HEALTH CARE INFLATION AND ITS IMPACT ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE
AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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HEALTH CARE INFLATION AND ITS IMPACT ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

TUESDAY, OCTOBER 16, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:23 p.m., in room 2247, Rayburn House Office Building, Hon. Dave Weldon (chairman of the subcommittee) presiding.

Present: Representatives Weldon, Morella, Souder, Davis of Illinois, and Norton.

Staff present: Garry Ewing, staff director; Scott Sadler, clerk; Tania Shand, minority professional staff member; Earley Green, minority assistant clerk; and Teresa Coufal, minority staff assistant.

Mr. WELDON. Good afternoon. The meeting will come to order. We will begin the hearing of the subcommittee.

I certainly want to welcome everyone to this hearing on the Federal Employees Health Program. The purposes of this hearing are to examine the causes of the steep rise in health insurance premiums under the FEHBP program for 2002, to also examine the continuing exodus of HMOs from the program, and to examine any limitations in current law or practice that might restrict competition and innovation in the program.

There have also been other important developments in the FEHBP that are of interest to the subcommittee. In particular, the merger of the Blue Cross/Blue Shield High Option and Standard Option plans and the creation of a new, lower-cost option is a matter of great interest to many.

For the 5th straight year, premiums in the program will increase sharply. According to the Office of Personnel Management, on average those premiums will rise by 13.9 percent. Fortunately, the FEHBP is a market-oriented program. Employees and retirees have the opportunity to choose among competing plans during an open season in the fall of each year. The Office of Personnel Management estimates that consumer choice will reduce the average increase from 13.9 percent to 13.3 percent.

The FEHBP is one of the most important programs this subcommittee oversees. As a physician myself and the Representative of Florida's 15th District, I am keenly aware of the importance of

the FEHBP. Approximately 9 million Federal employees, retirees, and dependents rely on it for high-quality health care options at affordable prices.

And I share their concern with the continued escalation of FEHBP premiums, which have risen by 46 percent since 1997. I believe that it is imperative that Congress understand the forces driving up health care premiums in the FEHBP and private plans. We must, however, avoid legislative actions or other heavy-handed governmental intervention to satisfy short-term political goals at the expense of the long-run health of the program.

I look to our witnesses today for a clear explanation of the causes of these premium increases. I will also ask them to recommend ways to address those causes while we work to preserve competition and consumer choice. These key features have made the FEHBP a widely admired model employer-sponsored health care program.

I am also concerned about the continuing decline in the number of HMOs participating in the program. Since 1996, many HMOS have left the program or withdrawn from specific service areas. That trend continues. At the end of this year, 28 HMOs will leave the program, and HMOs are withdrawing from 20 service areas.

The loss of these HMOs reduces the choices available to Federal employees and retirees. In some cases, this reduction is severe. No HMO in Delaware will participate in the FEHBP. In North Carolina the number of participating HMOS will drop from five to one, and in West Virginia the number of HMOs will go from three to one. I will ask our witnesses, particularly the Office of Personnel Management, to recommend ways to make the FEHBP more attractive to HMOs.

In addition, I am also concerned that current law and practices may unduly restrict competition and innovation in the program. Today, for example, the Office of Personnel Management has only limited authority to contract with fee-for-service plans. Plans are also restricted to offering two levels of benefits only.

Mandates, whether imposed by Congress or the Office of Personnel Management, also restrict competition and limit innovation. They drive up costs and reduce the ability of carriers to design affordable benefit packages that will be attractive to Federal employees and retirees.

I will ask our witnesses for recommendations that this subcommittee and the administration should consider to foster competition and innovation in the FEHBP. I look forward to hearing the testimony of our distinguished witnesses today, and I thank them for appearing.

[The prepared statement of Hon. Dave Weldon follows:]

OPENING STATEMENT
Hon. Dave Weldon
Chairman
Subcommittee on Civil Service and Agency Organization

Health Care Inflation and Its Impact on the FEHBP
October 16, 2001

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I will ask our witnesses for recommendations that this subcommittee and the Administration should consider to foster competition and innovation in the FEHBP.

I look forward to hearing the testimony of our distinguished witnesses today, and I thank them for appearing.

Mr. WELDON. I would like to now ask unanimous consent that all members of the subcommittee be permitted to place any opening statement in the record. Without objection, so ordered.

[The prepared statement of Hon. Constance A. Morella follows:]

Morella Remarks

I want to thank Chairman Weldon and Ranking Member Davis for holding this hearing today. There is no more important priority of this subcommittee than to ensure that the FEHBP maintain its position as one of the best healthcare insurance systems. Unfortunately, as premiums continue to rise, the FEHBP is losing its luster. Many individuals can no longer afford to pay into the FEHBP. Presently, 15% of the 1.8 million federal employees do not participate in the FEHBP and that number may rise as the biggest increase in many years is set for the 2002 Open Season. This rise in premiums coupled with the continuing increase in prescription drug costs and the loss of almost 170 health plans in the last four years, has startled everyone of us that is involved with the FEHBP. It is time that we begin to look into ways to not only reduce the costs of the FEHB but alter its structure so as to make sure that it continues to be a viable program for all federal employees and retirees.

I look forward to the hearing today and hearing any counsel from former Congressman Coburn and I yield back the balance of my time.

Mr. WELDON. I ask further unanimous consent that all witnesses be permitted to include their written statements in the record. Without objection, so ordered.

We will hear the opening statement from the ranking member when he arrives. As I understand it, his plane just touched down a little while ago.

This morning the subcommittee received a letter from Mr. Charles W. Jarvis, chairman and chief executive officer of the United Seniors Association, and written statements from Frank G. Atwater, president and chief executive officer of the National Association of Retired Federal Employees, and Bobby Harnage, national president of the American Federation of Government Employees. I ask unanimous consent that these items be entered into the record. Without objection, so ordered.

[The information referred to follows:]

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STATEMENT BY
FRANK G. ATWATER
PRESIDENT AND CHIEF EXECUTIVE OFFICER
NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

SUBMITTED TO
THE SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON
GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

HEARING ON
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
(FEHBP)

OCTOBER 16, 2001

Mr. Chairman:

On behalf of the more than 400,000 member National Association of Retired Federal Employees (NARFE), we appreciate the opportunity to express our views on the recently announced 2002 rate increase for the Federal Employees Health Benefits Program (FEHBP).

NARFE congratulates you, Dr. Weldon, on your ascendance to the chairmanship of the Civil Service Subcommittee. We enjoyed working with your predecessor, Representative Scarborough, and we look forward to working with you and your staff.

Like others in the federal community, we were disturbed by the Office of Personnel Management's (OPM) recent announcement that FEHBP premiums would increase by an average of 13 percent next year. Federal annuitants will be particularly hard hit by the 2002 premium increases because they live on fixed incomes and have had to absorb significant rate hikes during the previous three years.

While providing little comfort to our members, we understand that costly FEHBP premium increases are not unique to FEHBP and other large employer-sponsored health insurance systems are experiencing similar spikes. For instance, the California Public Employees Retirement System (CALPERS) health plan, second only in size to FEHBP, will also increase premiums by an average of 13 percent in 2002.

Although the average FEHBP premium increase in 2001 was 10.5 percent, the consulting firm Watson Wyatt found in a survey of large employer-sponsored health insurance plans that average employee costs increased by 12.2 percent and costs for Medicare-covered retirees rose by 13.3 percent this year. Another reputable employee benefits consulting firm -- Hewitt Associates -- said its clients paid an average premium increase of 14 percent this year. Additionally, CALPERS premiums increased by an average of 12.9 percent in 2001.

As we see it, there are several reasons why high care costs have spiked during the past few years.

First, the cost containment features and efficiencies of managed care plans -- like health maintenance organizations (HMOs) -- have proven to be temporary. As a result, the significant savings achieved by these plans in the 1980s and early and mid-1990s have diminished. For instance, FEHBP managed care plans will increase premiums by 14 percent next year while fee-for-service options will match the program-wide average increase of 13 percent. No doubt savings have been "squeezed" out of the program – but at what cost to the federal family? We were heartened by the preservation of choice in FEHBP but implore you not to waiver on your vigilance in providing quality benefits in order to recruit and retain employees and fulfill the promise of deferred compensation in federal employment through annuities and benefits.

FEHBP expenses have also risen because the program serves an aging community of coverage – both employees and retirees. For example, the average age of an FEHBP enrollee is 54. In Blue Cross/Blue Shield's standard option -- the largest FEHBP plan -- the average participant age is 60. Indeed, 30 percent of the current federal workforce will be eligible to retire in the next five

years. As individuals age, health care utilization increases and with greater utilization comes greater cost. Consequently, FEHBP has higher expenses than other employer-sponsored plans with younger participants.

Like other health plans, the skyrocketing cost of prescription drugs has significantly contributed to higher insurance premiums. Several years ago, drug costs accounted for less than 10 percent of health plan expenses. Today, that amount has increased to 25 percent of insurance benefits in FEHBP. According to the Food and Drug Administration (FDA), prescription drug costs rose 17 percent in 1999 alone. And, a recent study published in the November/December 2000 *Health Affairs* revealed that 44 percent of new health care costs in 1999 were associated with rising drug expenses.

Most health policy analysts agree that drug use has risen because there are more pharmaceuticals available today that sustain, or improve the quality of, life. However, direct industry-to-consumer marketing of new drugs has also influenced increased utilization. In fact, drug companies spend as much as 35 cents of every dollar of revenue on marketing.

According to the nonpartisan Congressional Research Service (CRS), the pharmaceutical industry in recent years earned about 18 cents after taxes for every dollar of revenue, or three times the rate of the average U.S. company.

While much of the 49.8 percent increase in FEHBP premiums since 1998 can be attributed to rising drug costs, utilization, technology and medical inflation contributed a larger share to the

2002 rate hike. In fact, a recent study by the Center for Studying Health System Change (HSC) found that inpatient and outpatient hospital services accounted for 47 percent of all health care costs in 2000.

According to HSC, "consumer demand for broad provider networks and the retreat from tightly managed care, coupled with hospital consolidation and reduction in excess capacity have increased some hospitals' bargaining leverage with health plans. Growing numbers of contract showdowns between providers and health plans are occurring as providers use their clout to gain higher payments."

Lessening the Burden

Section 125 of the Internal Revenue Code presently allows employers in the public and private sectors to permit their employees to pay for health insurance with wages excluded from both income and social security payroll taxes. President Clinton offered this "premium conversion" benefit to federal employees in October 2000 through Section 125. According to OPM, the average federal worker saves about $434 a year by lowering their taxable income by the amount of an employee's health care premium. These so-called "premium conversion plans" are available to many employees of large private-sector companies.

However, federal annuitants were excluded from the program since tax code authority to make premium conversion benefits available to retirees is less clear. Federal annuitants must receive such relief since they also shoulder the burden of increasingly high health insurance costs and are

particularly hard hit because they live on fixed incomes.

NARFE supports H.R. 2125 and S. 1022, legislation introduced by Representative Tom Davis and Senator John Warner, to allow federal annuitants to use pre-tax annuities to pay their share of FEHBP premiums. Federal annuitants with family FEHBP plans could save an average of $405 a year on their income taxes if federal annuitants were allowed to pay premiums with pre-tax annuities. Military retirees would also be permitted to pay their share of TRICARE premiums with pre-tax retirement pay under the Davis and Warner bills. We urge you, Mr. Chairman, and members of the subcommittee, to support H.R. 2125 and to seek its speedy consideration and approval.

The burden borne by federal annuitants and employees would also be reduced by H.R. 1307, legislation introduced by Representative Steny Hoyer that would increase the government contribution from 72 to 80 percent of the weighted average of all FEHBP plan premiums. Many employers contribute a larger share than the federal government for employee premiums. In a competitive labor market, increasing the FEHBP employer share would help the federal government attract the best and brightest to public service.

Containing Costs

In addition, NARFE supported the Special Agents Mutual Benefit Association (SAMBA) prescription drug demonstration program that was canceled by OPM last year due to the pharmaceutical industry's refusal to participate in the project. The pilot project would have

allowed SAMBA to buy certain drugs for its enrollees at the discount mandated by the federal supply schedule (FSS), a procurement tool used by the Department of Defense and Veterans Administration health care systems. NARFE was disappointed that some major pharmaceutical companies refused to play a role in a modest proposal to contain high drug costs for working families, retirees living on fixed incomes and the taxpayers. We were also troubled by the opposition of some FEHBP insurance carriers to the SAMBA demonstration while the same firms seemed to be less concerned about shifting new costs to enrollees.

Beyond the SAMBA demonstration, NARFE is interested in discussing other ways to contain prescription drug costs with this panel and OPM. For instance, some FEHBP plans use pharmaceutical benefit managers (PBMs) to lower or contain drug costs by negotiating discounts with pharmaceutical manufactures. Indeed, some of the Medicare drug benefit proposals considered this year would employ PBMs.

NARFE supports enhancing the ability of pharmaceutical benefit managers to leverage the federal community's large economy of scale when negotiating drug discounts with the pharmaceutical industry.

Enhanced PBM leverage could also be complemented if OPM, federal employee and annuitant organizations, and FEHBP carriers joined together in educating enrollees about the benefits of using generic drugs -- specifically, that generic drugs, when available, are almost always a medically appropriate substitute to name brands and that greater use of generics could result in significant savings for participants and taxpayers.

Quality, Coverage and Access vs. Cost Containment

In an environment of double digit premium increases, our members support innovative methods of reining in out-of-control health care costs in FEHBP. At the same time, however, most federal annuitants and workers would prefer to retain the ability to select their own physicians, specialists and other providers under their current fee-for-service plans. For that reason, we have concerns about any plan that attempts to reduce access to providers and facilities. That is why NARFE supported the February 1998 executive order that required FEHBP carriers to provide access to specialists and emergency room care, disclose financial incentives and provide continuity of care. An internal and external appeals process for consumers who have grievances with health providers or plans has been developed. And, FEHBP plans are prohibited from imposing gag rules on participating physicians.

NARFE also endorsed the strong and enforceable patient protections in S. 1052, "Bipartisan Patients' Protection Act", as approved by the Senate on June 29. In addition, we specifically support S. 1052's FEHBP liability provisions -- as included in Senator Don Nickles' amendment to the bill -- because federal employees and annuitants should receive the same accountable and enforceable protections that other Americans will acquire through the Patients' Bill of Rights and because new costs are likely to be nominal.

We also support significant improvements in mental health and substance abuse parity in FEHBP plans that were made in response to 1999 White House Conference on Mental Health recommendations.

Senator Pete Domenici told the Senate Health, Education, Labor and Pensions (HELP) Committee in July that breathtaking medical advances have occurred because health insurance has covered ailments like heart disease while "those suffering from a mental illness do not enjoy those same benefits of treatment and medical advances because all too often insurance discriminates against illnesses of the brain." As Senator Domenici said to the HELP Committee, the cost of mental health parity "is negligible, especially contrasted with the to cost impact of society." NARFE supports continuation of mental health and substance abuse parity in FEHBP.

Shifting Costs to Enrollees

Proposals to shift costs to enrollees -- that are cynically promoted as cost containment or consumer choice initiatives – have been suggested by some during previous rate hikes.

For example, in the fiscal year 1999 Budget Resolution, the House Budget Committee sought to limit annual growth in the government's share of FEHBP premiums to the consumer price index (CPI). According to a Congressional Budget Office (CBO) estimate prepared in 1997, the federal government would have cost-shifted $400 in added annual cost to federal annuitants and employees in 2002 and more in later years if this artificial limitation had become law. The entirety of federal government budget savings would have been attributed to shifting costs to enrollees. Indeed, federal employees and annuitants would have paid an ever-increasing proportion of premium costs each year FEHBP rate hikes exceeded general inflation as measured by the CPI. This was a virtual guaranty, given the historical pattern where premium increases have outpaced inflation.

Other proposals have been made to offer a cafeteria-style benefit offering to federal workers and annuitants. Under this approach, federal employees -- and perhaps annuitants -- would receive a tax-free fixed dollar government/employer contribution, adjusted annually for inflation, to pay for FEHBP, life insurance and presumably the Thrift Savings Plan. Like the premium-indexing proposal included in the FY 1999 budget resolution, this proposal would limit future government contributions to the CPI and costs above general inflation would be shifted to enrollees. The lump-sum government contribution could also force employees and annuitants to forgo one benefit to pay for another, and in the case of FEHBP, could increase the number of uninsured persons. While NARFE supports informing consumers and incentives to control of health costs, we oppose forcing only enrollees to shoulder the burden of increased premiums.

NARFE is also concerned about any proposal that would end the present limit on the FEHBP government contribution to 75 percent. Such an initiative has been included in the FEHBP-inspired "premium support" Medicare reform plan. Under FEHBP, enrollees pay at least 25 percent of their health plan premiums. Absent this cap, the enrollee share of FEHBP premiums could be zero if enrollees select the lowest cost plans -- giving enrollees a "premium-free" option. This option could have a significant effect on the rest of the program. The availability of a no-cost plan would serve as a particularly strong incentive to younger, healthier employees. The unintended risk selection would not only draw enrollees away from plans where risk would more likely be spread over a wider pool of risk but would also lead to more and more enrollees congregate in the no-cost plans. Since the FEHBP "Fair Share" government contribution formula is weighted to the number of enrollees, a no-cost plans that attracts a large share of enrollees would reduce the overall dollar amount of the maximum government contribution

under the premium support proposal. Consequently, costs would be shifted to enrollees in all other plans, increasing enrollee costs and effectively limiting consumer choice.

Shifting benefit costs to individuals devoting, or who have devoted, their careers to public service is the wrong signal to send at any time, particularly when the federal government is facing a human capital crisis. Moreover, the premium indexing, premium support and some cafeteria-style benefit proposals do nothing to contain costs. We urge the subcommittee to oppose these and other proposals to shift costs to federal employees and annuitants.

Medical Savings Accounts/High Deductible Catastrophic Health Insurance

Medical Savings Accounts (MSAs) are the combination of a tax-exempt account used for medical expenses and a high-deductible catastrophic health insurance policy. Although MSAs would cost taxpayers and enrollees more money rather than contain costs, supporters sometimes suggest them as an FEHBP reform proposal.

One of the chief advantages of an employer-sponsored group health insurance program like FEHBP is that it spreads the risk of health costs across a large community of coverage. Without risk sharing, high users of health care would face exorbitant medical costs. When introduced in a group health environmental, MSA circumvent the benefits of risk sharing and encourages adverse selection. That's because the controversial plans are specifically designed to divide sick from healthy enrollees. Healthier enrollees tend to gravitate to MSAs because they reward low health care users with cash balances at the end of each year. Higher users are left in traditional plans and carriers are forced to raise premiums, cut benefits or both. Indeed, the nonpartisan

Congressional Budget Office (CBO) said in 1998 that mandating MSAs in FEHBP "would increase premiums for comprehensive plans by siphoning off relatively health enrollees in catastrophic/MSA plans." As a result, CBO estimates that imposing MSAs in FEHBP would result in nearly $1 billion in new costs, over and above what taxpayers currently spend to finance the government's share of providing health insurance to federal employees, annuitants and their families.

Adverse selection -- and subsequent premium increases in comprehensive plans -- occurred when the plans were offered to public employees in Ada County, Idaho and Jersey City, New Jersey. As a result, the county and city stopped offering MSAs to their employees.

Providing cash balances at the end of the year to anyone who believes their health care costs will be low is a powerful incentive for enrollment. However, this incentive could also encourage FEHBP enrollees to "game" the system by switching to a comprehensive plan during the program's annual "open season" in any year they know their health care expenses will multiply. This "gaming" will only exacerbate the adverse selection anticipated from the introduction of MSAs in FEHBP.

MSA proponents often say that adding the costly plans to FEHBP would offer enrollees with more choice. While making MSAs available to small business employees or the self-employed might make sense in an environment where there are frequently few choices, such an option is unneeded in a health insurance system with more plans and better provider access than any other employer sponsored program in the country.

The FEHBP-MSA proposal is a major threat to the future health security of federal annuitants and workers. That's why keeping MSAs out of FEHBP is a NARFE legislative priority in the 107th Congress. For that reason, NARFE urges the members of this subcommittee to oppose any legislation that would impose MSAs on FEHBP.

Conclusion

For 41 years the FEHBP has minimized costs and provided a wide choice of comprehensive health insurance plans to nearly nine million federal employees, retirees and their families. OPM's ability to minimize expenses is now being challenged by significantly higher health care costs. We stand ready to work with this panel, others in Congress and OPM to contain out-of-control health care costs without sacrificing quality, access and coverage and absent proposals that only shift costs to enrollees or that circumvent risk sharing in our group plan environment.

AFGE Congressional Testimony

STATEMENT BY

BOBBY L. HARNAGE, SR.
NATIONAL PRESIDENT

THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
AFL-CIO

BEFORE

THE CIVIL SERVICE SUBCOMMITTEE

OF THE

HOUSE GOVERNMENT REFORM COMMITTEE

REGARDING

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

OCTOBER 16, 2001

American Federation of Government Employees, AFL-CIO
80 F Street, NW, Washington, D.C. 20001 ★ (202) 737-8700 ★ www.afge.org

Mr. Chairman and Members of the Committee: My name is Bobby L. Harnage and I am the National President of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the more than 650,000 federal employees our union represents, I thank you both for holding this hearing and for accepting my testimony.

The Federal Employees Health Benefits Program (FEHBP) has become a scandal. Each year, Congress holds hearings after premium increases are announced. AFGE denounces the increases as exorbitant, and the Office of Personnel (OPM) responds that there is simply nothing they can do to restrain them. But this year marks a new low. Emboldened by their success in walking away with some of the highest increases in the nation four years in a row, this year the carriers, led by their Most Valuable Player, Blue Cross/Blue Shield, shot for the moon and got it.

I am here today to urge you not to accept OPM's contention that they are powerless to resist the insurance companies' demands. The United States government is not the hapless and weak Charlie Brown, and its response must be more than a shrug and a murmured "good grief." This is a $17 billion program, and nine million federal employees, retirees, and dependents will be forced to live with the consequences of OPM's continued failures.

This year there are two big stories from OPM's annual "negotiations" with the carriers. First are the astronomical premium increases. Second is the departure of 50 plans from the program, including Blue Cross/Blue Shield's replacement of its High Option with a new Basic Option plan. I will address premium increases first.

FEHBP's 2002 Premium Increases

While the headlines talk about 13 percent average increases, the real story is quite different. The two million federal employees and retirees who have been in the two traditional Blue Cross/Blue Shield plans will experience premium increases 50 percent higher than that 13 percent reported average.

Mark Twain's famous dictum on damn lies and statistics has never been more apt. While Blue Cross/Blue Shield's Standard Option premiums are going up by a total of 15 percent, the premiums that employees and retirees will have to pay will go up by much more. The employee share for Family coverage under Blue Cross/Blue Shield Standard will go up by 17 percent. For coverage of Self the Blue Cross/Blue Shield Standard will go up by 20 percent.

Furthermore, the so-called "Fair Share" formula adds another kick in the pants so that the government's overall share of costs for Blue Cross/Blue Shield Standard Options will go down to 70 percent. It is a popular misconception that under the

"Fair Share" formula the government pays 72 percent of premiums. Not true. The government pays 72 percent of *average* premiums, and this amount serves as a cap on the dollar amount that agencies pay. There is also a cap on the percentage of premiums that agencies pay (75 percent). *However, there is no cap on either the dollar amount or the percentage of what employees pay.* Thus, in 2002, federal employees will pay a full 30 percent of Blue Cross/Blue Shield Standard Option premiums.

When OPM announced the premium increases for 2002, they handed out a chart with the title "Contributors to the Premium Increase." While a truer chart might have listed the amounts that Blue Cross/Blue Shield executives and administrators of the FEHBP account were paid, what this one purported to show was the relative importance of factors such as drug prices, "utilization, technology, and medical inflation", demographics, benefit changes, enrollee choice (plan movement), and reserve and financing costs. The chart uses data from the FEHBP as a whole, and thus does not explain Blue Cross/Blue Shield's increases only the overall average increase of 13 percent.

The data show that the combination of benefit changes and enrollee choice, as manifest through plan movement, combined to cause premiums to decrease by 2.2 percent. The relative shares were a minus 1.6 percent for benefit changes, and a minus 0.6 percent for the effect of enrollee choice through plan movement.

The causes of over all increases were "increased drug costs" at 4.9 percent, utilization, technology, and medical inflation at 9.5 percent, demographics at 0.7 percent, and "other (reserves, financing, etc.) at 0.4 percent.

Each of these is interesting and deserves close inspection. I want to note, however, for the record that AFGE requested disaggregated data to learn the reported causes of increases in individual plans, but OPM refused to supply it to us. They call it "proprietary", which is interesting because as I understand the term, propriety refers to ownership. Ownership should accrue to the individual or group that pays for the good or service. As the representative of federal employees who pay for FEHBP and everything associated with it not only as taxpayers contributing to the government's share, but also as payers of the 28 percent and up forced upon federal employees under Fair Share, one would think we were proprietors too. But OPM obviously thinks otherwise.

Thus, we are left to try to make sense of these highly aggregated data on "contributors to the premium increase." We are unable to learn whether "utilization, technology, and medical inflation" costs were tempered at all by the use of prescription drugs. We are unable to learn whether "prescription drug costs" are affected more by the price of prescription drugs, or the utilization of prescription drugs. We are left to wonder about the relative importance of the many factors that make up "utilization, technology, and medical inflation." Indeed, how can medical inflation be a separate factor? The data themselves

are supposed to describe the causes of inflation. How can medical inflation cause inflation? How can one cite changes in the price of health care to explain changes in the price of health care? With analysis like this, it is no wonder OPM comes back to us with premium increases dictated by the insurance companies.

Since OPM refuses to reveal to federal unions why the prices for health insurance are going up, plan by plan, we ask the Members of the Committee to request this information. The data show that benefit changes in FEHBP constituted a negative factor in the explanation of overall premium inflation for 2002. At the same time, OPM has maintained that the elimination of the FEHBP plan with the richest set of benefits, which was also the most expensive plan in the program, is not reflected in that 1.6 percent decline. Further, when asked to specify which plans cut benefits, and which benefits were cut, OPM refused. Again, I ask that the Committee request this information from OPM so that we can begin to answer these questions.

