FEHB RATE HIKES—WHAT'S BEHIND THEM?

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON
GOVERNMENT REFORM
AND OVERSIGHT
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

OCTOBER 8, 1997

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FEHB RATE HIKES—WHAT'S BEHIND THEM?

WEDNESDAY, OCTOBER 8, 1997

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

The subcommittee met, pursuant to notice, at 8:30 a.m., in room 2247, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Pappas, Norton, and Ford.

Staff present: George Nesterczuk, staff director; Garry Ewing, counsel; Caroline Fiel, clerk; and Cedric Hendricks, minority counsel.

Mr. MICA. Good morning. I would like to call this meeting of the House Civil Service Subcommittee to order. We are expecting other members, but we are up against a time deadline this morning, so I would like to go ahead and begin the hearing.

I would like to also take this opportunity to thank our witnesses and others for coming out on short notice. As I said, we are a little bit hard-pressed on time, as we have full committee meetings today beginning this morning, and tomorrow, and then the Congress will not be voting, and most folks will be away the next week. We felt this issue needed an immediate airing, so I thank you for coming this morning for an early start on this hearing.

The purpose of the hearing this morning is to examine the causes of the increases in health care premiums for plans participating in the Federal Employees Health Benefits Program. The Office of Personnel Management announced on Friday, September 26, that FEHBP premiums will increase by an average of 8.5 percent for 1998. This increase follows 5 years of relatively stable premiums, including 2 years in which average premiums declined.

We should note, however, that the average rates mask wide variations in individual plan experiences. For example, monthly premiums for the Blue Cross and Blue Shield high option plans remained unchanged, as did the Alliance high option plans. A number of point-of-service plans and health maintenance organizations experienced outright declines. In contrast, the monthly premiums of some other plans increased dramatically. Monthly premiums for two employee-organization sponsored plans rose a whopping 26 percent and 21.5 percent.

Federal employees and Federal retirees depend on the FEHB Program to provide them and their families with options for high-quality health care at reasonable prices, but they do not pay "average" premiums. Their bills are determined by the premiums of par-

ticular plans. For example, while the monthly premiums for Blue Cross and Blue Shield high option plans remained steady, the individual's shares actually decreased. At the other extreme, the 26-percent increase in one of the employee-sponsored plans translated into a 75-percent increase in the employee's share.

As we examine this issue, a number of questions arise: Are there current economic factors forcing premiums to rise that were not present in previous years? Are governmental policies contributing to these increases? Are there actions Congress can take, consistent with free-market principles, to minimize future FEHBP premiums?

Let me caution, however, that Congress should not react to premium increases by adopting anticompetitive and command-and-control measures to ensure compliance or impose caps or try to overregulate the market. The government must not pursue policies that shield plans or individuals from premiums that reflect the real, in fact the true, cost of benefits offered. Prices convey important information to consumers, and it is consumer reactions to changes in relative prices that make markets work.

The strength of the FEHB Program is its market orientation. Our goal should be, I believe, to strengthen market forces and consumer choice in order to keep premiums affordable.

I have raised a number of questions today. I hope we can gain some answers through this panel. We have a single panel, but individuals who are very actively involved in this health care issue.

So, that is the purpose of the hearing this morning and my opening statement.

[The prepared statement of Hon. John L. Mica follows:]

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OPENING STATEMENT
Chairman John L. Mica

FEHB Rate Hikes -- What's Behind Them?

October 8, 1997, 8:30 a.m.
Room 2247, Rayburn HOB

Good morning. I thank you all for agreeing to appear before this subcommittee on very short notice.

The purpose of this hearing is to examine the causes of the increases in health care premiums for plans participating in the Federal Employees Health Benefits Program. The Office of Personnel Management (OPM) announced on Friday, September 26, 1997 that FEHBP premiums will increase by an average of 8.5% for 1998. This increase follows five years of relatively stable premiums, including two years in which average premiums declined.

We should note, however, that the average rates mask wide variations in individual plan experiences. For example, monthly premiums for the Blue Cross and Blue Shield high option plans remained unchanged, as did the Alliance high option plans. A number of point-of-service plans and Health Maintenance Organizations (HMOs), experienced outright declines. In contrast, the monthly premiums of some other plans increased dramatically. Monthly premiums for two employee-organization sponsored plans rose a whopping 26% and 21.5%.

Federal employees and federal retirees depend upon the FEHB Program to provide them and their families with options for high-quality health care at reasonable prices. But they do not pay "average" premiums. Their bills are determined by the premiums of particular plans. For example, while the monthly premiums for the Blue Cross and Blue Shield high option plans remained steady, the individual's shares actually decreased. At the other extreme, the 26% increase in one of the employee-sponsored plans translated into a 75% increases in the employee's share.

As we examine this issue, a number of questions arise. Are there current economic factors forcing premiums to rise that were not present in previous years? Are governmental policies contributing to these increases? Are there actions Congress can take, consistent with free-market principles, to minimize future FEHBP premiums?

Let me caution, however, that Congress should not react to premium increases by adopting anti-competitive, command-and-control measures to stifle market forces. The government must not pursue policies that shield plans or individuals from premiums that reflect the true cost of the benefits offered. Prices convey important information to consumers, and it is consumer reactions to changes in relative prices that make markets work.

The strength of the FEHB Program is its market orientation. Our goal should be to strengthen market forces and consumer choice in order to keep premiums affordable.

DAN BURTON, INDIANA
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
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ONE HUNDRED FIFTH CONGRESS

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TO: Members of the Subcommittee on Civil Service

FROM: John L. Mica
Chairman

DATE: October 3, 1997

RE: Background Memo - Hearing on FEHBP Premium Increases

On Wednesday, October 8, 1997, the subcommittee will hold a hearing to examine the causes of the recently announced FEHBP premium increases for 1998. The hearing will be held in Room 2247, Rayburn HOB, from 8:30 a.m. to 10:00 a.m.

The Office of Personnel Management (OPM) announced on Friday, September 26, 1997 that FEHBP premiums will increase by an average of 8.5% for 1998. This increase follows five years of relatively stable premiums, including two years in which average premiums declined. OPM also asserts that private sector insurance plans are expected to experience a "double digit" rise in premiums.

According to OPM, the biweekly increase in the employees' share of health care premiums will rise by $3.32 for self coverage (from $24.42 to $27.74) and $8.64 for family coverage (from $54.15 to $62.79). The maximum biweekly government contributions in 1998 will be $65.96 for self coverage and $142.27 for family plans.

These average rates mask wide variations in individual plan experiences. A number of plans experienced rate decreases. For example, monthly premiums for the Blue Cross and Blue Shield high option plans remained unchanged, as did the Alliance high option plans. A number of point-of-service plans and Health Maintenance Organizations (HMOs), experienced outright declines. In contrast, the monthly premiums of other plans increased dramatically. For example, monthly premiums for the National Association of Letter Carriers Health Plan rose a whopping 26%, and the American Postal Workers Union plan shot up 21.5%.

From the perspective of federal employees and retirees, these premium adjustments are often magnified by the peculiar formula under which the government's share of the premium is determined. Even though the monthly premiums for the Blue Cross and Blue Shield high option plans remained steady, the individual's shares actually decreased, by $6.78 for the high self plan and by $15.88 for the high family plan. The 26% increase in the Letter Carriers Plan translated into 75% increases in the employee's share. (Congress recently adopted a new formula, the Fair Share formula, in the recent budget reconciliation act that may ameliorate some of this burden shifting.)

A number of factors affect the premiums charged for FEHBP plans: the benefits provided, the age of the workforce, utilization rates, the prices charged by hospitals and doctors, the amount of a plan's reserves, and governmental policies such as mandated benefits.

This year all plans will provide at least 48 hours of inpatient care for normal childbirth, 96 for caesarean deliveries. Mastectomy patients must have the option of inpatient care and must be permitted to stay at least 48 hours. OPM also eliminated maximum dollar limits on covered mental health care, as required by the Mental Health Parity Act passed by Congress last year. These particular mandates are not expected to have contributed substantially to the recent premium increases. However, the difficulties experienced by Maryland-based HMOs reveal the extent to which mandates can drive up costs and the influence of OPM policies on FEHBP premiums.

According to a recent news report, HMOs based in Maryland have been placed at a competitive disadvantage in the FEHBP market because of state-mandated benefits and OPM's refusal to exercise its statutory authority to disregard those mandates. Under 5 U.S.C. § 8902(m)(1), FEHBP contracts "supersede and preempt any State or local law ... which relates to health insurance or plans to the extent such law or regulation is inconsistent with such contractual provisions." In short, OPM may permit a health care plan to offer fewer benefits through the FEHBP than are required by state law. Nevertheless, according to the report OPM has declined to do so. Consequently, these HMOs contend they have been placed at a competitive disadvantage in the National Capital Area because compliance with Maryland's mandates drives up their premiums.

Table 1 compares the monthly premiums for NYLCare plans in Maryland, Virginia, the District of Columbia and the states of New York and New Jersey:

TABLE 1

OPTION	MD/DC/VA	NY	NJ
HIGH SELF	195.13	193.81	170.73
HIGH FAMILY	458.58	503.92	444.02
STD. SELF	132.95	N/A	N/A
STD. FAMILY	312.41	N/A	N/A

(Source: OPM, Non-Postal Premium Rates for the Federal Employees Health Benefits Program)

As table 1 shows, the high self option costs $1.32 more per month, or $15.84 per year, in the National Capital Area than in high-cost New York state. The contrast with New Jersey rates is even more pronounced. The high self option costs $292.80 more per year in the local area than in New Jersey, and the high family option is $174.72 more expensive.

This extra burden is shared by the taxpayers and individual employees and annuitants. Table 2 shows the amount by which the individual's share of the NYLCare monthly premium in the three-state capital area exceeds (or in the case of the New York High family option, is lower than) individual shares in New York and New Jersey.

TABLE 2

OPTION	Capital Area	Capital Area- NY	Capital Area- NJ
HIGH SELF	$52.22	$1.32	$ 9.54
HIGH FAMILY	150.33	-45.34	14.56
STD. SELF	33.24	N/A	N/A
STD. FAMILY	78.10	N/A	N/A

(Source: OPM, Non-Postal Premium Rates for the Federal Employees Health Benefits Program)

For the high self option, employees and annuitants in the National Capital Area pay $15.84 ($1.32 x 12) more per year than their New York counterparts and $114.48 ($9.54 x 12) more than their colleagues in New Jersey. They also pay $174.72 ($14.56 x 12) more for the high family option than their employees and annuitants in New Jersey. As a result, these individuals bear the entire burden of the difference between premiums for the high option self plan in the National Capital Area and New York and the difference between high option family plan premiums in the local area and New Jersey. Although

other factors undoubtedly also contribute, Maryland's mandates no doubt account for a substantial portion of these differences.

As this example illustrates, Congress must carefully examine the effect of mandates on FEHBP premiums in order to prevent unnecessary increases in the future. The importance of carefully reviewing OPM's mandates is reinforced by a statement in the press release announcing the current premium hikes. According to the release, OPM "sought to bring about more improvements in mental health benefits," but its "success was limited" because "all plans were faced with premium increases to cover higher health care costs." Nevertheless, OPM promises to work for "improved mental health coverage" in future plans. This promise portends higher costs for carriers and warrants close congressional scrutiny.

A copy of OPM's press release is enclosed.

WITNESS LIST

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OPM NEWS

R E L E A S E

FOR IMMEDIATE RELEASE
September 26, 1997

Contact: Sharon J. Wells
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1998 FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPEN SEASON HIGHLIGHTS

Washington, D.C.--Federal health plan enrollees will continue to pay lower average rates than the private sector as they have since 1995, the U.S. Office of Personnel Management said today in announcing that premiums for the Federal Employees Health Benefits Program will increase by an average of 8.5 percent for 1998.

"This is the first significant increase in federal health insurance premiums in five years, and in two of those years the average premium actually decreased," said OPM Acting Director Janice R. Lachance. "We expect that the 1998 increase will be significantly lower than the average private sector increase as it has been through most of the 1990s."

In 1996, the last year for which data is available, the average federal premium was $3,699 while in the private sector, the figure was $3,915. During the first three years of the decade, when federal enrollees paid increases of 8.7, 4.7 and 7.4 percent respectively, the average private sector premium increased 17.1, 12.1 and 10.1 percent. In 1995 and 1996, private sector premiums went up while federal plan costs decreased.

As widely predicted by health insurance experts, the trend toward higher health care costs continues. Industry trends indicate a double digit private sector increase next year compared to the federal hike of less than 9 percent.

For 1998 the FEHB Program will have a number of new benefits. All plans will provide at least 48 hours of inpatient care for normal childbirth and 96 hours of inpatient care for caesarean deliveries. Mastectomy patients must have the option of inpatient care and must be permitted to stay at least 48 hours.

--more--

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As stipulated in the Mental Health Parity Act, OPM also eliminated maximum dollar limits on covered mental health care. OPM sought to bring about more improvements in mental health benefits, but because all plans were faced with premium increases to cover higher health care costs, success was limited.

"As we look toward the next century, our goal is to make sure federal employees can choose among health plans that provide high quality care and service, including improved mental health coverage, at competitive prices," said Janice Lachance. "We will continue to work hard to achieve that goal."

The managed care component of the FEHB Program continues to grow in both size and strength. The 1998 program will contain additional point-of-service products. These products allow enrollees to minimize their out-of-pocket costs by using selected panels of providers. Enrollees also retain the freedom to choose other providers, but at additional cost. These point-of-service products have proven successful in reducing the rate of premium increases by facilitating the transition to managed care.

Because the current formula for dividing premium increases between the government and employees is based on a simple average premium of specified health plans, federal employees and annuitants will, on average, see a biweekly increase of about $3.32 for self coverage, from $24.42 to $27.74 and about $8.64 for family coverage, from $54.15 to $62.79. The maximum biweekly government contributions in 1998 will be $65.96 for self coverage and $142.27 for family.

For 1999, the share of premiums paid by employees and the government will be calculated under a new formula. The so-called "Phantom" Formula gives way to a Fair Share formula recently enacted by the Congress. The Fair Share formula will divide premium costs based on a weighted average of the premiums of all plans in the program.

Federal employees may select new health plans during the annual Open Season which runs from November 10 through December 8. Worldwide, federal employees and retirees will have over 350 plans from which to choose, including some plans that are new to the program.

"We encourage all FEHB enrollees to carefully review the 1998 premium and benefit changes to assure that they continue to receive the maximum value for the dollars they invest in their health care," Lachance added. "Federal employees, annuitants and their families have a wide choice in plans. We hope they'll take advantage of that choice."

The 1998 premium rates for non-postal enrollees are attached. Postal premium rates are available upon request.

