

FEDERAL EMPLOYEE HEALTH BENEFITS: OPM PROGRAM GUIDANCE FOR 1999

HEARING
BEFORE THE
SUBCOMMITTEE ON THE CIVIL SERVICE
OF THE
COMMITTEE ON
GOVERNMENT REFORM
AND OVERSIGHT
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTH CONGRESS
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FEDERAL EMPLOYEE HEALTH BENEFITS: OPM PROGRAM GUIDANCE FOR 1999

TUESDAY, MARCH 17, 1998

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

The subcommittee met, pursuant to notice, at 1:05 p.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Pappas, Morella, Cummings, and Norton.

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

Mr. MICA. Good afternoon. I'd like to call this meeting of the House Civil Service Subcommittee to order.

The subject of today's hearing is Federal employee health benefits and OPM program guidance for 1999. This, I will begin with my opening statement and then yield to the ranking member for his comments, and to other Members as they arrive.

I called this hearing today so that the subcommittee will have an opportunity to examine the policy objectives of the Office of Personnel Management which they intend to implement in contract year 1999.

These policies are of vital concern to this subcommittee. Approximately 9 million individuals, active and retired Federal employees and their families, rely on the Federal Employees Health Benefit Program for high quality and, hopefully, affordable health insurance. OPM's policies directly affect the quality and cost of their health insurance.

Members of this subcommittee and many others were taken by surprise last fall when OPM announced an average 8.5 percent jump in FEHB premiums for 1998. Employees' shares of the premiums rose even faster, increasing on average 15.4 percent. We conducted a hearing of our subcommittee on October 8, 1997, to examine the causes of these increases. Testimony at that hearing revealed that those rate hikes were primarily caused by increases in general health care cost.

However, there were other factors. Witnesses at the hearing also warned us against overregulation of the FEHB market and excessive mandates which brought on additional costs. Both of these actions tend to drive up the costs of health insurance.

The FEHBP is a true success story often cited as a model employer-sponsored health benefits program. This success is primarily due to its market orientation. The program relies on the market forces of competition and consumer choice to ensure both competitive premiums and quality coverage.

This subcommittee is vitally interested in preserving the FEHBP's distinctive character which offers our employees and annuitants a broad range of options with regard to health care insurance.

In recent years, however, OPM has used its call letter to mandate that all carriers provide specific benefits. OPM even used that call letter to promote the hiring of former welfare recipients, an objective that is not really relevant to providing reasonably priced health care benefits to active and retired Federal employees.

[The information referred to follows:]

FEHBP Letter
All Prepaid CarriersU.S. Office of Personnel Management
Office of Insurance Programs

FEHBP Letter No. 97-9
Prepaid(S) Fee for Service()**Date: March 31, 1997****Subject: Annual Call Letter for the 1998 Contract Year**

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1998, will be considered through May 31, 1997.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 15, 1997.

Guidance on Benefits

Public Law 104-204, the Veterans Affairs - Housing and Urban Development Appropriations Act for Fiscal Year 1997, imposes a number of changes on all health insurance carriers. The guidance below on new benefit coverages includes the effect of this legislation on the FEHB Program.

A. Fee-for-Service Plans

We are committed to providing Federal employees, retirees and their families with high quality, comprehensive and affordable health care. Carriers are encouraged to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. We also expect carriers to put in place procedures to capture discounts from bills presented, where it is cost effective to do so. Likewise, we expect carriers to continue to encourage competition among subcontractors to reduce administrative costs.

As in past years, we will not accept proposals for second options. A proposal for a Point of Service product, discussed under "Common Coverage Issues," will be considered within an existing option only and may not be rated separately.

B. Prepaid Plans

We will accept carrier-initiated benefit changes only to the degree that they reflect changes in the carrier's community package that we purchase. All prepaid plans must meet our minimum benefit requirements provided in the enclosures.

Proposals for service area expansions and/or new rating areas for 1998 must be summarized in your cover letter. We will not consider any new rating areas or service area expansions not proposed in your May 31 submission. Proposals for additional rating areas must also be presented in your rate submission.

C. Common Coverage Issues

- Mental Health and Substance Abuse Benefits.** Title VII of Public Law 104-204, the "Mental Health Parity Act of 1996," provides that health plans, including FEHB plans, may not impose annual or lifetime dollar limits on mental health benefits that are less generous than similar limits for other benefits. This change in the law signals an interest in adequate health care coverage for mental illness as a matter of public policy. We encourage all carriers to find ways to take significant steps toward improving access to appropriate health care for those suffering from mental illness.

In 1996, we required the elimination of lifetime dollar limits on mental health benefits. Beginning with the 1998 contract year, all plans must eliminate any annual dollar limits on benefits for the treatment of mental illness. In addition, while not required by law, we would like to see movement away from contractual day and visit limitations and high deductibles to improve access to appropriately managed care.

Although plans will be required to remove dollar limits, and we would hope day and visit limitations and high deductibles as well, we do not expect that plans will provide unlimited mental health benefits. Indeed, we expect that through judicious utilization management, plans can provide a higher level of care at no increase in cost. Accordingly, we will expect these benefit adjustments to be cost neutral across all plan benefits, at no additional premium cost to the Program. Consideration should be given to accomplishing this goal through the development of preferred provider organizations of behavioral health care providers and innovative benefits design. The Mental Health Parity Act of 1996 does not apply to benefits for the treatment of alcoholism or substance abuse.

- Maternity Length of Stay.** Beginning with the 1998 contract year, and in accordance with Title VI of Public Law 104-204, the "Newborns' and Mothers' Health Protection Act of 1996", the mother must have the option of remaining in the hospital for at least 48 hours after a regular delivery and 96 hours after a caesarean delivery. In addition, FEHB plans are expected to provide benefits for maternity admissions for as long beyond the 48 or 96 hours as the inpatient stay is medically necessary.

- **Mastectomy admission and length of stay.** Similarly, we want to prevent women who must undergo mastectomies from being required by their health plans to have this surgery on an outpatient basis or to leave the hospital prematurely. Beginning with the 1998 contract year, all FEHB plans must provide a mastectomy patient with the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
- **Mammography Screening.** Consistent with the President's announcement, the FEHBP will follow the recommendations of the National Cancer Advisory Board on mammography screening. Upon release of the specific recommendations, we will communicate them to you by separate letter.
- **Pre-existing conditions.** Most plans in the FEHB Program do not have any pre-existing condition limits in their benefit structures. A few plans have specific limitations that apply only to cosmetic surgery or dental benefits. Public Law 104-191, "the Health Insurance Portability and Accountability Act of 1996," amends the Public Health Service Act to limit waiting periods for coverage of pre-existing conditions. Therefore, beginning with the 1998 contract year, if your plan contains any pre-existing condition limitations, please submit a benefits proposal that eliminates them.

To the extent the FEHBP experience-rated carrier's actuarial projections demonstrate an increase in cost that would justify additional premium, we will entertain rate proposals related to any of the following: maternity length of stay, mastectomy admission and length of stay, and pre-existing conditions, as described above. To the extent that these benefits are not included in the Prepaid Plan's community package, we will entertain proposals for actuarially demonstrated loadings.

- **Point of Service Product.** Plans may again consider proposing a Point of Service (POS) product as an alternative choice within an existing option. We believe this is an effective way to encourage people to try managed care with the understanding that they can still exercise the choice to go outside the network for specific services if they decide to do so. Therefore, we will entertain proposals from both fee-for-service plans and prepaid plans for a POS product.

Fee-for-service plans may offer a POS product, and it may be offered on a pilot basis within a limited geographic area. Plans that offered a POS product on a pilot basis beginning in 1997 may propose an expansion of that product into additional geographic areas. Although plans may propose a POS product that requires a positive enrollee election, a rate differential will not be permitted for those electing the POS product.

Plans' POS offerings should specify network arrangements, including gatekeeper provisions, and benefit differentials for in- and out-of-network services. In-network POS benefits may be more comprehensive than the standard benefit package, except

for dental and vision care. Favorable consideration will be based on factors such as demonstrated experience with POS products by the sponsoring organization or network manager; presentation of an administrative/operational plan that addresses issues such as enrollee and provider education, the interrelationship between the POS product and the ongoing fee-for-service product; and presentation of a plan for evaluating pilot projects and expanding the POS product if it is successful. POS savings must accrue to the FEHB Program.

We will consider proposals from prepaid plans to offer a POS product only if the plan can demonstrate experience with a private sector employer who has purchased the product. As in past years, we will not accept proposals for second options. A POS product will be considered within an existing option only and may not be rated separately.

Prior Coverage Certificates

Beginning with the 1998 contract year, you will be required to provide certificates to individuals detailing prior coverage as required by the Health Insurance Portability and Accountability Act of 1996. As soon as the Department of Health and Human Services regulations are issued we will give you more information about this requirement.

Electronic Communication

In the past year, we have moved away from using the mail to communicate with plans to the extent feasible. We transmitted many All Carrier Letters by facsimile only and provided access to the FEHB Guide and plan brochures on the Internet. We wish to continue in this direction. Therefore, this year you will need to have internet capability prior to the beginning of the preparation of your brochure for this year's Open Season. This capability must include E-mail addresses for key personnel with whom we communicate regularly.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.
- ✓ Benefit changes and clarifications must be submitted in a specific format. **This format is mandatory.** Specific instructions for submitting your proposed changes and clarifications are included in the enclosures.

- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the enclosure. You must include language for a "How Benefits Change in 1998" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English and explain how the change will affect the customer from the customer's point of view.

Additional benefit proposal instructions appear in the enclosure.

Please note that we have temporarily relocated. Send your proposals to:

(Overnight delivery)
 U.S. Office of Personnel Management
 Office of Insurance Programs
 1900 E Street, NW., Room 4416
 Washington, DC 20415

(Regular mail)
 U.S. Office of Personnel Management
 Office of Insurance Programs
 P.O. Box 707
 Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

You will continue to have the responsibility for producing the actual brochures from agreed-upon text provided to you on disk after the conclusion of benefits negotiations. Details of the process to be used in creating that disk are under consideration. We will give you more information about the process very soon.

Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting

We remain committed to the Government's policy of encouraging small, small-disadvantaged, and women-owned small business subcontracting in the performance of Federal agency contracts. Therefore, it is important for both OPM and FEHB Program carriers to continue to look for additional ways to expand relevant subcontracting opportunities.