AFGE wants access to these data because we are forced to bear such a large share of the costs for FEHBP. While large private sector firms and state governments routinely pay anywhere from 80 to 100 percent of premiums for their employees, the federal government pays only 70 percent in the plan that enrolls fully half of all participants in the program. While unionized employees elsewhere in both the public and private sectors are able to have a meaningful voice in the inevitable trade-offs between premium increases and covered

benefits, OPM insists on making these decisions for us, with no input from employee organizations whatsoever. Why should an OPM official decide to keep a benefit that is profitable for Blue Cross/Blue Shield to provide but which makes health insurance coverage unaffordable for a GS-5 VA hospital worker in Wilkes-Barre, Pa.?

At one time, the answer to that question might have been that the worker had a choice under FEHBP. She could bite the bullet and pay the high costs of Blue Cross/Blue Shield, or if that were too expensive, she could enroll in a less costly local HMO. The idea was that this so-called freedom to choose would keep the pressure on Blue Cross/Blue Shield to keep premiums reasonable. While that was never a legitimate argument, today it is literally not true.

Forty-nine health plans will pull out of FEHBP as of January, 2002; 50 if Blue Cross/Blue Shield High Option is included. These numbers represent about 27 percent of FEHBP's plans as of this year. The departures mean that approximately 135,000 FEHBP enrollees will have to find a new plan, but many will no longer have an HMO option. In central Pennsylvania, 14,000 will have no HMO. Several states will now have only one HMO, including North Carolina (which last year had five), West Virginia (which last year had three), Rhode Island, and South Carolina. The state of Delaware will have no HMO option. OPM reports this news in its typical "there's nothing we can do" fashion. They have allowed the big plans to segment the FEHBP market so that premiums

reflect the risk characteristics of the covered group rather than the value of medical benefits provided. Federal employees, retirees, and their dependents are the losers in this game of risk selection and the big plans are the winners. OPM, which should be performing an active role of oversight and control, just throws up its hands.

Blue Cross/Blue Shield's Big Coup

If an award were given to the health insurance company that exploits OPM's weaknesses most effectively and most profitably, and that is the most shameless in using its size, power, and influence to extract the largest possible amount of money from federal agencies and federal employees through the FEHBP, the winner would undoubtedly be Blue Cross/Blue Shield. Perhaps we would call it the Profiteer of the Year Award. If it existed, Blue Cross/Blue Shield would not only have won easily this year, but in each of the last five years. While average premiums between 1998 and 2002 will have gone up by 49 percent, Blue Cross/Blue Shield has topped the average amount each year.

This year, however, Blue Cross/Blue achieved its most stunning victory. It withdrew its High Option plan, and replaced it with a new, highly restrictive plan that is far less comprehensive than the Standard plan, simultaneously lowering the ceiling and the floor on benefits available under FEHBP. What is more, they managed to pass on the full cost of insuring the high-risk individuals who had enrolled in their High Option onto federal agencies and federal employees who

pay for the Blue Cross/Blue Shield Standard Option. ***The federal government will realize no savings at all, either now or in the future, as a result of the elimination of the most costly plan in the FEHBP.***

While the possibility of the establishment of a new, low-benefit, low-cost plan in FEHBP had been discussed in previous years, it was always proposed in the context of bringing FEHBP costs down and reaching out to federal employees and annuitants who are uninsured because they cannot afford FEHBP's high prices. But this year's move by Blue Cross/Blue Shield and OPM is the worst of all worlds for federal employees. We lose a comprehensive old plan, we gain a new plan with very poor benefits, and costs for both are higher than straightforward insurance principles indicate they should be.

For example, the new Basic Plan under Blue Cross/Blue Shield which replaces the comprehensive High Option plan is designed to punish enrollees financially when they need care from outside a very narrowly defined network. Further, it places high and frequent out-of-pocket costs on enrollees, e.g. the maximum supply of mail-order maintenance drugs for chronic illnesses will be 32 days rather than the more typical 90-day supply. This will force enrollees to pay three prescription drug co-payments rather than one over the course of a 90-day period. The design of that one benefit will have an adverse impact on the whole of FEHBP, and is a textbook case of risk selection by the insurance companies

that undermines the benefits of group insurance for those who pay. OPM should not have permitted such blatant manipulation of the FEHBP market.

By OPM's own admission, if OPM had not agreed to allow Blue Cross/Blue Shield to end the High Option plan, premiums in the Standard Option would have risen by 12.5 percent next year instead of 15 percent. Two million federal employees and retirees will pay an extra $55 this year to Blue Cross/Blue Shield that they should not be paying, and would not be paying if OPM had done its job of protecting the interests of taxpayers and enrollees in its annual negotiations with the insurance carriers. Of course, that $55 will be compounded annually for as long as Blue Cross/Blue Shield remains in FEHBP, adding insult to injury forever.

These two changes are good examples of changes which would not have won the approval of federal employees if we had been at the negotiating table hammering out terms for the 2002 FEHBP contract year. While before certain audiences OPM claims to represent the interests of federal employees and agencies, brandishing focus group and survey data, what they tell audiences of insurance companies is another story. The fact is that 650,000 federal and District of Columbia employees who participate in and pay for FEHBP have elected AFGE to speak for them. Indeed, our union exists to give voice to the concerns and interests of our members. AFGE members know that when their

union is at the table, there is only one goal: to stretch each taxpayer dollar as far as possible to provide affordable, reliable, high quality health care.

OPM, on the other hand, routinely refers to FEHBP's insurance carriers as its "partners." Federal employees are held at arm's length, denied information, denied a voice, and denied the right to reject the terms OPM and its partners contrive to present to us. I ask the Members of the Committee to require OPM to work with federal employee unions, to bring us into the negotiations with FEHBP's carriers so that OPM will be reminded at each moment of the interests of those who struggle to pay the bill for FEHBP – taxpayers, federal employees and federal retirees.

FEHBP and Cost Accounting Standards

When OPM justifies our annual fleecing by Blue Cross/Blue Shield, they protest that FEHBP premiums in experience-rated plans are merely a reflection of costs. Profits are not even in the equation, not even a percentage but a fixed amount paid for administrative costs. Everything is to be explained by costs. There are some insurance arrangements and some government contracts for which these arguments are true, and verifiably so. But it is impossible for anyone in the federal government –particularly OPM – to say with any seriousness or certainty that Blue Cost/Blue Shield premiums are a reflection of the previous year's costs.

The reason why OPM does not know in any useful way what Blue Cross/Blue Shield's FEHBP-related costs are for any year is that five years ago Blue Cross/Blue Shield won from Congress an exemption from adherence to the government's Cost Accounting Standards. The government's Cost Accounting Standards are set by the Office of Management and Budget (OMB). They are designed to instruct government contractors how to report their reimbursable costs in a consistent and uniform manner so that the government can make sure that no costs have been assigned or allocated to the government improperly. In the case of Blue Cross/Blue Shield, adherence to the government's Cost Accounting Standards would prevent them from charging the government for costs they incurred in the course of doing non-FEHBP business.

But Blue Cross/Blue Shield is a government contractor that is above the law that applies to other government contractors. The billions it charges annually for FEHBP are reported in a manner of Blue Cross/ Blue Shield's own choosing and design. When they report that their costs went up by 15 percent, it is impossible for OPM, OMB, or any federal employee or agency that must pay the bill to verify the charges. The Congressional Budget Office (CBO) estimated in 1998 that adherence to the Cost Accounting Standards saved roughly $10 million per year in the FEHBP by avoiding payment of fraudulent charges. Thus for the 5-year period during which there has been no application of the Cost Accounting Standards, the government has likely been bilked out of $50 million.

Requiring Blue Cross/Blue Shield, and indeed all government contractors with cost-based contracts, to adhere to the government's cost accounting standards has become an increasingly important policy issue. President Bush has ordered federal agencies to target 425,000 federal jobs for contracting out and privatization over the remainder of his term. Agencies are being forced either to hand these jobs directly over to private contractors, or hold public-private competitions, at their discretion. In cases where agencies decide to hold public-private competitions federal employees will have the opportunity to compete in defense of their jobs. While AFGE strongly supports public-private competition, we are concerned that the costs of FEHBP puts federal employees at a competitive disadvantage.

FEHBP prices go into every in-house cost estimate that a federal agency compiles in the course of a public-private competition held under OMB Circular A-76 (which regulates source selection for federal agencies considering contracting out). When OPM grants FEHBP carriers premium increases that exceed the increases faced by private sector firms, which will have been the case in each of the past five years, federal employees are put at risk of losing their jobs through no fault of their own. The stakes could not be higher.

AFGE urges the Subcommittee to consider reimposing the requirement that all cost-based FEHBP contractors, including the largest, Blue Cross/Blue Shield, adhere to the government's cost accounting standards. It would be an important

step in assuring that FEHBP plans were not overcharging or otherwise improperly allocating costs to the government. It would also improve the process of public-private competition by helping agencies to make informed decisions about whether an in-house or a contractor bid would cost the government less.

Conclusion

AFGE's criticism of OPM raises the question of how we would handle Blue Cross/Blue Shield and other aspects of the negotiations over FEHBP prices and benefits differently. This is a difficult question for AFGE to answer because we are barred from access to information about the plans. In addition to the fact that carriers are not required to report costs according to the same standards for measurement, assignment, and allocation to which other government contractors must adhere, OPM refuses to share with us the data Blue Cross/ Blue Shield does provide. The first step AFGE would insist be taken would be a thorough audit of the costs reported by not only Blue Cross/Blue Shield, but other carriers as well. Such an audit would make clear the costs associated with particular providers and benefits, and point to areas where FEHBP might use the combined purchasing power of nine million to secure discounts on prescription drugs, medical tests, and hospitalizations.

AFGE deserves a seat at the table at the annual negotiations over premiums and benefits in each of FEHBP's plans. The affordability of FEHBP is a growing

problem for both blue collar and white-collar federal employees and their families. What is more, the high cost of FEHBP is continuing to pose a threat to federal employees' jobs in cost comparisons under A-76. Federal employees want a voice in decisions that have such a far-reaching and profound effect on their economic well-being.

This concludes my testimony. I will be happy to answer any questions the Committee may have.

Mr. WELDON. I will introduce our first witness. I would like to ask our first witness to come forward.

Ms. NORTON. Mr. Chairman?

Mr. WELDON. Yes?

Ms. NORTON. I would like to offer an opening statement.

Mr. WELDON. Well, go ahead.

Ms. NORTON. Thank you, Mr. Chairman. I have been on this committee for 11 years, and there has never been any reluctance to allow members to offer an opening statement. This is a very important hearing, and I appreciate your calling this hearing. I would like the opportunity to express my own concerns concerning what has happened to this very important program.

Mr. WELDON. Would the gentlelady yield? Let me just share with you why I wanted to limit it to Mr. Davis and me.

Ms. NORTON. Yes, I would appreciate it.

Mr. WELDON. This is a relatively small committee. You are the only person here, but I have been in the Congress for 7 years and I have gone to a lot of hearings where Member after Member makes an opening statement. Frequently, witnesses fly in from faraway places and sit and listen to Members. I personally prefer a policy where the chairman and the ranking member make their statement and the other Members submit them for the record.

As I said, it is a small group. I would be happy to let you go ahead and make your opening statement.

Ms. NORTON. Yes, I would ask the chairman not to break the longstanding policy of this very small committee to allow Members to express their views in opening statements, particularly since on FEHBP there is usually only one hearing per year, and I assure you, Mr. Chairman, most of the witnesses here have flown in from OPM and other far-flung parts of the District of Columbia.

If I may, I am very concerned and want to have the opportunity to express that concern because I think only when those concerns are expressed will there be the kind of response and pressure that we need when we see the kinds of costs we are seeing in the FEHBP program. I would not want to hide my disappointment at what has happened to this program since I have been a Member of Congress for 11 years.

Today the last thing the Federal workers and other Americans need now are large increases in health care, but what FEHBP is offering is not only inflation, but hyperinflation. This really takes us back to the bad old days that we haven't seen in years now, where you have an almost 50 percent increase in FEHBP premiums over a period of 4 years. So that I just want to say that this Member who has been fond of calling FEHBP a model program for the country is going to cease doing so, because I think now FEHBP compares unfavorably to other plans in the country.

For example, people in the Federal sector and elsewhere embraced HMOs in order to cut costs, and yet we see in our program that the HMOs have increased slightly more than the fee-for-service, 14 percent for HMOs, 13 percent for fee-for-service. We see HMOs fleeing FEHBP. So, clearly, they don't consider this a hospitable program.

I am concerned that the usual suspects such as drug costs, while significant, are not even the main culprit. One of the things I want

to ask the witnesses concerns this category called utilization technology and medical inflation, which apparently accounts today for the most important part of the increase. There is something called medical inflation which accounts for 60 percent of this category of increase. I will certainly want to know what in the world that is because it is undefined.

When I look at what has happened to FEHBP over the years that I have watched this program, I am inclined to compare what is promoting increases to the usual suspects. Mandates, for example, are 1.5 percent of the additional cost. Well, that is more than I would like, but that doesn't compare to 9.5 percent, which is caused by utilization technology and medical inflation.

You would think demographics, another of the usual suspects, would account for a greater part of the cost, of the increase in cost, because the average employee for the Federal Government is retiring age, ladies and gentlemen, at 58. That is why we are going to see an exodus of Federal employees in very large numbers in the next year or two. But you have a 0.7 percent for the average employee who is 58 and the average retiree is 71 percent. So that doesn't account for this large increase.

I just want to say, Mr. Chairman, this is some model—with the FEHBP premium increase more than the average for all employers. So we are behind other employers who don't have this full range of competition in their plans. It is some model when almost half of all employers in the country pay 100 percent of the premium, almost half, for health insurance for their employees, and FEHBP still is stuck at 72 percent. The country is falling behind, not moving ahead in health care, and FEHBP is falling behind even further.

A major problem may be that we do not manage administrative costs in the various health care plans. We simply proliferate administration. So one plan does costly administration and the next plan does costly administration, and we get to pay for all of that.

Medicare administrative costs are 1.7 percent. Medicaid administrative costs are 4.4 percent. I am not sure what the average administrative cost is for a plan like Blue Cross/Blue Shield. That is something I would very much like to know.

FEHBP, we know this, is a model of competition. It would be hard to find any plan that had 180 carriers. It has many cost-saving HMOs, so-called cost-saving HMOs, but the results are not what competition and cost-cutting plans are supposed to give us.

Mr. Chairman, these annual hearings have had no effect whatsoever on the same problems. They go up each year. I believe that the time has come for thinking beyond the boundaries that Congress and the OPM have brought to the problem, that we ourselves have to take responsibility for allowing this to get out of control.

Thank you, Mr. Chairman.

Mr. SOUDER. Mr. Chairman?

Mr. WELDON. Does the gentleman have an opening statement?

Mr. SOUDER. I would like to submit my opening statement for the record and go on record as saying I believe it should be the chairman and the ranking member that generally do the statements. That is the way we do most of the Government Reform committees. There are exceptions that we can do, but that, combined

with the late start, I have two other things I have to go to. I am not going to now be able to hear more of the witnesses, and I am frustrated.

Ms. NORTON. Because one member gave an opening statement?

Mr. WELDON. No, we were delayed waiting for Mr. Davis. His plane arrived late.

Mr. SOUDER. I basically agreed with your points, but I hear them all the time.

Mr. WELDON. Well, I understand the gentleman's frustration and we will go ahead and proceed.

I would like to introduce our first witness, Dr. Tom Coburn. Dr. Coburn is a distinguished former Member of the House, having represented the 2nd District of Oklahoma from the 104th Congress through the 106th. During that time he was an active and articulate spokesman on health care issues, and he is today a practicing physician.

Dr. Coburn, I welcome you to this hearing and I look forward to hearing your testimony. If you could please stand and allow me to give you the oath?

[Witness sworn.]

Mr. WELDON. Note for the record that the witness responded in the affirmative.

Dr. Coburn, you are recognized. If you could please try to summarize your statement to 5 minutes, we would appreciate it.

STATEMENT OF DR. TOM A. COBURN, M.D., A FORMER REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Dr. COBURN. I would be happy to do that.

First of all, let me thank you and say it is good to see Ms. Norton and Mr. Souder. I miss my times with you in the House, but I thoroughly enjoy myself in medical practice today.

I think that it is important that this hearing not just concern itself with the increases that you are seeing in the FEHBP arena because it is only one symptom of what is actually occurring out there, and it is based on multiple factors.

I also think that you ought to have a realistic perspective of what has happened in medicine. Medicine is no longer an altruistic, benevolent profession. It has been turned into a hard-core business, and decisions about people's lives and their health have more to do with dollars than they have to do with caring of the individuals, and that is unfortunate in this country. I think we ought to try to put incentives into place that would move us back to that of the science that is based on care of the individual.

I also would say that many of the people who are participating in the field of medicine are not unbiased, as I am not myself. I am a purchaser of multiple plans of health care for businesses that I have. I also am biased in that I am one of the providers in health care. I tend to bias toward my own advantage. Therefore, everything that I say, as well as every other person who is giving testimony here, has a vested interest in their own perspective that makes their testimony somewhat suspect.

But I do have the ability of having been in Congress, also having practiced medicine, also having been a purchaser, a large pur-

chaser of health care benefits. I have seen what I think to be are multiple numbers of the problem.

The first thing is it looks like this last year we spent $1.4 trillion on health care, of which about $400 billion of it had nothing to do with helping someone get well. That is a large number. It is somewhere estimated that the paperwork costs alone with medicine are around 19 percent. That is atrocious.

When we quote what Medicare and Medicaid is, that has nothing to do with the real cost of the paperwork because that has all been shifted to the providers. Medicare and Medicaid are wonderfully efficient now that they don't have the responsibility of providing any of the documentation or paperwork associated with it.

The Federal employees' program is a great program. It is one of the best in the country. It allows the most choice. It allows the greatest freedom of opportunity. It allows people to make decisions about their own lives.

Ms. Norton noted that it is markedly increasing. The reason the private sector's prices are not increasing as much is because all the people who are providing those are cutting benefits to maintain and control costs. The reason that they are having trouble controlling the cost is because the government isn't funding the actual cost of Medicare and Medicaid. It is being tremendously cost-shifted to all the other sectors.

So we can run around and look for the cost-drivers, and there's multiple cost-drivers, but one of the most important is the lack of proper funding for the health care programs that we provide for the elderly and indigent in this country. Therefore, we tax everybody else in this country indirectly through their health care premiums for providing those services. To deny that is to stick our head in the sand and say that we are not causing the prices to go up by what is happening in Washington the way they fund Medicare and Medicaid and at the States.

The one criticism I would have of the Federal employees, and one of the reasons that it would tend to go down rather than go up, is if they had a truly high deductible policy that would incentivize people to not overutilize the system, I think, No. 1.

The second real problem with cost-drivers in health care is perverse incentives. There is no incentive not to overutilize the system and there is every incentive, especially with low deductible and managed care plans, to overutilize the system. There are no strong incentives throughout the country for preventative care. One of the things that we can do that will make a tremendous difference in the long run: preventative care in terms of diabetes, preventative care in terms of hypertension, preventative care in terms of giving the deductible to anybody who decides to choose to have a preventative health care exam so that they can get the benefits of knowing what they can do to change their life, so that they won't succumb to an illness in the future that will cost all of us, including them.

Great examples of that are pneumo-vacs for seniors. We have less than 50 percent of our seniors immunized against the No. 1 cause of hospitalization, which is pneumococcal pneumonia. Yet the drug companies that make that and several other people can show us that would be a cost benefit. Why wouldn't we want to

incentivize the physicians to immunize their seniors, like we do with flu vaccine?

Vaccine programs for children, we are now shifting all that to the health departments around the country because the absolute cost of paperwork alone to administer vaccines to children is a losing proposition for every pediatrician, family practice, and internal medicine doctor in this country. We lose money every time we vaccinate a child. That has to stop.

So what happens is we shift the cost. We send them to the health department. Consequently, many of them don't get immunized. We have a program to immunize children, but because it is not reimbursed to a point where it can be justified, we lose.

I will wrap up here real quick just by saying I think another significant thing is pharmaceutical costs. We are the only Nation I believe in the world that allows direct consumer advertising. There was recently a study put out by Lancit that questioned the motivations and the advertising techniques and the truthfulness of that.

There are significant consequences to that in terms of doctor/patient relationship, in terms of overutilization. We now have to reeducate patients when they come to our office about why they don't need a medicine that the pharmaceutical company convinced them they did through a TV ad. That takes time. That increases cost. That increases complexity. $2 billion is going to be spent this year on TV advertising by the pharmaceutical industry for prescription drugs, without adequate advertising limitations, which the FDA recognizes and as does the general medical field.

Finally, one of the most perverse incentives in a study out of Indiana in 1993 discusses the cost of ordering tests that aren't necessary. That is all based on a tort system that says medicine is to be perfect, and it is not. It is an art. We tend to want to think of it only as a science. It is an art that utilizes science to affect the medical or scientific result.

Because of that, one-third of all the tests that are ordered in this country are unnecessary. That has been documented. So if we decrease that, we could save another $10 billion just by reforming the tort system in this country so that we order tests—or put the system to a point where it is arbitration, something that says we won't continue to order the tests.

Now if you look at that study, it said even the doctors who said they don't order tests to protect their back side, when looked at in retrospect, it said they did. So we all do, because none of us wants to get sued. So we order tests to justify and defend our positions for the future that has nothing to do with the care of the individual.

Finally, Medicare has designed a system that is designed to be defrauded. It is easy to defraud Medicare. If you look at what HCFA, which has now changed its name, said about echocardiograms by cardiologists in this country, and that about 500,000 are done each year that don't need to be done, and yet we have not seen any decrease in that number since that statement was made, there have to be some questions as to whether or not the system is designed to be overutilized and defrauded.

The last thing the government needs to do is to make more regulations in the health care industry that will require more bureau-

crats chasing more paperwork. What I believe that the government needs to do, and for Federal employees as well, is create a program that incentivizes preventative care and incentivizes against over-utilization.

With that, I will end my testimony.

[The prepared statement of Dr. Coburn follows:]

TESTIMONY OF TOM COBURN M.D.

OCTOBER 16,2001

I WANT TO FIRST THANK THE COMMITTEE FOR THE OPPORTUNITY TO TESTIFY BEFORE YOU TODAY AND EXPRESS TO YOU THAT ONE OF THE MOST IMPORTANT WAYS TO ENHANCE THE STANDARD OF LIVING FOR BOTH FEDERAL EMPLOYEES AND THE REST OF US IS TO GET A HANDLE ON THE COST DRIVERS IN HEALTH CARE IN AMERICA. TO HAVE THE OPPORTUNITY TO DISCUSS MY OBSERVATIONS WITH YOU IS A PRIVILEGE.

YOU ARE GOING TO HEAR TESTIMONY FROM MANY INTERESTED PARTIES IN RELATION TO FEDERAL EMPLOYEE HEALTH COSTS. AS YOU MEASURE THAT TESTIMONY IT IS IMPORTANT THAT YOU LOOK AT MOTIVATIONS AND BOTTOM LINES. UNFORTUNATELY HEALTH CARE HAS EVOLVED FROM THE HEALING ARTS AND AN ALTRUISTIC MOTIVATION TO A COLD HARD BUSINESS THAT IS INCENTIVIZED FOR PROFIT NOT PEOPLE. ASSOCIATED WITH THAT IS STANDARD BUSINESS PRACTICES THAT ARE USED TO INCREASE MARGINS AND OR REVENUES WHILE DECREASING COSTS.

I MYSELF AM NOT UNBIASED. I HAVE SEVERAL BUSINESSES THAT BUY HEALTH INSURANCE FOR OVER FORTY EMPLOYEES AND WE HAVE SEEN OUR COSTS SKYROCKET AS WELL. I AM ALSO BIASED IN THAT I AM A PRACTICING PHYSICIAN AT THE MERCY OF THE MANY PAYERS WHO ARE OUT THERE WHO DECIDE WHAT MY SERVICES ARE WORTH AT THE PRESENT. THESE ARE MOST OFTEN MARKET DRIVEN DECISIONS WHICH HAVE NO RELATIONSHIP TO SKILL TIME OR EXPERIENCE BUT RATHER TO THE LOWEST COMMON DENOMINATOR IE WHAT CAN WE VALUE THE SERVICE AT AND STILL ATTRACT A MINIMUM NUMBER OF PROVIDERS.

LET ME ALSO STATE THAT FEDERAL EMPLOYEES HEALTH BENEFITS ARE THE BEST OR NEAR THE BEST THROUGHOUT THE COUNTRY. AFTER

RECEIVING A SET GOVERNMENT CONTRIBUTION, FEDERAL RETIREES AND EMPLOYEES ADD THEIR OWN MONEY TO PAY THE PREMIUMS FOR THE INSURANCE PLAN THEY CHOOSE FROM AMONG A GOOD NUMBER OF COMPETING PLANS. THIS METHOD OFEMPOWERING CONSUMERS WITH BOTH THEIR OWN MONEY AND THEIR OWN FAMILY'S HEALTH AT STAKE TO MAKE THEIR OWN JUDGMENTS ABOUT WHAT PLAN BEST SUITS THEM IS AN EXCELLENT WAY OF BALANCING VALUE AND COST.

NOW TO COSTS... I BELIEVE THAT I SHOULD LIST THE COST DRIVERS IN AN ARBITRARY ORDER SAVING TO LAST WHAT I BELIEVE TO BE THE NUMBER ONE INFLUENCE ASYOU WILL QUIT LISTENING AND DETERMINE THAT ALTHOUGH YOU HAVE HEARD IT BEFORE IT IS NOT ACCURATE.

NUMBER 1- GREED... 1.4 TRILLION DOLLARS IS A LOT A BUCKS.. AND THAT IS PROBABLY AN UNDERESTIMATE OF THE DOLLARS SPENT IN 2001 ON HEALTH CARE IN THE U. S. EVERY SEGMENT OF THE INDUSTRY IS GUILTY, FROM YOU WHO DESIGN GOVERNMENT RUN PROGRAMS DOWN TO THE LOWEST OF THE LOW ON THE FOOD CHAIN IN HEALTH CARE. WHEN YOU HAVE THAT MANY DOLLARS BEING CHASED THERE IS BOUND TO BE A SIGNIFICANT INFLUENCE OF LESS THAN HONORABLE STATURE ACQUIRING A PERCENTAGE OF THE PIE.. THE GREED ASPECT PERMEATES ALL LEVELS AND IS RATIONALIZED AT ALL LEVELS WITH JUSTIFICATION BY WHAT

THAT LEVELS CONTRIBUTION IS DEEMED TO BE. WE SEE THIS IN EVERY OTHER AREA IN OUR COUNTRY WHERE THERE IS SIGNIFICANT EXCESS DOLLARS.

