

**FEHBP FINANCIAL PROBLEMS AND BLUE CROSS BENEFIT REDUCTIONS AND
PREMIUM INCREASES**

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Committee on Oversight and Government Reform

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Mr. Chairman, and members of the Subcommittee:

I am pleased to testify before you today concerning the current status and performance of the Federal Employees Health Benefits Program (FEHBP).¹ The FEHBP is a vital component of Federal employee compensation—providing the majority of employees and annuitants a benefit whose cost for the government share of a family premium averages about \$6,000. This is \$6,000 in compensation that most employees and annuitants don't even realize they get because it never shows up in a pay stub or W-2 statement.

Total spending in this program in 2009 will be approximately \$38 billion for premiums—both government and enrollee share—and \$5 billion more in enrollee cost sharing. Eight million people depend on it for health care. It is a large responsibility for the Office of Personnel Management and for the Congress.

The FEHBP program is a remarkable success among Federal health insurance programs, both for its ability to control costs and for its ability to meet enrollee needs. It is perennially cited as a model for national health insurance reforms. It was the model for the Medicare Advantage program enacted in 2003 in the Medicare Modernization Act. I won't dwell on its successes because others and I have amply explained these in many previous evaluations. Important among these, however, is its continuing ability to hold down health care costs while meeting enrollee preferences for benefits and service. Until very recently, it had a record in holding down health insurance costs that clearly outperformed Original Medicare. It achieved this result through competition among plans to meet consumer needs, not through price controls and other top-down mandates.

Unfortunately, in recent years FEHBP performance has greatly slipped. In the ten-year period from 1989 through 1998, the average annual increase in per enrollee costs, adjusted for benefit improvements, was 7.5 percent in Medicare and 5.1 percent in the FEHBP. The FEHBP was outperforming Medicare, hands down. In the ten-year period from 1999 through 2008, the average annual increase was 5.6 percent in Medicare and 7.5 percent in the FEHBP, a complete reversal in relative performance (from Walton Francis, *Putting Medicare Consumers in Charge: Lesson from the FEHBP*, AEI Press, forthcoming).

Meeting enrollee health care needs through choice among plans is perhaps the program's strongest feature. Every fall I counsel hundreds of employees and retirees on health plan choices at seminars, on the radio, and by email. What constantly amazes and pleases these consumers is that there is a health plan to meet almost any need. Unlike almost all private sector employers, decisions on benefits are made by plans responding to consumers, rather than by faceless headquarters bureaucrats. In the FEHBP, enrollees who vote with their feet, not by fiat, make most final decisions.

However, before enrollees “vote,” plans make marketing choices, sometimes to increase benefits and sometimes to decrease benefits. I am here today to talk to you about:

1. The surgical benefit limitation and other recent decisions of the Blue Cross plans,

¹ I am testifying in my personal capacity, not as the principal author of *CHECKBOOK's Guide to Health Plans for Federal Employees*, and not as a consultant to the Centers for Medicare and Medicaid Services. All views expressed are my own.

2. Underlying and potentially fatal trends and flaws that are increasingly crippling both the FEHBP as a program and the ability of plans to effectively manage both benefits and costs, and leading to decisions such as the ones made by Blue Cross, and
3. Essential reforms if the program is to regain its ability to contain costs while delivering quality services, and to thrive over the years ahead.

1. The Blue Cross Standard Option Benefit Cutback for Surgery Performed by a Non-Participating Surgeon.

Substantial controversy has arisen over one of the many benefit changes that the Blue Cross and Blue Shield plan (Blue Cross for short) has made for the 2009 plan year. I would like to comment on that change from the perspective of effects on enrollees, wearing my consumer advice hat.

This particular change should be put in a larger perspective. Over the last three years Blue Cross has made several dozen changes to its Standard Option benefits. Most of these have been reductions designed to reduce costs and hold the premiums down, but some have been improvements. For example, for 2009 the plan is reducing its coinsurance for generic drugs purchased at retail from 25 percent to 20 percent, and is providing the first four generic mail order prescriptions at no cost. As requested by OPM, and like most other plans, Blue Cross is also adding a hearing aid benefit for adults, one that will be particularly significant since about half of Blue Cross Standard enrollees are annuitants.

However, the benefit reductions over the past several years have been far more significant. Taking the plan years 2007 to 2009, and focusing only on preferred providers, some (but not all) benefit reductions include:

- The deductible has risen from \$250 to \$300 per person (maximum of two per family),
- The per visit physician copayment has risen from \$15 to \$20,
- The hospital copayment per admission has risen from \$100 to \$200,
- The copayment for mail order brand name drugs has risen from \$35 to \$65 for a 90 day supply, and
- The catastrophic limit has risen from \$4,000 to \$5,000 (both self-only and family) when using preferred providers.

Some of these benefit reductions affect all enrollees, and most of them potentially impact most enrollees in important ways. Singly and cumulatively, they are far more important to most enrollees than reducing one fee-for-service benefit that is relatively rarely used.

Moreover, during this same period the enrollee share of the Blue Cross Standard Option premium has risen very substantially, considerably more than the average for other plans. In 2007 the total self only premium (both government and enrollee share) was near the enrollment-weighted average for all plans. However, by 2009 the total premium was well above the average for all plans. Because the FEHBP premium sharing formula is designed to reward more frugal plan choices, enrollees must pay the entire premium above 72 percent of the all-plan average. As a result, although the Blue Cross Standard Option total increase over the most recent two-year period was only about 13 percent, the enrollee share of premium jumped by about 22 percent.

Recent Blue Cross Standard Option Premium Increases

	2007	2008	2009	Increase 2007-2009
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Total Annual Premium:

Self Only	\$5,180	\$5,390	\$5,870	13.3%
Family	\$11,860	\$12,340	\$13,450	13.4%

Enrollee Share of Annual Premium:

Self Only	\$1,490	\$1,620	\$1,820	22.1%
Family	\$3,490	\$3,770	\$4,280	22.6%

These premium increases occurred despite the rather significant benefit reductions I have already described. Had benefits remained unchanged, the Blue Cross premium increases would have been substantially higher. For example, assuming an average of about eight or nine physician visits, the combined effect of the higher deductible and per visit copayment increase would be about \$100 on the enrollee share of premium, and the enrollee premium increase would have been about 25 percent for families, and about 30 percent self only, without these benefit reductions. In the latest edition of *CHECKBOOK's Guide to Health Plans for Federal Employees*, Blue Cross Standard Option rates as one of the most expensive half-dozen plans, usually one of most expensive three plans, in every comparison we make for employees and annuitants among the 29 plan options available in the DC metropolitan area.

