WE'D LIKE TO SEE YOU SMILE: THE NEED FOR DENTAL AND VISION BENEFITS FOR FEDERAL EMPLOYEES

HEARING

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE
AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

ON

H.R. 3751

TO REQUIRE THAT THE OFFICE OF PERSONNEL MANAGEMENT STUDY AND PRESENT OPTIONS UNDER WHICH DENTAL AND VISION BENEFITS COULD BE MADE AVAILABLE TO FEDERAL EMPLOYEES AND RETIREES AND OTHER APPROPRIATE CLASSES OF INDIVIDUALS

FEBRUARY 24, 2004

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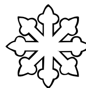

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WE'D LIKE TO SEE YOU SMILE: THE NEED FOR DENTAL AND VISION BENEFITS FOR FEDERAL EMPLOYEES

TUESDAY, FEBRUARY 24, 2004

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

The subcommittee met, pursuant to notice, at 3:11 p.m., in room 2247, Rayburn House Office Building, Hon. Jo Ann Davis (chairwoman of the subcommittee) presiding.

Present: Representatives Davis of Virginia, Blackburn, Chairman Tom Davis (ex officio), Davis of Illinois, Norton, and Van Hollen.

Staff present: Ron Martinson, staff director; Chad Bungard, deputy staff director; Rob White, communications director; Chris Barkley, professional staff member; Reid Voss, clerk; John Landers, detailee; Tania Shand, minority professional staff member; and Teresa Coufal, minority assistant clerk.

Mrs. DAVIS OF VIRGINIA. A quorum being present, the Subcommittee on Civil Service and Agency Organization will come to order.

I want to thank you all for joining us today as we take a look at how we can make available better dental and vision benefits for members of the Federal family. I know this issue is of great importance to Federal employees, retirees, and their families. These two benefits are consistently at the top of their wish list.

Earlier this year I introduced H.R. 3751, which requires the Office of Personnel Management to study the options for enhancing Federal dental and vision benefits, and to issue a recommendation to Congress by June 30th of this year. I felt it was time for OPM to reevaluate its dental and eye care offerings to the Federal Employees Health Benefits Program.

For reasons that I expect OPM to explain in detail here today, the dental and vision benefits offered through the FEHBP have essentially remained unchanged for about 15 years. A lot has changed in that time. Primarily we have learned a great deal more about the importance of dental and vision care to our overall health. I think it is a black mark against the Federal Government that its current dental and vision offerings are so meager.

We have held several hearings in this subcommittee and endorsed several pieces of legislation to assist the Federal Government in attracting and retaining talented workers. Employee bene-

fits are another piece in this puzzle, because the Federal Government is lagging behind its competitors. Just look at dental benefits. Nearly every midsized and large private sector firm offers fairly generous dental care. Federal employees understand this disparity.

My hope is that this hearing and my introduction of H.R. 3751 can be the start of a collaborative process by which the House, the Senate, the administration, and industry representatives can determine the best way to enhance both dental and vision benefits while maintaining the overall strength of the FEHBP.

I want to thank you all for being here today.

And I would like to recognize my ranking member, Mr. Davis, to see if he has an opening statement.

[The prepared statement of Hon. Jo Ann Davis and the text of H.R. 3751 follow:]

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Chairwoman Jo Ann Davis
Subcommittee on Civil Service and Agency Organization

"We'd Like to See You Smile:
The Need for Dental and Vision Benefits (H.R. 3751)"
Opening Statement
February 24, 2004

Thank you all for joining us today as we take a look at how we can make available better dental and vision benefits for members of the federal family. I know this issue is of great importance to federal employees, retirees and their families – these two benefits are consistently at the top of their wish lists.

Earlier this year, I introduced H.R. 3751, which requires the Office of Personnel Management to study the options for enhancing federal dental and vision benefits and to issue recommendations to Congress by June 30th of this year. I felt it was time for OPM to re-evaluate its dental and eye care offerings through the Federal Employees Health Benefits Program.

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My hope is that this hearing, and my introduction of H.R. 3751, can be the start of a collaborative process by which the House, the Senate, the Administration and industry representatives can determine the best way to enhance both dental and vision benefits while maintaining the overall strength of the FEHBP. Thank you.

108TH CONGRESS
2D SESSION

H. R. 3751

To require that the Office of Personnel Management study and present options under which dental and vision benefits could be made available to Federal employees and retirees and other appropriate classes of individuals.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 30, 2004

Mrs. JO ANN DAVIS of Virginia introduced the following bill; which was referred to the Committee on Government Reform

---

A BILL

To require that the Office of Personnel Management study and present options under which dental and vision benefits could be made available to Federal employees and retirees and other appropriate classes of individuals.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. REPORTING REQUIREMENT.**

4 (a) IN GENERAL.—Not later than June 30, 2004, the
5 Office of Personnel Management shall submit to Congress
6 a report describing and evaluating options whereby dental
7 and vision benefits could be made available to—
8 (1) Federal employees and retirees;

1 (2) qualified relatives of Federal employees and
2 retirees; and
3 (3) other appropriate classes of individuals.
4 (b) REQUIRED CONTENT.—The report shall in-
5 clude—
6 (1) a description of the specific benefits that
7 could be offered, including any relevant maximums,
8 limitations, exclusions, and definitions;
9 (2) a description of the classes of individuals
10 who should be made eligible for benefits;
11 (3) a description and assessment of the various
12 contracting arrangements available to the Govern-
13 ment, including whether benefits should be con-
14 tracted for on a regional or national basis;
15 (4) the estimated cost of those benefits, includ-
16 ing a statement as to whether any regular Govern-
17 ment contributions or allocation for start-up costs
18 might be necessary or appropriate;
19 (5) a statement as to how those benefits might
20 be offered through—
21 (A) the Federal employees health benefits
22 program,
23 (B) one or more programs apart from the
24 Federal employees health benefits program,

1 (C) the program described in subpara-
2 graph (A) in combination with one or more of
3 the programs described in subparagraph (B),
4 and
5 (D) any other program or method not oth-
6 erwise described in this paragraph,
7 as well as the advantages and disadvantages of each;
8 (6) a recommendation from the Office as to its
9 preferred method or methods for providing such ben-
10 efits; and
11 (7) any legislation or other measures the Office
12 considers necessary in order to implement any of the
13 foregoing.

○

Mr. DAVIS OF ILLINOIS. Thank you very much, Madam Chairwoman, and let me thank the witnesses for coming.

Visual health and oral health are integral to general health. Eye and oral diseases are progressive and becoming more complex over time. Our ability to eat, see, read, learn, and communicate all depends on good visual and oral health.

Periodic eye and dental examinations are an important part of routine preventative health care. Many visual and oral conditions present no obvious symptoms; therefore, individuals are often unaware that problems exist.

There are safe and effective measures to prevent the most common eye and dental diseases. That is why early diagnosis and treatment are important for maintaining good visual and oral health and why a vision and dental benefit should be made available to Federal employees and annuitants.

We know that in 1987 the Office of Personnel Management stopped plans in the Federal health benefits program from adding new vision and dental packages. OPM did so for various reasons. However, that decision was made more than 15 years ago, and it is now time to take a fresh look at how we can meet the visual and oral health needs of Federal employees.

Let's not be shortsighted. In the long run, preventive care through periodic examinations and doctor visits will help keep down long-term vision and dental costs due to early detection.

I have worked in the health area for many years and prior to running for public office actually served as president of the National Association of Community Health Centers, and health was something that I paid a great deal of time on and attention to, and I often wondered why we didn't put as much emphasis on prevention and early detection even as we talked about cost containment and lowering the costs of health care. I think that we can be most effective in improving health status when we make sure that each and every individual has optimal opportunity to prevent themselves from getting ill to the point where they have to be institutionalized, hospitalized, or have expensive doctor visits and perhaps even surgery.

So, Madam Chairwoman, I thank you for holding this hearing, and look forward to some very positive results.

[The prepared statement of Hon. Danny K. Davis follows:]

**STATEMENT OF THE HONORABLE DANNY K. DAVIS
AT THE SUBCOMMITTEE ON CIVIL SERVICE
AND AGENCY ORGANIZATION
HEARING ON**

**WE'D LIKE TO SEE YOU SMILE: THE NEED FOR DENTAL AND
VISION BENEFITS FOR FEDERAL EMPLOYEES**

February 24, 2004

Chairwoman Davis, visual health and oral health are integral to general health. Eye and oral diseases are progressive and become more complex over time. Our ability to eat, see, read, learn, and communicate all depend on good visual and oral health.

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We know that in 1987 the Office of Personnel Management (OPM) stopped plans in the Federal Health Benefits program from adding new vision and dental packages. OPM did so for various reasons. However, that decision was made over 15 years ago, and it is time to take a fresh look at how we can meet the visual and oral health needs of federal employees.

Let's not be shortsighted (no pun intended). In the long run, preventive care, through periodic examinations and doctor visits, will help keep down long term vision and dental costs due to early detection.

I look forward to the testimony of the witnesses and appreciate them taking the time to share their insight on this issue.

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Davis.

I would now like to recognize Ms. Holmes Norton for an opening statement.

Ms. NORTON. Thank you very much, Madam Chairwoman, and I very much appreciate your interest in augmenting the FEHBP and your bill, as well as your study.

Even without vision and oral care, the FEHBP is behind the great Fortune 500 companies and has been for some time. So the fact that we are trying to catch up is nothing to congratulate ourselves about, but I am very pleased to see leadership of the Chair in focusing on yet another shortcoming. The problem I have is of course that when you already have a benefit plan where the employer does not pay what it would pay if it were a Fortune 500 company—and the last time I looked, there isn't a Fortune 500 company as big as the government of the United States—then of course to go forward and add to that raises yet another question, and that is who is going to pay for it. I think that employees should wonder whether we are going to get the kind of benefit that they got with long-term care: 100 percent paid for by the employee. In that case, the employer becomes a vessel.

Thank you very much, and it's good to have those who can afford it get it, but I would hate to see the idea of cost sharing gradually disappear from the FEHBP.

Now, you could argue that with long-term care it's so expensive that's why the Federal Government couldn't possibly do it. Well, it could have done something. It could have done a little bit of it. But it did none of it. So my question, at a time when people all over the United States are striking, not for wages but for loss of health care, my question is, is the employer ready to pick up his share along with the employee? Because, if not, I'm not sure how the employees will look at this.

Employees who can already afford it perhaps already pay for their dental care or for their oral care, so the employees I'm most concerned about are employees in the lower grades for whom some subsidy here could have some real meaning. And we have to recognize that employers who pick up part or all of the cost of health care in fact are calculating that in their wages. So in fact it's not ever free to the employee. But if the employee only becomes a vessel, then I'm not sure what role the employer is playing except to provide a group umbrella. And I suppose we should all be grateful for small favors. There are a lot of those group umbrellas that people can join right now. You can go out and join other kinds of groups outside of your employer today because they are forming as a result of the cost of health care.

I am very concerned about the rising cost of FEHBP. I am not among those who hold FEHBP up the way it is always held up in all Presidential campaigns. They say look at this FEHBP. I know that Federal employees must say what are they talking about? If our costs are going up 10 percent a year or 12 percent a year or 15 percent a year, what is happening out there in the rest of the marketplace?

So I am concerned about how we would pay for this. And, frankly, I have a hard time with this if in fact there was not cost sharing

here, because I believe it would be the beginning of the end of cost sharing.

I would love to know what the figures are in the public sector. In the private sector there are many millions of people who are dropping their own health care or dropping family members or having employers drop health care or offload more of it onto employees because of the rising cost of health care. So if this is an add-on to today's health care cost for the employee, then I think the committee would want to look more closely at what we are doing for the employees, and I think that Uncle Sam ought to be willing to step up to the plate the way far smaller employers than our government does.

Thank you very much, Madam Chairwoman.

Mrs. DAVIS OF VIRGINIA. Thank you, Ms. Norton. That's why we've asked OPM to do a study on it and to give us some recommendations, because if we do anything we want to make sure we do what's right for the employees.

And I would just testify from my own personal experience. I don't take FEHBP. I opted not to when I was elected because my husband's insurance through the city where he worked, where he retired from was actually better. But from a personal standpoint, I just spent $13,000 out of my own pocket for dental because we don't have dental. So if there is some way that we can help the Federal employees, we want to do that.

Ms. NORTON. Now we see an additional motivation, Madam Chairwoman.

Mrs. DAVIS OF VIRGINIA. Actually, that was after the fact. But it has become an additional motivation.

Mr. Van Hollen, welcome. Do you have an opening statement?

Mr. VAN HOLLEN. No, thank you, Madam Chairwoman. Just I appreciate the fact that you are holding this hearing and looking into this issue. So thank you.

Mrs. DAVIS OF VIRGINIA. Thank you.

I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record, and that any answers to written questions provided by the witnesses also be included in the record. And, without objection, it is so ordered.

I ask unanimous consent that all exhibits, documents, and other materials referred to by Members and the witnesses may be included in the hearing record and that all Members be permitted to revise and extend their remarks. Without objection, it is so ordered.

I also ask unanimous consent that statements from Delta Dental of California and the National Association of Retired Employees may be included in the hearing record. And, without objection, it is so ordered.

I would like to welcome our panel today, and to thank you all for coming and for being patient with us.

With us today we have Ms. Abby Block, the Deputy Associate Director of Office of Personnel Management. After Ms. Block, we will hear from Mr. Ed Wristen, the president and CEO of First Health. Then we are going to be hearing from Dr. Stan Shapiro. Dr. Shapiro is the vice chairman of CompBenefits. And then after Dr. Shapiro we will hear testimony from Mr. John Seltenheim, the chair-

man of the National Association of Dental Plans. And, last but not least, will be Dr. Howard J. Braverman, the past president of the American Optometric Association.

It's standard practice for this committee to administer the oath to all witnesses; and if all witnesses could please stand, I will administer the oath. If you would stand, please, and raise your right hands.

[Witnesses sworn.]

Mrs. DAVIS OF VIRGINIA. Let the record reflect that the witnesses have answered in the affirmative, and you may be seated.

The panel will now be recognized for an opening statement, and we ask that you summarize your testimony in 5 minutes, and that any further statement you may wish to make will be included in the record.

I would again like to first welcome Ms. Abby Block, and I thank you for being with us today, Ms. Block. You are now recognized for 5 minutes.

STATEMENTS OF ABBY BLOCK, DEPUTY ASSOCIATE DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT; ED WRISTEN, PRESIDENT AND CEO, FIRST HEALTH; DR. STAN SHAPIRO, VICE CHAIRMAN, COMPBENEFITS; JON SELTENHEIM, CHAIRMAN, NATIONAL ASSOCIATION OF DENTAL PLANS; AND HOWARD J. BRAVERMAN, O.D., PAST PRESIDENT, AMERICAN OPTOMETRIC ASSOCIATION

Ms. BLOCK. Thank you, Madam Chairwoman, and members of the subcommittee. I am pleased to appear before you today on behalf of Director Kay Coles James to discuss the views of the Office of Personnel Management on dental and vision benefits under the Federal Employees Health Benefits Program.

Director James has always expressed a willingness to review the policies and programs affecting the pay and benefits of Federal employees in order to ensure their effectiveness for employees, the Government, and the taxpayer. As you know, this year for the first time we made flexible spending accounts available to Federal employees. Pretax dollars deposited into those accounts can be used to cover the cost of deductibles and co-payments and other health care costs that are not covered by FEHBP plans, and also to pay eligible dependent care costs. Director James is firmly committed to the ongoing review of all the benefits offered under the FEHB Program.

Of course, given the ever increasing cost of providing health benefits coverage throughout the Nation, we must be mindful of the effects of any changes on the cost of coverage for Federal employees, retirees, and their families. Under the leadership of Director James, and through a combination of tough negotiating and careful scrutiny, we have managed to restrain the cost increases for our program in recent years below the level for the economy generally. We would not want to do anything that would not reflect the same level of due diligence and careful concern.

With regard to your bill, H.R. 3751 would of course require OPM to study and present recommendations under which dental and vision benefits could be made available to Federal employees and retirees and other appropriate classes of individuals. Regrettably,

since the bill was introduced so recently, the administration has not yet developed a position. Therefore, I am not able to express a view on it at this time. I can say, however, that even where there is no objection to conducting a study or review, traditionally the administration has objected to any statutory requirement to make recommendations.

I will, of course, be happy to discuss the extent of dental and vision coverage under the current FEHB Program. At Director James' request, we have been gathering information on dental and vision care programs so we can be aware of the practices of other employers and cognizant of industry trends. I also would be happy to offer any information I have about how such programs are structured and administered by the industry for other purchasers. I would be pleased to answer any questions you might have in that regard.

[The prepared statement of Ms. Block follows:]

STATEMENT OF ABBY L. BLOCK
DEPUTY ASSOCIATE DIRECTOR
FOR EMPLOYEE & FAMILY SUPPORT POLICY
OFFICE OF PERSONNEL MANAGEMENT

at a hearing of the

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

on

H.R. 3751 AND DENTAL AND VISION BENEFITS
IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEBRUARY 24, 2004

MADAM CHAIRMAN AND THE MEMBERS OF THE SUBCOMMITTEE:

I AM PLEASED TO APPEAR BEFORE YOU TODAY ON BEHALF OF DIRECTOR KAY COLES JAMES TO DISCUSS THE VIEWS OF THE OFFICE OF PERSONNEL MANAGEMENT (OPM) ON DENTAL AND VISION BENEFITS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM.

DIRECTOR JAMES HAS ALWAYS EXPRESSED A WILLINGNESS TO REVIEW THE POLICIES AND PROGRAMS AFFECTING THE PAY AND BENEFITS OF FEDERAL EMPLOYEES IN ORDER TO ENSURE THEIR EFFECTIVENESS FOR EMPLOYEES, THE GOVERNMENT, AND THE TAXPAYER. AS YOU KNOW, THIS YEAR, FOR THE FIRST TIME, WE MADE FLEXIBLE SPENDING ACCOUNTS AVAILABLE TO FEDERAL EMPLOYEES. PRE-TAX DOLLARS DEPOSITED

INTO THOSE ACCOUNTS CAN BE USED TO COVER THE COST OF DEDUCTIBLES AND COPAYMENTS AND OTHER HEALTH CARE COSTS THAT ARE NOT COVERED BY FEHB PLANS AND ALSO TO PAY ELIGIBLE DEPENDENT CARE COSTS. DIRECTOR JAMES IS FIRMLY COMMITTED TO THE ONGOING REVIEW OF ALL THE BENEFITS OFFERED UNDER THE FEHB PROGRAM.

OF COURSE, GIVEN THE EVER INCREASING COST OF PROVIDING HEALTH BENEFITS COVERAGE THROUGHOUT THE NATION, WE MUST BE MINDFUL OF THE EFFECTS OF ANY CHANGES ON THE COST OF COVERAGE FOR FEDERAL EMPLOYEES, RETIREES, AND THEIR FAMILIES. UNDER THE LEADERSHIP OF DIRECTOR JAMES, AND THROUGH A COMBINATION OF TOUGH NEGOTIATING AND CAREFUL SCRUTINY, WE HAVE MANAGED TO RESTRAIN THE COST INCREASES FOR OUR PROGRAM IN RECENT YEARS BELOW THE LEVEL FOR THE ECONOMY GENERALLY. WE WOULD NOT WANT TO DO ANYTHING THAT WOULD NOT REFLECT THE SAME LEVEL OF DUE DILIGENCE AND CAREFUL CONCERN.

WITH REGARD TO YOUR BILL, H.R. 3751, IT WOULD, OF COURSE, REQUIRE OPM TO STUDY AND PRESENT RECOMMENDATIONS UNDER WHICH DENTAL AND VISION BENEFITS COULD BE MADE AVAILABLE TO FEDERAL EMPLOYEES AND RETIREES AND OTHER APPROPRIATE CLASSES OF INDIVIDUALS. REGRETTABLY, SINCE THE BILL WAS INTRODUCED SO

RECENTLY, THE ADMINISTRATION HAS NOT YET DEVELOPED A POSITION. THEREFORE, I AM NOT ABLE TO EXPRESS A VIEW ON IT AT THIS TIME. I CAN SAY, HOWEVER, THAT EVEN WHERE THERE IS NO OBJECTION TO CONDUCTING A STUDY OR REVIEW, TRADITIONALLY THE ADMINISTRATION HAS OBJECTED TO ANY STATUTORY REQUIREMENT TO MAKE RECOMMENDATIONS.

I WILL, OF COURSE, BE HAPPY TO DISCUSS THE EXTENT OF DENTAL AND VISION COVERAGE UNDER THE CURRENT FEHB PROGRAM. AT DIRECTOR JAMES' REQUEST, WE HAVE BEEN GATHERING INFORMATION ON DENTAL AND VISION CARE PROGRAMS SO WE CAN BE AWARE OF THE PRACTICES OF OTHER EMPLOYERS AND COGNIZANT OF INDUSTRY TRENDS. I ALSO WOULD BE HAPPY TO OFFER ANY INFORMATION I HAVE ABOUT HOW SUCH PROGRAMS ARE STRUCTURED AND ADMINISTERED BY THE INDUSTRY FOR OTHER PURCHASERS.