NUMBER 2. PERVERSE INCENTIVES.. EVERY WHERE WE LOOK IN HEALTH CARE THERE IS AN INCENTIVE TO SPEND MONEY,NOT EFFICIENTLY USE IT. THERE IS NO TRUE REWARD SYSTEM TO ENCOURAGE THE EFFICIENT UTILIZATION OF RESOURCES.. WE HAVE TRIED MANAGED CARE AND WE ARE NOW SEEING THAT EVEN WITH MANAGERS OVER ALL ASPECTS OF THE DELIVERY SYSTEM WE CANNOT CONTROL COSTS. WHY NOT? BECAUSE THERE IS EVERY INCENTIVE NOT TO.

SOME EXAMPLES....PREVENTATIVE CARE... THERE IS NO INCENTIVE IN MEDICARE, MEDICAID AND MOST INDEMNITY AND MANAGED CARE PLANS TO ENCOURAGE EFFICIENT AND UP TO DATE PREVENTATIVE CARE. PNEUMOVAX WHICH IS A VACCINE AGAINST PNEUMONIA IS AVAILABLE TO PROTECT MANY OF OUR SENIORS FROM ONE OF THE MAIN CAUSES OF PNEUMONIA WHICH IS ONE OF THE PRIME REASONS FOR HOSPITALIZATION .. WHERE IS THE MEDICARE BONUS TO ENCOURAGE PHYSICIANS TO UTILIZE THIS TOOL.

I AM SURE THERE IS A PUBLIC HEALTH STUDY SOMEWHERE AND ALSO A PHARMACEUTICAL FIRM THAT CAN SHOW SIGNIFICANT COSTS SAVINGS TO MEDICARE IF ALL SENIORS WERE IMMUNIZED.

VACCINE PROGRAMS.... THEY ARE NOW SO COSTLY AND SO LOWLY REIMBURSED THAT PHYSICIANS LOSE MONEY EVERY TIME THEY GIVE AN IMMUNIZATION TO PEDIATRIC PATIENTS WHEN ONE CONSIDERS THE TIME CONSTRAINTS ON STAFF AND RECORD KEEPING THAT IS REQUIRED..THERE FORE MANY OF THE IMMUNIZATIONS ARE NOW GIVEN AT LOCAL HEALTH DEPARTMENTS TO DEFER COSTS. THIS IN TURN RELATES TO A LOWER EFFECTIVE IMMUNIZATION RATE WHICH IN TURN INCREASES ILLNESS AND HOSPITALIZATIONS.

ANOTHER PERVERSE INCENTIVE IS LOW DEDUCTIBLES AND LOW COPAYS WHETHER BY MANAGED CARE FIRMS , ;INDEMNITY FIRMS, AND SUPPLEMENTAL INSURANCE PROGRAMS FOR MEDICARE PATIENTS. THERE IS NO INCENTIVE TO NOT UTILIZE THE HEALTH CARE SYSTEM..AND WITH THAT THERE IS NO INCENTIVE FOR THE INDIVIDUAL USER OF THE HEALTH CARE SYSTEM TO TRULY CARE ABOUT COST BECAUSE **SOMEONE** ELSE IS PAYING THE BILL.. THAT SOME ONE IS THE AMERICAN TAXPAYER IN ALMOST 50% OF THE COSTS AS YOU ARE NOW SEEING. I ROUTINELY HAVE PATIENTS IN MY PRACTICE THAT ARE SEEKING CARE WHEN THEY DO NOT NEED TO BE THERE... WE HAVE RAISED A GENERATION OF UTILIZERS WHO REALIZE NO CONNECTION BETWEEN COST OF HEALTH CARE AND THEIR POCKET BOOK..

FINALLY ONE OF MY FAVORITE PERVERSE INCENTIVES IS THAT I AM FORCED BY THE TORT SYSTEM TO ORDER TESTS THAT I KNOW ARE NOT NECESSARY SIMPLY TO BE ABLE TO DEFEND MY SELF AGAINST AN AGGRESSIVE AND OFTEN TIMES IMMORAL ATTACK ON THE ASSUMPTION THAT MEDICINE IS A PERFECT SCIENCE RATHER THAN AN ART OF HEALING THAT UTILIZES SCIENCE TO EFFECT A CERTAIN RESULT... THERE WAS AN INTERESTING STUDY DONE BY THE UNIVERSITY OF INDIANA WHICH I BELIEVE WAS PUBLISHED IN 1993 THAT SHOWED OVER THIRTY PERCENT OF ALL MEDICAL TESTS AND PROCEDURES PERFORMED WERE ON THE BASIS OF THIS PERVERSE INCENTIVE.. EVEN DOCTORS WHO SAID THEY NEVER ORDERED TESTS ON THIS BASIS WHEN THEIR CHARTS WERE REVIEWED

CONCURRED THAT TESTS WERE ORDERED ON THE BASIS OF COVERING ONES' BACKSIDE.

THERE ARE MANY OTHER EXAMPLES THAT I SEE DAILY WHICH IF CORRECTED I BELIEVE WOULD RESULT IN LOWER COSTS AND MUCH IMPROVED QUALITY OF CARE BOTH IN THE OFFICE SETTING AND THE HOSPITAL SETTING AS WELL.

NUMBER 3. PHARMACEUTICAL COMPANIES USE OF TELEVISION, PRINT, AND MEDIA ADVERTISING WHICH ENCOURAGES OFFICE VISITS FOR MEDICINES NOT NEEDED, WITH ADVERTISING TECHNIQUES WHICH CREATE A DEMAND WHERE NONE IS NEEDED OR EXPECTED. A RECENT LANCET ARTICLE PUBLISHED THIS LAST MONTH LOOKED AT THE INACCURACIES AND FALSE INCENTIVES OF MOST OF THESE ADS AND QUESTIONS THE TECHNIQUES USED IN INCITING SOMEONE TO OBTAIN SUCH MEDICINES.

ONE SHOULD ALSO CONSIDER THE FACT THAT NOT ONLY DOES THE HEALTH CARE PROVIDER HAVE TO DISSUADE A PATIENT FROM ONE OF THESE MEDICINES WHEN NOT NEEDED IT ALSO UNDERMINES THE RELATIONSHIP BETWEEN PROVIDERS AND THEIR PATIENTS BY CREATING DOUBT... TO CHANGE THAT TAKES TIME IN THE OFFICE THAT IS OFTEN NOT AVAILABLE... THEREFORE

CONFIDENCE IS DEPLETED AND THAT IS ONE THE MOST POWERFUL TOOLS I HAVE AS A PROVIDER IN GETTING SOMEONE WELL. IT ALSO RAISES COSTS BY INCREASING THE FREQUENCY AND COMPLEXITY OF OFFICE VISITS.

I BELIEVE WE ARE THE ONLY NATION THAT ALLOWS SUCH ADVERTISING AND THAT A SERIOUS RELOOK AT SUCH PRACTICE SHOULD BE UNDERTAKEN BY THE FDA.. I MIGHT ALSO ADD THAT NOT LONG AGO THE NEW ENGLAND JOURNAL OF MEDICINE EDITORIALIZED THAT THE FDA IS TOO CLOSE TO THE DRUG COMPANIES AND THAT THEIR INDEPENDENCE AND JUDGMENT IS JEOPARDIZED (My words not theirs). ONE SHOULD ALSO LOOK AT THE 2 BILLION DOLLARS THAT WILL BE SPENT ON TV ADVERTISING FOR PRESCRIPTION DRUGS THIS YEAR AND ASK IF THAT IS A WISE USE OF OUR HEALTH CARE DOLLARS

NUMBER 4. THE LIMITED AVAILABILITY OF HIGH DEDUCTIBLE HEALTH INSURANCE. THINK FOR A MINUTE OF THE COSTS ASSOCIATED WITH AN OFFICE VISIT IF YOU WOULD.. AN APPOINTMENT IS MADE...RECEPTIONIST, SIGN IN AT THE DOCTORS OFFICE AND DOUBLE CHECK TO MAKE SURE PATIENT IS COVERED BY A CARRIER-PAPER PUSHER, CHECK IN AND ACTUAL OFFICE VISIT-DOCTOR AND NURSE, CHECK WITH INSURANCE COMPANY TO SEE IF RECOMMENDED DRUG IS ON LIST OF COVERED MEDICINES.. PAPER PUSHER, COLLECTION O F COPAY-CHECK OUT CLERK, FILING OF INSURANCE CLAIM-INSURANCE STAFF, REJECTION AND REFILING IF DEDUCTIBLE IS NOT MET AND STATEMENT SENT TO PATIENT-INSURANCE AND BILLING DEPARTMENT, ACTUAL PAYMENT RECEIVED AND POSTING OF PAYMENT, PAST DUE CLERK TO ATTEMPT TO COLLECT UNPAID BILL, ALL OF THIS FOR FORTY FIVE DOLLARS... HARDLY MAKES SENSE WHEN I AM SPENDING THE ENTIRE REIMBURSEMENT IN COSTS ASSOCIATED WITH THIS ONE CLAIM .

IF HIGH DEDUCTIBLE AND OR CATASTROPHIC POLICIES WERE AVAILABLE I BELIEVE MOST PEOPLE WHO ARE PAYING THE BILLS FOR HEALTH CARE IN THIS COUNTRY WOULD OPTED FOR SUCH PLANS PROVIDED THERE IS A MECHANISM FOR PREVENTATIVE CARE IE. A DIRECT TAX DEDUCTION FOR WELL PERSON CARE EACH YEAR UP TO 300 0R 400 HUNDRED DOLLARS..

IN MY BUSINESSES I HAVE GONE EXCLUSIVELY TO MEDICAL SAVINGS ACCOUNTS

WITH HIGH DEDUCTIBLES AND AM PLACING 1200 DOLLARS PER YEAR IN AN MSA.WE ALSO PROVIDE FOR REIMBURSEMENT OF THAT DEDUCTIBLE IF A HOSPITALIZATION OCCURS. WE HAVE SEEN UTILIZATION RATES DECREASE AND PREVENTATIVE HEALTH CARE INCREASE UNDER SUCH A SYSTEM. THE PROBLEM IS THEY ARE LIMITED IN AVAILABILITY AND OUTSIDE OF MSA HIGH DEDUCTIBLE POLICIES ARE ALMOST NON EXISTENT.

IF I REMEMBER CORRECTLY NINETEEN PERCENT OF EVERY DOLLAR SPENT ON HEALTH CARE IS NOW CONSUMED NOT ON HEALTH CARE BUT ON ONEROUS PAPER WORK AND NON PRODUCTIVE WORK ASSOCIATED WITH INSURANCE, MEDICARE, AND MEDICAID PAPER WORK.. IF THAT IS SO THEN NINETEEN PERCENT OF 1.4 BILLION DOLLARS EQUATES TO 266 BILLION DOLLARS, MORE THAN ENOUGH TO CARE FOR EVERYONE WHO HAS NO COVERAGE TODAY.

WHAT IS NOT A SOLUTION, AND WHAT WILL ACTUALLY MAKE THINGS WORSE, IS FOR THE FEDERAL GOVERNMENT TO IMPOSE ONE FORM OR ANOTHER OF PRICE CONTROLS ON THE COST OF MEDICAL CARE OR HEALTH INSURANCE. SUCH ARTIFICIAL CONSTRAINTS DO NOT INCREASE EFFICIENCY; THEY DO CURTAIL CARE AND EFFECTIVELY BRING ABOUT RATIONING. SIMPLY URGING OR REQUIRING THE OFFICE OF PERSONNEL MANAGEMENT TO LIMIT THE PREMIUMS THAT INSURANCE PLANS CAN CHARGE WHEN THEY COMPETE IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM IS JUST ANOTHER WAY OF IMPOSING PRICE CONTROLS. SUCH A COURSE OF ACTION WOULD LIMIT CHOICE, RATION CARE, AND CONSEQUENTLY THREATEN THE HEALTH AND EVEN THE LIVES OF PATIENTS.

NUMBER 5 AND MOST IMPORTANT.... THE FEDERAL AND STATE GOVERNMENTS WHO THOUGH WELL INTENDED HAVE TOTALLY DISRUPTED THE PRIVATE HEALTH CARE MARKET.. LET ME GIVE SOME OBSERVATIONS...

MEDICARE REIMBURSEMENT RATES.... ALMOST ALL CARRIERS NOW PAY BASED ON SOME PERCENTAGE OF MEDICARE REIMBURSEMENT RATES.. THAT WOULD BE FINE IF THEY ACTUALLY MATCHED REIMBURSEMENT WITH COSTS BUT THERE IS NOT NOW NOR HAS THERE BEEN GOOD CORRELATION BETWEEN RATES AND COSTS.. WE HAVE GEOGRAPHIC DIFFERENCES IN RATES THAT ARE NOT BASED ON COSTS BUT ON POLITICAL GEOGRAPHICS.

MEDICARE, MEDICAID RULES AND REGULATIONS THAT ARE WELL INTENDED BUT ACTUALLY DRASTICALLY INCREASE COSTS WITH VERY LITTLE BENEFIT. MANY OF WHICH CAME ABOUT BECAUSE A SYSTEM WAS PUT IN PLACE THAT WAS AND IS DESIGNED TO BE DEFRAUDED..WE CAN NOT CHANGE THE MORALS OF THE HEALTH CARE SYSTEM BUT WE CAN INCENTIVIZE TO CREATE PROPER AND ETHICAL BEHAVIOR.. WE CAN DESIGN A SYSTEM THAT REWARDS EFFICIENT CARE AND PENALIZES OVER UTILIZATION BY PROVIDERS. BUT WHAT EVER WE DO WE MUST LOOK AT THE CONSEQUENCES OF EVERY RULE AND REGULATION PUT OUT ON MEDICARE **BECAUSE** EVERY OTHER PAYER FOLLOWS IN ONE WAY ANOTHER THESE REGULATIONS. AND WHAT WE ULTIMATELY SEE IS A TRAIL OF ANTS DOING WORK THAT HAS NO BENEFIT FOR ANYONE AND ESPECIALLY OUR PATIENTS. EXAMPLES..... TO DECREASE UTILIZATION EACH MEDICARE PATIENT MUST BE GIVEN INFORMED CONSENT PRIOR TO A TEST THAT MAY NOT BE COVERED BY MEDICARE.. OFTEN UNTIL WE HAVE A DIAGNOSIS WE WILL NOT KNOW IF MEDICARE WILL COVER THE SERVICE THERE FOR EACH AND EVERY MEDICARE PATIENT WHEN THERE IS SOME QUESTION MUST SIGN A FORM IN MY OFFICE PRIOR TO ME DOING TESTS THAT MAY OR MAY NOT BE COVERED JUST TO ASSURE THAT WE CAN COLLECT IF MEDICARE SAYS IN THEIR WISDOM IT WAS NOT NECESSARY... A GOOD IDEA BUT A BETTER WAY TO DO THAT WITH OUT THE ASSOCIATED COSTS IS TO SURVEY SCIENTIFICALLY PROVIDERS TO SEE IF THEY ARE DOING TESTS THAT ARE

UNNECESSARY ON A RANDOM BASIS. ALL THE RULES AND REGULATIONS COST MONEY THE QUESTION IS WHETHER THEY ARE EFFICIENT TO GET TO THE DESIRED RESULT. I BELIEVE MOST DO NOT.

ANOTHER EXAMPLE WOULD BE SOONER CARE IN OKLAHOMA AND ITS REIMBURSEMENTS FOR STERILIZATION. MOST OF MY PRACTICE IS MEDICAID AND MUCH OF IT IS OBSTETRICS. SOONER CARE WILL NOT COVER A VASECTOMY FOR THE HUSBAND OF A WOMAN WITH THREE CHILDREN EVEN THOUGH SHE WANTS NO ADDITIONAL CHILDREN. THEY WILL COVER STERILIZATION ON HER WHICH COSTS THEM OVER THREE THOUSAND DOLLARS WHEN A VASECTOMY WOULD COST THEM FIVE HUNDRED DOLLARS. SO WE END UP IN SPITE OF THE BEST EFFORTS OF ALL OF US WITH ANOTHER PREGNANCY AND SIGNIFICANTLY HIGHER MEDICAID COSTS.

ANOTHER EXAMPLE WOULD BE CLIA.. A WELL INTENDED PROGRAM THAT HAS BROUGHT VERY LITTLE BENEFIT AND HAS ADDED MILLIONS OF DOLLARS TO THE COST OF LABORATORY SERVICES IN PHYSICIANS OFFICES. I HAVE A MEDICARE AND CLIA CERTIFIED LAB BUT I CAN TELL YOU NONE OF THE REQUIREMENTS OF CLIA OR MEDICARE HAVE ADDED TO THE QUALITY OR EFFICIENCY OF THAT LAB BUT WHAT THEY HAVE ADDED TO IS THE COST TO PERFORM SUCH LABORATORY TESTS. THERE ARE STILL TESTS THAT CAN NOT BE PERFORMED IN A PHYSICIANS OFFICE UNDER CLIA THAT A PATIENT CAN BUY AT THE DRUG STORE AND PERFORM THEMSELVES. (OVULATION KIT)

THE CONGRESS MUST RECOGNIZE THAT THE SYSTEM OF HEALTH CARE WE HAVE NOW IS INEFFICIENT AND IT IS INEFFICIENT BECAUSE WE HAVE NOT UTILIZED THE COMPETITIVE PROCESSES TO ALLOCATE SUCH AN IMPORTANT AND CRITICAL RESOURCE FOR OUR NATION. THERE IS NOW ONLY LIMITED COMPETITION, AND WHERE IT EXISTS IS OFTEN TIMES HAMSTRUNG BY RULES AND REGULATIONS THAT MAKE IT INEFFICIENT.. I BELIEVE THE AMERICAN PUBLIC ARE PRETTY SAVVY PURCHASERS AND I BELIEVE THRU INCENTIVES THEY CAN APPLY THAT SAVVY TO GET HIGHER QUALITY HEALTH CARE AT LOWER COSTS WHICH WILL BENEFIT NOT ONLY THE PRESENT GENERATION BUT THOSE TO COME WHOM WILL ALL KNOW WILL BE PAYING A HIGHER AND HIGHER PERCENTAGE OF THEIR INCOME THRU MEDICARE TAXES AND GENERAL REVENUE TAXES IF SOMETHING IS NOT CHANGED.

THE CONGRESS MUST INSTEAD REALIZE THAT THE INDIVIDUAL CONSUMER OF HEALTH CARE MUST TAKE ON MORE RESPONSIBILITY IF WE TO CONTROL WASTEFUL UTILIZATION. THE AMERICAN PUBLIC HAS BEEN EFFECTIVE AT PURCHASING ALMOST EVERY OTHER NEED WITHOUT INTERFERENCE FROM THE GOVERNMENT AND I BELIEVE ITS TIME FOR SOME TRIAL BASED ON PROPER INCENTIVES AND PERSONAL RESPONSIBILITY WITH APPROPRIATE REWARDS TO CONSUMERS WHO DO NOT OVERUTILIZE THE SYSTEM.

Mr. WELDON. I thank the gentleman for his testimony, and I recognize myself for 5 minutes for questioning.

Were you recommending, as you got to the conclusion of your statement there, that FEHBP offer a high deductible option for employers kind of like a medical savings account? Do you have any experience—you said you have been an employer for many years—either as a provider with medical savings accounts or as an employer with medical savings accounts?

Dr. COBURN. I have two separate plans, Congressman, that have over 40 employees in them and we now utilize medical savings accounts. We have saved the first year $87,000; the second year, about $60,000, in terms of cost to my businesses for their health care. With that, we put $100 a month into a medical savings account. We cover the entire family, which none of our competitors do. Our employees don't contribute anything. For their first hospitalization, until their medical savings account meets the deductible, we pay the deductible. So they have a no-cost program that has, in essence, saved us a tremendous amount of money. It would have saved us money if we would have had a 20 percent utilization rate at the hospital.

So the idea of a high deductible policy that incentivizes people not to overutilize and incentivizes people to have preventative care is something that lowers cost, improves health care, and decreases internal costs in terms of health care providers. There is no paperwork to shuffle.

Mr. WELDON. Could you elaborate a little more on the plan that you are using in your business in terms of the premium structure, how it works? Then you have commented a little bit on preventative health care. Have you monitored that at all within your medical savings account plan?

Dr. COBURN. We have I think it's a $3,800 deductible this year. Last year the maximum we could have was set by Congress, and it was something lower than that. We are raising the deductible every year as we go, but we are also increasing the amount of money that we are putting monthly into their medical savings accounts, which they have an option to go use on dental or drugs or anything related to health care that they can or they can leave it there and earn tax-free earnings on it.

But our monthly premiums were cut by two-thirds as we converted to that system over where we were in an indemnity fee-for-service plan or a PPO plan that we were in. So we have effected great savings for us, and we have increased the care for our employees and their families and actually cut their costs. It is because of the incentives to not overutilize it.

Every day in my practice, Congressman, I have 10 people who are in my office who don't need to be there. They have no need to be there.

Just one point on that: The No. 1 reason——

Mr. WELDON. By the way, I practiced medicine.

Dr. COBURN. I understand.

Mr. WELDON. I saw the same thing.

Dr. COBURN. The No. 1 reason that I have seniors in my office—and my practice is about 65 percent Medicaid, about 15 percent Medicare, and the rest private practice. So I have a large Medicaid/

Medicare practice. The No. 1 reason that seniors are in my office, and this is my summation of why I believe they are there, is they are lonely. The last time they heard from their son or their daughter or their brother or their sister—they are isolated and lonely. They need someone.

So, consequently, what is a better deal? Get $30—you pay 20 percent; if you have met your co-pay, you can go and talk to your doctors. It is a great way. So there are all sorts of social motivations that we have that impact our utilization rates. It is not just as simple as economics. There are other issues as well.

Mr. WELDON. In the remaining time I have, let me ask you explicitly: We are dealing with FEHBP right now. That is the committee's jurisdiction. Is there one thing that you could recommend for us to do as we look at FEHBP in the future, making changes in the program? Is it offering this high deductible medical savings account option? Are there other structural changes that you think we can or should be making?

Dr. COBURN. I think it would be interesting to offer a high deductible. I think you would be surprised at the number of people who would take the difference in what they pay and put it into a checking account and save it for whatever emergency they might have or borrow against some other method for a hospitalization.

The real thing that I believe we have to get to for not only Federal employees is we have to have catastrophic health insurance in this country for everybody. We have enough waste in the present system to cover everybody out there that is not presently covered with health insurance. There is $250 billion worth of waste in the present system, in my estimation. If we had a system that was properly incentivized, that cared for those who couldn't care for themselves, made sure we kept our commitments to the seniors, did not underfund the cost of that, then we could, in fact, improve everybody's care and control some of the cost.

The American public knows how to purchase everything except what we think they can't purchase, which is health insurance. They don't have enough knowledge, savvy to do that. That has been our estimation through the years, and we have never decided we were going to let them do that. I believe they would do just as well at that as they do every other aspect of purchasing, whether it is autos, homes, or clothes.

Mr. WELDON. Thank you. The Chair recognizes the gentlelady from the District of Columbia for a question.

Ms. NORTON. Thank you, Mr. Chairman, and I appreciate very much your testimony, Dr. Coburn, given your experience both in the Congress and in the practice of medicine.

By the way, I will be interested, in light of what you said about the way in which high deductibles are disincentivized, overuse, I will be interested to hear from our OPM witnesses about whether or not people are in fact being driven more and more to higher deductible plans, because I would imagine that would be one way of saving the cost of the premium.

I note that two of the things that you mentioned, shifting of costs of Medicare and Medicaid, as a factor in the increasing cost to all the rest of us is important to note. You also testified that we need incentives for preventative care. It seems to me that both of those

would add cost to somebody. I take it the cost would be added to the Federal Government.

For example, if Medicare and Medicaid costs are not shifted to younger people and insurance plans, then somebody would have to pay the cost. Who do you imagine should pay those costs then?

Dr. COBURN. They are paying them already, Congresswoman.

Ms. NORTON. Well, we are paying them, you said.

Dr. COBURN. No, no. We are paying them. The private sector is paying those costs today through inflated premiums because the Federal Government does not cover the cost of care for those people who they have committed——

Ms. NORTON. See, that is your point. I take your point, and I am saying, suppose that this cost-shifting was not going on. Would that not mean that the Federal Government would be paying billions more? Is that what you are saying should occur, that we should just step up to the plate and pay for the cost of Medicare and Medicaid instead of shifting the cost to private parties such as those in the FEHBP plan?

Dr. COBURN. I believe it would help you better manage the programs. Today you are making decisions on false assumptions of what the costs are. If the Federal Government assumes the cost, that means we all assume the cost. So we are going to pay for it either way, but the goal ought to be to effectively manage it.

I think we have a culture that has developed while I have been a doctor. It is, how do you stay ahead of the game? I think this is a real important point. We are out there figuring out—I am budgeting for next year in my practice of five doctors. How do we stay ahead of the game? How do we stay even as our revenues are declining from the private sector, what they are willing to pay us for delivering a baby or caring for a family, and we are getting a small increase from Medicare and no increase from Medicaid. Our costs of doing business are going up. How do we manage to stay even?

Ms. NORTON. You don't. You don't because people——

Dr. COBURN. Oh, yes, we are figuring it out. Here is what you are seeing: You are seeing increased utilization of testing and resources and overutilization because that is a human response in this market. You will never control the costs in health care until you reconnect the purchaser with some of the money coming out of their pocket. That is my whole point with high deductibles. That is why you see a decreased utilization, and it is not an underutilization. You are bringing it back down to the level it should be.

The number of young mothers who now don't come into my office because their deductible is high, they make a phone call: "Should I watch my child with this fever?" We have children overutilizing primary care facilities like crazy simply because we have raised a generation that has been taught to do so because there has been no financial cost to utilize that resource.

All I am saying is we have to reconnect the cost with the utilization of the resource. If we do, we can still have great medicine, and we can still take care of all those—actually, we can do a better job of taking care of those who have no insurance today, if we would do that.

Ms. NORTON. By paying providers, by the government paying providers what it cost the government, one point I take from your

testimony is that, instead of spreading the cost to albeit a large number, but, nevertheless, other insured people, we spread it to an even wider base because you spread it to the entire country through the tax system. I agree, I think that makes better sense. We had just as well face it, somebody's paying for it.