Last year, we implemented a pilot project with the seven FEHB Program carriers that represent the greatest portion of total Program enrollment. The outcome of the project will determine the best way to integrate the small, small disadvantaged, and women-owned small business programs into the FEHB Program. For all other carriers, we want to emphasize

your responsibility to look for ways to expand small, small disadvantaged, and women-owned small business subcontracting opportunities in accordance with FAR clause 52.219-8, "Utilization of Small, Small-Disadvantaged and Women-Owned Small Business Concerns."

Employing Welfare Recipients

Last summer, the President signed welfare reform legislation that imposed time limits, required work, and extended child and health care to enable people to move from welfare to work. At the same time, he called upon business to employ former welfare recipients in appropriate roles. This month, the President issued a complementary directive to Federal agencies to take steps to employ former welfare recipients. In order to further this objective, we expect that FEHB carriers will look for, and use, appropriate opportunities to support this initiative. Though no specific reporting mechanism is contemplated, FEHB carriers can reasonably be expected to outline steps they have taken and results achieved in this area.

Disclosure Policy Under The Freedom of Information Act

Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we intend to release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1998 Contracts

We will send 1998 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1998 contracts are expected to be signed before the 1998 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myer
Assistant Director
for Insurance Programs

Enclosures

Enclosure for Prepaid Plans

This enclosure provides prepaid plans with additional guidance on benefit changes and instructions on the submission of benefit and service area proposals for the upcoming contract term (January 1 through December 31, 1998). You are expected to propose benefit changes in accordance with the "Guidance on Benefits" found in the call letter. It is important that all prepaid plans review this entire enclosure; certain information is required of all plans.

There are four main parts to this enclosure:

- Part One - Guidance on Benefit Changes
- Part Two - Preparing Your Benefit Proposal
- Part Three - Changes in Service Area
- Part Four - Open Season Materials and Reimbursement of Printing Costs

Complete and return the enclosed Certificate of Program Integrity - Modification with your May 31 submission.

If you have any questions about your benefits submission, please call your contract representative.

Any additional forms and materials needed to prepare your brochure and other open season documents will be sent to you by mid-April. These will include:

1. Revisions to mandated (i.e., non-negotiable) language and required changes for the 1998 brochure.
2. Printing specifications for the 1998 brochure and for the 1998 Rate Sheet.

Graphics and OPM authorization block for the cover of your 1998 brochure will be sent to you in June. Your brochure quantities form, shipping labels, and related open season instructions will be sent to you in August.

Rate instructions will be sent under separate cover. It should be remembered at all times that FEHB rate submissions are the cornerstone of our financial relationship with prepaid plans. The FEHB rates and their supporting documentation are subject to audit to ensure their accuracy and reasonableness. Misrepresentation of your FEHB Program rates can result in criminal or civil legal actions against the Plan or its officials. We, with the support of the Inspector General's Office and the Justice Department, intend to aggressively pursue health plans that attempt to cheat the FEHB Program.

Part One - Guidance on Benefit Changes

In keeping with the spirit of the call letter, carrier-initiated benefit improvements will be accepted when they are part of the community package. However, we do prefer that benefits remain stable. With this in mind, we offer the following guidance for the 1998 contract term:

- A. **Mental Health and Substance Abuse** - As indicated in the call letter, beginning in 1998, all plans must eliminate any annual dollar limits they have on benefits for the treatment of mental illness. This does not apply to benefits for inpatient treatment of alcoholism and drug abuse. Lifetime benefit maximums for treatment of mental conditions have not been permitted. In addition, we encourage plans to move away from contractual day and visit limitations and high deductibles for treatment of mental conditions. All mental health benefit adjustments, however, must be cost neutral across all plan benefits. Plans are encouraged to accomplish this through their managed care networks of behavioral health care providers and innovative benefits design.
- B. **Maternity and Mastectomy Length of Stay and Mastectomy Admissions** - All plans must provide for maternity admission lengths of stay of at least 48 hours after a regular delivery and 96 hours after a caesarean delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
- C. **Mammography Screening**. Consistent with the President's announcement, the FEHBP will follow the recommendations of the National Cancer Advisory Board on mammography screening. Upon release of the specific recommendations, we will communicate them to you by separate letter.
- D. **Pre-existing Conditions** - Beginning in 1998, plans will not be permitted to have pre-existing conditions limitations on any benefit, including cosmetic surgery and dental benefits.
- E. **Point of Service Product** - We will consider proposals from prepaid plans to offer a Point of Service product (providing reimbursement for plan members who elect to receive non-emergency care from non-plan providers at reduced indemnity rates) under the FEHB Program only if the Plan can demonstrate experience with a private sector employer who has purchased this benefit.
- F. **Waiver of Office Visit Copayments for Prenatal and Postnatal Care** - A number of plans currently waive these copayments as a means of helping assure that pregnant members obtain adequate pre- and post-natal care, and thereby increase the likelihood that their babies will be born without complications. We encourage other prepaid plans to do the same.

- G. **Coverage for Fertility Drugs** - All prepaid plans are required to cover treatment of infertility, but many do not cover related prescription drugs. To better inform FEHB members, if they have not already done so, plans should clarify their brochure language to indicate whether fertility drugs are covered or not covered, in both their infertility benefit description and their prescription drug benefit description.
- H. **Immunizations for Children** - All FEHB plans must provide coverage (including the cost of inoculations or sera) for childhood immunizations.
- I. **Transplants** - We require that all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney transplants be covered. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. Coverage for these three conditions may be limited to services received in clinical trials, provided both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but the Plan must provide necessary follow-up care to the experimental procedure. All prepaid plans must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors, the Plan will coordinate benefits according to NAIC guidelines, as with any other benefit.
- To the extent permitted by applicable State law, other transplants not mandated by OPM may be excluded from the FEHB benefits if they are not in the community benefit package which we purchase.
- J. **Dental and Vision Benefits** - We will consider new dental or vision care benefits only from community-rated plans and only when they are an integral part of the community benefits package we purchase.
- K. **Prescription Drugs** - All plans must provide at least a minimum level of coverage for all medically necessary drugs that require a prescription for their use, and insulin. Drug benefit deductibles may not exceed \$600 and member coinsurance may not exceed 50%. Lifetime or annual benefit maximums on prescription drugs are not permitted.

Coverage must be provided for disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. In addition, benefits must be provided for "off-label" use of covered medication if prescribed for such use by a Plan doctor.

A drug formulary may be used as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. The formulary cannot be

used as a means to exclude benefits for the types of drugs mandated for the FEHB. Blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables" are not acceptable.

- L. **DHHS-Mandated Benefits** - All prepaid plans must offer certain benefits that are mandated for qualified plans by the Department of Health and Human Services (DHHS), without limitation as to time and cost, other than as prescribed in the Public Health Service Act and DHHS regulations. These required benefits include:
- ✓ Nonexperimental bone marrow, cornea, kidney, and liver transplants (see H. above for other FEHB requirements in this area);
 - ✓ Short-term rehabilitative therapy (physical, speech, and occupational) the provision of which can be expected to result in significant improvement in the patient's condition within two months;
 - ✓ Family planning services, including all necessary nonexperimental infertility services, to include artificial insemination with either the husband's or donor sperm. The cost of donor sperm need not be covered. Other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) may be excluded to the extent permitted by applicable State law.
 - ✓ Home health services;
 - ✓ Inhospital administration of blood and blood products (including "blood processing");
 - ✓ Surgical treatment of morbid obesity, when medically necessary;
 - ✓ Implants - the procedure must be covered, although the cost of the device may be excluded;

Federally-qualified community-rated plans offer these benefits at no additional cost, i.e., within the community rate. Plans that are not Federally-qualified should reflect the cost of any non-community benefits on Attachment 2 of their rate calculation (if there is no additional cost, the cost entry should be zero).

- M. **Service Area and Additional Geographic Areas** - Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an additional geographic area that surrounds, or is adjacent to, your service area you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the State where you have legal authority to operate permits you to enroll members who work but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy on the cover of your brochure.

Since benefits may be restricted for nonemergency care received outside the service area where plan providers are generally located, your proposal must include language to clearly describe this additional geographic area as well as your service area. These descriptions will appear on the brochure cover unless they are lengthy or include zip codes. In that case, a general description and page reference will appear on the brochure cover and the lengthy details inside.

Mr. MICA. The President recently directed OPM to implement certain provisions of the so-called Patient's Bill of Rights within our Federal Employees Health Benefit Program. The subcommittee would like to determine what specific steps OPM will take to implement each of these provisions in the next contract year, and assess the impact of those actions on the cost and the quality of our Federal employees' and retirees' health insurance.

The subcommittee also will examine whether OPM is moving to standardization of the benefits available through the program. Observers have noted that in recent years, OPM has limited the variation and benefit packages. There is evidence that differences in the actuarial value of benefit packages offered by FEHBP carriers have narrowed considerably. I'll ask each of our panelists whether such standardization is desirable.

By examining OPM's policies before the 1999 call letter is issued, the subcommittee has an opportunity to focus attention on the impact of those policies on health care providers and carriers who participate in the program and, most importantly, the individuals who rely on our Federal Employees Health Benefit Program.

Those are my opening comments. I would like to yield now to our distinguished ranking member, the gentlemen from the great State of Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

The Federal Employees Health Benefits Program is a proven health benefit which has served Federal employees and their families since 1960. Just 5 years ago, during congressional consideration of health care reform legislation, FEHBP was roundly hailed as a model for the Nation because of the wide array of health plans and benefit options it offered. Customer satisfaction surveys conducted annually by the Office of Personnel Management consistently indicated high levels of satisfaction with this program. Last year's survey results revealed that, on average, more than 85 percent of the enrollees in fee-for-service plans and health maintenance organizations were satisfied with their plan and the service it provided.

The positive perception of FEHBP took a beating last fall when OPM announced that there would be a significant increase in the 1998 premiums. This news came as a shock, given the program's modest growth in premiums in recent years. Since 1989, it only increased at an annual rate of 3.7 percent. In response, this subcommittee held an oversight hearing to determine the cause of what OPM projected to be an average 8.5 rate hike. What we found out was that the increase was really going to be as high as 15 percent.

The prospect for some kind of increase in premiums was signaled this time last year when OPM sent out its 1998 call letter to participating health plans. In that letter, OPM mandated new coverage requirements for mastectomies, mammograms, maternity, and mental health services.