In summary, the Blue Cross Standard Option is a plan in competitive trouble, and a plan that is trying to work out of its trouble. In the second part of my testimony I will address the causes of the problems that afflict this and other plans.

In this larger context, the reduction in benefits for using non-participating surgeons is arguably a small and relatively unimportant change. I do not know why the plan made this change, and you will learn the answer in other testimony. I suspect, however, that the primary purpose of this change was to deal with erosion of market share of preferred providers caused by recent growth in so-called "Specialty Hospitals" and "Ambulatory Surgical Centers." These provider types are putting great pressure on community hospitals because they have been able, on average, to deliver specialized surgical and other services at lower costs. To the extent that enrollees can find alternative providers at attractive rates, this puts great pressure on the ability of Blue Cross to build and retain its preferred provider network. Regardless of this or other factors that may seemingly justify this benefit reduction, I think the surgery benefit change that Blue Cross proposed, and that the Office of Personnel Management approved in contract negotiations, was not well considered.

The specific change that has attracted so much attention, as described in Section 2 of the 2009 Blue Cross brochure, "How we change for 2009," is that **"You now pay 100% of the billed amount up to a maximum of \$7,500 for surgery performed by a Non-participating physician. Previously, you paid 25% of the plan allowance, plus any difference between our allowance and the billed amount."** To take a concrete example, suppose an enrollee used a non-participating surgeon for an operation for which the charge was \$5,000. Assume that the Blue Cross allowance for this surgery was \$4,000. Then under the old benefit the enrollee would

pay \$1,000 (25%) for coinsurance, and \$1,000 for the difference between the allowance and the billed amount—a total of \$2,000. This was a hefty penalty for not using a participating provider, but a rational consumer might well make that decision for any of a number of good reasons. However, under the 2009 benefit change, that same enrollee would have to pay the entire cost of the surgery—\$5,000.²

There was a further potential problem, because there are emergency circumstances where the enrollee might not have a practical choice. So a surgery that might otherwise have cost only \$400 (10 percent of the plan allowance was the coinsurance for “preferred” physicians in 2008) would unexpectedly and involuntarily jump to \$5,000 in my example, and even more in other scenarios. This potential problem has been eliminated by a clarification issued just a few days ago by Blue Cross and OPM, so I will defer to other testimony and ignore it in the rest of my testimony.

For a prudent enrollee, who wisely and carefully uses “due diligence” to understand plan benefits and limits his use of physicians and other providers to those who are “preferred” or “participating,” the entire matter seems unimportant. There is no issue, and no problem. To this enrollee, this is an irrelevant change. Almost all HMOs cover none of the costs for surgery or other medical care when using non-network providers and that even larger benefit limitation is well understood and accepted.

However, there are four important aspects of the \$7,500 cost exposure that make it extremely consumer unfriendly and an arguably unreasonable benefit change.³

First, for an enrollee who has good and sufficient medical or other reasons for using a particular non-participating physician, this is a massive benefit reduction. One way to think of it is as an additional deductible (or copayment). If an enrollee has only one medical procedure in a particular year, and uses a network hospital but a non-participating physician for that surgery, under the old benefit he would pay the regular \$300 deductible, and the \$200 hospital copayment, for a total of \$500, before cost-sharing kicked in. Under the reduced benefit he would pay that same \$500, plus an additional \$7,500 copayment or deductible, for a total of \$8,000 before he saw a penny of plan payment. \$8,000 is an extraordinarily steep set of deductibles.

Second, this massively reduces catastrophic protection under the plan. The 2008 catastrophic protection out-of-pocket maximum for Blue Cross Standard Option, using non-preferred providers, is stated to be \$6,500. There are some categories of expense not included in this amount, most importantly the difference between the Plan allowance and the billed amount, but these are unlikely to empty anyone’s wallet and in any event cannot be measured in advance (I assume no one would be foolish enough to use a non-participating hospital for a major medical procedure involving a lengthy stay). For 2009, that limit is raised to \$7,000, and the \$7,500 cost exposure is added as an additional exclusion. In other words, the enrollee’s out-of-pocket exposure is raised from about \$6,500 to about \$14,500. This is a huge decrease in catastrophic

² Blue Cross distinguishes among three classes of provider: preferred, participating, and non-participating. Cost sharing for most benefits depends on which class is used. I try to avoid undue details on these differences wherever possible.

³ In my discussion, I will ignore the almost unbelievable additional limitation imposed by Blue Cross, in charging the enrollee up to \$7,500 for the surgery “per surgeon per surgical day.” Whatever this language means exactly, it seems to suggest that (say) a burn victim being debrided might face many \$7,500 penalties, not just one.

protection. By far the most important purpose of health insurance is to limit exposure to catastrophic expense, and \$14,500 hardly seems to be a reasonable level of protection.

Third, this is fundamentally inconsistent with the explicit and implicit premises underlying the Blue Cross Standard Option model. Enrollees understand and expect that Blue Cross will cover much and usually most of the cost of services even at non-preferred providers. The Blue Cross Standard Option, like all other national plans other than Blue Cross Basic, is technically and legally a fee-for-service plan that covers services from any licensed provider. As the brochure cover states in large type, it is “a fee-for-service plan ... with a preferred provider organization.” One of the very important reasons consumers pay higher premiums to join such a plan, rather than an HMO, is to be able to use non-network providers without having to pay most or all of the cost. Whether described as a deductible of \$7,500, or as a catastrophic limit of \$14,500, this penalty is inconsistent with that role.