I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU MIGHT HAVE IN THAT REGARD.

Mrs. DAVIS OF VIRGINIA. Thank you, Ms. Block.

Mr. Wristen, you will be recognized for 5 minutes.

Mr. WRISTEN. Thank you, Chairwoman Davis, and members of the committee.

I am Ed Wristen, president and CEO of First Health. First Health is a premier national health benefits services company and provides integrated managed care solutions serving the group health, workers compensation, State agency and Federal Government markets.

First Health has been a provider of managed care services in FEHBP since 1985. Since July 2002, First Health has served as the plan administrator, underwriter, managed care service provider and PBM, fully integrating all those functions for the second largest plan in the program, Mail Handlers Benefit Plan. We appreciate this opportunity to present testimony on H.R. 3751.

As a company that strives to remain at the cutting edge in providing quality health care options, we believe we can offer valuable perspective and assistance in this matter.

What are the current options for dental and vision benefits? We would like to emphasize that Federal employees currently have dental and vision benefits available to them for many plans participating in FEHBP. Currently, there are 12 fee for service plans, 6 open to all Federal employees and 6 closed plans limited to employees of specific agencies. Approximately 70 percent of all FEHBP members are in these 12 plans. Five of those six open fee for service plans and three of the six closed fee for service plans have dental benefits included in their FEHBP offerings. The remaining 30 percent of FEHBP enrollees are in some 210 comprehensive, or HMO plans, some of which offer dental coverage in the FEHBP benefit packages.

In addition, five open fee for service plans with dental also offer supplemental dental plans to their members at 100 percent member cost that augment FEHBP offerings, and three offer supplemental vision plans.

Finally, four of the six closed plans offer supplemental dental and vision, and in addition many of the HMOs in FEHBP offer supplemental dental or vision benefits.

The benefit issue OPM is to study is not one characterized by lack of availability. Numerous options already exist for Federal employees to obtain dental and vision benefits. The issue that merits attention is how the delivery of these benefits can best be enhanced while maintaining a strong and viable FEHBP.

How can the existing structure be enhanced? Obviously, what would be most attractive to Federal employees is the enhancement of dental benefits and the addition of vision benefits to current FEHBP offerings. If this were done, the Federal Government would shoulder most of the increased cost. However, budgetary constraints impacting FEHBP since the early 1980's have served to limit virtually any benefit increases, especially those for dental or vision benefits. We do not see these constraints changing substantially in the current environment, although some relaxation of this situation would be warranted and welcome.

What OPM has done to address budgetary constraints is arguably a reasonable approach: They have allocated scarce government

contribution dollars to preserve medical benefits rather than permitting benefit increases for dental benefits or the addition of vision benefits existing in FEHBP plans since 1987. Thus the dental benefit offerings with FEHBP have been in effect at 1987 levels. This has led to the state of affairs where they are considered inadequate by 2004 standards.

What about supplemental plans? Many of the FEHBP plans offer various supplemental dental plans to compensate for the FEHBP dental coverage occasioned by the freeze. This has been done with OPM's knowledge, encouragement, and assistance. OPM allows FEHBP carriers to use their official plan brochure to announce the availability of non-FEHBP offerings, such as dental and vision supplements, and permits FEHBP to discuss the offerings at health fairs. These dental and vision supplemental offerings have become part of these FEHBP plans' total offerings to Federal employees.

Why is the government carve-out for dental and vision not a solution? Introducing a new carved-out dental or vision benefit plan will upset the current competitive balance in FEHBP which has served the government and Federal employees since inception in 1960, and it will do so without any discernible benefit as these benefits are already available. There is no magic bullet of cost savings or quality of benefit gains. Instead, doing so by creating an additional subcontracting system would add cost and complexity where there already exists a system and experienced carriers providing dental and vision benefits. The existing system can handle any enhancements that Congress or OPM desire to see made in dental or vision benefits. And with minor adjustments, they are currently offering benefits to the broad health care needs of Federal employees.

Why is the long-term care program not a model? The issue at the heart of this bill doesn't require a new contracting system like created for long-term care. That offering was an entirely new benefits program. Dental and vision have been an integral part of FEHBP for years. We already have the infrastructure in FEHBP, and using the current FEHBP and its carriers will preserve the competitive environment. The system of balanced competition is a model for private sector and Medicare reform. It shouldn't be tampered with. Any new resources by the Congress or OPM should be used to enhance the existing program.

Chairwoman Davis and members of the committee, thank you again for this opportunity to share our views. I hope that my testimony helps clarify some of the issues associated with the delivery of dental and vision benefits, and would welcome the opportunity to further work with you and your committee as you examine those issues.

[The prepared statement of Mr. Wristen follows:]

Statement of

Edward L. Wristen, President and CEO
First Health Group Corp.

on

Dental and Vision Benefits
For Federal Employees

HOUSE GOVERNMENT REFORM COMMITTEE

SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION

Tuesday, February 24, 2004

Chairwoman and Members of the Committee, I am Edward L. Wristen, President and Chief Executive Officer of the First Health Group Corp. ("First Health"). First Health is the premier national health benefit services company. We specialize in providing large payors with integrated managed care solutions. First Health serves the group health, workers' compensation, state agency, and Federal Government markets. First Health, and its predecessor company, has been a provider of managed care – both broad-ranging, integrated medical management and Preferred Provider Organization ("PPO") – services in the Federal Employees' Health Benefits Program ("FEHBP" or "Program") since 1985, serving as a subcontractor to various employee organization carriers participating in the Program. In addition, since July, 2002, First Health has served as the plan administrator, underwriter, managed care service provider, and pharmacy benefit manager, fully integrating all those functions, for the second largest plan in the Program, the Mail Handlers Benefit Plan ("MHBP") sponsored by the National Postal Mail Handlers Union, a Division of the Laborers' International Union of North America, AFL-CIO.

First Health appreciates this opportunity to present testimony on H.R. 3751 to require that the Office of Personnel Management study and present options under which dental and vision benefits could be made available to Federal employees and retirees and other appropriate classes of individuals. As a company that strives to remain at the cutting edge in providing quality health care options, world-class customer service, and consumer choice – and as one now with 20 years' participation in the Federal employees' health care arena – we believe we can offer valuable perspective and assistance in this effort.

First of all, First Health would like to emphasize, as we are sure others will, that Federal employees and annuitants, and their dependents, currently have both dental and vision benefits available to them from many of the health plans participating in the FEHBP. Currently, there are 12 fee-for-service plans in the FEHBP, six of whom are open to all Federal employees and annuitants, and six of whom are "closed" plans whose enrollment is limited to employees of

specific agencies. Approximately 70 percent of all FEHBP members are in those 12 plans. Five of the six open fee-for-service plans have dental benefits included in their FEHBP offerings, and three of the six closed plans have dental benefits included in their FEHBP offerings. The remaining 30 percent of FEHBP members are enrolled in some 210 comprehensive, or HMO, plans that are available in their respective service areas. Many of those HMO's offer dental coverage in their FEHBP benefit packages.

In addition, those five open fee-for-service plans offer supplemental dental benefit plans to their members (at 100 percent member cost) that augment their FEHBP dental offerings,[1] and three of them also offer supplemental vision plans. Four of the six closed fee-for-service plans offer both supplemental dental and vision benefits to their members. In addition, many of the HMOs in the FEHBP offer supplemental dental and/or vision benefits plans to their members.

Thus, as you can readily see, the benefits issue OPM is to study pursuant to this bill is not one characterized by lack of availability. There already exist numerous options and choices for Federal employees and annuitants and their dependents to obtain dental and vision benefits both within and outside the FEHBP. The issue that merits attention here is how the delivery of these benefits can best be enhanced in tandem with maintaining a strong and viable FEHBP.

Obviously, what would be the most attractive to Federal employees and annuitants is the enhancement of dental benefits within, and the addition of vision benefits to, their FEHBP plan offerings without the requirement of any offsetting reductions in the other medical benefits in their FEHBP plans. If this were done, the Federal Government as employer

[1] The Government Employees Hospital Association ("GEHA") supplemental dental and vision plans are available to all Federal employees and annuitants (and their dependents), not just to members of the GEHA FEHBP health plan. For 2005, the supplemental dental and vision plans offered by the MHBP and First Health will be available to all Federal employees and annuitants (and their dependents).

would shoulder most of the increased costs under the current FEHBP financing arrangement.[2] However, there have been budgetary constraints impacting the FEHBP since at least the early 1980's that have served to limit virtually any benefit increases in FEHBP plans, and especially those for dental or vision benefits. First Health does not see these constraints changing substantially in the current economic environment, although some relaxation of this situation would be both warranted and welcome.

What OPM has done to address these budgetary constraints is arguably a reasonable approach: OPM has allocated scarce Government contribution dollars to financing the preservation of medical benefits to the detriment of permitting any dental benefit increases in existing FEHBP plans since 1987, or adding any vision care benefits. Thus, the dental benefit offerings within FEHBP plans, most of which are based on scheduled-allowances for given procedures, have in effect been frozen at 1987 levels. This has led to the state of affairs today where FEHBP plan dental benefits are considered inadequate by 2004 standards.

To address this situation, many of the FEHBP plan carriers have offered various supplemental dental plans to try and compensate for the insufficiency of their FEHBP plan dental coverage occasioned by this "freeze". This has been done with OPM's knowledge and encouragement and, to some extent, with OPM assistance. This assistance has been in the form of OPM's allowing FEHBP carriers to use a page in their official FEHBP plan brochure to announce the availability of non-FEHBP benefit offerings, such as dental and vision supplements, and in permitting FEHBP plans to discuss these supplemental benefit offerings at Government-sponsored health fairs and in other promotional activities allowed during the annual FEHBP Open Season.

These dental and vision supplemental benefit offerings have thus become part and parcel of these FEHBP plans' total offerings to Federal employees and annuitants. Medical and

[2] The addition of any such benefits to the FEHBP plans approved by OPM would raise the weighted average cost of all plans and thus the required Government contribution under 5 U.S.C. § 8906(b).

the OPM-permitted dental benefit levels are provided as the "official" FEHBP offering that is financed in large part by a Government contribution toward the cost, while supplemental dental and vision benefits are offered by the FEHBP plans to fill-in the "gaps," with 100 percent of the cost being shouldered by the Federal employees and annuitants who select them. Together, these two elements form integrated benefits packages offered in the competitive environment in which the FEHBP plans operate.

Introducing new, carved-out, dental or vision benefit plans into this mix as some advocate will serve only to upset that competitive balance in the FEHBP, which has served the Government and Federal employees and annuitants well since its inception in 1960, and it will do so without any discernible benefit to the Government and Federal employees and annuitants. There is no magic bullet of cost savings or quality-of-benefit gains in separating these types of benefits from those being offered already by the FEHBP and its carriers. Instead, doing so will serve to create an additional contracting system with which OPM will have to deal that will add cost and complexity where there already exists a contracting system and experienced carriers providing dental and vision care benefits to Federal employees and annuitants. The existing FEHBP carriers and the FEHBP contracting system in place have the capability to handle any enhancements that Congress or OPM desire to see made in dental or vision benefits for Federal employees and annuitants, and they can do so with minor adjustments to what they are already doing to serve the broad health care needs of Federal employees and annuitants.

Thus, the issue at the heart of this bill does not call for a new contracting system or program like that created for the offering of Long-Term Care Insurance to Federal employees and annuitants. That offering was a new benefits program, unlike dental and vision care benefits, which have been an integral part of the FEHBP carriers' total offerings to Federal employees for many years. The Long-Term Care program needed an infrastructure in which to operate. The FEHBP and its carriers already provide that infrastructure for any enhancements that need to be

made to dental or vision benefits for Federal employees and annuitants. Utilizing the FEHBP system and its carriers to do so will preserve the relative competitive environment among the plans in the FEHBP system that has served the Government and Federal employees and annuitants so well.

The FEHBP system of balanced competition and choice is one that has become a model for both private sector health insurance and Medicare reform. It is not one that should be tampered with by having its plans' integrated benefit offerings – those in their "official" FEHBP plans and those in their supplemental dental and/or vision offerings – broken apart, stripped away, and parceled out to a new and unnecessary contracting program. Any new resources that can be brought to bear, by Congress or OPM, in the form of financial assistance to enhance dental or vision benefits for Federal employees and annuitants, or in the form of marketing assistance in promoting any desired changes in those benefits, should be channeled to the existing FEHBP program and carriers rather than devoted to establishing a duplicative infrastructure for a new, unproven, and unnecessary Government contracting program. The Government and Federal employees and annuitants will receive far more "bang for their buck" from the investment of scarce resources in a proven entity than in an unproven hope.

First Health thanks the Committee for the opportunity to make these comments.

True to life.®

Edward L. Wristen
President and Chief Executive Officer

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March 15, 2004

The Honorable Jo Ann Davis
House Subcommittee on Civil Service and Agency Organization
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairwoman Davis and Members of the Subcommittee:

I am writing this letter to follow up on several questions and comments made during the February 24 Subcommittee on Civil Service and Agency Organization hearing on H.R. 3751 relating to dental and vision benefits for federal employees. The committee has asked us to explain why a stand-alone, separately contracted dental benefit would not be in the best interest of federal employees, from both a cost and quality perspective. In addition to addressing this question, I wish to add important clarifications and point out omissions in the testimony presented by other witnesses in regard to the scope of dental benefits currently available within the Federal Employees' Health Benefits Program ("FEHBP") and in the supplemental dental benefit plans offered by many of these plans.

What Do Federal Employees Want?

During the hearing a question was directed to the OPM witness as to whether they had focus-group data on what Federal employees desired in the way of dental benefits. OPM responded that they did not possess this type of information; however, the Mail Handlers Benefit Plan ("MHBP"), which is administered by First Health, has collected this data. Although the information is somewhat dated, in light of the restriction on increased dental benefit offerings within FEHBP since 1987, our data indicates that while Federal employees indeed do want greater dental benefits, they want them within their FEHBP plans where the Government as the employer pays approximately 70% of the cost. There is no great clamor by Federal employees for dental benefits where they have to pay 100% of the premium. In fact, as First Health indicated in our testimony, there currently exist ample opportunities for Federal

employees to obtain an adequate level of dental or vision benefits if they are willing to purchase the supplemental plans offered by many of the existing FEHBP carriers at 100% cost to them.

Put another way, there is no void that needs to be filled by a new, stand-alone dental or vision plan and a new government-contracting infrastructure.

The Cost of Dental Benefits in FEHBP

Members of the subcommittee inquired as to the cost of dental benefits currently offered in the FEHBP (which are generally agreed to be inadequate because they have been frozen at 1987 levels). In addition, the Subcommittee inquired as to what level of increase would be necessary to raise FEHBP dental benefit levels to acceptable, present-day levels. It is difficult to address this question with absolute precision because the current FEHBP plans offer varying levels of dental benefits now – some with comprehensive offerings in the sense that they cover most dental procedures but at somewhat meager benefit payments in 2004 terms. Speaking from our own experience, the MHBP—the second largest plan in the FEHBP—offers a comprehensive scheduled dental benefit in its High Option. The cost of that dental benefit currently is approximately 2% of the MHBP High Option premium, and that benefit now covers approximately 25% of the cost of submitted dental charges. To raise that benefit to a point where the schedule would cover approximately 75% of the cost of submitted dental charges would entail a tripling of the premium cost associated with the dental benefit – or an increase equal to 4% of the premium, for a total cost of 6% of the MHBP High Option premium attributable to the dental benefits. In fact, the first year cost most likely would be greater because of the pent-up demand factor. Enrollees could be expected to utilize dental benefits at an increased rate because of the greatly increased benefit payment.[1]

While First Health and the MHBP can readily agree that Federal employees need and deserve increased dental and vision benefits, and that they deserve those increases without having to sacrifice the level of medical benefits coverage in their health plans, we are not confident that in these economic times the additional funds to achieve this are going to be committed. Thus, if Federal employees are going to enjoy any increased dental or vision benefits, they are most likely going to come only through a program where all, or most, of the

[1] For FEHBP plans that did not have a dental benefit as comprehensive as that of the MHBP High Option to begin with, their increased cost could be expected to be in the range of the full 6% increase in their premium cost with an additional first year pent-up demand increase as well, assuming that their enrollment base utilized dental benefits at approximately the same rate as do the members of the MHBP High Option. If vision benefits were added to FEHBP plans, the increased cost of the plans would obviously rise an additional modest amount.

increased premium cost is going to be borne by the Federal employee. As described in our written testimony, these needs are being addressed now by the supplemental dental and vision benefit plans offered by many of the FEHBP carriers.[2]

Preserving the Competitive Balance in the FEHBP

The integrated benefits offered within official FEHBP plans and the unofficial supplemental dental and vision benefits are at the foundation of the competitive balance in the FEHBP. Plans use these total/integrated benefit offerings to compete for members during the FEHBP Open Season and OPM provides limited assistance in this regard by: (1) allowing carriers to advertise the availability of these supplemental offerings in a special page in their official FEHBP brochure; and (2) allowing the FEHBP carriers to discuss those supplemental offerings at official Open Season agency functions and in carrier promotional materials. Any carved-out, stand alone dental or vision benefit plan that is introduced into this mix will serve only to do damage to the FEHBP competitive model that has worked so well and has become the envy of the private sector and a template for Medicare reform. Moreover, it will do harm to the existing FEHBP program with no measurable gain for Federal employees or the Government.

There is No Added Value To a Stand-Alone Dental or Vision Benefit

The value of a stand-alone dental or vision benefit plan for Federal employees over the current structure in which these benefits are delivered is non-existent, and the cost of utilizing a stand-alone model will be greater than if benefits enhancement were addressed within the confines of the existing FEHBP environment for the following reasons:

[2] The CompBenefits Corporation reported to the Subcommittee that their evaluation of 150 FEHBP plans (looking at their FEHBP offerings) found that only one of them provided preventative dental care for children and that the majority of plans did not cover preventative care (exams and cleanings) at all. We do not know which 150 FEHBP plans CompBenefits evaluated, but, as the First Health testimony revealed, five of the six FEHBP fee-for service plans open to all Federal employees offered dental coverage and three of the six closed FEHBP fee for service plans offered dental coverage and all of them provide preventative dental care benefits for children as well as adults. Over 70% of all FEHBP enrollees are in those fee-for service plans. In addition, OPM has informed First Health that some 65 out of 210 comprehensive plans (HMOs) in the FEHBP also offer dental benefits as part of their FEHBP offerings and that virtually all of them cover preventative services for adults and children. First Health and the MHBP do not dispute that dental benefits within the FEHBP official offerings are inadequate by 2004 standards, but that is attributable to the OPM freeze, not the inadequacy of the FEHBP plans or carriers to address the issue. The FEHBP carriers with the overwhelming majority of FEHBP enrollees have, in fact, addressed that issue by their offering of supplemental dental and vision plans (which have to be offered at 100% employee cost) and making them part of their integrated, official FEHBP and non-official supplemental, offerings and competing for Federal employee subscribers on

(1) No greater savings, less coordinated care: Although the subcommittee heard testimony that the "reimbursement rate" would be superior under a stand-alone arrangement, based on our experience in this market for nearly 20 years, we do not think this is the case. Whether a dental or vision benefit structure is offered as part of an existing FEHBP plan, as part of a supplemental plan offered by a FEHBP carrier, or by a separate stand-alone carrier is of no consequence. The same benefit level/reimbursement rate can be offered in each of these settings. In addition, to the extent that the discovery of dental disease can be an indicator of perhaps a more serious medical problem – such as the emerging relationship of periodontal disease to cardiac conditions – having the patient care bifurcated in two separate health plans with two separate carriers may well impede discovery of a problem and the delivery of appropriate, quality care to that individual. This is much less likely to happen if the dental and medial care is provided within the confines of the same benefit plan or one being administered by the same carrier.

(2) Purchasing power subject to local markets: The assertion that greater value can be obtained by amalgamating the specter of the Government's purchasing power in the hands of a single vendor so that superior discounts from dental or vision providers can be obtained does not withstand scrutiny. While the Government may be the largest single employer in the Nation, its employees are scattered throughout the country, although many are concentrated in and around the Washington, DC, area. The largest dental PPO providers are highly unlikely to gain materially greater economic leverage with local providers even if they had Federal employees accreted to their existing business. The discounts that they receive currently from the dental and vision providers who are in PPO networks are based on their total books of business. The addition of Federal employees, particularly if the dental plan offered is at 100% employee cost, is highly unlikely to attract sufficient additional plan members to increase the PPO's leverage in a given local market, and almost certainly will not increase that leverage to the extent that it will make a significant impact on the cost of a regional or national dental or vision benefit plan.

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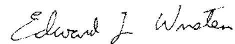
that basis. (We note again that the GEHA dental and vision supplemental plans are open to all Federal employees, not just those enrolled in the GEHA health plan. In 2005 the same will hold for the MHBP dental and vision supplemental plans).

(3) Increased government costs: Finally, the addition of a new Government contracting program and new stand-alone plans is virtually certain to entail an element of increased complexity and administrative cost over utilizing the existing successful FEHBP infrastructure. On top of this cost will also be the cost the new plans must incur to establish and operate new eligibility and claims payment systems. This is unnecessary. The existing FEHBP contracting infrastructure and claims systems are sufficiently scalable and already exist to do that job in the most cost effective manner.