###

Mr. MICA. On our first panel, we have William E. Flynn. Ed Flynn is the Associate Director for Retirement and Insurance Services, Office of Personnel Management. We have Joseph A. Antos, the Assistant Director for Health and Human Resources of the Congressional Budget Office. And we have Steven W. Gammarino, vice president of the Federal Employee Programs of the Blue Cross-Blue Shield Association.

If you could come up.

We have also been joined by our acting ranking member this morning. Both Mr. Cummings and Mrs. Morella personally asked to be excused this morning. They have functions in their district that they had previously committed to, but will have statements for the record and possibly join us before the conclusion of the hearing.

I would like to take a moment, if I could, and yield now to Ms. Norton from the District.

Ms. NORTON. Thank you, Mr. Chairman. This morning you made me acting ranking member. I can only recall that you had to make me acting chairman.

Mr. MICA. I made you chairman.

Ms. NORTON. Last week.

Mr. MICA. I even checked with the Parliamentarian to see if I could do it.

Ms. NORTON. I always take orders from my chairman, of whatever party.

I very much appreciate your initiative, Mr. Chairman, in calling this hearing. This is a very timely, very important hearing and shows the extent to which the chairman and the committee are on the cutting edge of the issues that are most important to Federal employees.

I ask unanimous consent that Mr. Cummings' opening statement be admitted in the record.

Mr. MICA. Without objection, so ordered.

[The prepared statement of Hon. Elijah E. Cummings follows:]

OPENING STATEMENT OF THE HONORABLE ELIJAH CUMMINGS

BEFORE THE SUBCOMMITTEE ON CIVIL SERVICE

HEARING ON THE FEHBP RATE HIKE

October 8, 1997

I want first to thank the Chairman for calling this extremely important hearing to examine the proposed premium increase for the Federal Employees Health Benefits Program (FEHBP). With 21,391 federal employees and 11,552 retirees in my congressional district, this steep 8.5% hike in health insurance costs will significantly tap my constituent's pocket books.

The prospect of an increase was forecast earlier this year when the Office of Personnel Management (OPM) sent out its Annual Call Letter for the 1998 Contract Year. OPM mandated new coverage levels for mastectomies, mammograms, and maternity and mental health services. Nonetheless, an increase of this magnitude came as somewhat of a shock to me, particularly given the modest growth in FEHBP premiums over the past last years and higher increases affecting private sector plans.

The Federal Employees Health Benefits Program has in the past been hailed as a model for the private sector because of its wide array of health plans to choose from and its high degree of customer satisfaction. This success can quickly be undermined if program costs cannot be contained.

OPM has indicated that this trend toward higher health care costs will continue and that it is the inevitable result of pent-up inflation. It points out that the private sector is likely to see a double-digit health insurance premium increases next year. This suggests that we should, somehow, find comfort in the fact that our rates will only grow by 8.5%. Well, given that FEHBP is the largest group health insurance program in the nation, covering approximately 9 million persons, its bargaining power within the industry should produce premiums lower than what can be found in the private sector. The real issue for us to focus on here today is not whether our rates compare favorably with the private sector, but whether OPM, as our program administrator, is doing its utmost to ensure that FEHBP premiums are fairly established and reflect the best value of the medical services they purchase.

Mr. Chairman, my concerns this morning are twofold: I want to know the whole story behind the 1998 premium increase; and I want to know what enrollees are to expect for 1999 and 2000. Are there any more surprises in store for us? The 8.5% increase could mean spending up to nearly $100 more per month on health care for some families. This hits the lowest salaried front-line workers the hardest, since they pay the same premiums as a senior executive making three times more than they do. When you're on a tight budget, $100 per month more in expenses is more than just an inconvenience: it can literally keep you from providing food and clothes for your family.

I look forward to the testimony of each of our witnesses, and I hope that this

hearing will shed some light on the reasons for the premium increase.

Thank you Mr. Chairman.

Ms. NORTON. We all cheered when it appeared that health care premiums were declining, although there was always some speculation that this was temporary. My own speculation is that at least part of the decline was the good news that came from President Clinton's initiative to try to get wholesale health care reform finally.

But now that it is clear that this Congress is not ready for such large changes, even if the American people are, the health care industry may have gotten just the opposite message. That message, of course, is that it is now possible to return to business as usual; that at best Congress will micromanage cost-cutting, such as initiatives that require the health care industry to pay for certain things, such as the controversy that has come out of 24-hour birthing stays in the hospital, or drive-through mastectomies.

As egregious as anecdotal abuses which quickly get the attention of Congress are, they are no substitute for health care reform that can permanently assure providers and Americans alike that we are stabilizing the cost of health care reform.

In light of this unexpected increase, what this committee initiated in the Balanced Budget Act becomes all the more important. I am referring, of course, Mr. Chairman, to Public Law 105–33 that establishes a permanent method for determining the respective shares that employees and the government will pay as 72 percent of the weighted average for all plans.

I believe that the FEHBP is a superior plan to most plans in the country and continue to believe that we can do what we have historically done, and that is take some leadership in pointing the way toward a stable health care plan approach. Even with what we did in the balanced budget bill, which is effective only in 1999, we may face these kinds of surprises in the future.

One of the things I believe the committee should do is to see whether or not the permanent weighted average for all plans helps to stabilize this matter, or whether further action is needed.

Again, I thank you very much, Mr. Chairman, for your initiative in calling this hearing so early after the report of these increases.

Mr. MICA. I thank the gentlewoman, and would like to now recognize vice chairman of our panel Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman. I really want to thank you for calling this hearing. You know, we are all concerned, I know you are, I certainly am, and I certainly believe Ms. Norton is, concerned about the impact these proposed increases will have on our Federal retirees. Often these folks, and many of them live within my district, are living on very limited incomes, and I am deeply concerned about the impact or potential impact of this rather significant increase on those retirees. I hope that the hearing today will shed some light on that.

I thank the chairman.

Mr. MICA. I thank the gentleman, and also share his concerns.

I am pleased also to see and note Mr. Charles Jackson, president of the NAFRE, National Association of Federal Retired Employees, with us this morning, and share your concern, Mr. Pappas, about, again, this significant increase, potential increase, on our Federal retirees.

I again would like to welcome our panel. As you know, some of you have testified before, some of you are new, this is an investigation and oversight subcommittee of Congress, and it is our custom to swear in our witnesses. If you would stand, please, and raise your right hand.

[Witnesses sworn.]

Mr. MICA. Thank you. To our newcomers, Mr. Antos and Mr. Gammarino, we also have the tradition of allowing lengthy statements to be entered in the record, and we ask you to try to summarize, if you can.

We will open this morning with Mr. Flynn. We are under some time constraints, but I think we have plenty of time to get a good overview of what is happening. Welcome back, Mr. Flynn.

Mr. Flynn is, again, the Associate Director of Retirement Insurance Services of the Office of Personnel Management. Welcome, and you are recognized, sir.

STATEMENTS OF WILLIAM E. FLYNN, III, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE SERVICES, OFFICE OF PERSONNEL MANAGEMENT; JOSEPH R. ANTOS, ASSISTANT DIRECTOR FOR HEALTH AND HUMAN RESOURCES, CONGRESSIONAL BUDGET OFFICE; AND STEPHEN W. GAMMARINO, VICE PRESIDENT, FEDERAL EMPLOYEE PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. FLYNN. Thank you, Mr. Chairman. Good morning to you and to the other members of the subcommittee. We appreciate the invitation you extended to us to come today to discuss factors which required us to increase premium rates under the Federal Employees Health Benefits Program for 1998.

As has been widely reported, the average premium increase for the Program as a whole amounts to 8.5 percent. The average participant contribution will increase by $3.32 for self coverage, and $8.64 for family coverage on a biweekly basis next year.

One of the hallmark features of the Federal Employees Health Benefits Program is choice. By carefully reviewing available plans and personal health care needs, individuals can choose a health plan that addresses their needs and is at a price that they can afford.

While any increase is a cause for concern for us, OPM believes that the increase will likely be lower than the average private sector increase, as has been the case for most of this past decade. First, the average premium in the Federal Employees Health Benefits Program for 1996, the last year for which data was available, was $3,699, while the comparable figure for the private sector was $3,915. If the Federal program had been growing at the same rate as the private sector since 1990, the average Federal premium would have been $4,574. Current reports on health insurance costs predict high single- and double-digit increases for renewals during 1998. For these reasons, we believe the Federal Employees Health Benefits Program will continue to offer good value and remain a low-cost leader.

You asked us to identify the causes which led to this increase after several years of premium stability in the program. I think it

is important at the outset to mention the several key factors that have been important to that stability.

First is the widespread use of numerous mechanisms to control cost and utilization in appropriate ways. Second, we expend great effort to inform participants about the Program and the plans available to them, enabling them to make informed choices each year. Third, the annual competition for participants helps to keep premiums competitive. Finally, the Program has built up healthy reserve levels which we have used over the past several years to mitigate premium increases.

Nonetheless, we must deal with the underlying rate of medical inflation. Medical costs have been increasing for years at an annual rate between 6 and 7 percent. In the face of this, the measures outlined above have kept premiums stable. However, with the seemingly inexorable increases in the cost of care and a reduction in the rate at which we are bringing reserve levels to their target, we find ourselves with an average increase of 8.5 percent for next year.

You also asked about what role, if any, government policies may have played in the cost increase. Plans in the Program will offer a number of new benefits in 1998. First, all plans will allow benefits for at least 48 hours of inpatient care for normal childbirth and 96 hours of inpatient care for cesarean deliveries. The plans will eliminate annual dollar limits on covered mental health care, and in addition, plans will follow the recommendations of the National Cancer Advisory Board regarding mammography screening. Finally, all plans will allow mastectomy patients inpatient benefits for at least 48 hours following the procedure.

We also sought additional improvements in access to mental health care for our participants next year.

The above benefit goals are illustrative of OPM policy over the past several years to identify benefits that, as an employer, we feel will promote the well-being of Federal workers, annuitants and their families. Our requests for 1998 amount to about one-third of 1 percent of Program costs, or an average premium of $15 per year. Given the minor impact on costs, we believe these have been choices worth making.

I think it is fair to say that premium increases have much less to do with Call Letter policies than with how successful a plan manages utilization, encourages healthy lifestyles, pays the lowest available rate for covered services and supplies, and accurately sets rates in conjunction with reserve levels.

Finally, Mr. Chairman, you asked me to compare the impact of 1998 rates on the participant's share of premiums, in terms of both the average percentage and the average dollar increase, against increases that would have resulted assuming the new fair share government contribution formula was in effect for 1998, and assuming the Chair's proposal for adjusting a fixed-dollar government contribution by annual increases in the overall rate of inflation. Those figures are attached to my statement and portray that information on a comparative basis in a table.

I would be happy to answer any questions you or the other members of the subcommittee may have for me.

Mr. MICA. Thank you, Mr. Flynn. We will defer questions until we finish other witnesses.

[The prepared statement of Mr. Flynn follows:]

Mr. Chairman and members of the Subcommittee, I am happy to be here today to discuss premium increases in the Federal Employees Health Benefits program and trends in private-sector health expenditures. With your permission, I will submit my written statement for the record and summarize it briefly here today.

The Office of Personnel Management recently announced that premiums for the Federal Employees Health Benefits program will increase by an average of 8.5 percent in 1998, after two successive years of decline. Enrollees will see an even steeper increase in the premiums they pay directly, which will rise by over 15 percent next year.

Although those are large increases compared to recent experience, they appear to reflect the same factors that are putting upward pressure on premiums for private health insurance.

The 1990s have witnessed a fundamental transformation of health care markets that has contributed to the slow growth in insurance premiums in recent years. Competition has strengthened, with

employers becoming much more aggressive in their price negotiations with an increasing number of health plans. Managed care plans—which are better able to control costs and, hence, premiums—have steadily gained market share at the expense of conventional fee-for-service plans. Not only have they sought to reduce inefficiency in delivering health services, but they have also been able to take advantage of considerable excess capacity in the health care industry to drive hard payment bargains with providers.

Rising costs in the past two years, however, are threatening profit margins in the managed care industry. In 1996, the profits of HMOs fell by an estimated 60 percent and some plans were forced to use their capital reserves to meet their medical costs. That erosion of profits reflects the recent pattern of premium increases that have not kept up with general price inflation.

Although premium increases remained low in 1997 (less than 2 percent), they were higher than in 1995 and 1996, suggesting that the downward trend may have come to an end. Premium increases for 1998

are likely to be larger still as plans more fully adjust to 1996's disappointing performance.

The longer-term outlook for slow growth of premiums may also be dimming because of a growing backlash against managed care. State and federal governments are imposing new requirements for health plans, which add to the cost of coverage. In addition, large employers and their employees may be increasingly willing to pay higher premiums rather than switch health plans and personal physicians in order to get the lowest possible price.

Nonetheless, health care markets in most areas are still extremely competitive, and aggressive purchasing by employers is likely to continue. Although their concerns about quality of care and employee satisfaction may be growing, their concerns about costs will remain. Based on those considerations, CBO's most recent projections assume that private health expenditures will grow more rapidly over the next 10 years than they have in the past few years, with growth rates averaging 5 to 6 percent increases a year between 1998 and 2007.

<PAUSE>

The 8.5 percent increase in total FEHB premiums projected for next year reflects business conditions facing health plans in dozens of local markets across the country, as well as more general factors influencing health care costs nationwide. Although FEHB is the largest employer-sponsored program in the country, it does not dominate many local markets and one might expect FEHB rates to increase at about the same rate as those obtained by other large employer groups.

A particular concern facing both FEHB and private health plans is the imposition of mandates that expand benefits or modify the way in which those plans are operated. Such mandates are not a new phenomenon. States have traditionally regulated health plans, resulting in a complex pattern of requirements that plans must meet. Recently the federal government enacted several mandates relating to the portability of insurance coverage and covered benefits.

Those mandates should not, however, result in large premium increases for either private plans or for FEHB in 1998. For example, the requirements for minimum hospital stays for maternity patients and mental health parity will increase total FEHB spending by about $20 million in fiscal year 1998. That amount is extremely modest compared with the $17 billion in total spending for federal employees' health benefits projected in CBO's baseline.

Even so, as more state and federal mandates are imposed in the future, their cumulative effects on premiums could become considerable. That issue, which affects both private and FEHB plans, is one of the factors causing uncertainty about future growth in premiums.

To conclude,

Although an 8.5 percent increase for FEHB in total premiums is somewhat higher than CBO and other observers have projected for the growth of private insurance premiums for 1998, it does not appear to be

out of line with developments in the private market. Moreover, that increase does not mean that a return to double-digit rates is inevitable or even likely in the foreseeable future. It may, instead, reflect a return to a more sustainable trend after a period of rate increases that did not keep up with general inflation.

Mr. MICA. Mr. Joseph R. Antos, Assistant Director for Health and Human Resources, Congressional Budget Office. Welcome. You are recognized, sir.

Mr. ANTOS. Thank you.

