS PLEASED TO WORK WITH THE OTHER QuIC AGENCIES WITH FEDERAL HEALTHCARE RESPONSIBILITIES TO DEVELOP IT.

THE PRESIDENT HAS SET A GOAL FOR THE NATION OF A 50 PERCENT REDUCTION IN PREVENTABLE MEDICAL ERRORS IN 5 YEARS. WE BELIEVE THAT PATIENT SAFETY IS A VITAL ISSUE AND DEMANDS PRIORITY

ATTENTION BY ALL HEALTH CARE PURCHASERS, PROVIDERS, AND USERS. THE IOM REPORT, THE QuIC REPORT, AND THE PRESIDENT'S RESPONSE HAVE MOBILIZED FEDERAL AGENCIES, PRIVATE SECTOR HEALTH CARE PURCHASERS, INDEPENDENT ACCREDITING ORGANIZATIONS, AND HEALTH CARE QUALITY COALITIONS TO SEEK AND SUPPORT APPROACHES SHOWN BY SCIENTIFIC EVIDENCE TO HAVE A POSITIVE IMPACT ON SAFETY.

WE WILL NOT IMPOSE UNIQUE REQUIREMENTS ON HEALTH PLANS IN OUR PROGRAM, BUT RATHER ENCOURAGE THEIR SUPPORT OF STRATEGIES THAT HAVE DEMONSTRATED EFFECTIVENESS IN PROMOTING HEALTH CARE QUALITY. FOR CONTRACT YEAR 2001, WE EXPECT ALL PLANS, AT A MINIMUM, TO ADVISE US ON ERROR-REDUCTION STRATEGIES THEY CURRENTLY HAVE IN PLACE-- FOR EXAMPLE, SYSTEMS TO ALERT PHARMACIES TO POTENTIALLY HARMFUL DRUG INTERACTIONS, DISEASE MANAGEMENT PROGRAMS TO MONITOR CARE OF PATIENTS WITH CHRONIC DISEASES-- AND FUTURE PLANS TO STRENGTHEN THEIR SAFETY PROGRAM. DURING THE OPEN SEASON THIS FALL, WE WILL PROVIDE OUR MEMBERS WITH INFORMATION ABOUT WHAT PLANS ARE DOING TO ASSURE THAT PATIENT SAFETY IS A PRIORITY AND WHAT INITIATIVES ARE IN PLACE TO SUPPORT THIS PRIORITY. WE ALSO EXPECT PLANS TO COOPERATE WITH PROVIDERS, INDEPENDENT ACCREDITATION AGENCIES AND OTHERS ON PATIENT SAFETY IMPROVEMENT PROGRAMS. IN THE INTEREST OF

INFORMING FEHBP MEMBERS AND HELPING HEALTH PLANS LEARN FROM AND SHARE BEST PRACTICES FOR PATIENT SAFETY, WE WILL REPORT THEIR INITIATIVES ON OUR WEB SITE. THESE EFFORTS WILL NOT CAUSE ANY PROGRAM COST INCREASES FOR CONTRACT YEAR 2001. MORE IMPORTANTLY, THE EVIDENCE IS CLEAR THAT EFFECTIVE ERROR-REDUCTION PROGRAMS ULTIMATELY REDUCE HEALTH CARE COSTS, PROMOTE QUALITY CARE, AND RESULT IN HEALTHIER PEOPLE.

AS AN INTEGRAL PART OF THIS EFFORT, WE ARE ENCOURAGING OUR PLANS TO DESIGNATE A PERSON OR OFFICE TO MANAGE PATIENT SAFETY INITIATIVES. WE ALSO ARE ENCOURAGING PLANS TO CONSIDER ERROR-REDUCTION STRATEGIES ENDORSED BY EMPLOYER HEALTH CARE COALITIONS SUCH AS THE BUSINESS ROUND TABLE'S LEAPFROG GROUP. WE ALSO STRESS THE IMPORTANCE OF WORKING WITH NETWORK PROVIDERS ON IMPLEMENTATION OF ACCOUNTABILITY SYSTEMS TO ENSURE THAT PATIENTS RECEIVE APPROPRIATE SERVICES IN OPTIMAL SETTINGS AND THAT PROVIDERS WHO EMPLOY SOUND PRACTICES ARE NOTED AND REWARDED. AT A MINIMUM, WE ENCOURAGE PLANS TO ANNOTATE PROVIDER DIRECTORIES ACCORDINGLY AND EDUCATE PLAN MEMBERS ABOUT SUCH INITIATIVES. IN 2002, WE WILL REQUIRE ALL PLANS IN OUR PROGRAM TO BEGIN SEEKING ACCREDITATION FROM A NATIONALLY-RECOGNIZED ORGANIZATION THAT HAS INCORPORATED APPROPRIATE PATIENT SAFETY

STANDARDS INTO ITS ACCREDITATION REQUIREMENTS.

THE CALL LETTER ALSO PROVIDED GUIDANCE ON SEVERAL OTHER ISSUES. IT INCLUDED SECTIONS ON PRESCRIPTION DRUG BENEFITS AND COVERAGE FOR HIGH DOSE CHEMOTHERAPY/AUTOLOGOUS BONE MARROW TRANSPLANTATION.

EQUITABLE DRUG FORMULARIES

BECAUSE PRESCRIPTION DRUG COSTS REPRESENT A SIGNIFICANT PORTION OF PROGRAM COSTS AND PREMIUMS, HEALTH PLANS ARE INCREASINGLY FOCUSING ON COST CONTAINMENT THROUGH USE OF DRUG FORMULARIES AND COST SHARING DIFFERENTIALS TO ENCOURAGE USE OF THE LOWEST COST, THERAPEUTICALLY EFFECTIVE DRUG. WE SUPPORT PLAN INITIATIVES TO CONTROL COSTS AND AGREE THAT PLAN MEMBERS SHOULD ASSUME RESPONSIBILITY WHEN THEY CHOOSE ONE DRUG OVER ANOTHER AS A MATTER OF PERSONAL PREFERENCE. HOWEVER WE ARE VERY CONCERNED ABOUT FORMULARIES THAT FEATURE 3-TIER COPAYS – GENERIC, PREFERRED NAME BRAND, AND NON-PREFERRED NAME BRAND – AND USE THE THIRD TIER SIMPLY TO SHIFT GREATER COSTS FOR WIDELY USED DRUGS TO MEMBERS. WE WILL REQUIRE ALL NEWLY-PROPOSED 3-TIER DRUG FORMULARIES TO DOCUMENT THAT THE MAJORITY OF SAVINGS COME FROM

CHANGING PRACTICE PATTERNS, INCENTIVES FOR USE OF DRUGS WITH LOWER INGREDIENT COSTS, OR IMPROVED MANUFACTURER DISCOUNTS. PLANS WITH 3-TIER FORMULARIES NOW IN PLACE NEED TO EVALUATE THEM AND BE PREPARED TO SUPPORT THEIR APPROPRIATENESS WITH COST SAVINGS DATA. WE WILL BE LOOKING AT PLAN DESIGNS TO ENSURE THAT THE CHOICES AVAILABLE TO MEMBERS ARE CLEAR, AND THE ASSOCIATED COSTS VISIBLE AND UNDERSTANDABLE.

COVERAGE OF ABMT FOR BREAST CANCER

OPM HAS NOT CHANGED ITS 1994 DECISION TO REQUIRE ALL PLANS TO OFFER BENEFITS FOR AUTOLOGOUS BONE MARROW TRANSPLANT WITH HIGH DOSE CHEMOTHERAPY (ABMT) CONSISTENT WITH CURRENT MEDICAL PRACTICE. AS IN THE PAST, PLANS MAY ELECT TO RESTRICT COVERAGE OF TREATMENT TO CENTERS OF EXCELLENCE OR PARTICIPATION IN QUALIFIED CLINICAL TRIALS IN THE INTEREST OF DIRECTING PATIENTS TO AN OPTIMAL SETTING AND BRINGING ABOUT THE MOST POSITIVE OUTCOMES. OUR POLICY IS CONSISTENT WITH THE APPROACH CURRENTLY FOLLOWED BY SOME OF THE NATION'S LARGEST INSURERS AND REFLECTS OUR BELIEF THE PATIENT AND A QUALIFIED PHYSICIAN ARE IN THE BEST POSITION TO EVALUATE AND DECIDE UPON TREATMENT OPTIONS. CLEARLY, THESE DECISIONS MUST BE MADE ON THE BASIS OF WHAT IS MEDICALLY EFFECTIVE, AND NOT SOLELY

ON THE BASIS OF CONTRACT LANGUAGE.

WE ARE AWARE OF STUDY RESULTS AND REPORTS THAT HAVE RESURFACED QUESTIONS ABOUT THE APPROPRIATENESS OF THIS TREATMENT. NEVERTHELESS, CLINICAL TRIALS ON THIS THERAPY FOR BREAST CANCER ARE CONTINUING. GIVEN THIS, WE DETERMINED THAT CHANGING OUR BASIC COVERAGE REQUIREMENT WAS NOT NECESSARY. WE CONTINUE TO BELIEVE IN THE EFFECTIVENESS OF THE APPROACH WE TOOK EARLIER.

CLAIMS FOR ABMT IN OUR PROGRAM HAVE DECLINED STEADILY SINCE WE BEGAN COVERING THE PROCEDURE. IN THE WAKE OF STUDIES RELEASED IN 1999 THAT FOUND NO DIFFERENCE IN SURVIVAL RATES FOR PATIENTS WHO UNDERWENT ABMT THAN THOSE WHO ACCEPTED MORE CONVENTIONAL TREATMENT, THE NUMBER OF ABMT PROCEDURES FOR BREAST CANCER COVERED BY FEDERAL EMPLOYEES PROGRAM PLANS DROPPED FROM 88 IN 1997 TO 40 LAST YEAR. WE BELIEVE THIS AFFIRMS THE CORRECTNESS OF THE RATIONALE BEHIND THE DECISION WE MADE.

YOU ALSO ASKED FOR INFORMATION ON SEVERAL ITEMS THAT WERE NOT MENTIONED IN OUR ANNUAL CALL LETTER.

PILOT FOR PRESCRIPTION DRUGS FOR SAMBA

FIRST, LET ME REPORT ON THE ISSUE OF THE PILOT PROGRAM TO ACCESS THE FEDERAL SUPPLY SCHEDULE FOR PRESCRIPTION DRUGS FOR THE SPECIAL AGENTS MUTUAL BENEFIT ASSOCIATION (SAMBA).

AS PART OF ITS RATE AND BENEFIT PROPOSAL FOR THE 2000 CONTRACT YEAR, SAMBA REQUESTED OPM AUTHORIZATION TO ACCESS THE PHARMACEUTICAL FEDERAL SUPPLY SCHEDULE TO ACQUIRE PRESCRIPTION DRUGS FOR ITS MAIL ORDER DRUG BENEFIT. THE OFFICE OF PERSONNEL MANAGEMENT DETERMINED THAT ALLOWING FOR A TWO-YEAR DEMONSTRATION IS CONSISTENT WITH OUR GOAL OF RESPONSIBLE MANAGEMENT OF THIS PROGRAM AND IS PERMISSIBLE UNDER CURRENT LAW.

WE HAVE BEEN WORKING WITH THE DEPARTMENT OF VETERANS AFFAIRS TO REACH AGREEMENT ON CONDITIONS OF A PILOT UNDER WHICH SAMBA MAY PLACE ORDERS UNDER THE FEDERAL SUPPLY SCHEDULE PROGRAM.

THE GOAL OF THE PILOT WILL BE TO DETERMINE IF A SCHEDULE SIMILAR TO THE FSS SHOULD BE ESTABLISHED TO PROVIDE PHARMACY BENEFITS TO THE FEHBP COMMUNITY. THE DEPARTMENT OF VETERANS AFFAIRS WILL

PROVIDE LOGISTICAL SUPPORT TO OPM. AT THE SAME TIME, THE OFFICE OF MANAGEMENT AND BUDGET WILL MAINTAIN SUFFICIENT OVERSIGHT OF THE PILOT TO ENSURE THAT THE INITIATIVE DOES NOT ADVERSELY AFFECT THE DEPARTMENT OF VETERANS AFFAIRS AND THE FEDERAL BUDGET

LEGISLATION TO HELP CONTROL FUTURE PREMIUM INCREASES

LAST FALL, WHEN WE ANNOUNCED PREMIUMS FOR THE YEAR 2000, DIRECTOR LACHANCE SAID THAT THE PREMIUM INCREASES OF THE LAST SEVERAL YEARS WERE UNACCEPTABLE AND THAT SHE INTENDED TO SEEK AMENDMENTS TO THE CURRENT LAW TO COUNTERACT THEM. FIRST, WE WANT THE ABILITY TO SET STANDARDS FOR HEALTH PLAN PARTICIPATION THAT WILL PROMOTE HEALTH CARE QUALITY AND COST-EFFECTIVENESS. SECOND, WE NEED AUTHORITY TO ACHIEVE EFFICIENCIES AND ECONOMIES OF SCALE BY CONTRACTING DIRECTLY FOR SELECTED BENEFITS.

SURVEYS AND FOCUS GROUPS WITH PROGRAM PARTICIPANTS HAVE CONSISTENTLY IDENTIFIED DENTAL BENEFITS AS AN AREA WHERE PARTICIPANTS WANT MORE COMPREHENSIVE COVERAGE. THE EXPERIENCE OF OTHER LARGE EMPLOYERS DEMONSTRATES THAT STAND-ALONE DENTAL INSURANCE CAN BE COST-EFFECTIVE FROM TWO PERSPECTIVES: MAXIMIZING DISCOUNTS AND REDUCING ADMINISTRATIVE COSTS.

A DRAFT PROPOSAL IS CURRENTLY UNDER DEVELOPMENT WITHIN THE ADMINISTRATION. WHEN THE ADMINISTRATION'S INTERNAL CLEARANCE PROCESS IS COMPLETED, WE WILL TRANSMIT IT TO THE CONGRESS FOR ITS CONSIDERATION.

EXPECTED PREMIUMS FOR 2001

THE FY 2001 FEDERAL BUDGET ASSUMES THAT THE WEIGHTED-AVERAGE PREMIUM FOR THE FEDERAL EMPLOYEE PROGRAM WILL INCREASE 8.7 PERCENT IN 2001. THIS BUDGET NUMBER IS BASED ON ACTUARIAL PROJECTIONS OF MEDICAL COST INFLATION AND HEALTH PLAN RESERVE LEVELS. WHILE THIS IS A USEFUL NUMBER FOR BUDGET PLANNING, THE ACTUAL AMOUNT WILL NOT BE KNOWN UNTIL OUR NEGOTIATIONS HAVE BEEN COMPLETED.

HEALTH CARE COSTS CONTINUE TO INCREASE, ESPECIALLY FOR PRESCRIPTION DRUGS. SIMILARLY, THE TRENDS WE DESCRIBED LAST YEAR CONTINUE TO AFFECT OUR PROGRAM AND THOSE OF OTHER EMPLOYERS. AS YOU KNOW, THE 2001 AVERAGE PREMIUM INCREASE, WILL DEPEND ON THE RESULTS OF CONTRACT NEGOTIATIONS OVER THE SUMMER AND MEMBER ENROLLMENT DECISIONS DURING THE FALL OPEN SEASON. NONETHELESS, I AM NOT OPTIMISTIC ABOUT THE TREND WE CONTINUE TO SEE.

THIS CONCLUDES MY OVERVIEW OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND THE OBJECTIVES WE ARE MOVING FORWARD FOR 2001.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE AT THIS TIME.

Mr. SCARBOROUGH. We will get back to you on those questions after our two votes. We will stand in recess for approximately 15 minutes.

[Recess.]

Mr. SCARBOROUGH. While we are waiting for Mr. Cummings to come back, Mr. Flynn, I will ask a few questions and then we will give Mr. Cummings the same opportunity.

I wanted to ask you first of all about OPM proposing to allow SAMBA to purchase prescription drugs for its mail order program off a Federal supply schedule at a discount. What is the status of SAMBA's access to the FSS for prescription drugs?

Mr. FLYNN. I expect, Mr. Chairman, that we will have resolved that completely within a matter of days. We do know that we have now reached a framework of agreement under which SAMBA will be able to access the Federal supply schedule for prescription drugs for their mail order program. Details of that are being worked out, but it would be a 2-year pilot effort. We look forward to seeing the results of that and whether or not the savings generated might be applicable to other carriers in the FEHBP.

Mr. SCARBOROUGH. OK. So what is OPM's position regarding plan-wide access to the Federal supply schedule?

Mr. FLYNN. OPM's position is that we want to make sure that we get maximum savings on the drugs that we purchase on behalf of our members. Now, there are a variety of ways in which that might be done. Access to the Federal supply schedule gives us the opportunity to see some actual results in practice and to make a judgment about what ought to be done for the future.

Mr. SCARBOROUGH. How much does the FEHBP program spend per year on prescription drugs?

Mr. FLYNN. In round numbers, it is $1 out of every $4. We have a $20-billion-a-year program, which means $5 billion each year goes toward prescription drugs.

Mr. SCARBOROUGH. OK. For the past 2 consecutive years the law has exempted carrier contracts in the FEHBP from the application of cost accounting standards, and I was wondering is OPM currently devoting any resources or conducting any activities aimed at implementing these standards?

Mr. FLYNN. Well, Mr. Chairman, the activity that we have been engaged in within OPM, with representatives of the carriers, and with staff of the Cost Accounting Standards Board has been an effort to look at the generic standards that the board has created, and which are intended to apply to Federal contracts above a certain threshold, and look for ways in which, given their applicability to those Federal contracts, they might be adapted for use in the Federal Employees Health Benefits Program. That has been the focus of our effort, Mr. Chairman.

Mr. SCARBOROUGH. Just for the record, I was talking to your good friend, Mr. Mica, going over to the vote. He sends his best. I don't know if he will make it here or not. He was complaining about the continued rise every year in the cost of the plan, and again he blamed the mandates for the increase. What did you say the increase was this year, 8.7 percent?

Mr. FLYNN. The 8.7 figure is what was included in the budget projection, President's budget for fiscal year 2001.

Mr. SCARBOROUGH. What was it the year before that?

Mr. FLYNN. Last year it was 9.3 percent, and I believe 9.5 the year before that. We will check that and make sure that we have it correct for the record.

[The information referred to follows:]

This year's average premium rate increase of 9.3 percent follows a 9.5 percent increase in 1999 and a 7.2 percent increase in 1998.

Mr. SCARBOROUGH. Over the past 3 years, that cost has skyrocketed, close to 30 percent. Now, Mr. Mica, and I think myself and others, might say that the mandates which have been added add to that. What is your best explanation why you believe that the cost of this plan has skyrocketed close to 30 percent over just the past 3 years? That certainly is a burden, obviously, on the working men and women that take part in the program.

Mr. FLYNN. Mr. Chairman, just as you and others find it unacceptable, we do as well. Emphatically so.

Let me say to you that mandates, although I would tend to characterize them as objectives of ours as a purchaser of health benefits for an employed and retired population, have done very, very little to impact those increases over the past 3 years. In fact, the increases have come about primarily from three areas. First, the aging of the Federal population that is covered, and you'll hear reference to this in testimony today from the Blue Cross and Blue Shield Association.

Second, the combined impact of medical technology and utilization. And I include in that increases in the cost of prescription drugs. They have been running probably, on average, 20 percent a year for the past 3 or 4 years and, as I mentioned a minute ago, now account for $1 in every $4 in the program. And third, medical inflation in general. What we are experiencing in this program, while I don't want to resort to it as an excuse, is what other employers are facing as well.

That is why we believe that it is so important to undertake some initiatives to get some handle on these premium increases so we can at least mitigate the rise and maintain an affordable program for the almost 9 million people who participate in it.

Mr. SCARBOROUGH. I am not being combative here, I am just curious, would you think—and obviously you guys should know this, you should be looking into it—but have costs for private insurance programs across the industry shot up by 30 percent over the past 3 years?

Mr. FLYNN. Costs for private employer-sponsored programs are shooting up dramatically. It is very difficult, because you have a lot of apples and oranges and pomegranates and pears out there, to try and compare that to the Federal Employees Health Benefits Program and its statutory structure. But as a general rule, and I think you will hear it in testimony from others this morning, yes, they are.

Mr. SCARBOROUGH. Are they going up at that rate?

Mr. FLYNN. They are going up at similar rates, Mr. Chairman.

Mr. SCARBOROUGH. Mr. Cummings.

Mr. CUMMINGS. Mr. Flynn, I want to go back to the chairman's question with regard to the prescription drugs. You said, now $1 out of every $4?

Mr. FLYNN. That's correct, Mr. Cummings.

Mr. CUMMINGS. Has that percentage changed? In other words, 3 or 4 years, were we still spending $1 out of $4?

Mr. FLYNN. That percentage has changed dramatically over the years, over the history of this program. There was a time when prescription drugs accounted for 3 to 5 percent of the total cost of the program. They now account for 25 percent. That was in the early eighties. I will check that for the record, but I believe that is pretty close.

[The information referred to follows:]

The following chart shows how prescription drug costs have grown as a percentage of total FEHB benefit costs.

YEAR	Rx BENEFIT COSTS
1981	03.5%
1985	08.0%
1987	05.6%
1990	12.2%
1991	13.0%
1995	18.4%
1996	18.8%
1997	20.9%
1998	24.1%
1999	25.7%

Mr. FLYNN. Now, costs have increased for a lot of reasons. I think it is important to say that prescription drugs are an important component today in the healthiness of people who participate in this program and other health insurance programs. So they have increased in terms of cost and in terms of their proportion, but they have also had a very good impact in terms of the health of the population covered.