While I applaud the expansion of these very important benefits, it must be understood that expansion does not come without a cost. According to OPM, these charges contributed to no more than 2 percent of the increase and that the major cause was pent-up inflation. Nonetheless, if more benefit changes are being contemplated

for next year, it is important that this subcommittee receive an early warning of their possible impact. We also need to know if there are any other factors that are likely to spark premium increases.

Today's hearing has been convened so that the subcommittee can continue its close oversight over this essential benefit program. Specifically, we will seek to determine the nature of the guidance to be provided participating health insurance plans by OPM through its call letter for the 1999 contract year. In addition, the subcommittee will seek to determine the impact on FEHBP of President Clinton's recently issued executive memorandum mandating compliance with the Health Care Consumer Bill of Rights.

Whether either of these will likely lead to significant changes in FEHBP's administration or costs is what I will seek to find out from each of our witnesses. This subcommittee's responsibility is to ensure that FEHBP premiums are fairly established, affordable, and purchase the best quality of the medical services. It is also our responsibility to ensure that our enrollees are provided with the scope of benefits and levels of coverage that meet their individual or family needs.

Finally, it is our responsibility to ensure that FEHBP is administered in an equitable and efficient manner and that all of its enrollees are afforded basic consumer protections. My colleagues and I take these responsibilities very seriously. Hearings such as this one are essential to our efforts to meet those goals.

I look forward to the testimony of each of our witnesses and I hope that this hearing will shed some light on what we can expect in the future from FEHBP.

Thank you, Mr. Chairman.

Mr. MICA. Thank you, Mr. Cummings. And I now recognize Ms. Norton from the District.

Ms. NORTON. Thank you, Mr. Chairman. I want to thank Chairman Mica for holding this early warning hearing and for the vigilant oversight this subcommittee is giving to the Federal Employees Health Benefits Program this year.

The subcommittee has understood that strict oversight is necessary ever since our hearing of October 8, 1997, when we learned that the average premium would increase by 15.4 percent, or almost twice as much as had been previously announced.

The FEHBP continues to be cited as the model for health care reform. It provides the most extensive mixed HMO-PPO system in the country and an unusual array of choices that allow employees to tailor health care for themselves. Thus, I have special concern about the standardization of health care coverage in the FEHBP. If the choice feature that has made the FEHBP work so well is to be reduced, comparable or better benefits to employees should be required. Americans are not yet prepared to understand what Europeans and Asians have long accepted, that is that we cannot all have it all, and that there must be tradeoffs if health care is to be made widely available. However, tradeoffs must be specific, calculated, measurable, and acceptable. It is the obligation of this subcommittee to make sure that any proposed tradeoffs follow such standards.

Fortunately, the Patient Bill of Rights does not involve tradeoffs, but only minimal standards that every insured person should expect from any health care plan. By issuing an executive memorandum mandating compliance with the Patient Bill of Rights, President Clinton has taken an important act of leadership. Now it is up to Congress to follow his lead. Health care plans should get there before Congress does.

I thank the chairman for today's hearing, once again, and look forward to the testimony of today's witnesses. Thank you, Mr. Chairman.

Mr. MICA. I thank the gentelady and now will recognize the gentelady from Maryland, Mrs. Morella.

Mrs. MORELLA. Thanks, Mr. Chairman. I want to thank you for today's hearing on the Federal Employees Health Benefits Program. The FEHBP is an outstanding program, but even among the best, there is always room for improvement.

The FEHB program is critically important to my constituents and the 9 million Federal employees, retirees, and their families who rely on FEHBP. I see so many of my friends who are very cognizant of all of the nuances of the program and I want to single out Walt Francis, who is one of today's witnesses, who has been with me every year for my program in Montgomery County, MD.

FEHBP enjoys high customer satisfaction, over 85 percent of participants in fee-for-service plans and HMO's are satisfied with their FEHBP health plan. It is critical that we ensure that its success continues and that means ensuring that FEHBP does not tolerate managed care abuses.

I want to commend the President's intentions in the Patient Bill of Rights. We do need basic standards in health insurance, standards to ensure that patients can make informed decisions concerning their own health care and can have access to necessary care. It is critical that managed care patients have access to emergency care without prior authorization, have access to specialized treatment when it's medically necessary in the judgment of a health professional, and the guaranteed continuity of health care services. We also have ensure that there are no gag rules that prohibit doctor-patient communication. We must protect breast cancer patients from insurance agreements that release them from the hospital prematurely.

It is important to note, however, that most of the FEHB plans are already in substantial compliance with the President's Consumer Bill of Rights. Improvements can, and should be made, but not at the expense of hurting the plans in FEHBP that already provide quality care.

While our requirements are aimed at correcting perceived abuses in managed care plans, they may complicate things for fee-for-service and PPO plans. These plans have reimbursement agreements with physicians and hospitals, but don't directly employ doctors or hospitals, and, therefore, don't collect clinical data. PPO plans don't restrict a patient from seeing a specialist or going out of network. There are no industry standards for measuring clinical quality in PPO's, and I do worry that the Patient Bill of Rights will place unnecessary administrative burdens on PPO's.

I am concerned about bringing in medical savings accounts [MSA's] to FEHBP. That may result in cherry picking in FEHBP, resulting in higher premiums for those who don't choose the MSA's and for those who are less healthy.

So I really do look forward to the witnesses' responses to that idea. We must maintain the high quality of affordable health care provided by the FEHBP and I hope that today's hearing keeps us on the right track, and I thank you, Mr. Chairman.

Mr. MICA. I thank you.

There being no further opening statements, I'll call up our first panel. We have just one witness who is Edward (Ed) Flynn III, Associate Director of Retirement and Insurance Services of the Office of Personnel Management.

Since he's been on numerous times, he knows the routine.

[Witness sworn.]

Mr. MICA. Thank you. The witness answered in the affirmative. Welcome back. Mr. Flynn, you are recognized.

**STATEMENT OF WILLIAM E. FLYNN III, ASSOCIATE DIRECTOR
FOR RETIREMENT AND INSURANCE, U.S. OFFICE OF PER-
SONNEL MANAGEMENT**

Mr. FLYNN. Thank you, Mr. Chairman. Let me get organized here.

Mr. Chairman and members of the subcommittee, I very much appreciate the opportunity to be here before you today. I do have a statement that I have submitted and I will summarize it if I might.

Mr. MICA. Without objection, that will be made a part of the record. Thank you.

Mr. FLYNN. Mr. Chairman, in inviting us to this hearing, you asked that we pay particular attention to the policies that we would like to achieve in the Federal Employees Health Benefits Program for the 1999 contract year which begins next January.

And you noted in your invitation that the program has become a model employer-sponsored health benefits program through reliance on market forces of competition and consumer choice.

We agree with that, Mr. Chairman, and believe the program will continue to reflect these principals. We also believe the program should offer a comprehensive core of medical benefits so individuals can always be assured that their important health care needs will be addressed.

Mr. Chairman, you and several others mentioned the 15.4-percent average enrollee increase for premiums in 1998 and, in your letter of invitation there was a seeming linkage of that and a concern over the impact of overregulation and mandates in the program.

One thing I would like to do is make clear that the rate increase was, in fact, primarily driven by increases in health care costs generally and by the old Government contribution formula which has now been fixed, the new formula will be in place in 1999.

OPM's benefit objectives for 1998 may have added 3 cents per pay period to the participant's premium, less than seven one-hundredths of 1 percent.

Now I would like to discuss, just very briefly, our objectives for the coming contract year and first talk about the Patient Bill of Rights.

As has been noted, our program is already in substantial compliance with the Patient's Bill of Rights. Unparalleled consumer choice among health care delivery systems and providers is an FEHB hallmark. Comprehensive consumer information and equitable treatment of participants have existed in the program since its inception. We have provided participants with an independent third-party review of disputes for over 20 years and much information about plan characteristics and performance is already available to our customers through the annual open season guide, plan brochures, provider directories, and other sources.

Nonetheless, some actions will be needed to fully comply with all of the Patient's Bill of Rights. In this year's call letter, OPM will begin a collaborative process with all health plans to reach agreement on the steps we and they will make to achieve the President's directive.

Because we are already in substantial compliance with the Patient's Bill of Rights, we expect the costs of these additional steps to be insignificant in the context of the program overall. Our preliminary cost estimate for consistent disclosure of health plan information, improved access to specialists and continuity of care amounts to \$32.5 million.

In concrete terms, in terms of what an individual might be expected to pay, that comes out to an average of 5 cents every 2 weeks for an individual or self-only plan and 12 cents for a family plan.

Next, Mr. Chairman, I would like to talk briefly about some initiatives we hope to see in the mental health area. Last year, as required by the Mental Health Parity Act of 1996, plans eliminated any dollar limitations for treatment of mental illness which were less generous than similar limits on other benefits.

We encouraged plans last year to look for ways to improve their mental health benefits by adopting innovative benefit designs and using preferred provider organizations that have been so successful in other areas of health care.

This year we want to continue to move in that direction. We will be asking plans to cover pharmacotherapy benefits under their general medical benefits portion of their programs.

Pharmacotherapy involves such allied tasks as the prescription of medications, observation of responses to those medications, and the regulation of dosages. In this regard, we believe it is reasonable that management of the physiological aspects of mental health conditions should be reimbursed the same as pharmaceutical management of any other disease process.

Finally, Mr. Chairman, I'll address one other area that we will focus on in our call letter for next year, and that has to do with the establishment of performance incentives for health maintenance organizations that participate in the program.

We plan to advise health maintenance organizations about our dialog with several carriers and industry representatives about adding performance incentives to our contracts with those plans. While program regulations and contracts have specified perform-

ance standards for several years, no real incentives exist for high performing HMO's, even though such incentives are a common feature in HMO industry contracts.

We believe this is in the program's interest and we'll invite all prepaid plans to assist us in a cooperative dialog which will culminate in the introduction of performance incentives for these plans in the future.

Mr. Chairman, this concludes my overview of the broad objectives that we seek to achieve in 1999. I will be happy to answer any questions that you may have.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

at an oversight hearing of the

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

on

THE 1999
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

March 17, 1998

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

GOOD AFTERNOON. I APPRECIATE THIS OPPORTUNITY TO ADDRESS YOU CONCERNING THE 1999 FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM.