Mr. Chairman and members of the subcommittee, I am happy to be here today to discuss premium increases in the Federal Employees Health Benefits Program and trends in private-sector health expenditures.

The Office of Personnel Management recently announced that premiums for the Federal Employees Health Benefits Program will increase by an average of 8.5 percent in 1998, after 2 successive years of decline. Enrollees will see an even steeper increase in premiums they pay directly, which will rise by over 15 percent next year.

Although those are large increases compared to recent experience, they appear to reflect the same factors that are putting upward pressure on premiums for private health insurance.

The 1990's have witnessed a fundamental transformation of health care markets that has contributed to the slow growth in insurance premiums in recent years. Competition has strengthened, with employers becoming much more aggressive in their price negotiations with an increasing number of health plans. Managed care plans, which are better able to control costs and hence premiums, have steadily gained market share at the expense of conventional fee-for-service plans. Not only have they sought to reduce inefficiency in delivering health services, but they have also been able to take advantage of considerable excess capacity in the health care industry to drive hard payment bargains with providers.

Rising costs in the past 2 years, however, are threatening profit margins in the managed care industry. In 1996, the profits of HMO's fell by an estimated 60 percent, and some plans were forced to use their capital reserves to meet their medical costs. That erosion of profits reflects the recent pattern of premium increases that have not kept up with general price inflation.

Although premium increases remained low in 1997—less than 2 percent—they were higher than in 1995 and 1996, suggesting that the downward trend may have come to an end. Premium increases for 1998 are likely to be larger still as plans more fully adjust to 1996's disappointing profit picture.

The longer-term outlook for slow growth of premiums may also be dimming because of the growing backlash against managed care. State and Federal Governments are imposing new requirements for health plans that add to the cost of coverage. In addition, large employers and their employees may be increasingly willing to pay higher premiums rather than switch health plans and personal physicians in order to get the lowest possible price.

Nonetheless, health care markets in most areas are still extremely competitive, and aggressive purchasing by employers is likely to continue. Although their concerns about quality of care and employee satisfaction may be growing, their concerns about cost will remain. Based on those considerations, CBO's most recent projections assume that private health expenditures will grow more rapidly over the next 10 years than they have in the past few

years, with growth rates averaging 5 to 6 percent a year between 1998 and 2007.

The 8.5-percent increase in total FEHBP premiums projected for next year reflects business conditions facing health plans in dozens of local markets across the country, as well as more general factors influencing health care costs nationwide. Although FEHBP is the largest employer-sponsored program in the country, it does not dominate many local markets, and one might expect FEHBP premiums to increase at about the same rate as those obtained by other large employer groups.

One particular concern facing FEHBP and private health plans is the imposition of mandates that expand benefits or modify the way in which those plans are operated. Such mandates are not a new phenomenon. States have traditionally regulated health plans, resulting in a complex pattern of requirements that plans must meet.

Recently the Federal Government enacted several mandates relating to the portability of insurance coverage and covered benefits. Those mandates should not, however, result in large premium increases for either private plans or for FEHBP in 1998.

For example, the requirements for minimum hospital stays for maternity patients and mental health parity will increase total FEHBP spending by about $20 million in fiscal year 1998. That amount is extremely modest compared with the $17 billion in total spending for Federal employees' health benefits projected in the CBO's baseline. Even so, as more State and Federal mandates are imposed in the future, their cumulative effect on premiums could become considerable. That issue, which affects both private and FEHBP plans, is one of the factors causing uncertainty about the future growth in premiums.

To conclude, although an 8.5-percent increase for FEHBP in total premiums is somewhat higher than CBO, and other observers have projected for the growth of private insurance premiums for 1998, it does not appear to be out of line with the developments in the private market. Moreover, that increase does not mean that a return to double-digit rates is inevitable or even likely in the foreseeable future. It may instead reflect a return to a more sustainable trend after a period of rate increases that did not keep up with general inflation.

Thank you. I would be happy to take questions.

Mr. MICA. Thank you.

[The prepared statement of Mr. Antos follows:]

Mr. Chairman and members of the Subcommittee, I am happy to be here today to discuss premium increases in the Federal Employees Health Benefits program and trends in private-sector health expenditures.

The Office of Personnel Management (OPM) recently announced that premiums for the Federal Employees Health Benefits (FEHB) program will increase by an average of 8.5 percent in 1998, after two successive years of decline. The announcement also stated that OPM expected the percentage increase in FEHB premiums to be significantly lower than the corresponding increase in the private sector.

OPM's statement has caused considerable concern among policymakers and raised several important questions about the future course of private-sector premiums in general and FEHB premiums in particular.

- Does the FEHB premium increase mean that we are about to return to double-digit increases in private-sector health expenditures?

- What factors drive the growth of premiums in the private sector and the FEHB program? In particular, are government actions to mandate health benefits responsible for an upsurge in health care costs?

- If cost pressures are beginning to grow, can FEHB premiums continue to grow less rapidly than private-sector premiums?

RECENT TRENDS

As is widely known, private-sector health expenditures have been growing much more slowly in recent years than in the 1980s. Surveys of employers show that the annual growth of premiums in employment-based plans dropped from double-digit rates at the beginning of the decade to 2 percent or less for the past three years—rates that are below the general rate of inflation (see Table 1). While demonstrating a similar trend, FEHB premiums have generally grown at rates lower than those reported by nonfederal employers, and average premiums actually declined in 1995 and 1996. The California Public Employees Retirement System (CalPERS), another major public purchaser of health care, has also reported premium reductions in recent years.

Health policy analysts generally agree that the 1990s have witnessed a fundamental transformation of health care markets that has helped to slow the growth of health spending, at least temporarily. The most visible sign of that transformation is the shift of workers from conventional fee-for-service coverage into various forms

TABLE 1. ANNUAL GROWTH OF PREMIUMS OR COSTS FOR HEALTH INSURANCE, 1990-1997 (In percent)

Source	1990	1991	1992	1993	1994	1995	1996	1997
FEHB	9	6	7	10	2	-4	a	3
CalPERS	17	11	6	1	-1	n.a.	-4	-1
Hay/Huggins	17	13	12	8	3	1	-3	n.a.
Foster Higgins	17	12	10	8	-1	2	2	n.a.
KPMG Peat Marwick	n.a.	12	11	8	5	2	b	2
Bureau of Labor Statistics	12	11	10	8	6	2	a	b
Memorandum:								
Consumer Price Index for All Urban Consumers	5.4	4.2	3.0	3.0	2.6	2.8	2.9	2.4

SOURCE: Congressional Budget Office based on the sources cited below.

NOTE: FEHB = Federal Employees Health Benefits program; CalPERS = California Public Employees Retirement System; n.a. = not available.

a. Decline of less than 0.5 percent.

b. Growth of 0.5 percent or less.

SOURCE NOTES

Office of Personnel Management, Federal Employees Health Benefits Program: The 1997 estimate is based on 1996 enrollment patterns and does not consider changes in enrollment during open season.

CalPERS, Health Plan Administration Division: Data for 1995 are unavailable because CalPERS changed the definition of its contract year. Before 1995, the CalPERS contract year ran from August 1 to July 31. In 1995, CalPERS began to switch its contract year to a calendar year basis. The 1996 data are for the contract year starting on August 1, 1995, and ending on December 31, 1996. Data underlying calculations for 1997 correspond to calendar year premium costs.

Hay/Huggins, *Benefits Report* (Washington, D.C.: Hay/Huggins, 1990 through 1996): The surveys use average premiums for all employers for the most prevalent plan, based on a sample of public and private employers that generally have at least 100 employees.

Foster Higgins, *National Survey of Employer-Sponsored Health Plans* (New York: Foster Higgins, 1990 through 1996): The surveys are based on a sample of private and public employers with 10 or more employees.

KPMG Peat Marwick, *Health Benefits* (Tysons Corner, Va., and San Francisco: KPMG Peat Marwick, 1990 through 1997): The surveys are based on a sample of private and public employers with 200 or more employees.

Department of Labor, Bureau of Labor Statistics, employment cost index: The index covers only the employer's share of premiums or costs. Growth rates measure changes in cost over a 12-month period from March to March.

of managed care. In 1997, fewer than 20 percent of employees are enrolled in conventional plans, compared with more than 70 percent just nine years ago.[1]

The shift to managed care reflects an increasingly competitive health care marketplace, for which both demand- and supply-side factors are responsible. On the demand side, employers have become considerably more aggressive in their price negotiations with health plans. A key force instilling competition in the marketplace has been their willingness to change health plans to obtain lower premiums.[2]

On the supply side, health plans have been focusing on expanding their shares of the market. With employers becoming more price sensitive, plans' market shares have depended increasingly on their relative prices. Thus, managed care plans—which are better able to control costs and, hence, premiums—have steadily gained market share at the expense of conventional fee-for-service plans. Not only have they sought to manage care more effectively, but they have also been able to take advantage of considerable excess capacity in the health care industry to drive hard payment bargains with providers.[3]

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1. KPMG Peat Marwick, *Health Benefits in 1997* (Tysons Corner, Va., and San Francisco: KPMG Peat Marwick, June 1997), p. 28.

2. Paul B. Ginsberg and Jeremy D. Pickreign, "Tracking Health Care Costs: An Update," *Health Affairs*, vol. 16, no. 4 (July/August 1997), pp. 151-155.

3. See, for example, Kathryn Saenz Duke, "Hospitals in a Changing Health Care System," *Health Affairs*, vol. 15, no. 2 (Summer 1996), pp. 49-61.

Managed care plans may not be able to continue to constrain premium growth, however, because of rising costs that are threatening their profit margins. Striking evidence of the upward pressure on premiums emerged in 1996 when the profits of health maintenance organizations (HMOs) fell by an estimated 60 percent and some plans were forced to use their capital reserves to meet their medical costs.[4] That erosion of profits reflects the recent pattern of premium increases that have not kept up with general price inflation.

Although premium increases remained low in 1997, they were higher than in 1995 and 1996, suggesting that the long downward trend may have come to an end. But because of the way in which insurers and health plans set those premiums, analysts did not expect the full impact of the 1996 profit squeeze to be felt until 1998. Considerable evidence suggests that health insurance premiums track changes in profits with a lag of about two years. That lag may reflect the time needed to collect and analyze the necessary data on claims experience, as well as the time needed to implement a premium change.

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4. Julie A. Jacob, "HMO Profits Plunge in '96; Premium Hikes Likely Result," *American Medical News*, vol. 40, no. 35 (September 15, 1997), pp. 11-12.

PROJECTIONS OF PRIVATE HEALTH EXPENDITURES FOR 1998 AND BEYOND

Whether the recent slowdown in the growth of private-sector health spending will continue has been the subject of considerable debate. Once competitive forces have wrung inefficiencies out of the system, will the demands created by medical advances and new technologies drive spending back to the rapid growth rates of the 1980s and early 1990s? Or will continuing market pressures result in permanently lower rates of spending growth?

The Congressional Budget Office's (CBO's) most recent projections assume that private health expenditures will grow more rapidly over the next 10 years than they have in the past few years, with growth rates averaging 5 percent to 6 percent a year between 1998 and 2007.[5] At present we see no reason to modify those projections, which reflect the effects of several opposing forces within the health care system.

Upward pressure on premiums is coming from reduced profit margins, new requirements for health plans that the state and federal governments are imposing, and an overall change in the environment for managed care plans. That change reflects a growing backlash against some of the management practices that plans

5. Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1998-2007* (January 1997), Appendix H.

employ, causing plans to become increasingly concerned about their public image. But how far plans will voluntarily modify their practices in response to consumers' complaints is uncertain.

Moreover, there are indications that large employers may be modifying their market behavior, and some plans are beginning to find that raising premiums does not necessarily result in loss of market share. Although small employers still respond rapidly to price changes, large employers are apparently becoming less willing to change health plans when premiums rise, because of the resulting disruption in their employees' health care.[6] When employers were primarily offering conventional fee-for-service insurance, switching insurers did not have much effect on employees because they could generally see the same providers as before. But with most employees now enrolled in some form of plan with a restricted panel of providers, changing health plans may well mean changing physicians, which could cause considerable discontent.

Nonetheless, health care markets are still extremely competitive, and aggressive purchasing by employers is likely to continue. Although their concerns about quality of care and employee satisfaction may be growing, their concerns about costs will remain. Continued low inflation over the next several years is also

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6. Jacob, "HMO Profits Plunge in '96."

expected to temper the growth of premiums; although price increases for medical services were greater than general inflation in the 1980s, rising prices in the overall economy certainly contributed to the rapid growth of health spending. CBO's projections assume that general inflation will remain at about its current rate for the foreseeable future.

FUTURE GROWTH IN FEHB PREMIUMS

Health plans offered by the FEHB program consist of a few large managed fee-for-service plans that operate nationwide and several hundred smaller point-of-service plans and HMOs that serve local markets across the country. All of those plans are subject to many of the same forces as private-sector plans more generally, as well as to the unique and varied pressures that exist in local markets. Thus, just as one sees wide variations in levels and rates of growth of private-sector premiums across the country, one would also expect to observe similar patterns in FEHB premiums.

The projected 8.5 percent increase in FEHB premiums should therefore be interpreted carefully. Because of the large market share of the national fee-for-service plans, especially the Blue Cross-Blue Shield standard-option plan, average premium increases in local markets may appear deceptively similar. Family

premiums in that plan will rise by 7.5 percent throughout the country, an increase that does not reflect the conditions in any particular local insurance market.

The regional pattern of rate increases appears to be consistent with conditions in local markets. For example, changes in premiums for the three local plans in California with the largest family enrollments range from a slight drop to an increase of less than 5 percent. That performance is consistent with the overall increase of less than 3 percent projected by CalPERS for 1998. In contrast, family premiums in the three local plans in the District of Columbia with the largest enrollment will all increase by more than 10 percent.

THE ROLE OF MANDATES

One factor that contributes to the growth of health insurance premiums is mandates on health plans that expand benefits or modify the way in which those plans are operated. Such mandates are not a new phenomenon. States have traditionally regulated health plans, resulting in a complex pattern of requirements that plans must meet. But self-insured plans are exempt from most of those requirements under the provisions of the Employee Retirement Income Security Act (ERISA). In the past two years, however, the federal government has enacted several mandates relating to the portability of insurance coverage and covered benefits that will affect all health

insurance plans, including those that are self-insured. Several other federal mandates are under consideration.

Although health insurance mandates generally increase the cost of providing health coverage and result in an increase in premiums, the magnitude of such increases for the recent federal mandates has not been large. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) made it easier for people who change jobs to maintain health insurance. According to CBO's estimate, the act's provision for insurance portability will impose mandate costs on the private sector of $440 million in fiscal year 1998, or about 0.1 percent of the more than $300 billion spent annually on private health insurance. In contrast, HIPAA did not impose any additional costs on the FEHB program, which already covers new employees without restriction.