Fourth, this change creates a major “gotcha” trap for the unwary. Most enrollees do not study the brochure. They have no expectation that such a penalty exists. This is a very high price to pay for a failure in due diligence. Importantly, the summary descriptions of the program fail to disclose the existence of this trap. Page 132 of the official Blue Cross brochure for 2009 presents a “Summary of benefits” for the Blue Cross Standard Option. That summary contains no hint that surgery might cost not just the stated “30% of our allowance” and actually goes on to say that there is “no deductible for surgery.” The summary further states that the catastrophic protection out-of-pocket maximum for PPO/Non-PPO costs is \$7,000. Almost as an aside, it says, “some costs do not count towards this protection.” Surgery is not just “some costs” but a major component of benefits, and an extra \$7,500 is not just “some costs.” Furthermore, the official OPM Web site at www.opm.gov/insure contains a plan comparison feature that shows the Blue Cross Standard Option deductible to be \$300 and its catastrophic limit to be \$7,000 when using non-preferred providers. A note says that “copayments for certain services may not count toward your ... maximum,” which hardly warns the user that for surgery the catastrophic limit is more than doubled.

These issues and problems might be acceptable if unavoidable. But they are not. No other plan feels impelled to impose such a financial penalty, although there are gaps in catastrophic limits in other plans that should be closed, as discussed later in my testimony.

Most importantly, it is hard to believe that there weren't reasonable alternatives. For example, if a deductible is clearly the best approach to solve the underlying problem, surely a lesser amount such as \$1,000 or \$2,000, followed by 25 percent coinsurance and payment of all amounts above the plan allowance would have sufficed to eliminate most if not all of the problem. Enrollees already faced a substantial financial penalty for using non-preferred providers, and at some point additional penalty is overkill.

Other alternatives might have been possible. The catastrophic limit might have been raised to \$10,000, without excluding the \$7,500. Second opinions could have been required. Precertification or prior approval could have been extended from covering only non-emergency hospital stays to covering all non-emergency surgery whose costs exceeded a certain level, or all surgery of the specific types (whatever they may be) that seem to be causing the most network problems.

In considering the reasonableness of options that the Plan and OPM might have considered, it is important to consider the roll of Medicare. As shown in the table below, about one third of total

Blue Cross Standard Option enrollment is enrolled in Medicare Parts A, B, or (overwhelmingly) both. These enrollees are not subject to the \$7,500 deductible. They have 100 percent coverage for surgery whether or not they use preferred providers. Hence, the change in cost sharing had no effect on their incentives. However, alternative incentives, such as prior approval, or even a nominal copayment such as \$100 might have been effective with these enrollees. Blue Cross added a prior approval requirement for surgery for morbid obesity for 2009, and could have expanded this to cover other types of surgery.

Blue Cross Standard Option Enrollment in 2008

	Self	Family	Total
Total	970	1,051	2,021
Employee	349	631	980
Annuitant	621	420	1,041
Annuitant percent	64%	40%	52%
Medicare percent (assumes program average of 2/3 of annuitants)	43%	27%	34%

2. Trends and Flaws that are Increasingly Crippling the FEHBP and Driving Blue Cross Costs Upwards.

The FEHBP program is showing its age. It has a number of important defects, some self-inflicted, but most simply reflecting a program design that has not significantly changed in almost 50 years. That design has withstood the test of time remarkably well, but is frayed around the edges in several areas. I am going to focus on four areas, though there are others:

- Complexity of Benefit Design and Catastrophic Protection
- Aging Work Force and Health Care Costs
- Premium Design
- Medicare and FEHBP Coordination

Complexity of Benefit Design and Catastrophic Protection. Over the years, plan design has gotten increasingly complex. Twenty years ago, three and six tier prescription drug benefits did not exist. High deductible plans did not exist. So-called “specialty drugs” were rare and relatively inexpensive. Few plans used provider networks. And so on.

As plans have used these and other tools to control costs, the numbers of gaps and loopholes in benefits have grown. For example, most national plans used to include prescription drugs in their catastrophic limits. Today, many do not, relying on relatively nominal copayments to limit enrollee cost exposure. But that has created problems when enrollees require “specialty drugs” that can cost thousands of dollars. OPM has worked diligently to close these gaps, but that has led to increased complexity in catastrophic limits. Some plans now have two limits, one for medical costs and one for drug costs.

This has led to serious inconsistencies in the ways plans determine as well as present their catastrophic limits. It is an important part of the issue regarding the Blue Cross surgery benefit limitation, but it appears in many other plans. For example, here is a comparison table similar to one in *CHECKBOOK's 2009 Guide to Health Plans for Federal Employees*, showing how two plan's stated limits are calculated, but not clearly presented, in the plan brochure and in OPM's online plan comparison table:

Adjusting Catastrophic Limits to Make Them Comparable

Mail Handlers Self	HDHP	Standard Option
Limit Stated in Plan's Summary of Benefits and OPM Comparison:	\$5,000	\$4,500
Deductibles	Included	\$350
Hospital, Physician, Drug Copays	Included	\$2,560
Specialty Drug Limit	Included	\$4,000
Actual Total Limit	\$5,000	\$11,410