In conclusion, if there is a desire to offer enhanced dental or vision benefits that are deemed acceptable by government policy makers, that objective can be addressed within the confines of the exiting FEHBP. OPM can establish minimum standards that an FEHBP supplemental plan would have to meet to receive a "government certification." To the extent that an FEHB carrier meets this test, additional resources could be made available to that carrier to promote those dental or vision care offerings, or the carrier could be granted government assistance in gaining marketing access to Federal employees and annuitants. Such a system would foster the same type of managed competition model for acceptable dental or vision supplemental plans that gives Federal employees a choice in their health care coverage decisions and has made the FEHBP the success and envy that it is.

First Health thanks the Chairwoman and the Members of the Subcommittee for the opportunity to present these additional views on this important issue. If we may be of further assistance to you or your staff, please feel free to call upon us.

Yours truly,



Edward L. Wristen
President & Chief Executive Officer

cc: Members of the House Civil Service and Agency Reorganization Subcommittee

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Wristen.

I would now like to recognize Dr. Stan Shapiro. Thank you for being with us today, and you may proceed with your statement. You are recognized for 5 minutes.

Dr. SHAPIRO. Chairwoman Davis and members of the subcommittee, my name is Dr. Stanley Shapiro, and for more than 33 years I have been privileged to provide dental benefits, both as a practicing dentist as well as an executive officer of one of America's leading dental benefits companies. I am grateful for this opportunity to speak with you today in support of H.R. 3751, which may potentially lead to expanding Federal employee health care benefits to include voluntary dental and vision plans.

Our Nation has made great strides in educating Americans about the importance of oral health, and there is a growing recognition that oral health is integral to general health. New products, therapies, and technologies have enabled people to retain their natural teeth throughout their lives, thereby enhancing their health and well-being. Today, the percentage of Americans who receive dental care is higher than ever before, and I believe this has occurred as a result of third party funding through government programs for the underserved and private dental coverage offered in the workplace. Statistics indicate that 54 percent of all Americans currently have dental coverage, yet throughout my career I have witnessed the role that cost has played as a barrier to accessing dental care. This is unfortunate since it is well established that dental disease is preventable, and children who receive routine preventive care have the opportunity to live their lives free from dental cares and periodontal disease. Oral Health in America, a report of the Surgeon General in the year 2000, stated that children from families without dental insurance are three times more likely to have dental needs than children who come from families with dental insurance.

The FEHBP is a successful model for demonstrating the purchasing leverage of the Federal Government and the ability to provide choice among the types of plans offered. But while some of these medical plans include dental and vision benefits, they are difficult to evaluate and typically provide very low levels of coverage when compared to the wide array of plans that are readily available in both the public and private sectors.

To demonstrate this point, we have evaluated 150 FEHBP medical plans to define the levels of dental benefits coverage. Out of 150 plans, only 1 provided preventive dental care for children. Out of 150 plans, only 14 offered orthodontic coverage. Furthermore, reimbursement levels and annual maximum benefits were limited. Similar results occur for vision benefits, creating a confusing basis for FEHBP participants to evaluate the cost of high option medical plans against the actual benefits received. All too often there are failed expectations, and the perception is that dental and vision benefits offered by FEHBP are inadequate and disappointing. This is exacerbated by the escalating costs and structural changes in health plans that Federal employees encounter when selecting the appropriate medical coverage for their families. The FEHBP acknowledges the low dental benefits levels and communicates this fact on its Web site to Federal employees. It responds to a fre-

quently asked question, by stating, "Everyone wants to keep premium increases as low as possible, so generally, to increase benefits plans make tradeoffs. We would not want to sacrifice medical benefits to get dental or vision benefits."

In contrast, employees of 48 State governments have voluntary dental benefits, and 44 of those are stand-alone plans that offer benefits which are superior to those included in the FEHBP medical plans. In my home State of Florida, for instance, State employees may select from eight different stand-alone dental plans, and more than 50 percent of employees currently participate in one of the plans. For the past 3 years, and despite rising medical costs, enrollment in the voluntary dental plans in Florida has increased as a percentage of the work force from 49 percent in 2001 to 55 percent in 2003. The same trends hold true for the voluntary vision plan. In the private sector, dental plans are both varied and affordable. Of the three most popular plan types that include orthodontic coverage, the average monthly premium for an employee is $14.10 for a dental HMO, $22.07 a month for a dental PPO, and $28.20 for a full indemnity plan. An employee can cover his or her spouse and children through a dental HMO for an average monthly premium of only $36.35. Once enrolled in the plan, there are typically no deductibles or annual maximums, no charges for preventive care, minimal direct cost for restorative care, savings of up to 50 percent on major services, and reductions of 25 to 50 percent in the cost of orthodontic treatment. It is no surprise that employees appreciate this purchasing leverage and utilize dental plans to facilitate their access to care.

Employers have learned that dental benefits are an important component of employee benefit programs. Surveys indicate that 95 percent of employers with 500 or more employees provide dental benefits as well as 48 of the 50 State governments and thousands of county, city, and municipal government and school districts.

In the competition for quality employees, voluntary dental and vision benefits fulfill employee expectations and create a competitive advantage for any employer. With the largest work force in America, the Federal Government can establish without cost a more comprehensive ancillary benefits program that will enhance the oral and general health of Federal employees and be perceived with value by all participants.

To that end, I urge you to support H.R. 3751. Thank you very much.

[The prepared statement of Dr. Shapiro follows:]

Resources on Optional Dental/Vision Benefits for Federal Employees

A Report to the Subcommittee on Civil Service and Reform
U.S. House of Representatives Committee on Government Reform
February 24, 2004

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Resources on Optional Dental/Vision Benefits for Federal Employees

A Report to the Subcommittee on Civil Service and Reform
U.S. House of Representatives Committee on Government Reform

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- Survey of Current Vision Coverage for Federal Employees

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- Testimony of Stanley Shapiro, D.D.S., Vice Chairman, CompBenefits Corporation to the Subcommittee on Civil Service and Reform, United States House of Representatives Committee on Government Reform (February 24, 2004)

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An Introduction to Optional Dental/Vision Benefits for Federal Employees

The Federal Government manages health benefit programs for the largest single employee base in the United States, covering more than 9 million individuals. Great strides have been taken to ensure that basic health benefits are comparable to those offered anywhere. However, ancillary benefits such as dental care and vision care have not received the same attention.

EMPLOYEE BENEFITS

Optional benefit programs, selected and paid for by the employee:

- Provide an opportunity for the employee to reduce total out-of-pocket costs related to dental and vision expenses
- Have the ability to select benefits most appropriate to their needs
- Obtain more comprehensive coverage
- Improve their general health and sense of well-being

EMPLOYER BENEFITS

The employer, the Federal Government, shares in the positive results from such a program because proper oral and vision health contributes to:

- Increased productivity and on-the-job efficiency
- Reduction in lost time from dental or optical disease
- Better employee satisfaction

Dental and vision benefits are the most requested health benefits after regular health insurance. The majority of federal health benefit plans offer no dental or vision coverage or only very limited coverage as an added inducement. It is impossible for the employee to determine the true value of any ancillary benefit because the cost is imbedded in the health premium.

The purchasing power of the federal government, coupled with market-driven competition, should be leveraged to allow more comprehensive optional benefits to be offered than are presently available and at a much more economical cost to the employee. Allowing an employee-paid optional dental/vision benefit provides the opportunity to select coverage best suited to the needs of a particular employee and/or family.

The following pages illustrate the savings that will be realized by an employee taking advantage of the proposed sample dental and vision benefit.

Dental Care Benefit & Cost Comparison

Studies indicate that oral health is a critical component of general health and should be included as an integral part of any well-designed employee benefit program. A review of the current plans offered shows that only minimal dental coverage, if any, is provided through the FEHB health plans.

The following is an example that illustrates typical employee savings over the course of a year if enrolled in a proposed competitive dental benefits plan (based on charges in the Washington, DC area).

Dental Cost Savings Example:

Procedure	Retail Charge	Current FEHB Plan Covers	Proposed Sample Plan Covers
Oral exam	$ 45	$ 25	$ 45
Bitewing x-rays (set of 2)	$ 46	$ 27	$ 46
Dental Cleaning	$ 88	$ 53	$ 88
Tooth-colored composite filling (2 surface, anterior)	$190	$ 116	$ 150
Crown (porcelain / base metal)	$1,169	$ 254	$ 889
Simple extraction	$160	$ 98	$160
Orthodontics (Braces)-Children	$ 5794	$ 0*	$ 3709
TOTAL	$ 7492	$ 573	$ 5087

**Most FEHB plans do not cover orthodontics, however a few cover 25% of the dentists usual fees.*

In this example, total retail charges are $7492. A participant in a current FEHB dental plan will be covered for $573 or 8% of the total retail charge. A participant in the proposed sample dental plan will be covered for $5087 or 68% of the total retail charge.

Vision Care Benefit & Cost Comparison

Professional eye care should be an integral part of every employee health program. Recent estimates indicate that 67% of U.S. workers wear prescription lenses. Early detection and correction of basic vision problems can increase workers' productivity, which will have a significant impact on operational efficiency. A vision care plan fills the coverage gap left by many health insurance plans that exclude eye exams and corrective lenses and frames.

The focus of a vision care plan is to provide:

- high quality care
- savings and value to enrollees
- cost containment
- responsive service

Here is an example that illustrates typical employee savings over the course of a year if enrolled in a stand-alone vision care plan (based on charges in the Washington DC area).

Vision Cost Savings Example:

Procedures	Retail Charge	Current FEHB Plan Covers	Proposed Sample Plan Covers
Eye exam	$ 85	$ 85	$ 75
Frame (fashion style)	$ 120	$ 0	$ 105
Lenses	$ 75	$ 0	$ 75
Option (tint)	$ 15	$ 0	$ 15
Scratch-resistant coating	$ 18	$ 0	$ 2
TOTAL	$ 313	$ 85	$ 272

In this example, total retail charges are $313. A participant in a current FEHB vision plan will be covered for $85 or 27% of total retail charges. A participant in the proposed vision plan will be covered for $272 or 87% of total retail charges.

Optional Dental Benefit for Federal Employees

Benefit Assessment

Benefits for Federal employees and their dependents comprise a major cost center in the Federal budget. The benefit programs offered through the Office of Personnel Management (OPM) cover more than nine million persons.

Dental hygiene and oral health have come increasingly more into view as concerns for the general health and well being of individuals. Unfortunately, more than one-third of the U.S. population (more than 108 million adults) has no dental insurance or dental coverage. According to the Surgeon General of the United States insurance coverage for dental care is increasing, but still lags behind medical insurance. For every child less than 18 years of age without medical insurance there are at least two children without dental insurance. For every adult 18 years of age or older without medical insurance there are three adults without dental insurance. Data cited in the report indicates that lack of dental insurance, private or public, is one of several impediments to obtaining optimal oral health care.

Employed adults are reported to lose more than 164 million hours of work each year due to dental disease or dental visits. Studies indicate that oral health is a critical component of general health and must be included in health care in the design of benefit programs. The Surgeon General's report indicates that new research points to association between chronic oral infection and heart and lung disease, stroke, low birth weight, premature birth and diabetes. That information has been confirmed by studies done and reported by the American Dental Association.

Other indicators pointing to the benefit of regular oral health checkups show that the mouth reflects what is happening inside the body. The mouth may show signs of nutritional deficiencies and serve as an early warning system for diseases such as HIV infection and other immune system problems. The mouth can also show signs of general infection and stress related problems. The Surgeon General's report says that oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the food we choose, our appearance, and how we communicate. These diseases can affect economic productivity and compromise our ability to work. These oral diseases are more preventable, with proper care, than are other types of health problems.

The current stated policy of OPM is to provide health insurance as the primary benefit for federal employees. Dental insurance is provided as "add-on" benefits, and employees are not given the option of selecting better coverage, even on an employee-paid basis.

A survey of the benefit programs offered through OPM indicates a wide range of programs. The majority of health care providers offer no dental benefit. Those that do

offer dental benefits have no consistent pattern in the level or type of coverage. *(see "Survey of Dental Coverage" chart)*

An analysis of specific plans shows that only minimal coverage is provided through any of the health plans. *(See "Sample Plan Cost Comparison")* The out-of-pocket cost varies widely from plan to plan. The vast majority of the plans do not cover preventive care (exams and cleanings) specifically for children, and sixty-five percent of the plans do not offer preventive care for adults.

Environmental Assessment

Dental insurance can be viewed as a reflection of the medical industry. While affecting less coverage dollars than medical, dental costs have exhibited a similar and steady increase in claims cost.

As costs began to escalate in the late 1980's and early 1990's, employers began scrambling to find more efficient programs to offer employees without compromising benefits. The dental industry swiftly evolved to match the benefits spectrum offered by health insurers.

There are currently three reimbursement models dominating the marketplace: traditional fee-for-service (Indemnity), discounted fee-for-service (PPO – Preferred Provider Organization) and prepaid (DHMO – Dental Health Maintenance Organization). A fourth type of plan that is showing promising results is the dental referral plan, which is also referred to as a discount plan or a reduced fee-for-service plan.

Indemnity plans or fee-for-service plans are traditional insurance plans where the dentists are reimbursed after a claim is filed based on the dentist's usual and customary fee, the benefit schedule and the policy terms. Members are not required to go to any specific dentist to receive the plan benefits. Although indemnity plans still cover more enrollees than any other segment of the industry, growth rates have been declining in the last decade with the introduction of PPOs and HMOs.

Dental PPO plans are basically discounted fee-for-service plans. Providers contract with the insurer and accept payment below their customary fee or according to a fixed schedule. Payment occurs after a claim is filed. Members may obtain care in the network of participating providers or out of the network; however, going out of the network may reduce their benefits. The dental PPO market is currently the fastest growing segment of the managed dental market.

Dental HMO plans contract with providers and agree to pay them a set fee per member per month whether or not members utilize services. This payment is called capitation and is a supplement to the discounted co-payments that the provider will receive directly from the Members when services are rendered.

Dental Referral plans are not insurance plans but they provide access to dental care at discounted rates when the Member obtains care from a network provider. Typically, a small monthly fee is paid for access to a list of dentists that have agreed to accept certain negotiated rates for services. The Member may go to any of the dentists in the network buy they will pay the full discounted cost at the time of service. HMOs and PPOs sometimes provide this type of product as an ancillary benefit when funding is not available for an insured product. The companies that specialize in developing and marketing referral products alone are experiencing the highest rates of growth in the industry – often over 50% annually.

Nationwide, indemnity plans still account for 61.7% of the total, with PPOs at 16.6%, DHMOs at 18.0% and referral plans at 3.7%. Participation in indemnity plans is decreasing while PPOs and DHMOs are both increasing in popularity and have more than doubled their market share in the last five years. Referral plans entered the market later than PPOs and DHMOs but have gained popularity among certain market segments and managed to grow more rapidly than other segments.

New sales are even more heavily weighted toward managed care plans and substantial shifts in business are predicted by most analysts and observers in the coming years. The managed dental care segment of the market continues to far outpace overall market growth. By the end of 1997, dental managed care – dental HMOs/PPOs and referral plans – represented 38.3% of the market for dental benefits.

Despite the fact that dental has been one of the fastest growing lines of business in the employee benefits arena over the past two decades, virtually half of the population remains uninsured, yet receptive to low cost offerings that can be developed.

Dental Benefit Overview

Federal employees may elect health coverage from any one of twelve plans offered on a nationwide basis. Employees in specific agencies have the option of electing from six additional plans, or, the employee may elect from one of the regional or local carriers authorized to provide benefits through OPM programs. Choices vary – employees in 26 States may elect from up to three (3) additional carriers while those in 19 States may elect from four (4) or more carriers. Premiums vary widely. Employees in Washington, D.C. may chose from plans ranging in price from $134.04/month to $242.58/month (for employee only); premiums in New York range from $152.21/month to $372.63/month (for employee only).

A review of dental benefits was done to compare the relative value of those benefits in various plans. No attempt has been made to compare health benefits or to conduct an actuarial analysis of premium value. Information available during this review did not indicate the level of participation or the utilization in any particular benefit plan.

The review does indicate that dental benefits are significantly lacking as an option for federal employees. The review covered 150 of the plan documents of carriers authorized to provide benefits through OPM. The attached chart, *"Survey of Dental Coverage"*, indicates that only one carrier offered specific preventive care for children, approximately one-third (53) carriers offer preventive care for all ages, less than one-third (43) offer minor restorative dental care, one-fifth (30) offer any major restorative dental care, and only 14 carriers offer any orthodontic care.

None of the federal employee plans offers dental coverage that would be competitive by today's standards. Two of the nationwide health plans do offer dental coverage that would be considered better than the coverage offered by the other federal programs. In one, the member pay nothing for preventive care as long as service is provided by a plan doctor and the member pays only 20% of the plan allowance for restorative care. In the other, the member pays $5.00 per visit for listed preventive care procedures and listed restorative care. Neither plan covers orthodontic care. In comparison, the majority of the federal employee plans offer no dental coverage or coverage equivalent to a discount plan in which the member receives a small reduction off the normal charge collected by the provider.

In view of the proven relationship between good oral health and good overall health it appears that the Federal government would benefit from offering a stand-alone dental program which could be accessed by employees desiring such coverage. Better dental health could result in a reduction in lost time, improved on-the-job efficiencies and prove to be, in the long run, a cost reduction measure. In addition, the "purchasing power" of the federal system and the availability of a payroll deduction option for dental could result in better coverage being available at a lower cost than would be the case if employees were to purchase coverage on an individual basis, or even in smaller collective groups.

An adequate stand-alone DHMO plan would provide, at a minimum the following:

- Diagnostic procedures at no cost
- Preventive care at no cost, or significantly reduced charges
- Minor restorative care (amalgam fillings) at no cost, and reduced cost for other procedures
- Coverage for crowns, bridges, endodontics, periodontics, prosthodontics, and orthodontics

Dental insurance coverage is the most requested health benefit after regular health insurance. Employers across the nation have discovered that employee-paid dental insurance has become a benefit of choice. A two-level approach in which the employee

could select either a DHMO or a program which allows freedom of choice in the selection of dentists would provide options that mirror most commercial business employee benefit programs.

Optional Vision Benefit for Federal Employees

Market Assessment

Human Resource Managers today are faced with demand for better benefit packages despite shrinking budgets. Low unemployment and eroding employee loyalty creates a challenge in how to attract and retain the best workforce while keeping costs especially benefit costs, low. This becomes an almost impossible task when taken in consideration with the double-digit inflation that the health insurance market has been experiencing. Medical costs are increasing faster than payroll increases, causing employees to look for creative ways to help reduce out-of-pocket costs.

Vision benefits are not currently offered to Federal employees as a separate benefit. We surveyed 150 medical PPO and HMO plans that are offered to Federal employees and analyzed the vision benefits. 72% offered minimal vision benefits (exam only). 28% did not offer any vision benefits at all. Only 12% of the plans offered glasses and lenses and 10% offered coverage for contacts. The majority of federal employees still have to pay for glasses, frames and lenses and in many cases, eye exams.

More than half of your employees, (60% of the population) already wear eyeglasses or contact lenses, and the average family spends $660 a year on eyecare benefits that are typically not covered by medical coverage. A recent Mercer/Foster Higgins study found that 65% of employees would trade one or two vacation days for vision care coverage. Not only are Vision benefits one of the most highly desired and frequently requested employee benefits, but they also benefit the employer. Employees with better visual acuity will perform more efficiently. Vision Benefits are rapidly becoming a standard and expected part of a complete employee benefits package. Since Vision Care Benefits, when structured properly, are very inexpensive, the improvement in productivity alone may even pay for the entire program.

The Case for Vision Care

Almost half of all Americans had a comprehensive eye health examination in the past year resulting in the finding that an estimated 70% of them need vision correction.

Annual eye examinations are an essential part of any preventative health care program. Regular, comprehensive eye exams can help ensure early diagnosis and clinical intervention of systemic diseases such as diabetes, high blood pressure, rheumatoid arthritis, and lupus. They also can help detect numerous, serious *medical* eye conditions, including:

- *Macular degeneration.* If left untreated, it may lead to legal blindness.
- *Glaucoma.* Half of all patients with glaucoma do not know they have it, and there are no symptoms until it's too late. That's why glaucoma is called the "silent thief."
- *Cataracts.* This is the leading cause of blindness in American adults.
- *Diabetic retinopathy.* Diabetes puts people at risk of developing this serious eye disorder, but about half of all diabetics are not receiving timely and recommended eye care to detect, diagnose, and treat diabetic retinopathy. If untreated, retinal detachment will occur, leaving the patient completely blind.

Experts estimate that each year more than 90,000 new cases of blindness could be cured or prevented through timely detection and treatment.

Summary

Vision Plans, like Health Plans, offer a great value to both the employer and employee, but should be offered to employees as a separate stand-alone benefit to enhance the benefits and coverage and help pay for expenses that are incurred. These comprehensive vision care plans should be made available to employees on a voluntary, payroll deduction basis as part of your organization's dedication to preventive health care.