Other recent federal health insurance mandates, however, are expected to increase the costs of both FEHB and private plans. As a result of legislation passed last year, all health plans must cover at least a 48-hour hospital stay for normal deliveries (96 hours for a cesarean section) and meet certain parity requirements for mental health coverage. In addition to those legislated mandates, OPM will now require that FEHB plans cover at least a 48-hour hospital stay for mastectomies. According to CBO's estimate, the requirement for maternity stays will increase federal spending for the FEHB program by $4 million (subject in part to

appropriations) in fiscal year 1998, and mental health parity would increase federal FEHB spending by $10 million in that year. Counting both the federal and employee shares of the premium, FEHB spending will rise by almost $20 million in fiscal year 1998 as a result of those mandates.[7] That amount is extremely modest compared with the $17 billion in total spending for federal employees' health benefits projected in CBO's baseline. The impact on private-sector costs is somewhat more significant. CBO estimated private-sector mandate costs of $180 million for the requirement for maternity stays and $1.2 billion for mental health parity in fiscal year 1998.

By themselves, those mandates should not add significantly to the growth in health insurance premiums between 1997 and 1998. Nonetheless, as more state and federal mandates are imposed, their cumulative effects on premiums could become considerable. That issue, which affects both private and FEHB plans, is one of the factors causing uncertainty about future growth in premiums.

CONCLUDING THOUGHTS

The recently announced 1998 premium rates for the FEHB program represent a significant rise in health care costs for federal employees. Although an 8.5 percent

7. That estimate does not take account of any change in enrollment patterns that might occur as a result of the spending increase.

increase is somewhat higher than CBO and other observers have projected for the growth of private insurance premiums for 1998, it does not appear to be out of line with developments in the private market. Moreover, that increase does not mean that a return to double-digit rates is inevitable or even likely in the foreseeable future.

The geographic pattern of FEHB premium increases for local health plans suggests that OPM is obtaining premium offers that are consistent with conditions in those markets. The low increase for FEHB premiums in California, for example, is consistent with the experience of CalPERS. The FEHB program may be able to negotiate rate increases below the average increase in private insurance rates in some markets, primarily those in which there is already substantial competition among health plans and in which the FEHB program has a large share. But even in those areas, FEHB rates would not be immune to the forces driving health insurance costs in general.

Mr. MICA. We will defer questions until we finish with Steven W. Gammarino, vice president of Federal Employee Programs for Blue Cross and Blue Shield.

You are welcome and recognized, sir.

Mr. GAMMARINO. Thank you, Mr. Chairman and members of the subcommittee. Mr. Chairman, I would like to take advantage of your offer to have our full testimony read into the record.

Mr. MICA. Without objection, it will be made part of the record.

Mr. GAMMARINO. On behalf of the association, I thank you for the opportunity to appear before you today to discuss the 1998 premium increases in the Federal Employees Health Benefits Program and related matters.

As you know, the 56 Blue Cross and Blue Shield plans jointly underwrite and deliver the governmentwide service benefit plan, which currently covers over 3.6 million members.

I would like to address the following three points in my testimony. First, the 1998 premium for the service benefit plan and the factors affecting that premium; second, the expected impact of the premiums on our open season enrollment; and third, our perspective on the FEHBP generally.

Today, 95 percent of our enrollees are in our standard option plan. This plan will have a premium increase of 7.5 percent for contract year 1998. As pointed out in your letter of invitation, this increase is lower than the average increase in the Federal program. I would also note that there are no reductions in our benefit package for 1998, and there are actually a few modest enhancements. Even with the rate increase, we believe we have a superior insurance product providing excellent value for our members.

Variability in premiums from year to year is, I am afraid, not unusual in the insurance industry. Generally speaking, premium increases are driven by four factors: One, benefit changes; two, the cost of health care; three, utilization patterns; and, four, the demographics of a particular group.

Coping with these changes and finding ways to mitigate their effects on premiums is the insurance carrier's major task. Additionally, because the FEHBP is a mature program with an aging risk pool, containing costs is particularly challenging.

We, like most other health plans in the insurance industry, are indeed experiencing an increase in health care trends, and we expect those trends to continue in 1998. By far the fastest growing component of that increase is in the prescription drug area. While similar changes appear to be taking place throughout the industry, our drug program trend may, in fact, be higher because of the large number of elderly enrollees.

We are proud that we have been able to keep our rate of increase below the average. We also know, however, that we must find new ways to control these costs in order to be successful in this program.

Because some of our competitors experienced rate increases significantly higher than ours, and in some cases reduced benefits, it is possible that we could see a substantial number of enrollees transferring to our plan this coming open season. Our delivery system makes it relatively easy for us to accommodate even large in-

creases in the covered population, and therefore we do not anticipate any difficulty in providing services to these new enrollees.

We do, however, have some concern that our plan may suffer a degree of adverse selection during open season. That is, it may attract a disproportionate share of people with serious health problems. To the degree that we experience adverse selection, the task of controlling our costs in the future will be even more challenging.

We have begun to implement some innovative programs that we believe will lead to better and more cost-effective care for our enrollees in the future. For example, this year we launched a program called Blue Health Connection that provides nurse triage and individual health care counseling on a 24-hour basis and health care information via both the telephone and the Internet.

With these types of programs, we can play a role in containing costs without impairing, but indeed in many cases improving, the care our enrollees receive. We plan to continue looking for such pilots in the future.

As you know, this program is the largest employer-sponsored health program in the world. By most accounts, it has been very successful in delivering quality insurance to millions of enrollees for the past four decades. We believe that the reason for this success is the critical but delicate balance of the roles of both the government, the private sector and enrollees. In that regard, let me commend you for holding this hearing, because congressional oversight is a primary function in maintaining this balance.

We see the role of OPM, the administering agency, as vital as well. In our view OPM should serve primarily as a market regulator, charged with maintaining a level playing field among the competitors in this sector; in addition, providing an environment in which employees and retirees, who are the ultimate consumers, can make informed choices.

We see a distinct and important role for the competing health plans as well. The FEHBP law provides ample ground rules for basic and minimum coverages. With this foundation, each carrier must strive to bring a quality product to the marketplace that will attract a broad segment of the population while remaining financially strong. As new medical technology evolves and new management techniques become available, each carrier must be able to offer innovative benefit designs and care management programs to the consumer.

Finally, the individual Federal employee and retiree must seize the opportunity to study the offerings and make the selection most appropriate to his or her needs and family requirements. The consumer is and must be the ultimate decisionmaker in this marketplace.

Thank you, Mr. Chairman. I will be glad to answer any questions at this time.

[The prepared statement of Mr. Gammarino follows:]

Mr. Chairman and Members of the Subcommittee:

I am Stephen W. Gammarino, Vice-President, Federal Employee Program at the Blue Cross and Blue Shield Association. On behalf of the Association, I thank you for the opportunity to appear before you today to discuss 1998 premium increases in the Federal Employees Health Benefits Program (FEHBP) and related matters.

As you know, the fifty-six Blue Cross and Blue Shield Plans jointly underwrite and deliver the Government-wide Service Benefit Plan. This Plan has been in the Federal Program since its inception in 1960 and is the largest Plan in the Program. The Service Benefit Plan currently covers over 1.8 million contracts and more than 3.6 million lives.

I will address the following points in my testimony:

- The 1998 premium for the Service Benefit Plan and the factors affecting that premium;
- The expected impact of premiums on Open Season enrollment changes and how Blue Cross and Blue Shield is preparing to deal with such changes; and
- The Blue Cross and Blue Shield perspective on the FEHBP generally.

1998 Rate Increase

Ninety-five percent of our enrollees are in our Standard Option, which will have a premium increase of 7.5 percent for contract year 1998. As pointed out in your letter of invitation, this increase is lower than the average increase in the Federal program. I would also note that there are no reductions in our benefit package for 1998 and a few modest enhancements. Even with the rate increase, we believe there can be no question that our Standard Option is a superior insurance product and provides excellent value for our federal subscribers.

Variability in premiums from year to year is, I am afraid, not unusual in the insurance industry. It is reflected in the ten year history of premium changes for the Service Benefit Plan that you requested, as shown below:

Annual Increase in FEP Gross Premium Rates

	High Option	Std. Option
1989	50.0%	22.0%
1990	7.0%	12.0%
1991	11.0%	0.0%
1992	-8.0%	12.0%
1993	1.2%	10.6%
1994	-2.0%	3.4%
1995	-7.0%	-3.0%
1996	0.0%	2.0%
1997	0.0%	0.0%
1998	0.0%	7.5%

Generally speaking, premium changes are driven by benefit changes, changes in the cost of health care, changes in utilization patterns, and changes in the demographics of a particular group. Since rate setting necessarily involves

projecting into the future, often based on incomplete information about the recent past, carriers frequently either over or underestimate the degree of change in these factors. Coping with these changes and finding ways to mitigate their effects on premium is the insurance carrier's major task. It is also an apparently unending task, requiring extraordinary effort. Because FEHBP is a mature program with an aging risk pool, containing costs is particularly challenging.

We are indeed experiencing an increase in our health care trends and we expect that increase to continue into 1998. By far the fastest growing component of that increase is in the prescription drug area. While similar changes appear to be taking place throughout the industry, our prescription drug trend may be unusually high because of the large number of older people in our Plan.

We are proud that we have been able to keep our rate increase for 1998 below the average for the program. We also know that we must look for new ways to keep our costs, including our prescription drug costs, under control in order to assure our continued success in the FEHBP in the future.

Open Season Changes

Because some of our competitors experienced rate increases significantly in excess of ours and also reduced their benefits, it is possible that we could see a

substantial number of enrollees transferring to our Plan during Open Season. The decentralized nature of our delivery system makes it relatively easy for us to accommodate even large increases in the covered population, and thus, we do not anticipate any difficulty in providing services to new enrollees.

We have some concern that our Plan may suffer a degree of adverse selection during Open Season, that is, it may attract a disproportionate share of people with serious health problems. There is no way we could—or would—try to discourage any individual or subgroup from joining our Plan. On the contrary, all are welcome. To the degree that we experience adverse selection, however, the task of controlling our costs in future will be even more challenging.

We have already begun some innovative programs that we believe will lead to better and more cost effective care for our enrollees in the future.

In 1997, we launched a program called Blue Health Connection that provides nurse triage and individual health counseling on a 24-hour basis, and health care information via telephone and Internet. The program will be expanded in 1998.

We will be launching several voluntary programs for people with chronic diseases in 1998. The purpose of these efforts is to help our enrollees manage

their conditions, prevent acute episodes, and when they do need-care, to make sure they get the care that is most appropriate for their condition.

We are also expanding our point of service pilots in 1998. In these pilots enrollees reduce their out-of-pocket expenses by staying within a network and having their care coordinated by a physician they select.

We believe each of these programs can play a role in containing cost without impairing—indeed while improving—the care our enrollees receive. We plan to continue looking for and piloting such programs in the future.

General Perspective on the FEHBP

The FEHBP is the largest employer-sponsored health care program in the world. By most accounts, it has been very successful in delivering quality insurance coverage to million of Federal employees, retirees, and their dependents for nearly four decades.

The Blue Cross and Blue Shield Association strongly believes that the reason for this success is the critical—and delicate—balancing of the roles of the Government, the private sector, and the enrollee. To maintain the balance, all parties must play their roles appropriately. In that regard, let me commend you for holding this hearing because Congressional oversight is a primary function in

maintaining the balance. In particular, Mr. Chairman, we very much appreciate your role in recognizing the contribution of the private sector in making the FEHBP a success. Time and again, you have taken a critical view of mandated activities in this program, whether they have been proposed by the Congress or the Office of Personnel Management (OPM) or by private sector entities seeking to gain a competitive advantage.

We see the role of OPM, the administering agency, as vital also. In our view OPM should serve primarily as the market regulator, charged with maintaining a "level playing field" among the competing private sector carriers, and an environment in which employees and retirees—the ultimate consumer—can make informed choices. We specifically reject any notion of a scenario whereby OPM would dictate the specifics of benefit design and coverages above the statutory requirements or where the agency would attempt to determine winners and losers among the carriers. Over the last several years, we have seen a number of OPM benefit mandates. While the individual benefits may have merit, we generally oppose benefit mandates and hope this is not a trend that we will see in the future.

We see a distinct and important role for the competing carriers in the program. The FEHBP law provides ample ground rules for basic and minimum coverages and has prohibited exclusionary practices, waiting periods, or the use of

preexisting conditions since the beginning of the Program (long before such features became fashionable). Thus, each carrier must strive to bring a quality product to the market place that will attract a broad segment of the FEHBP population, while remaining financially solvent. As new medical technologies evolve and new health care management techniques become available, each carrier must be able to offer innovative benefit designs and care management programs to the consumer. And they must live with the consequences, for the enrollee is free annually to accept or reject the offerings.

Finally, the individual Federal employee and retiree must seize the opportunity to study the offerings and make the selection most appropriate to his or her needs and family requirements. The consumer is and—must be—the ultimate arbiter of the market place.

Thank you, Mr. Chairman, I would be glad to answer any questions.

STEPHEN W. GAMMARINO

VICE PRESIDENT
FEDERAL EMPLOYEE PROGRAM
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Stephen W. Gammarino (Steve) is Vice President of the Federal Employee Program (FEP), Blue Cross and Blue Shield Association. Mr. Gammarino has extensive experience in the Health Care Administration. Mr. Gammarino is responsible for the planning and direction of the FEP. The FEP is the largest privately underwritten Health Care program in the world, servicing almost four million enrollees with a premium income of over $6 billion. This responsibility includes operations, financial, marketing, legal, legislative and contractual activities necessary to ensure the delivery of quality and cost-effective health care services to federal employees and retirees.

Prior to this, Mr. Gammarino held a number of positions in the Blue Cross and Blue Shield System.

Mr. Gammarino received a Bachelor of Arts Degree in 1971 at West Virginia Wesleyan College. He is currently enrolled at the University of Maryland pursuing a Master of Science Degree in Technology Management.

August 26, 1997

BlueCross BlueShield Association

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Vice President
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October 8, 1997

Committee on Government Reform and Oversight
Subcommittee on Civil Service
U.S. House Representatives
Washington, D.C. 20515

To Whom It May Concern:

In order to comply with Clause 2(g)(4) of Rule XI of the Rules of the House, I am stating that Blue Cross and Blue Shield Association contracts with the federal government in its administration duties related to the Medicare contractor program and the Federal Employee Program and receives approximately $50 million annually for these responsibilities.

Sincerely,

Stephen W. Gammarino

Stephen W. Gammarino
Vice President
Federal Employee Program

Mr. MICA. Thank you for your testimony. In fact, I thank all of our witnesses.

Mr. Flynn, I was sort of shocked when I got page 7. I want to make sure the other members have a copy of this little addendum and chart. I guess that OPM has put out the total premium increase is going to be 8.5 percent, and it looks like the enrollee's share, the increase is going to be a shocking 15.4 percent. Is that correct?