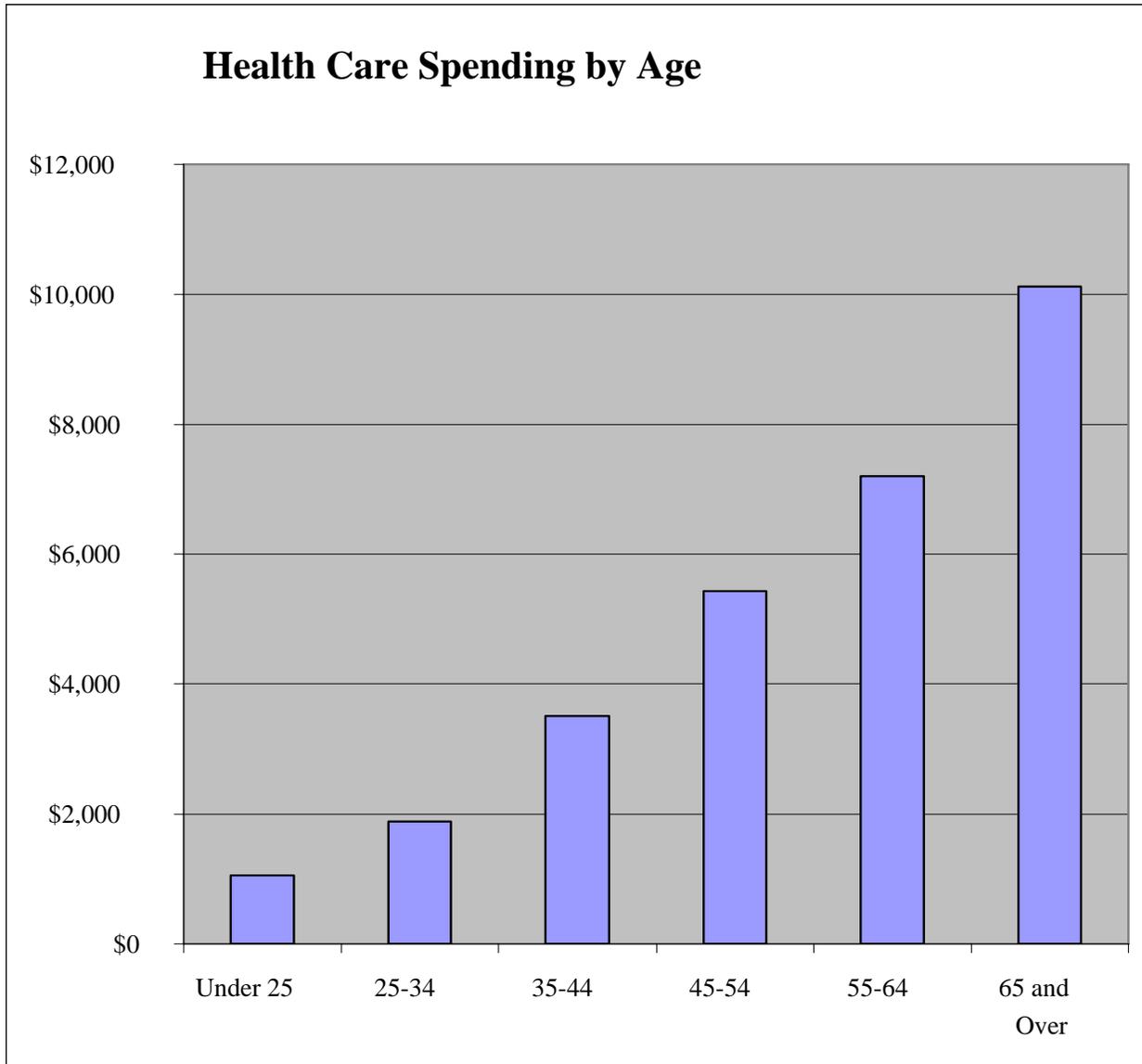
Here is another example:

Coventry Iowa Self	HDHP	High Option
Limit Stated in Plan's Summary of Benefits and OPM Comparison:	\$5,000	\$2,500
Deductibles	Included	Included
Hospital, Physician, Drug Copays	Included	\$4,110
Specialty Drug Limit	Included	Included
Actual Total Limit	\$5,000	\$6,610
Note: certain assumptions about numbers of visits for very heavy users are used to calculate copays.		

What these tables show is that a plan that seems to have a far lower limit than another plan sponsored by the same company can actually expose enrollees to a considerably higher catastrophic maximum. In both of these cases the limits are included in the same brochure, but the same kinds of inconsistencies exist across many plans and many brochures.

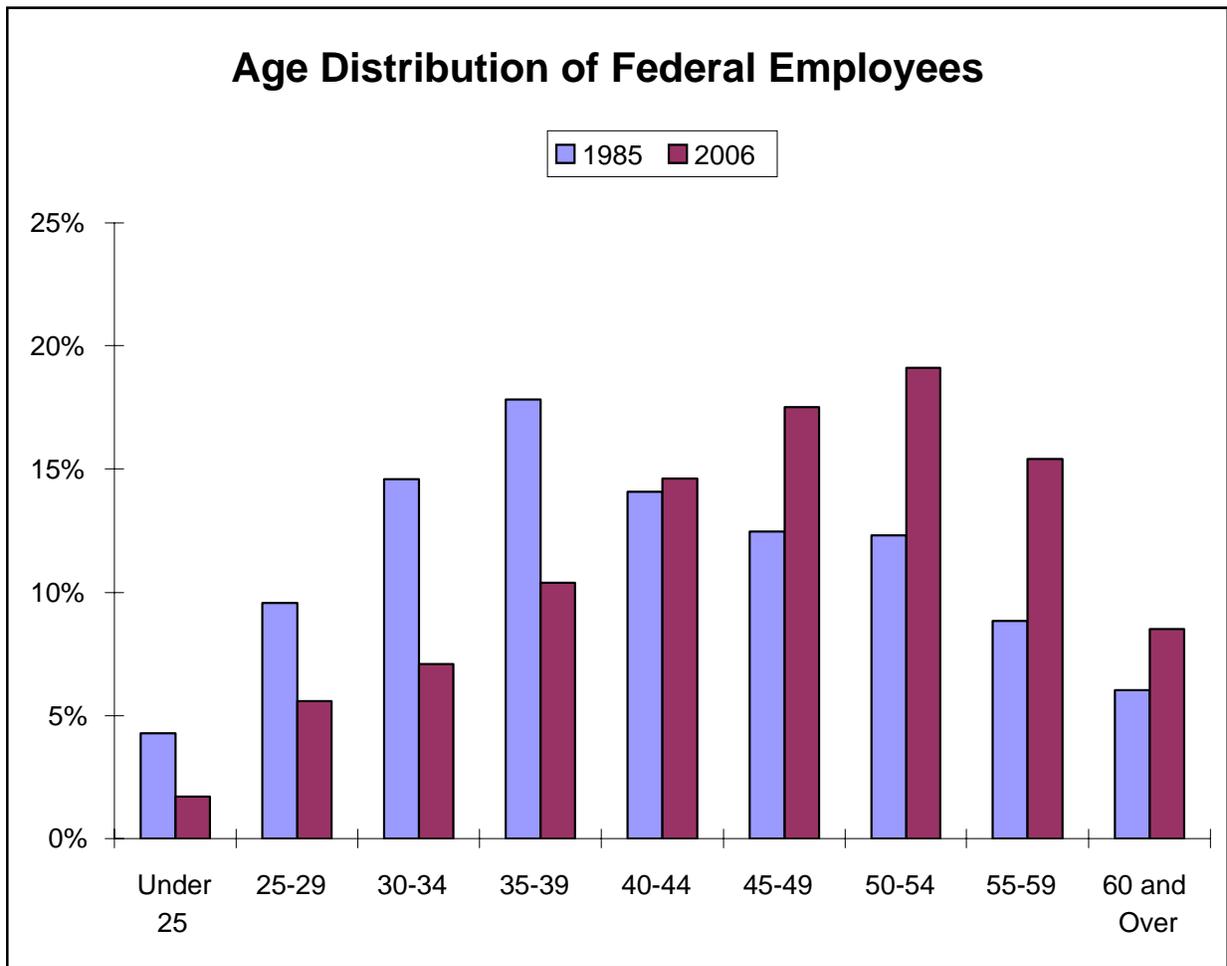
Aging Work Force and Health Care Costs. Federal employees and annuitants tend to stay in their plans, despite the multiple alternatives offered them every Open Season. While there are apparently no hard data, only about one enrollee in twenty switches plans in Open Season. This has benefits for program and plan stability, but penalizes the most popular plans. The problem is that as enrollees age, they get more expensive. The thirty year old that enrolled in Blue Cross Standard Option twenty years ago is very likely still in that plan today, but twenty years older and correspondingly more expensive. While it is a commonplace that health care costs rise with age, it is always well to be reminded of the extent to which this occurs, as shown in the chart