IN MARCH OF EACH YEAR, WE ISSUE OUR ANNUAL CALL LETTER TO ALL PARTICIPATING HEALTH PLANS. IN IT, WE PROVIDE GUIDANCE ON PROGRAM GOALS FOR THE COMING YEAR. WHILE EACH HEALTH PLAN'S BENEFITS AND RATES ARE THE PRODUCT OF BILATERAL NEGOTIATIONS, THE CALL LETTER BEGINS THE PROCESS BY COMMUNICATING OUR GENERAL EXPECTATIONS FOR CONTRACTING OUTCOMES. WE ATTEMPT TO LEAVE AS MUCH FLEXIBILITY AS POSSIBLE FOR EACH PLAN TO MAKE PROPOSALS WHICH WILL ACHIEVE THE DESIRED OUTCOMES.

YOUR LETTER OF INVITATION NOTED THAT THE FEHB PROGRAM HAS BECOME A MODEL EMPLOYER-SPONSORED HEALTH BENEFITS PROGRAM THROUGH RELIANCE ON THE MARKET FORCES OF COMPETITION AND CONSUMER CHOICE, AND THAT PRESERVING CHOICE AMONG A BROAD RANGE OF OPTIONS IS VITALLY IMPORTANT. WE AGREE AND BELIEVE THE PROGRAM WILL CONTINUE TO REFLECT THESE PRINCIPLES. WE ALSO BELIEVE THE PROGRAM SHOULD OFFER A COMPREHENSIVE CORE OF MEDICAL BENEFITS SO INDIVIDUALS CAN ALWAYS BE ASSURED THAT THEIR IMPORTANT HEALTH NEEDS WILL BE ADDRESSED.

IN YOUR LETTER, YOU MENTIONED THE 15.4 PERCENT AVERAGE ENROLLEE INCREASE IN PREMIUMS FOR 1998, AND LINKED THAT TO A SUBCOMMITTEE CONCERN ABOUT THE IMPACT OF OVER-REGULATION AND MANDATES. WE WOULD LIKE TO MAKE CLEAR ONCE AGAIN THAT THE RATE INCREASE WAS DRIVEN BY INCREASES IN HEALTH CARE COSTS GENERALLY, AND BY THE OLD GOVERNMENT CONTRIBUTION FORMULA, NOW FIXED. OPM'S BENEFIT OBJECTIVES FOR 1998 MAY HAVE ADDED 3 CENTS PER PAY PERIOD TO THE PARTICIPANT'S PREMIUM, LESS THAN 7/100 OF 1 PERCENT.

OBJECTIVES FOR 1999

PATIENT BILL OF RIGHTS

IN NOVEMBER 1997, THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY REPORTED ITS RECOMMENDATIONS FOR A PATIENT'S BILL OF RIGHTS. THE PRESIDENT ENDORSED THE REPORT AND ASKED OPM AND OTHER EXECUTIVE BRANCH AGENCIES TO ADVISE HIM ON HOW TO ACHIEVE COMPLIANCE WITH IT.

ON FEBRUARY 20, 1998, THE PRESIDENT DIRECTED EACH AGENCY TO TAKE ACTIONS CONSISTENT WITH ITS MISSION TO COMPLY WITH THE PATIENT'S BILL OF RIGHTS.

THE PRESIDENT DIRECTED OPM TO ENSURE THAT ALL FEHB PLANS ACHIEVE FULL CONTRACTUAL COMPLIANCE NO LATER THAN THE END OF 1999, AND FURTHER DIRECTED THE AGENCY TO PROPOSE REGULATIONS EXPRESSLY PROHIBITING "GAG CLAUSES" OR OTHER MECHANISMS WHICH RESTRICT PHYSICIAN-PATIENT COMMUNICATION ABOUT TREATMENT OPTIONS.

THE FEHB PROGRAM IS ALREADY IN SUBSTANTIAL COMPLIANCE WITH THE PATIENT'S BILL OF RIGHTS. UNPARALLELED CONSUMER CHOICE AMONG HEALTH CARE DELIVERY SYSTEMS AND PROVIDERS IS AN FEHB HALLMARK. COMPREHENSIVE CONSUMER INFORMATION AND EQUITABLE TREATMENT OF

PARTICIPANTS HAVE EXISTED IN THE PROGRAM SINCE ITS INCEPTION. WE HAVE PROVIDED PARTICIPANTS WITH AN INDEPENDENT, THIRD-PARTY REVIEW OF DISPUTES FOR OVER 20 YEARS. MUCH INFORMATION ABOUT PLAN CHARACTERISTICS AND PERFORMANCE IS ALREADY AVAILABLE TO FEHB CUSTOMERS THROUGH THE ANNUAL OPEN SEASON GUIDE, PLAN BROCHURES, PROVIDER DIRECTORIES, AND OPM'S WEB SITE WHICH FEATURES DIRECT LINKS TO MANY FEHB RESOURCES. NONETHELESS, SOME ACTIONS WILL BE NEEDED TO FULLY COMPLY WITH ALL OF THE PATIENT'S BILL OF RIGHTS. FOR EXAMPLE, WE WILL BE REQUESTING SPECIFIC PROPOSALS FROM THE CARRIERS REGARDING ACCESS TO SPECIALTY CARE AND CONTINUITY OF CARE, TAKING INTO CONSIDERATION CLINICAL EFFICACY, PLAN DESIGN, AND COST.

IN THIS YEAR'S CALL LETTER, OPM WILL BEGIN A COLLABORATIVE PROCESS WITH HEALTH PLAN'S TO REACH AGREEMENT ON THE STEPS WE AND THEY WILL MAKE TO ACHIEVE THE PRESIDENT'S DIRECTIVE.

BECAUSE WE ARE IN SUBSTANTIAL COMPLIANCE ALREADY, WE EXPECT THE COSTS OF THESE ADDITIONAL STEPS WILL BE INSIGNIFICANT FOR THE PROGRAM. OUR PRELIMINARY COST ESTIMATE FOR CONSISTENT DISCLOSURE

OF HEALTH PLAN INFORMATION, IMPROVED ACCESS TO SPECIALISTS, AND CONTINUITY OF CARE AMOUNTS TO \$32.5 MILLION. IN CONCRETE TERMS, PARTICIPANTS WOULD PAY AN AVERAGE OF 5 CENTS EVERY 2 WEEKS FOR THIS PROTECTION AND FAMILIES WOULD PAY 12 CENTS.

THE CALL LETTER WILL ALSO ASK HEALTH PLANS TO PROPOSE BENEFITS ALLOWING DIRECT ACCESS TO QUALIFIED OB-GYN SPECIALISTS FOR WOMEN'S PREVENTIVE CARE SCREENING. WE WILL ALSO WORK WITH PLANS ON THE UNIFORM APPLICATION OF THE "PRUDENT LAYPERSON" STANDARD FOR COVERAGE OF EMERGENCY CARE. I MIGHT ADD THAT THIS IS NOW THE PREDOMINANT STANDARD IN THE PROGRAM. FINALLY, WE WILL ADVISE CARRIERS THAT WE WILL ISSUE PROPOSED REGULATIONS PROHIBITING "GAG CLAUSES". AS PART OF THIS, WE WILL EMPHASIZE OUR EXPECTATION THAT CARRIERS ENCOURAGE THEIR CONTRACTING PROVIDERS TO FULLY DISCUSS TREATMENT OPTIONS, INCLUDING THE CONSEQUENCES OF NON-TREATMENT, WITH PATIENTS.

IMPROVEMENTS IN MENTAL HEALTH

LAST YEAR, AS REQUIRED BY THE MENTAL HEALTH PARITY ACT OF 1996,

PLANS ELIMINATED ANY ANNUAL DOLLAR LIMITATIONS FOR TREATMENT OF MENTAL ILLNESS WHICH WERE LESS GENEROUS THAN SIMILAR LIMITS ON OTHER BENEFITS. WE FURTHER ENCOURAGED PLANS TO LOOK FOR WAYS TO IMPROVE MENTAL HEALTH BENEFITS BY ADOPTING INNOVATIVE BENEFIT DESIGNS AND USING PREFERRED PROVIDER ORGANIZATIONS THAT HAVE BEEN SO SUCCESSFUL IN OTHER AREAS OF HEALTHCARE.

THIS YEAR WE WANT TO CONTINUE TO MOVE IN THAT DIRECTION. OPM WILL ASK PLANS TO COVER ALL PHARMACOTHERAPY UNDER THE GENERAL MEDICAL BENEFITS PORTION OF THEIR PROGRAMS. PHARMACOTHERAPY INVOLVES THE PRESCRIPTION OF MEDICATIONS, OBSERVATION OF RESPONSE TO MEDICATION, AND REGULATION OF DOSAGES. IN ADDITION, WE WILL PROPOSE THAT ALL LABORATORY TESTS ASSOCIATED WITH PHARMACOTHERAPY FOR MENTAL CONDITIONS BE REIMBURSED AS A MEDICAL BENEFIT. WE BELIEVE IT IS REASONABLE THAT MANAGEMENT OF THE PHYSIOLOGICAL ASPECTS OF MENTAL HEALTH CONDITIONS SHOULD BE REIMBURSED THE SAME AS PHARMACEUTICAL MANAGEMENT OF ANY OTHER DISEASE PROCESS.

PERFORMANCE INCENTIVES

WE PLAN TO ADVISE HMO PLANS ABOUT OUR DIALOGUE WITH SEVERAL CARRIERS AND INDUSTRY REPRESENTATIVES ABOUT ADDING PERFORMANCE INCENTIVES TO OUR CONTRACTS WITH PREPAID PLAN'S. WHILE PROGRAM REGULATIONS AND CONTRACTS HAVE SPECIFIED PERFORMANCE STANDARDS FOR SEVERAL YEARS, NO REAL INCENTIVES EXIST FOR HIGH-PERFORMING HMO PLANS, EVEN THOUGH INCENTIVES ARE A COMMON FEATURE IN HMO INDUSTRY CONTRACTS.

WE BELIEVE THIS IS IN THE PROGRAM'S INTEREST AND WILL INVITE ALL PREPAID PLANS TO ASSIST US IN A COOPERATIVE DIALOGUE WHICH WILL CULMINATE IN THE INTRODUCTION OF PERFORMANCE INCENTIVES FOR THESE PLANS.