Dr. COBURN. Right.

Ms. NORTON. And the real question is, does somebody who is a Federal worker who can hardly afford insurance payments as it is, is that who the cost should be shifted to?

Let me ask you about your really interesting point, one that has struck me as I look at these ads on TV that, as you indicate, invite us all to try to get whatever is advertised. Would you make the cost of those ads less deductible than ordinary costs? I mean, how would you go at that, understanding that censorship and the like is not, of course, allowed in our country?

Dr. COBURN. Oh, it is.

Ms. NORTON. Would you just say you don't get the same rate off for that?

Dr. COBURN. No, it is. The FDA has the power today to withdraw those ads.

Ms. NORTON. And you think they should?

Dr. COBURN. Absolutely. They are a wasted resource in terms of improving the quality of health care in this country.

Mr. WELDON. The gentlelady's time has expired.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. WELDON. The Chair recognizes the gentleman from Indiana, Mr. Souder, for 5 minutes.

Mr. SOUDER. Thank you. I first want to say I am glad to see you still have your passion and your idealism and haven't gone all soft and flabby now that you are gone from the Congress.

Dr. COBURN. Thank you, Congressman.

Mr. SOUDER. I have a couple of questions I want to ask you for the record. You have testified about the danger of rationing associated with government-imposed price controls on health insurance premiums. Are you aware of any evidence that some government workers would rather have health insurance plans that they think are less likely to deny them needed care even if they have to pay for it?

Dr. COBURN. I think the opposite is true. I think you have probably seen through the experience of the Federal employees, and I think it is the standard family policy where you have seen, even though premiums have gone up, you have seen a marked increase in utilization of that plan.

I believe the American consumer is a smart consumer, and they will make the best choices. Unfortunately, in this country we have manipulated the system to not give them every choice that they should be able to have, which one thing that is missing is a high deductible policy for everybody, so that they can once again be responsible for their health care.

Mr. SOUDER. In other words, you are saying some will at least pay more to get more?

Dr. COBURN. Absolutely.

Mr. SOUDER. Because some of us are concerned that, in fact, those choices may deprive individuals. One of the arguments is,

some people argue that it is unfair to let some Federal workers who would pay more for a program that, for example, is less likely to ration health care because it would be unfair to those Federal workers who can't afford to pay for it. What is your argument?

Dr. COBURN. Well, you are just going to shift costs away, so they are going to end up having to pay more. They are going to end up getting less care. So all that is going to do is accentuate the cost-shifting that we have going on right now. So they are less likely to get care if you limit that because you will shift more cost.

Mr. SOUDER. Well, it is a model plan and I hope we can continue to have that model.

I want to ask you one other basic type of question. As a former Member, your idealism was there on the catastrophic, but I think it is important for the record to show that you said, and I would like to ask you to kind of rethink that in this context: You said you believe catastrophic should be covered if we could eliminate the waste, could control the Medicare and Medicaid, presumably have tort reform, and a number of other things.

For example, having been a Member of this body and banged our heads against a body that is two-thirds attorneys, do you really think we can get tort reform? Do you really think we are going to pay for Medicare and Medicaid? Do you really think Chairman Burton and I are going to vote against Eli Lilly being able to advertise? Do you really think that we are ever going to get a hold of the waste? In other words, that is an idealistic goal, but is it a realistic goal?

Dr. COBURN. I don't know how to answer that, Congressman, without offending you.

Mr. SOUDER. You do all the time. [Laughter.]

Dr. COBURN. I believe if the Members of Congress will search their hearts to do what is in the best interest of the country, not what is in the best interest of their region, that in fact all of us would be better off. To do less than that penalizes us every day.

Eli Lilly was making lots of money before they started advertising on television. What we have now is the money that they are making is causing an inflated cost elsewhere in the health care industry because we are spending time and charging Medicare more money now because we have a much more complex visit that is covering several other things that you are paying for. So it is wonderful to support our constituency, but the No. 1 oath that we take when we come up here is to defend the Constitution, not our constituents.

Mr. SOUDER. I could make a pretty good argument on behalf of advertising, as somebody in marketing, that in fact that is one way the market sorts through. But rather than do that, let me rephrase my question, and it is my last question.

Would you favor instituting catastrophic health insurance coverage if these other things don't occur?

Dr. COBURN. We would not have to have catastrophic health insurance if some of the other things would occur. If you have $1.4 trillion, and if I am right, which I honestly believe, and all my staff, we researched this all the time I was in Congress, almost 30 percent of that goes nowhere to help somebody get well—just silly rules that Medicare imposes on a hospital that ends up creating

bureaucracies that have nothing to do with quality of care and have everything to do with pushing paperwork, so somebody in a position of power at a Medicare payer can have higher control. Then, yes, we could save a ton of money in health care.

My whole point is: Incentivize the proper utilization of this scarce resource. If you allow people a choice to do that, and allow the market to work within a framework that gives preventative care the No. 1 priority that it should be, which will save us dollars down the road, then I think you can save a ton of money. You can lower the cost of Medicare. You can lower the cost of Medicaid. You can get a whole lot more for the dollars that you spend.

Tort reform in the states, it has happened; we are seeing the tests go down. So we know it works. The question is—in my State it is one of the worst.

Mr. WELDON. The gentleman's time has expired. The Chair now recognizes the ranking member, Mr. Davis, who will make his opening statement and then proceed to questions.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

Let me, first of all, apologize for being late at your first hearing, but let me also congratulate you on being named chairman of this subcommittee and indicate that I look forward to working with you.

I was intrigued by the dialog that has taken place. I would like to just make a brief opening statement, and then I do have a question, too, that I would like to ask.

Mr. Chairman, over the last several years the subcommittee has held hearings on the dramatic increase in premiums in the Federal Employees Health Benefits Program. Next year these premiums are expected to rise an average of 13.9 percent. This follows a 10.5 percent increase in 2001 and a 9.3 percent increase in 2000.

The Office of Personnel Management has cited increased use in prescription drugs and medical services, advances in medical technology, and an aging Federal work force as reasons for the dramatic hike in 2002 premiums. Health care inflation, Federal mandates, and increased prescription drug costs have also been cited as reasons for increased premiums.

Regardless of the causes, Federal employees are bearing the brunt of these increases. The question we must ask is, how do we address increased premiums in the Federal Employees Health Benefits Program?

Last year OPM established, and was forced to cancel, a pharmaceutical pilot project for the Special Agents Mutual Benefit Association [SAMBA]. SAMBA is a small health plan in the FEHBP that provides coverage for 16,000 active and retired Federal law enforcement employees.

Under the pilot, SAMBA would have purchased mail order pharmaceuticals off the Federal Supply Schedule, generating savings to the government, SAMBA, and enrollees in the health plan. However, the three companies that dominate the pharmaceuticals market, Pfizer, Merck, and Parke-Davis, refused to supply their products to SAMBA from FSS. This I think was unfortunate because the pilot program would have provided useful information about alternative methods for controlling the escalating costs of prescription drugs.

Alternatively, Representative Steny Hoyer introduced H.R. 1307, a bill that would increase the government contribution for Federal employee health insurance. Currently, the Federal Government and enrollees jointly pay FEHBP premium costs according to a statutory formula. The government contributes 72 percent of the FEHBP premiums. H.R. 1307 would increase the government's contribution to 80 percent of these premiums.

Federal employees are feeling the effects of these increased costs every day. Therefore, the subcommittee should hold bipartisan hearings on these and other proposals that specifically address how we can stabilize, if not decrease, premium rates for the approximately 9 million enrollees in the FEHBP program.

I thank you, Mr. Chairman, and certainly would like to engage in questions with Dr. Coburn.

Mr. WELDON. The gentleman is recognized.

Mr. DAVIS OF ILLINOIS. Thank you very much. Doctor, I certainly want to welcome you and indicate that I have always been intrigued listening to your positions relative to health care delivery, coverage, and how we might be able to shape our system in such a way that we get the most benefit for the money that is being paid or the greatest bang for the buck.

Let me ask you, do you think that there is a way to actualize cost in such a manner that whoever is receiving the service actually pays that cost? I am saying, whatever payment mechanism that is used is actually paying that cost, saying it is not being shifted any place other than right there.

Dr. COBURN. I think it is reasonable to assume that such a market would do that, but you have to have a true market, I believe, to allocate that cost to the individual consumer. What you see in a free market is that costs end up reflecting supply and demand. What we have not done, and the worst thing we can do, is put more price controls on the health care industry.

You did not see health care inflation prior to the imposition of Medicare. You did not see significant health care inflation prior to the imposition of Medicare price controls. When Medicare became a price-controlled system and out of the fee-for-service, totally controlled, that is when you saw health care inflation take off everywhere else in this country. It simply reflects a disruption in the market and shifting of the cost.

So the only way I believe that you could actually see that is go back to actually a free market system. I am not sure we could do that. I am not sure we could go back to a free market system. We have tremendous moral problems in health care in terms of billings, overutilization. And I am talking about my own profession. I am not talking about just patients, and I am not talking about just doctors. I am talking about every aspect of the system sees a pot of gold out there and grabs in and puts its hand in.

That is why the first part of my statement I said this has become a business; it is no longer an altruistic profession to care for somebody's health. It is driven by business concerns, not health concerns. We need to get back to health concerns.

Mr. DAVIS OF ILLINOIS. Since that is the case, since you cannot orchestrate market conditions—I mean, the market is the market, and this isn't to suggest by any stretch of anybody's imagination

that you would be in favor of what I am going to ask you. Could a national health plan, where everybody is in, the costs have been determined, and everybody gets service based upon whatever their needs are—obviously, some of the incentive will be gone in terms of certain kinds of practice and certain kinds of practice conditions and all, but would that even in any kind of way the playing field?

Dr. COBURN. No, I don't think it would. Even though it might change some of the cost pressures, what it does is ration care. What you are going to see is end-of-life issues. You are going to see that the elderly have no value under that system. That is ultimately where we will go. The value of life, once somebody becomes dependent on the health care system, will no longer have value because the cost associated with that value will be so high.

You cannot put a system together like that. Just look at Canada. They ration care now. We have three orthopedists in my home town now who moved to my home town from Canada simply because they couldn't do the things that people needed to have done for them. Now that is not to say that people in Canada don't get adequate care, but there is rationing going on.

I would tell you that my own organization, the American Academy of Family Physicians, has endorsed a national payor system because the physicians are fed up trying to chase this monkey. But it is not in the best interest—I would go back and here would be my statement: I believe that in every area in our country, of all resources, that if we allow a true market to work, the most people will get the best benefit if we allow that to happen. We have nothing close to that now in health care, and that is why you have the cost inflation that you have.

Mr. DAVIS OF ILLINOIS. Of course, as long as we have advertising as a part of our society the way that we do, of course, that would never exist either. I mean, because people will be influenced and certainly influenced to the extent——

Dr. COBURN. But they are not the payors today, Congressman. We have advertising right now, but they are not the payors. So you get it utilized without it costing you anything. It costs your employer or it costs the Federal Government, but there is no cost to you personally for utilizing it. So you don't have a market. So, yes, you could have that, if there was a reconnection to your billfold when you overutilized the system. We don't have any of that. So there are these perverse incentives: Since it cost me nothing, I am going to utilize the system. That is the problem where we are today in health care, and that is one of the reasons, one of the main reasons besides greed among all in this system, of driving the cost up.

Mr. DAVIS OF ILLINOIS. Tom, let me thank you very much. You do remind me, when we start talking about payment of something, what Frederick Douglass was supposed to have said one time, and that is: He knew one thing if he didn't know anything else, and that is in this world we may not get everything that we pay for, but we most certainly will pay for everything that we get. [Laughter.]

If we don't pay one way, we will pay the other.

Dr. COBURN. Well said.

Mr. DAVIS OF ILLINOIS. Thank you.

Dr. COBURN. Thank you.

Mr. WELDON. The gentleman's time has expired.

I want to thank Dr. Coburn for coming here from Oklahoma. Your testimony was very informative, and we certainly look forward to hearing from you again in the future on these issues. Thank you very much.

I would like to now call up the second panel. This will include our first witness, Mr. Ed Flynn. He is the Associate Director of Retirement and Insurance Services at the Office of Personnel Management. He has appeared frequently before this subcommittee to discuss FEHBP.

The second witness is Steve Gammarino, senior vice president of the Blue Cross/Blue Shield Association. Mr. Gammarino has also testified a number of times before this subcommittee on FEHBP.

Colleen Kelley, our third witness, is president of the National Treasury Employees Union and represents many Federal employees who rely on FEHBP.

Our fourth witness is Lawrence Mirel, the commissioner of the District of Columbia's Department of Insurance and Securities Regulation. Commissioner Mirel is an expert on insurance, including health insurance. He has thought carefully about some of the problems affecting health insurance today.

Bob Moffitt is our final witness on this panel. Mr. Moffitt is the director of domestic policy studies at the Heritage Foundation. He has studied the FEHBP for years and has developed a real expertise in this area.

I thank all of our witnesses for participating and I am looking forward to hearing your testimony. I see you know the drill. You remain standing.

[Witnesses sworn.]

Mr. WELDON. Note for the record that the witnesses responded in the affirmative.

I would like to go ahead and recognize Mr. Flynn for 5 minutes.

STATEMENTS OF WILLIAM E. FLYNN III, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE SERVICES, OFFICE OF PERSONNEL MANAGEMENT; STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, BLUE CROSS BLUE SHIELD ASSOCIATION; COLLEEN M. KELLEY, PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION; LAWRENCE MIREL, COMMISSIONER, DISTRICT OF COLUMBIA, DEPARTMENT OF INSURANCE AND SECURITIES REGULATION; AND ROBERT E. MOFFITT, DIRECTOR, DOMESTIC POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. FLYNN. Good afternoon, Mr. Chairman and members of the subcommittee. Thank you very much for your invitation.

You have already entered my prepared remarks, and I will just summarize from those, with your approval, Mr. Chairman.

I would like to focus my remarks on this year's average premium increase in the Federal Employees Health Benefits Program, the changes that will occur in the Blue Cross and Blue Shield Plan, and the need to do something about the continuing withdrawal of health maintenance organizations.

At OPM we run the Nation's largest employer-sponsored health insurance program. Since its inception, it has provided high-qual-

ity, affordable health care to almost 9 million Federal employees, retirees, and family members. The program is part of the government's overall compensation package and it helps government attract and retain its share of the talent needed to carry out critical public work.

Almost 85 percent of employees sign up for the program, and our surveys indicate a high degree of satisfaction with participating health plans, satisfaction levels that have remained stable even with the premium increases of the last several years.

The average increase next year will be just over 13 percent. No one is happy about that, least of all the Director of OPM and all of us who work on this program. There are, however, three key points I want to make about next year's increase.

First, market competition, consumer choice, and intensive negotiations with health plans do work to provide comprehensive benefits at an affordable cost. At the same time we are operating in a market where, according to USA Today, and I might just mention according to the New York Times of today, health insurance prices nationally are soaring and will range from 13 to 50 percent next year. Other surveys and some announcements by major public and private employers bear this out.

Second, we bargained hard for what we were able to get this year. Shortly after being sworn in, we briefed Director James on the key aspects of the program. Her charge to us was clear. She wanted us to get the best deal possible for participants without cutting benefits across the board or making major changes, and we did just that.

Initial proposals from health plans would have led to a premium increase of almost 16 percent. Through intensive bargaining, we shaved 2 points off that number and project an overall average of just over 13 percent at the end of open season.

Finally, there are trends we can identify that do affect the cost of this program. As has been the case in past years, the rising utilization and cost of prescription drugs tops the list, accounting for over one-third of the total. Other factors include overall utilization, technology advances, medical inflation, and a covered population that gets older on average each year.

Responding to our guidance and the same trends we were seeing in health care generally, the Blue Cross and Blue Shield Plan will introduce several major changes next year. They will merge their High Option Plan into the Standard Option and create new, lower-cost Basic Option which provides benefits essentially for in-network providers only. Had Blue Cross and Blue Shield not made this proposal, about 125,000 elderly participants in the High Option Plan would have faced a premium increase in the 30 to 35 percent range.

I might also add at this point that it is not unusual for health plans to merge, add, or drop options. That has always been a part of this program, reflecting its market orientation. We carefully consider proposals like these and we paid special attention to the Blue Cross/Blue Shield proposal because of its scope and the importance of the program overall.

In addition, throughout the spring and summer several participating health plans learned of the outline of the Blue Cross pro-

posal and expressed concerns about its impact. We met with the Coalition to Preserve Choice and others to ensure we understood and addressed their concerns as we negotiated with Blue Cross and Blue Shield. While we are confident we made the right decision in accepting the Blue Cross proposal, we will carefully monitor both its implementation and its effects to ensure the continued strength of the program.

Next year approximately 30 health maintenance organizations will leave the program. Because of that, almost 150,000 participants will have to select new plans. This continues a trend we have seen over the past several years. While we know that plans are leaving for business reasons unrelated to our administration of the program, it is, nonetheless, an area of concern to us. We have taken a number of concrete steps in the last several years to increase the number of health plans, albeit with limited success.

The President's budget reflects, among other things, a commitment to consider options to ensure that the program offers quality and cost-effective health plans not only now, but for the future. We are exploring ways to increase the health care options available to Federal employees, thereby increasing competition within the program. We look forward to working with you and the members of the subcommittee and others on this issue.

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

[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 AND AGENCY ORGANIZATION

COMMITTEE ON GOVERNMENT REFORM

U. S. HOUSE OF REPRESENTATIVES

on

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

OCTOBER 16, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

GOOD AFTERNOON. I AM PLEASED TO BE HERE TODAY TO DISCUSS THE STATUS OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND THE ISSUES IT FACES AS WE MOVE INTO 2002.

I WILL TALK ABOUT THE 13.3 PERCENT AVERAGE PREMIUM INCREASE FOR NEXT YEAR, WHICH, WHILE DISAPPOINTING AND UNACCEPTABLE, IS A REFLECTION OF OVERALL MARKET TRENDS. I ALSO WILL DISCUSS THE NEW CONFIGURATION OF THE BLUE CROSS AND BLUE SHIELD PLAN WITH ITS MERGER OF THE HIGH OPTION INTO THE STANDARD OPTION AND THE ADDITION OF A LOWER COST, IN-NETWORK ONLY, BASIC OPTION. FINALLY, I WILL ADDRESS THE CONCERN ABOUT THE WITHDRAWAL FROM THE PROGRAM FOR THE 4TH STRAIGHT YEAR OF A SIGNIFICANT NUMBER OF HMOS.

AS THE NATION'S LARGEST EMPLOYER-SPONSORED HEALTH INSURANCE PROGRAM, THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM HAS PROVIDED AFFORDABLE HEALTH CARE COVERAGE FOR FEDERAL EMPLOYEES, RETIREES, FAMILY MEMBERS, AND SURVIVORS FOR OVER FORTY YEARS. ALMOST NINE MILLION PEOPLE ARE CURRENTLY COVERED UNDER THE PROGRAM. THE PROGRAM PROVIDES OVER $24 BILLION ANNUALLY IN HEALTH CARE BENEFITS.

IN JANUARY 2002, ENROLLEES WILL HAVE APPROXIMATELY 180 HEALTH PLAN CHOICES -- DOWN FROM 245 PLANS IN 2001 -- INCLUDING OPTIONS UNDER 13 NATIONWIDE FEE-FOR-SERVICE (FFS) PLANS.

THE PROGRAM IS PART OF THE GOVERNMENT'S OVERALL COMPENSATION PACKAGE. AS A COMPONENT OF THE BENEFIT PACKAGE, IT ENABLES THE FEDERAL GOVERNMENT TO COMPETE WITH OTHER EMPLOYERS FOR ITS SHARE OF THE TALENT NEEDED TO CARRY OUT THE WORK OF GOVERNMENT.

THE FACT THAT CLOSE TO 85 PERCENT OF THE ELIGIBLE FEDERAL WORK FORCE PARTICIPATE IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM ATTESTS TO ITS POPULARITY. EMPLOYEES APPRECIATE THE HIGH DEGREE OF PROTECTION AVAILABLE TO THEM AT GROUP RATES AND THE CONVENIENCE OF MAKING PREMIUM PAYMENTS THROUGH PAYROLL DEDUCTION, AS WELL AS THE AVAILABILITY OF CONTINUED COVERAGE IN RETIREMENT. THE DATA WE RECEIVE EVERY YEAR THROUGH THE CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) CONFIRMS THE HIGH LEVEL OF SATISFACTION OF PARTICIPANTS IN THE PROGRAM.

THE OVERALL WEIGHTED AVERAGE INCREASE FOR 2002 WILL BE 13.3 PERCENT. PREMIUMS FOR HEALTH MAINTENANCE ORGANIZATIONS (HMOS) WILL INCREASE AN AVERAGE OF 14 PERCENT, WHILE FEE-FOR-SERVICE PLANS WILL INCREASE AN AVERAGE OF 13 PERCENT. THIS INCREASE IS DISAPPOINTING AND UNACCEPTABLE.

THERE ARE A NUMBER OF REASONS FOR THE PREMIUM CHANGES. IN GENERAL, THE FEDERAL EMPLOYEE PROGRAM RATES REFLECT CHANGES IN THE HEALTH CARE MARKETPLACE, AND THOSE COSTS ARE CONTINUING TO RISE. A *USA TODAY* ARTICLE CITED POTENTIAL INCREASES OF 13 TO 50 PERCENT.

THE FEDERAL PROGRAM USES PRIVATE MARKET COMPETITION AND CONSUMER CHOICE TO PROVIDE COMPREHENSIVE BENEFITS AT AN AFFORDABLE COST TO ENROLLEES AND THE GOVERNMENT. IN ADDITION, WE USE INTENSIVE NEGOTIATIONS WITH HEALTH CARRIERS TO KEEP COST INCREASES AS REASONABLE AS POSSIBLE. INITIAL PROPOSALS FROM HEALTH PLANS PRIOR TO NEGOTIATIONS WOULD HAVE RESULTED IN AN AVERAGE PREMIUM INCREASE OF 15.7 PERCENT.

WE BRIEFED THE NEW DIRECTOR OF OPM SHORTLY AFTER HER CONFIRMATION ON ALL KEY ASPECTS OF THE FEDERAL EMPLOYEE PROGRAM AND PRESENTED HER WITH STRATEGY OPTIONS FOR THE 2002 NEGOTIATIONS. HER CHARGE TO US WAS TO BARGAIN HARD FOR THE BEST RATES POSSIBLE WHILE KEEPING BENEFITS REDUCTIONS MINIMAL. WITH THAT GUIDANCE, WE WERE ABLE TO DECREASE THE OVERALL AVERAGE INCREASE FROM 15.7 TO 13.3 PERCENT.

OPM'S PREMIUM INCREASES WERE IN LINE WITH THOSE OF THE PRIVATE SECTOR. A RECENT HEADLINE IN *USA TODAY* STATED "HEALTH INSURANCE PRICES TO SOAR." THE ARTICLE SAID THAT PREMIUM INCREASES NEXT YEAR COULD BE 13 PERCENT OR EVEN 50 PERCENT, REFLECTING NATIONWIDE TRENDS. TRENDS ARE UP SINCE LAST YEAR. THE KAISER FAMILY FOUNDATION AND THE HEALTH RESEARCH AND EDUCATIONAL TRUST RECENTLY ANNOUNCED THE RESULTS OF THEIR ANNUAL SURVEY OF EMPLOYERS AND REPORTED THAT PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE ROSE AN AVERAGE 11 PERCENT IN 2001. FOR 2001, FEDERAL PROGRAM PREMIUMS ROSE AN AVERAGE OF 10.5 PERCENT.

SURVEYS DONE EARLIER THIS YEAR, SUCH AS THE HEWITT ASSOCIATES SURVEY, PREDICTED HIGH DOUBLE DIGIT OVERALL NATIONAL PREMIUM INCREASES. FACTORS CITED AS FUELING INCREASES INCLUDED PATIENT DEMAND FOR ACCESS TO THE LATEST TECHNOLOGY, TOP HOSPITALS, AND MORE CHOICE; DOCTORS AND HOSPITALS GAINING HIGHER REIMBURSEMENTS FROM HEALTH PLANS; AN

INCREASINGLY OLDER POPULATION; AND A RISE IN THE COST AND UTILIZATION OF PHARMACEUTICALS.

THE CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM (CALPERS) IS THE SECOND-LARGEST PURCHASER OF HEALTH BENEFITS AFTER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND HAS ANNOUNCED ITS PREMIUM INCREASES FOR 2002. THEIR INCREASES WOULD EQUATE TO AN AVERAGE INCREASE OF ABOUT 15.5 PERCENT UNDER THE FEDERAL PROGRAM.

EVEN THOUGH OUR PREMIUMS ARE AT THE LOW END OF THE INDUSTRY RANGE, WE ARE NOT HAPPY TO SEE SUCH SIGNIFICANT INCREASES. ONCE AGAIN, THE LARGEST CONTRIBUTOR TO THE INCREASE IN THE PROGRAM IS THE RISING UTILIZATION AND COST OF PRESCRIPTION DRUGS, WHICH ACCOUNT FOR ABOUT 4.9 PERCENTAGE POINTS OF THE TOTAL INCREASE. OTHER CONTRIBUTORS INCLUDE UTILIZATION OF MEDICAL SERVICES, THE COST OF ADVANCES IN MEDICAL TECHNOLOGY, MEDICAL INFLATION, AND A COVERED POPULATION THAT CONTINUES TO AGE.

ALTHOUGH PRESCRIPTION DRUGS CONTINUE TO BE THE LARGEST CONTRIBUTOR TO PREMIUM INCREASES IN THE FEDERAL PROGRAM, A SEPTEMBER 26, 2001, STUDY BY THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE (HSC) CONCLUDES THAT RISING HOSPITAL SPENDING WAS RESPONSIBLE FOR NEARLY HALF OF THE TOTAL INCREASE IN HEALTH CARE COSTS NATIONWIDE IN 2000. WHILE DRUG COSTS ARE STILL HIGH AND CONTINUE TO RISE, ACCORDING TO THE HEALTH SYSTEM CHANGE STUDY, THEY ACCOUNTED FOR A SMALLER PERCENT OF THE TOTAL NATIONWIDE HEALTH CARE COST INCREASE LAST YEAR THAN IN 1999. HOWEVER, COVERAGE OF RETIREE PRESCRIPTION DRUG COSTS IN THE FEDERAL EMPLOYEE PROGRAM IS A CONTRIBUTOR TO THE DIFFERENTIAL EFFECT OF PRESCRIPTION DRUGS IN OUR PROGRAM.