below.⁴



These differences are particularly important because the Federal work force has grown progressively and markedly older over the last two decades. Unfortunately, there are no extant age data that cover postal employees and annuitants as well as General Schedule employees. However, data from OPM on non-postal civilian employees show a massive deterioration in the relative proportion of lower-cost younger employees compared to older employees and retirees. From 1985 to 2006 the average age of these Federal employees increased from 42 years to 47 years, as shown by the data in the chart below.

⁴ Source: Pooled MEPS data for 2003 through 2005, adjusted for inflation to 2007, provided to author by Agency for Healthcare Research and Quality



Source: Office of Personnel Management, Office of Workforce Information, at www.opm.gov/feddata/html/Age_Dist.asp

Note: Data include only full-time permanent civilian employees, and exclude postal employees

I think that these two charts tell us a great deal about why Blue Cross has faced the need to make such substantial efforts to hold premium increases down.

Premium Design. Under current law the government gets 75 percent (or more, for postal and FDIC employees) of the premium saving from frugal plan choices made by enrollees. More specifically, since the government pays 75 percent (or more) of the premium up to a premium amount close to the all plan average, neither the plans nor the enrollees face a strong incentive to set or choose premiums well below that all plan average. Moreover, the higher the government share of savings, the less incentive enrollees have to choose frugal plan designs. Paradoxically, the seemingly enrollee friendly "Premium Conversion" reform reduced the incentive to shop frugally by reducing the *de facto* employee share of employee premiums from 25 percent to about 17 percent (varying with the precise tax bracket of each employee). Therefore, the government now retains about 83 percent of the savings when enrollees choose plans whose premiums are substantially below the all plan average premium. As a result, plans now have correspondingly reduced incentives to keep costs and premiums down. (This is one of the major adverse consequences of Premium Conversion, but not the worst).

There is one key feature in existing premium design that prevents disastrous growth in costs and premiums. With the government contribution pegged to the average plan cost, and the government paying no more than 75 percent of premiums that are near the all plan average cost, enrollees pay the entire excess cost of plan premiums that exceed the average. High cost plans are not rewarded in the FEHBP. But frugal plans and frugal purchasing decisions have never been well rewarded, and are now poorly rewarded. Plan competition expert Alain Enthoven has argued pungently that current employer health insurance contributions generally reward the health care equivalent of expensive, bloated gas-guzzlers, but should instead reward "Honda" health plans (Alain Enthoven, "Where Are Health Care's 'Hondas'?" in *The Wall Street Journal*, October 24, 2002). In his words, what we "need is for most employers to offer multiple choice and expose employees to **full** responsibility for premium differences" (emphasis added).

I would put the matter another way. Why should an enrollee have to return to the government 75 (really 83) percent of the premium savings achieved if he chooses a lower cost plan? What sensible person would even choose a lower cost plan facing such a penalty? The Medicare Advantage program reverses the percentages, and lets the enrollee keep 75 percent of the savings from choosing lower cost plans in either reduced premium or enhanced benefits (as in the FEHBP, enrollees pay the entire cost of plans above a benchmark average). That is smart premium design.⁵

Medicare and FEHBP Coordination. All of the national fee-for-service plans in the FEHBP offer age-65 enrollees a seemingly wonderful benefit enhancement. The plans promise that if the enrollee has both Medicare Parts A (hospital) and B (physician), all hospital and physician care will be free—no deductibles, no coinsurance, and no copayments. Not only that, all this medical care will be free whether or not the enrollee uses preferred providers—network constraints go away.⁶ What could be wrong with this wonderful benefit enhancement?

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

The great majority of retirees elect to pay the Medicare Part B premium at age 65, and enroll in one of the national fee for service plans. This wonderful coverage comes, however, at a high price. In 2009, the total premium cost for the most popular choice in combination with Medicare, Blue Cross Standard Option, will cost a retired couple \$6,590 in premium. This is a "for sure" expense, whether or not they ever see a doctor (of course, total cost is far higher, with most hidden in the government premium subsidies).

⁵ It is not a coincidentally smart decision. The Finance and Ways and Means drafters studied both the strengths and weaknesses of the FEHBP quite carefully.

⁶ Blue Cross Basic Option is a partial exception. It only provides this benefit within the network of preferred providers.

This same couple was most likely enrolled in Blue Cross until age 65, and was satisfied with its good benefits and reasonable premium. What changed upon turning age 65 that impelled them to pay an extra \$2,300 a year for two Part B premiums? They do get that reduced cost sharing, and the ability to leave the network without penalty. However, *CHECKBOOK's Guide* estimates that in 2009 the net effect of joining Part B is to cost the average retired couple in Blue Cross Standard option an extra \$670. The answer is that this decision is rational for that couple only because existing law is irrational.

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

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

Meanwhile, it appears that increasing numbers of age-65 retirees are deciding not to sign up for Medicare Part B. They calculate, correctly, that they will save substantially in most years by not having to pay two sets of premiums. There are alternatives, such as suspending FEHBP enrollment, paying only one set of premiums, and enrolling in a Medicare Advantage plan. But very few even know this exists, and even fewer choose it. This trend will accelerate as more and more higher income retirees face the Medicare income-tested Part B premium penalty.⁷ Every such decision actually saves the Federal government money by redacting incentives for wasteful overutilization, but those savings accrue primarily to Medicare. The effect on the FEHBP is to raise premiums overall, and especially in those plans that disproportionately attract retirees (e.g., Blue Cross Standard Option).

