

STATEMENT OF  
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before the

HOUSE COMMITTEE ON OVERSIGHT AND  
GOVERNMENT REFORM  
SUBCOMMITTEE ON FEDERAL WORKFORCE,  
POSTAL SERVICE AND THE  
DISTRICT OF COLUMBIA

on

“2009 Blue Cross Blue Shield Health Benefit: What it means for Federal Employees”

December 3, 2008

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss benefit and premium changes for the Blue Cross and Blue Shield Service Benefit Plan.

Established in 1960, the FEHB Program is the largest employer-sponsored health benefits program in the United States, with about 8 million participants. The FEHB Program annually provides \$34.9 billion in health care benefits. By law, participation of fee-for-service (FFS) plans is limited to one Service Benefit Plan, administered by Blue Cross and Blue Shield, one Indemnity Benefit Plan, and several employee organization plans. Health Maintenance organizations (HMOs) also participate in the program and

new HMOs may submit applications to participate in the program by January 31 each year without having to respond to a specific request for proposals.

OPM administers the FEHB Program on behalf of Federal employees, retirees, and their dependents. The FEHB offers competitive health benefits products for Federal workers, much like other large employer purchasers, by contracting with private sector health plans. In January 2009, enrollees nationwide will have 269 health plan choices from which they may select their coverage. There will be 14 fee-for-service (FFS) choices (ten open to all enrollees); 27 high deductible health plan (HDHP) choices; four consumer driven plan choices; and 224 local HMOs.

For five consecutive years, from 2002 to 2007, the rate of overall average premium increases in the FEHB Program declined from 12.1 percent to 1.8 percent. In 2008, rates increased slightly by 2.1 for 2008. In 2009, rate increases will be 7.0 percent. The increase is well within average increases predicted for other large employers which range from 4.3% to 10.6%, depending upon industry and type of health plan. In 2009, about 20% of enrollees will see an increase of less than 5% for their share of premiums. This year, however, enrollees in the BCBS Standard Option plan will see an increase of about 13%.

OPM annually negotiates benefits and rates with all carriers beginning each spring and continuing throughout the summer. Carriers are required to submit their proposals by May 31 and we act to conclude negotiations by August 31. During this time period, OPM contracting officials work with carriers to ensure that they offer a

comprehensive set of benefits and that any increases in premiums are necessary to protect the interests of enrollees and the Government. Once these negotiations have been concluded with all carriers, OPM issues a September press release announcing the Open Season event and health plan premium changes for the next contract year. Carriers are required to make copies of their brochures describing benefit and rate changes available to their members. OPM also publishes the brochures for all carriers on its web site prior to Open Season.

Now, I would like to discuss some of the benefit changes for next year. BCBS and other plans are expanding coverage for hearing benefits for adults, including hearing aids – most limit benefits to set dollar amounts (e.g. \$1000 per year per hearing aid). Last year, BCBS and other plans added or expanded hearing benefits for children. Due to increases in drug costs and utilization, BCBS is increasing cost sharing for brand drugs and decreasing it for generics to encourage patients to seek lower cost generic alternatives. BCBS is also increasing physician office visit co-pays by \$5.00 as well as other cost sharing for inpatient and outpatient facility care.

Last, beginning next year, enrollees in Blue Cross Blue Shield's Standard Option plan will have a \$7,500 copayment for surgical procedures performed by a non-participating physician. The reason this provision was included in the plan was to lower expenses for certain members of the Blue Cross Blue Shield Standard Option who choose out-of-network doctors for non-emergency surgeries. Previously, for elective surgeries, enrollees paid 25% of the Plan allowance, **plus** any difference between the allowance and the billed amount. While we estimate less than three percent of surgeries are performed

by non-participating providers, in some cases this amount totaled tens of thousands of dollars. Patients could not predict their out-of-pocket costs when using non-participating providers until the health care expenses had been incurred, and benefits were provided by the doctors. Many members filed disputed claims because the balance owed was a large amount, in most cases larger than the new \$7500 copayment, due to the difference between the allowed amount and the amount billed. For example, in 2007 a member filed a disputed claim concerning the costs for outpatient back surgery. In this case, the billed charge was \$63,525. Blue Cross and Blue Shield paid about \$5,700 leaving the member to pay the balance of almost \$58,000. The new policy was negotiated to allow enrollees who elect to use these providers to know what they must pay. We also negotiated this change to hold benefits steady in total for enrollees who obtain surgeries from non-participating doctors while reducing costs those using the most expensive services. The set copayment of \$7,500 enables members to know, should they choose a non-participating provider that they will be responsible for paying only up to that amount-- BCBS pays any amount in excess of the fixed copayment of \$7500. Obviously, plan members can choose to stay in network, at which point this policy does not apply or they can choose another plan besides Blue Cross Blue Shield. Also, the \$7,500 copayment does not apply to surgeries resulting from accidental or emergency situations, and is not subject to the annual deductible.

In switching to fixed copayments, we expect members will make informed decisions when selecting providers to ensure that out-of-pocket costs are not burdensome. Additionally, these fixed copayments will reduce the surprise of a larger

bill and will give members the information they need to make an informed choice of providers before having surgery. OPM encourages consumers to use in-network providers in order to reduce their out-of-pocket costs. Currently, enrollees who choose to use non-participating providers are at risk for paying any amounts the provider charges above the Plan allowance for the procedure.

One of OPM's Guiding Principles for FEHB carriers is "Strengthening information for consumers so they can be more involved and responsible for their healthcare decisions." All benefit changes are prominently described on the change page for each health plan brochure and which is available on OPM's web site. As I mentioned at the beginning of my testimony, there are 10 fee-for-service plan options as well as HMOs generally available for enrollees. OPM encourages enrollees to take the opportunity during Open Season to review their health insurance coverage needs and any changes in their plan's premium and benefits and then decide if they should consider a change in plans or options. A hallmark of the FEHB Program is "choice", meaning employees and retirees can use the Open Season to shop among plans and, perhaps, move to one that better meets their medical and financial needs.

Each Open Season, OPM also publishes the popular *Guide to Federal Benefits* and this year, OPM also unveiled a new Federal Benefits website which includes more information about all the Federal benefits programs available to employees.

Most enrollees in the FEHB are in plans whose premiums equal the cost of claims, allowable administrative expenses, and a small service charge. As claims

increase, the cost of health care increases, resulting in an increase in insurance premiums. Those premium costs are then shared by legislated formula between the enrollee and the government. Each year, OPM works with the insurance companies such as BCBS to negotiate a package of benefits that provides comprehensive coverage at the lowest possible cost. We work diligently to strike a balance of protection against catastrophic events without shifting a high premium burden to enrollees. We believe the high copayment for out-of-network surgeries in the Blue Cross Blue Shield Standard Option achieved that balance by limiting costs for users of expensive surgeries without transferring more costs to enrollees who stay within network.

OPM is proud of its record in administering the FEHB Program and believes it offers Federal employees and retirees a wide variety of options from which to select the health benefits and the premiums that best meet their needs.

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