THE NEW HEALTH BENEFITS PREMIUMS GO INTO EFFECT IN JANUARY 2002. ENROLLEES WHO HAVE SELF-ONLY COVERAGE WILL PAY ON AVERAGE ABOUT $4.32 MORE BIWEEKLY, WHILE THOSE WITH FAMILY COVERAGE WILL PAY ON AVERAGE $11.57 MORE BIWEEKLY. IN 2002, THE AVERAGE BIWEEKLY PREMIUM FOR SELF-ONLY COVERAGE WILL BE $40.89 FOR THE ENROLLEE AND $94.72 FOR THE AGENCY. FOR FAMILY COVERAGE, THE AVERAGE PREMIUM FOR THE ENROLLEE AND AGENCY WILL BE $92.10 AND $217.56, RESPECTIVELY. BY COMPARISON, THE AVERAGE 2001 BIWEEKLY RATE FOR SELF-ONLY COVERAGE IS $36.57 FOR THE ENROLLEE AND $83.71 FOR THE AGENCY. FOR FAMILY COVERAGE, THE AVERAGE RATE IS $80.53 FOR THE ENROLLEE AND $191.12 FOR THE AGENCY. AVERAGE PREMIUM INCREASES IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM INCREASES FOR THE PAST THREE YEARS WERE 10.5 PERCENT IN 2001, 9.3 PERCENT IN 2001, AND 9.5 PERCENT IN 1999.

REFLECTING SIMILAR VIEWPOINTS OF OTHER HEALTH CARE ANALYSTS, THE HEALTH SYSTEM CHANGE STUDY SUGGESTS THAT THE RETREAT FROM TIGHTLY MANAGED CARE HAS PLAYED AN IMPORTANT ROLE IN RISING COST TRENDS. AMONG OTHER DEVELOPMENTS, PROVIDER BARGAINING POWER, PARTICULARLY THAT OF HOSPITALS, IS NOW STRONGER IN RELATION TO THAT OF HEALTH PLANS. MANAGED CARE'S EMPHASIS ON A BROAD CHOICE OF PROVIDERS HAS HAD THE EFFECT OF FORCING HEALTH PLANS TO KEEP MOST HOSPITAL SYSTEMS IN THEIR NETWORKS. PROVIDER BARGAINING POWER HAS BEEN REINFORCED BY THE INCREASED CONSOLIDATION OF HOSPITALS DURING THE 1990'S AND THE REDUCTION IN EXCESS CAPACITY SINCE THE MID-1990'S.

BLUE CROSS AND BLUE SHIELD CHANGES

ON A RELATED ISSUE, OUR CALL LETTER FOR CONTRACT YEAR 2002, EXPRESSED OUR CONCERN OVER FOUR STRAIGHT YEARS OF RATE INCREASES THAT WERE SIGNIFICANTLY HIGHER THAN THE RATE OF INFLATION, AND WE ASKED PLANS TO THINK OF WAYS TO KEEP THEIR COSTS AFFORDABLE. BLUE CROSS AND BLUE SHIELD (BCBS) RESPONDED WITH AN INNOVATIVE APPROACH DESIGNED TO POSITION HEALTH CARE COSTS WITHIN THE MEANS OF ELDERLY ENROLLEES AND, AT THE SAME TIME, KEEP PREMIUMS AFFORDABLE FOR THE REST OF THEIR FEDERAL POPULATION. THEY PROPOSED TO MERGE THEIR HIGH OPTION, WHICH BECAME TOO EXPENSIVE, INTO THEIR STANDARD OPTION; THEY ALSO CREATED A NEW, LOWER COST, BASIC OPTION WHICH PROVIDES BENEFITS ONLY FOR IN-NETWORK PROVIDERS. IT IS NOT UNUSUAL FOR HEALTH PLANS TO MERGE, ADD, OR DROP OPTIONS, AND WE CAREFULLY CONSIDERED THEIR PROPOSALS. IF BLUE CROSS AND BLUE SHIELD HAD NOT COMBINED THEIR HIGH AND LOW OPTIONS, THE HIGH OPTION PREMIUM WOULD HAVE INCREASED 30 TO 35 PERCENT; WHEREAS, MERGING HIGH OPTION ENROLLEES INTO THE STANDARD OPTION INCREASED THE PREMIUM FOR THAT OPTION BY ONLY 2.5 PERCENT. ABOUT HALF OF FEDERAL EMPLOYEE PROGRAM ENROLLEES CURRENTLY SUBSCRIBE TO THE BLUE CROSS AND BLUE SHIELD STANDARD OPTION.

EARLY IN THE PROCESS, WE WERE MADE AWARE THAT SOME PARTICIPATING HEALTH PLANS AND OTHERS WERE CONCERNED ABOUT THE IMPACT OF THE BLUE CROSS BLUE SHIELD CHANGES ON THE FEDERAL EMPLOYEE PROGRAM. WE WORKED WITH THE COALITION FOR COMPETITION IN THE FEHBP AND OTHERS TO ENSURE THAT WE UNDERSTOOD THEIR CONCERNS AS WE PROCEEDED WITH NEGOTIATIONS WITH BLUE CROSS AND BLUE SHIELD AND ULTIMATELY ACCEPTED THEIR PROPOSAL AFTER THEY HAD ADDRESSED ALL OF OUR CONCERNS.

FEWER FEDERAL PROGRAM PLANS

APPROXIMATELY THIRTY HEALTH MAINTENANCE ORGANIZATIONS INFORMED US THIS YEAR THAT THEY WOULD NOT PARTICIPATE IN THE FEDERAL HEALTH PROGRAM AFTER DECEMBER 31, 2001. THE PLANS' ACTIONS WILL REQUIRE ABOUT 148,000 ENROLLEES TO SELECT NEW PLANS DURING THE UPCOMING OPEN SEASON. THIS NUMBER REPRESENTS TWO TO THREE PERCENT OF THE FEDERAL PROGRAM POPULATION. REASONS THE PLANS GAVE US FOR NOT RENEWING THEIR CONTRACTS ARE, IN DECLINING PRIORITY:

CORPORATE BUSINESS CONSIDERATIONS, INCLUDING FEDERAL PROGRAM LOW ENROLLMENT, POOR MARKET PENETRATION, PROFITABILITY, STATE REGULATORY ENVIRONMENT, AND PROVIDER RELATIONS;

CORPORATE CONSOLIDATIONS;

NON-COMPETITIVE RATES; AND

CORPORATE DISSOLUTIONS.

IT IS CLEAR THAT THE PLANS ARE MAKING BUSINESS DECISIONS BASED ON ENROLLMENT, PENETRATION IN THE MARKETPLACE, AND OVERALL PROFITABILITY.

INCREASING COMPETITION

THE PRESIDENT'S BUDGET FOR FY 2002 REFLECTS AMONG OTHER THINGS, A COMMITMENT TO CONSIDER OPTIONS TO ENSURE THAT THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OFFERS QUALITY AND COST EFFECTIVE HEALTH PLANS. WE ARE EXPLORING WAYS TO INCREASE THE HEALTH CARE OPTIONS AVAILABLE TO FEDERAL EMPLOYEES, THEREBY INCREASING COMPETITION WITHIN THE PROGRAM. WE LOOK FORWARD TO WORKING WITH MEMBERS OF THE SUBCOMMITTEE ON THIS ISSUE.

SUMMARY

OPM HAS WORKED TO CONSTRAIN PREMIUM INCREASES FOR 2002 WITHOUT REDUCING BENEFITS SIGNIFICANTLY OR ASKING ENROLLEES TO PAY SUBSTANTIALLY MORE OUT-OF-POCKET WHEN THEY NEED HEALTH CARE. WHILE THE FEHB PROGRAM WITH ITS COMPETITION AMONG PLANS CONTINUES TO BE A MODEL FOR EMPLOYER PROVIDED HEALTH CARE COVERAGE, WE LOOK FORWARD TO WORKING WITH THE CONGRESS AND WITH STAKEHOLDERS TO STRENGTHEN THE PROGRAM.

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

Mr. WELDON. Thank you, Mr. Flynn. Now, Mr. Gammarino, you are recognized for 5 minutes.

Mr. GAMMARINO. Good afternoon. I am Steve Gammarino, senior vice president at the Blue Cross/Blue Shield Association. On behalf of the Blue Cross/Blue Shield plans, I thank you for the opportunity to appear before you today.

With your permission, Mr. Chairman, I would like to submit my written statement for the record.

Mr. WELDON. Without objection.

Mr. GAMMARINO. In your letter of invitation you requested that I address several questions on health care trends and efforts by Blue Cross/Blue Shield to manage the rising cost of health insurance premiums. In addition, you requested that we discuss the new Basic Option Plan and any other issues that are important to the continued viability and stability of the Service Benefit Plan.

For 2002, overall health insurance premiums for the Blue Cross/Blue Shield Standard Option Plan will rise 15 percent. The premium increases we are experiencing are similar to industrywide trends. To gain insight into the trends in health care, it is useful to explain what we are experiencing in the marketplace. I call them the three "C's": cost, consumerism, and coverage.

First, premiums are being driven today by increased costs in all areas of health care. Prescription health costs continue to be driven by the rapid development of new, more expensive therapies which often substitute for less costly, existing therapies; rising prices for existing drugs and heightened demand and use of prescription drugs, fueled by the ever-increasing direct-to-consumer advertising.

Under Blue Cross/Blue Shield's Standard Option Plan, drug costs today represent almost 30 percent of our benefit cost. In addition, over the past couple of years we have begun to see an increase in cost for provider services which is due to rising prices in the use of hospital and physician services.

It is also important to realize that the FEHBP is dealing with an aging population. For example, the average Blue Cross/Blue Shield Service Benefit Plan enrollee today is 60 years old, and the average FEHBP member is 54. This is a much older population and a higher-risk group than most health plans in the private sector.

The second "C" is consumerism. In today's marketplace, especially in a competitive and individual choice market such as FEHBP, the consumer drives decisions. With the combined forces of the backlash against managed care restrictions on access and direct consumer advertising on prescription drugs, the consumer has become a key force in health care decisionmaking today.

The third category of health care trends is the changing perception of health coverage. Over the years expectations of what health insurance should cover have shifted. The original intent of insurance was to protect against catastrophic or acute situations while consumers paid for day-to-day expenses, similar to how car insurance works today.

However, today health care covers both catastrophic needs and routine care. Consumers have come to expect and demand from their State and Federal legislatures that health insurance plans cover a wide range of treatment that includes preventative care,

care that is experimental, and even care that is yet to be proven scientifically.

As the Service Benefit Plan continues to face increasing cost trends and an aging population, we are constantly exploring ways to manage those costs. While we are concerned about the trends and keeping overall costs contained, we are equally, if not more, concerned about the overall health outcomes and ensuring that our members receive quality care. To that end, we have also focused resources on strategies and programs that will improve patient safety and quality outcomes.

In your letter of invitation, you asked me to address our 2002 benefit changes; in particular, the rationale for merging High Option and introducing a new Basic Option. As you are aware, Blue Cross and Blue Shield currently offers two options: High and Standard. Each year we take a close look at our products to ensure that they provide value to our customers. Our research consistently shows that the Federal employees and retirees are very concerned about the cost of health care and that they want the best value when selecting a health plan.

Blue Cross/Blue Shield decided to merge High Option into Standard Option because High Option is no longer a viable product. Due to exceedingly high benefit costs, it has become a tremendous challenge to keep the product affordable.

In response to the demand for cost-effective health care coverage, we are introducing a new option for Federal employees and retirees. This new option, called Basic Option, is a preferred provider-only benefit package that includes co-payments for many services, no deductibles, and preventative dental coverage. It is designed to provide Federal employees and their families with a premium that is lower in cost than the majority of health plans in the FEHBP. We believe it is a ground-breaking product and offers what most individuals look for in a health care plan; that is, choice, access, and simplicity.

With regard to your inquiry on ways in which FEHBP can be improved, in our experience there has to be an appropriate balance between incentives and risk. With the reduction in the number of health plans participating today, we would suggest that the subcommittee might want to further examine the financial incentives and the significant underwriting and compliance risk required by a carrier participating in the program.

Finally, your letter of invitation expressed an interest in any matters beyond the specific focus of this hearing. One that is critical to Blue Cross/Blue Shield's continuing participation in the FEHBP is the exemption from the inappropriate application of the cost accounting standards. For the past 3 years, Congress has passed an appropriations act, a full statutory waiver requirement related to these requirements, and we urge the subcommittee to seek final resolution of this matter.

The Blue Cross and Blue Shield Association is proud of its role it has played in the Federal employee marketplace. I hope my remarks will help you in your deliberations and discussions. We look

forward to working with you to find ways to preserve and improve the strength and stability of this program. Again, thank you for the opportunity to appear before you today. I will be pleased to answer any questions you may have.

[The prepared statement of Mr. Gammarino follows:]

Good afternoon. 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 discuss the changes to the 2002 benefits and rates for the Government-wide Service Benefit Plan, the reasons for the premium increases, and other matters concerning the Federal Employees Health Benefits Program's (FEHBP) ability to preserve its status as a model employer-based health care benefit.

As you know, 44 Blue Cross and Blue Shield Plans jointly underwrite and deliver the Government-wide Service Benefit Plan in the FEHBP. The 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 49 percent of the enrolled population.

In your letter of invitation you requested that I address several questions on health care trends and efforts by the Blue Cross and Blue Shield Service Benefit Plan to help providers and participants manage the rising costs of health insurance premiums. In addition, you requested that we discuss the new Basic Option plan and any other issues that are important to the continued viability and stability of the Service Benefit Plan.

For 2002, overall health insurance premiums for the Blue Cross and Blue Shield Service Benefit Plan's Standard Option coverage will rise 15%. These premium increases are primarily due to increased spending on prescription drugs, greater use of medical services and technology, general medical inflation, and an aging population. The premium increases we are experiencing are similar to what is being experienced industry-wide, as the FEHB Program uses private market competition and consumer choice to provide comprehensive benefits to federal employees and retirees. According to a 2001 Hewitt Associates report, employers are expecting to experience double-digit health care cost increases of 14 to 20 percent. The coverage offered to federal employees, retirees, and their families under the Service Benefit Plan is similar to the coverage offered to Blue Cross and Blue Shield enrollees under private sector plans, hence our rates reflect the underlying health care trends in the health care marketplace.

Health Care Trends

To gain insight into trends in health care, it is useful to explain what we are experiencing in the marketplace in three categories known as "the three C's": cost increases, consumerism, and health insurance coverage.

Cost Increases

First of all, premiums are being driven by increased costs in all areas of health care. Prescription cost trends continue to be driven by the rapid development of new, more 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. Under the Blue Cross Blue Shield Standard Option plan, drug costs have rapidly risen to approximately 30 percent of total benefits.

In addition, over the past couple years, we have begun to see an increase in costs for provider services, which is due to rising prices from providers and increased hospital admissions. This is not unlike what has been reported nationwide. According to a September 2001 Health Affairs study, hospital spending accounted for the largest portion of medical cost increases. This is attributed partially to the retreat from tightly managed care

due to a strengthening of providers' bargaining power and reduction in required authorizations for services.

It is also important to realize that the FEHBP is dealing with an aging population in the Federal government. For example, the average Blue Cross and Blue Shield Service Benefit Plan enrollee is 60 years old and the average FEHBP member is 54 years old. This is a much older population, and a higher risk group, than most group health plans in the private sector. Data show that the quantity of medical resources, especially prescription drugs, increases as individuals age. Thus, it is important that the Federal government and its employees and retirees understand that demographics are also contributing to the increase in health insurance premiums.

Consumerism

The second "C" trend is consumerism. In today's marketplace, especially in a competitive and individual choice market such as the FEHBP, the consumer drives decisions. Our population in the Service Benefit Plan, and increasingly elsewhere in the market, expects the freedom to choose with minimal restrictions. With the combined forces of direct-to-consumer advertising of prescription drugs, the growth in life-style drugs, and the backlash against managed care's restrictions on access, the consumer is a key force in health care decision-making. Additionally, since for the most part, consumers are shielded from most health care costs, there is little incentive to limit demands for increased coverage.

Health Insurance Coverage

The third category of health care trends is the changing perception of health insurance coverage. Over the years, expectations of what health insurance should cover have shifted. The original intent of insurance was to protect against catastrophic and acute situations, while consumers paid for the day-to-day expenses – similar to how car insurance works. If your car gets damaged, your car insurance company pays for those damages above a certain threshold, but it doesn't pay for an oil change or a new battery. However, the current paradigm for the payment of health care tries to cover both catastrophic insurance and routine health care, in one package. Consumers have come to expect, and demand from their state and federal legislators, that health insurance plans cover a wide range of treatment that includes all aspects of care, from preventive care to care that is experimental, investigational, and yet to be scientifically proven. Over the years, the FEHBP, as well as plans in the private sector, have experienced this through increased mandates on specific benefits, the patient's bill of rights legislation, and other requirements. While each mandated benefit may not have significant costs, the unintended consequences of incrementally expanding mandated health coverage are increased costs to the FEHB Program and increased premiums for the consumer.

As the Service Benefit Plan continues to face increasing cost trends and an aging population, we are constantly exploring ways to manage costs that will have a minimal impact on our members. While we are concerned about trends and keeping overall costs contained, we are equally, if not more, concerned about overall health outcomes and ensuring that our members receive quality care. To that end we have also focused resources on strategies and programs that will improve patient safety and quality outcomes. Some of our strategies and programs are pharmacy programs, local care management, case management, and benefit design.

Pharmacy Programs

We obtain significant cost savings through our contracts with pharmacy benefit management companies, which are passed back on to our members. In addition, we have a number of patient quality and safety drug utilization programs in place such as drug utilization management, prior approval for those drugs that have higher incidences of abuse or are expensive, and fraud and abuse programs. We also provide incentives to our members to use generics through benefit design; in particular, through the amount of member cost sharing for prescription drugs. For example, this year in the new Basic Option we are introducing a three-tier copayment structure to help keep premiums affordable. For a 34-day supply from the retail pharmacy, members will pay $10 for a generic drug, $25 for a formulary brand-name drug, and 50% for a non-formulary brand-name drug (with a $35 minimum). This design gives consumers financial incentives to select cost-effective medications that have equal therapeutic value. We would estimate that our pharmacy benefits would cost as much as 30% to 40% more without the programs we have in place today.

Benefit Design

Benefit design is one of the most valuable tools available to help manage expenditures. Increased cost sharing, smaller networks, and formulary management are some of the ways that plans have achieved greater cost containment. In fact, with the rise in hospital costs, some private sector plans are now turning to a tiered copayment structure for different categories of hospitals and providers. However, when developing a benefits package, health plans and employers must make a trade-off between providing their members/employees the choice and access to a wide variety of providers and drugs/services and controlling costs. When developing our benefits for our federal employee customer, we not only look at program costs, but also the impact on the member, administrative feasibility, and our competing products. We try to reach a balance among these factors to bring the best value to our customers. For example, when we developed our new Basic Option, we knew that members were interested in having a low premium with as few restrictions on them as possible. In order to give our members the best value and the product we believed they were looking for, we included cost-saving factors in our benefit design such as an in-network only benefit, a three-tier copayment prescription drug design, and a copayment structure with higher copays for specialists than primary care physicians.

Local Care Management

Local care management consists of programs implemented in local Plans in order to provide Service Benefit Plan members with information and resources to improve health and quality of life and lower benefit costs. Examples are disease management programs, prenatal programs, mammogram reminders, and immunization programs. Because these programs for Service Benefit Plan members are in the early stages, we do not have outcomes data. Local Plans, however, have provided disease management program outcome data, which reflects both positive health and financial outcomes for their commercial lines of business. We anticipate the same results for the Service Benefit Plan.

Case Management

Case management attempts to determine the most effective means to providing quality, cost-effective care in the most appropriate setting for high-cost, catastrophic, or chronically ill members. Under case management, a nurse case manager works directly with the patient, his family, and providers to develop a treatment plan and assist in navigating the health care system. In addition, nurse case managers often work in concert with volunteer, local, state, and federal agencies to obtain and coordinate medical services when Plan benefits are limited or disallowed. Nurse managers help reduce fragmentation of care and

gaps in services that can lead to increased costs for the program and help assist with determining whether the cost for recommended care is reasonable and acceptable. While the focus of case management is to improve the quality of care of the member, reduction of costs is often a secondary outcome.

Blue Health Connection

Another program that we offer is Blue Health Connection. Blue Health Connection is a program that offers Service Benefit Plan members a number of health care services, including a 24-hour nurse information telephone service. By telephone or email, nurses are available to provide health information and clinical assessment to Service Benefit Plan members and physicians. The primary objectives of the program are to help educate our members to more appropriately utilize medical services and to help physicians in effectively managing the care and cost of providing health care services to members. In addition, if a member has a chronic or major illness, our registered nurse counselors will work with the member, physicians, and often a case manager to effectively manage the member's care. Blue Health Connection is also available online and members can participate in online conversations with physicians, email the nurses, and read about current health news and information.

Like you, we are concerned about federal employees and retirees facing additional premium increases. However, we think it is very important to realize that in spite of the premium increases of the past few years, which are being experienced everywhere in the industry, this Program continues to be the envy of many in the private sector.

In the private sector, typically an employee only gets one, maybe two, plan choices. Of those plans, the benefit structure is usually much more restricted and employees have fewer benefits from which to choose. Under the FEHBP, employees and retirees are able to choose each year from numerous plan choices that have different benefits, prices, providers, and cost sharing. The FEHBP gets the direct benefit of all private sector innovations in medical care management and contains costs through competition among private plans. We believe the FEHBP has outperformed every other federal health program in containment of costs both to consumers and the government, in benefit and product innovation, and in customer satisfaction. Moreover, the Government-wide Service Benefit Plan provides its members with a formidable benefits package; we have the broadest networks of any carrier in the FEHBP, provide members access to a wide array of benefits with minimal cost sharing, and provide quality customer service. The leveraging by the individual Blue Plans results in very large discounts to the federal government in an amount valued at more than $2 billion each year.

2002 Benefit Changes

In your letter of invitation you asked me to address our 2002 benefit changes; in particular, the rationale for merging our High Option plan and introducing a new Basic Option. As you are aware, the Blue Cross and Blue Shield Service Benefit Plan currently offers two options: High Option and Standard Option. Each year, we take a close look at our product offerings to ensure that we are providing our customers with products that provide the best value. We conduct research about health plan experiences and preferences of active and retired federal employees to help us develop benefit options. Our research consistently shows that federal employees and retirees are very concerned about the cost of health care and that they want the best value when selecting health insurance. To continue to offer affordable health insurance to our members, for 2002, we are merging High Option into Standard Option, and introducing a new Basic Option. In ten Plan areas, we also will be discontinuing Standard Option's Point-of-Service (POS) pilot program with the POS members remaining in Standard Option.

The Blue Cross and Blue Shield Association decided to merge High Option into Standard Option because High Option is no longer a viable product due to exceedingly high benefit costs that have become a tremendous challenge to keeping the product affordable. The difference in the premiums between High and Standard Options vastly exceeds the difference in the actuarial value of the benefits offered because of the population's high utilization of services. Enrollment in High Option, of which the average age is approaching 70 years, has declined to approximately 125,000. If the High Option had been retained in 2002 in its current form, the predominantly elderly enrollees would be forced to absorb a significant premium increase in the range of 30 to 40 percent, with out-of-pocket increases of more than 50 percent. Most federal employees are no longer able to afford this option and have told us that they would prefer a health plan that is lower in cost.

In response to the demand for cost-effective health care coverage, we are introducing a new option for federal employees and retirees. This new option, called Basic Option, is a Preferred Provider Organization-only benefit package that includes copayments for many services, no deductibles, and preventive dental coverage. It is designed to provide federal employees, retirees, and their families with a premium that is lower in cost than a majority of health plans in the FEHBP and is twenty percent lower in premium cost to the enrollee than our Standard Option. Basic Option provides benefits for services rendered only by physicians and facilities in the Preferred provider network, except in certain situations, such as emergencies. We are very excited about offering Basic Option to federal employees and retirees because we believe it is a groundbreaking product that offers what most individuals look for in a health care plan – choice, access, and simplicity. We believe that it is unique not only within the federal sector but the private sector as well.

We believe both the Standard Option and the new Basic Option will provide significant value to federal employees and retirees. While each option offers a strong comprehensive benefit package, the two options are designed with product features and benefit structures that are quite distinct from each other. For example, Basic Option covers chiropractic services and preventive dental care while Standard Option does not. Whereas, Standard Option has benefits that are not offered in Basic - such as the mail service prescription drug program and out-of-network provider coverage.

We know that these changes to our current options may be of interest and concern to many of our current members who have been with us for many years. For that reason, we have developed a comprehensive member outreach communications plan for all High Option and Point-of -Service members. Prior to Open Season, each enrollee will receive two different mailings, two phone call attempts, and a follow-up letter. In addition, a special inbound call center is open until December 31st to answer any questions. Moreover, members and prospective members can go to our website at www.fepblue.org to peruse the brochure.

With regard to your inquiry on ways in which the FEHBP can be improved, it is important to understand that the Blue Cross and Blue Shield Plans have a unique perspective on the FEHBP, having been in the program since its inception. In our experience there has to be an appropriate balance between the incentives and the risks. With the reduction in the numbers of health plans participating today, we would suggest that the Subcommittee might want to further examine the limited financial incentives and the significant underwriting and compliance risks required by carriers participating in the Program.

Beyond this fairly fundamental point, I would suggest that there must be a constant vigilance against the tendency to standardize benefits among the plans or to restrict innovation on the part of carriers. Moreover, we would continue to oppose mandates, whether statutorily required by Congress or administratively required by the Executive Branch, as they have a long-term adverse effect on the ability to manage benefits and

provide affordable health coverage to our members. In order to maintain effectively the continued viability and stability of the Service Benefit Plan and provide quality, cost-effective health care coverage, it is essential that we have the flexibility to manage the Service Benefit Plan.