Mr. FLYNN. Mr. Chairman, that is the average. It is a blend of self and self and family. But on average, that is correct.

Mr. MICA. Fifteen and four-tenths percent. I think there are going to be some folks that are shocked in January at what they see. When I saw these figures, and this, again, is an average, it appears that it is a lot more than the 8.5 that has been announced as the overall average premium increase.

Just for the government share, what kind of total increase in costs are we looking at?

Mr. FLYNN. That is also reflected on the table, Mr. Chairman.

Mr. MICA. I mean in dollars. Have you calculated what this is going to cost the Federal Government, that 5.7 percent?

Mr. FLYNN. When you say cost the Federal Government, in terms of the total amount?

Mr. MICA. Dollar amount.

Mr. FLYNN. Well, very roughly, this is quick in my head, I can prepare an answer for the record that might be a little better. If we have an $18 billion program that is looking at an increase of about 8.5 percent, that in round numbers is roughly $1.6 or $1.7 billion.

Mr. MICA. $1.6 or $1.7 billion, additional billion, additional, just to the Government?

Mr. FLYNN. No, in total.

Mr. MICA. The Federal Government would be a 5.7-percent increase.

Mr. FLYNN. It would be about three-quarters of that, Mr. Chairman.

Mr. MICA. About $1 billion?

Mr. FLYNN. I think a little over $1 billion. Probably in the neighborhood of $1.4 or $1.5 billion.

Mr. MICA. I was just trying to get some figures.

Mr. FLYNN. A little over $1 billion. Maybe a little less.

Mr. MICA. I was trying to get an idea of the impact this would have on the Federal Government. I think Federal employees and retirees are going to be shocked. It also has some impact on our Federal budget.

We have heard that some of the testimony—Mr. Antos said the cumulative effect of some mandated benefits are part of the problem. Is that what you testified to, Mr. Antos?

Mr. ANTOS. I would characterize it that the cumulative effect of possible future mandates could become significant.

Mr. MICA. What, in your opinion, is driving these costs specifically? What is the biggest factor? I noticed the Call Letters for contracts in 1995–96 had no mandated benefits required. Is that correct, Mr. Flynn; 1995–96, the Call Letter for 1997, we have a substantial number of mandated benefits.

Mr. FLYNN. Well, Mr. Chairman——

Mr. MICA. Maternity changes, inpatient care changes, preventive mammography screenings, preexisting conditions, some removal of limits. But in the previous years we have not had any.

Mr. FLYNN. There were no specific requests in 1995 and 1996, but there were requests in prior years, 1994, 1993, and 1992.

Mr. MICA. Right.

Mr. FLYNN. Your question had to do with what was the cost impact of the requests that we made in 1997.

We have estimated that at about one-third of 1 percent in the 1998 rates, about an average of $15 per participant for the year.

Mr. MICA. But that is a small fraction of the increase in costs.

Mr. FLYNN. In total increase.

If I could return to that just for a moment, Mr. Chairman, and try to put this a little bit in context, because you had mentioned surprise at the average increase in the enrollee's share of 15.4 percent.

What I would like to do is point out two matters that I think bear on that. The first is, as you mentioned in your statement, that an average always masks things at either extreme, because it is an average.

Next year, in terms of the share that individuals pay, 17 percent of the total nonpostal employee and annuitant population will see for the plan that they are in today, their share of premium either staying the same or not increasing more than 5 percent.

Mr. MICA. Seventeen percent?

Mr. FLYNN. Seventeen percent, almost 1 in 5. Another 60 percent will see their share increase between 5 and 20 percent. Then another quarter will see their share increase about 25 percent.

Now, first, as I mentioned in my statement, one of the hallmarks of the Federal Employees Health Benefits Program is choice. Because people have an annual open enrollment period, they can choose good value at a premium price that will be affordable for them.

The second point that I would make, Mr. Chairman, is that this is the last year in which the phantom formula will be used to calculate the distribution of the total premium between individual enrollees, Federal employees, annuitants, and the Government. That formula itself drives part of that difference in terms of the split, 15.4 percent on average for enrollees and 5.7 percent on average for the government. In fact, the table that we have provided shows you what the fair share formula would have produced using those same numbers and also the fixed-dollar formula that you had asked us about.

Mr. MICA. You are saying that there will be an opportunity for folks to shop in January?

Mr. FLYNN. Actually from late November until early December for effect in January.

Mr. MICA. Do we have any requirement for these carriers to notify employees and retirees of an increase in premium?

Mr. FLYNN. Absolutely, Mr. Chairman.

Mr. MICA. I know they get a rate sheet or whatever it is, but do they get a specific notice that their premium is going up?

Mr. FLYNN. Yes, Mr. Chairman, they do. There are two primary documents that are used to convey information to Federal employees and retirees during the open enrollment period. The first of those is a document that we publish which is the Federal Employees Health Benefits Guide that provides broad summary information for all of the plans that participate in the program. It shows what the premium will be for the coming year and has a summary of the benefits. It also includes other information about the results of our annual Customer Satisfaction Survey and other things that are important for employees and retirees making this choice.

In addition, each employee gets information from the plan in which they are enrolled which describes not only the premium changes, but also the benefit changes and the basic package of information that plans provide.

Those are the two primary documents. There are a wide variety of other sources of information that employees have available to them and which they use extensively. One that I might just mention, because it is under development and will be new for us this year, is a greatly expanded OPM Internet web site that provides this type of information in an enhanced way.

So, yes, there is a great deal of information that people who have the opportunity to change will get in order to help them make that change in an informed way.

Mr. MICA. Mr. Gammarino, you are probably the largest carrier at about 30 percent of the market.

Mr. GAMMARINO. We have a little bit over 40 percent of the market.

Mr. MICA. Forty percent. OK.

How could we bring premiums down, in your estimation? One of the things that has been mentioned is the inflexibility of some of the criteria that is set by OPM. Is that something we should look at? I don't want to put words in your mouth, but tell me what we could do to help you with bringing premiums down. You are the biggest carrier.

Mr. GAMMARINO. I think the biggest benefit we could derive of any action would be to have a, and assure a, free private market. The innovation that the carriers in the FEHBP can and sometimes do employ has to be encouraged, and in order to do that, we cannot, nor should we, have a program that is overly mandated and that is overly restrictive on what we can do in the marketplace.

The innovation and technology that you see today in medical care affords us a great opportunity. It does mean, however, we need to look at and pilot innovative ways. The agency from that perspective has actually helped us in many cases take a look at innovative approaches in that arena.

In the area of mandated benefits, although an individual benefit in and of itself may not be that costly, the cumulative effect, I think, does cost the program and enrollees money. At the same time it puts restrictions on the program for the long term.

Mr. MICA. Finally, you mentioned three things that drive up costs, affect or impact costs. You said benefit changes; the actual record of use, utilization of services, and changes in demographics.

We talked a little bit about benefit changes. What is happening in use and demographics to impact these costs? Are those major factors?

Mr. GAMMARINO. I think it should be clearly understood that the demographics of the Federal employee program overall is an aging one. The average age of the Federal enrollee is significantly higher than the average American. The average age of an enrollee for inprogram is 59½, and that presents a significant challenge. We see the aging of the Federal enrollee population as a significant issue, one in which we are developing ways in which to manage. That is the only way you are going to be successful in this marketplace.

Mr. MICA. I said that was my final question.

Mr. Flynn, are you auditing, reviewing, looking at these different plans and their costs and are you satisfied with what is going on and what you see?

Mr. FLYNN. Well, Mr. Chairman, we do that in two ways. First of all, the audit function in terms of looking at carriers' activities is performed by OPM's Inspector General, and I think the Inspector General works in concert with us, both in terms of the audit work they do and helping us give information on rate and premium negotiations.

At the same time, when we get into negotiations with individual carriers, those individual negotiations look at the results of carrier financial activities on a plan-by-plan basis because they are part and parcel of the rate-setting process.

So the quick answer to your question is yes, we do during rate-setting particularly, and also as part of the Inspector General audit process.

Mr. MICA. Thank you. I will get back to additional questions. I want to yield to Ms. Norton.

Ms. NORTON. Thank you very much, Mr. Chairman.

First let me say that there is some indication to be found in the fair share formula, if one looks at the employee's share increase, it does seem to me that mitigating that share when so many of those affected are retirees in addition to employees was an important aspect of the formula, if you look at the 10 percent as compared with the phantom share of 15.4 percent.

I am puzzled. I guess it was in Mr. Antos' testimony, it was full of discussion of managed care and the transition to managed care may be implicated in this increase. I have to say, wait a minute. More managed care should translate into reduced costs for everybody and reduced prices.

You also said there was more competition. I agree with both of those. We hear about it every day. We have cutthroat competition on managed care. Everybody is being pushed into managed care. And why? We are told, with some reason, that this is the cost of reducing costs—if I may use that word—the human cost of reducing health care costs.

I happen to be perhaps one of the few Members of Congress who will stand up for managed care, because I don't believe in the notion that you can have it all, and I think Americans have been used to having it all, which really means that those who have health care insurance have it all, and increasingly they can't have

it all because they can't afford 15 percent increases, or at least they scream at it.

Again, this was the whole point of trying to get universal health care, so that you don't move costs around the board and fool yourself into thinking that costs overall have gone down. But you need to explain to me why all this increase in managed care and all this increased competition does not steadfastly reduce costs every year, or has not at least in this plan? Mr. Antos, you may start, and any of you that have any ideas, I would be glad to hear them.

Mr. ANTOS. Thank you, Delegate Norton. Looking at the history of premium increases for the past 5 or 6 years in both FEHBP and the private sector, the rate of increase in both kinds of programs has declined substantially. We believe that is because of increased competition and increased participation of beneficiaries in managed care plans.

Ms. NORTON. Compare some year, let's say in the late 1980's or 1990's.

Mr. ANTOS. In the late 1980's, private-sector health plans' premiums were increasing between 15 and 20 percent a year, for example.

Ms. NORTON. Now we have 15 percent for FEHBP, at least for the employees.

Mr. ANTOS. That is right. But I think the comparable figure for FEHBP this year is 8.5 percent. I would put that in perspective. Mr. Flynn mentioned in his testimony that FEHBP has used its reserves to hold down premium increases for the last 2 or 3 years. What that means, as I interpret it, is that FEHBP premiums have not kept up with the actual costs of providing health benefits to Federal employees.

Ms. NORTON. See, that is my point. They have been herded into managed care programs, so why hasn't it kept up with the costs? The notion that with the kind of health care inflation we have, that we are not keeping up with the costs of that inflation, despite managed care, is puzzling to me.

Mr. ANTOS. But, Delegate, I think the FEHBP's performance is really quite incredible. In 1995, there was about a 4-percent decline in average premiums. In 1996, there was some smaller——

Ms. NORTON. You just said they used their reserves to do that, and not competition and not managed care. That is what my question goes to. Why can't the market and the managed care and the competition do it themselves so that you don't have to dip into reserves, if that is the whole point of getting people into managed care?

Mr. FLYNN. I might try and offer a little bit more on that. In 1995, it was a combination, Ms. Norton, of both reserves and managed care. I think the point that I would make on managed care in broad terms is that, quite honestly, the Federal Employees Health Benefits Program has been a leader in the introduction of managed care and in its expansion throughout the entire program.

Just as an example, the provider networks of physicians and hospitals that exist in the program provide savings to the program year in and year out, probably in the neighborhood of a little over $1 billion each year. That is just one component of managed care. You have others—drug utilization, and you could go on and on.

I think the point, though, that is important with managed care is that once the components are in place and they have been extended as broadly as one can make them in the program, it is essentially a one-shot deal. It doesn't provide added savings incrementally 1 year to the next.

If I could just real quickly make an analogy. If you go from real butter to margarine, you are going to perhaps achieve a cost savings, but then, to the degree that margarine increases in price at the same rate as inflation, it will continue to do that, even though in absolute terms you have a cost savings.

You may recall in my opening statement I mentioned the fact that average private sector premiums in 1996 were about $3,900 per person; in the Federal Employees Health Benefits Program, about $3,700. That is about a 5-percent differential, and we think that differential is in part due to the broad use of managed care techniques in the program. But, as I said, once you have achieved the savings, and once it has been extended throughout the program, it is a one-time deal, unless you find other ways, other techniques, for managing care that are not in the market today.

Ms. NORTON. I want to just take exception to that without having an extended conversation. I understand the notion when you go from fee for service, for example, to managed care where you get a fixed price perhaps, that there would be a one-time savings, but the way in which managed care is sold, it is that it is not simply the head count and what happens there, but it is sold in the same way that a business will sell you the notion that with efficiencies that are inherent in the way they do business—the way they do business, not just that you now do business with them, the way they do business—gets you savings. They will tell you, for example, that—the drugstores will tell you that they handle large customers and that that reduces the costs of various kinds—as you negotiate over time, of various kinds of pharmaceuticals.

I am sure if you talk to a managed care provider, that provider will tell you that after he got your folks, there were all kinds of efficiencies that result from the way in which they managed care.

So I have a conceptual disagreement with you, if you are telling me that all we can get out of managed care is a one-time cost reduction, because that is not what managed care sells. If that is what it is, I am getting off the train right now. I thought I was getting more efficient care.

I will tell you, if you ask employees, they will tell you that after you get the fixed-price care, you get, for example, fewer x rays, fewer kinds of special treatment that were otherwise available, and that those things do not simply occur, those savings, when you agree to a fixed price; that the management of care, once you have this group of patients, is what you are selling. We will give you the same quality of service, but you will see a difference in how we manage the care you are delivered.

Mr. FLYNN. Just very quickly, I think that actually we are more in agreement than we are in disagreement. There is no question——

Ms. NORTON. The margarine-butter was your analogy.

Mr. FLYNN. I understand. I am sure I am going to have to live with that. But to the degree that competition involves the introduc-

tion of different forms of managed care techniques, the point that you are raising is exactly right. My only point is that it is a process that has to evolve in order to continue to produce savings.

Ms. NORTON. Yes, so it seems to me that FEHBP and OPM and OMB has to keep pushing these folks to say we expect continued savings, and we expect them with no reduction in quality, because that is what you promised, even if some of the things you did you no longer do, because some of the things you no longer do—because they were not necessary. Managed care in and of itself is not no longer doing things they ought to be doing, but they are rooting out the excesses in the way in which we deliver health care.

I want to say, Mr. Flynn and Mr. Antos, that to the extent that—first of all, I want to congratulate you and thank you—that in order to keep these premiums from going up too rapidly, we have been going into reserves, but I want to tell you, that is nothing but price control. Again, because you are doing something, you are artificially keeping the premiums down. Don't misunderstand me. I thank you for doing that. I think this would have been—particularly before we got the new approach, this would have been intolerable for employees.

But that is not what we have been promised. We have been promised that with managed care, we will have increases that are far lower than the 15 percent employees will get. In fact, could I ask you how the reserves are accumulated? I want to make sure that the reserves don't get depleted as you try to do, it seems to me, the right thing.