Nonetheless, prescription drugs are the fastest growing component of the health care equation today, and they challenge us to look for ways in which we can do appropriate actions to mitigate those rises because they are making premiums unaffordable for some people.

Mr. CUMMINGS. It seems to me that we do have a major problem, because when you look at the fact that you've got—retirees get basically the same benefit, right?

Mr. FLYNN. Yes, sir.

Mr. CUMMINGS. So in other words, the government pays the same percentage?

Mr. FLYNN. Retirees participate fully in the FEHBP. When they turn 65, Medicare becomes their primary insurer and the FEHBP becomes the secondary; but the package of benefits is the same.

Mr. CUMMINGS. So you have a situation where people are retiring, they are getting older and it makes sense for them to stay in the program. With the way medical costs are these days, I don't see—I guess you have about 99 percent people staying in the FEHBP program?

Mr. FLYNN. Not quite that high, Mr. Cummings; 85 percent.

Mr. CUMMINGS. That is still high. So you have an older population. You have got a population that also probably needs prescription drugs more. Have you looked at what point—is there a line where, say, people if they get over 65—have you ever done any analysis like that? Where you see where a large chunk of that prescription drug money is spent? Is there a certain age, or is it spread throughout? I would guess that it would be more for older people.

Mr. FLYNN. You are correct. We have seen presentations from our health plans. We have looked at data and our actuaries have analyzed that as well. There is a curve and the curve begins to increase at a more rapid rate as one ages. It is just a natural function of the aging process, yes, sir.

Where that line is particularly, I couldn't say; but I would certainly be glad to come back to you with some information that might shed some light on that.

[The information referred to follows:]

As the following table shows, in terms of both the per-member cost and the percent of total benefits for prescription drugs, costs are significantly higher for individuals age 65 and over.

AGE BAND	AGE BAND'S AVERAGE COST COMPARED TO OVERALL AVERAGE COST	AGE BAND'S PERCENT OF TOTAL Rx BENEFITS PAID
< 20	16.2%	3.5%
20 - 24	35.7%	0.2%
25 - 29	25.6%	0.4%
30 - 34	31.5%	1.1%
35 - 39	38.9%	2.0%
40 - 44	48.5%	3.0%
45 - 49	72.0%	5.8%
50 - 54	86.4%	6.0%
55 - 59	106.5%	6.3%
60 - 64	128.9%	7.1%
65 - 69	174.1%	12.4%
70 - 74	196.3%	17.4%
75 - 79	197.1%	17.4%
80+	174.7%	17.4%

Mr. CUMMINGS. I was talking to Mr. Mica, too, and he was talking about this whole thing of mandated benefits, and I think the chairman talked about it briefly. But when you answered the question, you said it is not the mandated benefits?

Mr. FLYNN. No, sir.

Mr. CUMMINGS. So when I add up everything that we have talked about in the last 4 minutes, how do you bring the premiums down? It seems like it is a rocket going up and to try to push it back down is going to be kind of difficult because it seems like it is something that is already in motion.

Mr. FLYNN. I don't think that you bring premiums down. I don't think that is the case. I think what we have to find a way to do is make the rate of increase in premiums more moderate through

the use of things that other private employer-sponsored health plans have done. It has been demonstrated that plans that offer high quality do so cost effectively. Let's look for ways to use the purchasing power of the program at large as opposed to broken up into 280 or 300 parts to get the best value possible for the Federal employees and participants. Those are tools that can bring the rate of increase down.

But consider we are a very large health program—we have 9 million people. But, when you figure there are 250 million people in the United States we represent only 3 to 4 percent of health care consumers. So, we are part of the equation but we are not the driving part of the equation.

Mr. CUMMINGS. Mr. Harnage, the president of the American Federation of Government Employees, he is going to get up here in a few minutes and he is going to be concerned about the role that the union folks have played in this process. If you will recall, the last hearing we talked about the role of the union. And if I remember correctly, you said that you welcomed their participation because you thought it was important. I am just wondering, has OPM taken to include employee organizations in the benefit design and the administration of FEHBP?

Mr. FLYNN. Mr. Cummings, I also recall that testimony from last year, and we have taken a number of steps to bring, not only AFGE and some of the other unions that represent employees which participate in this program, but the National Association of Retired Federal Employees as well, into our discussions about how we can make this program better. I think that we have made an honest substantive effort for that to occur. I will let Mr. Harnage speak for himself. I think he would like to see even more, and I understand that.

I will do the best I can to make sure that their members and others are involved as we move this program forward.

Mr. CUMMINGS. Do you think that they have had any impact on what you have done at all? I'm just curious.

Mr. FLYNN. They and others have done two things that I think are helpful. They have kept us focused on the issue of the impact of rising health care costs on Federal employees and the ability of the Government to get its work done. That is a very important thing to keep right in front of us.

The second thing that they have done is they have come to us with ideas for helping to mitigate the impact of this on Federal employees. This October 1 we will implement a premium conversion plan for Federal employees across government. That means that they will be able to pay their share of the health insurance premium with pretax dollars and the effect of that will be to put an average $434 into the pocket of every Federal employee who participates in the Federal Employees Health Benefits Program. That came to us from those organizations and will have that kind of an impact. So yes, they have been very helpful.

Mr. CUMMINGS. Finally, sometimes when we sit in these hearings we wonder how much people do talk; in other words, people who need to talk, like you and Mr. Harnage and others. It sounds like you are having some good discussions. Is there any—and so I am going to do a little facilitating here. Is there anything that they can

do that would help you? It is in their interest to help you help their employees. Is there anything that they can do that you can think of that they are not doing that can help you in trying to accomplish all of the things that you just talked about?

Mr. FLYNN. I certainly can't speak for the organizations. The point that I want to make is—and I appreciate your efforts at facilitation—I want to be regularly at the table with them so that as they have ideas we look at ways in which we can make them come about when we and they agree that they make sense and can have a beneficial impact on this program. I will pledge that we will continue that, but I don't have anything specific in mind right now.

Mr. CUMMINGS. I just wanted to make sure that they are doing their piece. It is one thing for Mr. Harnage to come up here and say things are not working out. I want to make sure if you have something to say about him, you might as well say it while you are a few feet apart. I wouldn't want you to leave and——

Mr. FLYNN. No, Mr. Cummings, believe me, we appreciate not only in this area but in all areas, the advice and suggestions that AFGE and others bring to the table.

Mr. SCARBOROUGH. Thank you, Mr. Cummings. And Mr. Cummings is available for marriage counseling and mediation for any legal cases in the District of Columbia and Maryland after hours.

Connie, if you can give us an opening statement—and I would like to ask unanimous consent that the statement of Colleen Kelley, president of the National Treasury Employees Union be included as part of the record.

[The prepared statement of Ms. Kelley follows:]

TESTIMONY

OF

COLLEEN M. KELLEY

NATIONAL PRESIDENT
NATIONAL TREASURY EMPLOYEES UNION

ON

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

JUNE 13, 2000

SUBCOMMITTEE ON CIVIL SERVICE

HOUSE COMMITTEE ON GOVERNMENT REFORM

10:00 am

2154 RAYBURN HOUSE OFFICE BUILDING

901 E Street, N.W. • Suite 600 • Washington, D.C. 20004-2037 • (202) 783-4444

Chairman Scarborough, Ranking Member Cummings, Members of the Subcommittee, my name is Colleen Kelley and I am the President of the National Treasury Employees Union (NTEU). As you may know, NTEU represents more than 155,000 federal employees across the federal government.

NTEU very much appreciates your holding this oversight hearing today on the Federal Employee Health Benefit Program (FEHBP). Like you, NTEU's goal is to insure that the FEHBP provides the nine million federal employees, retirees and their families who rely on the FEHBP for their health insurance needs with the best coverage at the best rates.

The most critical compensation elements of federal employment - pay, retirement and health benefits - have each faced setbacks in recent years that have limited their ability to be competitive with private sector benefits. Attracting - and then retaining - employees with the best skills is a challenge for all employers. If the federal government is going to remain an employer of choice, adequate salaries, stable retirement benefits and affordable health insurance coverage are key components that Congress must address.

As you know, for the year 2000, FEHBP health insurance premiums increased dramatically, rising an average of 9.3%. The year 2000 also marked the largest federal employee pay raise in a decade, an average of 4.8%. Unfortunately, the additional money that ended up in our members' pockets as a result of this pay raise was, in many cases, eaten up entirely by their health insurance premium increases.

And the 2000 FEHBP premium increase was preceded by increases of 9.5% and 7.2% in 1999 and 1998. NTEU has urged the Office of Personnel Management (OPM) to take steps to stem these increases and to insure the continued viability and affordability of the program. There is little question that the federal government needs to better utilize the size of the FEHBP to obtain a better rate from insurance carriers and health care providers. If premiums continue to rise, we run the very real risk that people will be forced to make the hard choice not to have FEHBP coverage at all. With this in mind, there are several specific issues I would like to discuss further with the Subcommittee.

Prescription Drug Coverage

One of the fastest growing components of FEHBP premiums is prescription drug coverage. While rising prescription drug costs are responsible for health insurance premium increases in the

private sector as well, NTEU believes that the FEHBP - the largest employer-sponsored health insurance plan in the Nation - should use its buying power to negotiate discount rates and bring down costs in this area. The resulting savings would be dramatic for both federal employees and the government as employer.

In a positive move in this direction, this year the Special Agents Mutual Benefit Association (SAMBA) FEHBP plan proposed to OPM that it be permitted to purchase discounted drugs from the Federal Supply Schedule for its mail order drug program and pass the resulting savings along to both the federal government and its health plan enrollees. Although FEHBP providers have been permitted to purchase other goods from the Federal Supply Schedule for use in operating their federal health plans, until now, no participating health plan has asked to purchase its prescription drugs from the Supply Schedule.

To OPM's credit, it decided after thoroughly reviewing SAMBA's request, that SAMBA did, in fact meet the guidelines for purchasing discounted drugs from the Federal Supply Schedule. Unfortunately, SAMBA's proposal has met with opposition from the Department of Veterans Affairs, the primary purchaser of prescription drugs from this schedule for use in its hospitals. The VA has expressed concern that the more entities that purchase drugs from the schedule, the likelier it becomes that the pharmaceutical industry will raise its rates in order to recoup

lost profits!

Despite the fact that both SAMBA and OPM have estimated that this one move alone will lower SAMBA's premiums by 3 percent - 1/3 of this year's average premium increase - the Office of Management and Budget (OMB) has not yet agreed to allow SAMBA to purchase prescription drugs from the Federal Supply Schedule.

NTEU believes that not only should SAMBA's request be granted without further delay, we see no reason why all FEHBP providers who meet the guidelines for purchasing off the Federal Supply Schedule should not be permitted to do so as soon as possible. The potential for cost savings across the FEHBP, both for enrollees and for the federal government, is enormous.

Members of this Committee have repeatedly echoed NTEU's own views that the FEHBP must better utilize its buying power to negotiate discount rates and bring down costs. This could be the golden opportunity we have been looking for. I look forward to discussing this matter further with the Chairman in an effort to eventually permit all eligible FEHBP providers to purchase drugs at these discounted rates.

Direct Contracting for Benefits

It has been suggested that OPM could better use the FEHBP's

buying power by negotiating separately for certain benefits with one nationwide carrier. Dental benefits are an example of a benefit that has been mentioned in this regard.

OPM's annual Call Letter to FEHBP carriers points to its interest in further pursuing this avenue as one way to better achieve efficiencies in the program. NTEU wholeheartedly supports efforts to capture the buying power of the FEHBP by contracting directly for certain benefits where that process allows the employee to receive more comprehensive benefits at lower rates.

However, I also want to be clear that NTEU's position has not changed with regard to the employer contribution toward any benefit that may be offered separately from the core FEHB program. It is imperative that benefits currently provided under the FEHB continue to be offered with an adequate government contribution towards those benefits. Exploring the possibility of carving out benefits such as dental insurance can, and should be done, however, NTEU urges OPM as well as Congress to move cautiously in this area. It is possible a move such as this can save both the employee and employer premium dollars, however, NTEU will strongly oppose any efforts to carve out any current FEHB benefit and deny the employee a government contribution toward that benefit. Such a move would not only be an abdication of the government's responsibility toward its employees, it would

be counterproductive to current efforts aimed at attracting and retaining the best employees for the federal government.

Medical Savings Accounts

NTEU also wants to bring to this Subcommittee's attention a proposal pending before Congress that has the potential to add dramatic costs to the FEHBP. The Senate version of Managed Care legislation includes a provision requiring Medical Savings Accounts (MSAs) within the FEHBP. NTEU is extremely concerned that the addition of MSAs to the FEHBP could undermine the continued stability of the federal health program.

The hallmark of the current FEHBP is the choice it offers its participants. Annual open seasons permit enrollees to switch plans and options. Combining MSAs with an annual open season would place a serious strain on the program. Enrollees would be tempted to join traditional health plans in years they anticipated high health care needs, allowing their health providers to pick up the costs. Once completed, these same individuals would have an incentive to opt for an MSA during the following year's open season. Once enrolled in the MSA, these same individuals would have an incentive to postpone any necessary medical treatment until the following year when, once again, they could reenroll in a traditional health plan and seek necessary health services.

NTEU is concerned that in a short time frame, premiums for those remaining in FEHBP's traditional plans - primarily the elderly and less healthy - could skyrocket. As a result of increased usage by this group of older and less healthy individuals remaining in traditional health plans and younger and healthier individuals opting for MSAs, premiums could climb out of reach for many lower income federal employees and retirees.

Indeed, the Congressional Budget Office (CBO) has estimated that adding MSAs to the FEHBP would result in approximately $1 billion dollars in new costs to the program - costs that will be borne by federal employees as well as the government.

Those who support adding an MSA option to the FEHB program claim that it will expand the choices available to FEHBP participants. What they don't say, however, is that it will surely destabilize the program and insure that premiums can only go in one direction - up. On behalf of all federal employees, NTEU urges you to voice your opposition to this proposal in the strongest possible terms.

Premium Conversion Plans

NTEU is extremely pleased that Premium Conversion Plans (PCPs) will be made available to more of the federal workforce, effective October 1 of this year. As the Chairman knows, a

Premium Conversion Plan permits an employer to set up a mechanism under the Tax Code where an employee's health insurance premiums are paid with pre-tax dollars. Ninety percent of large private employers (those with 10,000 or more employees) and all but one state make pre-tax accounts available to their workforces.

Because FEHBP premiums are already withheld from employee's salaries, extending the Premium Conversion Plan to those portions of the federal workforce not yet participating in this benefit is relatively simple to establish. Moreover, this move puts the federal government on equal footing with other large employers and is another step toward improving the government's ability to compete in the current tight labor market.

Perhaps most important, Premium Conversion Plans will help reduce the out-of-pocket cost of health insurance for federal employees. It may even make it possible for those federal employees currently without FEHBP health coverage, especially lower graded employees, to be better able to afford coverage.

Mr. Chairman, in conclusion, affordable, quality health care is one of the most important issues for NTEU members. We will continue to fight to make sure that the FEHBP is the best it can be and we look forward to working with you toward that end.

Mrs. MORELLA. Thank you, Mr. Chairman. I appreciate your holding this oversight hearing to discuss the administration of the Federal Employees Health Benefits Program. I know that all members of this subcommittee will concur that the best possible health care for our Federal employees is among our highest priorities.

This year's policy guidelines as outlined by OPM emphasized several initiatives that I believe are essential to maintaining and improving the FEHBP. The first mandate by OPM is to stipulate that mental health and substance abuse parity be achieved by the 2001 contract year. I want to applaud this initiative and OPM's very direct involvement in crafting it. In fact, I recently held a meeting with representatives of the Washington Psychiatric Society, SAMHSA, the AMA, IMH, the American Psychological Association, and OPM. And Mr. Flynn was there and his colleagues to discuss the implementation plan.

The goal of the meeting was to ensure that parity is incorporated in the most effective and seamless way possible and that all of the participants—they felt while certain changes should be made, the overall plan was sound.

In addition, I want to applaud the decision by OPM to demand patient safety initiatives to reduce medical errors. The data from the November Institute of Medicine report showed that anywhere between 44,000 and 98,000 lives are lost each year to medical errors. This number is obscenely high. I know that several Members of Congress have drafted bills to remedy the situation, myself included, and I champion any efforts to diminish the accidental loss of lives in our hospitals and with our health care providers.

There are two areas that I am concerned about and that I am pleased that this committee will address. The first one was brought up last year, involving the premium increases in the FEHBP, and some discussion has ensued on that this morning. As I noted last May, premiums in private employer-sponsored health plans have risen at a slower rate in the past, and we want to make sure that our Federal employees are not paying unnecessarily high premiums, and I note, Mr. Flynn, that you said it is about the same. I think it is maybe a little higher.

I also want to ensure that the autologous bone marrow transplants for breast cancer are not hindering use of more effective breast cancer treatments. I know that OPM's goal is to bring about the most positive outcome for enrollees and I hope that this hearing will allow us to come to an agreement on how to best treat the most serious episodes of breast cancer. Those are some of the points that I wanted to bring out.

In the line of questioning, if I could have permission to ask just a couple of questions, one has to do with the prescription drugs, which has been mentioned, and it is something that we hear about all the time, Members of Congress taking constituents over to Canada to buy those prescription drugs, and we look to the Federal Government to being a real model.

I am curious; has OPM looked into doing some of that hard negotiating that has been done through the Veterans Administration for the very best price of prescription drugs and some of our other Federal entities? Are we doing anything in that regard, Mr. Flynn?

Mr. FLYNN. Mrs. Morella, I mentioned just before you came in, we will have our SAMBA health plan gaining access to the VA's prescription drug schedule for a pilot period in an evaluation to determine whether something like this would make sense for the balance of the plans that participate in the Federal Employees Health Benefits Program.

There are a number of other things that we and our participating health plans are doing to try to attack, confront directly, the issue of the rising costs of prescription drugs. We have undertaken a number of cost-containment initiatives in past years. The institution of pharmacy benefit management programs and the encouragement to use generic drugs when they are therapeutically equivalent to brand names are examples of discounts that currently exist on prescription drugs in the program. Clearly we need to do more.

You will hear also this morning from the Blue Cross and Blue Shield Association about some of the things that they have underway. Those are the kinds of things that we think are necessary. We want to always be careful, however, as we seek to control these costs, that we don't do so in ways that simply move or shift costs onto participants in the plan who have no other real alternatives. So it is a balancing that takes place here.

But these are the kinds of things that have been done. They are the kinds of things that are underway now. And we are looking at ways in which we can use the purchasing power of this program to get the best discounts and prices possible.

Mrs. MORELLA. I hope that you will share that with us because I think it is important that we are focusing on this, and again the Federal Government is considered to be exemplary in this regard.

I am curious, whatever statistics you discern with that 25 percent increase, whether it is people living longer and taking more drugs, and maybe having more prescribed, maybe more money going into research. I think it is kind of an interesting area for us to pursue as much as we can.

My final question has to do with medical errors. As you probably know, I have legislation in that would not mandate but very strongly urge all health care providers to be involved with a data base which would be confidential; the information would not be subject to subpoena or discovery in any administrative or civil proceeding. You discuss working with networks to implement accountability systems. I know that you don't necessarily want to mandate specific provisions for reducing medical errors, but are you also concerned about the lack of accountability—or that accountability systems could be too punitive and prevent and discourage the reporting of medical errors?

Mr. FLYNN. Mrs. Morella, we don't want to do anything that would be perceived to, or would in fact, drive reporting of medical errors underground. And I think some of the kinds of things that you've talked about in terms of the punitive aspects may do that. This is a very important area when you think of medical errors and how to deal with them. It is not an area that is something that we mandate or control in the Federal Employees Health Benefits Program—and if I can just use that as a jump-off point to talk about our approach.

Our approach in this area was to recognize that this is an issue that affects the entire health care system, and that if we were to do things that are unique or that are very prescriptive, we could actually thwart the ability to address the serious issues of medical errors in a way that makes sense across the entire system. So our approach was to say that what we expect health plans to do is to cooperate in that national effort and, as part of that cooperation, to give us information that we can then in turn provide our participants, the Federal employees, retirees and family members, to help them to choose health plans. And that information then could be made available to other health plan members conceivably.

But we didn't want to overlap any efforts that were going on in other areas. For example, the National Quality Forum is addressing this area. A number of groups I mentioned, such as the Leapfrog Group of the Business Roundtable, are looking at promoting computerized physician order entry systems for prescription drugs, evidence-based hospital referrals for certain kinds of procedures and intensive care specialists in intensive care units. We think that these make sense and people ought to know about them when they make choices about their health care.

There is a requirement which will go into effect in 2002. Beginning in that year, all Federal employee health plans need to seek accreditation from a national organization which incorporates patient safety standards into their accreditation process, and that is where some of that accountability comes in. We think that makes a lot of sense.

Mrs. MORELLA. The idea is to urge hospitals and health care providers to report what their errors are and receive in turn the incentive to be able to correct them in the future, and I am glad that you are proceeding in that particular regard. I know that there are a lot of companies that are coming up with remedies. I saw one recently, a machine to help with prescriptions, and I think it is an important issue. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Thank you, Mr. Flynn. We certainly appreciate your patience answering the questions and look forward to seeing you again soon.

Mr. FLYNN. Thank you.