3. Useful and Necessary Reforms

There is a menu of potential reform opportunities to address these and other problems:

- Reducing or eliminated Premium Conversion and other tax subsidies for wasteful overpurchase of health insurance and overutilization of health care (something that will undoubtedly be addressed in a broader context when President-elect Obama presents his detailed reform proposals).
- Adding mechanisms to control risk selection in the FEHBP

⁷ All or almost all GS-15 or higher-graded retirees will pay the higher income-tested premium if they enroll in Part B.

- Premium redesign to reward frugal enrollees
- Improving the coordination of Medicare and the FEHBP
- Eliminating arbitrary constraints on plan reimbursement for retirees on Medicare
- Admitting new plans to the program
- Expanding the program to cover military workers dependents
- Improving Information for enrollees to help and encourage them to make money-saving plan choices

Time does not permit in depth analysis of each of these issues and options today, but I would be glad to work with the Subcommittee or parent Committee in addressing any of these in more detail.⁸ OPM acting on its own can address some. This Subcommittee can address others; and still others would require action by the Ways and Means Committee. The Subcommittee could easily enlist the Congressional Budget Office, the OPM actuaries, or the Office of Management and Budget, to assist it in exploring these and related options. I strongly recommend that it do so.

Improving Catastrophic Protection Limits and Their Presentation. I think that the Blue Cross decision to impose a \$7,500 penalty for using non-participating surgeons in its Standard Option is best thought of as increasing catastrophic cost exposure of enrollees. This particular risk is unique to this plan. But there are many exclusions in other plans that have the effect of increasing maximum cost exposure far beyond stated limits. One set of plans, the High Deductible plans, all have essentially loophole-free and gap-free catastrophic protection. These plans follow Treasury Department guidelines in order to qualify as High Deductible plans.

I recommend that OPM undertake a comprehensive review of catastrophic limits, and include strong direction in next spring's Call Letter, to reform both the substance and presentation of these limits. The basic principle should be that all plans should to the extent reasonably feasible include all types of medical and prescription drug costs in one comprehensive catastrophic limit that is loophole-free (for plans that have both network and non-network benefits, each set of benefits would have its own limit). This does not mean that plans could not exclude such items as charges in excess of allowances, charges for visits that exceed specified numbers of visits, or noncompliance charges. But it does mean that separate catastrophic limits for drugs or surgery or mental health should either be eliminated, or included in a stated total limit on all benefit summaries. For example, it would be preferable if the NALC plan modified its benefits so that its total catastrophic limit was \$6,000 dollars (or whatever amount was actuarially neutral), but if it persists in having what appear to the reader to be three separate limits, \$4,000 for most medical expenses, \$4,000 for prescription drug expenses, and \$4,000 for mental health expenses, it should be required to summarize this is an overall limit of \$12,000. The same requirement imposed on Blue Cross Standard Option would doubtless lead to a different decision on its surgical "deductible," as it is unlikely that the plan would choose to show a catastrophic limit of \$14,500 in all summary materials.

I think it quite likely that this simple presentation change would have a salutary effect in leading plans to lower as well as combine limits, rather than have potential customers suffer potential "sticker shock."

⁸ I addressed more of these in testimony to a predecessor Subcommittee—Civil Service, Census, and Agency Reorganization—on December 11, 2002.

Equally importantly, limits should be presented and described in as standardized a method as possible. For example, currently many plans include, and many other plans exclude, deductibles from stated limits. Without making an actual benefit change in any of these plans, these disparate presentations can and should be eliminated. When a plan now says the most you can pay is \$6,000, and states in fine print that you also pay \$500 for the plan deductible that is excluded from that limit, that should be changed to say that the most you can pay is \$6,500 including the deductible. There is no substantive change, but now it becomes possible to compare plan limits without poring over the small print to see what presentation gaming is going on in some plans, but not others.

The opportunity should also be used to eliminate some of the more bizarre maximums, exclusions, and calculation methods. It is highly misleading to say that a plan has a \$6,000 limit if it excludes durable medical equipment or prostheses from that limit. Some HMO plans say that their limit is “the premium” without ever saying which premium: the total premium, the GS enrollee share of the premium, the postal enrollee share of the premium, etc. In every case the limit should be stated in dollars. Plans that claim a maximum based on dozens of “stated copays” scattered through their brochures should be asked to present a dollar number rather than sending enrollees on a “gotcha” hunt through a hundred page brochure. If “stated copays” are indeed small in all but the most exceptional cases, that dollar number can be small and the exceptional cases can be protected as well.

As a related presentation matter, some plans, especially some Consumer Driven plans, now obscure their substantial deductibles by use of clever and confusing nomenclature. This created a problem this year because one new plan, United Healthcare Consumer-Driven, was presented honestly and clearly in comparison charts and benefit summaries as having a deductible twice as high as its competitors, when the actual amount of spending before regular benefits kicked in was essentially identical. The correct solution is to show all these plans with the higher deductible, not to have them all mislead readers of their brochures.

These changes are simple and straightforward, will improve the program, and will greatly improve transparency and clarity for consumers. They can be accomplished without legislation or even codified regulation. They need not even include any actual benefit mandates. They require only an OPM decision to insist on clarity, honesty, and consistency in plan’s descriptions of their most important benefit.

Providing More Information for Enrollees. OPM is severely constrained in its budgetary resources for administering the FEHBP. This shows up in many ways, but one of the most dramatic emerges from a simple comparison of Medicare’s main information tool compared to OPM’s. Every Medicare beneficiary receives annually an approximately 100-page publication, handsomely printed, entitled *Medicare & You*. This publication provides a wealth of information on the program and among other things summarizes the benefits of all available plans.

In contrast, every Federal annuitant receives annually a 10-page mailing that provides highly condensed information, in print that is so small as to be almost unreadable. It provides no information on plans except their premiums. Nothing it contains is likely to lead annuitants to compare plans or to realize how widely plans differ. As a consequence, Open Season plan movement among annuitants is negligible, and neither the annuitants themselves nor the FEHBP trust funds receive the substantial savings that could be generated if, for example, some fraction of annuitants migrated to Medicare Advantage plans or to Consumer-Driven plans.