Attached are examples of two discrete benefit plans providing excellent vision care for outstanding value. The CompBenefits Basic plan provides annual eye exams, annual lens or lens replacement – for a nominal copayment, and new frames every two years at wholesale prices. The plan does require that service be obtained from a plan provider. The Enhanced Plan provides the same range of benefits with the added option of being able to obtain service from a non-network provider. Either plan may be structured to allow the copayment and the frequency of services to be at a level determined by the employer.

Vision Benefit Overview

Vision Plans are available in a variety of models and from a variety of sources. Vision only HMOs, traditional indemnity carriers and self-funded plans are the most common. Typically, a vision benefits program will provide an annual eye examination with either

no copayment or a very small one. The typical exam copayment is $5.00 to $10.00. The benefits on materials are more varied. Most plans offer glasses (frames and lenses) or contact lenses every year. Some offer glasses and contact lenses every year. A few limit the frame benefit to once every 24 months. There is usually a small co-payment required for the materials (typically about $20). The patient is typically limited to one eye examination and one pair of glasses (frame and lenses) or one pair of contact lenses per year.

Among the various vision approaches available are: Discount vision models, retail vision/mixed models, and private practice vision models. Which plan is best for your company and your employees? Here are some things to consider when reviewing a plan.

Discount plans can be hard to judge and offer less value than fully insured options. A discount from what? These plans also typically have a high average retail markup, and results vary by provider, and there may be incentives for providers to up-sell plan members. There also is no uniform EOB (Explanation of Benefits), no consistency in exam protocols, no audits, and often a limitation on available materials and services.

Retail/mixed models offer lower premiums, but use higher retail mark ups and incentives to up-sell select items. Your employees often become fair game for good sales people. Benefits generally vary by provider location, there tends to be less emphasis on eye health exams and patient continuity of care, and there is a risk of patient records being lost when doctors leave one retail chain for another. These networks often contain doctors who don't dispense and/or have opticians but no doctors. They also may force the use of a particular lab and offer limited selections of covered eyeglass frames.

Private practice plans are associated with high consumer satisfaction. They are convenient, comprehensive, relationship-oriented, and consistent and offer quality as well as value – to employers as well as employees. With a private practice plan, patients have wide access to care – and they have more choices. A large, contracted network of providers means good geographic coverage and consistent benefits across the network. Doctors provide full-service care, not just "exam or materials only," and patients have the freedom to select any contact lens instead of being dictated to by a restrictive formulary.

The quality of the care in private practice plans is excellent. There is a low rate of provider contract terminations, and doctors follow a specific and consistent eye health examination protocol. The doctors' focus is on quality care and long-term patient eye health care, resulting in stable patient/provider relationships which, in turn, leads to better continuity of care. Consistent policies also ensure uniformity of care from provider to provider. There are fixed co-payments for covered exams and materials, and a specific and uniform wholesale allowance for covered in-full frames that does not vary by provider location. Patient frame upgrades are based on wholesale pricing to eliminate pricing variances, and providers use a specific and uniform price list for lens options. Private practice plans provide affordable eyecare. Private plan doctors provide exams as well as materials, have large paid-in-full frame selections with current styles, and are

subject to claims audits. Contrary to what many people think, prices at network doctors are frequently substantially lower than at retail stores. Typical savings are 68% off retail.

Appendix A

Survey of Current Dental Coverage for Federal Employees

Plan Type	Preventive Dental Care for Children	Preventive Dental Care for All	Minor Restorative Dental	Major Restorative Dental	Orthodontics
PPO --					
In-network					
Benefits offered	-0-	11	9	6	-0-
Benefits not offered	20	9	11	14	20
Out of network					
Benefits offered	-0-	11	10	3	-0-
Benefits not offered	23	12	13	20	23
HMO					
Benefits offered	1	42	33	24	14
Benefits not offered	126	85	94	103	113

A total of 150 plans were surveyed (127 HMOs and 23 PPOs or POS plans).
Statistics were not available to determine the level of participation in any of the plans.

Appendix B

Survey of Current Vision Coverage for Federal Employees

Name of Plan	Vision Benefits Offered
Alliance	None
APWU Consumer Driven Plan	Some
APWU High Option Plan	None
Blue Cross Blue Shield Standard	None
Blue Cross Blue Shield Basic	None
GEHA High Option	None
GEHA Standard Option	None
Mail Handlers High Option	None
Mail Handlers Standard Option	None
NALC	Some - exam only
PBP High Option	None
PBP Standard Option	None

Note: The APWU benefits include eye exams for children only and contacts to correct an impairment caused by accident or illness.

Appendix C

Testimony of Stanley Shapiro, D.D.S. Vice Chairman, CompBenefits Corporation to the Subcommittee on Civil Service and Reform, United States House of Representatives Committee on Government Reform (February 24, 2004)

INTRODUCTION

Chairwoman Davis and members of the subcommittee: My name is Dr. Stanley Shapiro, and for more than 33 years, I have been privileged to provide dental care both as a practicing dentist as well as an executive officer of one of America's leading dental benefits companies. I am grateful for the opportunity to speak with you today in support of HR 3751, which may potentially lead to expanding federal employees healthcare benefits to include voluntary dental and vision plans.

Our nation has made great strides in educating Americans about the importance of oral health, and there is a growing recognition that oral health is integral to general health. New products, therapies, and technologies have enabled people to retain their natural teeth throughout their lives, thereby enhancing their health and well being.

Today, the percentage of Americans who receive dental care is higher than ever before, and I believe this has occurred as the result of third party funding through government programs for the underserved and private dental coverage offered in the workplace. Statistics indicate that 54 percent of all Americans currently have dental coverage. Yet, throughout my career, I have witnessed the role that cost has played as a barrier to accessing dental care. This is unfortunate since it is well established that dental disease is preventable, and children who receive routine preventative care have the opportunity to live their lives free from dental caries and periodontal disease. "Oral Health in America: A Report of the Surgeon General" in 2000 stated that children from families without dental insurance are three times more likely to have dental needs than children from families with dental insurance.

FEHB is a successful model for demonstrating the purchasing leverage of the Federal Government and the ability to provide choice among the types of plans offered. But while some of these medical plans include dental and vision benefits, they are difficult to evaluate and typically provide very low levels of coverage when compared to the wide array of plans that are readily available to both the public and private sectors.

To demonstrate this point, we have evaluated 150 FEHB medical plans to define the levels of dental benefits coverage. Out of 150 plans, only one provided preventive dental care for children. Only 14 out of 150 offered orthodontic coverage. Furthermore, reimbursement levels and annual maximum benefits were limited. Similar results occur for vision benefits, creating a confusing basis for FEHB participants to evaluate the cost of high option medical plans against the actual benefits received. All too often, there are failed expectations and the perception is that the dental and vision benefits offered by

FEHB are inadequate and disappointing. This is exacerbated by the escalating costs and structural changes in health plans that Federal employees encounter when selecting the appropriate medical coverage for their families.

FEHB acknowledges the low dental benefit levels and communicates this fact on its Web site to Federal employees. It responds to a frequently asked question by stating: "Everyone wants to keep premium increases as low as possible, so, generally, to increase benefits, plans make trade-offs. We would not want to sacrifice medical benefits to get dental or vision benefits."

In contrast, employees of 48 state governments have voluntary dental benefits, and 44 are stand-alone plans that offer benefits that are superior to those included in the FEHB medical plans.

In my home state of Florida, for instance, state employees may select from eight different stand-alone dental plans and more than 50 percent of employees currently participate. For the past three years and despite rising medical costs, enrollment in the voluntary dental plans has increased as a percentage of the workforce from 49 percent in 2001 to 55 percent in 2003. The same trends hold true for the voluntary vision plan.

In the private sector, dental plans are both varied and affordable. Of the three most popular plan types that include orthodontic coverage, the average monthly premium for an employee is $14.10 for a DHMO, $22.07 for a DPPO, and $28.20 for an indemnity plan. An employee can cover his or her spouse and children through a DHMO for an average monthly premium of $36.35. Once enrolled in the plan, there are typically no charges for preventative care, minimal direct cost for restorative care, savings up to 50 percent on major services, and reduction of 25 to 50 percent in the cost of orthodontic treatment. It is no surprise that employees appreciate this purchasing leverage and utilize dental plans to facilitate their access to care.

Employers have learned that dental benefits are an important component of employee benefit programs. Surveys indicate that 95 percent of employers with 500 or more employees provide dental benefits, as well as 48 of the 50 state governments, and thousands of county, city and municipal government and school districts.

In the competition for quality employees, voluntary dental and vision benefits fulfill employee expectations and create a competitive advantage for an employer. With the largest workforce in American, the Federal government can establish, without cost, a more comprehensive ancillary benefits program that will enhance the oral and general health of Federal employees and be perceived with value by all participants. To that end, I urge you to support HR 3751.

Thank you.

Mrs. DAVIS OF VIRGINIA. Thank you, Dr. Shapiro.

I now would like to recognize Mr. Seltenheim. You are recognized for 5 minutes.

Mr. SELTENHEIM. Good afternoon, Chairwoman Davis, Ranking Member Danny Davis, and members of the subcommittee. Thank you for the opportunity to testify before the subcommittee on providing stand-alone dental benefits to Federal employees. My name is Jon Seltenheim, and I am chairman of the Board of Directors of the National Association of Dental Plans.

NADP represents the vast majority of regional and national companies that offer dental benefits. I testify today supporting H.R. 3751. NADP believes OPM will conclude as we have that FEHBP should provide dental benefits in the same excellent manner they provide medical insurance coverage to Federal employees, their families, and retirees. However, unlike the majority of private sector programs, FEHBP provides little in the way of dental coverage.

The first portion of my testimony points out the value of dental coverage. And this is not simply anecdotal, but comes from Federal Government reports, empirical data, claims data from our member companies, and reports generated from impartial research institutes.

The landmark 2000 Surgeon General Report, "Oral Health in America," has as its primary theme "Oral health is integral to general health." This report documented that the two primary dental diseases, caries and periodontal disease, are still common and widespread despite safe and effective measures to prevent them. The report goes on to document that the primary barrier to dental care is cost, and the existence of dental benefits helps to overcome this barrier and provide access to care.

Beyond cost, research continues to show that the potential association of dental disease, especially advanced periodontal conditions, with coronary heart disease, has an association with coronary heart disease, stroke, and low-weight premature babies. Dental disease does have broader health and financial impacts which must be considered in reviewing the value of dental benefits.

In the 2000 report of the Surgeon General, the estimate was that 108 million Americans did not have access to a dental benefit, about two and a half times the uninsured medical population. The report also noted that 70 percent of individuals with private dental insurance reported seeing a dentist in the past year, while 50 percent of those without dental benefits did, a 120 percent difference.

So you can clearly see that dental benefits facilitate people going to the dentist. And as the report notes, preventive care is essential to keeping down overall dental and medical costs, because early detection of other diseases can be found through oral checkups, especially things like oral cancer.

The National Institute of Dental and Craniofacial Research estimates that for every dollar spent on dental disease and prevention, $4 is saved in subsequent treatment costs. Therefore, promoting access to dental care is essential to keeping up our Nation's oral and general health.

Based on the 2003 NADP/DDPA dental benefits report, enrollment is conservatively estimated in the year 2002 to be 154 million

Americans, or about 54 percent of the population have dental coverage. This is a 63 percent increase from the 1989 HHS report.

The products that comprise the market have changed over time with the most recent growth being in the PPO market and discount dental segments. The most accurate look at what U.S. employers provide in terms of dental benefits is the Mercer Survey of Employer Sponsored Health Plans. This 2003 report found that 66 percent of all employers provided dental, 96 percent of employers with more than 500 employees, and 98 percent of large employers, those with over 20,000 employees, provided a dental benefit. For county, city, and State government entities, the survey revealed that 95 percent of government employers with more than 500 employees offered dental benefits, with a median deductible and maximums of $50 and $1,000 respectively. This would indicate that most are offering comprehensive fee-for-service programs. This is significant as it definitively illustrates that FEHBP is out of step in this arena with similarly situated large employers, whether private or governmental.

In conclusion, the study requested of OPM is timely and important to the oral and physical health of Federal employees. NADP believes that offering a dental benefit to Federal employees will not only provide a valued dental benefit from the employee's perspective, but will also serve to provide a benefit package that is more competitive with other governmental, commercial and military offerings. NADP stands willing to provide additional detail in these and other areas of investigation by OPM in response to the study requested by H.R. 3751.

[The prepared statement of Mr. Seltenheim follows:]

TESTIMONY TO THE

SUBCOMMITEE ON CIVIL SERVICE AND REFORM

U.S. HOUSE OF REPRESENTATIVES COMMITTEE

ON

GOVERNMENT REFORM

By

MR. JON SELTENHEIM

Chairman of the Board of NADP

NATIONAL ASSOCIATION OF DENTAL PLANS

February 24, 2004

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INTRODUCTION

Good afternoon, Chairman Davis, ranking member, Danny Davis, members of the Subcommittee. Thank you for the opportunity to testify before this Subcommittee on the issue of providing stand-alone dental benefits to federal employees. My name is Jon K. Seltenheim and I am Chairman of the Board of Directors for the National Association of Dental Plans (NADP). NADP is the representative and recognized resource for the dental benefits industry. NADP's members provide dental benefits to 86 million of the 155 million Americans with dental benefits, i.e. 60% of the total dental benefits market. There is no other trade association, health or dental, that can claim this breadth of representation of the dental benefits industry. Our members include major commercial carriers as well as regional and single state companies that offer all lines of dental benefits including dental HMOs, dental PPOs, dental indemnity and discount dental plans.

Personally, I have over 20 years of group insurance and managed care experience. I am Sr. Vice President of Customer Service Operations for United Concordia Companies, Inc. where I am responsible for claims administration, customer service, professional relations, information systems and implementation. Prior to joining United Concordia, I was the Chief Operating Officer for MIDA, Inc., before United Concordia subsequently purchased it. Prior to MIDA, I was with CIGNA Healthcare for 15 years.

Today, the Federal Employees Health Benefits Program provides excellent medical insurance coverage to federal employees, their families, and retirees; however, unlike the majority of private sector programs, the FEHBP provides little in the way of dental coverage.

The FEHBP program does not make available separate dental policies, usually referred to as stand-alone dental policies, which are the primary vehicle for dental coverage in the marketplace. My understanding is that this Subcommittee's interest is in exploring the provision of stand alone dental coverage rather than the piecemeal, limited coverage that is provided through some of the federal employee's medical plans. As the largest representative of the dental benefits industry, we will provide testimony on the following:

1. value of dental benefits
    a. relationship of dental care to overall health
    b. supporting access to dental care
2. dental benefits market
3. trends in employer offerings of dental benefits
    a. number of employers offering dental benefits
    b. contributions to dental benefits
    c. array & cost of dental benefit products
    d. satisfaction with dental benefit products
4. broad recommendations for offering dental benefits
5. assistance in OPM's future analysis under HR 3751.

I. THE VALUE OF DENTAL BENEFITS

Before discussing how the federal government could offer dental benefits to its employees, it's critical that this Subcommittee understand why dental benefits are so important. Therefore, I have devoted the first part of my testimony to the value of dental coverage. The information is

not simply anecdotal, but comes from federal government reports, empirical data generated from industry reports, claims data gathered from our member companies, and reports generated from impartial research institutes.

Oral health & overall health.

The landmark 2000 Surgeon General report, "Oral Health in America" had as a primary theme that "oral health is integral to general health." This report documented that the two primary dental diseases (i.e. caries and periodontal disease) are still common and widespread despite safe and effective measures to prevent them. The report goes onto document that the top barrier to dental care is cost and that the existence of dental benefits helps to overcome this barrier and promotes access to care. Beyond cost, research continues to support the association of dental disease, especially advanced periodontal conditions, with coronary heart disease, stroke, and low weight, premature childbirth. Dental disease does have broader health and financial impacts which must be considered in reviewing the value of dental benefits.

Promoting Access to Care.

In the Surgeon General's report, it was estimated that in 2000, approximately 108 million Americans did not have access to a dental benefit, about 2.5 times the number who do not have medical coverage. The Surgeon General's Report noted that 70.4% of individuals with private dental insurance reported seeing a dentist in the past year while only 50.8% of those without benefits did. So you can clearly see that dental benefits facilitate people going to the dentist. And as the Report notes, preventive

care is essential to keeping down overall dental and medical costs because early detection of other diseases can be found through oral check-ups. The National Institute of Dental and Craniofacial Research estimates that for every dollar spent on dental disease prevention $4 is saved in subsequent treatment costs. In conclusion, promoting access to dental care is essential to keeping up our nation's oral and general health.

II. DENTAL BENEFITS MARKET

The **NADP/DDPA 2003 Dental Benefits Joint Report:** Enrollment, September 2003 (Joint Report)[1] conservatively estimates the total dental benefits market is at year-end 2002 to be 154.5 million or close to 54% of the US population. **(Exhibit I—Dental Benefits Market at a Glance)** This represents a 63% increase coverage (or access) from the 1989 HHS report of covered lives for dental. The products that comprise the market have changed over time with the most recent growth in the dental PPO and discount dental segments, but overall the market continues to expand.

The Joint Report not only estimates national enrollment, but enrollment by state as well. When analyzing states with the highest level of enrollment, California leads in enrollment with 77% of the total population or 27 million with no other state over one third that many lives. Following California is Texas with 45% or 9.4 million; New York with 49% or 9 million; and Illinois with 64% or 8.8 million. **(See Exhibit II—Top 10 States for Dental Benefits Enrollment).**

[1] Delta Dental Plans Association (DDPA) is a national network of 39 independently operated not-for profit dental service corporations specializing in providing dental benefits in all 50 states, the District of Columbia and Puerto Rico.

III. EMPLOYER OFFERINGS OF DENTAL BENEFITS

Another way to compare where the FEHBP stands in terms of providing access to dental benefits is to examine the popularity of dental benefits and the percentage of employers offering dental benefits by size of employer.

Popularity of Dental Benefits

The U.S. Chamber of Commerce Annual Report on Employee Benefits has consistently shown for the past 10 years that dental is one of the top 5 benefits included in employee benefit packages along with medical, life, long-term disability, and 401-Ks.

Employers Offering Dental Benefits

The most accurate look at what US employers provide in terms of benefits is the Mercer Survey of Employer-Sponsored Health Plans (ESHP). This report has been produced annually since 1986 and is based on a random, stratified sample of employer benefit offerings. Thus, it is a reliable representation of the benefit practices of employers and statistically significant results are available for many of the areas included in the survey.

The 2003 Report found that 66% of ALL employers, 96% of employers with 500 or more employees, and 98% of large employers (>20,000 employees) provide dental benefits. For county, city, and state government entities, the survey revealed that 95% of the aforementioned government employers with 500+ employees offered dental benefits with median deductible and maximums of $50 and $1,000 respectively. This would indicate that most are offering comprehensive plans, since high maximums are uncommon for

"preventive only" plans. This is significant as it definitively illustrates that the FEHBP is out of step in this arena with similarly situated large employers in the public and private sector.

If federal employees have dental benefits, they have largely preventive benefits folded in with medical plans. The Blue Cross Blue Shield (BCBS) Plan Standard Option, the most widely used of all the health plans under FEHBP, pays just a fraction of dental costs for preventive and minor restorative dental care. For instance, BCBS pays $8 of a $24 Maximum Allowable Charge for a periodic oral evaluation (check up). That's just 33% of the Maximum Allowable Charge (MAC) under the plan for a participating dentist and a lesser percentage for nonparticipating dentists. For a filling, the plan pays $31 of a MAC charge of $120 and of a non-MAC charge of $175, just 26% and 18% respectively. A typical stand-alone dental plan will cover all of these at a much higher level. The Standard Option plan does not cover any portion of the cost (usually running upwards of $700) of a crown—a major restorative procedure; a stand-alone plan will cover 50% or more. This is not sufficient coverage to maintain oral health.

Trends in Employer Contribution to Benefits

According to the Joint Report, one-fourth (1/4) of DPPO products and a third of DHMO products as well as Discount Plans were fully paid by the employees. Two-thirds (2/3) of dental indemnity products were fully paid by employees. These offerings are defined as "voluntary coverage," i.e. employee-paid. **(Exhibit III—2002 Commercial Funding Sources for All Lines of Dental Benefits)**

When contributions are shared, NADP reports show that the employers' portion has been decreasing in recent years. According to our most recent reports, employer contributions decreased from 61% in 2000 to 58% in 2002. Employees' portion rose from 38% to 42% over this same period. **(Exhibits IV—Allocation of Shared Premium Cost)**

Array & Cost of Dental Benefit Products

There are a wide variety of stand-alone dental plans on the market, which would provide a number of options for FEHBP participants to choose from, in terms of both premiums and benefits. Such plans include Dental HMOs, Dental PPOs, Dental Indemnity, and Discount Dental plans **(See Appenix A–Definitions)**. Premiums range from a few dollars a month for Discount Dental plans (where participating dentists agree to a lower charge but the member pays the discounted cost out-of-pocket) to an average of $90 a month for family Indemnity plans (regular fee-for-service plans). **(Exhibit V—Dental Benefit Premium Trends Over Time)**

Satisfaction with Dental Benefit Products

NADP has aggregated survey results on satisfaction from member dental benefit plans. These surveys routinely find overall satisfaction with dental benefits in the 80% to 90% range, with quality of care reported in a range 5 points higher. Consumers complaints to insurance departments about dental benefits are low, usually a fraction of a percent per 100,000 enrollees. This demonstrates that the OPM will experience minimal complaints and administrative issues with dental benefits.