Mr. SCARBOROUGH. I would like to call up the second panel. We have Stephen Gammarino, Bobby Harnage, and Scott Nystrom. Mr. Gammarino is senior vice president for the Blue Cross and Blue Shield Association. He has extensive experience in health care administration and is responsible for the planning and direction of the Federal Employees Program, serving almost 4 million enrollees. Mr. Gammarino has been a frequent witness before this committee on FEHBP issues and we certainly appreciate his efforts.

Bobby Harnage is the National President of the American Federation of Government Employees. AFGE represents more than 600,000 Federal and District of Columbia employees, and this is Mr. Harnage's second appearance before this subcommittee and we appreciate your time and efforts here and look forward to hearing AFGE's views.

Scott Nystrom is an adjunct scholar at the Mercatus Center at George Mason University. Dr. Nystrom served as a senior policy adviser to the Bipartisan Commission on Entitlement and Tax Re-

form chaired by Senators Bob Kerrey and John Danforth. He has worked on the Hill as budget associate senior legislative assistant at the House of Representatives and at the Office of Personnel Management, analyzing health issues among others. This is Dr. Nystrom's first appearance before the subcommittee and we certainly welcome him also. If you all could stand I will administer the oath.

[Witnesses sworn.]

Mr. SCARBOROUGH. We will begin with you, Mr. Gammarino.

STATEMENTS OF STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, BLUE CROSS/BLUE SHIELD ASSOCIATION; BOBBY L. HARNAGE, SR., NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO; AND SCOTT NYSTROM, ADJUNCT SCHOLAR, THE MERCATUUS CENTER AT GEORGE MASON UNIVERSITY

Mr. GAMMARINO. Mr. Chairman, good morning and thank you for the opportunity to appear before you today to comment on the Office of Personnel Management's policy and guidance for 2001. What I would like to do is summarize my written testimony. I would like to submit the testimony for the record.

In your letter of invitation, you requested our views on how various proposals and recommendations contained in the 2001 call letter would affect the costs and quality of health care coverage offered through the FEHBP and any other issues that are important to Blue Cross and Blue Shield Service Benefit Plan. In addition, you requested that I discuss efforts by Blue Cross and Blue Shield to restrain prescription drug costs.

As a general rule, Blue Cross and Blue Shield Association opposes Federal mandates and believes that they have a long-term adverse effect on the ability to provide affordable health care coverage. However, the level of impact can vary significantly depending on the degree of flexibility afforded the health plans.

My testimony today will focus on two major initiatives prescribed in OPM's call letter: the first, achieving mental health and substance abuse parity; and the second, improving the quality of health care by reducing medical errors and increasing patient safety.

Blue Cross and Blue Shield has worked closely with OPM to develop and enhance the mental health substance abuse [MHSA] benefits. We have appreciated OPM's ongoing involvement of the carriers and leaders in the managed behavioral health care field to better understand the implications of this enhanced benefit for the program. In order to comply with this mandate and control the benefit and administrative costs associated with it, we are developing a benefit proposal that utilizes a care management strategy. The Service Benefit Plan intends to buildupon existing local Blue Cross and Blue Shield plans' managed behavioral health networks. We are prepared to work closely with the agency to ensure that enrollees use benefits in the context of a care management strategy designed to promote the appropriate use of those benefits.

Additionally, it is unlikely that we will know the true cost of this benefit for 3 to 5 years as it will take time for members and provid-

ers to understand the program and for the inherent delivery patterns to change.

The second initiative is patient safety. Patient safety is a critical and sensitive problem that demands the respect and attention of all stakeholders. We support the President and the agency's initiatives to reduce medical errors and increase patient safety in all health care settings. However, it is important to understand that it is the physician and the hospital communities, not the local health plans, who must devise the clinical strategies to address patient safety concerns. The primary role of the local plan like the FEHBP Blue Cross and Blue Shield must be to respond to physician and hospital initiatives, and to then support their needs with our own resources.

We are committed to working with providers, independent accreditation agencies and others to implement patient safety programs. Blue Cross and Blue Shield Service Benefit Plan has developed and shared with OPM a number of initiatives that focus on improving health quality and patient safety.

In the letter of invitation, the subcommittee also asked us to focus on prescription drug cost trends and how prescription drugs have contributed to the overall costs of health insurance. Making drug coverage affordable to our members and keeping premiums stable continues to be the one most difficult challenging initiative facing our program.

Prescription drug cost trends continue to be nearly three times greater than our other trends in other areas, and currently our program spends about 30 percent of our premium dollar associated with drugs. These cost trends continue to be driven by the rapid development of new, expensive drug therapies which substitute for less expensive existing therapies, rising prices for existing drugs, and heightened demand and utilization of prescription drugs fueled by the ever expanding direct-to-consumer advertising.

It is important to realize that this program is dealing with an aging population. The average member in the FEHBP is 54 years old. And the average member in the Blue Cross and Blue Shield standard option is 60. Data has shown that the quantity of medical resources and specifically prescription drugs increases as individuals age.

It is also important to understand that these trends are not dissimilar to those experienced industry-wide. In addition to the Service Benefit Plan's numerous initiatives, we are also focusing on a number of other areas from the Association's perspective. As part of this effort to restrain prescription drug costs, the Association, that is Blue Cross and Blue Shield, is a founding member of the RxHealth Value Coalition, a coalition of 30 consumer groups, private employers, purchasers, providers, labor unions and others that seek to ensure credible analysis is done to ensure that these drugs provide value to the community.

In addition, we have also launched an independent not-for-profit pharmacy evaluation program known as Rx Intelligence. This is scheduled to become operational June 30. It will be an independent company designed to alert employers, insurers, and consumer groups to new drugs nearing regulatory approval. It will provide quick analysis of these medicines once they are on the market and

conduct indepth reviews and cost benefit analysis of these new and existing drugs.

Additionally, your letter asked that we address any other important issues. We remain concerned about the administration's continued efforts to impose cost accounting standards on the FEHBP. Blue Cross and Blue Shield Association has actively sought exemption for the past 2 years, after an exhaustive analysis determined that the cost accounting standards are fundamentally incompatible and inappropriate for our health insurance system. Despite the clear will of Congress and the overwhelming strength of the arguments against imposing these standards, the administration continues to oppose this exemption. Applying CAS will not only not add value to the program, it would degrade the commercial capabilities on which our plans' core business depend.

Therefore, as I have testified before, Blue Cross and Blue Shield cannot sign any contract with the agency that contains the CAS clause or otherwise seeks to implement these standards which have been exempted by law.

In conclusion, the Federal Employees Health Benefits Program is widely admired throughout the country as a model of efficiency and effectiveness due to the private sector competition and consumer choice. Blue Cross and Blue Shield is very proud of the role that the Blue Cross and Blue Shield plans have played in helping to make this program as successful as it is today, and we look forward to finding ways to preserve and improve the strength and stability of the program for Federal workers and their family members. Thank you.

Mr. SCARBOROUGH. Thank you, Mr. Gammarino.

[The prepared statement of Mr. Gammarino follows:]

TESTIMONY OF

BlueCross Blue Shield Association
An Association of Independent
Blue Cross and Blue Shield Plans

Before the

Subcommittee on Civil Service
Committee on Government Reform
United States House of Representatives

On

The Federal Employees Health Benefits Program:
The Office of Personnel Management's Policy Guidance for 2001

Presented by:

Stephen W. Gammarino
Senior Vice President
Federal Employee Program
And Integrated Health Resources

Tuesday, June 13, 2000

Good morning. I am Steve Gammarino, Senior Vice President, Federal Employee Program and Integrated Health Resources, at the Blue Cross and Blue Shield Association. On behalf of the Association, I thank you for the opportunity to appear before you today to comment on the Office of Personnel Management's policy guidance for 2001.

As you know, BlueCross BlueShield Plans jointly underwrite and deliver the Government-wide Service Benefit Plan in the Federal Employees Health Benefits Program. This Service Benefit Plan has been offered in the FEHBP since its inception in 1960 and is the largest plan in the Program. The Service Benefit Plan currently covers approximately four million federal employees, retirees, and their families, or about 48 percent of the enrolled population.

In your letter of invitation you requested our views on how the various proposals and recommendations contained in the 2001 call letter would affect the costs and quality of health care coverage offered through the FEHBP, and any other issues that are important to the continued viability and stability of the Service Benefit Plan. In addition, you requested that I discuss efforts by Blue Cross and Blue Shield Service Benefit Plan to restrain prescription drug costs and various options to manage the rising costs of prescription drug costs.

As a general rule, the Blue Cross and Blue Shield Association opposes federal mandates and believes that they have a long-term adverse effect on the ability to provide affordable health care coverage. However, the level of impact can vary significantly depending on the degree of flexibility health plans are given to develop, implement, and manage these federal initiatives. This year, the call letter prescribes two major initiatives that are likely to impact quality of health care and costs of the Service Benefit Plan:

- Achieving Mental Health and Substance Abuse Parity, and
- Improving the Quality of Healthcare by Reducing Medical Errors and Increasing Patient Safety.

My testimony today will focus on these two initiatives, as well as other issues and trends that are important to the Blue Cross and Blue Shield Service Benefit Plan.

Mental Health and Substance Abuse Parity

Blue Cross and Blue Shield Association (BCBSA) has been working closely with OPM to develop and enhance Mental Health and Substance Abuse benefits (MHSA). We have appreciated OPM's ongoing involvement of FEHBP carriers and leaders in the managed behavioral health field to better understand the implications of enhanced MHSA benefits for FEHBP. We have valued the opportunity to learn from other experts and to share with OPM the Local Blue Cross and Blue Shield Plans' experience with managed behavioral health in a Preferred Provider Organization (PPO) environment. As we continue to work with OPM and other leaders in the industry on developing a MHSA benefit, we'd like to emphasize that it is our understanding, from conversations and meetings with OPM that our implementation strategy will meet OPM's expressed intent of enhancing MHSA benefits for 2001.

Blue Cross and Blue Shield Association and the local Blue Cross and Blue Shield Plans that participate in the Service Benefit Plan have devoted, and continue to devote, considerable effort to making this challenging federal mandate a reality.

In order to comply with this mandate and control the benefit and administrative cost increases, BCBSA is developing a benefit proposal that utilizes a care management strategy. The Service Benefit Plan intends to build upon existing local Blue Cross and Blue Shield Plans' managed behavioral health (MBH) capacity. A large number of Blue Cross and Blue Shield Plans contract with managed behavioral health vendors to provide coverage for both mental health and substance abuse services. Our proposed delivery model will include a two-tier behavioral health network with enhanced MHSA benefits when provided by Preferred/in-network providers; and a toll-free number to explain 1) the benefit implications for in- and out-network services, 2) inform the member of in-

network providers, and 3) encourage use of the most appropriate setting of care and provider type.

We are prepared to work closely with OPM to ensure that enrollees use benefits in the context of a care management strategy designed to promote appropriate use of those benefits. However, as the Service Benefit Plan is primarily a PPO program and typically doesn't use HMO-type techniques, we also face the additional challenge of educating our enrollees and our providers to make sure they understand the administrative process of obtaining MHSA benefits. In addition, significant adverse selection and higher utilization than anticipated could cause costs to be significantly higher than anticipated. Moreover, it is unlikely that we will know the true costs of this new benefit for three to five years, as it will take time to for members and providers to understand the program, for inherent delivery patterns to change, and for members to avail themselves of the enhanced mental health/substance abuse benefits available to them.

Patient Safety

Patient Safety is a critical and sensitive problem that demands the respect and attention of all stakeholders. Even one death as a result of a preventable medical error is one too many. We support the President and the Agency's initiative to reduce medical errors and increase patient safety in all health care settings. However it is important to understand that it is the physician and hospital communities, not local health Plans, who must devise the clinical strategies to address patient safety concerns. Physicians and hospitals must be free to craft legal and administrative solutions to these challenges without the burden of external requirements. They must tell us how local Plans can lend support to their efforts. The primary role of the local Plan must be to respond to physician and hospital initiatives and to then support their needs with our own resources. We are committed to working with providers, independent accreditation agencies, and others to implement patient safety programs

With this thought in mind, Blue Cross and Blue Shield's Service Benefit Plan has developed, and shared with OPM, a number of initiatives that focus on improving health care quality and patient safety. Some of these initiatives are as follows:

PPO Performance Measurement

Under this initiative, we will pilot a new approach to enhance patient safety that supports quality health care decisions and measure performance in PPOs. This will include a regular assessment of claims data against a set of clinical algorithms to identify members at risk for adverse events, and provide information to physicians for their consideration and action. The pilot program will include testing of programs to enhance patient safety, quality of care and the development of performance measures (i.e. examining how well we identify high-risk members). While still in the planning stages, we plan to implement the first pilot program at the Empire Blue Cross and Blue Shield Plan of New York this summer. Moreover, we also anticipate that three to five Local Plans in various geographic locations will be involved in piloting this initiative.

Local Care Management

Local Care Management has been defined as programs implemented in the local Plans which are intended to provide Service Benefit Plan members with information and resources which will have the desired outcomes of improved health and quality of life. Examples are disease management programs, prenatal programs, mammogram reminders, and immunization programs. The Local Care Management program concept was developed to provide us with a unique opportunity to:

- Focus on diseases relevant to the Plans' populations;
- Maximize greater physician acceptance; and
- Provide the local Plans with the opportunity to quickly implement programs for Service Benefit Plan members that demonstrate safety, effectiveness and efficiency.

Pharmacy Quality Initiatives

The Service Benefit Plan has in place a number of pharmacy programs that focus on improving patient safety and quality. For example, the Concurrent Drug Utilization

program provides the pharmacist with an alert message at the time a prescription is filled. The alert provides information that identifies potential drug interactions, drug duplications, compliance issues, and precautions. Other programs include the Prior Authorization Program, the Senior Drug Utilization Program, the Retrospective Drug Utilization Review, and Fraud and Abuse Programs.

Prescription Drugs

In the letter of invitation, the Subcommittee asked BlueCross BlueShield Association to focus on prescription drug cost trends and how prescription drugs have contributed to the overall cost of health insurance. I appreciate the opportunity to comment on this critical issue.

Making drug coverage affordable to our members and keeping premiums stable continues to be one of the most difficult challenges facing the Service Benefit Plan. Prescription drug cost trends continue to be nearly three times greater than all other benefit cost trends. The Blue Cross Blue Shield standard option plan has drug costs that are approximately 30 percent of total benefits. These cost trends continue to be driven by the rapid development of new, expensive drug therapies which often substitute for less expensive existing therapies, rising prices for existing drugs, and heightened demand and utilization of prescription drugs fueled by ever expanding direct-to-consumer advertising.

In addition, it is important to realize that the Federal Employees Health Benefits Program is dealing with an aging population in the Federal government. As illustrated in a May 7th Washington Post article, "Retirement Wave Creates Vacuum," one-half of federal government workers fall between the ages of 45 and 60 and only 5 percent are ages 29 or younger. The average BlueCross BlueShield Service Benefit Plan member is 60 years old and the average FEHBP member is 54 years old. Data has shown that the quantity of medical resources and specifically prescription drugs increases as individuals age. Thus,

it is important that the Federal government and its employees understand that demographics and increased federal mandates will result in premium increases.

It is important to understand that the drug cost trends that the Service Benefit Plan is experiencing are not dissimilar to those experienced industry-wide. Prescription drugs are the fastest growing-area of health spending. National spending on drugs is growing three times as fast as overall health spending. According to a University of Maryland study commissioned by Blue Cross Blue Shield Association and the Health Insurance Association of America, spending on prescription drugs is estimated to increase annually by 15-18 percent from 1999-2004 and will double from $105 to $212 billion during these years. A new study, by the Brandeis University Schneider Institute for Health Policy and PCS Health Systems, Inc., found that prescription drugs costs grew at an annual rate of 24 percent per year from 1996-1999. Between 1993 and 1999, BCBS Plans' aggregate spending on outpatient drugs increased an estimated 92 percent, from $7.6 billion to $14.6 billion.

For the most part, the Blue Cross BlueShield Service Benefit Plan's prescription drug benefit is structured similar to what one might see in a traditional large employer or union plan. It maintains an open formulary, has an extremely broad network of over 51,000 pharmacies, requires a minimal list of products that require pre-authorization, and requires low to moderate cost-sharing by members. Members get access to significant discounts because the Blue Cross and Blue Shield Service Benefit Plan obtains significant pharmacy and manufacturer discounts with Pharmacy Benefit Managers.

As you are probably aware, last year, Blue Cross Blue Shield Association made changes to our prescription drug benefits to keep premiums at a competitive level. After careful consideration and with great concern for the effects of such a change on our older members, we decided it was necessary to take some action to offset our ever-increasing drug costs. For instance, to help manage prescription drug costs, the 2000 copayment amount for mail service increased, and the copayment for Medicare Part B members is no longer waived.

However, even with last year's changes, our prescription drug costs continue to increase, requiring us to explore additional methods to contain costs with minimal impact on our members. This year, we are exploring additional changes that further encourage the use of generic drugs. We believe that these changes will result in increased savings. We are also exploring other administrative changes to the delivery of our pharmacy benefits to reduce drug costs and trends. We are hopeful that we can work in a cooperative and beneficial way to manage our prescription drug benefits and find ways to reduce costs that will not harm the member.

It is important to understand that health plans and employers must make a trade-off between providing their employees the choice and access to a wide variety of drugs and controlling costs. Our population in the Service Benefit Plan expects the freedom to choose with minimal restrictions. However, as a responsible plan, we need to balance these expectations with managing rising prescription drug costs and keeping overall premiums at an affordable level.

New Blue Cross Blue and Blue Shield Association Pharmacy Initiatives

In addition to the Service Benefit Plan's numerous pharmacy initiatives and new efforts to manage costs in the Federal Employees Health Benefit Program, the Blue Cross Blue Shield Association is dedicated to finding solutions to this growing crisis. As part of an effort to constrain growing prescription drug costs, Blue Cross Blue Shield Association is a founding member of the RxHealth Value Coalition, a coalition of more than 30 consumer groups, private employers, purchasers, providers, labor unions, and academicians. This coalition seeks to establish a credible system for analyzing and determining the health and economic value of prescription drugs. It is committed to:

- sponsoring research to inform and educate consumers, providers, employers and government about the benefits and costs of drugs as they contribute to overall health;
- proposing solutions in the market for drugs that encourage competition and foster appropriate and safe utilization of drugs; and
- encouraging the creation of independent scientific-based entities to conduct clinical research regarding the value of specific drugs.

In addition, BCBSA has recently launched an independent non-profit pharmaceutical evaluation program known as Rx Intelligence. Scheduled to become operational by June 30, this new independent company will alert employers, insurer, and consumer groups to new drugs nearing regulatory approval, provide quick analyses of medicines once they are on the market and conduct in depth reviews and cost-benefit analyses of new and existing drugs. The focus is to give physicians, patient, employers, and plans unbiased information about the value and efficacy of new and existing drugs and discourage inappropriate use or overuse of certain drugs.

In addition, the Blue Cross Blue Shield Association believes that there are a number of steps that the Federal Government can explore to help improve the affordability of drugs without resorting to price controls or increased cost-shifting to consumers. For example:

1. **Examine and Revise Federal Policies Contributing to Escalating Drug Costs:** BCBSA believes that a vigorous competitive market – rather than price controls – is the best way to improve the affordability of prescriptions. To ensure vigorous competition, however, the United States will have to eliminate any market protections that do not have a clear benefit for consumers and foster actions that promote competition.

   The government should conduct a careful review of the vast array of prescription drug policies throughout the federal government to identify those areas that

contribute to accelerating drug costs. This review should recommend appropriate regulatory or legislative policy changes in such areas as:

- Current and proposed legislative initiatives to extend market exclusivity protections for prescription drugs.
- Whether, and in which cases, federally subsidized research should be made available to private pharmaceutical companies to develop prescription drugs with no economic advantages to the federal government.
- Patent extensions for individual drugs, such as the legislation now pending before Congress, which would extend the patent for Claritin, and several other drugs. Granting Claritin a 3-year patent extension would cost consumers up to $5.3 billion from 2002 to 2007, according to researcher Stephen Schondelmeyer.
- The current rules governing the movement of a prescription drug to over-the-counter status.

2. **Support the Focus of All Purchasers on Prescription Drug Value:**
   It is critical that consumers, clinicians, government and private payers have information to make wise choices, and to assure that scarce health care dollars are not spent for drugs that are high cost alternatives to equally effective, existing drugs. The federal government should support efforts of independent private sector entities to evaluate the relative value of competing new drug therapies, and should:

- Support research to assure that consumers, physicians, and purchasers have adequate information to evaluate the value of prescription drugs (the benefits, risks, cost of a drug) and the relative value of alternative therapies.
- Ensure that direct-to-consumer advertising is accompanied by clear and understandable information for consumers of the risk of the prescription drug advertised; and that consumers and physicians have access to unbiased information on the cost of the drug, and the benefit, risk and cost of alternative drug therapies (prescription or over-the-counter).

DoD/FEHBP Demonstration Project

I would also likely to briefly comment on the three-year demonstration project permitting Medicare-eligible retirees and their dependents to enroll in health benefits plans in the FEHBP. From the beginning, the BlueCross Blue Shield Association has been committed to working with OPM and DoD on the demonstration project to determine whether FEHBP participation is a viable option for the retired military community and to inform and educate the eligible population about the demonstration project.