Mr. FLYNN. I can assure you, Ms. Norton, we have no intention of depleting reserves. These reserve levels have built up over the past several years to the point that they were about 2½ times the target.

Ms. NORTON. Are they a required amount you have to put into reserves?

Mr. FLYNN. We set a target level of about 2 months' worth of claims across the program. We do account for it plan by plan, but I am talking in the aggregate right now.

We had reserve levels going back 3 or 4 years ago about 2½ times that target level, and we have been gradually over the past several years—in the aggregate in the program, so there will be differences from one plan to the next—bringing those down to that target level.

We have reduced the rate at which we are bringing them to target level for 1998, but we have no intention of going below target levels, and we need to keep those reserves healthy, to mitigate the very things that we are talking about here and to provide for contingencies that no one could foresee.

Ms. NORTON. One more question, Mr. Chairman, if I can, on mandates. First of all, I think we ought to be clear where mandates really have come from at the FEHBP program, because they have come from the Congress. Mental health and maternity came straight from us. Preexisting conditions came straight from us.

Now, I would say that even the bone marrow transplants came straight from us, because although you did it, you had a lot of pressure from Members like me, and I must say I think many Members, when it became clear that these bone marrow transplants

were very effective in the treatment of breast cancer, although the Congress didn't pass a law, it was clear that many Members on both sides of the aisle and Members, well beyond women Members of Congress, were very concerned that there was a treatment that was available if you weren't in FEHBP, but was not in FEHBP, and it was very costly, and its track record seemed very promising.

So I don't see that you are too generous saying, let's do a bunch of mandates. I have already said for the record that I disagree with mandates as an approach to health care reform, although I have myself supported them, supported them in the absence of any other alternative, because if you don't give me health care reform, then this piecemeal approach is what you get as anecdotal abuses are uncovered. Frankly, only the most privileged get served that way, and we enforce the worst aspects of health care in the United States. Nevertheless, it would have been very hard to have said drive-by mastectomies or 24-hour childbirth, or, for that matter, autologous bone marrow transplants should not be done.

Could I ask you, though, to estimate for me your view of how this contributes to costs and whether or not you think they are counterproductive in a cost? We know they are not counterproductive for the individuals involved, but from a cost point of view, are they so serious an additional cost that any cost-benefit analysis would say they shouldn't be done?

Mr. FLYNN. Let me try and do that. We went back and we looked, not at the source of mandates, but at things we have required carriers to provide for in our call letters annually going back to 1992.

Our actuarial estimate of the cost of all of those, bone marrow transplant included among the list is about $300 million. That amounts to just about 1.8 percent of our total program costs, and I tell you, that is a high-side estimate.

Let me take bone marrow transplant as an example of that. We priced out today's cost of that at about $120 million a year. That is a gross cost; it doesn't take into account costs which have occurred for treatment that otherwise would have been provided had bone marrow transplant not been used. So I think it is a high-side estimate.

A 1.8-percent increase for this program amounts to an out-of-pocket cost for an individual of about $20 per year, out of that $3,700 average 1996 premium that I mentioned.

As I said, I think this is a relatively minor issue. I think it is an area where we are exercising our responsibilities as an employer-sponsor, and promoting the interests of Federal employees and retirees who participate in this program. As I said, I think, given the size of this program, we are looking at a very minor impact and one that has very beneficial effects.

Ms. NORTON. I understand that one of you testified that there were other Federal mandates under consideration. What are they?

Mr. ANTOS. I was the person who said that. In the spring we may see Federal mandates—actually the mandates would echo FEHBP's decision for the coming year—to require hospital stays for mastectomies. There is also, we understand, some interest in revisiting mental health parity and going back to perhaps the fuller form of that provision, which was not passed the first time.

Ms. NORTON. Thank you very much, Mr. Chairman.

Mr. MICA. Thank you. I recognize Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman.

I want to probe two areas; one that you just mentioned, the area of mental health services.

As I understand it, OPM had sought to extend mental health services as part of a benefit that would be available. I am wondering if you could tell us where that stands?

Mr. FLYNN. I would be happy to try to do that, Mr. Pappas. I mentioned two points. First of all, we were successful in our work with plans for 1998 to have all plans be in compliance with the provisions of the Mental Health Parity Act of 1996.

What we further attempted to do was to recognize the evolution in the thinking about mental health, mental health care, and its impact on health in general, and ask carriers to consider ways in which they might expand the mental health services offered to Federal employees and retirees who participate in this program. We expected to use the same techniques that have been so successful in the more traditional areas of health plan coverage we are all familiar with, the development of networks of preferred providers and facilities, utilization review and things like that—so that we could take the existing range of covered mental health benefits and perhaps broaden its availability and its accessibility to Federal employees who participate in this program.

I think we saw in the various proposals what I would characterize as some success in this area. We think that there is room for additional improvement, and this is an area that we want to pay attention to as we consider the program for 1999.

Mr. PAPPAS. What do you envision this costing, both in terms of cost to the Federal Government as well as participants?

Mr. FLYNN. It is hard to say at this point, unless we have a specific proposal in front of us, what its cost impact would be. However, when we ask plans to consider what program design innovations they might be able to put in front of us for 1998, we asked them to do so in ways that would be cost neutral.

We are very sensitive to premium increases in this program. We have seen, as I mentioned to Ms. Norton, extraordinary savings resulting from managed care, networks, other utilization kinds of reviews and techniques, and we ask carriers to design benefit improvements in such a way that the impact on the program from a cost standpoint would be neutral.

As I say, we have had limited success, but in the absence of a specific proposal, and recognizing that we really do encourage great variety in program design, because a hallmark feature of this program is innovation, a lot of things can be proposed. Many of them will work, some better than others, and I think over time evolving design strategies and delivery mechanisms tend to bring out the best.

We will continue to look for ways in which we can do this in a cost-neutral way, and we will just have to see what we are able to do as we go forward.

Mr. PAPPAS. As you say, in a cost-neutral fashion have expanded mental health coverage or services been made available to greater numbers of people; are they taking advantage of that opportunity?

Mr. FLYNN. Because the changes that we are looking at will not really actually go into effect until 1998, we will not really know until the end of next year what the effect of that will have been. We do expect that with the elimination of a limits and maximums will give people a bit more peace of mind about the mental health design that their particular insurer offers, and we have seen, as I said, some limited success in terms of introducing networks of mental health care providers.

I am hopeful that in those areas as well we will see some improved access, and, in fact, better mental health care as a result. But we will not really know until after 1998 is over.

Mr. PAPPAS. The other area I want to question a bit is something I know you spoke about earlier, and maybe to just place greater emphasis on it, even though you may feel you have responded. But the decision about the increase and why the increase may have been so great, 8.5 percent or 15.5 percent, 15.4 percent, for the enrollee's share, whatever the amount is, it follows, as the chairman said in his opening statement, I guess, 5 years of relatively stable premiums. I guess two of those there was an average decline?

Mr. FLYNN. That is correct.

Mr. PAPPAS. What prompted, in your estimation, the change; who made the decision; what did they base that decision on; and when was that decision made?

Mr. FLYNN. Let's see. The best way for me to answer that is that these are actually 350 individual sets of decisions, because they are decisions that are made plan by plan in our negotiations.

What we are reporting on is the aggregate, cumulative effect of those decisions, and they vary, as we have heard in testimony this morning, plan by plan.

Again, just to provide a summary of that, about one in five participants will see either no premium increase, or a decrease, or a premium increase of less than 5 percent. About 60 percent will see premium increases between 5 and 20 percent, and about a quarter over 20 percent.

That is a reflection of the actual experience of each plan, the medical costs that they have incurred in the prior year, the trend rate that we expect medical costs to reflect in the coming year, and the balancing of that with the value of the benefit package and the reserve level.

So all of those factors go into consideration. It is a bilateral negotiation between the plan CEO, or his or her designated representative, and our representatives that ultimately results in an agreement plan by plan.

So, as I say, it is not as if we came into this with the idea that we would have 9 percent or 7 percent. It is a reflection of the aggregation of market forces among 350 plans. And the fact that about 20 percent of rate changes are actual declines or very modest increases, and 60 percent are moderate increases, and another 25 percent even larger increases, I think, is a reflection of the sort of economic activity that is going on in the health care market.

There is not a single decisionmaker saying, here is what we will do. It is a reflection of 350 sets of negotiations.

Mr. PAPPAS. So not one individual made the decision that came to the announcement on September 26th that these increases

would occur? You are telling me no one made the decision to announce that, not one person made the decision?

Mr. FLYNN. Well, perhaps I am not understanding your question exactly. The average premium is the aggregation of all those decisions. I take that to the Director of the agency and say, here is what we have. We think this is an appropriate reflection of the way in which the program expects to operate next year, and, to the degree it needs to, is a reflection of the costs we experienced last year, and we should go forward with this.

Mr. PAPPAS. I understand what you are saying. Maybe you are not in a position to respond, but that is something I would like a very specific response to, which is a very specific question, which is who made the decision, when was it made, and then when was the decision made to announce that change of the premium increase? If you can't answer now, that is fine, I don't mean to force you to respond today, but I am very interested to know after 5 years relatively stable premium increases, 2 of those years being a decline, on the average, there must have been a report that someone was given.

You have indicated there are 350-some decisions based upon the relationships with the various carriers. I understand all that. But at some point some report must have been forwarded to some individual, and they based their decision on a particular day, based upon a particular piece of information or series of pieces of information. I would like to know when that took place, who made the decision, and why that particular time.

I am just curious, if I could elaborate as to my motivation for these questions, I am curious as to why now, when we have seen the stability over the last 5 years.

Mr. FLYNN. If I may, let me try and respond to that quickly.

The first point that I guess I want to make is that, as I said in my opening statement, while we have seen stability in this program over the past several years, we nonetheless have continued to see, and I think as Mr. Antos indicated, health cost increases in the range, in his estimation 5 to 6 percent, in ours 6 to 7 percent, annually. That underlying rate of medical inflation has always been there.

The introduction and the expansion of managed care have helped keep premiums low. The competition in the program has helped keep premiums low. As I also mentioned, our use of reserves in a judicious way from 1 year to the next has done that. Several of those factors were not there as we negotiated benefits for 1998, and, as a result, you see the manifestation of the 8.5-percent premium increase.

Let me come back, and we will provide a more full answer to your question when we provide it for the record, but you have suggested that there is a report prepared and someone acts on it, and that is really not the case. These are individual negotiations that result in an aggregate. After decisions have been made plan by plan, we multiply each rate by the plan's present enrollment to produce the aggregate premium cost, divide by the aggregate enrollment for an average premium cost, and compare it to the present average cost. That comes to me, and I will tell you that I briefed the Acting Director of the agency 24 hours before the re-

lease was made, but the release, for all simple matter purposes, had already been prepared, and it was a question of announcing it, not a question of deciding to announce it.

Mr. PAPPAS. I guess part of the reason for me to ask the question was to get an answer, but also to help me understand the process by which you folks come to issue statements such as that. The Federal Government and its agencies are very large and complex, and some decisions are complex. Some decisions, though, I think are simple decisions based upon complex information. So I appreciate your attempt to respond, and, if you could kind of chew on my question and provide something in writing, I would appreciate it.

Mr. FLYNN. Sure.

[The information referred to follows:]

Determination of Average Annual Premium Increase For The Federal Employees Health Benefits Program

Premium rates under the Federal Employees Health Benefits (FEHB) Program are a product of bilateral contract negotiations between the Office of Personnel Management (OPM) and each participating health plan carrier. Each year during March, OPM initiates the process with an annual call letter to participating plans which invites proposals for benefit and rate changes for the contract year commencing the following January 1.

The call letter outlines broad FEHB Program goals as well as procedures for the upcoming negotiations. For example, since 1991, OPM has advised plans that proposals for carrier-initiated benefit improvements will be considered only to the degree they are cost neutral in fee-for-service plans or they reflect changes in a health maintenance organization's (HMO) community package. Further, the letter specifies actuarial data plans must submit to support premium rate proposals. The call letter also reminds the plans that FEHB regulations impose a May 31 deadline for submitting any proposed changes, and that OPM operates to ensure completion of all negotiations by late August.

OPM does not establish a Program-wide premium adjustment target in advance of negotiations. As each contract proposal comes into OPM, it is reviewed by an FEHB contract specialist and the Office of Actuaries who determine whether each plan proposal meets benefit guidelines in the call letter and is offered at the lowest possible cost.

An important factor in rate negotiations is the position of the plan's FEHB reserves. Applicable law provides for accumulation of a contingency reserve account for each FEHB plan which is available, subject to minimum balance requirements and other conditions in OPM regulations, to defray future premium increases or to reduce contributions of enrollees and the Government for the plan from which the reserves are derived. The cost for each FEHB enrollment includes a three percent payment to the plan's contingency reserve in the Employees Health Benefits Fund in the U. S. Treasury. In addition, OPM regulations require experience-rated plans to deposit any income related to FEHB enrollments which exceeds expenses for negotiated benefits, administrative expenses, and retentions in a "special" reserve.

Rates concluded with fee-for-service plans and the few experience-rated HMOs are a reflection of: the plan's gains or losses from actual FEHB claims experience for the prior year; the trend OPM expects in the plan's claims and administrative expenses and in medical cost inflation in the coming year; a service charge (or

profit) based on performance factors set out in OPM regulations; and the balance in the plan's contingency reserve.

When contracting with HMOs, OPM's starts with the basic community package purchased by the majority of a plan's other subscribers, thus ensuring that FEHB enrollees have access to mainstream benefits (not the richest or least costly package). In addition, OPM requires all participating HMOs to offer FEHB enrollees the minimum benefits required for certification as a Federally-qualified HMO (to provide comprehensive basic benefits for all FEHB enrollees) and to include any standard FEHB benefits.

Most HMOs use community rating which essentially charges all subscribers the same rates, with limited variations not related to a group's actual benefit utilization. OPM looks at how the plan develops rates in the community and requires use of the same methodology for FEHB enrollees. We require HMOs with significant FEHB enrollment to document rates for its two subscriber groups most similar in size to the FEHB group, to ensure that the FEHB premium rate reflects any rating advantage the plan gives to the similarly sized subscriber groups (e.g., premium reduction based on group's average age or average family size). Once OPM approves a base rate for community benefits, we negotiate charges for additional benefits to meet FEHB Program requirements (e.g. prescription drug benefits, if not offered as part of the basic community benefit package).

It has been OPM's practice, at the conclusion of FEHB contract negotiations for the upcoming calendar year, to determine the program-wide weighted average premium charge based on the newly-approved premium rates and to compare this average to a similar calculation using the existing premium rates, as an illustration of the Program's overall premium cost trend. For purposes of calculating the annual weighted average premium rates, we multiply the respective premium rates in effect for each year by the corresponding number of non-Postal employees and any annuitants enrolled, as of the most recent March 31, in the plan option to which each rate applies and divide the aggregate annual premium income from all plans by total enrollees reflected in the computation. For 1998, the weighted average biweekly premium amounts to $153.02, reflecting an 8.5 percent increase over $141.01 for 1997.