THIS CONCLUDES MY OVERVIEW OF OBJECTIVES WE HOPE TO ACHIEVE IN 1999. I WILL BE GLAD TO ANSWER QUESTIONS YOU MAY HAVE NOW.

Mr. MICA. Thank you, Mr. Flynn. I'll get right to the heart of it here. First of all, you said that we'll see an increase in costs or expenses of \$32.5 million. Is that the expense to the Federal employees and Federal participants?

Mr. FLYNN. Well, Mr. Chairman, that's the expense to the program as a whole. Generally speaking, the participants in the program pick up about a quarter of that.

Mr. MICA. So 25 percent, and that's what you alluded to as the 5 cents every 2 weeks—

Mr. FLYNN. That's correct, Mr. Chairman.

Mr. MICA [continuing]. And 12 cents for a family?

Mr. FLYNN. That's correct, Mr. Chairman.

Mr. MICA. So the Government's share?

Mr. FLYNN. Would be 15 and 36.

Mr. MICA. OK.

Now, what about costs to the health care providers?

Mr. FLYNN. Well, the costs to the health care providers, Mr. Chairman, would be the corollary of that. I mean, the reason that extra amount would be included in the premium is to reimburse the carriers for the cost of implementing those particular provisions.

Mr. MICA. So you believe that this will cover all of the expenses to be compliant with the Patient's Bill of Rights?

Mr. FLYNN. Let me try and answer that a bit more fully. The short answer to that is yes, we do. We've had our actuaries looking at the Patient's Bill of Rights, those areas where we are in substantial compliance and those areas where we have a bit more work to do in terms of achieving consistency—some of the areas that I mentioned in my statement.

Mr. MICA. Have you surveyed any of the providers to get their opinion as to what the cost increases they'll experience, or that they anticipate, may be passed on?

Mr. FLYNN. We have had discussions with several of our carriers, Mr. Chairman, and with organizations that represent the carriers that participate in the program. We have not, at this point, attempted to take that information and form it into a cost estimate. I think our cost estimates at this point are pretty reasonable.

As I indicated in my statement, what we intend to engage in over the course of the next year or so, is a collaborative effort with our carriers so that this implementation can be done in ways that are appropriate for us and for them, that reflect the many different ways in which health care is delivered through the carriers, and that make sense from the standpoint of the program overall.

Mr. MICA. There's also, I guess, information under the Patient's Bill of Rights that requires the compilation and publication of a broad range of information about providers. This includes not merely name, address, certification, and other medically relevant information, but also matters such as accessibility to the handicapped, languages spoken or availability of interpreter services.

Is that figured into the cost estimates you are giving us?

Mr. FLYNN. Yes, sir, it is, Mr. Chairman.

Mr. MICA. This health care Bill of Rights requires providers to ensure that the provider contracts do not contain any so-called gag clauses or other contractual mechanisms that restrict health care

providers' ability to communicate with and advise patients about medically necessary treatment options.

What is the problem, the specific problem, that this provision would address?

Mr. FLYNN. We're not aware, Mr. Chairman, of any instance in the FEHB. No specific circumstance or set of circumstances has come to our attention that suggests such clauses exist or that such clauses or other mechanisms are preventing individuals and their physicians from having a full, free and open communication about an individual and his or her health.

By the same token, we want to make sure that we don't ever find ourselves in a situation where that might occur and so what we are proposing to do, in the next month or so, is to issue a set of proposed regulations not unlike the regulations, at least in terms of their intent, that have been issued in the Medicare program. We will invite parties to comment on those, and then move through the regulatory process to ensure that these types of restrictions don't exist in the program.

Mr. MICA. I'm wondering if this provision might circumvent any of the current provisions of law that prohibit providers participating in the Federal Employees Health Benefit Program from referring patients for abortions.

Mr. FLYNN. I'm not aware of anything that would restrict that, Mr. Chairman. But, of course, this is something that we would want to take a look at and make sure we are operating consistently with current law in this area.

Mr. MICA. Let me ask a question about the mental health benefits you talked about. You say that OPM will ask for, as you stated, plans to cover all pharmacotherapy and all associated laboratory tests. This is part of your plan, as you said, to continue to improve mental health benefits. Will the plans really have an option of rejecting your request or this request really a mandate?

Mr. FLYNN. I would not characterize it as a mandate, Mr. Chairman. As I mentioned, for the past several years, we have paid attention to a better understanding that the distinction that plans have traditionally regarded between mental health on the one hand and general medical benefits on the other is not a sharp distinction. There is, in fact, a fairly gray line and a fairly wide gray line. One of the things that we have tried to do is to look for ways in which we can, without significantly affecting the cost of this program, make a broader array of mental health benefits available to individuals. We think this is a step in that direction. But we will be looking for plan proposals in response to our call, and I would not characterize this as a mandate in that regard.

Mr. MICA. You indicate that this is part of an ongoing process of improving mental health benefits. Does OPM have a strategic plan for gradually adding mental health benefits in the future and, if so, could you describe any plans in detail to us?

Mr. FLYNN. We do not, Mr. Chairman, have a plan that is written that suggests, in 1997 we'd like to do "X," in 1998, we'd like to do "Y," and so on and so forth.

What we do, however, attempt to do, is listen to all of the people who have an interest and a voice in this program, and to be aware of the general evolution of health care generally, and in the process

of being aware of that evolution, try and make sure that the Federal Employees Health Benefits Program remains contemporary in that regard.

Mr. MICA. Now if we were to mandate that coverage, what would you estimate the cost to be? Have you done any—

Mr. FLYNN. Again, Mr. Chairman, we have had our actuaries looking at this, we think that it might be somewhere in the neighborhood of \$8 to \$10 million in total for the program.

Mr. MICA. I have no further questions at this time. Mr. Cummings.

Mr. CUMMINGS. Thank you very much. The \$32.5 million figure, can you tell me how you arrived at that?

Mr. FLYNN. Yes, sir, Mr. Cummings. We looked at the areas of the Patient's Bill of Rights where we felt that more consistency than now exists in the program will be needed.

There are three primary areas. First, information disclosure to participants; second, provisions for continuity of coverage for individuals in the program; and finally, access to specialists in the program. And I don't have it right off the top of my head, but I believe that, of the three, information disclosure was the most expensive, at about \$17.5 million, and I think the other two essentially split the difference for the remainder.

Mr. CUMMINGS. And why does that take up such a big portion of the \$32.5?

Mr. FLYNN. Primarily because, while there is a great deal of information being provided to individuals about the program today. Most of that information focuses on plan performance and it doesn't get down to individual providers who are in the plan. And there are also different ways in which that information can be provided.

Mrs. Morella mentioned the distinction between health maintenance organizations and preferred provider organizations. We want to look at ways in which we can satisfy that objective for the FEHB Program and recognize also that, when it comes to physicians and other providers in the program, these are the same providers who provide health care to people who don't participate in the Federal Employees Health Benefits Program—people who get their coverage from private-sector employers, who participate in Medicare, and others. So we want to look for ways in which we can increase the amount of information people get, but do it in ways that are consistent and cost effective. It also incorporates, Mr. Cummings, information about the accreditation of providers, and the types of things that Mr. Mica indicated in his remarks.

Mr. CUMMINGS. Now, in reviewing Mr. Gammarino's statements, he states that Government's added rules and regulations are burdensome to carriers and stifles innovations and flexibility and does not add value for the consumer.

Do you have an opinion on that? I'm just curious.

Mr. FLYNN. Yes, sir, I do Mr. Cummings. As I was reviewing Mr. Gammarino's statement, I think that while it may be interpreted somewhat broader, the focus of his statement is a series of Cost Accounting Standards which we are implementing in the program.

I think that along with participation in this program comes an appropriate level of accountability and responsibility so that people can understand that the activities of the organizations that partici-

pate in this program are appropriate, are above board, and things of that nature.

We certainly don't want to overregulate. We certainly don't want to add burdensome requirements that don't add value.

But with respect to the cost accounting standards, I think that there are reasonable efforts underway to ensure that the costs associated with this program are appropriately allocated to this program, are capable of being audited, and that we have a mechanism to assure members of this subcommittee, the public in general, and others that this program is being operated from a financial standpoint in accordance with generally accepted standards.

Mr. CUMMINGS. In talking to Members of Congress, my colleagues, on both sides of the aisle, a number of them have conducted these hearings where their constituents come out and state what their concerns are about their various health plans, so not all of these are Federal employees, I want you to understand that. But from what I understand people come out of the woodwork to attend these hearings because a lot of people are very dissatisfied with what is going on with regard to health care and their programs.

And I was just wondering, this bill of rights, does it address things that you hear a lot as far as complaints? You talk about things that you didn't hear a little bit earlier, I'm just wondering, I'm sure you all get complaints in there and I am just wondering do you think this bill of rights addresses those things of many them?

Mr. FLYNN. I think it does, Mr. Cummings. As you mentioned, this is a program that enjoys widespread support among a majority of its participants. Nonetheless we do hear from individuals about such things as access to specialists, about such things as not understanding the manner in which their reimbursements are calculated, about such things as whether or not they will be able, if they are vacationing in Florida, to have access to emergency care if it's necessary, and things of that nature.

So, yes, I do think that the bill of rights addresses some of the concerns that participants in this program have expressed to us even though, as I say, it enjoys widespread support among most of its participants.

Mr. CUMMINGS. Do you think that because of the bill of rights, you will have carriers withdrawing?

Mr. FLYNN. I don't believe so, Mr. Cummings. I think, quite honestly, the carriers that participate in this program, for the most part, feel as strongly about these issues as we do. What we're dealing with here, I think, is a measure of consistency in how information is provided and the degree of knowledge that people have about the rights that are available to them. I wouldn't presume to speak for Blue Cross and Blue Shield but I think, shortly after the President's announcement several weeks ago, they issued a statement indicating broad support for the Patient's Bill of Rights and a willingness to work with us to ensure that they are implemented effectively.

Mr. CUMMINGS. Now, do you believe that the bill of rights adversely affects some carriers and is beneficial to others in any way?

Mr. FLYNN. I have not seen anything in the bill of rights, Mr. Cummings, that would suggest that to me. I think that there are

differences in plan design, in how plans operate with respect to their providers, and in the people who participate in those plans, that we have to pay attention to and make sure that we don't unnecessarily complicate. But I don't think that there are advantages that necessarily accrue to one type of plan as opposed to another.