Finally, your letter of invitation expressed an interest in any matter beyond the specific focus of this hearing that we thought should be brought to your attention. One issue of critical importance to the ability of Blue Cross and Blue Shield Plans to continue participating in the FEHBP is exemption from the inappropriate application of the specific Cost Accounting Standards (CAS) promulgated under Section 26 of the Office of Federal Procurement Policy Act. On June 29, 2001, I wrote to then-Chairman Scarborough, with an identical letter to Ranking Member Davis, explaining this issue in considerable detail. For the past three years, Congress has passed in the Appropriations Acts a full statutory waiver of the requirement to apply the CAS to contracts under the FEHBP. The Blue Cross and Blue Shield Association, as the agent for our Plans, has explicitly stated that it cannot sign any contract with OPM that contains the CAS clause or that otherwise seeks to implement the standards currently exempted by law. A copy of that letter is appended to my testimony and I would urge the Subcommittee to seek final resolution of this matter, which has the potential to threaten the very viability of the FEHBP.

Conclusion

The Blue Cross and Blue Shield Association is proud of the role it has played in the Federal Employees Health Benefits Program. I hope my remarks to you will be helpful in your deliberations and discussions. We look forward to working with you to find ways to preserve and improve the strength and stability of the Program for all federal workers, retirees, and their family members into the future.

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

Mr. WELDON. Thank you. Ms. Kelley, you are recognized for 5 minutes.

Ms. KELLEY. Thank you, Chairman Weldon. As the national president of the National Treasury Employees Union and the 150,000 Federal employees who we represent, I would like to congratulate you on your chairmanship of this subcommittee and look forward to working with you in the future on these important issues.

Mr. WELDON. Thank you very much.

Ms. KELLEY. The Federal Government faces a human capital crisis today with inadequate pay and benefits being the primary obstacles to both attracting and retaining highly qualified employees by the Federal Government. The FEHBP used to be considered a crown jewel in the Federal employee benefit package, but today it has become prohibitively too expensive for lower-paid employees and unattractive to prospective employees.

More than 9 million Federal employees, retirees, and their families depend on the FEHBP for coverage, and they are alarmed over the recent dramatic premium increases. OPM's announcement of over 13 percent on the average rate increases for 2002 follow premium hikes the past 3 years of 10.5 percent, 9.3 percent, and 9.5 percent in 1999.

Since 1997, FEHBP premiums on the average have increased a total of more than 46 percent. To put this in perspective, during the same timeframe from 1997 through 2001, Federal employees' salaries increased an average of 17 percent.

Mr. Chairman, Florida's 15th Congressional District is the home to more than 23,000 Federal employees and retirees. An employee in the district saw their FEHBP premiums consume 8.6 percent of their take-home pay in 1998. By 2001, that amount has increased to over 11 percent.

For these reasons, it is critical that the FEHBP receive careful scrutiny. NTEU does not believe that occurred this year. Earlier this year NTEU raised concerns about Blue Cross's proposal to merge its High and Standard Option programs. To date, we do not know the impact of that merger on future rates or on the stability of the FEHBP or even whether there is a need for the new Blue Cross plan. We do know that this will result in increased premiums for those in the Blue Cross Standard Option and the need for a major education campaign of both employees and retirees, so that they know and understand the changes in the Blue Cross plans.

We all agree that the government needs to better use the size of the FEHBP pool to obtain better rates from insurance carriers and from health care providers. According to the Kaiser Family Foundation's Employer Health Benefits Annual Survey for 2001, FEHBP premiums increased at a rate higher than many other large employers: over 13 percent for FEHBP and an average of only 10.8 percent in 2001 for firms and companies with 5,000 or more employees. The numbers were similar in the year 2000, when the Kaiser Survey reported an average premium increase of 7.1 percent and the FEHBP premiums increased 10.5 percent.

But the differences the Annual Kaiser Survey reveals do not stop here. As an employer and as Ranking Member Davis has noted, the government pays an average of 72 percent of the premium. Em-

ployees pay the other 28 percent. As the chart attached to my testimony shows, the average employee in employer-sponsored health insurance pays 15 percent of the premium for single coverage and 27 percent for family coverage.

Not surprisingly, when asked by Kaiser, employers cited recruitment and retention of employees as one of the main reasons that they absorbed most of the health insurance premiums for their employees. Most State and local government employers today pay at least 80 percent of the premium.

To help address the effect that health insurance premiums have had on the human capital crisis for the Federal Government, NTEU worked with Congressman Steny Hoyer on bipartisan legislation, H.R. 1307, that would increase the employer's share of the FEHBP premiums to the most common industry standard of 80 percent. Without competitive pay and benefits, the Federal Government will be unable to compete for the talent that it needs. NTEU asks that you hold hearings on this important legislation.

Nothing is driving premiums increases as rapidly as prescription drug costs. We have heard that already from a number of speakers. In the year 2000 OPM stated that prescription drugs represented $1 of every $4 in FEHBP costs, and when announcing the 2001 premium increases OPM stated that 40 percent of the premium increase was the result of the drug costs.

NTEU thinks that OPM should negotiate discount prescription drug rates for the FEHBP similar to those that are available under the Federal Supply Schedule. Ranking Member Davis described in great detail the SAMBA pilot that was canceled in 1999. This was a lost opportunity for a potential solution to the prescription cost at least of the FEHBP. But lost, too, were the taxpayer savings that were inherent in negotiating the discount prescription drug rates. The SAMBA pilot was estimated to save $2.4 million a year, savings that would have flowed to both Federal employees and to taxpayers.

Reducing drug costs programwide in the FEHBP holds the potential to save much more. This idea continues to merit exploration, and NTEU asks that this subcommittee pursue this issue.

This concludes my remarks. Thank you very much, and I would be glad to answer any questions you have.

Mr. WELDON. Thank you very much for your testimony. We will now hear from Mr. Mirel. Did I pronounce your name correctly?

Mr. MIREL. Yes, you did, thank you. Most people don't.

Mr. WELDON. OK.

Mr. MIREL. I appreciate that.

Mr. WELDON. You are recognized for 5 minutes.

Mr. MIREL. Chairman Weldon, members of the subcommittee, Delegate Norton in particular, my Representative in the Congress, I am Larry Mirel, commissioner of insurance for the District of Columbia. The agency that I head was created originally in 1901 by Congress to regulate the business of insurance in the District of Columbia. It is now part of the home rule government that was created in 1974. Although I am a member of that government, I am testifying here today on my own behalf and not on behalf of the Williams administration.

Our Department regulates all lines of insurance, including health insurance. But I have to tell you that I have not seen the kind of anger with any other line of insurance that we see regularly with health insurance. I can't tell you how many people call my office or come in and complain that items that they thought were covered in their insurance it turns out were not covered. I hear from doctors all the time furious with the kinds of hoops they have to go through to get themselves paid for services that they have provided; hospitals who come in and complain that they are facing bankruptcy because they cannot get reimbursed for services that they have actually provided.

And the insurance companies are not happy either. They don't like the mandates that are enacted that throw off their calculations, and the system in general, it seems to me, could not be designed to be worse, to create that kind of anger. I don't think I am alone in that view. I think many Americans share that view of our health payment system.

I have thought a lot about the reasons why this should be the case. I think really there are two fundamental flaws with the current system of health insurance in this country, paying for health care.

The first is that a large portion of what is paid for is just not insurable and should not be covered by insurance. I take the point that Mr. Flynn, I guess it was, made before, which is that originally you bought insurance to protect yourself against catastrophic loss; that is, the loss from serious illness or injury. But over the years the concept has been expanded and now covers what used to be considered routine health care costs that you paid out of your pocket.

The problem with that is that we have left the entire system in the hands of insurers. Insurers are just the wrong people to run a system like that. It is the wrong mindset for routine health care. Insurers are very cognizant of utilization. A good insurance company is one that limits the number of claims that are filed. The essence of insurance is underwriting.

The idea of limiting claims is a good one if you are talking about major illness or injury. To give just one example, Workers Compensation insurers spend a lot of time and money and energy trying to make the workplace safer, so that there will be fewer claims. They do it for the noblest of reasons, which is they earn more money when there are fewer claims. That is how insurance companies think.

The problem is you can't apply that same kind of thinking to routine health care. You want people to go to the doctor. You want them to get inoculated. You want them to do the kinds of preventative things that they should to take care of their health.

When you put it in the hands of insurance companies, what they do is they start managing it the way they would any other kind of claims to reduce the number of claims. So you get the kind of paperwork that you have, and you have the kinds of managed care issues that you have—all of which adds enormous costs as well as frustration to the system. That is the first problem.

The second problem, in my view, is that health insurance is a contract; that is, it doesn't cover anything that goes wrong with you

in a health context. It covers only the things that are specified in the contract and are not excluded.

The contract, however, is negotiated between the employer, who pays for it, and the insurance company that provides the coverage, the health plan that provides the coverage. The people who are mostly affected by that contract, however, are the employees, the ones who are covered, and the providers, those who provide that coverage. Neither of them are part of the negotiating process. This, in my view, is a very bad way to do business.

It is bad in another way, too, and that is that insurance is a very competitive business. Employers are always looking for ways to save money. They, therefore, look to cheaper insurance plans. The insurers know this. So they vie with each other to provide cheaper plans, so that they will be able to pick up a larger share of the market.

There are really only two ways to reduce the cost of insurance, in my view. One is to reduce the benefits that are provided, and the other is to pay the providers less. Insurance companies are doing both. They are dropping coverages that they used to routinely cover, and they are continually squeezing the providers to do more for less money—to the point where the providers are finding themselves strapped and unable to provide what they think of as good medical costs.

Are there solutions to this kind of a situation? I believe that there are, and I believe that the solution lies in something that Dr. Coburn talked about before, which is a high deductible policy that covers catastrophic loss of illness and injury, and then covering the rest by a medical savings account; that is, taking the money that is saved by buying a high deductible policy which is cheaper and putting it in individual medical accounts for the employees. The employees would then be able to control their own medical care, pay for the things they want to pay for, and have more direct connection with the doctors and the providers that they deal with.

I will stop at this point. My entire statement I believe is in the record. I would be glad to answer questions.

[The prepared statement of Mr. Mirel follows:]

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON GOVERNMENT REFORM

SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION

HEARING ON HEALTH CARE INFLATION AND ITS IMPACT ON THE FEHBP

OCTOBER 16, 2001

TESTIMONY OF LAWRENCE H. MIREL, COMMISSIONER

DISTRICT OF COLUMBIA DEPARTMENT OF INSURANCE

AND SECURITIES REGULATION

Chairman Weldon, Members of the Subcommittee, I am Lawrence Mirel, Commissioner of the District of Columbia Department of Insurance and Securities Regulation. The agency that I head was originally created in 1901 by Congress to regulate the business of insurance in the District of Columbia. It is now part of the "home rule" government of the District of Columbia. Although I am a member of that government I am testifying here today on my own behalf, and not on behalf of the Administration of Mayor Anthony Williams.

Our Department regulates all lines of insurance, including health insurance. It is clear to me—as it is to most Americans—that there are serious problems with the way in which we pay for health care in the United States. As Insurance Commissioner I regularly hear complaints from policyholders about denials of claims they thought were covered by their policies. I hear from doctors and other providers

of health care frustrated with the hoops they must jump through to get paid for their services, the delays, the paperwork, the second-guessing of their professional judgments by persons less qualified than they are who have not seen or examined their patients. I hear from hospital administrators furious with refusals by insurers to pay for services that the hospitals actually provided in the good faith belief they were necessary. I hear from insurance companies and health maintenance organizations distressed with laws passed by the Council of the District of Columbia mandating that they provide certain services their insurance contracts do not cover, or that they submit their payment decisions to outside reviewers.

Why does our system generate so much anger? Why is it so difficult for the average person to understand what his health insurance covers and does not cover? Why must decisions about what kind of health care to pay for be made so often by legislatures responding to public outrage, instead of by physicians seeking the best medical outcomes?

Since I was appointed Commissioner some two years ago I have given a lot of thought to those questions, and I have come to the conclusion that there are two fundamental flaws with the current structure of health care financing in this country.

The first is that we are trying to use the insurance system to pay for something that is inherently uninsurable—that is, health care. We can insure *against* illness or injury, but we cannot insure *for* health care. Insurance is a mechanism for sharing the risk of unintended and unexpected loss. Because serious illness or injury is rare, and expensive when it occurs, insurance against such events makes good sense.

The cost of maintaining good health, however, is an altogether different kind of expense. We hope and expect that people will go regularly to their doctors for check ups, for diagnostic tests, for inoculations against disease, for treatment of minor illnesses or injuries before they become major problems. These are, for the most part, planned events. They are not rare or unexpected. They are not hugely expensive. In short, they are not insurable events.

By trying to use the insurance mechanism to pay for health care we are buying trouble. Insurers are expert at projecting the risk of major claims among wide populations. They price their products according to those projections and then they work hard to reduce the number of claims below their projections. Reducing the number of expected claims can have a very salutary effect, as when workers' compensation insurers make great efforts to improve the safety of the workplace in order to reduce injury claims.

But the mindset of reducing the number of claims is counter to the purpose of good health care. We want to encourage people to see their doctors regularly, get their shots, take their diagnostic tests, care for minor illnesses or injuries promptly. The insurance model is the wrong paradigm for health care.

The second flaw with the current system is that it is contract-based and the contracts are not negotiated by the people who are most directly affected by the contract's terms. A health care insurance contract does not cover all medical and health expenses. It covers only those specific events that are enumerated and are not excluded. What is covered and what is not covered largely determines the cost of the policy. Employers pay for most health insurance in this country, and employers are always seeking ways to cut expenses. Health insurers compete on the basis of cost, and therefore they are looking for ways to reduce the cost of their products so that more employers will choose them. There are really only two major ways to reduce costs. One is to offer less coverage, or to limit claims for covered benefits through managed care. The other is to reduce the compensation paid to providers—that is, to the doctors, hospitals and other suppliers of health care.

The insurance contract is negotiated between the insurance company and the employer. The people affected by the contract, however, are the employees and the providers, neither of whom are part of

the negotiation process. The employee ordinarily only learns of the limitations on coverage when he files a claim that is rejected—too late to be useful information. Providers find out what they will be paid after the contract has been signed and they are told how much the insurer is willing to pay them for their services. If they are unwilling to accept the offered payments they will not be on the list of providers that the employees must utilize.

This is not a system designed for high efficiency and low friction. Instead it leaves everyone unsatisfied and angry, and that anger is turned into pressure for legislative intervention on behalf of one group or another. A system that should be run on the basis of what is optimum medical care instead becomes a political football that bedevils state and national legislators alike.

What are the answers? I make no claim to have a universal solution, but some answers seem quite obvious to me. Certainly we should separate out the insurable part of health care—that is, risk of loss from major illness or injury—and deal with the non-insurable part—the routine health care and preventive medicine component—in a separate way.

And secondly we should put the people who are most impacted by health care—the providers and their patients—back in direct negotiations with each other.

The best way to achieve both goals, in my view, is to use high deductible, so-called "catastrophic" policies, to cover the insurable part of the coverage and pay for routine health care through medical savings accounts (MSAs). High deductible policies are available on the market and cost far less than the comprehensive policies that are currently almost universally used by employers. The money saved on the purchase of high deductible insurance—all or a portion of it—can then be put by the employer into individual employee medical savings accounts and used by employees for whatever routine health care and health maintenance expenses they wish.

While high deductible insurance policies—whether for car insurance, home insurance or health insurance—are always bargains, the relatively new availability of medical savings accounts makes a two-tiered health payment system of the kind I am describing a most attractive choice. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for favorable tax treatment of money put into individual medical savings accounts. That provision of HIPAA has recently been extended for two years. Although the benefits of the law are currently limited to self-employed individuals and small employers (those with fewer than 50 employees), a bipartisan bill is currently before the Congress (H.R. 1524) that would extend these tax benefits to all employers and to all employees covered by high deductible health insurance policies. There is a similar bill pending in the Senate (S. 1067). Currently, as I understand it, the FEHBP menu does not include any "self-directed" high deductible choices. Yet these kinds of insurance policies could provide better health care benefits to federal employees at less cost to the Federal Government.

Here, in outline form, is how such a policy option would look. Instead of having to choose among various kinds of "low option" and "high option" policies, an employee would be given a new kind of choice, a high-deductible major illness and injury insurance policy combined with funding of an individual medical savings account for that employee. The employer—the Federal Government—would pay directly for the high deductible policy and would also put money directly into the participating employee's MSA.

The high deductible policy would pay for costs above a predetermined amount per year—typically between $4000 and $5000. Health care costs incurred below that amount would be paid for by the employee directly, using the funds in his MSA. In essence, the employee would be told that he is responsible for paying for routine health care costs for himself and his family, but he will be given the money to do so in the form of additional untaxed salary. He would be able to pay for any kind of health care related items or services he wished, as defined in section 213(d) of the Internal Revenue Code; there would be no contract to limit or restrict what is covered. That is, he could use the funds for eyeglasses, or dental care, or mental health counseling, without concern about whether those

services are covered under the provisions of some governing contract. He could even use the accumulated funds in his MSA to pay any coinsurance requirement in the catastrophic policy. Any MSA funds not used in a given calendar year would remain in the account and accumulate in subsequent years until the employee reaches age 65, after which the money could be used tax free for any purpose. Any interest earned on the money in the MSA would belong to the employee.

For the federal employee choosing such an option there would be no more restrictions on what medical provider he could go to; it would be his choice. He would not need to go through a primary physician gatekeeper. His physician would not need to get prior approval—or indeed any approval, except from his patient—for any services rendered. The amount of payment would be a matter between the physician and the patient. The patient would pay for the services directly, by writing a check (or using a debit card) on his individual medical savings account. The paper work would be minimal. There would be no "managed care." The physician would be solely responsible legally for the services he rendered; he could not be told by an insurance plan that the services are not "medically necessary" or that the particular drug he prescribes is not on the insurance plan's drug formulary.

Or the federal employee might choose to use the money in his MSA to pay for membership in a comprehensive health care program that would take care of the routine health care needs of himself and his family. Membership in such a plan would be reasonably priced because the plan would know that the employee has backup "catastrophic" insurance that would pay costs above the deductible amount.

There are already companies that offer plans along these lines. Some are small regional companies. Others are companies that sell individual policies only. The details and variations among the products now being sold are considerable. A request for proposals by the FEHBP for high deductible, "employee-directed" medical savings account programs, to be offered as an option to those employees who wish to try them, is certain to produce a strong response from the private insurance market. I would not be surprised, in fact, if major insurers that do not now offer such plans created them in order to be considered.

And if the FEHBP took the lead in offering such plans, other employers would be likely to take a look at them also. There are numerous advantages to private employers to such plans. One is that they are likely to be less expensive. Another is that the employer would not have to decide, year after year, what plan would serve both his employees and his own pocketbook best. His employees would get an additional amount in their paychecks and could decide for themselves what health care services they wished to pay for. The frustration and anger, the paperwork and delays that now plague the system would disappear.

Thank you for allowing me to testify. I will be happy to answer any questions you may have.

Mr. WELDON. Thank you very much, and we will conclude with our witness from the Heritage Foundation, Mr. Moffitt.

Mr. MOFFITT. Thank you very much, Mr. Chairman and members of the subcommittee. My name is Robert Moffitt. I am the director of domestic policy studies at the Heritage Foundation. In that capacity, I oversee the Foundation's analytical work in the area of health care policy, including the financing and delivery of health care services and government programs. It is an honor and a privilege to appear before the subcommittee today to discuss the current status and the future of the Federal Employees Health Benefits Program. It should be understood that the views I express here today are my own and do not necessarily represent those of the Heritage Foundation.

I ask that my written statement be submitted for the record, Mr. Chairman.

Mr. WELDON. Without objection.

Mr. MOFFITT. The Federal Employees Health Benefits Program is, as Mr. Flynn pointed out, the largest group health insurance program in the world. It provides health care coverage to all members of the Federal Government, including Congress, the White House, the Federal judiciary, as well as approximately 9 million Federal and Postal workers and retirees and their families.

This is an unusual program. It is run largely on the free market principles of consumer choice and market competition. No other insurance-based system of financing and delivery in the United States provides patients with such a broad range of choice of plans and benefits.

It is virtually the only system in the country in which individuals and families can choose from a broad range of health care plans, picking the kinds of benefits and treatments they want at prices they wish to pay, while pocketing the savings of wise choices. In that key respect, Mr. Chairman, it is virtually the only health care delivery system that even vaguely resembles anything that looks like a normal market in the area of health insurance.

The Office of Personnel Management, the Federal agency that administers the FEHBP, has broad authority, repeatedly upheld in Federal courts, to negotiate premium rates and benefits on behalf of Federal employees. As the Congressional Research Service observed in 1989 in the most comprehensive analysis ever published on this program, the basic structure of the FEHBP is "sound" despite changes in administration and the health care sector of the economy.

While the FEHBP retains a sound structure and a superior performance as a health care delivery system for its enrollees, it is, nevertheless, in 2001 a troubled program. Its problems are rooted in shortsighted government policies that are incompatible with its structure. The structure is the structure of consumer choice and competition, and the solutions to those problems are likewise rooted in government policies that are not only compatible with its structural advantages, but also would enhance consumer choice and competition.

For the next year, OPM projects an average premium increase of 13.3 percent among FEHBP plans. This does continue a painful pattern of significant premium increases over the past several

years. While these premium increases have been less than those commonly found in the private sector, they are, nonetheless, worrisome to Federal employees and retirees and their families.

As Mr. Flynn pointed out and Mr. Gammarino, these cost increases surely reflect the broader changes that are taking place in the health care system, particularly the growing patient demand for high-quality prescription drugs delivered through the mechanism of health insurance. But there are also other factors which are peculiar to the program that are driving the cost increases in the FEHBP and these factors are not inherent in the structure of the program.

The first, of course—Mr. Flynn had mentioned it, so did Mr. Gammarino—is the artificially skewed demographics of the Federal work force, which is significantly older than the private sector work force and is rapidly aging. Health care costs of older workers are, of course, significantly higher than those of younger workers. Related to the aging of the work force is the disproportionately large number of Federal employee health policyholders, roughly 40 percent, who are retirees. In contrast, many private sector companies have ceased or limited coverage for retirees.

A second reason for recent cost increases is the recent tendency of OPM to break with what the Congressional Research Service once described as its passive management of the program and adopt a much more aggressive regulatory approach to program management. Between 1990 and 2001, the executive branch, either independently or sometimes at the urging of Congress, made 44 specific benefit decisions relating to different aspects of health care benefits. If understood as ancillary to the basic statutory benefit requirements established clearly in Chapter 89 of Title V, these additions would have the equivalent economic impact of health care benefit mandates that are a prominent feature of State health insurance laws.

While it is true that any one of these benefit additions taken alone could be justified as fulfilling some particular need or desire, and while the degree of the impact of these benefit decisions on cost is a matter of some dispute, there is no debate that they add to premium cost. Whatever the merits of any particular intervention, mandates impose higher costs. The more mandates, the higher the costs.

My colleagues have pointed out that Members of Congress should maintain some perspective on the FEHBP increase, and they are right. Even with the 13.3 percent projected increase, when all is said and done, when the numbers are over and submitted in the year 2002, FEHBP is still likely to outperform private sector health insurance, particularly the corporate health insurance. Note that FEHBP benefits have, in fact, been increasing in value over the past 15 years; that is to say, the number and the quality of the benefits. Second, the annual projected increases in the FEHBP do not automatically translate into actual premium increases.

I have a number of suggestions, Mr. Chairman, to improve the program, which I have submitted in my testimony, but let me just make two fundamental points. One, FEHBP needs fresh blood. You have to get a change in the actuarial pool of this system or you are going to see greater and greater demographically driven price in-

creases that are not reflective of what is going on in the general economy.

The second point is that you must start to examine the impact, the economic impact, of the mandate system or the regulatory initiatives that have been taken over the past 10 or 15 years to get a clearer idea of how that is affecting the cost. You should also change the underwriting system in the FEHBP and do what Mr. Mirel suggests: Allow people to pay for health care services directly without imposing any kind of a tax penalty for doing so. Flexible spending accounts that are very common in the private sector for millions of Americans are one way to do it. Another option, of course, is medical savings accounts. But, in either case, make the health insurance system in the FEHBP operate more rationally, in accordance with and make it compatible with the basic structure of the program which, as the Congressional Research Service said, is structurally sound.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Moffitt follows:]

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Congressional Testimony

"RECENT PREMIUM INCREASES AND THE FUTURE OF THE FEHBP"

TESTIMONY BEFORE THE HOUSE SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION

BY

ROBERT E. MOFFIT, PH.D.

DIRECTOR OF DOMESTIC POLICY STUDIES

THE HERITAGE FOUNDATION

OCTOBER 16, 2001

Mr. Chairman and Members of the Subcommittee:

My name is Robert E. Moffit. I am the Director of Domestic Policy Studies at the Heritage Foundation. In that capacity, I oversee the Foundation's analytical work in the area of health care policy, including the financing and delivery of health care services in government programs. It is an honor and a privilege to appear before the Subcommittee today to discuss the current status and the future of the Federal Employees Health Benefits Program (FEHBP). It should be understood that the views I express here today are my own and do not necessarily represent those of the Heritage Foundation.

The Federal Employees Health Benefit Program is the largest group health insurance program in the world. It provides health care coverage to Members of Congress, White House staff, and the federal judiciary, as well as approximately 9 million federal and postal workers and retirees and their families.

Market-Based Structure. Though it is the largest group health insurance program in the world, the FEHBP is radically different in structure and organization from virtually every other private employment or government-run health insurance arrangement. The major difference: It is largely run on the free market principles of consumer choice and market competition. No other insurance-based system of financing and delivery in America provides patients with such a broad range of choice of plans and benefits.

Once a year, federal workers and retirees in any area of the country can personally choose from a variety of different plans. It is virtually the only system in the country in which individuals and families can choose from a broad range of health plans, picking the kinds of benefits and treatments they want, at the prices they wish to pay, while pocketing the savings of wise choices. In that key respect, it is the only health care delivery system that even vaguely resembles a normal market in health insurance.

The Office of Personnel Management (OPM), the federal agency that administers the FEHBP, has broad authority, repeatedly upheld in the federal courts, to negotiate premium rates and benefits on

behalf of federal employees. Beyond its responsibilities for carrying out these sensitive annual negotiations, OPM is responsible for enforcing the basic ground rules for competition among private insurers and making sure that private insurance companies meet the fiscal solvency, consumer protection, and basic benefit requirements outlined under Chapter 89 of Title V of the U.S. Code.