Mr. PAPPAS. That is all I have, Mr. Chairman, thank you.

Mr. MICA. Mr. Ford.

Mr. FORD. I will be very brief. Thank you, Mr. Chairman.

I have a question for Mr. Gammarino to follow on what Mr. Pappas said. With regard to some of the annual premium increases in FEHBP on page 2 of your testimony, I see from 1994 to 1997, it is very similar to Mr. Pappas' question. We see relative stability in terms of the increases, and we even witness a decrease. Below that you said, "Generally speaking, premium changes are driven by benefit changes, changes in the cost of health care, changes in utilization patterns, and changes in the demographics of a particular group."

Perhaps you can just elaborate. I know that Mr. Flynn has talked almost exhaustively about this, but if you could just give me a sense of what changed so dramatically in that sort of class of characteristics that forced this type of an increase or brought us to this point where we are seeing a 7.5-percent increase, sir?

Mr. GAMMARINO. Yes, we have the answer to that. The biggest factor for our program is the prescription drug cost. We are seeing trends in that area of around 15 percent as opposed to other areas of health care which are in the single digits. So that is a major driver for us, and why is that the case may be the next question.

There are a number of factors related to that. One is our specific population, which is an aging one. I mentioned our average age is close to 60 years old. That is a population that uses prescription drugs extensively to manage their health care.

Second, from the manufacturer's side of things, there are a number of innovative products on the market that have the end result of increasing costs. These are very expensive drugs for our program. They are in many cases necessary to not only manage, but to save lives. So costs for those new drugs are driving up the cost.

Utilization for those drugs by our members is also higher than they have been in the past. We are looking for ways to control this. One area that we will be working with the agency on next year is to look at more cost sharing with enrollees, because they do play a factor in the decisionmaking of their medical care, so we will be looking in that arena. But for our specific program, it is primarily the increase in prescription drugs.

Mr. FORD. I notice in the chairman's remarks, and I apologize, Mr. Chairman, again, for being tardy, the chairman asks the question of what are your current economic factors forcing the premiums to rise, and, more importantly, are there actions Congress can take consistent with free-market principles to utilize these?

You have perhaps answered, but what can we do to help mitigate some of those increases?

Mr. GAMMARINO. I think allowing the carriers, health plans such as us, freedom to try innovative approaches that may not be standard approaches today, that would include ways in which we involve both our subscribers and the providers in the management of care, and the benefit design itself.

What cannot occur or what should not occur, in my estimation, is that one or more carriers would be expected to provide a level of care that other health plans do not. For example, in this open season a number of those competing carriers that we will compete

with have had an opportunity to modify their drug benefit programs, for example, that will result in our program being very attractive; that will, in my estimation, result in some adverse selection against our program. Those people that are not as healthy as the average may look at our program as a safety valve for them, because their program has been allowed to change or reduce benefits for them.

Mr. FORD. One last question, Mr. Chairman.

I can appreciate your answer and clearly recognize the advanced technology innovations certainly cost money, but it took you from 1994 to 1997, you really didn't have increases at all, or very stable increases. From 1997 to 1998, you just realized these prescription drugs and the increases there would cause such a dramatic increase? Just out of curiosity, what lightning bolt struck you or Blue Cross and Blue Shield to force you to realize perhaps the costs ought to rise that dramatically?

Mr. GAMMARINO. Quite a few lightning bolts, I think, hit us. The cost of prescription drugs has risen dramatically in the health insurance industry over the last 12 months. The rise was not as high in the mid-1990's. It is significantly higher today. We have to rate against that experience. So it is the effect really of our experience going back to probably late 1996 and what we are experiencing this year relative to our drug Program.

Mr. FORD. So it has been in the past 12 months that you have experienced this dramatic increase?

Mr. GAMMARINO. In this particular area, yes.

Mr. FORD. That would cause from 1997 to be a zero percent to a 7.5 percent for 1998?

Mr. GAMMARINO. That is correct. It is primarily driven by our drug costs.

Mr. FORD. In the last 12 months. I just want to be clear.

Mr. GAMMARINO. Yes.

Mr. FORD. Thank you, Mr. Chairman.

Mr. MICA. Thank you.

Let me continue on a couple of issues, Mr. Gammarino. Both CBO and you have cautioned against the extensive use of mandates. You indicate there have been a number of benefits mandated by OPM over the past few years. Our committee staff, I asked them to look at it, and they found some 27 mandates imposed by OPM call letters since 1990.

Could you estimate for the subcommittee how much those mandates may have added to your premiums?

Mr. GAMMARINO. Yes, Mr. Chairman. We have evaluated mandates through the 1990's, and we estimate the cumulative effect for our program to be about $100 million, or about 1.5 percent of our benefit costs.

Mr. MICA. Do you think Congress should act to prevent these mandates, or what action would you recommend? Is there anything we could do to keep us out of the mandate business? We are probably responsible for some of those mandates.

Mr. GAMMARINO. Mr. Chairman, if you could, we would very much appreciate the lack of mandates, the reduction or elimination of mandates.

Any individual mandate looks good, particularly to the segment of population or the constituency that wants it, and sometimes it is hard to argue against a specific mandate. But the reality is that not only has it a cumulative effect which can be significant, but, more importantly, I think, I think it reduces the innovation that is necessary to move us forward into managing health care costs.

I would hate to think of what our health care delivery program may look like today if the norms in technology had mandated certain health care delivery patterns based upon what we knew in the 1950's and 1960's.

Mr. MICA. I try to look at the impact of what OPM has now announced as an average of an 8.5-percent increase. Blue Cross is the largest carrier and has 40 percent of the market. I would imagine the standard family plan has to be your big number of participants. I am probably in that.

Mr. GAMMARINO. Thank you.

Mr. MICA. I have to get a little bit parochial with this now. I asked staff to look at the increase, which is $6.55 biweekly. That is a 12-percent—oh, God, I thought it was 10 percent—a 12-percent increase I am looking at. So basically Blue Cross folks, like myself, standard family plan, are looking at a 12-percent increase.

Mr. GAMMARINO. That is correct.

Mr. MICA. A little bit higher than the average 8.5 percent, and that is going to affect a lot of folks it looks like.

You said prescription drug costs have been a double-digit increase factor. A couple years ago Blue Cross and Blue Shield adopted a plan to encourage the use of mail order pharmaceuticals. At the time, as I recall, it was quite controversial.

Would you please give the subcommittee an update on whether that plan has helped to control drug costs, and how has it been accepted by your policyholders?

Mr. GAMMARINO. Yes, Mr. Chairman, I would be happy to.

You might remember that there was an independent body that took a look at that change. GAO in 1996 evaluated the change that we made and took a look at our rationale behind that, and they fully gave us, I think, an unqualified approval in terms of our rationale, which was quite simply that we were able to negotiate better deals with the mail service program versus the retail side of the shop.

That report was issued in February of this year. So we think that, yes, there was good reason to do that, and we continue to think so.

Second, in terms of what our subscribers think about that, we do have ongoing satisfaction surveys produced by an independent organization, Gallup, that we use to measure the satisfaction of our enrollees across the board in a number of areas, and one of those is our drug program. The satisfaction of our enrollees is extremely high in our drug program, and that would include our mail order component. We rate on a 5-point scale, and Gallup has indicated to us that our average rating is about 4.5. They have indicated anything above a 4 in this type of industry equates to significant subscriber satisfaction.

Mr. MICA. Well, I am glad folks are satisfied. I am a little bit concerned about the cost. When you look at your budget, or my per-

sonal budget, and you see a cost that stands out, you look at some ways to bring that down.

Are there approaches you have considered, or is there something that Congress is doing or OPM is requiring, or something that we can do to help you bring prescription drug costs under check, under control?

Mr. GAMMARINO. One thing that we are—we would like, we attempted to do this past year, is to initiate a higher level of cost-sharing program for drugs. We do feel that the individual patient is a significant decisionmaker in their health care and the management of their health care. Our program is very rich, much richer than you would find in other private health care organizations, so we are working with the agency, particularly for 1999, to take a look at cost sharing for enrollees.

In addition, we are looking at a number of new management techniques to try to control costs. We certainly, as you are quite aware, are using traditional areas of price discounts, both from the manufacturers and from our retail and mail order vendors. We are also employing drug intervention activities to, where appropriate, have the least costly drug used, and that intervention involves the subscriber's physician.

Last, we are piloting a number of innovative areas in what we call disease management. There we are talking about interfacing with both the physicians and the patients to better manage their particular chronic condition that does involve prescription drugs, and we think there are good opportunities there that would result in not only reduced costs, but really in increased quality for the subscriber themselves.

Mr. MICA. What about flexibility? Do you have enough flexibility and options, or is OPM setting standards that do not allow you the flexibility to bring down costs or choices?

Mr. GAMMARINO. The agency has been very willing to work with us on a lot of managed care initiatives, so we really applaud that. The one area that we are continuing to work with them on and would like greater flexibility on is the benefit design itself. We cannot, and we feel we should not, be sort of the carrier of last resort. It would result in adverse selection that would be in the long run disadvantageous to us.

Mr. MICA. Thank you. The bad news is I am not through with my questioning. The good news is Mr. Ford has one more question.

Mr. FORD. Just one last question for Mr. Flynn based on what Mr. Gammarino said; really a two-part question. One, he mentioned in the last 12 months he has seen or experienced dramatic increases. Have you found that to be the case across the board? And, two, he also mentioned, Mr. Gammarino mentioned, in response even to Chairman Mica's question with regard to what we do here at the Federal level, at Congress, to help control or curb some of these increases, and with a prescription drug, Mr. Gammarino, you mentioned looking at how we may alter the copay and the cost-sharing aspect.

What are your thoughts on that, Mr. Flynn, the former and the latter, the 12-month experience as well as the copay for prescription drugs?

Mr. FLYNN. Thank you, Mr. Ford. Both those questions are very good ones. First of all, I think we see in the area of prescription drugs essentially the same thing across our other 349 participating plans that the Blue Cross and Blue Shield Federal Employee Program sees. Drug therapy, maintenance drugs, things like that, are playing an increasingly important part in the overall health of America, and we have seen increases not only in utilization, but also in terms of cost, and it is probably the single component of the health care market that is increasing at the most rapid pace.

I would like to comment just for a moment on this idea of copayment if I might. I will talk about it just in general terms.

If, in an effort to control costs, you introduce a copayment on a prescription drug, and that is all that occurs, you really have not imposed any cost control whatsoever; there has simply been a shift of who pays for that drug. That is all that really occurs.

If the issue is to control costs through controlling utilization, then one first has to look at whether or not there is overutilization. We are aware, as is Blue Cross and Blue Shield, that the average age of enrollees in the Federal Employee Program run by Blue Cross and Blue Shield is 58 or 59 years old, somewhere in that area, and one would expect that people in that age category would use prescription drugs at a rate higher than they might at younger ages. The issue here is are they overutilizing those drugs, and is that overutilization contributing to unnecessary increases in costs for the program?

I don't know the answer to that. But I will tell you, before I will be in a position as an employer-sponsor to authorize or to agree to a copayment of some amount, I will want to know what the underlying rationale is, before any negotiation.

In a negotiation, we are very much price-sensitive. But simply shifting costs out of the premium to come out of the pocket of an individual enrollee is not per se the way to deal with this.

Mr. Gammarino has mentioned several other mechanisms that might be more effective. We would want to explore those with him and with others as well. But this issue of a copayment, quite honestly, in the absence of some evidence of overutilization, strikes me as a sort of broad brush that may not produce the desired result and may, because it increases the out-of-pocket costs of some people who are least able to afford it, hold the potential to harm enrollees' health.

Mr. FORD. Thank you, Mr. Chairman. I would just ask unanimous consent to be able to insert my opening statement into the record.

Mr. MICA. Without objection, so ordered.

[The prepared statement of Hon. Harold E. Ford, Jr., follows:]

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Opening Remarks of Congressman Harold Ford, Jr.
Subcommittee Hearing on Increase in FEHBP Employee Rates
October 8, 1997

Thank you Mr. Chairman.

Rather than give lengthy opening remarks, I will simply say that I am concerned by OPM's recent decision to increase by 8.5% employee contributions to the FEHBP. And, therefore, I am particularly interested in hearing the testimony of today's panelists in hopes that it will shed some light on why such a sudden increase is necessary. After all, when we held hearing earlier this session on the FEHBP and ways to improve the current system, I do not recall any testimony that would have lead this Subcommittee to believe that such a significant premium increase was just around the corner.

Thank you Mr. Chairman.

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Mr. MICA. I will get back to Mr. Gammarino, if I may, with Blue Cross and Blue Shield.

You indicated that you are concerned that Blue Cross and Blue Shield may be affected by adverse selection during the upcoming open season, and I guess when people see that 12-percent increase, there are going to be folks jumping ship, looking for lower costs.

Is this adverse selection a major problem you see for yourself or for the whole program, and if you have folks jumping ship, how do you think that is going to affect your costs in the future?

Mr. GAMMARINO. Mr. Chairman, I don't think we are going to have people leaving our ship. I think we are going to have more than our fair share coming on board. A lot of our competitors, particularly the fee-for-service competitors, are the ones that have very significant increases. People that want a program that is big on freedom of choice with their providers are going to be still attracted to this program. Therefore we think we are going to have a significant increase in enrollees.

Adverse selection has always been a factor in the FEHBP. It happens simply because each year you have a choice, and people can be attracted to specific health plans during that enrollment period.

Generally Blue Cross and Blue Shield finds, at least from our perspective, that we have this problem for two reasons: One, generally speaking, when people, as they get more mature and have health-related conditions, they may be attracted initially to a managed care product, but when they get older, they want some freedom of choice, and therefore they are very attracted to the security of Blue Cross and Blue Shield. That is one reason why our average age is probably higher than the average plan.

Therefore, we just simply every year have that issue to deal with, and therefore we are conscious continually to attract, in addition to these people, a younger segment of the enrolled population.

More specifically, this open season we do have a concern because, quite frankly, when we took a look at some of our competitors' rate increases, we also took a look at their benefit changes. As I indicated before, particularly on the drug side, we did see that some carriers were allowed to make changes that would, in comparison, make our drug benefit seem very attractive. So we are concerned with managing this particular program.

In terms of what we would like to see, I think maybe there are two things. One is to ensure that there is a level playing field out there for all carriers in the FEHBP, that one carrier is not required to do things that others are allowed to do.

Second, since adverse selection is here probably to stay, there has been every once in a while a desire to take a look at risk adjusters, and that is some type of adjustment associated with the actual level of risk of the enrollees in any particular group.