Mr. CUMMINGS. Finally, you said that FEHBP is already in substantial compliance with the bill of rights and I was just wondering if you could cite specific programs where our program does not comply.

Mr. FLYNN. I don't think if you looked at the eight broad principals. Mr. Cummings, you would not find any place where the program does not essentially comply. What we do find is less than complete compliance in a couple of the areas I've mentioned concerning information disclosure, access to specialists, and continuity of coverage. We have areas where some additional work is needed.

There are some areas where we actually exceed the standards that are incorporated in the Patient's Bill of Rights already, particularly in the strength of our confidentiality requirements in the Federal Employee Health Benefits Program and in the review of disputed claims under the program itself.

Mr. CUMMINGS. Now you also mentioned that OPM will begin collaborative process. Can you explain to me how that is going to be done?

Mr. FLYNN. I will try to do that, Mr. Cummings. We, as I mentioned earlier, plan to incorporate into our call letter that we will issue later this month our expectations about the bill of rights in terms of outcomes.

I don't intend in any way to specify exactly how those should come about. We have a long history of collaborating with the health plans that participate in the program in many areas and what we will engage in over the course of the next year or so is exactly that type of effort. We sponsor plan conferences, we get together with individual plans, we get together with the organizations representing plans, like the American Association of Health Plans and others, and I think, through that process and through true collaboration with them, and with the other Government health care purchasers, we can work our way through these additional areas in ways that make sense for everybody.

Mr. MICA. Thank you. Now I'd like to recognize Mrs. Morella.

Mrs. MORELLA. Thank you, Mr. Chairman.

Thank you, Mr. Flynn. I was with the President when he spoke at the Wheaton center and it was terrific that one of our Federal retirees was the one who introduced him, who indicated that he was very happy with the FEHB Program and, as I mentioned in my opening remarks, so many others are.

Let me just pose a few questions quickly.

The OPM inspector general has examined FEHBP contracts and determined that there doesn't seem to be any problem with the silent PPO's and I just wondered if you might comment on it, Mr. Flynn. Is that correct?

Mr. FLYNN. Very briefly, I'd be glad to, Mrs. Morella. We, as you know, have been talking about this issue, and others with us, for the past several years. It reached a level of concern where, I believe at the request of the full committee, OPM's inspector general

came in and looked at the discounting practices that go on in the Federal Employees Health Benefits Program consistent with guidance that we had provided to the carriers in the past several years—about making sure that they look for discounts wherever they are available and wherever they are otherwise appropriate to the general business objectives of the carriers that participate.

There was a concern that these so-called silent preferred provider organizations, the definition of which has been laid out in the inspector general's report, somehow operated within the Federal Employee Health Benefits Program and did so in ways that were regarded as unethical and illegal. I think the inspector general's report lays that issue to rest conclusively and indicates that they did a broad review of these agreements. They looked at the chain of custody, if you will, all the way through to make sure that discounts were being taken properly and were being disclosed to the parties to the contract. With the exception of a very few instances of probable confusion—and when you are dealing with millions of transactions understandably so—they came to the conclusion that the FEHB did benefit from these discounting practices, that the contracts were appropriate, they were disclosed to all parties. I hope this puts this matter to rest conclusively.

Mrs. MORELLA. I do, too. It was my understanding, too, so it is great to hear you confirm that.

I also want to bring up the fact that the collection of data to measure quality could pose some real challenges. While it sounds like a great idea, there may be problems with how you work it out. For example, many PPO's have thousands of physicians, who have only one or two member patients. In many cases that, it appears to me, would render it almost impossible to really draw any significant conclusions from the limited data that is available.

So, is it relevant to collect clinical quality measures on fee-for-service plans where the plans have no control over the physician's practice and the patient makes the choice of provider?

Mr. FLYNN. That is not an easy question to answer.

Mrs. MORELLA. No, it is not.

Mr. FLYNN. Let me try and parse it out just a little bit. I am going to divide the world first by information that is more or less objective in nature about a provider, e.g., where he or she went to medical school, what certifications they may have, and say that I think those are probably more easily discernible and reportable than some of the types of things that you have mentioned having to do with the health outcomes of patients treated by a particular provider. I guess the best way to answer you in that latter part, or that second half of how I divided the world, is to say that this is something that individuals have been attempting to address for some time.

I think that the knowledge about health care in general and the types of treatments that are effective has certainly advanced greatly over the past 10 or 15 years and shows every prospect of continuing to advance.

I think, also, that the technology that is available to us today to collect data about individual treatments that a provider gives to a patient is much better today than it was 10 or 15 years ago. But I don't think that we are at the point today where we can have a

broad array of information about clinical outcomes—that conclusively demonstrates whether a particular provider is operating well above average, at the average, or well below average—in ways that can then be pulled out and given to individuals to make decisions about who they will go to for a treatment.

I do think, however, we are making progress in that area and that we ought to continue to encourage that type of thing and to look for ways in which one can collect and disseminate that information so that people can make reasonable choices. Notwithstanding the difficulty, I think it is worth pursuing.

Mrs. MORELLA. Are there any industry standards that exist for measuring and evaluating the clinical outcomes in the PPO industry?

Mr. FLYNN. Well, I think there are some standards with respect to the treatment of diseases like depression, asthma, diabetes, high blood pressure, and so on and so forth. And you can actually look at how a provider works with an individual patient and make some judgments about whether or not that provider seems to be putting individuals on the right treatment protocol so as to achieve healthy outcomes.

Again, it is very difficult, and it's particularly difficult in situations where a fee-for-service plan operates a broad, widely dispersed preferred provider organization. Again, I think the effort is worth pursuing, though I don't think we are there conclusively at this point.

Mrs. MORELLA. And who is going to assume the responsibility for the clinical quality surveys? Will it be OPM, will the plans have to assume that responsibility?

Mr. FLYNN. I think actually, Mrs. Morella, that is something that is also continuing to evolve. There are a number of purchaser coalitions, such as the Washington Business Group on Health, and others that exist in other places around the country that could perform that role. There are organizations like the Foundation for Accountability who have made efforts to initiate and to encourage pilot projects in various areas. As far as who the collector and disseminator might be, I think we're probably not at the point where that has really jelled well at this point. But I think, ultimately, continued efforts in this area will produce an entity that is capable of doing that; that has broad support and credibility in a community.

Mrs. MORELLA. I pose these things because they are concerns and I know that you will certainly try to be fair minded about the whole thing.

Mr. FLYNN. Absolutely.

Mrs. MORELLA. Just one final question. Although, Mr. Chairman, I would like to be able to submit my questions to Mr. Flynn, but in the interest of time, knowing that we have another panel, I'll just pose the idea of remembering that, you know, and something I agree with, allowing women undergoing mastectomies that 48-hour stay, if she and her doctor decide that it is appropriate. And I just wondered, Mr. Flynn, how does that work with the FEHB Program?

Mr. FLYNN. I'm sorry. How does it work?

Mrs. MORELLA. How has it worked?

Mr. FLYNN. So far as I can tell, Mrs. Morella, just fine. Again, this was something where there were not demonstrated problems in the Federal Employees Health Benefit Program, and we imposed this requirement in order to forestall any that might occur. So the requirement for all practical purposes has been in existence just since the first of January, but, to be quite honest with you, we had not encountered problems before and we certainly won't as we go forward. And if we did, we would certainly want to look into them.

Mrs. MORELLA. I commend you for drawing up whatever you need administratively, with regard to eliminating the gag rule in the ob-gyn examinations, and I thank you, Mr. Chairman.

Mr. MICA. Thank you. Mr. Flynn, I want to go back for just a second to this \$32 million which you have broken down into just a few pennies a day per Federal employee or retiree as far as increased cost.

I just calculated my taxes on my personal residence and it is only \$25 a day if I break it down; that sounds a lot more reasonable. But when we look at our Federal employees and our retirees, they are hit by these increases in health care costs and it is one of the concerns I hear wherever I go visit folks, they are getting a 2.8 percent increase and their costs are going up much more dramatically for health care and for other requirements. Of the \$32 million, what tangible health care services are they getting? And we have some emergency coverage now.

Mr. FLYNN. Yes, sir, we do.

Mr. MICA. But that has to be what doctor-authorized or something? And you are switching to lay person? Are we offering more tangible emergency service coverage? Is that what it is?

Mr. FLYNN. You are referring to the prudent lay person standard that is included in the Patient's Bill of Rights. That is, Mr. Chairman, the predominant standard in the Federal Employees Health Benefit Program.

Mr. MICA. So we already have that?

Mr. FLYNN. It's the predominant standard. That doesn't mean that every single plan of the 350 that participate use that standard, and so our efforts will be directed toward ensuring that all plans use that standard.

Mr. MICA. Well, OK. What I'm trying to get at is when these Federal employees and retirees get ahold of me, and we've got an increase, we have an estimate now, it's going to be \$32 million. I want to know what tangible health care benefit are they—

Mr. FLYNN. I think that is a fair question, Mr. Chairman. Let me try and give you three examples of things that I think address that.

First, let me return to the prudent lay person standard.

The fact that it is the predominant standard in the Federal Employee Health Benefits Program today means that in those areas where it isn't, and where an individual needs emergency care in an area, perhaps outside the service area of his or her plan, the reimbursement of that care today would come under a standard that is not the prudent lay person standard.

Mr. MICA. How much did you attach of that cost to this? Of the \$32 million, we're going to expand the emergency—

Mr. FLYNN. Well, as I said, Mr. Chairman, that—

Mr. MICA [continuing]. Services. That's not figured in?

Mr. FLYNN. That's really a negligible amount. The three areas that I talked about were information disclosure—

Mr. MICA. No, wait. Now information disclosure. Again, I'm going to get hit by these Federal employees and retirees and they want to know what kind of tangible health care benefit they are getting, and I go tell them they are going to get information disclosure for \$32 million. That is basically paperwork.

Mr. FLYNN. No, actually, I think, Mr. Chairman—

Mr. MICA. Can you assess for me a value to a hard health benefit that they are going to get for the \$32 million, maybe about \$10 million that you've assigned that they are going to get something here. How about the—

Mr. FLYNN. If I might, Mr. Chairman, that was a second example I was going to use.

Mr. MICA. OK. Go ahead. How much of that and what—

Mr. FLYNN. First of all, the estimate for information disclosure was about \$17 million.