III. RECOMMENDATIONS FOR IMPLEMENTING A FEDERAL STAND-ALONE DENTAL PLAN

In the current dental insurance market, there are both regional and national carriers and plans that provide a wide variety of stand-alone dental products. As stated earlier, premiums for these various plans can range from a few dollars a month for Discount Dental plans to an average of $90 a month for family Dental Indemnity Plans. With this variety of dental plans, in terms of both benefits and premiums, federal employees and retirees could choose the level of dental benefits appropriate for their individual needs and financial circumstances. Therefore, we urge that the legislation not impose a specific plan design nor select a single carrier but provide access to the range of products available in the marketplace.

If there are standards established, they should be broad in nature, focusing on general categories of coverage and desired benefit levels and not the minutia. For instance, DHMOs should not be required to have specific Point of Service coverage, but could be required to make available a general DPPO option. General qualifications for companies should recognize the state regulations to which most of these companies are subject which standardize time frames for claims processing, utilization reporting, and materials provided to consumers such as readable materials and toll free numbers for information.

IV. CONCLUSION

The study requested of OPM is timely and important to the oral and physical health of federal employees. NADP hopes these comments have provided a framework for the investigation that

is required as well as preliminary evidence that provision of stand-alone dental benefits would place federal employees on a par with their private sector counterparts.

NADP is willing to provide additional detail in these and other areas of investigation by OPM in response to the study requested by HR 3751.

EXHIBIT I: Dental Benefits Market at a Glance 1996 through 2002

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003

Line of Business	1996	1997	1998	1999	2000	2001	2002	2001-2002 Growth Rate	No. of Firms[2,3]	Market Segments 2002
Dental HMO SubTotal	24,455,225	26,970,659	27,686,519	27,163,914	26,366,494	23,455,747	23,282,273			
Est. Underrprtd. HMO (0.9%)	**24,668,084**	**27,205,413**	**27,927,504**	**27,400,350**	**26,593,150**	**23,657,381**	**23,482,415**	**-0.74%**	77	**17.21%**
Dental PPO Fully Insured	10,633,463	14,551,916	19,199,796	24,374,523	25,167,734	31,383,532	32,619,967	**3.94%**	**58**	
Dental PPO Self Insured	9,823,482	13,176,973	18,383,818	22,956,757	26,519,073	26,459,899	29,246,263	**10.53%**	**42**	
Dental PPO SubTotal	20,456,946	27,728,888	37,583,614	45,450,017	51,686,807	57,843,431	61,866,231			
Plus 4.8% Est. Underrprtd. PPO	**21,479,793**	**29,115,333**	**39,462,795**	**47,722,518**	**54,271,147**	**60,735,602**	**64,959,542**	**6.95%**	67	**35.11%**
Discount Dental Plan Subtotal[4]	8,229,417	8,993,953	10,047,367	11,413,496	12,565,496	10,769,938	11,360,632			
Plus Est. 5% Underrprtd. Discount Dental Plans[3]	8,640,888	9,443,651	10,549,735	11,984,170	13,193,771	11,308,435	11,928,664	**5.48%**	30	**8.54%**
Dental Managed Care SubTotal[3]	**54,788,765**	**65,764,397**	**77,940,034**	**87,107,038**	**94,058,068**	**95,701,418**	**100,370,621**	**4.88%**		**60.85%**
Dental Indemnity Fully Insured	44,187,754	42,285,492	39,706,077	37,284,006	33,039,945	30,757,469	28,309,709	**-7.96%**	**53**	
Dental Indemnity Self Insured	30,117,221	28,820,689	27,062,627	25,411,807	24,630,544	25,356,215	23,326,705	**-8.00%**	**41**	
Indemnity SubTotal	74,304,975	71,106,181	66,768,704	62,695,813	57,670,489	56,113,685	51,636,414			
Plus Est 5%. Underrprtd. Indemnity	**78,020,224**	**74,661,490**	**70,107,140**	**65,830,604**	**60,504,885**	**58,871,567**	**54,174,247**	**-7.98%**	62	**39.15%**
EST. Total Dental Benefits Market[3]	**132,808,989**	**140,425,887**	**148,047,174**	**152,937,642**	**154,562,953**	**154,572,985**	**154,544,868**	**-0.02%**	132	**100.00%**
% of Total Pop. with Dental Benefits	**52.44%**	**52.44%**	**54.78%**	**56.08%**	**54.92%**	**54.27%**	**53.59%**			

[2] Number of Firms includes both those directly reporting and those estimated based on secondary information sources.

[3] Thirty-nine Delta Dental plans are combined and included as one company.

[4] **Previous to this report, some Health Plans include a limited dental benefit. In 2003, some health plans with this limited benefit were removed from the Discount Dental Plan Subtotal (2000-2002) which illustrates the dramatic decrease.**

EXHIBIT I: Exhibit I provides a total dental benefits market estimate based on the data collected and estimates from sources sited in the methodology. This market estimate demonstrates that network-based dental benefits in 2002 jumped 3% to report to a total of 65% of the market. Overall, there was no market growth in Dental Benefits between 2001 and 2002.

DENTAL HMO DATA: Using NADP historical data and other industry sources as benchmarks, the 23.3 million dental HMO enrollees directly reported in this survey are judged to represent more than 99% dental HMO industry.

In 1999, contact with previously unrecorded plans with significant enrollment reduced the unreported enrollment estimate significantly. Thus, only 0.9% is added to the actual enrollment to account for future additions to the database. The total estimate of enrollment in dental HMOs in 2002 is 23.5 million which is down almost 175 thousand from 2001.

The area of growth in the dental HMO market continues to be in Medicaid and Medicare. Growth topped 10% in the DHMO Medicaid sector and 43% in the DHMO Medicare sector in 2002 which offset enrollment losses by some carriers.

DENTAL PPO DATA: The 62 million beneficiaries directly reported from plans that offer dental PPOs increased over 4 million from 2001. Two companies in the database added the PPO line of business in 2002. *NOTE: These companies do not include the consolidated Delta Dental PPO enrollment.*

Identification of insurers that offer PPO products and independent PPOs is a process that NADP is still refining. As a result, it is likely that the PPO market is underreported; thus 5% is added to this sector of market bringing estimated total dental PPO enrollment to 65.0 million in 2002 or 42% of the market. ***Clearly the dental PPO market is the fastest growing segment of the dental managed market although the rate of growth is lower than that reported in 2000.***

DISCOUNT DENTAL PLAN DATA: Discount Dental Plans- previously referred to as referral plans are benefits not defined as insurance but are a network-based product that provides access to dental care at guaranteed costs. Typically, a small monthly fee is paid by either the employee or the employer on behalf of the employee for a list of dentists that have agreed to accept certain negotiated rates for services. The employee and their dependents may go to any of the dentists in the network but pays the full cost of the service out-of-pocket albeit at the negotiated rate. A Discount Dental product is sometimes provided by dental HMOs or PPOs as a different way to market the networks developed for their insured benefit products. It allows the employer to provide a low cost fringe benefit when funding is not available for an insured product.

Increasingly, there are companies that specialize in developing and marketing Discount Dental products alone. These companies are experiencing the highest rates of growth. The overall growth of the discount dental market increased to 8% of total benefits in 2002. Most of this growth is in the larger plans. Some smaller plans are showing losses.

Please note: previous to this report, some Health Plans include a limited dental benefit. In 2003, some health plans with this limited benefit were removed from the Discount Dental Plan Subtotal (2000-2002) which illustrates the dramatic decrease in Discount Dental Plans.

DENTAL INDEMNITY DATA: NADP has significantly refined reporting of this sector of the market. In the 1998 report, 11 newly reporting companies identified an additional 37.8

million beneficiaries in the dental market through direct survey results rather than estimates. These companies were previously identified in the additional dental market estimates in the 1996 and 1998 NADP/InterStudy National Dental Benefits Census. Their historical data has been built into the data base back to 1994.

Overall, this market sector continues to decline. While many large dental indemnity insurers experienced losses, some small to medium sized companies often added indemnity as a product line and showed higher growth rates.

ESTIMATE of the TOTAL DENTAL MARKET: One of the key purposes of the 1996 NADP/InterStudy National Dental Benefits Census was to create a total dental benefits market estimate. Such an estimate had not been made since the US Department of Health and Human Services'(HHS) ***estimate in 1989 of 95 million individuals with dental coverage.*** Because of the broad demand for this estimate, this estimate is updated with the restatement of NADP's database.

To build this estimate, NADP examined the list of companies that responded to our surveys over the past several years. It was determined that the Delta, indemnity and self-funded sectors were undercounted by the survey. Since 2001, Delta Dental Association consolidated the enrollment numbers for all of the plans, and the under representation was eliminated.

OVERALL MARKET GROWTH: With enrollment from estimated sources added to the specific enrollment reports, the total dental benefits market is conservatively estimated at year-end 2002 to be 154.5 million or close to 54% of the US population. This represents a 63% increase coverage (or access) from the 1989 HHS report of covered lives. This represents a basically flat line growth in the market over the past three years—primarily in the dental HMO and Indemnity sectors of the market. The Medicaid, Medicare and dental PPO market also continues to expand as previously discussed.

Since the recent Surgeon General's report on Oral Health in America notes that cost is a major impediment to obtaining oral health care, this expansion of the dental market—largely the result of growth in network-based dental benefits is responsible for reducing the cost barrier for millions of Americans. Taking down the cost barrier should result in long-term improvement in oral health

The 23.5 million dental HMO enrollees, the 65.0 million dental PPO beneficiaries plus the 54.2 million in indemnity dental plans and 11.9 million in Discount Dental plans allows the NADP to account for over 95% of the estimated total dental benefits market from its own resources and that of DDPA, without turning to other sources for supplemental information. This is a significant improvement from the 1998 NADP/InterStudy National Dental Benefits Census which accounted for about two-thirds of the estimated total dental benefits market through direct survey responses. **Thus, the reliability of the total dental market estimate provided by NADP continues to improve.**

EXHIBIT II: Top Ten States for Total Dental Benefits Enrollment in 2002

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003

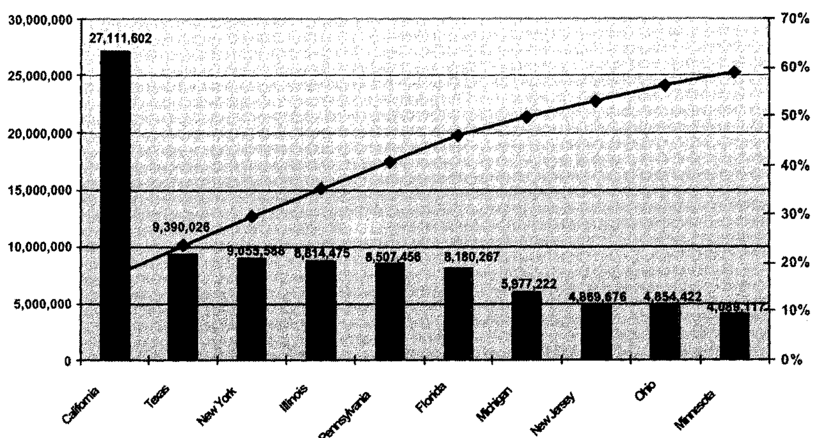


EXHIBIT II: Half of the top ten states for the total dental benefits market are also in the top ten for each line of network-based product reported in this survey. The exceptions are Massachusetts, Arizona, Georgia, Virginia, and Maryland. California dominates the total dental benefits market as it does in all dental product lines. Texas comes at a distant second in total market penetration.

Please note: the enrollment numbers in this graph represent an estimate of the entire dental benefits market. Previous to <u>NADP/DDPA 2002 Enrollment Model</u>, state and regional enrollment number were reported, not estimated. Therefore, these penetration rates cannot be compared with previous NADP reports.

Also, previous to this report, some Health Plans include a limited dental benefit. In 2003, some health plans with this limited benefit were removed from the Discount Dental Plan Subtotal (2000-2002) which illustrates the dramatic decrease in Discount Dental Plans.

EXHIBIT III: Commercial Funding Sources for All Lines of Dental Benefits

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003

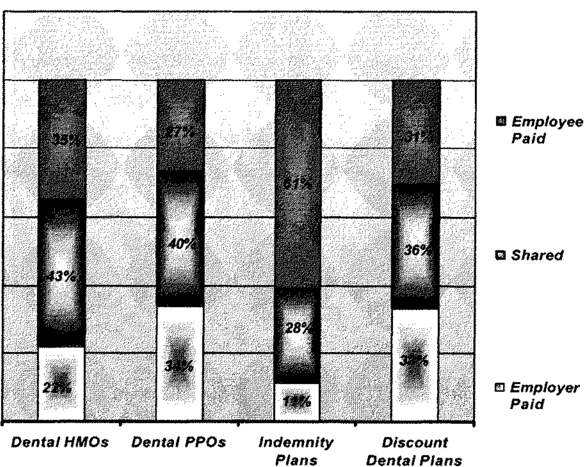


EXHIBIT III: Historical information indicates that employees are paying greater shares of dental benefits. In 2002, about one-fourth of DPPOs and one-third of DHMO & Discount Dental plans were paid for exclusively by employees. Almost two-thirds of employees in dental Indemnity plans pay 100% of premiums. This data shows that employers pay all dental premiums for employees in less than half the cases.

Note: Although, there were a few Delta plans that reported individually, this chart does not contain consolidated Delta Dental data.

EXHIBIT IV: Allocation of Shared Premium Costs 2000 to 2002

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003

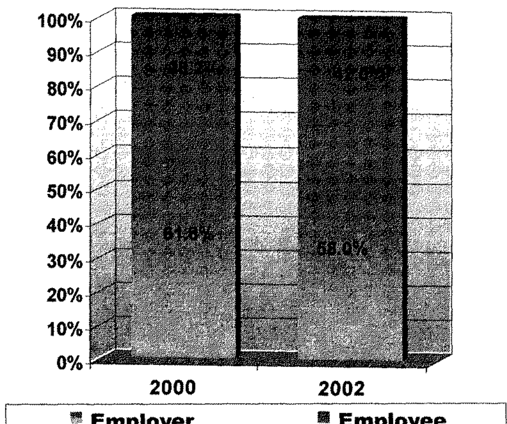


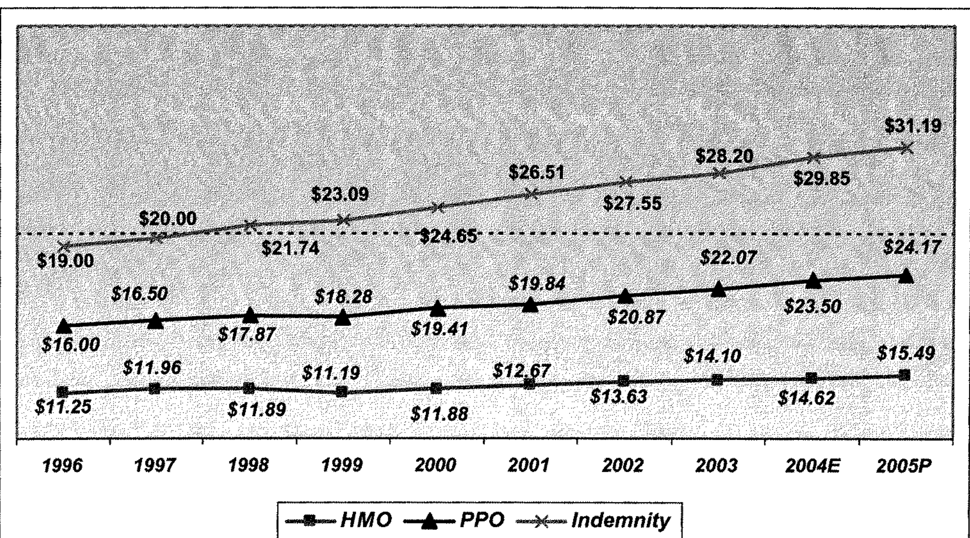
EXHIBIT IV: Of the employee/employer shared contributions, employers paid an average of 58.0% of the premium in 2002 and 61.8% in 2000. Employees paid an average of 38.2% in 2000 and 42.0% in 2002.

These results were not weighted by enrollment. Data was taken from 14 companies that provided 2000 data and 18 that provided 2002 data.

Note: Although, there were a few Delta plans that reported individually, this chart does not contain consolidated Delta Dental data.

EXHIBIT V: Comparison of Employee Only Monthly Premium Trends by Product (with Orthodontia) 1996 to 2005P

Source: NADP 2003 Dental Benefits Report: Premium Trends, October 2003



APPENDIX A—TERMINOLOGY

A common set of definitions is helpful in seeking dental benefits coverage. The terms used in this article are defined below:

Dental HMOs –refers to dental benefit plans that provide comprehensive dental benefits to a defined population of enrollees in exchange for a fixed monthly premium and pays for general dentistry services primarily under capitation arrangements with a contracted network of dentists. Enrollees must use network dentists to obtain coverage except where a point of service provision allows them to opt out of the network but at reduced coverage.

Dental PPOs --refers to dental benefit plans that have contracts with providers for the express purpose of obtaining a discount from overall fees. Enrollees receive value from these discounts when using contracted providers but may go outside the network of discounted providers but with a reduction in coverage. Providers are reimbursed on a fee-for-service basis after care is provided at either the discounted rate or the "ucr" (usual, customary, reasonable) rate recognized by the plan.

Dental Indemnity Plans–refers to benefit plans where the risk for claims incurred is transferred from employer to a third party insurer for a specified premium and providers are reimbursed on a fee-for-service basis and there are no discounted provider contract arrangements whereby the provider agrees to accept a fee below their customary fee.

Discount Dental Plans –refers to non-insured programs in which a panel of dentists agrees to perform services for enrollees at a specified discounted price, or discount off their usual charge. No payment is made by the discount plan to the dentists; dentists are paid the negotiated fee directly by the enrollee. These plans are sometimes referred to as "access plans" or "referral plans."

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Seltenheim.

Dr. Braverman, if you will bear with us for a moment. We have been very blessed to have our chairman of our full committee Chairman Tom Davis join us, and he is no stranger to caring about our Federal employees. And Chairman Davis, you are recognized for an opening statement.

Chairman TOM DAVIS. Well, first of all, thank you very much for being with us, and thank you, Madam Chairwoman and the other members. I think you can see the level of interest here on the subcommittee and full committee in trying to move this ahead.

FEHBP I think is a great program, but it's not going to remain a model for excellence in employer-provided health care coverage unless we continue to explore avenues to enhance the care and choice provided, And I would ask to put my entire statement in the record if that will be OK.

Mrs. DAVIS OF VIRGINIA. Without objection.

[The prepared statement of Chairman Tom Davis follows:]

Statement of Chairman Tom Davis
Government Reform Subcommittee on the Civil Service
Hearing on Dental and Vision Benefits in the FEHBP
Tuesday, February 24, 2004

Madame Chairwoman and Members of the Subcommittee, thank you for holding this important hearing today.

All of us here recognize the importance of the Federal Employees Health Benefits Program as we seek to recruit and retain the best federal workforce that this country has to offer. FEHBP covers over 8.6 million individuals, including 2.2 million federal and postal employees, 1.9 million federal annuitants, and 4.5 million dependents. There is no disputing that the FEHBP offers the widest selection of health plans in the country, enabling enrollees to compare the costs, benefits, and features of different plans.

However, this program will not remain a model for excellence in employer-provided healthcare coverage unless we continue to explore avenues to enhance the care and choice provided.

While dental benefits are currently available under most plans in the FEHBP, coverage is very limited. In addition, vision care is only available through HMOs. Over 15 years ago, OPM stopped allowing plans to add new dental and vision packages or to increase packages they already had in place, and consequently, the FEHBP has not kept pace in these areas. Today, an overwhelming majority of private-sector plans provide dental and vision coverage. In addition, numerous surveys have shown that federal employees and annuitants are very clear on this issue - more than any other benefit, they want better coverage for dental and vision care.

It's time to determine how to add dental and vision care to the insurance options provided under the FEHBP. H.R. 3751 provides a starting point to address this issue, requiring the Office of Personnel Management to submit a report to Congress outlining options available to provide dental and vision benefits to enrollees.

I commend the Subcommittee for taking a look at this issue today and look forward to working with all of you on this and other efforts to provide comprehensive, high-quality, affordable healthcare for our dedicated federal employees, annuitants and their families. The government's number one resource is its people, and they deserve nothing less.

Chairman TOM DAVIS. But we appreciate you being here today, and I think we would like to move ahead on this if we can. But see how the hearing goes, and maybe we can proceed to markup in the next few weeks. Thank you for your leadership.

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

Dr. Braverman, thank you so much for being patient, and now we will recognize you for 5 minutes.