Mr. MICA. So you believe you are going to see more folks jump ship to get into your plan?

Mr. GAMMARINO. Yes, we do.

Mr. MICA. Again, my question was what do you think this will do to your costs?

Mr. GAMMARINO. We have, Mr. Chairman, rated. When we heard there was going to be some significant rate increases, we did adjust

for that in our rate, so we have adjusted to the best we can, not knowing at the time exactly what the competition would look like, nor the decisionmaker, the enrollee, what they are actually going to do, but we have in our rate proposal to OPM, which they accepted, we did adjust for the fact that we think we are going to get some adverse selection this particular year. So the rate that you see, the increase reflects that.

Mr. MICA. A guesstimate of what your potential new enrollees and costs will be?

Mr. GAMMARINO. Yes.

Mr. MICA. And then I guess when you see actual performance, you will make an adjustment the following year; is that correct?

Mr. GAMMARINO. That is correct.

Mr. MICA. You say that Blue Cross and Blue Shield is expanding its use of point-of-service networks to control costs. Recently some have advocated statutory regulation of discounted rate networks. Both Chairman Burton and I are examining this particular issue. The staff from the full committee and the subcommittee have met with the health care providers, network operators, carriers and OPM recently to discuss this subject. Health care providers are particularly concerned about the use of silent PPOs, arrangements, as you know, under which a carrier silently gains access to a discount rate agreement that a doctor or hospital has made with other organizations in exchange for specific incentives.

I would appreciate the benefit of your thoughts on some of these questions, Mr. Gammarino.

Mr. GAMMARINO. I would be happy to.

Mr. MICA. Do you think Congress should attempt to regulate the use of discounted rate networks in FEHBP?

Mr. GAMMARINO. I would be happy to respond, Mr. Chairman. First of all, I would like to give you our perspective on silent PPOs. We do not endorse them. We do not use them. Rather, we have a network of physicians and providers and other health care providers that we contract directly for, and both we, the individual subscriber and the provider know exactly what the conditions of that arrangement are.

We do not support silent PPOs. We would be very concerned if there were any mandates that would require their use, because we fully do not support the use of silent PPOs. I think it is up to Congress to decide at what level they may want to regulate it, but in no case do we feel that we should be mandated or required to use them.

Mr. MICA. You think Congress should ban PPOs in the FEHBP?

Mr. GAMMARINO. I certainly wouldn't lose any sleep over it.

Mr. MICA. OPM has vigorously encouraged the use of discounted rate agreements, and the Federal Government itself has established medical rates under Medicare. Is there a danger that such governmental policies are inadvertently creating unnecessary pressure on carriers to use silent PPOs?

Mr. GAMMARINO. I think this issue gets really to the place of the Government in regulating health care. I think it is not good in the long run to think that government has a magic cure for how to control costs. I think the private sector is much more innovative and

can move much faster in the environment in which they have to work.

So generally the response to your question is similar to what I said earlier. I think the value in that area is little or no value, particularly as the health care industry moves at the rapid rate that it is doing today.

Mr. MICA. Thank you, Mr. Gammarino.

Mr. Flynn, I hate to get into one of these "I told you so's," but if you look back at your chart that I referred to earlier, page 7, you may recall that a year or so ago I had advocated using a fixed-dollar formula, and according to this little chart, in fact, if that had been instituted, the government share would be a 7.2 percent increase, and the enrollee's share would be 11.6, versus 15.4, on average. Is that correct?

Mr. FLYNN. That is correct, Mr. Chairman.

Mr. MICA. Now, with the fair share formula which we have recently instituted, we will see the Government share increase to 7.9 percent. That is after 1998, right; 1999 that kicks in?

Mr. FLYNN. It will go into effect in 1999. What you see in the table, Mr. Chairman, is what it would have been.

Mr. MICA. Right. And we would have had a 10 percent versus a 15.4 percent if that were in place now?

Mr. FLYNN. That is correct.

Mr. MICA. OK. I am not going to say I told you so.

Mr. FLYNN. Can I comment on it, Mr. Chairman?

Mr. MICA. No.

Does OPM believe that competition in the FEHBP could be enhanced by allowing additional plans to enter?

Mr. FLYNN. Well, Mr. Chairman, one of the hallmark features of the Federal Employees Health Benefits Program is the competition that occurs among plans. I mentioned earlier today that we will have 350 plans participating in the Program in 1998, and if you are a Federal employee or retiree living in a metropolitan area, generally speaking you have about a dozen plans from which to choose.

We have had higher numbers of plans in the Program in the past, though it predates my arrival. My understanding is that we were up around 420 or 430.

Mr. MICA. Have you had additional requests to enter new plans for this year?

Mr. FLYNN. We have a number of new plans this year. We have a number of plans that have dropped out, and a number of plans that have consolidated. That is a typical aspect of the Program, moving from 1 year to the next.

So I think my answer is, I think competition does benefit the Program. We have worked the Program with larger numbers of carriers, and we can work it with a larger number of carriers in the future.

Mr. MICA. Is there any legislation that is necessary to allow for new entrants or new competition? Is what we have on the books adequate?

Mr. FLYNN. Actually you raise a very good point, Mr. Chairman. It has been almost 38 years since the original act establishing this program came into being, and there have been few amendments to it over the years. But it probably would be time to sit down and

perhaps work with you and members of your staff on this particular question and to recognize the evolution that has occurred in the health care marketplace over time to see if perhaps there is a way to broaden the criteria for additional plans to enter.

Mr. MICA. In the same review, are there areas in which we might look at legislation to allow more flexibility in terms, or do you have adequate authority to provide flexibility to the plan carriers?

Mr. FLYNN. Well, I think this is another area where we might want to sit down and talk. The carriers that participate in the program, the Federal employees and the retirees, and this committee and others in the Congress are all very important stakeholders in how this Program is designed and operated. I think we have a large amount of flexibility now. I think that flexibility is a large part of the success of the Program. But to the degree there is interest in other areas of flexibility, we certainly want to do anything we can and work with anybody we can to improve this Program and its success.

Mr. MICA. One of the areas that has not been mentioned today is the area of fraud, waste and abuse. It is a topic that dominates almost all the reports we get from the OPM Inspector General, that there are efforts to combat waste, fraud and abuse in our program.

Is this a significant problem? Are we addressing this? Do we have proper oversight of these plans? I know that in the private sector Columbia has undergone a tremendous amount of scrutiny, and some of the other plans, HMOs and health care providers are under increased oversight and scrutiny, and, in some cases, prosecution.

Are we doing a good job monitoring this?

Mr. FLYNN. Mr. Chairman, this is an area that I think both we who run the Program and OPM's Inspector General who oversees, among other things, the financial operations of the program, would both have comments.

I think the answer is yes, largely we do a good job. As you know, the Inspector General has suggested, and we have provided support for some improvements in the debarment provisions that apply in this Program. That is something we support.

The health maintenance organizations that participate in the Program, we and the Inspector General have over the past several years collaborated in onsite reviews during the rate negotiation process, which I think has given us better rates and has given the Inspector General, from their onsite presence, a better insight into the plan's operation so when they go in and do their normal cycle of audits, they have just that much more information.

I might also mention, as you know, we have been meeting on Monday and Tuesday of this week with all of the carriers who participate in the Program. One of the featured speakers at that session was a gentleman from Harvard's Kennedy School of Government who has spent a great deal of time looking at fraud in health care and developing ways of combatting that. We wanted the participants in our program to have the benefit of his views.

So I think we do a good job. There is also room to do a better job.

Mr. MICA. I guess you are familiar with Chairman Burton's bill, it is H.R. 1836, Federal Employees Health Care Protection Act of

1997. It has some elements in it that would possibly assist your agency in this area. I guess you are supportive of that measure?

Mr. FLYNN. Yes. That is what I was commenting on in terms of the debarment provisions that the Inspector General is interested in.

Mr. MICA. At topic today has been that benefits drive up costs and premiums, particularly mandated benefits. Ultimately, in FEHBP it is the taxpayer, employees, and annuitants who bear the burden.

OPM has the authority to disregard certain State mandates. Why has it chosen not to do so?

Mr. FLYNN. Mr. Chairman, we do have the authority to preempt State mandates. We have generally used that authority in our relationship with plans that offer benefits on a nationwide basis. Blue Cross and Blue Shield, I think, is perhaps one of the best examples of that.

We offer in either a high or standard option a uniform set of benefits nationwide to all Federal employees, irrespective of where they live. We think that is important, because the alternative could be to have benefit packages that vary from one State to the other and conceivably even premiums that would vary from one State to the other, even though an individual was enrolled in Blue Cross and Blue Shield.

Now, this issue about State-mandated benefits has also come up in a somewhat localized context from health maintenance organizations. In particular, in Maryland there are a number of benefits that the State mandates that some of the health maintenance organizations in Maryland felt, put them perhaps in an unwarranted way, in a weakened position vis-a-vis other organizations who are domiciled in Virginia or DC.

That issue relates to our basic policy that health maintenance organizations which provide benefits in a limited geographic area should abide by State mandates wherever that particular corporation is domiciled. In this particular case—pardon me?

Mr. MICA. Go ahead.

Mr. FLYNN. In this particular case, there is a difference between mandated benefits in DC and Virginia and in Maryland. We don't think, however, that it puts a Maryland-domiciled plan operating in the DC metro area at a competitive disadvantage with other plans who are domiciled in other jurisdictions by virtue of those mandates. In fact, we think, quite honestly, that those mandates have virtually no effect on premiums whatsoever.

Mr. MICA. Well, I have been contacted by Mr. Wynn, my distinguished colleague from Maryland. I also received a copy of the Washington Post article, "Wynn Says Higher Standards Hurting State-Based HMO. Mandates Raise Costs for Federal Employees."

Without objection, I will make that part of the record.

Mr. Wynn has suggested that the Maryland-based HMOs be allowed to offer a package competitive with out-of-state plans and a package that incorporates Maryland's mandates.

Will OPM adopt that solution for the next contract year or consider it?

Mr. FLYNN. We certainly considered it, Mr. Chairman, but we have declined to do so, I think, for two very good reasons. First of

all, the underlying suggestion is that the Maryland plans are non-competitive with DC and Virginia plans which have been, in fact, characterized as bare bones or skeleton plans.

All of the plans that participate in the Federal Employees Health Benefits Program offer a comprehensive range of benefits. They differ on the margin. As we mentioned earlier, choice is an important component of this Program, but they do not differ substantially. So there are not, in effect, stripped-down health plans being offered to Federal employees in Maryland by DC and Virginia organizations.

Second, this is a policy that we have applied over a number of years affecting all metropolitan areas around the country, and we think it is one that makes sense.

In the context of this particular year's negotiations, I might just mention that all of the Maryland plans, all of the Maryland HMOs, accepted the Maryland State-mandated benefits with no increase in premium. So in that context, it doesn't seem wise to offer two options of a plan which are essentially equal in premium.

Chairman MICA. Thank you. We will pass that on to Mr. Wynn. I am sure you will be hearing from him.

Mr. Antos, your written statement identifies the following three factors as contributing to premium increases: Reduced profit margins, new State and Federal mandates, and overall change in the environment for managed care plans.

Congress does not directly affect profit margins, nor does it control the changing environment for managed care. However, it can exert some control over the growth of Federal mandates, which you estimate will increase FEHBP expenditures by about $20 million in 1998.

Would you recommend that Congress refrain from mandating benefits in FEHBP and carefully examine any mandates proposed by OPM?

Mr. ANTOS. I think we would recommend that Congress think very carefully before enacting any mandate. We are not really in a position to have a judgment about the benefits of mandates, but we are in a position to estimate the costs, and there is no question there are costs.

Mr. MICA. Are there any particular types of mandates that pose the greatest danger to premium stability that you have seen?

Mr. ANTOS. Perhaps regulations or legislation that would fundamentally alter the way health care plans operate—in other words, more far-reaching than the sorts of things that Congress has considered in the last 2 years—would be something to be most concerned about.

Mr. MICA. I have a question about implications of a lag between costs and premiums. You suggest that changes in premiums lag behind cost changes by about 2 years. Does the time lag have policy implications for management in the FEHBP?

Mr. ANTOS. I am not sure that I have an answer for that regarding FEHBP's management. This is really an observation that health analysts have made over the years, trying to understand the ebbs and flows of premium increases and costs.

It appears that at least the Blue Cross plan relatively quickly understands the cost pressures facing it. And according to Mr.

Gammarino's testimony, Blue Cross is in a position to negotiate on perhaps a more up-to-date basis than in general.

Mr. MICA. Well, in the forecast area of FEHBP premiums, CBO has estimated that private health care expenditures will increase on average between 5 and 6 percent a year between 1998 and 2007. Since FEHBP premiums have generally increased less than private-sector premiums, would it be reasonable to predict that our Federal Employees Health Benefits Program prices will increase by less than 5 to 6 percent over that same period of time?

Mr. ANTOS. In our current baseline, we estimate that the Federal costs of operating FEHBP will increase pretty much at 6 percent a year. However, I think it is premature to judge what the performance is likely to be for FEHBP compared to the private sector. In fact, it is premature to judge what the private sector will do, for that matter.

Mr. MICA. What do you see, Mr. Gammarino, as far as future costs based on past mandates, market conditions, and mandates that may be on the horizon? What is your prediction for the future?

Mr. GAMMARINO. In the short run, meaning over the next couple of years, we are forecasting also in the range you just heard, 6 to 7 percent trends, and our challenge is to beat those trends, to compete in the marketplace. We have on the books and will continue to do research in a number of areas to try to beat those trends so we can remain competitive and have an affordable product for our enrollees.

Mr. MICA. I heard Mr. Flynn say that we may need to go back and look at some of the 30-plus-year-old legislation that is on the books. We may also need to look at some of the inflexibility of the programs and congressional mandates.

What I would like to do is ask the staff to prepare a survey of these carriers and ask them for their recommendations. Maybe we could work with OPM to see what we could do, perhaps legislative changes or administrative actions. There may be some things we can do without legislation to bring some of these costs under control. I have had extensive conversations with the ranking member—who has a district commitment that he could not break this morning, but wanted us to proceed with this—and both he and I want to see if there is anything we can do legislatively, administratively, or working in partnership with the carriers and others to bring these costs down.

Let's see if we can't get that out, look at what is happening here, what we can do legislatively if we need a legislative fix, and then some way to bring the cost down for our Federal employees and retirees and their families.

I appreciate you all coming out. I love early morning sessions. I would start these at 7 a.m. if I could. I do have additional questions, believe it or not, and will submit them to you in writing and would appreciate your response. I would also welcome any organizations or interested individuals who wanted to comment for the record, we will leave the record open for 2 weeks for those submissions.

There being no further business to come before the Civil Service Subcommittee this morning, I would like to again thank our witnesses and call this meeting adjourned.

[Whereupon, at 10:40 a.m., the subcommittee was adjourned.]