Mr. MICA. \$17 million for paperwork?

Mr. FLYNN. Well, I think that it is actually more than paperwork, Mr. Chairman. Let me give you one—

Mr. MICA. Wait a minute. You told me for \$8 million we could do mental health coverage?

Mr. FLYNN. The increased coverage for pharmacotherapy—

Mr. MICA. Is that \$17 million per year?

Mr. FLYNN. Yes, sir, for information disclosure.

Mr. MICA. And then \$8 million you quoted also for mental health coverage is per year and would that cover our folks?

Mr. FLYNN. We believe that that would be the annual cost of coverage in the FEHB, Mr. Chairman.

Mr. MICA. OK. Somehow I think for \$8 million, I would vote for mental health coverage and a little less on the paperwork side. What do you think?

Mr. FLYNN. Well, Mr. Chairman, if one were to regard it simply as paperwork, I think that would probably be true, but quite—

Mr. MICA. Yes, but—

Mr. FLYNN [continuing]. Quite the opposite is the case. This is more than just paperwork. This is disclosing to a potential patient, for example, whether or not someone is board certified in the specialty that they are attempting to see the physician for, which I think does bear on an individual's assurance that he or she will get quality care, as an example.

Mr. MICA. Well, OK. You've got \$17 million and I'm counting. I still have \$15 million missing.

Mr. FLYNN. The best way that I could explain it, Mr. Chairman, would be to remind you that this is a program that encompasses 9 million people around the world, and many thousands of providers who operate through different plans. In that context, making sure that we are providing information consistently, I think, first, it does have an impact on health outcomes, and second, that \$17.5 million in that context is an appropriate judgment to make.

Mr. MICA. Well, I just have a little personal problem with it. Again, in chairing this subcommittee, and when I see these folks, they want to know what they are getting tangible for their money,

and, if we are mandating a certain amount of hospital stay, and coverage for mastectomies, or we have other tangible mandated benefits, real hard benefits and there are costs, I can tell folks that those are the costs. But I'm trying to figure out how much of this is paper production, and how much is hard, for \$32 million times 5, you know we could get it up to \$160 million over 5 years, and then I don't have coverage for mental health, which concerns me. Again, it's just a matter of priorities, and you set some of these by what you are doing now. Right?

Mr. FLYNN. Yes, sir. We do.

Mr. MICA. Well, it's a little bit frustrating. I have another question. I don't know if OPM has considered alternatives to mandating or standardizing benefits. For example, have you considered allowing individual carriers to offer optional insurance riders for certain benefits that employees can purchase at their own expense without government subsidy? It seems to me that this might be something we should consider and is, in fact, feasible.

Mr. FLYNN. Well, Mr. Chairman——

Mr. MICA. We recently received, I'll be through in a minute, this is a production I'm going to do here. We recently received a flyer in the office from BACE, B-A-C-E, offering a dental plan to all legislative branch employees regardless of the FEHBP health benefit plan they are in.

I'm wondering, why couldn't we have carriers similarly offer specific coverages within the FEHBP?

[The information referred to follows:]

BACE Notice

To: All Legislative Employees
 Re: Dental Plan

In response to your many requests, the Beneficial Association of Capitol Employees is now offering its dental plan to *all* legislative employees, regardless of your FEHBP Health Plan.

When you enroll in this plan, you select a primary dentist from among 500 *participating* dentists in the Washington - Baltimore metropolitan area. Your benefits will include:

- you and your eligible dependents will *not* be charged for preventive dental services (twice a year cleaning and related services) or fillings when you visit your selected participating dentist.
- you will receive a discount off other restorative care, like crowns, periodontal work or orthodontia - this discount usually ranges from 25% to 50% off the normal charge that the dentist charges.

Monthly Premiums *

- a self only plan costs \$12.00 per month
- a self plus one (or the two party) plan costs \$22.00 per month
- a family plan costs \$30.00 per month.

* Minimum enrollment is six months

Usually this plan can be used as a supplement to your current dental benefits in your FEHB Health Insurance plan.

For more information,

Please call BACE at 301-881-0510

Mr. FLYNN. Mr. Chairman, carriers do today offer supplemental coverages that are not subsidized by the government that are paid for by the individual employee. In fact, in each of the health benefit brochures of carriers that offer such supplemental coverages, there is a page devoted to that with information about what it is, what the requirements for participation are, and what the costs are. So, I think that, to the degree that carriers find it desirable to do that, we have given them an option to do so.

Mr. MICA. Is there anything as far as legislative constraints that do not allow you to make more options available?

Mr. FLYNN. Not that I am aware of, Mr. Chairman.

Mr. MICA. OK. All right. I have another question. Blue Cross and Blue Shield is concerned that the cost accounting for standards being imposed on FEHBP carriers is inappropriate for the health-care industry. They have given us information that the standards are designed more for manufacturing operations rather than the type of business we are in here in government. What's your position on this viewpoint question?

Mr. FLYNN. The first thing I would say, Mr. Chairman, is that the cost-accounting standards that apply to these contracts are standards that apply governmentwide and are issued by the Federal Cost Accounting Standards Board. They are not part of OPM, per se. The second thing that I would say is that those standards generally have to do with the allocability and reasonableness of overhead costs that are applied to Government contracts.

Taken in that frame of reference, the development and use of cost-accounting standards in the Federal Employees Health Benefits Program, I think, is a good thing that encourages and fosters accountability in the financial operations of the contractors with whom we deal.

By the same token, it is also true that the disclosure requirements under those standards did not contemplate the type of program that we have here, and we have committed to work with the Cost Accounting Standards Board and with our carriers that participate in the Federal Employees Health Benefits Program to arrive at a set of standards and a disclosure mechanism that makes sense for this program.

But I think, in general, the idea of having people operate under a reasonable set of standards for disclosing their financial operations is a good thing, and something we should encourage.

Mr. MICA. Well, is OPM considering modifying those standards to adopt them more closely to the health care industry?

Mr. FLYNN. Well, as I indicated, Mr. Chairman, OPM does not promulgate the standards themselves. We have made a commitment with our carriers to work with the Cost Accounting Standards Board to get standards in place that make sense for this program.

Mr. MICA. Since 1993, aside from mandated benefits established in call letters, or regulations, has OPM required any carriers to offer a particular benefit? And maybe you can provide an example and explain why you did.

Mr. FLYNN. I'm not sure I understand the question, Mr. Chairman.

Mr. MICA. Since 1993, aside from mandated benefits established in your call letters, or regulations, has OPM required any carriers to offer a particular benefit?

Mr. FLYNN. In late 1994, Mr. Chairman, we took an action that, as far as I know, is unprecedented in the history of the Federal Employees Health Benefits Program dealing with the provision of autologous bone marrow transplant and high-dose chemotherapy for women suffering from breast cancer.

We took that action because we felt it was the right action to take; women's lives were at stake and medical opinion was divided. I think, in the context of hindsight, it was the appropriate decision to take.

But that is the only one that I am aware of, Mr. Chairman.

Mr. MICA. Has OPM required any carriers to drop a benefit previously offered, either through its call letter regulations or negotiations and do you have any examples?

Mr. FLYNN. To drop a benefit? I'm afraid, Mr. Chairman, you've got me there. I will, if you don't mind, take that back to the office and make sure that I provide a complete answer for the record. I'm not aware of any.

[The information referred to follows:]

The Office of Personnel Management has required carriers in the Federal Employees Health Benefits Program to drop a previously-offered benefit in the following instances:

1. In accordance with Public Law 98-151, Providing Further Continuing Appropriations for FY 1984, OPM required FEHB plans to eliminate coverage of abortion beginning in January 1984 (except where the life of the mother would be endangered if a pregnancy continued to term). The mandatory prohibition of FEHB coverage for abortion continued in accordance with succeeding appropriations act restrictions through 1993. Another FEHB abortion ban took effect in January 1996 pursuant to Public Law 104-52 (except in cases where the pregnancy endangers the life of the mother, or is the result of rape or incest). This ban has continued to present as required by succeeding appropriations acts applicable to OPM.
2. Our March 1992 Call Letter advised fee-for-service carriers that mandatory second surgical opinions were no longer warranted since the plans had adopted pre-certification programs to verify the necessity of any hospital care, as required by section 7001(a) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 Public Law 101-508.
3. Some years ago, a few FEHB plans negotiated contracts which promised enrollees who had no benefit claims in a contract year an extra benefit in the succeeding contract year, such as a routine physical exam at no cost. This proved to be problematic if the plan subsequently withdrew from FEHB participation or proposed changing the special benefit. OPM adopted a policy of not accepting proposals of this nature.

Mr. MICA. If you'd look at that, I'd appreciate it. Also I'd appreciate again any further breakdown you can provide the subcommittee as to how you assign the costs for this at least \$32 million you've testified annualize costs to come into compliance with the Patient's Bill of Rights. And I think you've indicated where part of that is, but I still would like to see a breakdown.

Mr. FLYNN. We'd be happy to, Mr. Chairman.

[The information referred to follows:]

OPM actuaries estimate that bringing the FEHB Program into full compliance with the Patient Bill of Rights will result in annual costs in the following areas:

I.	Information Disclosure (1 full-time employee per plan)	\$17.5 million
II	Choice of Providers and Plans	
A.	Direct Access to gynecologists	\$ 2.9 million
B.	Ninety-day continuation of coverage upon termination of provider	\$ 3.8 million
C.	Non-network providers at network rates when insufficient specialists in network	\$ 8.3 million
Total		\$32.5 million

Mr. MICA. I have no further questions. Mr. Cummings.

Mr. CUMMINGS. I just have just a few questions. The bill of rights, I take it that you believe that employees under the FEHB program will be better off. Is that right?

Mr. FLYNN. I believe so, Mr. Cummings. This program is unique because it relies so heavily on participants' choices about what health plans they want to enroll in and, within the context of how those health plans operate, the particular physicians that they will want to go to for their medical care.

A program that relies so much on choices at the consumer level, I think, can't help but benefit greatly from ensuring that rights are understood and exist throughout the program.

Mr. CUMMINGS. You stated a little bit earlier in answering, I think one of Mrs. Morella's questions, that with regard to the mastectomy, that you had not had a lot of, I don't know if you said any or—

Mr. FLYNN. I was not aware of any, Mr. Cummings.

Mr. CUMMINGS. Why is that? Why do you think that is?