Dr. BRAVERMAN. Thank you.

Chairwoman Davis and Chairman Davis and members of the subcommittee, I am Howard Braverman, past president of the American Optometric Association. Currently, I am chairman of the AOA's Industrial Relations Committee and I am proud today to represent the American Optometric Association on this most important issue that's before you.

The AOA is a national organization that represents more than 30,000 doctors of optometry, educators, and students. We are dedicated to improving the visual health of the public, and appreciate the opportunity to be here today to discuss the important issue of vision care in the Federal work force.

AOA fully supports the intent of H.R. 3751 to require the Office of Personnel Management to study the issue of vision and dental benefits, and also to recommend to Congress how these can best be offered to all Federal employees. This is not only an important benefit, but an important health care issue, one that can enhance both employees' quality of life and their efficiency and job performance in the workplace. We commend you for your leadership on this issue.

In my remarks today, I will outline for you the need Americans, especially those of working age, have for routine vision care as well as the extent to which employees desire a vision benefit.

The U.S. Department of Health and Human Services estimates that 64 percent—that's 64 percent of the work force older than 17—need some form of visual correction. But in addition to the work force, we are really talking about 160 million Americans who need eyeglasses or contact lenses. And the sad truth is that fewer than 93 million get regular vision health care.

Today, vision care has become a valuable benefit not only to employees but also to their employers. There are a number of factors that are influencing that realization to both employer and employee. The first is presbyopia. In the aging work force it is the No. 1 reason why employees today are seeking a vision benefit that not only includes a comprehensive eye health examination but glasses or contact lenses at a reasonable cost, for by age 40 people start to experience a visual loss in the ability to read due to the aging process.

The second reason is that computers in the workplace have now caused a new syndrome called computer vision syndrome [CVS]. Workers who spend considerable time at computers are significantly at risk for this syndrome that causes headaches, dry eyes, and other related problems. The ability to have regular eye health examinations and glasses at a reasonable cost can go a long way to combat this problem.

Employees today have realized that eye health care is a must for their families. Mothers and fathers have learned that if their chil-

dren can't see then they can't learn. And today, the State of Kentucky requires children to have a comprehensive eye health examination, not just a screening, prior to entering public school. However, whether it's required or not, parents are realizing that it's most important to have their children's eyes examined prior to entering school. A voluntary vision benefit would be a great help to employees to pay for their families' regular eye health care and glasses or contact lenses.

Routine eye examinations provide an opportunity for early detection of potentially life threatening health problems, such as high blood pressure, arteriolosclerosis, and diabetes, diseases which, if they are not detected early, can result in major and expensive complications. There are many other serious conditions that can be identified through eye health examinations. They include glaucoma, cataracts, and macular degeneration, and of course diabetic retinopathy. Early treatment of these conditions is the key to avoiding serious or total vision loss.

Our senior citizens and our retirees have a great need for vision care, but only 16 percent have vision benefits. Forty percent of America's senior citizens report that the cost of routine eye examinations is just prohibitive. A recent Family and Work Institute study also found vision care to be one of the chief benefits that employees seek. In this study, vision benefits ranked second among nearly 40 optional benefits as the program for which they were willing to trade an existing benefit. In response to this demand, vision care benefit plans are more and more becoming one of the tools employers use to compete for talented employees.

For these reasons, and because people wear glasses and/or contact lenses for cosmetic reasons, a voluntary vision benefit for Federal employees will help control costs of these health requirements. The cost of a vision plan is low, about 3 percent of the cost of a medical premium. On average, American employees and their families would pay between $8 and $10 per month for their vision benefit. The premium is not so high that workers do not find it an attractive addition to their benefits portfolio.

The American Optometric Association supports regular eye examinations for everyone, and strongly endorses a voluntary benefit for Federal employees. We would be pleased to be of service in helping to point out the important considerations for selecting a vision plan. Improved access to eye care is an important component in any comprehensive health care strategy.

Before closing, I would like to also urge the subcommittee to favorably consider another piece of legislation, H.R. 3268, introduced by Congressman Cummings. H.R. 3268 would extend the same glaucoma screening coverage provided today by Medicare to Federal employees who are in high risk populations. This is a simple yet important step in the early detection and treatment of this debilitating disease. Caught early enough, glaucoma can be managed and serious damage, which can include blindness, can be prevented. The long-term savings both to society and to individuals whose quality of life will be preserved as a result of these screenings is well worth the modest investment to the program.

Thank you again for the opportunity to appear before this sub-committee, and I will of course be happy to answer any questions.

[The prepared statement of Dr. Braverman follows:]

Testimony of

Dr. Howard Braverman

Past President

American Optometric Association

February 24, 2004

House Committee on Government Reform

Subcommittee on Civil Service and Agency Organization

HR 3751, Dental/Vision Benefits for Federal Employees

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Introduction

Chairwoman Davis and members of the Subcommittee, I am Howard J. Braverman, O.D., Past President of the American Optometric Association (AOA). Currently, I am Chairman of the AOA's Industry Relations Committee, and I am proud today to represent the American Optometric Association on the issue before you.

AOA is the national organization that represents more than 30,000 doctors of optometry, educators and students. We are dedicated to improving the visual health of the public and appreciate the opportunity to be here today to discuss the important issue of vision care and the federal workforce.

AOA fully supports the intent of HR 3751 to require the Office of Personnel Management to study the issue of vision and dental benefits and to recommend to Congress how these benefits can best be offered to all federal employees. This is not only an important benefit but also an important health care issue, one that can enhance both employees' quality of life and their efficiency and job performance in the workplace. We commend you for your leadership on this issue.

In my remarks today, I will outline for you the need Americans, especially those of working age, have for routine vision care as well as the extent to which employees desire a vision care benefit.

Need for Routine Vision Care

The U.S Department of Health and Human Services estimates that 64 percent of the workforce older than 17 needs some form of visual correction. But in addition to the workforce, we are talking about 160 million Americans who need eyeglasses or contact lenses. The sad truth is that fewer than 93 million get regular vision health care.

Today, vision care has become a valuable benefit not only to employees but also to their employers. There are a number of factors that are influencing that realization to both employer and employee.

1. Presbyopia and the aging workforce are the number one reason why employees are seeking a vision benefit that not only includes a comprehensive eye examination but glasses or contact lenses at a reasonable cost. By age 40, people start to experience a visual loss in the

ability to read due to the aging process. People older than 40 not only need eye health examinations but also, in most cases, need eyeglasses or contact lenses to perform well in their job functions.

2. Computers in the work place have caused a new syndrome called "computer vision syndrome" (CVS). Workers who spend considerable time at computers are significantly at risk for this syndrome that causes headaches, dry eyes and other related problems. The ability to have regular eye health examinations and glasses at a reasonable cost can go a long way to combat this problem.

3. Employees have realized that eye health care is must for their families. Mothers and fathers have learned that if their children can't see, they can't learn. Today, the state of Kentucky requires children to have a comprehensive eye health examination (not just a screening) prior to a child's entering public school. Whether it is required or not, parents are realizing that it is most important to have their children's eyes examined prior to entering school. A voluntary vision benefit would be a great help

to employees to pay for their families' regular eye health care and glasses or contact lenses.

It is now recommended that children receive their first eye examination at six months of age. Using today's exam equipment, optometrists can check for symptoms of eye diseases like crossed-eye and lazy eye at this early age. They can also make certain that a baby's vision skills, such as eye-hand coordination, are developing properly. This first eye exam provides a baseline for the next comprehensive eye exam, which should be by age three.

4. Routine eye examinations provide an opportunity for early detection of potentially life-threatening health problems such as high blood pressure, arteriosclerosis and diabetes, diseases which, if they are not detected early, can result in major and expensive complications. There are many other serious conditions that can be identified through eye examinations, including glaucoma, cataracts, macular degeneration and diabetic retinopathy. Early treatment of these conditions is key to avoiding serious or total vision loss. Optometrists, in a routine exam, can diagnose

an eye disease even if the patient has not experienced any symptoms by examining the inside of the eye and using special equipment.

5. Senior citizens–retirees–have a great need for vision care but only 16 percent have vision benefits. Forty percent of America's senior citizens report that the cost of routine eye exams is prohibitive. Yet, the benefits of these eye exams are especially important to our senior citizens who are vulnerable to vision shifts, high blood pressure, cataracts and adult-onset diabetes.

Vision Care Benefits

In spite of the fact that annual eye examinations are an integral part of health care, only one third of American corporate health plans cover an annual eye exam. Seven out of 10 employees, however, desire a vision plan in their benefits portfolio. In fact, one study found that two-thirds of employees would trade a day off for a vision plan.

A recent Families and Work Institute study also found vision care as one of the chief benefits employees seek. In this study, vision benefits ranked

second among nearly 40 optional benefits as the program for which they were willing to trade an existing benefit. In response to this demand, vision care benefit plans are more and more becoming one of the tools employers use to compete for talented employees.

For these reasons and because people wear glasses and/or contacts for cosmetic reasons, a voluntary vision benefit for federal employees will help control costs of this health requirement. The cost of a vision plan is low, about three percent of the cost of a medical premium. On average, American employees and their families' pay between $8 and $10 per month for their vision benefit, the premium is not so high that workers do not find it an attractive addition to a benefits portfolio.

The American Optometric Association supports regular eye examinations for everyone and strongly endorses a voluntary benefit for federal employees. We would be pleased to be of service in helping to point out the important considerations for selecting a vision plan. Improved access to eye care is an important component in any comprehensive health care strategy.

Before closing I would like to urge the Subcommittee to favorably consider another piece of legislation, HR 3268, introduced by Congressman Cummings. HR 3268 would extend the same glaucoma screening coverage provided by Medicare to federal employees who are in high-risk populations. This is a simple yet important step in the early detection and treatment of this debilitating disease. Caught early enough, glaucoma can be managed, and serious damage, which can include blindness, can be prevented. The long-term savings, both to society and to individuals whose quality of life will be preserved as a result of these screenings, is well worth the modest investment to the program.

Thank you again for the opportunity to appear before the Subcommittee. I would be happy to answer any questions.

Mrs. DAVIS OF VIRGINIA. Thank you, Dr. Braverman, and thank you to all of our witnesses.

I would like to now move into the question-and-answer period, and I would like to yield to our Civil Service Subcommittee ranking member, Danny Davis. Mr. Davis, you have the floor.

Mr. DAVIS OF ILLINOIS. Thank you very much, Madam Chairwoman, and this is a question perhaps we could each respond to. Oftentimes when we start talking about dental health and the provision, there is a perception that it is too costly to provide. How do you respond to that perception?

Mr. SELTENHEIM. On a percentage basis of cost versus the medical premium, it's about 8 to 10 percent of the total medical premium that we see today. So we would say that it's an excellent benefit in relation to cost.

Dr. SHAPIRO. I would add, sir, that in the marketplace today there are such a wide variety of plans that if they were offered in a balanced program where this variety were added people could access the plan that best suited their individual needs. And as I indicated in my testimony, the price of some of these plans is very modest. You can then select the plan that is best structured to help you accomplish the types of cost savings you need to access your dental care.

Mr. DAVIS OF ILLINOIS. Would you have any recommendations in terms of cost sharing? That is, any part or percentage the employer should pay with the employee paying the rest.

Dr. SHAPIRO. My experience over my career of 25 plus years in this industry is that every employer views it in a different way. I will tell you, however, that in purely voluntary plans where there is no cost sharing, there is still a very high demand by employees. As the cost sharing goes up, of course then those numbers go up as well.

Mr. SELTENHEIM. And I would add that, you know, you can start with no contribution, you can then move to some employer contribution. And typically what the larger Fortune 500 firms are doing today is they are simply giving health credits that go toward medical and dental, so the employee has the choice as to the combination of medical and dental plans that they would choose to pursue based off of what their individual benefit needs are. So a family is going to have different types of benefit needs than an older couple or a single, so many employers are going to benefit credits and using that as a way of allowing the choice to be the employee's.

Mr. DAVIS OF ILLINOIS. Are we familiar with any research which delineates how important individuals feel that vision care is, how people feel about their vision, and the extent to which it should be taken care of?

Dr. BRAVERMAN. I can't speak to any particular plan, but I would be happy to supply the committee with the American Optometric Association studies that have shown how important vision care is and the advantages of having a voluntary vision plan. For example, the average cost of an eye examination and eyeglasses is well over $300. We are just looking at the premium for a stand-alone voluntary vision plan, it is one-third of that. So certainly we would be happy to supply you with that type of information, sir.

Mr. DAVIS OF ILLINOIS. Thank you very much.

I have no further questions, Madam Chairwoman.

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Davis.

Ms. Block, what is OPM's view of the adequacy of our current FEHBP dental and vision benefits, and how does it compare with the private sector?

Ms. BLOCK. Well, I don't have extensive data. My understanding is that there is a very broad range of what's actually offered in the private sector. So there is not a single model out there that one could compare us to. Without doubt, as has been said, we have established certain priorities in the FEHB Program, and those priorities have been in place for a number of years. And we work very, very hard, and under the guidance of Director James, as you know, we have worked particularly hard in the last few years to keep our premium increases below the national average and affordable for Federal employees and retirees.

Mrs. DAVIS OF VIRGINIA. Let me interrupt you.

Ms. BLOCK. And so there is a tradeoff involved.

Mrs. DAVIS OF VIRGINIA. Let me interrupt you right there. You said that those benefits have been in place for many, many years. Why hasn't OPM allowed any increases in the benefits since 1987?

Ms. BLOCK. Because to have allowed those increases without reducing medical benefits would have caused even greater premium increases than we have faced.

Mrs. DAVIS OF VIRGINIA. Does the administration have a position on providing an increase in dental and vision benefits for the Federal employees?

Ms. BLOCK. The administration does not have a position as yet on that issue.

Mrs. DAVIS OF VIRGINIA. When do you expect them to have a position on what I consider to be a very important issue?

Ms. BLOCK. I don't have a specific timeframe. But given the introduction of your bill, we are clearly looking at it.

Mrs. DAVIS OF VIRGINIA. What kind of a plan do you think that the Federal employees would probably take most advantage of? A stand-alone or what? Do you know?

Ms. BLOCK. I think that all of the issues that have been raised both by members of the subcommittee and the members of the panel are exactly the kind of issues that we would have to consider were we to do the study proposed under H.R. 3751. So I don't have an opinion at this time. Those are exactly the right issues to look at.

Mrs. DAVIS OF VIRGINIA. Is it possible to increase, in your opinion, the dental and vision benefits within FEHBP without expending any additional Federal money by reducing other rarely used health benefits currently offered by some of the plans? Assuming there are some pretty rare benefits that aren't used.

Ms. BLOCK. Well, there really aren't any rare benefits that aren't used. There is some group of people somewhere that are using every single benefit that is available now. The rate at which people use benefits of course varies, but the nature of the benefit dictates that certainly fewer people go to the hospital than visit the doctor; but we surely wouldn't want to reduce hospital benefits because that's the case. So we have carefully balanced the benefits with the help of our partners, the insurance carriers, over the years to try

to provide as good a balance of comprehensive benefits as we believe is affordable for our Federal employees and retirees.

Mrs. DAVIS OF VIRGINIA. What if you had an enrollee paid stand-alone package as opposed to an increase in the dental/vision benefits within the FEHBP? Do you think that would provide the best opportunities to select coverage suited to the needs of a particular employee and her family if it were an employee-paid stand-alone?

Ms. BLOCK. That would be one of the things we would have to look at as we study the issue more carefully toward evolving an administration position. I don't have a position at this time.

Mrs. DAVIS OF VIRGINIA. Do you think that offering a stand-alone dental/vision plan would result in damage to the current competitive foundation of the FEHBP, since current FEHBP health plans can distinguish themselves by combining supplemental dental policies with their health benefit plan?

Ms. BLOCK. I had not thought of it in that context, but it would certainly be something in the course of a study that we would want to discuss with the participating carriers in the FEHB program.

Mrs. DAVIS OF VIRGINIA. And just to clarify one thing, you said you are not allowed to give us recommendations? Is that what you said?

Ms. BLOCK. Yes. I believe that is the position of the Department of Justice that the legislative branch cannot require the executive branch to provide recommendations.

Mrs. DAVIS OF VIRGINIA. Thank you very much, Ms. Block.

Ms. Holmes Norton.

Ms. NORTON. I don't know if this is the park police case or not sprouting forward, Ms. Block, but my sympathy is with you. How many—approximately what percentage of employees have some dental health through FEHBP?

Ms. BLOCK. I think that depends on whether you consider what's available within the FEHBP plans, per se, or as Mr. Wristen mentioned in his statement, the various supplemental plans that are available.

Ms. NORTON. Give me both.

Ms. BLOCK. If you include the ones that have some supplemental benefit and/or an FEHBP benefit available, you are probably looking at close to 70 percent of the employees in the program. I don't have the exact number off the top of my head.

Ms. NORTON. So would you therefore characterize this as less a matter of access than of cost, since it looks like a great many have some form of dental insurance?

Ms. BLOCK. I think it's a question of how people view access, how or where they are, or what's available to them through the various plans, and what their expectations are.

Ms. NORTON. Would most of these—I note, for example, in Mr. Wristen's testimony—and I'm quoting here at page 2, the five open fee for service plans offer supplemental dental benefit plans to members at 100 percent of member cost. All of those supplemental plans would be at 100 percent of member cost. Now, it's hard for me to get around what you have done because it's hard for me to say that you have made an incorrect judgment in assuming that simply adding dental could be done without some kind of tradeoff, unless the Federal Government were willing to step up somehow

with a greater amount of money. Let me ask you this. Given your experience—and don't tell me you haven't done a survey, I understand that. Do you believe employees would rather have a greater contribution to their FEHBP plan, greater than 70 percent or whatever it is, if they were given that choice as opposed to dental and vision additions to their plan?

Ms. BLOCK. Ms. Norton, I truly am in no position to answer that question. I simply don't know the answer. I can't speak for Federal employees as a group.

Ms. NORTON. That's something—you know what? I don't know why FEHBP wouldn't at least—since 1987 have wanted to find out what employee preferences are. It seems to me that you ought to be doing that every few years anyway. Could I ask that you do that, to find out what their preferences are without promising to do anything, which are you not in a position to do anyway?

Ms. BLOCK. Well, I'm not in a position to promise that we could do such a survey, but it's certainly something that we could consider.

Ms. NORTON. Let me enter this notion about a wholly different infrastructure. Clearly, if an employee wants to pay for it, they can get dental, some dental. Now, are most of these plans—what we are accustomed to hearing is that these companies will pay for an itsy bitsy amount of what the dental work costs. I'm not sure about vision work. Are most of these 70 percent employees getting fairly minimal benefit in costs toward their dental work out of these plans?

Ms. BLOCK. I think each plan has a different structure, so I can't really generalize for all of them. Clearly, always, as with the FEHBP in general, premiums have to cover the cost of providing the benefit. That's always the issue. You always need to be sure that you have enough revenue to provide the services that you are contracting to provide. And that's why I don't know the answer. We don't get involved in any way with the non-FEHBP dental offerings, so I don't know data on them.

Ms. NORTON. What about the FEHBP dental offerings? Is that minimal? Tell me what you do know, Ms. Block.

Ms. BLOCK. The FEHBP, the current FEHBP offerings are typically a fee schedule, and that fee schedule has not increased in recent years.

Ms. NORTON. So that's what makes the amount so low that the employee can get?

Ms. BLOCK. And that's typical. There are exceptions to that. I mean, some of the HMOs actually provide services, for example. So again, because we have so many choices in the FEHB Program, there is no single structure or benefit pattern that I can say is typical of all of the FEHBP.

Ms. NORTON. What I'm confused about, and perhaps you, Ms. Block, perhaps the other panelists, can help me out on, is the notion of a stand-alone plan. I mean, why would we want an entirely new infrastructure that somebody has to pay for? That's what we have now. We have thousands of insurance companies, and that's where all our money goes. Our money doesn't go to health care, it goes to keep health care plans running. So once somebody tells me that we need another stand-alone something, I want to know more

about what you mean by a stand-alone plan, why whatever we are talking about couldn't just be part of FEHBP. That stands right there. Why couldn't we just incorporate it in there? What is to be gained by a wholly new infrastructure for some of the health care we would provide our employees?

Ms. BLOCK. Well, since we have not made any proposal in terms of any approach, I would defer to the other members of the panel who have addressed this issue.

Mr. SELTENHEIM. In terms of an objective for employees, I think the value of stand-alone benefits that is not within necessarily the medical offerings themselves could result in a high reimbursement rate and less out-of-pocket cost to the actual employees and their family members. I mean, I think that's part of the value of doing a study, is to take a look at what the reimbursement rate levels are today under some of the various plans and make a determination.

Ms. NORTON. Could you explain why—less cost to employee and higher reimbursement rate if it's a stand-alone plan?

Mr. SELTENHEIM. Right.

Ms. NORTON. Would you have several plans all competing with each other?

Mr. SELTENHEIM. And that's part of what helps to I think provide an opportunity. With the opportunity of choice employees can make a determination as to what benefit level are they seeking, what type of network do they want to have access to, and they can make a decision as to potentially what their out-of-pocket costs are. As of right now, where there are offerings it's in fact embedded within medical plans, although there are some supplemental programs available. I think it's a matter of offering employees greater choice, is what it boils down to.