As the Congressional Research Service observed in 1989, the basic structure of the FEHBP is "sound" despite changes in Administration and the health care sector of the economy. Historically, as the CRS further observed, OPM's managerial role in the FEHBP has been "passive." That managerial passivity, that historical tendency to refrain from attempting to micromanage the prices, plans, and benefits, has worked to the direct advantage of federal workers and their families, as well as the efficient functioning of the program. OPM has, in this respect, played a crucial role as both an umpire and a cooperative partner with the private sector in negotiating with health plans in order to secure high-quality health benefits while largely leaving the choice of those benefits to millions of consumers who make up the federal workforce and their families.

In recent years, there has been a noticeable change in this approach, with OPM pursuing a more aggressive regulatory approach and imposing the equivalent of "mandated" benefits on competing health plans. Nonetheless, although the FEHBP is not perfect, it retains many strengths, particularly its level of consumer choice and competition and the bountiful benefits of a market, which largely are unavailable to workers and their families in private, employer-based health insurance. Compared with Medicare and Medicaid, the levels of bureaucracy and regulation are very low.

While FEHBP retains a sound structure and superior performance as a health care delivery system for its enrollees, it is nevertheless a troubled program. Its problems are rooted in shortsighted government policies incompatible with its structure as a system of consumer choice and competition; and the solutions to those problems are rooted in government policies that not only are compatible with its structural advantages, but also would enhance consumer choice and competition.

The Problem of Rising Cost. For next year, OPM projects an average premium increase of 13.3 percent among FEHBP plans. This continues a painful pattern of significant premium increases over the past several years. And while these premium increases have been less than those commonly found in the private sector, they are nonetheless worrisome to federal employees, retirees, and their families. Ominously, such a premium hike in the FEHBP, which has a superior historical record of cost control compared to private employment-based health insurance, is a marker for even higher increases in premium costs throughout the rest of America's private, employment-based health insurance system.

Recent FEHBP cost increases surely reflect the broader changes in the health care market, particularly the growing patient demand for high-quality prescription drugs delivered through the mechanism of health insurance. But there are also factors, which are peculiar to the program, that are driving the cost increases in the FEHBP, and these factors are not inherent in the structure of program.

The first of these is the artificially skewed demographics of the federal workforce, which is significantly older than the private-sector workforce and is rapidly aging. Health care costs of older workers are, of course, significantly higher than those of younger workers. Related to the aging of the workforce is the disproportionately large number of FEHBP policy holders, roughly 40 percent, who are retirees. In sharp contrast, many private-sector companies have ceased or limited coverage for their retirees.

A second reason for recent cost increases is the recent tendency of OPM to break with what the CRS has described as its "passive" management of the program and adopt an active, aggressive, and regulatory approach to program management. Between 1990 and 2001, the executive branch, either independently or sometimes at the urging of Congress, made 44 specific decisions relating to health benefits. If understood as ancillary to the basic statutory benefit requirements established under Chapter 89 of Title V, these additions would have the equivalent economic impact of health benefit

mandates that are a prominent feature of state health insurance laws. While any one of these benefit additions, taken alone, can be justified as fulfilling some particular desire or need, and while the degree of the impact of these benefit decisions on cost is a matter of some dispute, there is no debate that they add to premium costs. Whatever the merits of any particular intervention, mandates impose higher costs; the more mandates, the higher the costs.

WHY FEHBP PREMIUMS HAVE BEEN RISING

In recent years, FEHBP premiums have been rising at a troubling rate. Bush Administration officials and Members of Congress, however, should maintain perspective on recent FEHBP premium increases.

First, even with a projected 13.3 percent average increase in 2002, in the crucial area of cost control FEHBP is still likely to outperform private employment health insurance, which will surely experience double-digit premium increases next year, and even highly regarded public programs of a highly competitive character. This has been the historical experience. Indeed, the California Public Employees Retirement System (CalPERS), a program often compared to the FEHBP, announced premium increases averaging 15.5 percent in 2002; in 2001, the celebrated California program reported an increase of 12.9 percent, while FEHBP projected an increase of 10.5 percent.

Second, projected annual increases in premiums do not automatically translate into actual annual premium increases in the FEHBP. The reason, which does not generally apply to workers who get their insurance through conventional private-sector employer plans, is simply the right and ability of federal workers and their families to vote with their feet and choose lower-cost health plans through the process of the annual "Open Season," during which individuals and families change or renew their health plan selections. Based on previous experience, it is likely that actual premium increases in 2002 will in fact be less than the 13.3 percent projected by OPM. In sharp contrast, private-sector workers often have no choice at all of a health plan; they get what their employer gives them, which is usually some sort of managed care plan. And among those private-sector workers who do have a choice of plan, compared to the options routinely available to federal workers, their choice is sharply limited.

FEHBP Reflects Broader Health Care Trends. Premium increases in the FEHBP reflect the cost of benefits; and precisely because of the competitive character of the program, the real possibility of losing market share, there is obviously no economic incentive for a health plan participating in the FEHBP to set rates higher than necessary. Nonetheless, the FEHBP is not immune to the trends in the broader health care system that are driving costs upward, including the general aging of the American population, the increase in the demand for hospitalization, the continuing and growing demand for newer and more effective prescription drugs, the recent double-digit increases in medical malpractice insurance, the economic impact of a growing body of state and federal regulatory initiatives, and the desire of patients to take advantage of the best and newest medical technology to lengthen or enhance the quality of their lives. These trends apply with equal force to patients enrolled in private employment plans and the FEHBP.

In private, employment-based health insurance, health benefits like wages are compensation for work. Every dollar increase in health care benefits amounts roughly to a dollar decrease in wages and other compensation. Under current arrangements, persons today are using insurance to cover small, routine, or purely predictable medical services. This results in workers' huge overpayments into the health insurance system and a proportional loss of disposable income. Federal employees are not immune. Ideally, routine medical services should be paid directly out of pocket and given the same tax relief that is available for insurance payments. Allowing persons to pay routine medical bills from tax-free flexible spending accounts or medical savings accounts would be the best way to accomplish that end.

Beyond the general increase in health care costs, particularly the demand for and higher utilization of

new and more expensive prescription drugs, there are two other major reasons why FEHBP is experiencing significant cost increases.

- **The FEHBP insurance pool is aging more rapidly than either the private-sector workforce or the general population.** Health care costs rise rapidly with age. There are 4.2 million active employees and retirees enrolled in the FEHBP. The average federal worker is roughly 46 years of age, much higher than the average for the private-sector population. Private-sector health insurance pools are considerably younger. Moreover, as of 1998, 1.85 million federal retirees also participated in the FEHBP; the average age of federal retiree participants is 71 years of age. The range of FEHBP retirees is broad because federal workers, with years and service, may retire as early as age 55; some, in certain occupations, may retire as early as 50 and get full health benefits. Even with Medicare coverage, federal retirees are more expensive than active employees. Unlike private employer-sponsored insurance where retiree coverage has been cut, drastically reduced, or discontinued, FEHBP continues to cover retirees, a growing group of policy-holders that has higher health care costs.

  Complicating the problems of this pool has been the downsizing of the active federal workforce over the past few years. Since 1993, the federal workforce has shrunk by 324,580, disproportionately among full-time workers at the Department of Defense. Moreover, 71 percent of the federal government's permanent workforce will be able to take normal or early retirement by 2010, and an estimated 40 percent of these workers are expected to do so. Thus, the growing imbalance between active employees and retirees will only deepen, making retirees the fastest growing group in the FEHBP program.

- **OPM, sometimes with congressional authorization, has imposed a large number of benefit changes that have had the equivalent effect of benefit mandates and has also pursued a more aggressive regulatory policy.** The Office of Personnel Management in recent years has largely broken with the past tradition of "passive management" of the FEHBP. That tradition emphasized give and take between the federal government and private plans in sensitive negotiations, and deference to private plans in the development of combinations of benefits and rates in meeting consumer demand.

  According to OPM's own estimate, there have been 44 significant "benefit changes" between 1990 and 2001. Most of these were benefit additions, and a number were benefit restrictions. According to OPM estimates, these changes have resulted in a cost increase of $733 million, or 3.74 percent of total program costs, combined with a net savings of $507 million, resulting in a net increase in costs amounting to $225 million, or 1.15 percent of total program costs.

  Some of these have been controversial. In 1994, for example, the Clinton Administration ordered FEHBP plans to cover an expensive and experimental treatment using bone marrow transplants to combat breast cancer within 24 hours or face exclusion from the program, even though the procedure was not widely tested and medical authorities generally favored restriction of the treatment to major academic medical centers. FEHBP coverage of bone marrow transplants for the treatment of breast cancer was, instead, the product of intense lobbying on Capitol Hill. The Clinton Administration ordered it to be included in the FEHBP benefit package. Subsequently, peer reviewed clinical trials of the procedure found that the transplants appeared to be no better than conventional chemotherapy in the treatment of breast cancer.

  The trend toward more aggressive regulatory control over the program has spawned special-interest lobbying for additional benefit mandates. For example, at a September 1996 hearing before this Subcommittee, witnesses advocated the annual inclusion of audiological services, acupuncture, pastoral counseling services, and even medical foods

as necessary benefits to be included in plans participating in the FEHBP. This type of aggressive lobbying serves, of course, to undermine the most basic feature of the program: the provision of benefits that patients actually want. Instead, patients increasingly are forced to pay for benefits that they do not want. While patient choice has been a distinguishing feature of the FEHBP, OPM policy has driven the program in a very different direction; it has been a process of gradually standardizing health plan policies, depriving individuals and families of the more customized options available to them in the 1980s. The difference in actuarial value of the packages offered in the FEHBP has likewise progressively narrowed.

Even if one assumes that any given required additional benefit is justified by a nominally small cost, the accumulation of these additions can have a significant impact over time. While any one benefit may be a minimal cost in its first year, increased utilization over subsequent years drives up overall costs. Moreover, as OPM has imposed an increasingly standardized benefit package on the program, there has been less opportunity for plans to offer different combinations of premiums and benefit options. In effect, this means that plan officials have had less room to initiate cost-saving innovations in the market that might be more attractive to federal employees and their families.

Furthermore, while OPM has used its authority to pre-empt state mandated benefits in plans offered on a nationwide basis, it has refused to do so among state-based HMOs, reducing the competitive position of these plans and forcing federal employees and their families in these states to pay higher premiums than they otherwise would have paid because of the additional cost of mandated benefits. These costs can be rather substantial in several states, like California and Maryland.

While OPM staff, as noted previously, have indicated that these "benefit changes" have had a positive effect on savings and little overall effect on the real growth of premiums, the Bush Administration and Congress should nonetheless take a good, close second look and pursue an independent economic analysis of the impact of these benefit changes over time. It is remarkable that independent, particularly private-sector, analyses of benefit mandates or regulation on health insurance show a much significantly greater impact on health care costs and premiums than indicated by the OPM staff analysis. For example, a 1996 study of additional health benefits mandated by state governments, conducted by the U.S. General Accounting Office (GAO), found that state mandated benefit laws accounted for 12 percent of the claims costs in Virginia, which had 29 benefit and managed care mandates, and 22 percent in Maryland, which had 36 mandates. Last year, Governor Howard Dean of the State of Vermont cited the negative impact of Vermont's benefit mandates on health insurance costs, saying that they contributed to about 25 percent of 1999 health insurance premiums, and asked the legislature to stop enacting them. Private economic analyses of the relationship between health benefit mandates and premium costs show similar results. Do trust OPM, but please verify.

On a related matter, Congress and the Bush Administration should more closely re-examine the recent historical relationship between OPM and the private health care plans that participate in the program. For whatever reason, there has been an alarming exodus. In the mid-1990s, there were almost 400 health plans competing in the program. For the calendar year 2001, OPM announced that only 245 plans were expected to participate. Between 1998 and 1999 alone, the FEHBP lost 65 plans, a stunning 20 percent of plans participating in the program. For 2002, OPM has announced there will be only 180 plans in the program. When firms participating in a government program do not behave the way government officials expect the firms to behave, one must not automatically assume it is the fault of the firms. With the large number of dropouts, the FEHBP has become less internally competitive, substantially reducing enrollee choice and contributing to higher premiums.

A NEW POLICY FOR THE FEHBP

Inasmuch as most of the problems of the FEHBP, particularly in terms of cost and efficiency, are traceable to government policy, it logically follows that most of those problems can be resolved by government policy. In that respect, there is much that the Bush Administration and Members of Congress can do to improve the program. I offer the following proposals for your consideration.

1. Seek an independent evaluation of the economic impact of "benefit changes" over the last decade, as well as regulatory initiatives, and make sure that OPM uses its legal authority to pre-empt state mandated benefits. The Bush Administration should not hesitate to rely on its statutory authority to negotiate benefits for federal workers and retirees and protect them from paying unnecessarily high premiums out of deference to state legislative mandates. Moreover, the Bush Administration should review the current regulatory regime in the FEHBP, including the addition of benefits beyond the core statutory requirements of Chapter 89, Title V, and seek an independent, preferably private-sector, evaluation of the economic impact of these OPM initiatives and specify their consequences on claims costs or premiums. Premiums reflect costs, and if premiums are to be restrained, costs must be restrained.

Meanwhile, the Bush Administration should return, to the extent practicable, to the older tradition of collegial private-public-sector negotiation to control costs and improve benefit offerings. For example, plans could be required to offer all of the current benefit packages, as reflected in the changes over the past 10 years or so, as a high-option plan. But they should also offer a variant of their core offerings, a low-option plan, without such "benefit additions" or mandates and allow consumers themselves to decide whether they want to pay the higher premiums to purchase such previously required benefits. This approach is perfectly compatible with the spirit of the program and fulfills its original intent of broadening consumer choice. Consumer choice and competition should be reinforced, not progressively weakened, if the FEHBP is going to remain a strong model for broader health care reform.

2. Ease the admission of new fee-for-service plans. Current law does not allow the OPM to admit any new fee-for-service plans into the FEHBP. New plans admitted by OPM must be health maintenance organizations (HMOs). Normal market efficiency is served when suppliers of services can freely enter and exit the market, responding quickly and efficiently to changes in consumer demand. This legal restriction is pointless and simply undermines both market competition and consumer choice.

3. Create a tax-free savings option for employees for the payment of routine medical expenses. Over 80 percent of large employers and a significant number of small and mid-size companies offer their employees benefits through pre-tax cafeteria-style plans. Among the most popular of these is the flexible spending account (FSA), the so-called Section 125 plans, that are routinely available to millions of workers in the private sector. An employee may pay for unreimbursed medical expenses from the FSA. Millions of workers in the private sector have access to flexible spending accounts, but federal employees today are not allowed to set aside tax-free income in FSAs for current or future health care expenses. Federal employees should be allowed this benefit, and its value should be increased by allowing federal workers to roll over unused funds tax free from year to year. At the end of their working career, they should be allowed to fold these funds into the federal Thrift Savings Plan (TSP) or use the funds built up in these accounts for health care expenses for their retirement.

A variation of this idea is allowing employees to use medical savings accounts (MSAs). Private health insurance plans competing in the FEHBP should be allowed to offer personal, tax-free MSAs to those workers who wish to have them. Likewise, under the tax changes, federal workers could roll over the funds from these accounts from year to year tax free and eventually use them to pay for health expenses in retirement, or offset long-term care costs, or fold them into their TSP accounts.

4. Address lingering problems of risk segmentation and adverse selection. A persistent irritant in the FEHBP has been a tendency toward risk segmentation or adverse selection. While this problem has not been as acute in recent years as in the past, and competing plans have found ways to adjust, it is still a lingering problem in the program. OPM has never proposed, and Congress has never enacted, legislation to reduce or enable OPM to reduce adverse selection in the program.

Any time one has a choice of plans, even if there are only two plans from which to choose, one will have adverse selection. In the FEHBP, the problem is aggravated by both the underwriting rules and the formula governing the government contribution. Under current law, active workers and retired workers pay the same premiums for health insurance despite dramatic differences in risk and health care costs. FEHBP plans cannot charge different rates based on these risks or costs.

In this narrow sense, the program operates under what can only be described as a crude form of "community rating;" 22-year-old joggers and 82-year-old smokers pay the same insurance premiums. When a larger number of older and sicker retirees congregate in a health plan, its costs and premiums soar, encouraging younger and healthier enrollees to drop out. These higher-cost plans find it difficult to compete with lower-cost plans with younger enrollees, and sometimes drop out of the program altogether.

Obviously, a large infusion of younger workers or enrollees would alleviate the problem. Obviously, also, if plans could charge older workers or retirees premiums that reflected their actuarial cost, not only would one have a more rational insurance market, but the decision of older workers or retirees to pick a particular health plan would not necessarily mean sharply higher premiums for younger workers and their families. Much of the adverse selection problem would disappear.

The best way to accomplish this would be to allow plans to charge different age groups different premiums, reflecting their real actuarial value in the market, and simultaneously adjust the government contribution to the plan premiums of higher-cost enrollees. Since age is the most significant risk factor, the government could adjust government contributions for a limited number of categories of enrollees: active workers, early retirees, retirees with Medicare, and the progressively smaller number of retirees without Medicare. Each of these groups can be protected from adverse cost effects by varying the government contribution. Since there is no risk adjustment mechanism at all in the FEHBP today, this would be a substantial improvement in the program.

5. Remove the 75 percent cap on the government contribution to the FEHBP plan chosen and allow federal workers to pocket any difference between that contribution and the actual cost of the plan as a rebate. Under the current financing formula, the government, regardless of how much it contributes in any given year, may not contribute more than 75 percent of the cost of any health plan's premium. A real consumer choice system should give individuals and families the full benefit of any savings that accrue from wise purchasing decisions. In calendar year 2000, for example, the maximum government contribution for family coverage was $4,580. Under this proposed change, workers who purchased a plan that offered an annual premium of $4,000 would get a rebate of $580.

Although the government's contribution, using the market-based formula, would vary every year and reflect changes in the market, the removal of the cap on the government contribution would give the competing plans in the FEHBP new incentives to offer benefit packages at a premium level equal to or below the government's defined contribution, and thereby increase price competition. More intensive price competition would help to stabilize the overall premium increases on which the total government contribution is based. Federal employees would have an incentive to purchase lower-cost plans to reduce out-of-pocket costs and directly pocket any savings. Federal workers and retirees who choose more expensive plans with richer benefits packages would still pay more in premiums and out-of-pocket costs.

The major difference between federal and private-sector employees is that federal employees

continue to have far more choices at competitive prices in a unique consumer-driven market. And with the removal of the 75 percent cap and allowance of a rebate of savings, the Bush Administration and Congress could make the already competitive private health insurance market in the FEHBP even more competitive.

6. Create a younger, healthier insurance pool and open up the FEHBP to young military families. The FEHBP needs young blood. One prominent option: Enroll military families and their dependents under the age of 65 under the same terms and conditions that apply to all federal employees, retirees, and their families. Representatives of military families have testified that they want to be enrolled in the FEHBP. These families have realized that under the FEHBP they would be given a much wider range of personal choice and a far superior medical system than they currently receive in the military health care system.

Because health care benefits, like wages, are normally counted as compensation, Congress could enroll military families in the FEHBP in a budget-neutral fashion and pass on any savings to these families in the form of rebates or pay increases. In any case, the movement of young military families into the FEHBP would be good not only for the military families, but also for the FEHBP itself. As noted previously, the average age of members of the federal workforce has increased in recent years, and is likely to continue to increase, while the number of workers eligible for retirement is expected to soar. The infusion of a large number of young military dependents would be the quickest and perhaps easiest way to provide them with access to a clearly superior health care system, improve the actuarial profile of FEHBP's subscriber pool, and stabilize future insurance premiums.

These policy proposals are not meant to be exhaustive, but they are compatible with the principles of consumer choice and market competition that are at the heart of the FEHBP's long record of success. I would be happy to answer any questions the Subcommittee might have.

Thank you.

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Mr. WELDON. Thank you, Mr. Moffitt. I want to thank all of our witnesses. This has been very informative and certainly stimulates a lot of areas for questioning.

I recognize myself for 5 minutes. The one I want to touch on first is the issue of the mandates. I am a little bit uncertain as to the full impact of the cost of the mandates. I have seen some data out of OPM that these mandates have had a negligible impact. I am curious if you, Mr. Moffitt, agree with that analysis, if you feel that we should get an independent analysis of that through an entity like GAO. There are a lot of mandates coming down from States on health plans, and how much the collective impact of these mandates is having on premiums I think needs to be explored in more detail.

Mr. MOFFITT. Exactly. Mr. Chairman, let me respond. I said in my testimony, borrowing a line from my old boss, Ronald Reagan, trust but verify. I trust OPM. I think they do a great job. I used to work at the Office of Personnel Management. I have profound respect for the staff.

The point that I made in my testimony is simply this: If you look at their analysis of the overall impact of 44 changes in benefits over the past 10 years and you look at the professional literature, the peer-reviewed journals of econometric analysis of benefit mandates at the State level, what you are finding is a significant difference.

The General Accounting Office did, indeed, do an analysis of the impact of mandates at the State level in 1996. In fact, I mentioned this to Congresswoman Morella's staff. I cited this in my testimony. The GAO estimated that State-mandated benefit laws accounted for 12 percent of the claims cost in Virginia, which had then 29 benefit and managed care mandates, and 22 percent in Maryland, which in 1996 had 36 mandates. This covers everything from mandatory chiropractor coverage to substance abuse, in vitro fertilization, you name it, psychological counseling. In Maryland today I think it is well over 50, maybe 54 or 55 mandates.

My point is that I think that you need, in the interest of Federal employees and the families who are paying these premiums, you have got to be clear in your own minds that the Office of Personnel Management is absolutely right. Because my point is that study after study shows that mandated benefits do, in fact, increase cost significantly. But two widely respected economists have indicated that one out of four of the people in the United States who are uninsured are uninsured because they have been priced out of the market by State-mandated benefits.

So my point is that you have a discrepancy here. I am not saying that OPM is wrong. I am saying it is our responsibility and the responsibility of the Bush administration to make sure that our understanding of the economic impact of these mandates is correct.

Mr. WELDON. Mr. Flynn, did you want to counter to that or add to that at all?

Mr. FLYNN. Mr. Chairman, I would simply say that we would welcome verification. I think the list of 44 mandates that Mr. Moffitt talks about is the same list that we prepared that I believe you and members of the subcommittee have seen. It covers a period

over the course of the past 10 years. The net effect of those changes at the Federal level was about 1.5 percent.

Even if you put aside for the moment the effect of mandates that decrease costs in the program, over that same 10-year period we have seen premiums rise in the program approximately 72 percent, and the mandates that increase cost amount to a little bit less than 4 percent. So I think in the context, while it is true that every time you add a benefit, you tend to add cost, I think it is important to look at it in the context of what has been going on in the program overall.

The other one quick thing that I would just simply say is that there is a lot of discussion in health care today about mandates, particularly those that are imposed at the State level. In the Federal Employees Health Benefits Program we have what is known as a preemption provision, where with the single exception of health maintenance organizations that are domiciled and operate solely within a State, we preempt State-mandated benefits.

For example, we don't have the Blue Cross and Blue Shield plan providing State-mandated benefits in California, Pennsylvania, West Virginia, New York, and what have you. It is a standard benefit package across the United States because of the preemption authority that we have in the FEHBP law. So the effect of mandates at the State and local level is very, very minor, we estimate about one-quarter of 1 percent of the total cost of the program. But those that have occurred at the Federal level, whether imposed by Congress or as part of the administration, we think, setting aside those that have actually reduced costs, amount to about 4 percent of that 72 percent increase in premiums over the same period.

But we would welcome GAO, anybody, to come in and look at our numbers. We think we have pretty good data.

Mr. WELDON. My time has expired. I would like to now recognize the ranking member, Mr. Davis, for 5 minutes.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

I listened rather intently to the discussion, and I must confess that I really appreciate the testimony that each one of you has provided. It seemed to me that, as I was listening, that there are, in fact, ways, based upon experiences that I have seen, to reduce cost, but of course oftentimes those are unacceptable to the users or it decreases users' satisfaction.

My question is a rather generic one. The more options and choices that consumers have, the more likely they are to use those. I am saying, if there are more choices, there are more options, the greater the use of those, which has a tendency to drive up costs. So my question is: Is there a way to provide the consumers what they need and at the same time get the cost down for what they would find satisfactory?

Mr. MIREL. Mr. Davis, let me take a crack at that. The alternative that I was talking about, which I think is the same thing that Dr. Coburn talked about in his testimony, is, first of all, a voluntary choice. We are talking about offering a choice that is not now offered through the Federal Employees Health Benefits Plan. That is a high deductible choice. With that would come additional nontaxable compensation, payment, in the form of additional untaxed salary that would be put into the individual employee's

medical savings account. The individual employee then could spend that money any way he saw fit, knowing that once the deductible had been met, $3,800 or whatever it is at the moment, the backup plan would kick in.

That means that you don't have to go through the difficult task of deciding what should be in the plan and what shouldn't be in the plan. It is up to the employee. If the employee wants to spend it on eyeglasses, he can spend it on eyeglasses. If he wants to spend it on dentistry, he can spend it on dentistry. It is his choice.

What it does is it cuts out an enormous amount of the transactional cost that now exists in the plans. What I would like to see happen is to have this offered as an option and see what happens, if people will take it and if they will like it, and if it will, in fact, reduce costs. I think it will have all of those effects.

Mr. DAVIS OF ILLINOIS. Why don't I just ask Ms. Kelley, would the unions be up in arms about such a plan, the high deductible choice?

Ms. KELLEY. We have a lot of concerns about the high deductibles and the medical savings accounts, most of which we are on record for. Would we be up in arms? I don't know. But we have concerns, and they are based around a number of things.

First of all, the choices that you described that Federal employees have today, in fact, have been one of the hallmarks of the FEHBP, that employees have had those choices. Yet, what we have seen every year is choices have decreased and yet premiums have increased. So decreasing the choices has not had the impact on the premiums that some would have hoped.

I think there are a number of issues around the high deductibles and the fear that employees would enroll in a program that wouldn't meet their needs, and they would find themselves later in a situation where they needed to move back into a traditional plan in the FEHBP. There is that movement every year now where employees have that choice, and they make a lot of use it. We know that.

So there are a lot of concerns that we would have and that employees would have. The fear is that they would be losing benefits, and that once those deductibles kicked in, where would the coverage come from? Maybe if there was a formal plan out there, we would be more than willing to look at it and to provide specific comments, but as a general rule, yes, we have a lot of concerns about the high deductibles and the medical savings accounts.