We are aware of the expansion of the demonstration project to two additional sites – Adair and Coffee sites – and have notified the local Blue Cross and Blue Shield plan serving those areas. We are also aware of additional changes included in legislation making its way through Congress that would eliminate most geographical restrictions and extend the time of the demonstration. We hope that these changes will aid in creating a larger enrollment base so that the demonstration project may indeed be a fair test of the FEHBP as an option for the uniformed service retirees.

We look forward to continuing to assist in these efforts once again. However, we urge OPM and DoD to enhance its education and outreach efforts to this community. A lesson learned from the past Open Season is that these retirees, unfamiliar as they are with the FEHBP, require a greater degree of engagement than civilian annuitants. Many more opportunities for these individuals to discuss in person the FEHBP and the health plans available to them are required so that these retirees begin to feel comfortable with their choices.

Cost Accounting Standards (CAS)

Your letter of invitation asked that we also address any other issues that are important to the continued viability and stability of the Service Benefit Plan. We remain concerned about the Administration's continued efforts to impose the cost accounting standards on carrier contracts in the FEHBP. These standards, developed primarily for contractors doing business with the Department of Defense, are promulgated by the Cost Accounting Standards Board. This Board is an entity within the Office of Management and Budget.

As you know, upon the request of this Subcommittee and full Committee, Congress passed in both the fiscal year 1999 and 2000 Appropriations Acts a full statutory waiver of the requirement to apply the CAS to contracts under FEHBP. Blue Cross Blue Shield Association has actively sought the exemption for the past two years, after an exhaustive analysis determined that the cost accounting standards are fundamentally incompatible with, and inappropriate for, our health insurance systems. Despite the clear will of Congress, and the overwhelming strength of the arguments against imposing the CAS on carrier contracts in the FEHBP, the Administration continues to oppose this statutory exemption.

The FEHBP accounts for only about 5 percent of the typical BlueCross BlueShield Association Plan's business. But because our federal enrollees use the same benefits and provider networks as do our private sector subscribers, they and the government obtain the benefit of the deep discounts that our Plans, collectively, are able to negotiate on behalf of more than 75 million people.

Because discounts and provider agreements are not separately negotiated by our Plans for the FEHBP population, nor are operational systems segregated as such, it would not make sound business sense for our Plans to redo their entire accounting systems simply to install the CAS. Not only would applying CAS not add any value to the FEHBP, but it would degrade the commercial capabilities on which our Plans' core business depends. Therefore, for these reasons, the Blue Cross and Blue Shield Association, as the agent for our Plans, cannot sign any contract with OPM that contains the CAS clause or that otherwise seeks to implement the standards currently exempted by law. We very much

appreciate the Committee understanding the gravity of this issue and your continued support for our position.

Conclusion

The Federal Employees Health Benefits Program is widely admired throughout the country as a model of efficiency and effectiveness due to private sector competition and consumer choice. It is often used as an example of what the private and public sector hopes to replicate. The Blue Cross and Blue Shield Association is very proud of the role Blue Cross and Blue Shield Plans have played in helping to make the Federal Employees Health Benefits Program the success it is today. We look forward to finding ways to preserve and improve the strength and stability of the program for all federal workers, annuitants, and their family members.

Again, thank you for the opportunity to appear before you today. I will be pleased to answer any questions you may have at this time.

Mr. SCARBOROUGH. Mr. Harnage, welcome back and we certainly look forward to hearing your testimony.

Mr. HARNAGE. Mr. Chairman and subcommittee members, I have submitted my written testimony and I ask that it be entered into the record.

A year ago, this committee held a hearing to examine the source of what was then a 2-year run-up in FEHBP premiums that infuriated our Members and many members of the subcommittee. Well, here we are again, 1 year later, and many millions of dollars poorer, as premiums in FEHBP again rose by over 9 percent this year. Again, Federal workers are seeing their hard-won pay raises eaten up by the health insurance premiums.

Since last year's hearing, OPM and AFGE have been engaged in some dialog regarding the administration and pricing of FEHBP, but this dialog has fallen far short of the relationship we want. We still pay roughly a third of the $18 billion annual cost of FEHBP, not counting the out-of-pocket copayments and deductibles; yet OPM maintains that only it has the right to make decisions on how the entire $20 billion is spent.

We contend that our $6 billion of financial responsibility should come with a voice on how the money is spent. There is no good reason why 6 to 7 billion out of pockets of Federal employees does not justify a seat at the table so that we can represent our own priorities and raise our own questions in negotiations with health insurance companies.

On behalf of the more than 600,000 Federal and District of Columbia workers AFGE represents and for whom the health benefit plan is the only reasonable choice, I ask the subcommittee to affirm that workers' voices should be heard in the annual negotiations over the terms of the health benefit contracts.

I want to say in the strongest possible terms that we do not believe that OPM speaks for us. Each year brings new evidence that our interests are not well represented by OPM. There has been no slowdown in premium inflation. The insurance companies are increasingly emboldened to press for less scrutiny of their contracts, fewer restrictions on benefit design, no restraint on how they obtain or what they charge for prescription drugs, and of course a blank check at the premium setting.

Following tradition, OPM again refers to the insurance companies as its partners in this year's call letter and congratulates them for cooperation and collaboration on many policy issues. If OPM describes its own relationship to the insurance companies as one of partnership, where does that leave us? Federal employees are tired of a situation where OPM collaborates with the insurers and passes the costs of such a cozy arrangement to us and our fellow taxpayers.

Time constraints preclude me from raising all of the issues, but I would like to touch on a few. The first is OPM's proposal to carve out or contract directly for certain health insurance benefits such as dental, vision, and prescription drugs and make them "employee-pay-all." This proposal was included in both President Clinton's 2001 budget proposal and OPM's call letter to carriers for 2001. The idea is that OPM would step in to use its previous unexercised buying power to obtain a good group rate and then

leave the rest to us. The employee-pay-all approach may be thoroughly consistent with the winner-take-all economic policies of the past 20 years, but it is in direct contrast to the values that AFGE upholds and we want no part of it.

The second is prescription drug prices and their effect on the health benefit premiums. Our employer is in a unique position to address this problem. The time is long overdue to make available to health benefit programs the discount and favorable treatment that the Federal Government has arranged for the benefits of the veterans and the military health care systems, Medicare, Medicaid, the Bureau of Prisons, and the Public Health Service.

The third issue is that for the last 2 years, insurance companies and the health benefit program have been exempt from the government cost accounting standards. The Federal Government imposes cost accounting standards on contractors as a safeguard. The standards from which health benefit program carriers have sought and won exemption in each of the past 2 years prohibit health insurers from passing on to the government illegitimate expenses.

In conclusion, it is almost impossible to open a newspaper today without reading about the impending crisis facing Federal agencies as they struggle to address the aging of the Federal work force and the challenge of recruiting, training, and retaining their replacements. The solution is so obvious that no one seems to recognize it.

The Federal Government operates in a competitive world. Downsizing, contracting out and privatization, and salaries and health insurance that are seriously inferior to what is offered in the private sector and State and local governments are the causes. The solutions must be addressed. The Federal Government must stop trying to get by on the cheap with regard to employee compensation.

Inadequate salaries and an over-expensive health insurance program are really two sides of the same coin. More than 200,000 Federal employees who are nominally eligible to participate in the health benefit program are uninsured, largely because they cannot afford the premiums. The lack of affordability of the health benefit program and the pretense that the government is powerless to improve the situation are problems that must be faced.

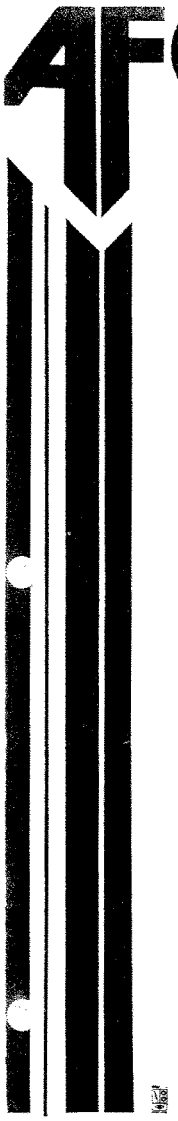
The Federal Government's CAS should be applied vigorously to make sure that every health care dollar devoted to the Federal Employees Health Benefits Program is actually spent on the program and its beneficiaries.

Finally, OPM should look around for a new partner to work with to sustain a minimum cost, efficient, and comprehensive health insurance program for Federal workers. We have a mutual interest in the best possible benefit at the lowest possible cost. OPM's collaboration with the insurance companies has not served the interest of the beneficiaries, the taxpayers, or the Federal workers, retirees and their families.

Mr. Chairman, that concludes my remarks and I am glad to answer any questions.

Mrs. MORELLA [presiding]. Thank you, Mr. Harnage.

[The prepared statement of Mr. Harnage follows:]



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STATEMENT BY

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AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
AFL-CIO

BEFORE

THE SUBCOMMITTEE ON CIVIL SERVICE

HOUSE COMMITTEE ON GOVERNMENT REFORM

REGARDING

FEHBP: OPM'S POLICY GUIDANCE FOR 2001

JUNE 13, 2000

Mr. Chairman and Subcommittee Members: My name is Bobby Harnage, and I am the National President of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the more than 600,000 federal and District of Columbia employees represented by AFGE, I want to thank you for the opportunity to testify here today on issues concerning the Federal Employees Health Benefits Program (FEHBP).

Almost exactly one year ago this committee held a hearing to examine the source of what was then a two-year run up in FEHBP premiums that infuriated our members and many members of the subcommittee. AFGE castigated the Office of Personnel (OPM) for its apparent indifference to the effect that this premium inflation was having on federal workers who are forced to pay at least 25 percent, but as much as 55 percent of premiums, along with considerable copayments and other out-of-pocket costs. Well, here we are, one year later, and many millions of dollars poorer, as premiums in FEHBP again rose by over nine percent this year.

I do want to give OPM some credit. This year, when announcing that FEHBP premiums would again rise by an average of 9.3 percent in 2000, there was no trace of the "let them eat cake" attitude of previous years. But the strong words of September 1999 have produced no policy initiatives from OPM aimed at restraining premium inflation, and again federal workers are seeing their hard-won pay raises eaten up by health insurance premiums.

Since last year's hearing, OPM and AFGE have been engaged in some dialogue regarding the administration and pricing of FEHBP. But this dialogue has fallen far short of the relationship to which our union has a right. Our members are not merely passive consumers of health benefits our employer purchases for us to enjoy. On the contrary, our members are "payors," in the jargon of the health insurance world. Federal workers and retirees contribute roughly a third of the $18 billion annual cost of FEHBP – that is about $6 billion, before the additional out-of-pocket expenditures on copayments and deductibles are factored in. Yet OPM is intransigent in its position that only it has the right to make decisions on how the entire $18 billion is spent.

AFGE firmly believes that our $6 billion of financial responsibility should come with a recognition of our right to a voice in the way the money is spent. There is no good reason why $6 billion out of the pockets of federal employees for health care costs does not justify our request for a seat at the table so that we are able to represent our own priorities, and raise our own questions in negotiations with health insurance companies.

I can also tell you that federal workers' resentment of the profligate ways of OPM would not rankle quite so much if we believed that the stewards of the program were using every tool at their disposal to ensure that every FEHBP dollar were spent carefully and prudently. When the federal government is forcing its workers' families to give up an average of $72 out of every biweekly paycheck to

pay for health insurance, it needs to do a better job of making sure that the money goes to health care, not superprofits for politically well connected industries or firms.

Yet federal workers lack this assurance primarily because we are shut out from the process of annual negotiations with the insurance companies over benefits and premiums. We are told that we lack the specialized knowledge necessary to advocate on our own behalf, and that we should be content to allow our betters at OPM to handle these complex and delicate negotiations. Federal employees are forced simply to trust OPM to take care of business, and pay whatever bill they send.

On behalf of the more than 600,000 federal and District of Columbia workers AFGE represents, and for whom FEHBP is the only reasonable choice for health insurance, I ask the Subcommittee to consider whether these workers' voices should be heard in the annual negotiations over the terms of FEHBP contracts. I want to say in the strongest possible terms that we do not believe that OPM speaks for us.

Indeed, each year brings new evidence that federal employees'interests are not well-represented by OPM in its annual negotiations with FEHBP's carriers. Although our efforts in forums such as today's hearing have made OPM more mindful of the public-relations angle of their acquiescence to the insurance

companies' demands, the outcomes tell the story. There has been no slowdown in premium inflation. In addition, the insurance companies are increasingly emboldened to press for less scrutiny of their contracts, fewer restrictions on benefit design, no restraint on how they obtain or what they charge for prescription drugs, and of course, unbridled greed in their premium setting.

Following tradition, OPM again refers to the insurance companies as its "partners" in this year's Call Letter, and congratulates them for their "cooperation and collaboration" on many policy initiatives. If OPM describes its own relationship to the insurers as one of partnership, where does that leave us? Federal employees are tired of a situation where OPM works together, "collaborates" with the insurers, and passes the astronomical costs of such a cozy arrangement on to us and our fellow taxpayers.

Carved Out Benefits

When OPM announced this year's 9.3 percent average increases, it promised something "bold and dramatic" to counteract what it called "steady increases" in FEHBP premiums. OPM did not disappoint. No once can say its initiative to stop funding certain already-existing health benefits under FEHBP and shift all the costs onto federal workers is not "dramatic." And responding to the federal government's inability either to recruit or to retain employees in a vast range of occupations and professions by raising employee costs for FEHBP, when other large employers in both the public and private sectors already provide

dramatically more generous health insurance benefits is surely "bold." But it only exacerbates these problems by moving in the opposite direction, away from what the most desirable workers want, expect, and in many cases receive from their employers.

I am referring here to OPM's proposal to "carve out" or "contract directly" for certain health insurance benefits such as dental care, vision care, and possibly prescription drugs, and make them "employee-pay-all". This proposal was included in both President Clinton's FY 2001 budget proposal, and OPM's Call Letter to carriers for the 2001 benefit year. Under this plan, OPM would graciously step in to use its *apparently* previously unexercised buying power to obtain for us a good "group rate" and leave the rest to us. The "employee-pay-all" approach may be thoroughly consistent, both philosophically and aurally, with the "winner take all" economic policies of the past two decades, but it is in direct contrast to the values AFGE upholds, and our union will oppose all such policies.

Make no mistake about this: AFGE will not stand by while the government relieves itself of the costs of providing health insurance to its employees by simply shifting more and more financial responsibility onto the backs of its workers. Interestingly, this gesture speaks volumes about OPM's own opinion of its accomplishments in the area of negotiating favorable terms with insurance companies on our behalf. Indeed, they recognize that they have done such a poor job that they want to cease to pay the inflated rates.

Employers seeking to shift the costs for health insurance onto their workers often claim they do so not only to save themselves money, but also to give workers more of an incentive to be responsible consumers. The federal government has often repeated this patronizing message to federal workers, arguing that it was important for us to shoulder an increasing share of the cost of health insurance so that we could learn the value of a health care dollar, and learn to be more frugal in our consumption of health care.

But today OPM is trying to abdicate its financial responsibilities with regard to several benefits currently covered under many FEHBP plans. It wants to limit its role to negotiating rates for others to pay, and shield itself from the consequences of its negotiations. AFGE is emphatically and unreservedly opposed to any so-called benefit carve-out which would result in any employee-pay-all arrangements.

AFGE wants OPM to hang in there and fight right alongside of us. There is much that OPM can do in partnership with *us* to bring down FEHBP's costs for many benefits, especially prescription drugs. Prescription drug prices have repeatedly been identified as the crucial "cost driver" or source of recent premium inflation. Again, we believe that OPM has chosen the wrong party as its partner. The public interest is best served when the government joins forces with those whose interest is the best value for the lowest price. It's not the contractor seeking

maximum profits for itself and its shareholder who has the public interest in mind, it is the workers.

Prescription Drugs

While there is some debate over the question of why prescription drug costs are such a large problem for FEHBP, there is no debate over whether these costs are a primary driving force behind the exorbitant premium increases of recent years. One of the most frustrating aspects of this fact is that it does not have to be the case. Although prescription drug prices and utilization trends are national problems, the federal government as an employer is in a uniquely advantageous position to address the prescription drug costs. Indeed, already this year, the government has taken steps to provide some prescription drug price relief for certain segments of the population – military retirees, Medicare recipients, and veterans. We are working to make sure that federal employees, retirees, and their families soon join this group whose status as participants in a government-sponsored health insurance program allows access to the government's discounts for prescription drugs.

AFGE believes that the time is long overdue to make available to FEHBP the discounts and favorable treatment that the federal government has arranged for the benefit of the Veterans' health care system, the military health care system, Medicare, Medicaid, the Bureau of Prisons, and the Public Health Service. While it may be OPM's preference to cease any employer financing for prescription

drugs through FEHBP as a way of dealing with high drug prices, it is our preference to take advantage of the federal government's already existing pricing and procurement arrangements to help the FEHBP lower its drug expenditures.

We propose this with the full knowledge that pharmaceutical companies have overbilled the federal government's Medicare and Medicaid programs at least as often as they have provided discounts. Indeed, we know that as this hearing takes place, the government is in settlement talks with the German pharmaceutical company Bayer for setting artificially high prices for the U.S. government while providing other customers with deep discounts. Nevertheless, we are convinced that access to the discounts the federal government has negotiated in its non-FEHBP health care purchasing could help ease some of the pain federal agencies and federal workers suffer in the course of paying undiscounted rates in FEHBP.

The *New York Times* last month published a major expose which recounted the ways pharmaceutical companies have managed to profit enormously from drugs developed on the basis of taxpayer-funded research. In addition, the article explained the ways this international industry manages to deprive the U.S government itself of discounts for these drugs, discounts to which the government is entitled by law. The article explained that the 1980 Bayh-Dole law allowed the federal government two alternatives: to purchase drugs developed through tax-financed research without paying any patent royalties, or to put up for

competitive bidding the right to manufacture a patented drug it helped develop if the holder of the patent denied the government adequate discounts.

The idea was that *the federal government* should not be price-gouged for drugs it paid to develop. The question of whether any *taxpayer* should be price-gouged for drugs developed with tax-funded research is not addressed in the law. But the other provisions were designed to help the federal government obtain favorable terms for these drugs for the Department of Veterans' Affairs, the National Institutes of Health, and other major federal purchasers of medicine.

Pharmaceutical companies like to justify their prices by claiming that the development and discovery of new drug treatments is enormously expensive, and that their profits are all plowed back into research. But a 1997 study commissioned by the National Science Foundation found that fully half of the significant scientific publications cited in medicine patents were the result of studies paid for by taxpayers. The *Times* reported that only 17 percent were from the drug industry, and the rest were from other public or private foreign sources.

OPM's claims of helplessness with regard to prescription drug prices have never been convincing to AFGE. The drug companies' strategies and obfuscation have been well-documented and are well-understood. It is time that OPM be

instructed to use all the tools at its disposal – including the annual Call Letter – to get tough on those who set drug prices, not those who pay them.

The Call Letter states that OPM believes "that members should shoulder the consequences of their desire for one drug over another and have allowed benefit designs that place the cost of those decisions on them." The Letter then goes on to describe how the carriers have created three-tier drug formularies that reflect not degrees of price discounts for various drugs, but progressive attempts to shift costs onto patients. Both practices are wrong.

OPM's principle of forcing patients to pay higher rates for some drugs is again a blame-the-victim policy. High drug prices are not a result of persnickety consumers who need to be punished for choosing one brand over another. Prescription drugs which are presented in formularies as alternatives to one another or reasonable substitutes are not necessarily identical. Further, it is not patients or consumers who prescribe or choose drugs according to "desire", but doctors.

As we all know, doctors select particular drugs for particular patients based on many variables, including drug interactions, previous reactions to a particular drug, etc. The simplistic rationale of financial penalty for selecting one drug over another may raise profits for OPM's partners in the insurance and drug industries, but it just impoverishes federal workers and retirees in FEHBP.

This year, the Special Agents Mutual Benefit Association (SAMBA) FEHBP plan attempted to exercise its right of access to the Federal Supply Schedule to purchase discounted drugs, and pass the savings along to the government and enrollees. As a fee-for-service plan with a cost-reimbursement type of contract with the federal government, SAMBA's use of the Schedule makes perfect sense. OPM estimated that SAMBA's use of the Federal Supply Schedule just for its mail-order pharmacy program would lower its premiums by 3 percent for 2000.

Although OPM has supported SAMBA's request as consistent with both the financial interests of the government and federal procurement law, this policy has turned out to be quite controversial. Again, there is no dispute regarding whether access to the Federal Supply Schedule's prices is legally permissible for FEHBP contracts like SAMBA's. It is purely a matter of turning that legal authority into genuine access.

As of this writing, the Office of Management and Budget (OMB) has still not decided whether to affirm OPM's decision. Apparently, the Department of Veterans' Affairs is opposed, arguing that including other federal agencies and programs in its prescription drug price discounts jeopardizes its relations with the drug companies. The DVA fears retaliation from the industry in the form of higher prices in the future. The U.S. government should have the courage to stand up to such threats, and do what it can to assuage the DVA's fears.

AFGE considers the approach initiated by SAMBA to be very promising. We ask that Congress weigh in on the grounds that an initiative that will save both the federal government and its employees money on health care costs should be pursued vigorously. We are convinced that the potential for cost savings are enormous, in spite of threats and warnings that the pharmaceutical companies may respond to this initiative by raising prices to other government purchasers or refusing to fill orders. AFGE does not give in easily to bullies, and we hope our government will stand with us.