Ms. NORTON. Thank you, Madam Chairwoman.

Mrs. DAVIS OF VIRGINIA. Before I go to Mr. Van Hollen, I just want to say—I had a town hall meeting recently and talked about the long-term health care plan, and it is my understanding that it is strictly with one carrier, and there is no competition. A lot of the people don't feel that they have a real choice because there is no competition.

Ms. NORTON. For FEHBP?

Mrs. DAVIS OF VIRGINIA. For long-term health care insurance.

Ms. NORTON. For our long-term health care? Well, maybe Ms. Block would want to tell us why they decided on that.

Mrs. DAVIS OF VIRGINIA. That's another hearing, and we are going to ask those questions then. But I think that's the whole——

Ms. NORTON. We didn't just—we are not doing a monopoly here. There was a competition, but they competed and this is the guy who said he would give us the best price.

Mrs. DAVIS OF VIRGINIA. Right. And there are a lot of complaints because they don't feel they have a choice now. And that's why I think that doing this where you have several different plans and several different carriers would give Federal employees better options. I don't know, but we can ask those questions at another hearing. I don't want to beat this horse to death.

Mr. SELTENHEIM. Just another thought. It's not only a matter of cost and types of plan, but it's also a matter of access. Who has a

large network in a particular area that would become attractive to an employee is something else to factor in.

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Seltenheim.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Madam Chairwoman.

I have a question, Ms. Block, just in terms of the administration's position on this. I realize you don't yet have a position, we don't know exactly when you have will have a position. I don't know what the schedule is for moving forward with the markup, but I hope we will have the benefit of the administration's views before that time. I want to make a distinction here because I wasn't quite clear what you meant by saying the Attorney General has taken the position that you are not required to make recommendations based on a request from Congress. It's one thing to say you oppose the bill, it's another thing to take the position that if the bill passes, because of separation of powers issues you are still not going to respond because it requires recommendations. And so what I want to know is if you're suggesting that the administration is taking the position that even if this bill passes that you are not required to respond.

Ms. BLOCK. No. I don't want to be misunderstood. We would be required to respond. We would certainly do the study, and we would be pleased to provide options. We simply would not be able to give recommendations unless the administration chose to do so.

Mr. VAN HOLLEN. OK. So you would——

Ms. BLOCK. I don't mean in any sense that we would disregard the provisions of the bill.

Mr. VAN HOLLEN. So you would respond by providing options, but not say this is our preferred option. Is that it?

Ms. BLOCK. That's correct.

Mr. VAN HOLLEN. Thank you. Just with respect to the last paragraph of your testimony, you said that, "OPM has been gathering information on dental and vision programs so that we can be aware of the practices of other employees and cognizant of industry trends. I also would be happy to offer information I have about how such programs are structurally administered by the industry for other purposes."

Could you give us, based on that review, your conclusions as to whether you see others in the industry providing greater benefits and still being able to contain costs in a way that could be a model? I understand you can't bless any model that could be a good model for us.

Ms. BLOCK. Well, that's exactly what we've started from a very preliminary perspective to look into. And at this point we're just asking questions. We have certainly not reached any conclusion. I have had the good fortune of meeting with some of the members of the panel, for example, and the organizations that they represent. But it has been strictly in terms of trying to understand how the industry functions and what the industry offers other employers in terms of structures, plan type, and so on. So we're at the very preliminary stages of trying to collect that kind of information, since up until now we have not offered or thought about a discrete benefit for dental or vision. This is very preliminary-stage information gathering for us.

Mr. VAN HOLLEN. OK. Now, I'm not sure I understand exactly how the FEHBP works in this respect. As I understand it, we put a freeze on an expansion of dental benefits under FEHBP; is that right?

Ms. BLOCK. Well, what we have done in terms of the expansion of any benefit, we have had a tradeoff policy for the expansion of any benefit in the FEHB Program for a number of years. And that's for cost containment purposes. So any time a carrier proposes to increase benefits or add benefits in one area, we look for a tradeoff that will cover the cost of expanding that benefit from some other area.

Mr. VAN HOLLEN. Sure. OK. So if a carrier is providing a plan under FEHBP right now, and they came to you and said, we want to expand dental benefits in this way and we're going to reduce other benefits in that way, they could do that now.

Ms. BLOCK. Well, we would prefer that they wouldn't. And we have asked carriers not to do that for a number of years because we have made the determination that, as valuable as we believe dental and vision benefits to be—and I don't want to at all give the impression that we don't understand the importance of those benefits, indeed we do, as we understand the importance of other benefits that our employees have expressed an interest in—we have simply made the determination that things like hospital care, physician care, maternity care——

Mr. VAN HOLLEN. If I might ask you——

Ms. BLOCK [continuing]. Are our priorities and those are the things that we need to prioritize.

Mr. VAN HOLLEN. Yes, I understand that. And that may well be my choice. And I don't know how FEHBP works completely, but my understanding—let's say a carrier was given that choice, and they did increase dental benefits and they reduced benefits somewhere else; isn't the ultimate choice left to the consumer?

Wouldn't that mean that they had—why would they do that if they didn't think more people were going to sign up? And if they did think more people were going to sign up, why don't you let them take the risk in making that determination rather than deciding for them?

Ms. BLOCK. There are other considerations that have to be weighed, considerations that have to do with anti-selection, for example. If one carrier offers a benefit that is typically used by otherwise low-utilizing members and drops a benefit that is typically very expensive, therefore discouraging enrollment in that plan by high-utilizing members, you get into a very dangerous anti-selection situation. And that's another part of the equation that we have to consider.

Mr. VAN HOLLEN. Thank you. Thank you very much.

Thank you, Madam Chairwoman.

Mrs. DAVIS OF VIRGINIA. Thank you, Mr. Van Hollen.

I enjoyed hearing the exchange on that and I guess I'm not real sure what you just explained, because I sort of liked what Mr. Van Hollen said, because when I came on board and saw the brochure on all these different plans, I mean, there were a gazillion choices. So why not, if we had a carrier that wanted to offer more dental, why not give the employee that choice?

The other thing that I thought was—my legal counsel was trying to explain it to me—in your responses several times, you said you have done it to keep the cost down. Boy, do I hear from my constituents how they get a little bit of a raise and their cost goes up 47, 48 percent on their health insurance. So I'm not sure I follow that line item. Maybe you can explain it to me later.

I want to thank all the witnesses for coming. We probably will have some questions for you for the record if we can submit them to you in writing and have you respond. And we will make sure that our members all have that same opportunity.

I'd like to again thank all of you for coming. I do think this is a very important issue and one that we hear about a lot from our Federal workers. Dental and vision plans are very important to them. So I'm certainly hoping that if we can get this bill passed, that we can get a study from OPM and maybe do something to help our employees from here on out. But thank you all very much for coming.

With that, the hearing is adjourned.

[Whereupon, at 4:15 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Statement of
Dr. Lowell G. Daun
Delta Dental of California

Hearing Title:
"We'd Like to See You Smile:
The Need for Dental and Vision Benefits
For Federal Employees"
February 24, 2004

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

STATEMENT OF DR. LOWELL G. DAUN, DDS, SENIOR VICE PRESIDENT FOR FEDERAL PROGRAMS, DELTA DENTAL OF CALIFORNIA. FEBRUARY 24, 2004

Thank you, Mr. Chairman.

Madam Chairwoman and distinguished members of the House Subcommittee on Civil Service and Agency Organization of the Committee on Government Reform: I would like to commend and thank the Subcommittee for its decision to explore the issue of dental and vision benefits for Federal civilian employees. I appreciate the opportunity to provide this statement for your consideration as you address this important issue.

My name is Dr. Lowell Daun and I am Senior Vice President for Federal Programs with Delta Dental of California. I also serve on the Delta Dental Federal Marketing Group (DFMG), a consortium of Delta plans that, under the leadership of Delta Dental of California, oversees the provision of dental benefits to military retirees and eligible family members under the Department of Defense TRICARE Retire Dental Plan (TRDP).

The lack of a comprehensive dental benefit has long been recognized as a gap in the health benefits available to Federal employees. In 1997, the following ran in a Federal Diary column in the *Washington Post* during open season for the Federal Employee Health Benefit Program (FEHBP): "The most-asked question about the Federal health benefits program may be: Why are dental benefits so poor?"[1] Over the past seven years, not much has changed: a Federal Diary column that ran just days ago noted that: "(f)or most Federal employees, their dental benefits are nothing to smile about. In fact, for numerous Federal employees, they are a kick in

[1] M. Causey, "*Picking Up the Dental Tab*"; **Washington Post**, Dec. 1997

the teeth." [2] After all this time, it is both exciting and encouraging to see renewed efforts being led by this Subcommittee to address this topic.

I'd like to begin by providing some background information about Delta Dental, Delta plans, and some of our experience with other key Federal dental insurance plans.

Delta Dental of California

Delta Dental of California is the largest of 39 independent Delta plans throughout the country that form a national network of local, not-for-profit dental service corporations. These Plans are all members of the Delta Dental Plans Association (DDPA), an umbrella organization that exists to coordinate the activities of the member plans and enhance their ability to provide dental benefits programs to customers and subscribers. Founded in 1954, Delta member plans conduct business in all 50 states, the District of Columbia and Puerto Rico, and are now collectively the largest dental benefits carrier in the nation covering more than 43 million Americans. Delta maintains participation agreements with three out of four dentists nationwide.

Delta Dental of California was the original contractor for the Defense Department's first comprehensive dental benefit for family members in 1987. We managed that contract for approximately 10 years, during which time we provided dental insurance coverage to approximately 1.8 million beneficiaries. Additionally, we have provided dental benefits to military retirees since 1997 and currently cover approximately 750,000 beneficiaries under that program.

[2] S. Barr, "*On Capitol Hill, There's Talk of Improving Dental and Vision Coverage*"; **Washington Post**, February 12, 2004.

Dental Benefits for Federal Civilian Employees

While Active Duty military service members have traditionally enjoyed access to comprehensive dental care, family members of active duty personnel have had access to a comprehensive dental benefit since 1987 and, since 1997, military retirees have also had access to a comprehensive dental benefit.

For a number of years now, dental benefits covered under the FEHBP have been constrained by policies that limited expansion largely to new benefits explicitly mandated by law, or only allowed "budget-neutral" benefits substitution. While individual plans participating in the FEHBP were permitted -- even encouraged -- to co-market dental care as a voluntary "Non-FEHBP Covered Benefit," many of these are really discount programs, rather than insurance per se, and all of them offer much less coverage than a traditional, comprehensive dental benefit.

Much of the current debate surrounding the Federal government's ability to attract and retain a high quality workforce focuses on efforts to match private sector approaches in the use of innovative compensation and state-of-the-art benefits programs. In order for the Federal government to attract the "best and brightest," it has to compete with job opportunities in the private sector, both in terms of compensation and benefits.

It is ironic that, as the government advances towards becoming a "model employer" and introduces innovative benefits programs (such as the Long Term Care program and Flexible Spending Accounts), one of the most highly-valued employee benefits in the private sector--dental benefits--are simply not available to Federal civilian employees in a comparable fashion.

Large private sector employers have recognized the significance of dental benefits for employees for quite some time. A U.S. Chamber of Commerce Employee Benefits Survey found that dental benefits are the third most common benefit provided to employees behind medical and short-term disability. In addition to promoting oral health, a quality dental benefits program clearly aids in the recruitment and retention of employees. A Metlife Employee Benefits Trend Study found that 77 percent of surveyed employers offered dental benefits. There's a reason for that: according to a survey conducted by Taylor Nelson/Sofres Intersearch, 78 percent of employees believe dental benefits to be important when considering taking a job.

There are a number of challenges presented by introducing comprehensive dental insurance in the public sector. Cost is obviously a major consideration, and it must be recognized that the cost implications will be very different both to the government and the beneficiary, depending on whether the benefit is a contributory model like the Tricare Dental Plan (TDP) for family members of active duty personnel and members of the Reserve Component in which the government contributes a portion of the annual premium, or a non-contributory model like the TRDP for military retirees in which the entire cost of the annual premium is borne by the beneficiaries. Clearly, the ability and willingness of the government to support a contributory program will be determined through the Federal budgetary process. It should, however, be noted that the perceived value of any program offered and the resulting participation rates will vary depending on the existence and size of any of any government contribution to the annual premiums.

If cost considerations for the government prevent offering a contributory model at the present time, at a minimum, a non-contributory should be considered. Even if the beneficiary

pays the entire cost of the premium, the sheer size and purchasing power of the beneficiary population will make the benefit significantly less expensive to the beneficiary than if it were purchased as an individual insurance product. If this argument sounds familiar, it is precisely the same justification used for the voluntary approach chosen for the Federal Long Term Care insurance program. While the government did not contribute to the premiums, it nevertheless sought to pass on the savings attributable to its purchasing power to beneficiaries who elected to purchase it.

Existing Models

Let me offer a few observations about relevant examples from the Department of Defense.

<u>SINGLE NATIONAL CONTRACT</u>

The Department of Defense has historically used a single national contract to acquire dental benefits as a stand-alone product for its different dental programs. A major advantage of a single national contract for dental benefits is that it is known to be a proven, successful model. Furthermore, this model has been successfully introduced under two very different financing mechanisms: first, as a contributory program under DoD's TRICARE Dental Plan (TDP), in which the government pays 60% of the premiums; and second, as a totally non-contributory program under DOD's TRICARE Retiree Dental Plan, in which the beneficiary pays the entire cost of the premium.

OPM's recent introduction of its Long Term Care (LTC) benefit provides an indicator of success for a non-contributory plan, while the DoD dental plans offer solid evidence that the use

of a single national contract will clearly work under the two major financing alternatives. This should afford both the Executive and Legislative Branches a high level of confidence in the integrity of this general model.

A single national contract will have the advantage of being relatively simple to administer from the government's perspective. While a concerted effort will initially be required to design and procure the benefit, once completed, the government's responsibility for ongoing management and oversight will be limited to a single contractor. Assuming that the contract is awarded for a multi-year period, administrative oversight would be further simplified, as the period of performance (e.g., base period plus number of option years) increases. A national contract also offers equity through uniform national benefits, although not necessarily uniform premiums.

MULTIPLE NATIONAL CONTRACTS

The FEHBP currently offers beneficiaries a choice of national plans regardless of location. Beneficiaries can choose from among multiple national contracts, including national Blue Cross/Blue Shield options, as well as several union and employee organization plans open to anyone, regardless of location. An advantage of multiple national contracts is that beneficiaries have a choice of plans to fit their particular family health situation.

Also competition among multiple national contractors will have a favorable impact for beneficiaries as carriers continuously compete against each other on the basis of important variables, such as price, customer service and quality. Obviously, any administrative savings and simplicity of oversight offered by a single national contract are reduced as the number of contractors increases.

ONE REGIONAL CONTRACTOR IN EACH OF SEVERAL REGIONS

A single regional contractor in each of several regions is a model currently used by DoD in its most recent generation of Managed Care Support (MCS) contracts. This is effectively a regional "winner-take-all" approach, in which the winner takes all of a defined territory.

Under this model, the entire national beneficiary population is never at risk in the event of plan failure. And contractors may have a somewhat easier task of developing comprehensive provider networks with an optimal number and mix of participating providers, if network development is either required encouraged. The territory for each contractor is simply smaller.

This model avoids the political challenges often associated with a "Winner take all" approach by providing multiple winners and spreading eventual economic advantages across a potentially wider front.

To summarize:

- Comprehensive dental care has always been provided directly by military and civilian dentists for active duty military personnel, and through dental insurance for spouses, family members since 1987, and retirees since 1997;

- Dental coverage is a standard benefit for most large private employers with which the government often competes for top quality workers;

- Current FEHBP-covered dental benefits are sporadic and limited;

- Federal employees deserve a good dental benefit as part of an overall compensation package;

- Much of the debate about a human capital resource strategy for the Federal government focuses on innovative approaches to human resource issues like pay-for performance, pay-banding, etc. Yet, a very basic benefit, like dental and vision coverage, is absent from the Federal benefits package;

- Lack of these benefits for the Federal civilian population is a notable omission in an overall benefits package designed to compete favorably with the private sector;

- The Federal government could greatly enhance the appeal of its compensation package if it made dental and vision coverage available to Federal employees--even if initially on a non-contributory basis -- as was done with long-term care;

- Two very successful and very different models of national dental benefits already exist within the military; and

- Dental benefits will be enhanced when combined with the tax-savings of the new Flexible Spending Accounts (FSA).

Again, Madam Chairwoman, I appreciate this opportunity to provide my views and experience with one portion of the Federal government in providing dental benefits and my thoughts as to how I believe a dental benefit for Federal employees could be best administered. Delta Dental remains committed to assist the Committee in its efforts to provide a dental benefit for Federal civilian employees. Thank you.

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on

"We'd Like to See You Smile:
The Need for Dental and Vision Benefits
for Federal Employees"
H.R. 3751

In Connection with the February 24, 2004
Hearing before the House Subcommittee on
Civil Service and Agency Organization of the
Committee on Government Reform

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Introduction

The American Dental Hygienists' Association (ADHA) appreciates this opportunity to submit testimony for the record of the February 24, 2004 House Civil Service and Agency Organization Subcommittee hearing entitled "We'd Like to See You Smile: The Need for Dental and Vision Benefits (H.R. 3751). ADHA enthusiastically supports this important legislation, which would require the Office of Personnel Management to study the options for enhancing federal dental benefits and to issue recommendations to Congress. This OPM study is vital because current dental benefits for federal employees are severely lacking.

ADHA applauds the Civil Service Subcommittee for holding this hearing on the importance of oral health benefits for the federal family. ADHA is hopeful that henceforth, whenever members of the Subcommittee think of general health, they will also think of oral health. As the May 2000 *Oral Health in America: A Report of the Surgeon General* has confirmed, oral health is a fundamental part of overall health and general well-being.

Unlike most medical conditions, the three most common oral diseases -- dental caries (tooth decay), gingivitis (gum disease) and periodontitis (advanced gum and bone disease) -- are proven to be preventable with the provision of regular oral health care. Despite this prevention capability, too many Americans seniors suffer from preventable dental disease. Clearly, more must be done to increase access to oral health care services. H.R. 3751 is an important step forward in improving access to oral health services.

ADHA is the largest national organization representing the professional interests of the more than 120,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals who are licensed in each of the fifty states. Dental hygienists are oral health educators and clinicians who, in coordination with dentists, provide preventive, educational, and therapeutic services supporting total health for the control of oral diseases and the promotion of oral health.

U.S. Surgeon General's May 2000 Report on Oral Health in America

The U.S. Surgeon General issued *Oral Health in America: A Report of the Surgeon General* in May 2000. This landmark report confirms what dental hygienists have long known: that oral health is an integral part of total health and that good oral health can be achieved.

Key findings enumerated in the Report include:

1. Oral diseases and disorders in and of themselves affect health and well-being throughout life.

2. Safe and effective measures exist to prevent the most common dental diseases -- dental caries (tooth decay) and periodontal (gum) diseases.

3. Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.

4. There are profound and consequential oral health disparities within the U.S. population.

5. More information is needed to improve America's oral health and eliminate health disparities.

6. The mouth reflects general health and well-being.

7. Oral diseases and conditions are associated with other health problems.

8. Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth and teeth.

With nearly two million federal annuitants, the oral health of older adults is of particular importance to the consideration of this legislation. The Surgeon General's Report on Oral Health specifically examined the oral health of older adults. Some of the key findings are set forth below:

1. Twenty-three percent of 65-74 year olds have severe periodontal disease (measured as 6 millimeters of periodontal attachment loss). At all ages men are more likely than women to have more severe disease, and at all ages people at the lowest socioeconomic levels have more severe periodontal disease.

2. About 30 percent of adults 65 years and older are edentulous (without natural teeth), compared to 46 percent 20 years ago. These figures are higher for those living in poverty.

3. Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 8,000 die from these diseases each year. These cancers are primarily diagnosed in the elderly. Prognosis is poor. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.

4. Most older Americans take both prescription and over-the-counter drugs. In all probability, at least one of the medications used will have an oral side effect—usually dry mouth. The inhibition of salivary flow increases the risk for oral disease because saliva contains antimicrobial components as well as minerals that can help rebuild tooth enamel after attack by acid-

producing, decay-causing bacteria. Individuals in long-term care facilities are prescribed an average of eight drugs.