We would much rather see something that we had started to work on and have seen the beginning of, the pre-tax flexible spending accounts that were mentioned by Mr. Moffitt, which now are available to Federal employees for their premiums only, not for their out-of-pocket expenses. Expanding that to Federal employees for their out-of-pocket expenses would be something that would be very much supported, and Federal employees have asked for this for years because the rest of the country has access to that, and yet Federal employees don't.

Mr. DAVIS OF ILLINOIS. Thank you.

Mr. WELDON. The gentleman's time has expired. The Chair now recognizes the gentlelady from the State of Maryland, the great State of Maryland.

Mrs. MORELLA. Thank you. The great State of Maryland. Thank you, Chairman Weldon.

I want to congratulate us and to congratulate you on your chairmanship of this important committee. It is one that I have been on during my 15 years because I think that, if you have a thriving democracy and a good democracy, you have a good civil service. I am pleased that you take over the chairmanship at a time when confidence in public service has been elevated. So this is a good time for us to move forward with recognition and encouragement of our public service.

OK, I am going to start off. This is a good panel. I am going to start off with Mr. Flynn. Nice to see you, and I think the panel was excellent.

The Center for Studying Health System Change has released a new study that shows employees nationwide pay lower premiums on average than those in the FEHBP program. I know that the FEHBP program has an older age population, as has been mentioned, but that increases premiums by less than 1 percent, according to your own data. I wondered if you might comment on that disparity?

Mr. FLYNN. Thank you, Mrs. Morella. It is good to see you again as well.

We actually have looked at that report. I think the first thing that I would do is comment on the year-to-year changes going back over the past 4 years that report comments on. If I recall it correctly, if you go back over the past 4 years, not counting the rate increase for 2002, it indicates that Federal premiums are 8.7 percent higher than private sector premiums.

I might just point to testimony from several of the witnesses, but actually go back 10 years and say to you that Federal premiums have increased 72 percent while private sector premiums have increased 87 percent. So a lot of times it depends on the time period you are looking at, the particular methodological assumptions that you make, whether they are pre- or post-negotiation increases, and so on and so forth.

I think, Mrs. Morella, the point that I would make is actually whether you looked at 4 years or whether you looked at 10 years, and I've seen actually studies that go even further which show that the differences are actually narrower, I am amazed that the figures are as close as they are when you consider all of the numbers and, as I say, some of the methodological differences that go into this.

I think what either set of numbers would reflect is a health care system at large, not just the FEHBP, which has seen increases over the past 4 years, over the past 10 years, that are well above the rate of inflation and that, for one reason or another, we have been largely unable to contain. In that respect, the FEHBP is no different.

Mrs. MORELLA. You present the broad-brush looking back. I guess there is some validity to that. But let me ask you about an offshoot of that. For the last several months I have been looking into different ways to try to alleviate the high cost of the FEHBP plan premiums and to lower costs. One approach was to lower prescription drug costs by taking advantage of the number of FEHBP participants. The idea was to create a programwide drug benefit in-

corporated into each FEHBP that employs pharmaceutical benefit managers—I noticed that Mr. Gammarino had mentioned that—to leverage the Federal community's large economy of scale. I know that OPM has looked into this because we have discussed this before. I am interested if there is any new information that you might offer about this concept.

Actually, maybe I could just also throw in the idea that Mr. Gammarino would note that the Blue Cross switched to a pharmacy benefit manager in its prescription drug benefit and received significant cost savings. Maybe you could, if I have time, Mr. Gammarino, comment on whether or not FEHBP should look at that.

Mr. FLYNN. I will try to do this very quickly to give Mr. Gammarino some time to respond to that as well. You are absolutely correct, Mrs. Morella, we have had discussions with you, your staff, and others about the possibility of doing something like this.

The first thing I would say is that, whether it is the mail order benefit or prescription drug benefits in general, they are already largely managed by the 180 health plans that participate in the Federal Employees Health Benefits Program. Mr. Gammarino can talk about that design in the Blue Cross/Blue Shield program.

So the first thing that I want to make sure we are all clear on is that it is not a situation where we have completely undiscounted drugs being made available to Federal participants today versus moving to prescription drugs being purchased in the aggregate and getting those discounts. It is a question of the marginal difference between the discounts that are currently being achieved under pharmacy benefit management programs versus those that might be achieved through the aggregation and use of the entire Federal Employees Health Benefits Program population as one purchasing pool.

It has been discussed already, the experience that we had with the SAMBA program last year. I think, had that program moved forward, we would have demonstrated modest savings, but savings, nonetheless, for those program participants. I think this is an area that continues to be worth analyzing, discussing with all the stakeholders. But it does come up against some of the arguments that you have heard from Mr. Moffitt having to do with large numbers of health plans competing with one another through informed consumer choice and the impact that has on the market as well. It is an area that we need to continue to explore, but I can't provide you with a definitive outcome.

Mrs. MORELLA. OK.

Mr. GAMMARINO. Yes, I could give you a couple of observations.

Mrs. MORELLA. I know my time has expired though.

Mr. WELDON. Go ahead and answer the question.

Mr. GAMMARINO. Congresswoman Morella, we would not support a government carveout of the prescription drug program and do direct contracting. One, philosophically, it is not consistent with the FEHBP, which is built on a private individual choice market with individual underwriting.

Two, as a manager of a health plan, I guess my question would be: Who's managing the shop? Am I doing it or the government?

Clearly, the intent of the FEHBP is that the private sector manage this.

Third, you are getting at probably a marginal issue. If price of the products were the only thing driving the trends that you are seeing, maybe we would all jump on board, but it would make a marginal difference in the rates you are seeing. Drug costs today are driven not as much by price as it is by use and the introduction of new drugs which provide a new pricing platform in which to start.

Mrs. MORELLA. Thank you. Thank you, Mr. Chairman.

Mr. WELDON. The gentlelady from the District of Columbia is recognized for 5 minutes.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Flynn, I note that you say in your testimony—well, first, let me say that, as you may remember from the time that President Clinton tried to get us into a national health care program, there were many of us who thought that the FEHBP might lead the whole Nation. I don't think a lot of us think that way anymore, frankly. We are not sure how to lead the whole Nation.

You say in your testimony that the fact that 85 percent of the eligible work force participate in the Federal Employees Health Benefits Program attests to its popularity. I wouldn't take that to the bank. I think people participate because they are intelligent people, they need health care, and they don't have any alternative.

I would rather go to the part of your testimony which is more explorative of ways to make that popularity more than something that people would almost have to do for their own sake, rather than risk being here without any health insurance. That is on page 10, where you say you are exploring ways to increase health care options available to Federal employees, thereby increasing competition within the program. This is, of course, the great savior that we all are looking for.

Of course, we see the opposite trend, for reasons, frankly, far beyond your control. When it is 245, there were 245, now 180, I know full well that has almost nothing to do with FEHBP, but with structural problems in health care in our country.

But what some of us were leery of, the notion of opening of FEHBP to kind of the great unwashed herd out there because we weren't sure that it wouldn't do anything but drive up rather than keep what was then fairly stable costs. It is as if the insurers were afraid that there was going to be some real government mandate to deal with health care for all the American people, and it was almost, "Let us keep these costs down," because the moment that went away, health care began to rise again. We had a few years of extraordinary stability. I think it was absolutely artificial.

If we look now at FEHBP, even though, according to your own records, the demographics don't account for very much of this hyperinflation, one can't help but look at this average age of 48, for God's sake, for the FEHBP, and 71, the average age for the retirees, and wonder how much longer you can keep a viable plan going that way.

I lay that predicate to ask this question, noting what Blue Cross/Blue Shield has done: Here Blue Cross/Blue Shield has collapsed its High Option, and if it hadn't, according to the testimony, then

it would have become untenable. It collapsed probably because the High Option people were people who used health care most often. So they mixed up their pool.

Is there any way to—and here I am not advising spreading FEHBP the way we in our wild imaginations thought might be possible just a few years ago—but is there any way to think about selective opening of FEHBP to sectors that might have some incentive to come into such a plan, which in many other ways may be very efficient, so that we could mix the pool up a bit and begin to reduce costs the old-fashioned way, by having a broader pool of those who are insured?

Mr. FLYNN. Ms. Norton, that is an extremely interesting question. Let me preface my comments about it by just simply mentioning, you mentioned the stable premiums in the FEHBP and how that was seen as a model or something to sort of move toward during the debate on health care reform. It has not always been the case that premiums in this program have been stable. We were seeing a period of increases that are of great concern to us now in the late 1980's; 1987, 1988, 1989, premiums were going up close to 20 percent a year; then in the late 1970's/early 1980's a similar period of premium increases.

Ms. NORTON. So why did it stabilize for those few years?

Mr. FLYNN. Well, you know, I guess I should say I am not an expert in health care policy. I think I am reasonably expert in acting as a purchaser of health insurance for an employer that wants to sponsor that as part of its compensation program. That is actually the avenue of my answer to your question, which is I would be very concerned about opening this program up to groups of people who have something other than an employment relationship with the Federal Government.

This is part of the compensation program. It is in that respect the same thing that General Electric and General Motors and other employers offer their employees, and in some cases retirees, although, as Mr. Moffitt says, retiree health benefits in this program actually stand unique from what other employers tend to do. So I would be very concerned about that.

I do think, however, that while I would be very concerned about opening this up to new groups of participants, I am less concerned about looking for ways in which we could perhaps open this up to new groups of health care delivery mechanisms. We have talked about the exodus of HMOs. We have done specific things to try to get health plans into the program over the past several years, but we are limited by the Federal Employees Health Benefits statute in terms of admitting plans other than health maintenance organizations.

I think that is an area where, working with the committee, working with other stakeholders and others who have an interest in this program, we may very well be able to come to some consensus about bringing in, for lack of a better term, other health insurers or health care delivery mechanisms to increase the level of competition in the program and have the kind of salutary effect that has been talked about by many of the people who have given testimony today.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. WELDON. The gentlelady's time has expired.

I would like to thank all of our witnesses. It has been very informative.

None of you really commented on the exodus of HMOs directly. Am I to interpret that to mean good riddance? Is that what you are all saying? [Laughter.]

Mr. FLYNN. Mr. Chairman?

Mr. WELDON. Yes?

Mr. FLYNN. I would be happy to offer just a quick comment on that. Going back to Mr. Moffitt's earlier testimony, this is an area where actually GAO came in and did verify that health maintenance organizations were leaving the program largely because of business reasons unrelated to the administration of the Federal Employees Health Benefits Program itself.

Congresswoman Norton mentioned the fact she was not surprised by the reduction in HMOs because it is largely what is going on in the national economy. So from that standpoint, it is something that we can live with, but at the same time it is something we need to think seriously about in terms of looking at ways we can enhance competition and give people more choices as we go forward, because I think that is one of the strengths of the program.

Mr. WELDON. Again, I want to thank all the witnesses. It has been a very informative hearing. This hearing is now adjourned.

Mrs. MORELLA. Could I ask another question or would you prefer that I submit the question?

Mr. WELDON. Is the lady asking for a second round of questioning?

Mrs. MORELLA. Only if it is amenable to you, because if not, I will submit it in writing.

Mr. WELDON. OK, well, why don't we just have a second round of questioning. I think I already took about a minute asking one question. So let me give myself another 4 minutes.

Under the plan, as I understand it, you have to offer two plans, correct? If you are in the FEHBP, is that true?

Mr. FLYNN. In the Blue Cross/Blue Shield Service Benefit Plan there are two options required by law, but not all plans are required to offer two options.

Mr. WELDON. OK. So they can have three options, four options? There is no limitation on the number of options?

Mr. FLYNN. No, I am sorry, I believe the issue is not more than two options.

Mr. WELDON. Not more than two?

Mr. FLYNN. Though the Service Benefit Plan is required to have two options. This is an area where it might be worthwhile to discuss whether or not additional options on the part of participating plans might be warranted. It is another area to think about, Mr. Chairman.

Mr. WELDON. Would that require a change in statute?

Mr. FLYNN. Yes, sir, it would.

Mr. WELDON. OK. If you had that kind of flexibility, would that have changed how you dealt with the situation you were in this year, Mr. Gammarino?

Mr. GAMMARINO. It certainly would have given us more flexibility. However, the High Option was in trouble.

Mr. WELDON. Now when you say "High Option was in trouble," the demand was just not there?

Mr. GAMMARINO. Well, yes, but we haven't mentioned this word, and that is "adverse selection." That is, you had a group of enrollees that had significant health care needs. The pooling of insurance where you have users and non-users really didn't work too well with High Option. You primarily had high users and they needed medical care. So the issue of cost for that group was really not an issue at all. They needed care and they needed somebody to pay for it.

Mr. WELDON. And that is why the premium, if you had kept that in place, would have gone up 30–50 percent?

Mr. GAMMARINO. It was based upon the experience of that group. In order to continue to underwrite that group and have the revenues to pay the expenses, you would have had to increase our rates. Just a reminder that plans like ours are experience-rated. Our premiums reflect the actual experience of the group.

So getting back to your question, would we have done something, we probably would have considered a third option. It would have been easier. It would have been easier to do. But the fact remained that the High Option product in terms of long-term viability had significant issues.

Mr. WELDON. Mr. Flynn, as I understand it, within FEHBP you can only charge individual or family, and you cannot prorate or adjust the family rate based on the number of dependents?

Mr. FLYNN. Right.

Mr. WELDON. Is that correct? What is going on in the private sector in that arena? Is that the standard in the private sector? It is either individual or family, or do they tend to adjust premiums based on the size of the family and the number of dependents?

Mr. FLYNN. Mr. Chairman, if you would allow me, I would like to do some confirming back at the office, but there is no sort of standard out there, but I would say that there are more health plans that center on the sort of self-plus-family, which is the family enrollment, without distinguishing in terms of one spouse, one spouse/one dependent, one spouse/two dependents, and things like that.

We have actually done some studies of what the effects of that might be on premiums, and they are sort of counterintuitive, but I think the dominant practice is still individual coverage, family coverage.

Mr. WELDON. Mr. Gammarino, in the private sector is that basically the way it is handled as well?

Mr. GAMMARINO. Yes, I would agree. I mean, there are exceptions to that, but primarily the major employers pretty much have the same type of health plans in terms of family and single coverage.

Mr. FLYNN. Where you do see some differences, Mr. Chairman, is that there is a larger proportion of employers, private employers, who will typically pay 100 percent of the self-only coverage and then ask the individual being covered to pick up the difference between that and family coverage. Again, that is not a predominant practice, but you see that more frequently in the private sector than you do in the public sector.

Mr. WELDON. My time has expired. Mr. Davis, did you have a question for the second round?

Mr. DAVIS OF ILLINOIS. Yes, thank you, Mr. Chairman.

Mr. Moffitt, I believe you mentioned the fact that we need to get some new blood or we needed to mix the demographics, that we needed a different composition. Then I noted that Delegate Norton mentioned the fact that 58 is an average age.

Mr. MOFFITT. Right.

Mr. DAVIS OF ILLINOIS. Are you suggesting in any way that we need to place more emphasis on factoring in the age of the population group that we are dealing with or that we need to do something to shift part of that age group out of the program?

Mr. MOFFITT. No. Congressman, what I am saying is basically expand the program. I think Mrs. Norton actually put her finger on it. We want to be careful how we do this. A suggestion that I made in my formal testimony is to expand it to people who do have a direct relationship with the Federal Government. That group are young military families who are enrolled right now in the military health care system. You are talking about between 5 and 6 million people.

Young military families are healthy. Their national representatives have testified before Congress that they would like to be in the Federal Employees Health Benefits Program. But the central value of it would be that it would improve the actuarial profile of the pool. As a result, it would stabilize and possibly even bring down premiums and give young military families access to what is clearly a superior health care delivery system than what they have got today.

So that is my view, Congressman. I think that there is an opportunity here and I think we ought to take advantage of it because we have a large number of people who would, in fact, benefit directly by having the opportunity to enroll in the best group health insurance program in the world, despite its minor flaws.

Mr. WELDON. Would the gentleman yield?

Mr. DAVIS OF ILLINOIS. Yes.

Mr. WELDON. Are you saying dependents——

Mr. MOFFITT. Yes.

Mr. WELDON [continuing]. Only?

Mr. MOFFITT. I'm not talking about—no, the military health care system is divided. You have a military health care system which is designed for military combat, and that is covering military personnel. I am talking about the program that covers dependents, which is a different program.

Very frankly, Mr. Chairman, this debate has been going on for some time internally within the Department of Defense, and certainly I am sure it is going to go on within this administration. But Department of Defense officials have recognized that there is an inherent tension between providing military services for basically civilians who are dependents of military personnel and the demands of a combat-ready medical system.

My argument is that we have a 9 million pool right now that is rapidly aging, which has an unusually large number of retirees compared to any other group health insurance system in the coun-

try. We can actually improve that pool by allowing young military families to take advantage of it.

What I said in my testimony is we can do this in a budget-neutral fashion. That is to say, let them come in on the terms and conditions that apply to Federal employees, but allow them to keep any of the benefits that they would reap by entering the FEHBP with either pay increases or rebates directly to those families.

Mr. DAVIS OF ILLINOIS. Well, let me ask Mr. Flynn. Mr. Flynn, how would you respond, OPM respond to that suggestion?

Mr. FLYNN. Mr. Davis, as Mr. Moffitt has indicated, this is an issue that has been discussed over a number of years and under a number of different administrations. There are views on the matter within the Defense Department and within the administration. I am going to express the view that we have always expressed when it comes to this program and how it might serve as a model.

We stand ready at any time and at any place to help people, employers and others, satisfy the health care needs of their employees, populations, what have you. But when it comes to fundamental changes to the nature of the FEHBP, we want to make sure that we understand exactly what it is we are being asked to do and what the pros and cons of any such step might be.

I will admit to you that at first blush there are some attractive notions associated with bringing military dependents into this program, but I also know, given the discussions that have gone on for as long as I have been in this job and before, that there are some very serious issues that need to be considered, not the least of which is the adequacy of the military health care system to serve its combat role on an ongoing basis under such a structure.

So I would simply say that is something else that clearly should be discussed. I am somewhat fine when we talk about new blood. I was saying to Director James that if we just hired 500,000 new Federal employees, we would bring premiums down in a heartbeat. [Laughter.]

But she keeps reminding me that I shouldn't be talking like that. [Laughter.]

But fresh blood, however it would be characterized, would have that type of effect on premiums in the long run.

Mr. WELDON. The gentleman's time has expired. The gentlelady from Maryland is recognized for 5 minutes.

Mrs. MORELLA. Mr. Chairman, thank you for allowing this second round.

Mr. WELDON. Yes.

Mrs. MORELLA. I did want to ask our two gentlemen, Mr. Mirel and Mr. Moffitt, about MSAs. You both have commented on being supporters of them, but I just wondered if you are aware that there was a 1998 CBO report that stated that imposing MSAs in the FEHBP Program would result in nearly $1 billion in new costs to the taxpayers and enrollees, and it would siphon off relatively healthy enrollees. Although it sounds good on the surface, I think that is a really pertinent point to consider with regard to MSAs.

I might add another part to the question, too. Is there anything that you think would stop an individual from so-called "gaming the system" by switching to a comprehensive plan during the FEHBP

annual open season in any year that they know that their health expenses, health care expenses are going to be higher?

So I put these two points out because I think that it seemed to us there were problems.

Mr. MOFFITT. Congresswoman, they are excellent questions. I will go first, and Mr. Mirel is chomping at the bit, but he will have patience, I'm sure. [Laughter.]

The CBO did make that analysis, and I am, frankly, only superficially familiar with it. So I don't want to comment on something that I am not thoroughly familiar with.

I think that this is one of those areas where either the committee or the Congress or the administration should make an effort to run some kind of a demonstration program in the Federal Employees Health Benefits Program to find out exactly what the effect would be of introducing a medical savings account option, the standard medical savings account option, like a high deductible plan with a catastrophic piece.

The CBO has said that this will cost money and that there will be significant adverse selection. The Rand Co. did a study in 1996; the subject of it was, "Can Medical Savings Accounts for the Non-Elderly Reduce Health Care Costs?" The Rand researchers predicted that, if all insured non-elderly Americans switched to MSAs, their health care expenditures would decline by as much as 13 percent.

You've got a competition here in terms of analysis. I think we have to study that further. But I would say one way to do this would be to run a demonstration project of maybe 100,000 or 200,000 Federal employees. Run it for a couple of years and see how it works.

With regard to the other question you are talking about, which is the gaming of the system, that goes on now. That goes on now because neither OPM nor the Congress has yet to address the issue of adverse selection in the Federal Employees Health Benefits Program, even though this has been going on, this debate has been going on as long as I can recall.

I have made a suggestion in my testimony to deal with that, and that is to vary the contributions among enrollees based on their age. That is to say, allow underwriting on the basis of risk, and at the same time vary the contributions of the government on the basis of that risk, in order to protect high-cost elderly or high-risk employees against substantial premium increases. That is an old idea actually. It has been kicked around by economists, who are familiar with the FEHBP, for many years, but nobody has ever acted on it.

But what you have got now is an irrational system. You have a system where, if you are an 88-year-old smoker, as I said in my testimony, or a 22-year-old jogger, you pay the exact same premium. So that means that every single time you have an elderly person enroll in a health care plan and that drives up utilization or the cost, it is an incentive for younger people to leave the program. If you would vary the contributions and allow a rational adjustment for risk, you would actually improve dramatically the functioning of the program. You would still have cross-subsidization, but you would be doing it through the government contribu-

tion system rather than trying to do it through the insurance market.

Mrs. MORELLA. If I could comment on the demonstration project, the National Association of Retired Federal Employees did submit separately a testimony. In looking it over, it indicates the fact that "adverse selection and subsequent premium increases in comprehensive plans occurred when the plans were offered to public employees in Ada County, ID and Jersey City, NJ. As a result, the county and city stopped offering MSAs to their employees." So we have had an example or demonstration program in that regard.

I guess I don't have more time. I will submit another question to you later.

Mr. WELDON. The gentlelady's time has expired.

Mrs. MORELLA. Thank you.

Mr. WELDON. The gentlelady from the District of Columbia is recognized for 5 minutes.

Ms. NORTON. This question is to Mr. Flynn, and it is based on the assumption that the further we get from the present system in our recommendations, the less likely it is that those changes will be made by Congresses as diverse as this one. So, Mr. Flynn, for example, whether we are talking about MSAs or—I mean, Mr. Souder made this point—whether you are talking about MSAs or whether you are talking about the government paying the full cost of Medicare and Medicaid, if it is not within the pattern, it is not likely to happen.

That is why I am a little disappointed, Mr. Flynn, in your response to Mr. Moffitt's suggestion because your response was very much in the box: "We are a health care plan like GM. We are an employer. We are set to offer a plan the way employers do"—even given the fact that you have a very atypical work force in many ways because it is older and getting older. It is likely to get older before it gets younger because of what is happening. Young people are certainly not coming to the Federal Government. They are going to the dot.coms or wherever else they go.

I would like to follow Mr. Moffitt's suggestion with even suggestion on top of Mr. Moffitt's suggestion. Mr. Moffitt's suggestion talks about young families. I mean, I have gone just since September 11th to send off young men and women from our National Guard who are leaving people at home without health benefits. I think that is a disgrace. Yet, it seems to me this Congress in a bipartisan way would be more likely to accept dependents of people going off to fight as a result of our country being attacked than it is to do some of the other things that some of us have suggested.

I was going to suggest I like Mr. Moffitt's suggestion, particularly coming as it does, which drives home the inequity of leaving people here to take care of themselves with no often major person who earns the funds. But I would like to go even further.

What is increasingly happening to the government is that we contract out much of our business. So I would like to ask, especially since some of those contractors are virtually permanent employees, whether you would count at least those people—at least those people—as Federal employees, since for all intents and purposes those are Federal employees and are likely to be far younger than the average Federal employee or the increasing rise in our work force.

Would you accept those as people that we might look to, even though it might make it bureaucratically a little more difficult for you to run? Don't worry, we will study it first. But would you be willing to look at that as a pool that might bring down the age, diversify the actuarial pool, and help cut costs?

Mr. FLYNN. Ms. Norton, if I conveyed from my earlier response that we don't want to talk about dependents of military members at all——

Ms. NORTON. That is what I got, sir. I didn't hear you say, yes, that is something we ought to look at.

Mr. FLYNN. Let me quickly correct that. All I simply meant to say was that there is a long history of discussions of that we need to take into account. We certainly can continue discussions within the Defense Department and the administration on the desirability of doing that.

Similarly, with respect to——

Ms. NORTON. See, that is exactly what I am after. I am asking whether or not somebody is willing to fish or cut bait on, one, taking care of finding a way to expand health care benefits and, two, diversifying the actuarial pool of the Federal Government. What you are telling me is something we should continue to discuss. That is what we have been doing every year since I have been on this committee, with inflation taking away whatever there used to be for FEHBP.

I am asking, is OPM willing to take some initiative in trying to diversify the work pool by moving this discussion beyond the discussion phase and seeing if we can come back to this committee with a proposal?

Mr. FLYNN. Ms. Norton, I am willing to take that back and to get the appropriate people around the table to talk about it——

Ms. NORTON. Thank you.

Mr. FLYNN [continuing]. Without question.

The one quick point I wanted to make was the point you made about Reservists leaving and leaving their dependents behind without health care coverage. There is a law that affects most employers. I don't know exactly the title of it, but it is called USARA. It affects the Federal Government and it affects private employers.

If individuals are called to Reserve duty and ship out with their units, employers generally are maintaining health insurance for dependents. So if they had health insurance when the call-up occurred, I think generally you are finding that is going to be continued at least for some period of time.

Ms. NORTON. Suppose they didn't. Many of my constituents did not. If, in fact, the person who earned the income is going off, it does seem to me that you are going to cover him now because he is going to be in the Persian Gulf, but his family is left here with nobody to cover them.

Mr. FLYNN. Yes, I don't know—you know, I am not technically expert in that. If they didn't have it to begin with, I doubt that the protections of that law would come into play. But I think for most people who did have it, there are significant protections for health insurance and other benefits under that law.

Mr. WELDON. The gentlelady's time has expired.

I want to again thank all of the witnesses for your very informative testimony.

The hearing is now adjourned.

[Whereupon, at 3:45 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.]

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