In fact, we believe that the drug companies are making empty threats. The prospect of the pharmaceutical companies effectively going on strike against the federal government for insisting that it not charge different prices to different government programs for the same drugs is highly unlikely. But the threat is highly instructive. As more questions are raised about their practices of price discrimination, for example, that they charge U.S. consumers higher prices than they do in Europe, Mexico, and Canada, and charge humans higher prices than other animals, it will be interesting to learn the extent of their arrogance.

Cost Accounting Standards

For the last two years, insurance companies in FEHBP have been exempt from the government's Costs Accounting Standards (CAS) due to the extraordinary political influence of one of its carriers. The federal government imposes cost accounting standards on most of its contractors as a public safeguard. These

standards are designed to ensure, among other things, that contractors with many customers do not improperly charge the federal government for costs incurred in the course of providing services to others. The standards from which the FEHBP carrier has sought and won exemption in each of the past two years prohibit health insurers from passing on to the government illegitimate expenses.

The FEHBP insurer has argued that CAS should not be imposed upon its operations because compliance would be too burdensome and is in any case inappropriate for health insurance. Yet the federal Health Care Financing Administration (HCFA), and the Defense Contract Auditing Agency use CAS successfully to hold down costs for the Medicare and TRICARE/CHAMPUS programs. AFGE believes, especially in light of the exorbitant premium increases this and other carriers have demanded from FEHBP, that federal employees and taxpayers deserve the same protections against contractor fraud as the beneficiaries of these other programs.

The authority for invoking a waiver of CAS for FEHBP has shifted this year from the CAS Board at the Office of Management and Budget (OMB) to OPM. We are hopeful that this will also be the year when the interests of federal employees and taxpayers take precedence over the profit interests of one FEHBP carrier. FEHBP should no longer be held hostage to such arrogant and narrow demands. What are the FEHBP carriers hiding? Simultaneous with the exemption from

CAS, FEHBP's insurance companies have demanded and received premium increases of more than 27 percent.

FEHBP's carriers must be subjected to the same scrutiny as other federal contractors. Federal employees and federal agencies simply cannot afford to give them a blank check. The issue is not unlike the question regarding SAMBA's access to the Federal Supply Schedule. The law is clear regarding the applicability of CAS to FEHBP, as it is regarding whether SAMBA may make reimbursable purchases off the FSS. The only question is whether Congress and the Administration's policy-making apparatus will use the tools at their disposal to require full accountability for the insurance companies through CAS and discounted drug prices through FSS. While OPM has signaled its support for the reapplication of CAS to FEHBP, and OMB has indicated that it will soon join OPM in advocating this position, we ask that Congress take the lead in insisting that FEHBP's carriers comply with CAS.

Conclusion

It is almost impossible to open a newspaper today without reading about the impending crisis facing federal agencies as they struggle to address the aging of the federal workforce, and the challenge of recruiting, training, and retaining their eventual replacements. The solution is so obvious that no one seems to recognize it.

The federal government operates in a competitive world. Downsizing, contracting out, and privatization, when combined with salaries and health insurance that are seriously inferior to what is offered in both the private sector and state and local government are the cause. The solution must address the cause. The federal government must stop trying to get by on the cheap with regard to employee compensation.

Inadequate salaries and an overly expensive health insurance program are really two sides of the same coin. More than 200,000 federal employees who are nominally eligible to participate in FEHBP remain uninsured, largely because they cannot afford the premiums. The federal government's claim that it cannot afford to match the private sector on salaries and health benefits are belied by the fact that government-funded contractors are paying these higher salaries and more comprehensively-financed health benefits, and sending the bill to Uncle Sam.

The lack of affordability of FEHBP, and the pretense that the government is powerless to improve the situation for its employees, are problems that must be faced. The SAMBA prescription drug initiative should be embraced for all eligible FEHBP plans, so as many federal employees as possible, as well as their employing agencies, are able to benefit from the savings. The federal government's CAS should be applied vigorously in order to make sure that every

health care dollar devoted to FEHBP is actually spent on the program and its beneficiaries.

Finally, OPM should look around for a new partner to work with to sustain a minimum-cost, efficient, accessible and comprehensive health insurance program for federal workers. That partner should be federal workers themselves. We have a mutual interest in the best possible benefits at the lowest possible cost. OPM's "collaboration" with the insurance companies has not served the interests of the program's payors or beneficiaries, taxpayers or federal workers, retirees, and their families.

Mr. MORELLA. I would like to recognize Scott Nystrom for his comments.

Mr. NYSTROM. Thank you, Madam Chairman. Thank you for asking me to testify on potential economic effects of allowing the Federal Employees Health Benefits Program health insurance carriers access to the Federal supply schedule for prescription drugs.

My goal today is not to advocate for particular policies, but rather to help analyze issues from an economic and market process perspective. I would like to highlight two potential economic consequences of allowing FEHBP carriers to access FSS for prescription drugs this morning. The first potential consequence would be to increase prices for nonFEHBP purchasers of certain prescription drugs. The second potential consequence would be to increase prices of prescription drugs for agencies currently receiving discounts on prescription drug prices from the FSS.

The market provides incentive for companies to generate enough aggregate revenue from their existing drug portfolio so they can fund promising new drug research ideas. If aggregate revenue for a company is reduced from one segment of the drug purchasing market, the company is likely to develop strategies to find resources to fund the next generation of promising new drug research ideas. This pressure to continually fill the pipeline with new drugs can be a major pricing consideration for pharmaceutical companies.

One of the greatest misconceptions is that there is one way to go about prescription drug pricing. For example, many believe that all pharmaceutical companies price their products based on how much they have already invested to discover and develop a drug and then add on whatever profit they want. On the contrary, pharmaceutical companies, as rational economic actors, are not likely to consider what economists call "sunk costs" when pricing pharmaceutical products.

Pharmaceutical companies go through a very complex process to determine what price to charge for newly discovered drugs. The first consideration is often the current and historical prices of competing drugs already on the market. Another consideration may be other similar and competitive drugs about to come to market. Another competitive factor may be the level of promotion among competing products.

Prescription drug prices are related to future investment of undiscovered drugs. Pharmaceutical companies want to invest in new drugs to meet consumers' wants in order to increase returns to investors. However, investment resources are scarce.

Pharmaceutical companies have a relatively limited amount of funds available compared to the near-infinite number of ideas for promising drug research. These companies must rank and prioritize the drug research ideas. The companies must then decide how many of the drug research ideas can be funded with available resources. More resources translate into more drug research ideas funded. Consequently, there is always pressure to price a company's existing drug portfolio high enough in the aggregate to fund promising new drug research ideas within the company.

As a result, if aggregate revenue for a company is reduced, as one segment of the drug purchasing market receives larger discounts than the previous year, the company has incentive to raise

enough revenue to fund the next unfunded promising new drug research idea. The above scenario is more than a theoretical concern. We have considerable evidence based on the Medicaid prescription drug rebate program.

OBRA 1990 established a system for pharmaceutical manufacturers beginning in 1991 to grant States rebates for drugs dispensed and paid for by State Medicaid programs. States would receive discounts from the list price equal to the best price available to private sector volume purchasers for manufacturers' drugs in exchange for a Federal mandate to eliminate restrictive State formularies.

The legislation altered the best price discounts offered by manufacturers in the first 3 years in the rebate program. Manufacturers responded to the Medicaid rebate by reducing the volume discounts they had offered to reduce the size of their legislative rebates and maintain revenue levels sufficient to fund priority research ideas and profitability. The average best-price Medicaid discount was reduced from roughly 33 percent in 1991 to about 23 percent by the second quarter of 1994. At that point it leveled off.

The Congressional Research Service reported that some manufacturers responded to the requirement to offer Medicaid their best price by raising prices charged to other customers, such as hospitals and HMOs, instead of lowering the prices to State Medicaid programs.

CRS cites the experience of Department of Veterans Affairs as evidence of government-induced shifting of the costs of rebates to other purchasers. Until 1991 the VA enjoyed deep discounts for certain drugs. Beginning in 1991, VA reported significant price increases due, they believe, to the implementation of OBRA 1990 best-price regulation.

In conclusion, I want to say whether or not it is a good or bad idea to extend the FSS to all FEHBP health insurance carriers is beyond the scope of my testimony. However, past evidence suggests that any attempt to provide access to the FSS for FEHBP prescription drug purchases is likely to lead to higher prices for certain yet undetermined prescription drugs for the nonFEHBP purchasers. Three groups that immediately come to mind are retail purchasers who are facing higher out-of-pocket costs due to rising prices. That group would include about a third of all Medicare beneficiaries. Current FSS purchasers, the Department of Veterans Affairs, the Department of Defense, the Public Health Service and the Coast Guard are likely to experience higher prices if this policy were to be taken to its logical conclusion.

Smaller managed care plans with lower volume of purchasing needs and weaker negotiating positions with manufacturers and wholesalers also would likely see higher prices.

One thing is that the FEHBP program drug expenditures of about $5 billion dwarfs the FSS with estimated pharmaceutical sales of $1.6 billion in 1999. In short, the FEHBP has the potential to become the major pharmaceutical purchaser from the FSS if allowed to participate.

If the SAMBA pilot were extended to all FEHBP carriers for all drug purchases, there is considerable uncertainty about the extent of the price increases and which nonFEHBP purchasers would be

more likely to experience price increases. However, history suggests that price increases for certain prescription drugs for nonFEHBP purchasers are likely to occur if the SAMBA pilot were expanded. Thank you very much.

Mrs. MORELLA. Thank you, Dr. Nystrom and all of the panelists for their testimony.

[The prepared statement of Mr. Nystrom follows:]

Statement of
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Mercatus Center at George Mason University

At an oversight hearing of the
Subcommittee on Civil Service
Committee on Government Reform
U.S. House of Representatives

On
FEHBP: OPM's Policy Guidance for 2001

June 13, 2000

Introduction

Mr. Chairman, and Members of the Subcommittee, thank you for asking me to testify on the potential economic effects of allowing the Federal Employee Health Benefits Program (FEHBP) health insurance carriers access the Federal Supply Schedule (FSS) for prescription drugs.

My name is Scott Nystrom. I am an adjunct scholar with the Mercatus Center at George Mason University. I have served for almost 20 years in various analytical capacities on federal, state, and local health policy issues.

The Mercatus Center at George Mason University is an education, research, and outreach organization that works with scholars, policy experts, and government officials to bridge academic theory and real-world practice. Many on Capitol Hill are familiar with Mercatus' policymaker outreach program, created to develop forums for informal dialogue among government officials and their staffs, leading academic thinkers, policy experts, and practitioners. The goal of the Center is to increase understanding of market processes
through retreats, conferences, workshops, and testimony before policymakers.

My goal today is not to advocate for particular policies, but rather to help analyze issues from an economic and market process perspective.

I would like to highlight two potential economic consequences of allowing FEHBP carriers to access the FSS for prescription drugs this morning. The first potential consequence would be to increase prices for non-FEHBP purchasers of certain prescription drugs. The second potential consequence would be to increase prices of

certain prescription drugs for agencies currently receiving discounts on prescription drug prices from the FSS.
The discussion that follows will provide information on pharmaceutical pricing and describe in some detail the reasons why allowing FEHBP health insurance carriers to access the Federal Supply Schedule for prescription drugs will likely raise prices for other prescription drug purchasers.

Pharmaceutical Pricing

The market provides incentive for companies to generate enough aggregate revenue from their existing drug portfolio so they can fund promising new drug research ideas. If aggregate revenue for a company is reduced from one segment of the drug purchasing market, the company is likely to develop strategies to find resources to fund the next generation of promising new drug research idea. This pressure to continually fill the pipeline with new drugs can be a major pricing consideration for pharmaceutical companies.

Pharmaceutical companies invest vast sums of money in research and development in hopes of finding new products to sell to consumers. The reason they can invest so much money in drug discovery is because consumers want new medicines to alleviate symptoms and cure diseases. Drug therapy use has increased over the past decade because of several perceived advantages. New drugs are viewed as more effective, less invasive, and less disruptive to patient's lives than non-drug therapies. Consumer demand is increasing for prescription drugs largely because of these advantages. If consumers did not want these new medicines, pharmaceutical companies would not attract investment capital. In exchange for providing capital for these companies, investors expect risk-adjusted market rates of return. Successful pharmaceutical companies are able to discover and bring to market drugs that consumers want to use. The incentive for this research, discovery and product launching activities is profit.

One of the greatest misconceptions is that there is one way to go about prescription drug pricing. For example, many believe that all pharmaceutical companies price their products based on how much they have already invested to discover/develop the drug and then add on whatever profit they want. On the contrary, pharmaceutical companies, as rational economic actors, are not likely to consider what economists call "sunk costs" when pricing pharmaceutical products. Pharmaceutical companies go through a very complex process to determine what price to charge for newly discovered drugs. The first consideration is often the current and historical prices of competing drugs already on the market. Another consideration may be other similar and competitive drugs about to come to market. Another competitive factor may include the level of promotion among competing products.

Another consideration for drug pricing is patient characteristics such as income profile. A lower income patient profile argues for a relatively lower price. The value of a drug therapy as an alternative to costly surgery can also inform the price of a new drug. The reasoning is that a new drug should be as valuable as the surgery it might displace. Disease characteristics such as whether a condition is symptomatic or asymptomatic can also influence new drug prices. Persons with symptomatic disease characteristics are more likely to take the correct dosages at the appropriate times of day making the argument for a relatively higher price compared to asymptomatic diseases. An increasingly important consideration in the pricing of new drugs is the impact of public policy. Critical responses by public officials to the price of a new drug may create pressure for a relatively lower price. Of course, every company and every new drug is different in the way pricing considerations are weighed. These are just a few of the potential considerations companies might study when pricing a new drug.

Another dimension is the potential for price discounting for large group purchasers of the drug. Price discounting is a response by drug manufacturers to the increasing price sensitivity of employers who negotiate health plan premiums for their employees. Competitive health plans, in turn, negotiate price discounts for prescription drugs from manufacturers. In many instances, group purchasing organizations successfully negotiate lower prices for hospitals and other providers.

Pharmaceutical manufacturers offer mutually negotiated discounts to purchasers depending on a combination of circumstances and conditions. Discounts may be offered for prompt payment, cash payment, volume purchasing, single-site delivery, use of formularies, and ability to move market share.

Finally, economic theory suggests that drug companies will set prices for products to cover—at a minimum—marginal costs. Marginal costs, in contrast to sunk costs represented by resources used for past research, include production, packaging, and marketing costs.

It is in the above context that prescription drug prices are related to future investment of undiscovered drugs. In simple language, pharmaceutical companies want to invest in new drugs to meet consumer wants in order to increase returns to investors. However, investment resources are scarce. Pharmaceutical companies have a relatively limited amount of funds available compared to the near infinite number of ideas for promising drug research. These companies must rank and prioritize the drug research ideas. The companies must then decide how many of the drug research ideas can be funded with available resources. More resources translates into more drug research ideas funded.

Consequently, there is always pressure to price a company's existing drug portfolio high enough in the aggregate to fund promising new drug research ideas within the company. As a result, if aggregate revenue for a company is reduced as one segment of the drug

purchasing market (say FEHBP health insurance carriers) receives larger discounts from the previous year, the company has incentive to raise enough revenue to fund the next unfunded promising new drug research idea.

The above scenario is more than a theoretical concern. We have considerable evidence based on the Medicaid prescription drug rebate program.

Medicaid Prescription Drug Rebate Experience

The Medicaid prescription drug rebate program provides insight on the potential impact of requiring discounts through the FSS to the FEHBP market. During the late 1980s, average prescription drug prices were increasing rapidly, a rate equal to more than two and one half times inflation. In response, Congress acted to control expenditures for prescription drugs by changing the Medicaid payment system for outpatient drugs. Legislation was proposed in 1990 that would reduce federal expenditures by requiring compulsory substitution of "preferred" drugs for prescribed drugs within "therapeutically equivalent" categories.

As an alternative to this proposed legislation, another proposal emerged to enact a rebate for state Medicaid programs. An agreement was reached and passed into law as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). OBRA 1990 established a system for pharmaceutical manufacturers, beginning in 1991, to grant states rebates for drugs dispensed and paid for by state Medicaid programs. States would receive discounts from the list price equal to the "best price" available to private sector volume purchasers for manufacturers' drugs in exchange for a federal mandate to eliminate restrictive state formularies.

The economics of the Medicaid drug rebate were similar to the imposition of an industry-specific sales tax on non-Medicaid purchasers. The Medicaid rebate legislation placed pharmaceutical companies at a financial disadvantage for offering best price discounts. Not unexpectedly, the legislation significantly altered the best price discounts offered by manufacturers in the first three years of the rebate program. Manufacturers responded to the Medicaid rebate by reducing the volume discounts they had offered to reduce the size of their legislated rebates and maintain revenue levels sufficient to fund priority research ideas and profitability.

The average best price Medicaid discount was reduced from 33.3 percent in the first quarter of 1991 to 23.5 percent by the 2nd quarter of 1994, where it leveled off. Products[1] with deep discounts of more than 30 percent decreased from approximately 45

[1] Data for all products discussed in this report have been weighted for dollar volume to the Medicaid program.

percent for the top 100 drugs to approximately 17 percent for the top 100 drugs. On the other hand, the number of drugs with minimal discounts was also reduced.

The Congressional Research Service (CRS) reported that some manufacturers responded to the requirement to offer Medicaid their best price by raising prices charged to other customers, such as hospitals and HMOs, instead of lowering the prices to state Medicaid programs.[2] CRS cites the experience of the Department of Veterans Affairs (VA) as evidence of government-induced shifting of the cost of the rebates to other drug purchasers. Until 1991, the VA enjoyed deep discounts for certain drugs. Beginning in 1991, VA reported significant price increases due, they believe, to the implementation of the OBRA 1990 best price regulation. In this way, companies were able to not only maintain, but increase their research budgets and future profits.

The Pilot

The Federal Employees Health Benefits Program (FEHBP) is a $20 billion a year program that provides health insurance for about 9 million individuals. FEHBP drug expenditures are about $4 billion. Around 300 private insurance carriers participate in the program, including 10 indemnity-type plans compete nationwide.

Growing prescription drug expenditures have been identified as a driver of premium increases in FEHBP. Private sector data show that increased utilization/intensity of use is likely the major contributor to growing prescription drug expenditures.

The Office of Personnel Management, as part of its policy guidance for FY 2001, has authorized SAMBA to access the pharmaceutical Federal Supply Schedule to acquire prescription drugs for its mail order drug benefit as a two-year pilot program. The goal of the pilot is to determine if a schedule referenced to the FSS should be established to provide benefits to other FEHBP health insurance carriers.

The Supply Schedule lists goods and services that are available for purchase at government mandated discounts. For prescription drugs on the schedule, there is a statutorily required discount of 24%. Drug companies are only required to provide the statutory discount to certain federal agencies (the Departments of Defense and Veterans Affairs, the Public Health Service, and the Coast Guard). If the companies refuse to sell drugs at this discount to these agencies, they are not allowed to sell their products to state Medicaid programs.

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[2]Congressional Research Service (1993). *Medicaid Source Book: Data and Analysis (A 1993 Update)*, Washington, D.C.: USGPO, p. 360.

Conclusion

Whether or not it is a good or bad idea to extend the FSS to all FEHBP health insurance carriers is beyond the scope of my testimony. However, past evidence suggests that any attempt to provide access to the FSS for FEHBP prescription drug purchases is likely to lead to higher prices for certain (undetermined) prescription drugs for non-FEHBP purchasers.

Non-FEHBP purchasers include retail purchasers who pay for Rx drugs with out-of-pocket funds. This group would be persons without prescription drug coverage, including about a third of all Medicare beneficiaries.

Other non-FEHBP purchasers likely to experience higher prices for certain (undetermined) prescription drugs are current FSS purchasers—the Department of Veteran's Affairs, the Department of Defense, the Public Health Service, and the Coast Guard.

Other private sector employer health insurance carriers would also likely see higher prices for certain (undetermined) prescription drugs—especially smaller managed care plans with lower volume of purchasing needs and weaker negotiating positions.

The FEHBP program drug expenditures of about $4 billion dwarfs the FSS with an estimated pharmaceutical sales of under $1.6 billion in 1999. The FEHBP has the potential to become the major pharmaceutical purchaser from the FSS if allowed to participate.

If the SAMBA pilot were extended to all FEHBP carriers for all drug purchases, there is considerable uncertainty about the extent of non-FEHBP purchaser price increases and which non-FEHBP purchasers would be more likely to experience price increases. However, history suggests that price increases for certain prescription drugs for non-FEHBP purchasers are likely to occur if the SAMBA pilot were expanded.

The Mercatus Center is a research and educational organization affiliated with George Mason University in Fairfax, VA. Views expressed in this testimony are solely those of the author. The Mercatus Center and George Mason University do not take positions on public policy issues.

Mrs. MORELLA. I will start with Mr. Harnage, because we heard your testimony and we also heard the questioning that Mr. Cummings had posed with regard to your concern about OPM not speaking that clearly for AFGE, for its members, in the annual negotiation with the carriers.

What do you think should be done? First of all, what expertise would AFGE bring to the negotiations? Second, would you recommend that other parties be included in the negotiations? And I also wonder why—maybe you might sponsor a plan, an AFGE plan like some unions might do. Maybe you would like to address that, Mr. Harnage, to give us direction so, working with OPM, we can make sure that you are included.