Clearly, too many Americans have significant unmet oral health needs. This is problematic for a number of reasons, including:

- Oral health problems can impede speaking, chewing and swallowing, adversely affecting interpersonal relations and proper nutrition. Seniors who can not interact socially become increasingly isolated, which can lead to depression. Seniors who have difficulty with chewing and swallowing find it difficult to maintain a proper diet and to take required medications.
- Research increasingly demonstrates a link between oral health and systemic health. The presence of periodontal disease has been linked to a number of systemic conditions, including coronary heart disease and stroke.
- The Centers for Disease Control (CDC) reports that the mouth can serve as an early warning system, alerting oral health providers of possible trouble in other parts of the body. For example, studies in post-menopausal women suggest that bone loss in the lower jaw may precede the skeletal bone loss seen in osteoporosis.
- Oral health care providers routinely examine patients for oral cancer. The incidence of oral cancer (which includes lip, oral cavity, and pharyngeal cancer) increases with age and is difficult to detect without an oral exam. Persons 65 years of age and older are seven times more likely to be diagnosed with oral cancer than those under age 65. Indeed, more older Americans died from oral cancer than from skin cancer in 1997. Oral cancers result in approximately 8,000 deaths per year, more than half of these deaths are among persons 65 years of age and older.
- Seniors who are edentulous (without natural teeth) and lack well-fitting dentures often suffer from poor self esteem and may have difficulty with such fundamental activities as speaking, chewing, and eating.

Lack of Oral Health Insurance

The failure to integrate oral health effectively into overall health is seen in the distinction between oral health insurance and medical insurance. While 43 million Americans lack medical insurance, a whopping 108 million -- or 45% of all Americans -- lack oral health insurance coverage. Studies show that those without dental insurance are less likely to see an oral health care provider than those with insurance. Moreover, the uninsured tend to visit an oral health care provider only when they have a problem and are less likely to have a regular provider, to use preventive care or to have all their dental needs met. Indeed, Medicare does not cover any routine oral health services and allows only a narrow exception for coverage of certain dental services necessary to the provision of Medicare covered medical services such as extraction of teeth prior to radiation treatment of the jaw.

ADHA urges this Subcommittee and all Members of Congress to work to strengthen and enhance dental benefits offered to federal employees. ADHA looks forward to a future in which all Americans have dental health insurance coverage.

Improving the Nation's "Oral Health IQ"

This House Subcommittee hearing is a critically important step forward in the effort to change perceptions regarding oral health and oral disease so that oral health becomes an accepted component of general health. Indeed, the perceptions of the public, policymakers and health providers must be changed in order to ensure acceptance of oral health as an integral component of general health. AHDA urges members of the Civil Service Subcommittee to work to educate their colleagues in Congress with respect to the importance of oral health to total health and general well-being. This hearing is an important signal to the public that oral health is important. ADHA hopes that further signals will be forthcoming.

The national oral health consciousness will not change overnight, but working together we can heighten the nation's "oral health IQ." ADHA is already working hard to change perceptions so that oral health is rightly recognized as a vital component of overall health and general well being. For example, ADHA has launched a public relations campaign to highlight the link between oral health and overall health. Our slogan is "Want Some Lifesaving Advice? Ask Your Dental Hygienist."

This ADHA campaign builds on the Surgeon General's report, which notes that signs and symptoms of many potentially life-threatening diseases appear first in the mouth, precisely when they are most treatable. Dental hygienists routinely look for such signs and symptoms. For example, most dental hygienists conduct a screening for oral cancer at every visit and can advise patients of suspicious conditions.

Conclusion

In closing, the American Dental Hygienists' Association appreciates this opportunity to participate in the House Subcommittee on Civil Service hearing on the need for dental benefits for federal employees. ADHA is committed to working with lawmakers and others to improve the nation's oral health which, as *Oral Health in America: A Report of the Surgeon General* so rightly recognizes, is a vital part of overall health and well-being.

Thank you for this opportunity to submit the views of the American Dental Hygienists' Association. Please do not hesitate to contact ADHA Washington Counsel, Karen Sealander of McDermott, Will & Emery (202/756-8024), with questions or for further information.

"We'd Like to See You Smile: The Need for Dental and Vision Benefits for Federal Employees (H.R. 3751)"

Subcommittee on Civil Service and Agency Organization
Chairwoman Jo Ann Davis
Questions Submitted for the Record

March 9, 2004

- **I've often found that dental and vision benefits are the most requested health benefits after regular health insurance. What is OPM's view of the adequacy of current dental/vision benefits provided under FEHBP?**

  The Federal Employees Health Benefits Program (FEHBP) does not currently provide comprehensive dental and vision coverage. However, five FEHBP fee-for-service plans, Blue Cross and Blue Shield Service Benefit Plan, Mail Handlers Benefit Plan, Association Benefit Plan, Rural Carrier Benefit Plan and SAMBA Health Benefit Plan offer supplemental dental and vision coverage to their members on an enrollee-pay-all basis. It should be noted that the latter three plans are only open to specific groups of employees. The Government Employees Hospital Association (GEHA) supplemental dental and vision plans are available to all Federal employees and annuitants, not just members of the FEHBP GEHA plan. In addition, employees can pay for out-of-pocket medical expenses, including dental and vision costs, using pre-tax dollars through the Flexible Spending Account Program (FSAFEDS), which was implemented in July of 2003.

- **In your statement, you said, "OPM has been gathering information on dental and vision programs so that we can be aware of the practices of other employers and cognizant of industry trends. I also would be happy to offer information I have about how such programs are structured, administered by the industry for other purchasers." In light of what you have found, how do dental offerings in the FEHB compare with those in the private sector?**

  While we have no formal data on private sector practices, we have been collecting information for several months and we have learned something from industry providers and from our informal research. We believe that many employers offer dental and vision coverage as part of their benefits package. However, those offerings are structured in many different ways. Often they are carved out as separate programs which may be offered on a contributory basis. Stand alone programs tend to have more comprehensive benefits than offerings incorporated into a comprehensive health plan.

- **Does OPM currently believe that the level of dental and vision offerings for federal employees are adequate? Should these benefits be increased, decreased, or left as they are?**

We continually review the Federal government's health benefits package. As part of our on-going review, we will soon be conducting a formal survey with results expected in the Fall of 2004, to better gauge employee perception of their current benefits package.

- **H.R. 3751 would have OPM undertake a thorough reevaluation of its policy towards dental and vision benefits in the FEHBP, and make recommendations to Congress for possible changes. When was the last time OPM conducted a significant comprehensive reevaluation of its dental/vision policy?**

OPM reevaluates its health benefits policy each year prior to issuing the Annual Call Letter that provides negotiations guidance to the FEHB carriers. Consideration of dental and vision benefits as part of the overall health benefits package is routinely a part of that evaluation. Around 1990, in recognition of the fact that dental coverage in the Program was not keeping pace with increasing costs of services, OPM encouraged participating plans to offer a non-FEHB dental benefit (as well as other ancillary benefits such as vision care) to Federal members. We created a non-FEHB benefits page in the plan brochures that facilitates providing information on non-FEHB benefits offerings to enrollees.

- **As you stated in your testimony, OPM has begun gathering information to revisit the issue of dental offerings for federal employees. How long has OPM been looking into this issue? What type of information are you currently analyzing? When will the Administration take a position on the need for extending dental benefits?**

We have been gathering information for several months and we are continuing to compile and collect data. We have met with leading service providers and have asked them for data on costs and participation rates for the different structures typically offered by other purchasers. We will also be conducting a survey to better gauge employee perception of their current benefits package and we will review the impact on recruitment and retention. The Administration has not taken a position while we are still compiling and collecting data.

- **In your testimony, you stated that FEHBP would suffer adverse selection if OPM were to lift the freeze on dental benefits and allow each carrier to include dental benefits as each saw fit, with each employee choosing a plan based on individual needs. Can you further clarify why this option would be a detrimental situation for the FEHBP?**

Cross subsidization, which spreads the risk over a large group of people, is at the foundation of group health insurance. Without cross subsidization, the premium equals the cost of the benefit. When a plan offers a diverse and comprehensive package of services, the claims experience is spread among all of the members. In a consumer choice environment like the FEHBP, if one plan's benefits package is designed to attract enrollees who typically utilize fewer or lower cost services and at the same time not

attract potentially more costly members, adverse selection or anti-selection against the other plans in the Program occurs because, over time, the high utilizers congregate in those plans that have retained coverage for the more expensive services they need and use. As those plans' premiums keep escalating, more and more healthier enrollees leave for other plans. Plans that have experienced such a "death spiral" in the FEHBP have left the Program over the years. In order to keep its premiums competitive while enriching its dental benefit, a plan would have to reduce or eliminate coverage elsewhere in its benefits package, setting the stage for adverse selection in the Program.

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Dr. Howard Braverman, AOA:

- **What level of vision coverage is typically offered by private sector plans? Do any plans within the FEHBP currently offer this type of coverage or anything similar?**

  A typical plan would provide coverage for a yearly comprehensive eye health examination, corrective lenses or contact lenses yearly, and an eyeglass frame every two years. We are unaware of any FEHBP currently offering this type of coverage.

- **In your testimony, you cited a study showing that vision benefits ranked second in a list of 40 benefits that employees most want. Do you think that adding vision benefits to the FEHBP would significantly help the federal government compete for employees in a tight labor market?**

  Yes, based on the results of employee benefit preference studies, I believe that adding this benefit would be a significant help in competing for qualified employees.

- **How could vision-related health problems affect the productivity of federal workers and thus the effectiveness of federal government programs?**

  Employee productivity can be affected in many ways by vision related health problems. Conditions can range from Computer Vision Syndrome to cataracts and glaucoma, and each could have a significant impact on productivity. CVS sufferers can experience serious headaches and dry eyes, which result in inability to perform necessary functions and missed days at work. The more serious problems such as glaucoma can lead to reduced vision or blindness if not diagnosed and treated in a timely manner.

ALL:

- **Studies have indicated that overall health is closely related to dental and vision health. Would adding these options to the FEHBP likely result in greater overall health of the federal workforce?**

  Certainly adding a vision benefit is likely to result in greater overall health of the federal workforce in two essential ways; first by assuring optimal visual performance, and second by acting as a preventive measure to diagnose and treat serious eye and systemic diseases in a timely manner.

- **In your opinion, what is the best reason for increasing dental and vision benefits to federal employees?**

  The best reason is that adding this coverage is a win-win for both employees and the federal government. Employees will gain access to cost-effective important care for themselves, and their families, and the government will be improving the efficiency of the workforce.

Dr. Stanley Shapiro
"We'd Like to See you Smile: The Need for Dental and Vision Benefits for Federal Employees (H.R. 3751)"
Subcommittee on Civil Service and Agency Organization
Chairwoman Jo Ann Davis
Questions Submitted for the Record
March 9, 2004

Questions and Responses:

ALL

Studies have indicated that overall health is closely related to dental and vision health. Would adding these options to the FEHBP likely result in greater overall health of the federal workforce?

The Surgeon General's report established that oral health is integral to general health, and there is significant scientific evidence correlating both oral and visual health with general health and well-being. Despite this indisputable evidence, a relationship exists in all phases of healthcare between cost and access to care. Healthcare consumers rely upon insurance to minimize out of pocket costs. Therefore, the federal employees and their families would increase their access to dental and vision care with more favorable benefit plans, enhancing their health and retaining money that can be applied to other preventive and diagnostic medical benefits. The relatively low costs of dental and vision benefits will produce favorable health outcomes that far exceed the modest costs of purchasing the plans.

In your opinion, what is the best reason for increasing dental and vision benefits to federal employees?

As the largest employer in America, the federal government has the resources to establish an employee benefit program comparable to employers in the private sector, state and municipal governments. A voluntary program has minimal cost to the federal government, but potentially saves significant money for its employees. Dental and vision benefits provide value for each participating employee, but also incrementally reduce long term health expenditures by helping employees achieve optimal health and well being. Productivity will be enhanced through higher levels of health and job satisfaction within the federal workforce.

DR. SHAPIRO

Why shouldn't OPM work to promote the existing supplemental plans offered in FEHBP instead of offering a stand- alone plan.

The existing supplemental dental and vision benefits are inferior compared with benefits offered to private sector employees and employees of 48 of the 50 state governments. OPM has stated that the existing supplemental plans offered in FEHBP have not been enhanced in fifteen years. Furthermore, employees must differentiate the dental and vision benefits bundled with a particular health plan, resulting in decisions that are misinformed and costly. The popular trend toward Consumer Driven Health Plans recognizes the purchasing leverage achieved when complex benefits are unbundled and offered as distinct components with defined costs. A voluntary stand-alone program will provide superior benefits at lower costs, and the federal government will serve the best interests of its employees in a relevant and meaningful way.

How would adding dental and vision coverage through a separately contracted plan benefit the FEHBP and its participants? How do you respond to those who believe that this method would add needless complexity to OPM's management of the FEHBP?

Ninety-five percent of employers with more than 500 employees, as well as 48 out of 50 state governments, administer stand-alone voluntary dental and vision benefits for their employees. Typically, these programs are neither complex nor difficult to administer. Once the program is established, vendors provide information, enrollment materials, customer services, etc. OPM will be able to manage the FEHBP with minimal distraction from a stand-alone dental or vision benefit program, while differentiating medical benefits and costs more accurately for federal employees to utilize in the selection of plans and benefits options.

Can dental and vision benefits be added to the FEHBP in a cost-effective way that still provides adequate coverage for employees and their families?

Yes. A program of dental and vision benefits may be designed around prices and benefits that are cost-effective for employees and their families, and superior to any supplemental dental/vision plan currently available through the FEHBP. As the largest employer in America, the federal government has enormous purchasing leverage to establish benefits/prices on the most favorable terms. The current supplemental dental and vision

benefits are inferior when compared with plan designs and premium levels commonly available to smaller employers in the private and public sectors.

In your testimony you state that by adding a stand-alone dental/vision benefit to the FEHBP, the federal government would have a competitive edge in attracting quality employees. How important do you think these benefits are to prospective employees in today's labor market?

Prospective employees generally compare the aggregate value of salary plus benefits, and frequently differentiate job opportunities on the basis of benefits. The advantage of having a strong dental/vision benefits program is that they require relatively inexpensive payroll deductions, but provide significant cost savings when utilized by the employee. Outside the federal government, stand-alone dental and vision plans are commonplace and highly valued in employee surveys.

Responses to Questions Submitted for the Record
Subcommittee on Civil Service and Agency Organization
By
Jon K. Seltenheim
Chairman, National Association of Dental Plans

Questions Submitted to All Participants

- Studies have indicated that overall health is closely related to dental and vision health. Would adding these options to the FEHBP likely result in greater overall health of the federal workforce?

  As mentioned in my testimony on February 24, 2004, the link between caries, as well as advanced periodontal conditions with coronary heart disease, stroke and low weight, premature babies has been made in multiple studies. It has been discussed in the Surgeon General's Report on Oral Health in 2000 and was also the subject of a symposium at the National Institutes of Health in April of 2001. In general, research shows less of a direct causative effect but instead, more of an associative effect with substantial research continuing to prove the relationship between oral health and overall health. Researchers and the dental profession would be best qualified to describe the status of the latest scientific research as it relates to overall health.

  The position of the National Association of Dental Plans; however, is that dental benefits provide for better oral health as seen by greater utilization of dental services by those with dental benefits, versus those who are directly responsible for paying for their dental care. We know that the utilization of dental care increases from 50% to 70% when dental benefits are provided. We also know regular preventive dental care results in lower loss of teeth and improved oral health. Once again, as mentioned in my testimony, research has shown that there is a $4 savings in dental treatment for each dollar spent on preventive care.

  As the benefit levels/reimbursement rates for dental care are generally quite minimal in the existing program through the medical carriers, we believe that the federal workforce would more regularly seek dental treatment if a benefit with greater access and lower out-of-pocket costs was available. Given the linkages just mentioned in relationship to usage and improved oral health through preventive services, we can only conclude that the federal workforce would be healthier as a result of a stand-alone dental benefit.

- In your opinion, what is the best reason for increasing dental and vision benefits to federal employees?

  I will defer to Dr. Braverman and the AOA regarding vision benefits, but the best reason for offering a dental benefit is the need for benefit offerings to federal employees to be competitive with both their private business and other governmental

entity counterparts. As mentioned in my testimony, Mercer Human Resource Consulting identified in their 2003 Survey of Employer Sponsored Health Plans that 96% of employers with more than 500 employees and 98% of employers with more than 20,000 employees offer dental benefits. For city, county, and state governmental entities, the survey revealed that 95% of the entities with more than 500 employees offered dental benefits with a median deductible and maximums of $50 and $1,000 respectively. Based on my years of experience in the dental benefits industry, I do not believe that these percentages have varied much over the past 10 years, and more than likely, 15+ years.

Add to that the fact that the reimbursement levels for the existing FEHBP dental benefits program have not changed in years, it is clear that federal employees are at a benefit disadvantage in comparison to their private industry and other governmental peers. This would seem to provide ongoing challenges to the federal government when it comes to recruiting and retaining the "best and the brightest" for public service.

<u>Questions Personally Directed to Jon K. Seltenheim</u>

- What do you envision as an adequate level of coverage for the dental needs of federal employees? Do you find this level of coverage anywhere in FEHBP as it currently exists?

  The range of dental benefits that could be offered can be as simple as access to discounts through a recruited network, a dental health maintenance organization (DHMO) benefit with no deductible and no maximums, to fee-for-service programs with reimbursements for most procedures, including orthodontics, TMJ and even implants. Also influencing the benefit offering would be geographical considerations and the types of networks available locally, as well as whether there will be any contributions by the Federal Government.

  The overriding objectives that a successful offering of dental benefit choices should have would result in the following:

  - Assuming there are minimal or no contributions to the program by the Government, enrollment levels greater than 20-30% would be achieved initially, then rising to 60%-75% over subsequent years;
  - Substantial use of preventive and diagnostic benefits, greater than 50% of all services provided, in order to improve and stabilize oral health, as well as to control longer-term costs;
  - Depending upon the networks and products offered, satisfaction levels between 75% and 90% could be achieved, as measured by regularly conducted member satisfaction surveys.

  There are many more measures of a successful that could be identified, but these three summarize the most significant: enrollment, utilization and satisfaction.

The best approach for the government to determine the optimal offering should begin with a study of dental benefit programs available. This should begin by releasing a Request for Information (RFI) out to dental benefit carriers to study the types of products, networks, benefits and relative pricing levels available for the government's major locations. Literally the number of options available is innumerable, but gaining a better understanding of the "playing field" and matching that against known needs of the Federal employees is the best starting point.

It would also make sense to look at other comparable programs that can provide a benchmark for providing a choice of dental benefits. Given the contribution levels normally associated with large employers in the private sector, it may be better to look at large offerings in the public sector where there are no contributions by the governmental agency.

For instance, examining the present offerings through Tricare and the Department of Defense could be very helpful. The offerings are fee-for-service, but for the Reservists and the Retirees, the programs are entirely voluntary. These may be among the largest voluntary benefit programs offered anywhere today. Among some of the things learned would be marketing approaches, benefit levels, billing practices, network options, provider contracting and fee schedules, service options, credentialing and quality assurance practices, and utilization patterns.

Other benchmark subjects would be state governmental programs where the benefit is totally, or largely, paid by the enrollee. From personal experience, I am aware that the State of Maryland offers a voluntary DHMO program, while the State of Georgia offers a voluntary fee-for-service program. A scan of other states would reveal that these southern states would probably provide the best examples of voluntary offerings. Programs with contributions tend to be more prevalent in the north where negotiated benefits influenced the richness of the benefit design and the contribution levels.

NADP does not have enough detailed information to comment accurately on the benefit programs offered today through FEHBP. We are aware that, in general, the benefits tend to be relatively low in comparison to stand-alone programs for a variety of reasons and we strongly advocate using whatever contributions are provided for today within the medical program to be transferred to a stand-alone dental program. The value of doing this will be to maximize the initial enrollment and to minimize the chances of anti-selection amongst the earliest enrollees.

- Surveys have indicated that dental coverage is the most requested benefit after general medical benefits. How could adding dental benefits to the FEHBP be useful to the federal government as a human resources tool?

Due to the statistics mentioned earlier, a dental benefits program would offer a more competitive benefit package when an employee is weighing multiple job

opportunities, especially against an employer, private or public, with more than 500 employees. As 5% or less of employers of that size do not offer a stand-alone dental benefits program, the federal government seems to be at a disadvantage in a competitive situation.

Beyond the hiring process, retention of valued employees would also be a major consideration. For instance, employees with families are frequently challenged when their children require orthodontic treatment and bearing the entire expense of orthodontic treatment that is routinely between $3,500 and $4,500, depending upon geographical location and services required, is a substantial burden. Another example is the "Baby Boomers" who often have to deal with root canal and crown placements, which can easily run into a $1,000 or more. The offering of a stand-alone dental benefit program will help reduce the out-of-pocket costs associated with these situations and therefore result in greater satisfaction with the benefits offered through the federal government.

Additionally, a good dental benefit program promotes prevention and over the long-term, improved oral health. As the oral health of a population improves, there is less need for time off from work for more extensive treatment for conditions like advanced periodontal disease, root canals, or oral surgery/extractions. There is clearly a benefit from reduced sick time, but there is also a hidden benefit of overall improved health and self-esteem.

Finally, and this may be the most indirect human resource tool, but Americans as a culture value their appearance and their smiles. The increased popularity of cosmetic dentistry, not covered by most dental benefit programs for cost containment reasons, is proof of the value that Americans place on an attractive smile and good oral health. The increasing popularity of adult orthodontia is another reinforcement of that principle. Consequently, a solid dental benefit program will not only help attract and retain employees, it can also reduce sick time, as well as improve their oral health and their self-esteem.

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