The current information dissemination practice does minimize postage costs. It literally saves pennies while leaving on the table hundreds of millions of dollars in potential savings if enrollees switched to plans that better control costs and keep their premiums lower.

It should not be beyond the ingenuity of OPM or the Subcommittee to create a mechanism to enable the costs of a serious information dissemination effort to escape the penny-wise and pound-foolish constraints of the current annual budgetary and appropriation's processes. For example, building on approaches successfully used for brochure printing and dissemination, and for customer surveys of enrollees, plans could be required to purchase and mail to their enrollees a copy of OPM's *Guide to Federal Benefits for Federal Retirees and Their Survivors*.

Controlling Risk Selection in the FEHBP. The FEHBP is often accused of the dreaded "death spiral" through "adverse selection" by advocates who oppose consumer choice among competing plans. In reality, the FEHBP is remarkably stable. Although enrollees vote with their feet in Open Season, most of those who should change plans do not. This is despite my utmost efforts, through *CHECKBOOK's Guide* and through television, radio, and speaking engagements, to persuade enrollees to save themselves a lot of money by switching to plans that would lower their costs, often by thousands of dollars.

Most recently, the wise OPM decision to encourage Consumer-Driven and High Deductible plans to compete within the program was accompanied by wails of anguish and predictions that all the young and healthy employees would join these plans and leave annuitants stuck in expensive plans (why annuitants and those in ill health would not avail themselves of the same opportunity to join bargain plans with superb catastrophic protection was never explained). In the event, only about 40,000 enrollees, almost exactly 1 percent of total enrollees, have joined these plans during the five years they have existed. This is not exactly a stampede.

There is nonetheless a risk selection problem in the FEHBP, and the failure to risk adjust premiums interferes with orderly and effective plan competition and consumer choices. Suppose there had been a mass migration to High Deductible plans? With risk adjustment of premiums there would have been no deleterious effect on those few annuitants left behind, since government contributions to their plans would have risen. Again, the problems facing Blue Cross in competing against other plans are aggravated by the failure of the FEHBP to have any risk adjustment mechanisms that compensate the plan for attracting a disproportionate share of the oldest and sickest.

Under current law, the FEHBP program averages all risks and both contributes to and charges individual enrollees the same amount regardless of age, distinguishing only between self only and families of two or more. This seems to be a perfectly reasonable approach to "fairness" in compensation policy, though the resulting high premium charge for younger workers is doubtless one of the main reasons why about 5 percent or more of the Federal work force, mostly younger workers, has no health insurance at all. But it is a flawed approach to premium design in a market driven system. Furthermore, in practice it fails to achieve its equity objective because the plans that disproportionately attract older enrollees have to charge a higher premium to break even, and the older and sicker wind up paying more.

There is a simple fix that would preserve the "single pool" design of the program. Under this reform, the statute would be amended to require the government to pay differential amounts to plans based on the age and Medicare status of enrollees. The share that enrollees pay in any given risk category would be "held harmless" on average.

Put another way, the current statute says, in effect, that the government should pay about 70 percent of the premium on average for all enrollees, taken as an average. But it could say, instead, that the government will pay (as an over-simplified example) 80 percent of a more costly average for those over age 55, and 60 percent of a smaller average for those under age 55, and still pay 70 percent on average. Amended to adjust for age-related risk, the FEHBP would allow enrollees to select the best plans without having to flee those plans that attract a disproportionate number of union shop stewards (older and more expensive), diabetics, annuitants age 55 to 64, and 85 year old annuitants without Medicare.

One very important risk factor, in this context, is Medicare status. With Medicare as the primary payer for the great majority of annuitants over age 65, FEHBP plans only have to pay residual expenses. These can be very high, and are made even higher by induced overutilization, but it appears that plans roughly break even by attracting this group. Medicare status should dictate the government share of premium paid.

Devising a risk-adjusted premium that will be fair to all groups, both in reality and as perceived by advocates, will potentially be politically and actuarially complex. But it can be done, without descending into a swamp of health status details.⁹ Adjusting for nothing more than two age categories (above and below 55) and Medicare status (both A and B, A only, B only, or neither) would greatly attenuate the bizarre incentives to both plans and enrollees created by current premium sharing arrangements. The Congress need not (and in my view should not) attempt to write a rigid formula. For those with a long memory, the original design of the FEHBP called for a 60 percent government share of premium, but due to drafting myopia and a bizarre "big six" formula the government wound up paying about a 72 percent share of the average premium. Instead, the Congress could simply mandate that OPM devise an actuarially fair system that will not penalize any category group by more than a few percent in the amount of enrollee premium it pays.

There are alternative ways to reduce risk selection in the program. For example, the risks from enrollees with costs above \$100,000 in a year could be pooled and reinsured, so that the smaller plans and those with disproportionate shares of older and more expensive enrollees did not face a disproportionate cost burden. I have heard that one of the better small plans left the program a decade ago because of a multi-million dollar premature birth disaster, and that another good but small plan left the program because of expenses from HIV-infected enrollees. Some form of reinsurance could be factored in as well, but would not suffice to replace a system based on age and Medicare status.

If the enrollee share of premium for each plan bore a reasonably rational relationship to plan benefits, without the artificial effects of differential by age and Medicare status, then plans could concentrate their energies on devising benefit and service reforms that best served their

⁹ Medicare uses complex risk adjustors based on health status to determine contributions to Medicare Advantage health plans. The FEHBP cannot do this because, unlike Medicare, it doesn't have a database of medical records for all its enrollees. But it doesn't need to do so. Relatively crude risk adjustors would work reasonably well without the complexity of the more sophisticated Medicare system. In fact, because the underlying Medicare Advantage payment is based on complex and artificial geographic differentials that reflect waste and fraud as much as genuine differences in health care, even a simple FEHBP system would arguably be as good or better.

customers. In this regard, while the plans have often been accused of using benefit design decisions to "cherry pick" to get the healthiest enrollees, it is apparent that such behavior has been infrequent. Indeed, some of the plans with the strongest incentives to do so have not only not skewed benefits, but also gone out of business through "failing" to do so. Of course, this is due in part to OPM's stewardship in reviewing plan change proposals. Regardless, any reform that reduces risk selection or its costs also reduces incentives to plans to design benefits to discriminate against sicker enrollees.