Mr. HARNAGE. First of all, I haven't given any thought about AFGE having its own health benefit program. We did many years ago, but because of the problems that we had with people meddling in the business, we found it much better to get out of the business and try to make the Federal Employees Health Benefits Program better. What I mean by that is—I will give you an example. One year we looked at Blue Cross and Blue Shield, Aetna and AFGE's plan, and came up with a Cadillac plan which would provide the best benefits available for Federal employees. Although our cost went from $12 to $16 premium, and we would love to see those premiums again, it was considered inflationary because it was a 25 percent increase in cost. That same year, Blue Cross and Blue Shield was an $18 premium with less insurance. We weren't allowed to be competitive, and the excuse that Mr. Divine gave us, and we all remember him, was that he had to maintain the competitive edge. So it wasn't looking for the best deal for the government or the taxpayers, it was looking for the best deal for the insurers. So we got out of the business. I am not too sure that I want to get back into that.

We have seen an improvement in our opportunity to talk with OPM about the program. Our problem is that we are not getting to the substance of the issues and we are not participating directly with the carriers so that we can bring our opinions and thoughts to the consideration.

We travel all around the Beltway and deal with Congressmen and their staffs and committees and subcommittees and their staff. I have work groups working in the Pentagon and OMB and OPM, all over government, and I think everybody will recognize that we bring quite a bit of expertise to the table. We give people more facts to consider; not that we are always right, but it is good food for thought. If I don't have the expertise that they need, I will certainly get it. But there is no need for me to get that expertise and not have an opportunity to use it, so the excuse that we are not qualified is not a real justification for not letting us be at the table.

Mrs. MORELLA. You are not at the table but you can offer suggestions?

Mr. HARNAGE. Exactly. We have some discussions in what is referred to as a work group, but we are not getting down to the nuts and bolts.

Mrs. MORELLA. Would you include other parties?

Mr. HARNAGE. Sure. We think we are the best, but we would allow them to be in the room also.

Mrs. MORELLA. You said employees could not afford the premiums. I will ask later whether that is a great number and what you would do to resolve that.

But let me get on to Mr. Gammarino. A constituent of mine suffers from periodic migraine headaches, cluster headaches, and her prescription drug is for Imitrex, and each prescription includes 6 doses and can be refilled 3 times a year, 18 doses per year. These migraines plague her once or twice a month. With the medication she can function normally, and without it the pain is too intense for her to do anything.

In her particular FEHBP program, prescription drug costs are controlled by limiting the number of doses. Clearly her plan is trying to hold down costs, which is laudable, but it seems like the cost restraint objective could be met as well by making more widespread use of the Federal supply schedule's discount prices for those covered by other FEHBP plans. Would you comment on that?

Mr. GAMMARINO. Well, I heard two questions. One was associated with this particular case and the quality assurance program that this health plan has associated with ensuring that the medication is dispensed according to the guidelines, not knowing the particular case. That is one issue that the health plan is involved in screening for this.

I would say one is a program that also has these prior approval programs. The goal is not cost containment. It is part of the patient safety. There are FDA guidelines for dispensing drugs. One of the issues that we all face is that many times the pressures at the point of dispensing is to go beyond those guidelines. So not knowing that particular case, there is a balance between quality and cost.

The second question gets to the Federal supply schedule. I can't tell you how strongly I am opposed to it. One is, from my layperson's reading of the statutory requirements to obtain these types of discounts, I think it is inappropriate for any FEHBP carrier to receive them.

Second, this is not a government program. It is not Medicare, it is not Medicaid. This is a program that the government has chosen to use, the private insurer competitive model to provide the type of care and health care coverage that enrollees would like.

I think a couple of questions should be asked. I don't know the specifics of what SAMBA is actually requesting or what they are actually going to get, but if I were a Federal enrollee I might ask two questions. One is, what drugs am I going to be allowed to receive if I use the VA price schedule? Is there any type of restrictions associated with that? I don't know the answer.

Second, where do you stop? If you want to use the VA price schedule, and this clearly is driven by cost and not quality, this initiative, then do you use other Federal advantages? Do you go far—would the enrollees next expect to, instead of having the selection of health care providers like Georgetown and Johns Hopkins, would they be able to get access to the VA facilities, if price is the sole objective of these types of initiatives?

So I think from the enrollee point of view I would be concerned and have some questions about where the government is going when they seek to go this route.

Mrs. MORELLA. I thank you.

In the next round of questioning, I would ask Dr. Nystrom also about his opinion on that Federal supply schedule concept. But my time has now expired. I am pleased to recognize Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Madam Chair.

Let me ask you this, Mr. Gammarino. You mentioned a few minutes ago this whole idea of prescription drugs being advertised on television. I guess that is what you are talking about.

Mr. GAMMARINO. That is one of the primary vehicles, and print campaigns also.

Mr. CUMMINGS. So you all can see—has this—if I understand your testimony, you believe that there is a direct link between that advertising and the fact that more and more people are getting these prescriptions?

Mr. GAMMARINO. Yes. Studies have been done. For example, the top 10 drugs today that are advertised, that are—the Claritins, etc., they make up 20 percent of the prescription dollar today. I think there have been enough studies already to show a direct correlation.

If you just go back 5 years in terms of how information was dispensed, primarily drugs were under the control of a doctor. They were heavily detailed by drug manufacturers. They had all of the information. The Information Age has changed all of that. We applaud that, but one of the problems you have is now you have the consumer, that patient walking into their doctor with that ad, and they say, "I have the migraine; I not only want relief, but I want relief with this." That is the real world. I think studies have shown that doctors feel considerable pressure to meet that demand.

Mr. CUMMINGS. The way it used to be, if you did that, it was because one of your neighbors or friends said, we have the same problem and I am using so-and-so drug. That is probably about the only way it would have come up.

Mr. GAMMARINO. Right. So the informed consumer is driving some demand, and that is not all bad. We support and are going to continue to provide ways to allow our members to receive information. I think one of the things that we have to ensure is that the information is balanced and that they see more than just the green fields and the yellow flowers that they see in the ad, that they have been exposed to the fine print that shows how drugs, if they are misused, you can have adverse reactions and wind up in the emergency room.

Mr. CUMMINGS. Do you think one of the factors for the greater use of drugs is this whole movement—it is kind of old now—towards ambulatory care as opposed to people spending time in hospitals? Do you think that has had any impact at all? In other words, people more or less taking care of themselves outside the hospital? Has any of that had an affect, such as Mr. Flynn saying at one time it was 3 percent and now it is $1 out of $4 spent for drugs?

Mr. GAMMARINO. I am sure that is a piece of it. There are so many components. One thing that I would like everybody to reflect when they talk about the changes, everybody seems to focus on price. And I will be the first to tell you I would like better discounts and will try to achieve them. But the reality is, Mr.

Cummings and Mrs. Morella, that if we got the VA pricing schedule, you would still have us up here. You would still have us up here asking why the rates are the way they are, because that is not the primary reason that these health care costs are where they are today.

The milieu has changed. Drugs are a benefit for enrollees. They are used very differently today. I mean, my father had a heart attack at 53. That is the first time he was identified as having that condition. No prior use of drugs. Today an individual probably is on blood pressure medicine at 30 and he is on it for the rest of his life. And the reality is that it costs money, and the reality is that Blue Cross and Blue Shield specifically is here to serve those people, and we use our leverage in the marketplace to make it as affordable as possible, but the reality is that many of these people need this medical care.

Mr. CUMMINGS. What are your suggestions as to how to prevent the costs from going up? I am trying to stabilize them to some degree. Seeing this 30 percent over the last 3 years, and now it looks like we have another 8.7 percent possibly coming up, and I know you must think about this all of the time and try to figure out what you can do, and is there anything that we can do as a Congress to help out?

Mr. HARNAGE. Well, there are two ways to—I think three ways to effect change in this area. One is benefit design. Two is the price that we pay for the services; that is, the discounts that we get from the providers and the drug manufacturers. And the third is ensuring that it is used where it is appropriate. I think we are going to need a combination of all of those. I know that we are going to spend a lot of time trying to educate our enrollees about how to make informed decisions because this is a market today that is driven by the consumer, make no mistake about it. The insurance companies have very little control over utilization, and I would tell you, and I would say if you had a panel of physicians up here, many of them would tell you they lost control over how things are used. So a lot of our efforts are going to be on the enrollee.

We feel that this particular population would be—would adapt very well to information and education. They are smart. They are educated. They have information tools through the Internet, etc., that if we make a big push with the support of the agency, AFGE, other groups, we think that we can make an impact that way. But we are not going to do it in restricting care. We are not going to do it in saying no.

With that I will respond to any other questions you have.

Mr. CUMMINGS. Thank you.

Mrs. MORELLA. I am pleased to now recognize the gentlewoman from the District of Columbia, Ms. Norton.

Ms. NORTON. Thank you, Mrs. Morella. I apologize and regret that I could not be here to hear the Office of Personnel Management's testimony.

I do want to say this for the record. That I am very disappointed in OPM and FEHBP in the last few years and the increases that the Federal workers have had to absorb. During the time that the President was seeking to universalize health care, an effort that the Congress turned back, FEHBP was continually cited as a

model—even if we couldn't do it that way when the President proposed several different approaches to get to universal health care. Look at what the Federal Government does for its employees and the Members of Congress, and you will see that they take advantage of the large number of employees and they provide model health care and they keep costs down. Bull.

In fact, we saw that costs were kept down for a number of years, and I believe that the reason that those costs were kept down was almost entirely in response to the threat of universal health care, because as soon as that threat passed, not only were increases experienced throughout the private marketplace, but right here where we were supposed to have a model system, costs began to jump straight up.

I have asked that question at prior hearings of this kind and I was assured that there were different market conditions now, and I must tell you, I no longer believe that. One reason I no longer believe that is because the costs keep going up, and another is because OPM appears to be moving backward.

I want to say in no uncertain terms, when we have 60 million people without health care, at a time when we are only incrementally, child by child perhaps, trying to get people who are not covered, the whole notion that OPM would come forward with an employee-pay-all notion is preposterous and outrageous.

The Federal Government is not going to be able to hire doodedly squat if in fact it continues to go in this direction. The Federal Government is facing a complete evacuation of the Federal Government because of the numbers of retirees, we have already downsized the number, and because, very frankly, where it is at today is in the private sector. That is where all of the sex appeal is. That is where the tech jobs are. So the model work force that we have had, we would have a hard time getting it if we paid 100 percent of health care, the way many private companies do, and now we are going in the opposite direction. Do you expect somebody to want to work for the Federal Government?

I think this is so outrageous when the analysts are already beginning to do what I can only call scary analysis of who is going to run this government. The President was right to do voluntary downsizing, to right-size the government. It should have stopped now, at least a couple of years ago, when you consider that we are taking the head off the body, and the people who make things run have found out that they can make a lot more money making things run for the private sector, and the people who have not yet gotten their careers started don't even want to talk to Federal recruiters.

And now what does OPM say? We are going to carve out some stuff that you can pay for yourself and maybe we will help you out a little bit and referee when you do that. This is crazy. It is going to hurt the Federal service and every Member of Congress when we run a government that cannot be run with the first class people that we have been able to attract in no small part because of retirement and health benefits.

The private sector has long ago leapfrogged over us and what we see is an FEHBP that I no longer consider a model, and an FEHBP who is pricing our people out of it. The Federal Government has

nothing to be proud of. You have the largest work force in the country, you have something to work with. You have got market strength. You can make things happen not only for the Federal Government worker but for everybody else by leading the way.

We are not using the economy of scale that is ours simply because we have the largest work force in the country. We are diddling and acting as if we were some corporate employer trying to save money and trying to carve out, until he finds out that his competitors are stealing all of his workers. Our competitors have been doing that now for at least a couple of decades, and we are asleep at the wheel. The way to become completely unconscious is to start messing over people's health benefits, to keep allowing these benefits to go up without finding some way to contain these costs.

I don't know what you have had to say today, but I hope that OPM had something to say that begins to move beyond their business as usual. This is the old 1940's Federal Government approach to employee benefits, especially health benefits and the need for the Federal Government to retain and recruit workers. Thank you, Madam Chair.

Mrs. MORELLA. Thank you, Ms. Norton.

Dr. Nystrom, I would like to ask you about the Federal supply schedule and your opinions.

Mr. NYSTROM. My response today to being asked to be a witness was that there are impacts, there are consequences of extending the FSS schedule to the FEHBP program. And the consequence—we can project the direction—that is, prices in other segments of the market will probably go up, but it is difficult to predict exactly which segments will be hardest hit and which drugs will have their prices raised by the industry if the deep discounts enjoyed by VA and other agencies are also included through the FEHBP.

Mrs. MORELLA. I noted also, switching around, Mr. Gammarino, I know that you have to leave by 12:30. I am going to ask you one question. You have permission to leave at any time and we appreciate you being here. I am interested in your response to the medical errors concept that we talked about and the fact that there is legislation, and the bill that I have been pushing was crafted with the U.S. Pharmacopeia in terms of the data bases and the voluntary reporting of errors in order to share solutions. I wonder if you might comment on that.

Mr. GAMMARINO. What I would like to comment on is how we can participate in this activity. We do have a role, although we don't dispense drugs and we don't deliver health care. We do have information and we are probably the best source of information for many patients because we have through our claims records, we have the history of the drugs that they have received and the medical care that they are getting today. We have a number of things that we want to look at. We have one pilot that we have talked to OPM about and we are both excited about exploring it.

It would take an initiative that is in the private sector of Blue Cross and Blue Shield, specifically the Empire Blue Cross and Blue Shield plan, that allows us to provide information to the patient's attending doctor that would allow that provider the information to better manage that individual's care.

We have seen it work in the area of drugs where one physician may not know about how drugs are being dispensed by other physicians that that patient may be receiving and that can actually save lives.

It can also be used in other areas of medical care to red-flag and provide information to the provider if in fact, for example, a person with chronic diabetes is not receiving the types of followup care he or she may be needing. We hope to have this pilot going later this summer and we hope next year to have various forms of this pilot out there in other Blue Cross and Blue Shield plans. We are excited about the ability to support this initiative, particularly with the unique role that we can play.

Mrs. MORELLA. Excellent. I am glad to hear that.

Ms. Norton, did you have a question that you wanted to ask of Mr. Gammarino before he leaves?

Ms. NORTON. No.

Mrs. MORELLA. Mr. Harnage, what can we do about these Federal employees that you say find the premiums prohibitive? Do you have a suggestion, or is this just a suggestion about the statement that we can't keep having medical costs go up year after year?

Mr. HARNAGE. The basic question that I continue to ask myself is why is the largest employer in the United States paying the highest premium and doesn't have as good of health care as much smaller employers do, and why aren't we looking at what is going on? We want to follow the best practices of the private sector, and I don't particularly like that term because it indicates a reverse. I can remember when the Federal Government set the precedent and was looked at as the model employer. Why aren't we looking at those employers that are much smaller than the U.S. Government that have better plans at a lower cost and see what they are doing that the Federal Government could be doing?

We are not taking advantage of the volume that we represent at the marketplace. The comment was made that this is not a government program, and I am inclined to agree with that, although the government is paying for it. What we do is we ask each year in November for the individual Federal employee to go shopping, and they go shopping for what they can afford, not for what they need; instead of the Federal Government going shopping for them in volume, and saying here are the programs that we want to provide for our employees regardless of what you charge for them.

Instead of taking the opportunity for volume dealing, we are letting the insurers tell us what it costs and then letting the Federal employee do the shopping for us. I think that has got things backwards. Those are the simple questions that you ask yourself.

When we talk about the Federal supply on the prescription drugs, that it is going to increase the costs for those currently participating in it, I think that is missing the mark. We are looking at everything as if we had 50 different governments in the United States, and we have only one. So if you reduce the cost of the Federal Employees Health Benefits Program by $1, but you increase the cost of the other participants by a dime, it doesn't take a rocket scientist to know that you are 90 cents better off overall.

And to compare the Federal Government to the private sector, to the entire population of the country, you have to be talking about

socialized medicine to make that comparison. We have to compare the Federal Government as an employer, not to the population. But if we increase the cost for a tin of aspirin by a nickel, but we reduce the government's cost by a dime, that person that is paying that additional nickel is getting a dime's worth of benefit in reduced taxes. Again, it doesn't take a Ph.D. to figure out that you are saving money.

That is what we are looking at. The Federal employees are the largest single group of taxpayers in this country. We have an interest in what taxes are. If we can reduce the cost of government, we can reduce the cost of our taxes as well.

Mrs. MORELLA. I thank you for that very thoughtful statement. And I will pick up finally with Dr. Nystrom again, because of something that earlier had been in the testimony that Mr. Harnage had presented, again dealing with prescription drugs and the fact that drug prices are higher in the United States than in Europe and Mexico, Canada, and that drugs for humans are more expensive than drugs for animals.

I just wonder how you would respond to this statement. Are Americans being gouged by drug companies? Mr. Gammarino raised a number of concerns about government policies that may contribute to high drug costs, and I wondered if you would agree with any of them, or do you believe that some policies of the Federal Government do artificially raise the costs of drugs; and if so, what are these policies? I wanted to get your opinion on the prescription drug a bit more.

Mr. NYSTROM. I guess I would not use colorful language like "gouged." I would say that the market, on the contrary—for example, you talk of other countries having lower drug prices. Many of these countries have price controls on their pharmaceutical products, and as a result I think an economist would look at those countries as more free riders on the overall system of the pharmaceutical industry.

And, as such, there are differences in price for all kinds of different reasons, and there have been a few studies on this, some done more methodologically rigorous than others. But Mexico, which has a lower per capita income, they don't have the income to purchase at the prices that U.S. consumers might be willing to pay because of the value of the drug. They have weaker patent protections in some of these countries, Mexico being one, at least before 1992 and NAFTA. They also have—consumers are probably a little more price sensitive outside of the income issue. So there are different reasons why prices are different in different countries, and I think it is extremely complex and I wouldn't begin to talk about it in this forum without spending a lot more time looking at it.

You asked about policies of the Federal Government raising—artificially raising the cost of drugs. There are two policies that contribute a good deal to the cost of drugs. One is the FDA approval process which is very time-consuming and very costly. The other is probably the patent protections that are offered to companies. Now there are reasons why the government offers patent protections to companies that innovate drugs. It is because they want companies to have the financial and economic incentive to go out and discover

new drugs. Without patent protections, you don't have the incentive that you need if you want new drugs. Were those the two questions that you asked?

Mrs. MORELLA. Yes. Mr. Gammarino, do you want to make any final comment?

Mr. GAMMARINO. No. I appreciate you listening and will enjoy working with you in the future.

Mrs. MORELLA. Thank you. Mr. Harnage, any final comments?

Mr. HARNAGE. I appreciate this committee's interest in this issue, and in particular yours. But today there was a question about CAS, the cost accounting standards from the representative of OPM. One important thing was not said, and that was that OPM opposes the waiver of the CAS standard. Why that wasn't said this morning puzzles me, since I have had conversations with the administration and with the Director of OPM about how this has happened in the past. It caught us all by surprise when it was put in last year. When I asked how it happened they said, we were not aware of it, it snuck by us. I said, let's don't let it happen again in 1999. It happened again in 1999, although they got a letter over on the Hill at the 11th hour that they were opposed to it.

This year I asked them to get the word on the Hill earlier and more strongly that they were opposed, and I have been assured that they would do that.

For the representative of OPM today to not quickly and emphatically state to you that they are opposed to the waiver of the CAS standard is puzzling to me, and I am going to find out the answer to that and I hope you will, too.

Mrs. MORELLA. We will, and we still have some OPM representatives here.

Dr. Nystrom, any final comments?

Mr. NYSTROM. No. It is very gratifying to be here and especially to appear before my own Congresswoman, and I hope that I have been of some assistance.

Mrs. MORELLA. I didn't realize you were a constituent. Indeed, I should have realized from how brilliant you are.

I do want to thank you for being here for this panel and ask you if it is OK for some questions to be forwarded to you. There are a number of questions that we didn't get to, and we would like the benefit of your responses; and OPM knows that we traditionally do that also.

And so on behalf of the entire subcommittee, I thank you. The hearing is adjourned.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

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July 10, 2000

Honorable Joe Scarborough
Chairman
Civil Service Subcommittee
Government Reform Committee
United States House of Representatives
Washington, DC 20515

Dear Chairman Scarborough:

Thank you for allowing me the opportunity to testify on June 13, 2000 before your Committee on the Office of Personnel Management's 2001 Call Letter and various other important issues. At the hearing, the Office of Personnel Management informed the Committee that OPM is working with the Department of Veteran Affairs (VA) to initiate a two year pilot program under which the Special Agents Mutual Benefit Association (SAMBA) will have access to the VA Federal Supply Schedule Program for prescription drugs. During my testimony, I was asked if the Blue Cross and Blue Shield Association (BCBSA) believed that FEHBP carriers should be allowed to purchase drugs off the FSS. While I briefly expressed some of our initial concerns on this issue, I would like to take this opportunity to further elaborate and discuss some of the reasons why we believe that FEHBP carriers should not have access to the FSS.

I. FEHBP contracts are not authorized to have access to the VA FSS

Authorizing FEHBP contractors access to the VA FSS for prescription drugs would be contrary to the Federal Acquisition Regulations (FAR). Under the FAR 51.101, contractors may be authorized to use Government sources of supply in performing either Government cost reimbursement contracts, or in performing other types of negotiated contracts when the agency determines that a substantial portion of the contractor's contracts are of a Government "cost-reimbursement nature." FEHBP contracts are neither cost reimbursement contracts nor of a "cost-reimbursement" nature.

The FAR defines cost reimbursement contracts as contracts that:

> Provide for payment of allowable incurred costs, to the extent prescribed in the contract. These contracts establish an estimate of total cost for the purpose of obligating funds and establishing a ceiling that the contractor may not exceed (except at its own risk) without the approval of the contracting officer (FAR 16.301-1).

In contrast, fixed price types of contracts are defined as those that

> Provide for a firm price or, in appropriate cases, an adjustable price (FAR 16.201).

Further the FAR notes that firm fixed-price contracts have a contract price that:

> Is not subject to any adjustment on the basis of the contractor's cost experience in performing the contract. This contract type places on the contractor maximum risk and full responsibility for all costs and resulting profit or loss. It provides maximum incentive for the contractor to control costs and perform effectively and imposes a minimum administrative burden upon the contracting parties (FAR. 202-1).

FEHBP contracts are a combination of fixed priced contracts with provisions for a form of retroactive price redeterminination, and while they may not be an exact match for any of the contract types enumerated in the FAR, what is clear from their structure and operation is that they are *neither* cost reimbursement contracts *nor* of a "cost-reimbursement" nature. Each year the premium is set for the following year of insurance coverage for enrollees. The premium paid entitles the enrollee to payment by the carrier of all covered health services incurred by enrollees and dependents during the year. Once the premium is determined for the year, there is no retrospective change in the amount, regardless of the costs actually incurred by the Plans during the contract year. Underwriters of experienced-rated FEHB Plans, including the Service Benefit Plan, are bound by the FEHB contract to pay all claims incurred for the premium income received. If the accumulated premium income is insufficient, underwriters must pay remaining claims and expenses out of their own funds.

Unlike cost reimbursement contracts in which the contractor has a low risk of financial loss and the Government assumes a high risk of cost overruns, experience rated FEHBP plans always bear the risk that costs of performance will exceed both premium revenue and available reserves. Unlike cost reimbursement contracts where there is no limit on the amount of reimbursement that the contractor may receive, FEHBP contracts cannot receive reimbursements that exceed the amount of money in the reserve funds. OPM

may for "good cause" authorize additional payment to the carrier from the contingency reserve; however, the contractor has no right to any additional payments beyond the residue of the contingency reserve regardless of the extent of unanticipated adverse experience during the contract period. Thus FEHBP contracts bear all the health care cost experience risk in excess of the reserve funds. In fact, there is a history of carriers losing large amounts of money on the Program. This would not happen if the FEHBP contracts were cost reimbursement contracts. For instance, in 1990, the House held a hearing on the FEHBP, in which a Vice-President of Mutual of Omaha testified that his company had lost approximately $70 million underwriting FEHBP plans. The Service Benefit Plan itself suffered $200 million in losses in 1981.

It is important to note that OPM itself prior to September 10, 1997 characterized its FEHBP contracts as "a combination of negotiated fixed price contracts with provisions for a form of retroactive price redetermination." (FEHBP Acquisition Regulation 1616.102(b)) and included in the Service Benefit Plan contract and other FEHBP contracts standard FAR clauses for fixed price contracts. Only in final regulations issued September 10, 1997 for the purpose of applying the Truth in Negotiations Act to community rated contracts did OPM change its description of experience rated contracts to "negotiated benefits contracts." Moreover, it wasn't until June of 1998 that we are aware of any OPM statement characterizing experience rated contracts as "cost type" contracts.

II. Allowing Access to the VA FSS would have long term ramifications on the commercial health insurance sector

Not only is the Blue Cross and Blue Shield Service Benefit Plan the largest plan in the FEHPB, but the local BlueCross BlueShield plans are also the Nation's largest private insurer, covering one out of four Americans (or approximately 80 million lives). Given BCBSA's role in both the public and private health insurance sector we must be cognizant of the economic impact that FEHBP access to the FSS will have on the private health insurance sector. Allowing plans access to the FSS is tantamount to extending government price controls to a dynamic, and critical, sector of our Nation's economy, which inevitably would shift the overall product costs to the private sector. Drug manufacturers, seeking to recoup losses would shift costs to the private payers; which not only includes health insurance carriers, but also retail purchasers who pay for Rx drugs with out-of-pocket funds. In particular, this group would include persons without prescription drug coverage, including about a third of all Medicare beneficiaries. This cost shift would make drug coverage that much less affordable in the private sector.

At a time when prescription drug cost trends continue to grow and the number of uninsured is increasing at a rate of 1 million per year, BCBSA has serious reservations about expanding access to additional entities because of the potential impact it might have on consumers.

Past evidence suggests that any attempt to provide access to the FSS for FEHBP prescription drug purchases is likely to lead to cost-shifting and higher prices for non-FEHBP purchasers. For example, the Medicaid Prescription Drug Rebate Program provides insight on the potential impact of requiring discounts through the FSS to the FEHBP market. Under the Omnibus Budget Reconciliation Act of 1990, a system for pharmaceutical manufacturers was established to grant states rebates for drugs dispensed and paid for by state Medicaid programs. States would receive discounts from the list price equal to the "best price" available to private sector volume purchasers for manufacturers' drugs. Not unexpectedly, drug manufacturers responded by reducing the volume discounts they had offered to reduce the size of the legislated rebates. In addition, some manufacturers responded by raising prices charged to other customers, such as hospitals and health insurance carriers, instead of lowering prices to state Medicaid programs. While up until 1991 VA enjoyed deep discounts, beginning in 1991, the VA reported significant price increases due partially to the implementation of the OBRA 1990.

III. Allowing Access to the VA FSS Could Undermine the FEHBP

The FEHBP, by statute, is a program of insurance in which competing private sector carriers offer benefit packages to federal enrollees. Key to the success of the FEHBP is the essential role of the private sector. The proposal to allow SAMBA access to the FSS is tantamount to procuring prescription drugs from a governmental source. Separating the prescription drug benefit from the overall benefit package would set a bad precedent by eroding the original Congressional intent of a competitive insurance program in which each plan provides a comprehensive set of benefits to each member. If prescription drug benefits are carved out of the insurance product, what benefit is next? Would OPM next conclude that federal enrollees should be required to first use governmental medical facilities or VA hospitals since they may appear to have lower costs? How will this affect the quality and accessibility of health care to our federal employees? Because the Blue Cross and Blue Shield Association believes quality of health care is equal in importance to cost of health care, the Blue Cross and Blue Shield Association cannot support any action that may negatively impact the FEHBP, and ultimately, the health of federal employees.

In conclusion, we believe that FEHBP plans should not be allowed access to the FSS not only because it is statutorily not permitted under the FAR, but also because it potentially would have long-term consequences on non-FEHBP purchasers and would undermine the FEHBP. Therefore, we believe that the VA should not authorize SAMBA, or any other FEHBP carriers, access to VA's Federal Supply Schedule.

Sincerely,

Stephen W. Gammarino

Stephen W. Gammarino
Senior Vice President
Federal Employee Program
and Integrated Health Systems

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July 14, 2000

Honorable Joe Scarborough
Chairman
Civil Service Subcommittee
Government Reform Committee
United States House of Representatives
Washington, DC 20515

Dear Chairman Scarborough:

I am responding to specific questions raised by your Subcommittee following the June 13, 2000 hearing on the Office of Personnel Management's policy guidance for the FEHBP. Please do not hesitate to contact me if you have any further questions or concerns regarding my testimony or my responses to your questions. I look forward to working with you in the future.

Sincerely,

Stephen W. Gammarino

Stephen W. Gammarino
Senior Vice President
Federal Employee Program
And Integrated Health Systems

Cost Accounting Standards

1. **In his testimony, Mr. Harnage argued that since the Cost Accounting Standards are applied to Medicare and Tricare, they should also be applied to the FEHBP. What is your response to this argument?**

We disagree strongly with Mr. Harnage's argument because it fails to recognize fundamental differences between the FEHBP and Medicare or TRICARE/CHAMPUS. We are pleased to take this opportunity to address this issue in detail.

Medicare. Very few local Blue Cross and Blue Shield Plans (or other FEHB Program carriers) are performing under CAS covered contracts. This is true in part because HCFA made the decision to exclude the major Medicare contracts from CAS application – including the "mega" Part A contract performed by the Blue Cross and Blue Shield companies. Only **new** Medicare contracts include CAS, and most (such as the program safeguards and software maintenance contracts) do not meet the threshold for full CAS coverage. In contrast, if CAS were applied to the FEHB Program, almost **every** local Blue Cross and Blue Shield Plan would be required to comply, since all but one Plan participates in the Program.

In addition, HCFA requires that contractors have separate, dedicated Medicare segments, and as a result the carriers performing CAS covered contracts would be able to apply CAS only to the Medicare segment of their business, where required. In contrast, for Blue Cross and Blue Shield Plans, the FEHB Program activity is an integral part of the Plans' regular, commercial health insurance business. The Plans' ability to provide FEHB Program benefits depends on the extensive networks of providers that each Plan develops and maintains in connection with their underwritten commercial business. Put another way, FEHBP members could not, on their own, obtain pricing from the providers that larger commercial insurers can command. The dependence on commercial provider networks causes the FEHBP contract to be fully integrated into the Plans' organizational and accounting structure. CAS could not be implemented in the Plans for the FEHB Program without drastic changes and disruption of the Plans' established accounting systems. And if a Plan were forced to place its FEHBP account(s) in a separate business unit, this separation could jeopardize the Plan's ability to extend their highly favorable provider pricing arrangements and extensive provider networks to FEHB subscribers. As a result, if Blue Cross and Blue Shield Plans had to apply CAS via the FEHB Program, they would be forced to do so for their whole business, even though in many cases FEHB business is a very small portion of their overall activity.

In contrast, the Medicare contracts are essentially service agreements that do not depend at all on the relationship with the Plans' provider networks. They also tend to be very large contracts, which would justify the expenses of setting up separate segments and a CAS accounting systems. Indeed, Plans tend to house their Medicare business in separate buildings from the commercial (and FEHBP) operations, in part because of HCFA imposed limits on square footage, but also to avoid the possibility that Medicare data might inadvertently be seen by personnel on the commercial business. In some cases, Plans have established separate subsidiaries to handle Medicare work, again in part because the size of the contracts can justify it. As a consequence, the Plans are much better situated to develop distinct, CAS covered accounting systems for their Medicare contracts without having to change their accounting systems Company-wide.

TRICARE/CHAMPUS. Many of the same distinctions with the FEHB Program discussed with respect to Medicare exist with TRICARE/CHAMPUS as well. Again, few of the Blue Cross and Blue Shield companies have TRICARE/CHAMPUS contracts. With regard to Blue Cross and Blue Shield Plans, there are three TRICARE/CHAMPUS contractors: BCBS of South Carolina, Anthem Blue Cross and Blue Shield and TriWest, a company owned by several Blue Cross and Blue Shield Plans. In each case, the TRICARE/CHAMPUS business is housed in separate corporate segments. In part, this is because the size of the Plans' involvement in TRICARE/CHAMPUS justifies separate business units and accounting (as opposed to FEHBP, which is often a very small part of the Plans' overall business). In the case of TriWest, the TRICARE/CHAMPUS activity is in a separate corporation. Again like Medicare, in each case, the Plans are much better situated than they would be with the FEHB Program to develop distinct, CAS-covered accounting systems for their TRICARE/CHAMPUS contracts without having to change their accounting systems Company-wide.

In addition, the TRICARE/CHAMPUS contracts impose very different program requirements on the Plans than the FEHBP contracts or the Plans' commercial accounts. As a result, it would be very difficult for the Plans to build their TRICARE/CHAMPUS business by integrating it into their commercial business. In contrast, the FEHBP contracts work ideally through integration with the Plans' commercial business because (as discussed above) the FEHBP relies so heavily on the commercial arrangements made between Plans and providers. Again, TRICARE/CHAMPUS can easily be, and is, segmented by Plans. FEHBP cannot easily be, and is not, segmented by Plans, and to ask Plans to integrate CAS into its accounting system company-wide for what is often a very small portion of the Plans' overall business is onerous and, in the final analysis, unrealistic. It is also significant to note that Congress recognized in the Defense Authorization Act of 1997 (Public Law 104-201, Section 722(b)) that certain TRICARE contracts for managed health services should not be subject to the Cost Accounting Standards by virtue of their commercial item status. Given the

fact that implementation of CAS would provide no benefit to the government, would be expensive to implement and maintain, and would deprive Plans of needed information they derive from their current accounting systems, it makes little sense to force Plans to either make CAS part of its overall business or leave the FEHB Program.

Prescription Drugs

1. In your testimony, you say that new drugs are often substituted for treatments that are less expensive. Are less expensive treatments equally effective or nearly so?

There is no simple yes or no answer to this question because it depends on the types of drugs being examined. It is important to distinguish between new drugs that are "breakthrough" products, which treat diseases and conditions that previously lacked effective therapies, and "me-too" drugs, which are replacement therapies that have marginal improvements on side effects and effectiveness. Pharmaceutical companies tend to promote (via direct-to-consumer advertising), and physicians tend to adopt, such new technology rapidly, and they are often expensive.

For example, a University of Maryland study found that when a new pain reliever, Cox-II inhibitors, came on the market in early 1999, the cost of treating patients increased by almost 50 percent, even though the number of prescriptions written for this category of drugs stayed the same. However, the truth is that Cox-II inhibitors are not better at relieving pain or reducing inflammation – what they do is modestly lower the risk of gastrointestinal bleeding for those patients who are at high risk for a bleed. These patients represent only 2-5 percent of the population. Yet Cox-II's make up 30 percent of all prescriptions for anti-inflammatory drugs.

A lot of people are spending a lot of money on prescription drugs, believing that they are getting a superior drug benefit, but the evidence to support it is not there. Given the significant increase in prescription drugs being approved for the market, and the much higher cost of these new drugs, more information is needed to judge the relative value of replacement therapies. Consumers, physicians, government, employers, and others need unbiased information to weigh the benefits, risks, and costs of drug therapies.

2. You also advocate making information on the relative safety and effectiveness of alternative therapies more readily available to "consumers, physicians, and purchasers". Will more information really be sufficient to change behavior if the person who benefits from the more expensive treatment does not have to bear the full cost difference? For example, if a new, more expensive drug were somewhat more effective than an existing but cheaper alternative what economic incentive would either the consumer or the physician have to weigh the incremental benefit it will bring against its incremental cost?

We believe that making more information on the relative safety and effectiveness of alternative therapies more readily available to consumers, physicians, and purchasers is a helpful, and very necessary, **first** step toward controlling drug costs. Consumers need access to unbiased information on the value and efficacy of new and existing drugs so that they can have a better understanding of the value and benefits of these drugs.

Changing the behavior of consumers, physicians, and others to purchase equally effective, lower cost, alternative prescription drugs will be a difficult task. We recognize that educating and providing unbiased information to consumers and physicians alone will not change current practices. Rather, it will take a combination of initiatives to constrain rising drug costs and a formidable and focused effort by all parties who **want** to change current practices. Thus far, those who might most readily manage the expectations of insured citizens have been unwilling to do so. For example, providers need to be more accountable and responsible to their patients by only prescribing those drug therapies that will treat the patient effectively at the lowest cost, rather than prescribing prescriptions based on advertising-generated patient demand. A recent study conducted by the Harvard Medical School found that 46% of physicians cited "patient demand" as reasons for inappropriate prescribing decision, fearing that refusal to accommodate patients might result in a loss of business and reputation.

In addition, purchasers (such as employers and unions) must manage consumers' expectations by realigning consumer expectations with economic realities. Drug costs and utilization trends can be contained by implementing a range of strategies and incentives so that enrollees make cost effective drug purchases and only use drugs that are both clinically efficacious and cost effective. For example, health plans are increasingly using three tier copayment arrangements. A three tier copayment system offers consumers the drugs they want but with the caveat that they have to pay extra out of pocket where there is an alternative that is equally as effective and less expensive. Consumers appear to be very accepting of this type of benefit management approach and nearly one-half of employers are now using this type of prescription drug design. In

addition, the Service Benefit Plan has in place percentage-based coinsurance for prescription drugs purchased at participating retail pharmacies. With coinsurance, members have the incentive to seek the best value/least cost for comparable benefit.

Last, we believe that there are a number of steps that the federal government can take to improve affordability of prescription drugs and eliminate those prescription drug policies that do not have any clear benefit to consumers. A number of these recommendations are discussed in my written testimony of June 13, 2000.

3. Some argue that the long time it takes to get FDA approval for new drugs is a major contributing factor to high drug prices. Do you agree? Should Congress consider reforming the FDA process to speed up the drug approval process?

Our initial reaction would be that the long length of time it takes to get FDA approval is not a contributing factor to high prices. In fact, as a result of massive investment in pharmaceutical research and development and legislation to speed up the process for approval of prescription drugs, the number of new drugs and the pace of their entry into the market has accelerated in recent years. In addition, manufacturer's promotion of drugs has resulted in faster penetration of the drugs in the market. Finally, legislation passed in 1997 that provided the FDA with "fast track" approval authority also raises some safety concerns. "Fast track" drugs – those that treat life-threatening illnesses, especially those lacking robust therapies – can be approved based on "surrogate" markers of a drug's efficacy. As a result of these policies, consumers are at a higher risk of unanticipated drug reactions and interactions; thus one must be cognizant of the heightened safety issues to consumers. BCBSA believes that in such cases:

- Pharmaceutical companies should only promote the drug to physicians with expertise to monitor the unique clinical circumstances and drug risks that may be associated with the product – and not to consumers; and

- The FDA or the pharmaceutical company should adhere to a clearly defined process for monitoring and tracking any adverse reactions and make such findings public.

In addition, BCBSA recommends that the FDA adopt a fundamental policy that a drug should be designated as prescription only where it is not safe and effective for the drug to be designated as an over-the-counter (OTC) prescription drug. In order to achieve this objective, BCBSA recommends that the FDA engage in proactive and continuous review of prescription drugs to identify drugs that are safe and effective for OTC designation based on clinical and safety evaluations.

Also, other parties other than manufacturers should be allowed to participate in the FDA's scientific and clinical evaluation of drugs potentially eligible for a switch from prescription to OTC.

There is evidence that when a drug is appropriately moved from prescription to OTC status, consumers benefit. Evidence has shown that when a drug moves from prescription to OTC, prices drop to a level that consumers can afford. For example, OTC Zantac (75 mg) had a cost of $.28 per tablet when purchased whereas the Average Wholesale Price for prescription strength Zantac (150mg) was $1.77 per tablet. The designation of certain drugs as OTC will lower the overall prescription drug spending and will result in wiser use of scarce health insurance premium dollars.

4. You also identify consumer advertising as a contributor to increased drug costs. Some have argued that advertising by pharmaceutical companies informs people suffering from various conditions of potential treatments they otherwise would not know about. How would you respond to this argument? Do you believe the government should restrict direct-to-consumer advertising? If so, how?

There are clear benefits to consumer advertising and we recognize that the public has a personal interest in health care. Advertising that increases public awareness about disease symptoms, informs consumers about available treatment options and diagnostic procedures that may be of benefit, and encourages consumers to lead healthier lifestyles, can improve the health status of patients. Direct-to-Consumer advertising can be beneficial by encouraging consumers to become more proactive about their health in general and by developing a dialogue between patients and their providers regarding their care.

At the same time, we do believe that consumers, physicians, and others should receive balanced and unbiased information about all drug therapies. Advertising of drug therapies should inform consumers about the potential risks of using the product, the alternative treatment options available, and cost information. Today, the primary source of information on the value of drug therapies is from the manufacturers of these drugs. It is critical that all purchasers have access to independent clinically sound information on the relative value of alternative competing drug therapies.

In addition, it is important to realize that direct-to-consumer advertising has had a significant impact on prescription drug spending. While the total impact of advertising is unknown, according to a 1999 National Institute for Health care Management Foundation study, the 10 most heavily promoted drugs in 1998 accounted for over a fifth (22 percent) of the total growth in prescription drug

expenditures from 1993 to 1998. In addition, increased advertising is encouraging more visits to physicians. Although overall visits to physicians increased only 2 percent during the first half of 1998, visits related to heavily advertised drugs rose 11 to 19 percent. This finding suggests that consumer promotion has indeed helped to propel prescription drug spending over the last few years.

5. OPM has expressed concern over three-tiered drug co-payment systems, contending that some simply shift greater costs for widely used drugs to members. Does BlueCross BlueShield have a three-tiered co-payment system? Do you share OPM's concerns about three-tiered co-payment systems? Why or why not?

The Service Benefit Plan does not utilize a three-tiered copayment system at this time. In 1999, we proposed the system to OPM as part of a Point-of-Service (POS) product design change. Because we believe this is a reasonable approach to utilization management, we wanted to use the small POS population to serve as a demonstration project for a multi-tiered system. OPM dismissed the proposal without discussion.

Multi-tiered systems can be constructed to shift greater costs to members or to blend the formulary to provide a neutral plan/member shift. We have reviewed formularies that obtain greater shift to members and those that represent the neutral shift. In both situations, savings are derived by additional rebates, reduced product costs, and greater member cost participation. Philosophically, we believe that in the future, multi-tiered formularies will be the best method to manage drug costs while giving member's flexibility to receive drugs of their choice. Because there is redundancy within therapeutic drug classes, choice can be maintained without compromising clinical efficacy with multi-tiered approaches. Increasingly, local BCBS plans and other health plans are implementing tiered-copayment programs. While relatively new, three-tier copay structures have had almost instant popularity because of the choice they offer plan enrollees; nearly half of employers are now using three-tiered copays to keep drug costs down. While the Service Benefit Plan does not currently offer a multi-tier copay program, we believe a multi-tiered structure that is responsibly designed can be an effective tool to both manage costs while still providing consumer choice and flexibility.