Premium Incentive Redesign. It is possible and relatively easy to adjust the government contribution formula to improve the incentives for enrollees to choose, and plans to offer "Hondas" while remaining budget neutral. For example, if the government share were made 100 percent of premium up to a maximum of 70 percent of the all plan average, and nothing thereafter, the overall contribution would still be near 70 percent of the all plan average. However, incentives would change radically. Employees would now keep 100 percent of the savings from selection of lower cost plans, down to the maximum contribution level. The most important effect would occur over time: plans would selectively take cost-reducing steps to keep premiums down, and employees who became more frugal users of health care as copayments increased would help drive down the overall costs and premiums of the entire program.

Less drastic formula changes could achieve any desired mix of incentives and rewards. For example, a formula paying 90 percent of premium up to a maximum of about 80 percent of the all plan average would also result in an overall government subsidy of about 70 percent, but largely incentives for both plans and enrollees to go to even lower cost plans than those at the 80 percent maximum.

Under either of these options, plans would have greatly increased incentives to devise cost sharing provisions that, like their prescription drug benefits, would reduce overall utilization costs and hence unnecessarily large premiums.

Note also that under either formula suggested above, the enrollee premium share for a frugal plan would be reduced, and the incentive of healthy, young employees to enroll in the FEHBP significantly increased. These enrollees would, on average, reduce overall premium costs and help to reduce the premium creep created by a rapidly aging Federal work force. In other words, these are employee-friendly reform ideas, to be welcomed rather than feared.

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

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

and the taxpayer would be involved. Alternatively, the dental subsidy could be directed towards “free” enrollment in those plans.)

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

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

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

For reasons lost in history, a quarter century ago the Ways and Means and Finance committees quietly inserted an unprecedented constraint on the FEHBP into the Medicare statute. Under Section 1840 of the Social Security Act, no FEHBP plan is apparently allowed to subsidize the purchase of Part B, unless the funds involved come from (nonexistent) sources other than FEHBP premiums.¹⁰ The Federal government is now the only employer in America that cannot defray the cost of Medicare Part B for its retirees. This perplexing enactment costs Medicare far more than it saves, since the great majority of age-65 enrollees nonetheless pay for Part B and generate \$2 billion a year or more in unnecessary spending. It certainly costs the taxpayer far more than it saves. Were FEHBP plans allowed, encouraged, or required to pay Part B premiums, reducing current wraparound coverage on an actuarially comparable basis, the plan budgets would benefit substantially from net increases in Part B enrollment, and from net decreases in health care utilization. This would in turn create the savings and additional benefits described above.

This reform would require legislation, and would be under the jurisdiction of the Ways and Means and Finance Committees.

Expanding the Program to Cover Military Personnel. The FEHBP does not cover almost half of all Federal employees and dependents: U.S. Military personnel and their dependents. This is particularly anomalous because the medical skills and equipment needed for military preparedness and operations, such as emergency medicine and surgery, are not those associated

¹⁰ Section 1840 (d) reads, in pertinent part: “A plan described in section 8903 or 8903a of title 5, United States Code [i.e., an FEHBP plan], may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part [i.e., the Part B premium] if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions [FEHBP premiums] described in section 8906 of such title.”

with pediatric, obstetrical, and other civilian-oriented services that comprise the overwhelming majority of DOD sponsored health care. While the tens of thousands of high ranking officers who constitute the military health establishment are unlikely to voluntarily relinquish their bureaucratic turf and give up their well paid administrative jobs, the Secretary of Defense has voiced concern over the huge resources devoted to DOD sponsored health care. The Tricare system is unpopular with military dependents. There is no reason that the FEHBP statute should not be amended to provide OPM authority to fold any or all military families into the FEHBP for non-service related health care, upon reasonable premium contributions by the Department of Defense. Providing legal discretion to OPM to implement this option in the future need not wait, or depend upon, the views of the uniformed service brass.

If such a reform ever came to pass, the DOD might well decide to fund a higher percentage of premium cost than received by most civilian employees, because military personnel pay no or very low premiums. This would not depart significantly from the current FEHBP model, which allows for higher government premium shares in the Postal Service and FDIC. A proper study of military health care costs (many of which are concealed within base budgets for facilities and equipment) would undoubtedly show that DOD could save a great deal of money by dismantling Tricare and buying into the FEHBP, even if it had to pay the entire cost of premiums.

A particular advantage to the FEHBP of such a reform is that it would bring a lower cost pool of enrollees into the program; thereby reducing average premiums for both employing agencies and, in the case of annuitants, OPM.

Premium Conversion. Premium conversion was a serious error in program design, whatever its advantages in terms of aligning Federal fringe benefits with those of the large private corporations. It greatly reduced incentives for frugality on the part of both enrollees and plans. In a perfect world I would recommend its elimination, with an appropriately large increase in the annual "cost of living" salary increase to offset the effects of its elimination. Assuming, however, that such a reform is either unlikely in the extreme or unlikely outside the context of a larger reform of the taxation of health insurance premiums, I would recommend that at the very least the Congress refrain from extending premium conversion to annuitants. That change would eliminate the strongest remaining enclave of necessarily cost-conscious enrollees in the FEHBP. Annuitants already receive a tax-free benefit of over \$4,000 (self only) or over \$9,000 (family) for health care insurance through the government contribution to their plan's total premium cost. No private sector retirees receive premium conversion. Enough is enough.

Conclusion. Every one of the reforms discussed above would advantage enrollees, plans, the FEHBP program as a whole, and taxpayers. All will particularly benefit enrollees in the long run, by holding down unnecessary spending and reducing premium costs. Every one of them would have ameliorated the kinds of pressures that led the Blue Cross plan to reduce benefits so sharply in the last several years. If some of these reforms are not made, the FEHBP is likely to see costs surge over time. I urge the Congress to think "out of the box" in assessing the current state of the FEHBP and possible reform options like these. There is plenty of practical and analytic help to be found in the CBO, OMB, GAO, and OPM itself. I wish you success in the coming session of Congress in making needed reforms to this vital program. It is not aging well.