6. Among your recommendations for controlling drug costs is to eliminate market protections that do not have a clear benefit for consumers and fostering competition. You cite proposed patent extensions for Claritin and other drugs. Can you give the subcommittee other examples of market protections that do not benefit consumers?

In the United States, branded prescription drugs enjoy several forms of intellectual property protection (IPP); the most prominent of which are patents and market exclusivity. Patents are contracts with the federal government which confer on the owner the right to make, use, and sell an invention to the absolute exclusion of others for a fixed period of time, currently 20 years from the date of application. Market exclusivity, a special form of IPP extended to pharmaceuticals, generally prevents the FDA from approving the same compound for a competing manufacturer for a certain length of time, which varies for different types of qualifying drugs. Both patent protection and market exclusivity keep generic versions of branded drugs off the market for as long as they are in effect, thereby reducing price competition. As a result, these protections have been critical to the industry's ability to sustain the profitability of their products.

In order to promote vigorous competition, BCBSA believes that the environment should be free of market protections that do not clearly benefit consumers. BCBSA recommends that policy makers review the various forms of IPP to determine if they benefit consumers.

These protections are codified in: the Drug Price Competition and Patent Term Restoration Act of 1984 (the Waxman-Hatch Act), the FDA Modernization Act of 1997 (FDAMA) and the Orphan Drug Act of 1983 (ODA). They are outlined below.

Waxman-Hatch

Waxman-Hatch contains several provisions that increase the intellectual property protection enjoyed by branded drugs. In particular, it provides:

- **Patent term extensions**. Waxman-Hatch provides patent extensions for new chemical entities equal to the "regulatory review period," for up to five years. Manufacturers may apply for one patent extension per drug for a period of time equal to one-half the time typically consumed by clinical testing and FDA review of the drug. Although the extension may be as long as 5 years, it may not result in more than 14 years of effective patent life.

- **Market exclusivity for new forms of existing drugs.** The Waxman-Hatch Act also provides 3 years of market exclusivity for new forms of existing drugs, starting on the date of FDA approval of the new drug. This provision allows manufacturers to time the introduction of a new form of the product to coincide with the expiration of the originator drug's patent. Once this patent expires, generic manufacturers may introduce copies of the older product. However, for as long as the new form of the drug has market exclusivity protection, the FDA may not approve a competing compound. In many cases, physicians will switch their patients to the new formulation of the drug, which may offer a more convenient dosing form or milder side effects. Thus, manufacturers are often able to retain pricing leverage that they would otherwise lose.

- **Data exclusivity for new drugs**. Waxman-Hatch provides five years of "data exclusivity" following FDA market approval for new drugs. Because generic drug makers need prove only bioequivalence under the accelerated approval process instituted by Waxman-Hatch, they are sometimes said to "rely on" the clinical data developed by the manufacturers of originator drugs. Data exclusivity prevents generic manufacturers from relying on such data for a period of five years after the FDA has approved a new drug. While generic manufacturers are free under law to conduct their own clinical trials, most find it prohibitively expensive to do so. Hence, "data exclusivity" provides an effective barrier to generic market entry.

FDA Modernization Act of 1997

In 1997, Congress enacted FDAMA, which contains several provisions that increase the period of effective patent life enjoyed by prescription drugs. In particular:

- **Reduced clinical study and FDA approval time**

  FDAMA reauthorized user fee support of the FDA's premarket review program and set even more ambitious performance goals. In addition, the Act contained several provisions designed to reduce the clinical study time required for the development of new drugs. According to the Tufts Center for the Study of Drug Development, the resulting combination of reduced FDA approval time and reduced clinical study time shortened the total average development time by over two years for drugs that were approved in the period 1996–1998 versus 1990–1992. This reduction in development time has resulted in a commensurate gain of over two years in the effective patent life of these new drugs. Although faster development time will enable patients to have access to new drugs sooner than before, it will also prolong the period of patent protection during which the manufacturer will be able to charge high prices for their branded products.

- **Six month market exclusivity for pediatric research.**

  FDAMA authorizes the FDA to grant six months of market exclusivity to qualifying drugs. In order to obtain this protection, the manufacturer must complete clinical studies on the performance of the drug in children at the agency's request. This period of exclusivity is to be added to the end of the product's patent term or of any other market exclusivity that applies, whichever expires last. "Pediatric exclusivity" applies to the product, and not just the pediatric indication, making it particularly attractive to sponsors of drugs with blockbuster sales.

  In May 1998 the FDA published a list of drugs for which it deems pediatric studies appropriate. After reviewing public comments on a preliminary list of drugs, the agency decided that pediatric studies would be useful for any drug or biologic product that is used in children. Hence, all such drugs are considered to be "on the list." However, inclusion in the list does not by itself constitute a request from the FDA to perform pediatric studies.

  It is unclear how many drugs will ultimately receive extensions under FDAMA's pediatric exclusivity provision. The pediatric exclusivity provision is scheduled to sunset on Jan. 1, 2002. Against that background, drug manufacturers have criticized the agency for being slow to issue pediatric study requests, and would like the FDA to ask Congress for an extension of the sunset date. However, Commissioner Jane E. Henney, M.D. testified before the Senate in October 1999 that it was too early to determine whether the agency should make such a request.

Orphan Drug Act

Once the FDA approves an orphan indication of a product, it may not approve the same chemical compound for competing sponsors for the same orphan use for seven years. A sponsor may request orphan designation of a previously unapproved drug, or for orphan designation of a marketed drug. The seven-year term of market exclusivity begins when the FDA approves the drug for the orphan designation. If the drug has any remaining patent life at that time, the patent and market exclusivity term run concurrently until one or the other expires.

Moreover, a drug that receives approval as an orphan may be used for other approved indications or for off-label uses in large populations. Some have alleged that the law allows manufacturers to use market exclusivity granted under ODA as a way to protect monopolies for drugs that are used primarily for non-orphan indications. One of the most egregious examples of this is Taxol, a drug that received orphan approval as a treatment for Kaposi's sarcoma, an AIDS related disease, even though it is one of the most potent drugs available to

treat breast and ovarian cancer. Last year, Taxol generated sales of almost $1.5 billion last year for Bristol-Myers Squibb, primarily as a cancer treatment.

DoD Demonstration for Military Retirees

1. **You state that one of the lessons we should have learned from the dismal implementation of the FEHBP demonstration project for military retirees is the need for more effectively educating this group. Has DOD consulted you since our last hearing on how to improve its educational effort? If so, what have you told them?**

We have contacted DoD to obtain updates on their education and marketing efforts for the upcoming Open Season, have had one conference call meeting, and have corresponded electronically numerous times. Thus far, DoD has provided us with a list of some preliminary plans for the upcoming year. They also informed us that they are working to establish an aggressive educational strategy, complete with early mailings and education meetings throughout the fall and during Open Season. They have provided us with a list of their scheduled meetings and have invited the local BCBS Plans to attend the educational sessions.

As we told both the Committee and DoD, we stand ready to assist DoD and OPM in any way possible to inform and educate military retirees about the FEHB program. It is our experience that this population of individuals has a lot of questions about the individual health plans and need a greater degree of engagement than civilian annuitants. In order to determine whether the FEHBP is a viable option for military retirees, it is essential that DoD and OPM engage in an aggressive education and outreach effort to the retired military community. Moreover, we have recommended to DoD that they allow plan representatives attending the meetings the opportunity to speak so that they can provide an explanation of the benefits, products, and coordination with Medicare/Medigap.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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July 18, 2000

Honorable Joe Scarborough
Chairman
Civil Service Subcommittee
Government Reform Committee
United States House of Representatives
Washington, DC 20515

Dear Chairman Scarborough:

In questions from your Subcommittee following the June 13, 2000 hearing on the Office of Personnel Management's policy guidance for the FEHBP, we were asked to respond, for the record, to a position advanced by the American Federation of Government Employees (AFGE) that the Cost Accounting Standards (CAS) should be applied to the FEHBP because they are applicable to Medicare and TRICARE. We have responded to that question, and several others, under separate cover.

I wish to take this opportunity to express the Blue Cross Blue Shield Association's strong objection to several misstatements of fact and unwarranted attacks contained in AFGE's official statement for the hearing. As you know, the Blue Cross Blue Shield system of companies, as the collective carrier for the Government-Wide Service Benefit Plan—the largest plan in the FEHBP—has openly sought the statutory exemption from CAS Congress granted FEHBP carrier contracts starting in 1998, because we believe the application of the inappropriate requirements of CAS would jeopardize the stability of this vital program without adding any benefit to the government, enrollees, or to taxpayers generally.

We respect AFGE's right to disagree with any Blue Cross Blue Shield position, and to lobby aggressively for their point of view. We believe, however, that the public policy debate is not furthered by the type of unsubstantiated and incorrect statements made by the AFGE. Rather, the record should be set straight.

> **AFGE asserts that the statutory exemption granted by the Congress for two consecutive years is "due to the extraordinary political influence of one of its carriers", that "the federal government imposes cost accounting standards on most of its contractors as a public safeguard", and "The standards from which the FEHBP carrier has sought and won exemption in each of the past**

two years prohibit health insurers from passing on to the government illegitimate expenses".

These comments improperly ascribe an underhanded motive to our efforts in seeking the exemption, and totally ignore the merits of our position. Specifically, we have demonstrated that: 1) the health insurance provided to federal employees, particularly by the Blue Cross Blue Shield companies through the Service Benefit Plan, is a "commercial item"; 2) the CAS requirements, which were developed to measure and control the costs of defense contracts, are inappropriate for insurance contracts, particularly those like the Service Benefit Plan that are commercial items; 3) the imposition of CAS to FEHBP would require Blue Cross Blue Shield Plans to restructure their entire accounting systems because federal employee accounts (which amount to on average 5 percent of a typical Plan's overall business) are fully integrated with their commercial lines of business as intended by the original FEHB Act; and 4) the imposed restructuring of our Plans' total accounting systems would degrade the financial capabilities needed to service their commercial business, making continued participation in the FEHBP untenable.

Further, FEHBP carriers already are subject to a broad array of cost accounting requirements, including those contained in the Federal Acquisition Regulations (FAR) and Generally Accepted Accounting Practices (GAAP). The Office of Personnel Management (OPM), has acknowledged their sufficiency, stating specifically in testimony before the CAS Board Review Panel that OPM has successfully monitored and audited FEHBA carriers for the 40 years of the FEHB Program without CAS. OPM has also admitted, by way of its CAS Handbook, that almost none of the CAS requirements should apply to the FEHB Program.[1] In sum, no one close to the operation of the FEHB Program day-to-day has any real interest in applying CAS to it.

AFGE's supposition that the cost accounting standards would prohibit charges that somehow are now passed on to the government also shows AFGE's complete ignorance of CAS. In truth, CAS has no impact on what is charged to the government; it only affect how those charges are accounted for and reported.

AFGE asserts its belief that "in light of the exorbitant premium increases that this and other carriers have demanded from the FEHBP, that federal employees and taxpayers deserve the same protections against contractor fraud as...", and its hope that "the interests of

[1] While OPM contends that some CAS requirements may provide value, it so narrowly interprets those requirements as to make them meaningless or largely inapplicable.

federal employees and taxpayers take precedence over the profit interests of one FEHBP carrier".

The above statements show a clear misunderstanding of the purposes of CAS and how the FEHB Program actually operates. For example, FEHBP carriers do not "demand" premium increases. Each year, carriers propose benefit packages in accordance with OPM's policy guidance and directives with respect to benefits,[2] and the carriers propose premium rates that are calculated to reflect reasonably the costs of those benefits. Negotiations ensue between the carriers and OPM, and OPM has the final say with respect to rates and benefits. Premium rates are set in accordance with the Federal Employees Health Benefits Act, 5 U.S.C. § 8902 (i). This provision requires that rates for the Government-wide Service Benefit Plan, in particular, be "determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers". (This provision, incidentally gives further weight to the argument that our contract is a contract for "commercial items"). By any measure, AFGE's linking the word "fraud" in the same sentence discussing premium increases is totally groundless.

One final point should be addressed from AFGE's statement. The "profit" on FEHBP carriers' contracts is strictly limited by regulation and negotiations with OPM. Over the past several years, the "profit" paid to carriers, in the form of a negotiated service charge, has remained steady at less than 1 percent. (It is worth noting that defense contractors, for whom the cost accounting standards were developed, typically receive profits many times greater.) Clearly, it is illogical to attribute the rise in health care costs, and the resulting FEHBP premiums, to carrier "profits".

The FEHBP carriers have encouraged an open and honest discussion of the cost accounting standards issue. Indeed, we have met on several occasions with OPM and other federal regulators to give our honest assessments of the cost/benefit and the reasons why we believe that these standards not only would not add value, but would actually jeopardize the FEHBP.

[2] For example, in 2001 OPM is directing the carriers to provide an enhanced mental health benefit.

We appreciate the opportunity to submit these views and we respectfully request that this letter be inserted at an appropriate place in the hearing record following AFGE's statement. Thank you for your consideration.

Sincerely,

Stephen W. Gammarino
Senior Vice President
Federal Employee Program

SWG:gm

United States
Office of
Personnel Management
Washington, D.C. 20415

In Reply Refer To: Your Reference:

AUG 16 2000

Honorable Joe Scarborough
Chairman, Civil Service Subcommittee
Committee on Government Reform
U.S. House of Representatives
Washington, DC 20515-6143

Dear Mr. Chairman:

I am pleased to enclose the responses to the Subcommittee's questions for the record of the June 13, 2000, oversight hearing "FEHBP: OPM's Policy Guidance for 2001." As requested, we also are submitting the responses to the Subcommittee's questions via diskette.

Thank you again for the opportunity to discuss our views with respect to OPM's policy guidance for FEHBP, and for your support of our efforts to keep this a model group health insurance program.

Sincerely,

William E. Flynn, III
Associate Director
for Retirement and Insurance

Enclosures

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING JUNE 13, 2000 ON
"FEHBP: OPM'S POLICY GUIDANCE FOR 2001"

QUESTIONS FOR THE RECORD FOR

MR. WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

Inspector General Report.

1. **Question**. In a response to a letter from Senator Fred Thompson regarding management challenges, OPM's Inspector General examined financial management oversight of the FEHBP. As a result of enrollment discrepancies and underpayments, carriers filed several lawsuits. These lawsuits resulted in a one- percent premium surcharge paid to FEHBP carriers to cover any losses incurred. How many carriers received the one percent surcharge? What is the aggregate sum of surcharges paid? What steps has OPM taken to correct this problem?

   Answer. In 1999, 226 health insurance plans received the one percent load, translating to $45 million in surcharges paid.

   OPM is assisting FEHBP carriers in resolving enrollment discrepancies and maintaining accurate enrollment databases. On November 4, 1998, OPM published final FEHBP regulations allowing FEHBP carriers to disenroll individuals when carriers cannot verify the validity of an enrollment. Additionally, OPM is creating a clearinghouse to improve enrollment reconciliation between Federal agencies and FEHBP carriers. We expect the clearinghouse to be operational before the 2002 contract year begins. With establishment of the clearinghouse, agency payroll offices will submit enrollment data to one entity -- the clearinghouse. Currently, they must submit enrollment data to each of the approximately 285 individual carriers. Similarly, FEHBP carriers will obtain enrollment data from one source, the clearinghouse, rather than from over 250 individual payroll offices. The clearinghouse will be responsible for following up with any payroll offices late in submitting their quarterly enrollment report. OPM expects the combination of the FEHBP clearinghouse and the disenrollment regulations to eliminate the enrollment discrepancies that led to the premium underpayment lawsuits. At that time, we expect the surcharge to be eliminated or substantially reduced.

Cost Accounting Standards

1. **Question**. Your testimony states that OPM has been engaged with representatives of the carriers and with members of the Cost Accounting Standards Board in an effort to look at the standards the Board has created and how they might be adapted for use in the FEHBP. Please provide the subcommittee a full report of the staff years, costs, and consultants' fees for individuals involved in such activities during the period since enactment of the initial statutory exemption.

   Answer. In September 1998, OPM formed a Steering Committee to examine the Cost Accounting Standards (CAS), how they might apply to the FEHBP, and what steps would be required to apply them. Beginning in January 1999, a workgroup was formed in which OPM met with insurance carriers as well as organizations representing carriers, such as the Association of Federal Health Organizations (AFHO). This workgroup held 12 meetings through the end of April 1999, at which point some of the carriers terminated their membership in the workgroup because of differences in opinion regarding the best approach to the task. OPM then formed a new workgroup in July 1999, consisting of OPM employees and an outside consultant who meet weekly to develop standards to apply CAS to the FEHBP.

   The following data includes staff years, costs, and the consultant's fees for the above outlined activities from the October 1998 enactment of the initial CAS statutory exemption to the present:
   - Staff years = 2,500 hours (1.25 staff years)
   - Costs (staff years converted to dollar figure) = $90,250
   - Consultant's fees = $174,000 (through June 1, 2000).

SAMBA's Pending Access to the Federal Supply Schedule

1. **Question**. Your testimony stated that OMB plans to announce a two-year pilot program allowing the Special Agents Mutual Benefit Association (SAMBA) to purchase prescription drugs for its mail order program off the Federal Supply Schedule (FSS) Class 65 at a discount. What is the status of the two-year pilot program? On what basis was the decision reached to initiate a pilot program instead of a change in policy granting SAMBA permanent access to the FSS?

   Answer. The pilot program began following a Department of Veterans Affairs letter sent to OPM on July 14, 2000, endorsing SAMBA's access to the FSS for pharmaceuticals on a 2-year pilot basis. The decision to initiate a pilot program, instead of a change in policy granting SAMBA permanent access to the FSS, was made in order to allow OPM and VA time to examine the impact of granting this access to SAMBA. The SAMBA pilot will be used simply and exclusively to establish a base line and experience against which to assess the desirability of establishing a separate schedule for the Federal Employees Health

Benefits Program and what that schedule might look like and how it might be implemented.

2. **Question**. Will the project be constructed differently than originally intended by OPM when it granted SAMBA access? If so, how will it be constructed?

   Answer. The original intent of the pilot was to grant SAMBA access to the FSS and then, based on this experience, determine whether it would be in the Government's interest to expand access beyond SAMBA. The program will not be constructed as originally intended. In fact, one of the key provisions of the SAMBA pilot is the agreement by OPM and the VA that access to the FSS for pharmaceuticals by health insurance carriers within the FEHBP will not be extended beyond the SAMBA health plan. Rather, the SAMBA pilot will be used simply and exclusively to establish a base line and experience against which to assess the desirability of establishing a separate schedule for the Federal Employees Health Benefits Program and what that schedule might look like and how it might be implemented.

3. **Question**. Testimony given during the hearing stated that prescription drugs account for $5 billion of FEHBP spending, and for calendar year 1999, total spending on the Federal Supply Schedule for prescription drugs was $1.57 billion. Did OPM conduct any market research or analysis of the impacts SAMBA's access might have on prescription drug prices both within and outside of the FSS prior to approving access to SAMBA? If so, please provide a copy of any reports generated in connection with such analysis.

   Answer. In its review, OPM discovered the following:

   Four agencies, the Department of Veteran's Affairs, the Department of Defense, the Coast Guard, and the Public Health Service, have statutory entitlement to pharmaceutical discounts and consume 95% of the drugs sold through the FSS.

   Other agencies that purchase drugs, such as the Bureau of Prisons, sometimes benefit from these statutory discounts and sometimes pay a higher price. The price paid by these other agencies depends on whether the supplier of drugs chooses to establish a second pricing tier for buyers not otherwise entitled to the statutory discount. Many suppliers have not established a second tier of prices since the volume for other buyers is so low –only about 5%.

   SAMBA is not entitled to the statutory discounts. Like the Bureau of Prisons, it is required to pay the second tier prices for drugs where one exists. SAMBA's volume of pharmaceutical purchases amounts to three-tenths of one percent of the total volume of drugs currently purchased from the FSS.

4. **Question**. What steps did OPM follow in determining it is in the Government's interest to allow SAMBA access to the FSS?

Answer. Pharmaceutical spending is a growing component of FEHBP expenditures. Drug costs currently are increasing at a rate of 20 percent a year, and in 1999 they accounted for 26 percent of benefit costs, or $4.66 billion. Taken alone, prescription drugs today can account for up to a five-percentage point increase in a health plan's annual premium.

As the largest employer-sponsor of any health benefits program in the nation, OPM has a duty to both taxpayers and our participants to ensure that the program is as cost efficient as possible while preserving the open competition among plans on which the program is based. Access to price schedule discounts for prescription drugs has the potential to reduce premium increases and focus competition on other areas of plan performance such as quality and service levels. Using the FSS to evaluate the potential of extending savings to other FEHB plans through a separate schedule is a smart business decision.

5. **Question**. Does OPM have any plans to expand access to the pilot program? If so, please describe in detail.

Answer. One of the key provisions of the SAMBA pilot is the agreement by OPM and the VA that access to the FSS for pharmaceuticals by health insurance carriers within the FEHBP will not be extended beyond the SAMBA health plan. Rather, the SAMBA pilot will be used simply and exclusively to establish a base line and experience against which to assess the desirability of establishing a separate schedule for the Federal Employees Health Benefits Program and what that schedule might look like and how it might be implemented.