Mr. FLYNN. Well first of all, I think because we have such a good program, we don't have situations where individual carriers unwittingly, or perhaps otherwise, create or provide for treatments that are outside the mainstream. I think, for example, the issue of outpatient mastectomies was one that was of great concern to people but one that was, quite honestly, not prevalent across health care in general in the United States.

But we wanted to make sure that there was no misunderstanding about how this type of treatment should be given to participants in the Federal Employees Health Benefits Program and that's why we took the action we did.

Mr. CUMMINGS. Going back to the bill of rights for a moment, and this \$32.5 million, I'm just wondering, when you looked at the cost, that \$32.5, I mean is that a hard figure, in other words, is there some flexibility there or is it that bare bones to accomplish what is in the bill of rights?

Mr. FLYNN. Let me try and answer that two ways, Mr. Cummings. First, it's not a hard figure. It's our best estimate, looking at the bill of rights and looking at the 350 plans that participate in the program. It's our best estimate of the amount of money that it would take to fully implement the bill of rights across the program.

I think that, as we engage in this collaborative effort, we may find areas in which we can take advantage of technology, or take advantage of collaborative efforts that are going on elsewhere, and it may cost less than that. But that is certainly a possibility.

Mr. CUMMINGS. I guess what I'm getting at that, that, listening to some of Mr. Mica's questions and your responses, I'm just wondering if we are in a situation where that cost to the enrollees, the employees, could be reduced in any way and still accomplish what is aimed for, the bill of rights.

I do have a concern and I'm sure that Mr. Mica and other members have a concern about the cost, and it may not seem like a great cost to some of us, but when you are on a kind of strict budget and you are trying to make ends meet, you know, those kind of things do add up, and so I was just wondering if there was any

kind of flexibility but at the same time maintaining what the goals are, still being able to attain the goals that are set out in the bill of rights.

Mr. FLYNN. Mr. Cummings, the last thing I would want to do would be to underestimate the cost, but if we—

Mr. CUMMINGS. I agree.

Mr. FLYNN [continuing]. If we could bring this in at less cost or at no cost, certainly, I'll be just fine with that.

Mr. CUMMINGS. At what point, let's say for example you find out that it costs you, instead of \$32.5, it costs you, say, \$25 million. At what point, how does that reduction taken off of the, or a portion of it, I think you said a fourth of it would be, of that \$32.5 would actually be paid for by enrollees. How would that happen.

Do you follow what I'm saying?

Mr. FLYNN. Sure, exactly. That is a function of the new fair-share formula that came into being as a result of the Balanced Budget Act last summer. And a good rule of thumb to use here is that for every \$1 increase in cost in program, or for every \$1 decrease, for that matter, generally speaking the Government picks up 75 percent of that, the individual picks up 25 percent. The actual percentages are 72 and 28, but for rule of thumb purposes, one-quarter, three-quarter works pretty well.

Mr. CUMMINGS. You didn't answer my question, though.

Mr. FLYNN. I'm sorry, I—

Mr. CUMMINGS. I mean that's part of it. I said, so what happens if when you find out, if you found out, that say it would cost 25 instead of 32, then at what point does the, does that reduction kick in for the enrollee?

Mr. FLYNN. It kicks in at the first dollar. If it was \$32.4 million, as opposed to \$32.5, that \$100,000 kicks in for the enrollee and the Government at the same rate.

Mr. CUMMINGS. All right. Thank you.

Mr. MICA. I thank the ranking member. Mr. Pappas, did you have any questions at this time? I know you just joined us.

Thank you, I think Ms. Norton has gone. Well, Mr. Flynn, this concludes another chapter in your presentations before our subcommittee. We're delighted to have you back. We appreciate your cooperation. If you could supply us with that information, we will monitor very closely the actions taken by OPM. I appreciate your being with us today.

Mr. FLYNN. Thank you, Mr. Chairman.

Mr. MICA. Our second panel today consists of two individuals, Mr. Steve Gammarino, vice president of Federal employees programs at Blue Cross and Blue Shield Association; and Mr. Walton Francis. Walt Francis is consultant and author of the "Checkbook's Guide to Health Insurance Plans for Federal Employees." If you could come forward, please.

We will have Mr. Gammarino here and Mr. Francis there. Gentlemen, we do swear in our witnesses. This is the investigations and oversight subcommittee of Congress. If you'd raise your right hands, please.

[Witnesses sworn.]

Mr. MICA. Thank you. And welcome. I know we have at least one individual who hasn't testified before, but we would like to have

you submit any lengthy statements for the record. They'll be made a part of the record upon request, and we try to limit your oral presentations to about 5 minutes.

With those comments, I'd like to welcome Mr. Gammarino with Blue Cross and Blue Shield. You're recognized sir.

STATEMENT OF STEVE GAMMARINO, VICE PRESIDENT, FEDERAL EMPLOYEE PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. GAMMARINO. Yes, and taking up on your advice, we did submit our testimony for the record so I will be summarizing.

Mr. MICA. That will be made a part of the record, without objection. Go ahead, sir.

Mr. GAMMARINO. Thank you, Mr. Chairman, and members of the subcommittee. On behalf of the Blue Cross and Blue Shield Association, I thank you for the opportunity to appear before you today. As you know, Blue Cross and Blue Shield plans jointly underwrite and deliver the governmentwide service benefit plan.

This plan has been in the Federal employee program since its inception and now covers over 1.9 million contracts with over 3.6 million lives.

Today, I'd like to cover two points in my testimony. First concerning the bill of rights and then other areas of FEHBP administration.

On the consumer rights, as you know on February 20, President Clinton directed the heads of all Federal agencies with jurisdiction over public health programs to come into compliance with the bill of rights as recommended by the President's Advisory Commission on Consumer Protection and Quality in Health Care Industry.

We who manage the service benefit plan support these initiatives that will improve the overall quality of health care and seek to maintain affordability. And I'm pleased to report that we already comply with many of these responsibilities.

Indeed, we believe that most of the FEHBP complies with this bill. There may be some areas of the FEHBP where minor changes would constitute an improvement, but we believe any policy changes must protect the value of products that are now enjoyed by the enrollees. Much of the Consumer Bill of Rights is intended to address characteristics of a tightly controlled network product such as an HMO and is not generally applicable to our service benefit plan which is primarily a PPO or preferred provider product. Thus, we believe it vital to assure that in making any changes to accommodate the Consumer Bill of Rights the value of our product is protected.

In this regard, we are guided by the following principles.

First, our PPO is an indemnity product that operates quite differently than an HMO. It encourages the use of a very large network of preferred providers while requiring a lesser degree of cost sharing by the consumer and it does not restrict access to other providers.

Second, one of the fundamental economic principals of the FEHBP is the Government's ability to take advantage of the private sector's provider discount arrangements. With few exceptions, our provider contracts are not specific to the Federal program.

They are proprietary agreements, negotiated, administered, and leveraged in the local markets.

Third, compliance with the intent of the bill should be cost effective.

Fourth, the health care provider, we think, plays a critical role in fulfilling the obligations under the bill.

And, fifth, the needs of the business and the patient regarding disclosure of information should be balanced.

We've analyzed each of the areas of the bill against the principles enumerated above and provided OPM a detailed position paper that we attached to our testimony.

While we must await OPM's issuance of the call letter, and proposed regulations, to assess the extent to which the agency has considered our views, their report to the President and Vice President on implementing the bill in the FEHBP gives us some concern.

The report indicates, for example, that they intend to require PPO plans to compile and make available to enrollees information on providers, such as languages spoken, office hours, and whether the office is accessible to the disabled.

This is not currently captured by our plans.

Such information collection and disclosure may be important when potential employees are evaluating plans with narrow networks and severe restrictions on access outside the network, since it may impact their decision to select a plan.

Collecting and publishing information on more than 400,000 providers in our PPO is another matter. We do not believe it would add significant value and it would be expensive to collect and nearly impossible to keep current and accurate. Moreover, the information is already easily available. The subscriber has only to call the provider listed in our directories that are of potential interest to him or her and ask.

In summary, in developing implementation programs along these lines, we hope OPM will consider the differences in the nature of the products being offered and in each instance balance the cost and burden on the carriers with the added value to the enrollee.

And my second point deals with general issues on administration which you've asked us to comment on. In our view the Government, although well intended, has expanded and continues to expand its role on a number of fronts. Its initiatives, like the Consumer Bill of Rights, when taken individually appear to pose little threat to the roles of the FEHBP stakeholders.

However, collectively they erode the best attributes of this private, consumer choice program. The erosion is caused by increased regulatory control, mandates, and directives, and results in reduced flexibility, increased costs, and reduced competitions.

Examples include mandates. As I testified before your subcommittee last year, we estimate the cumulative effects of mandates imposed by OPM and the Congress through 1990 have added about \$100 million to our program, or about 1.5 percent of our annual benefit costs.

Second, as perhaps the most successful carrier in the program, we are especially sensitive to not becoming the one carrier that can afford to offer certain benefits or is required to defer changes while

other carriers are permitted to institute benefit changes or make changes deemed necessary to ensure their survival.

In other words, we believe the long-range integrity and stability of the program depends upon allowing the carriers to offer enrollees a variety of genuinely different products to choose from, while maintaining a level playing field on which all carriers compete.

An additional area of concern to us is implementation of rules and regulations that burden the carriers while adding little value to the program. A case in point are the cost accounting standards which recently was made applicable to the FEHBP.

In summary, the Blue Cross and Blue Shield Association supports the goals of the Consumer Bill of Rights and our service benefit plan already incorporates many of them. We believe any further implementation and administration along these lines, must be sensitive to the nature of the product being offered and should carefully balance added value to the customer with the cost and burden to the health plan.

We're also concerned to protect and preserve what we believe is the secret to the FEHBP's long-running success—carrier flexibility in anticipating and meeting customer needs, a level playing field, and enrollee choice among a variety of offerings.

Thank you, Mr. Chairman. I'll 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, Senior Vice President, Federal Employee Program at Blue Cross and Blue Shield Association. On behalf of the Association, I thank you for the opportunity to appear before you today to discuss the administration of the Federal Employees Health Benefits Program (FEHBP) by the Office of Personnel Management (OPM).

As you know, the 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 and is the largest Plan in the Program. The Service Benefit Program currently covers over 1.8 million contracts and more than 3.6 million lives.

I will address the following points in my testimony:

- ◆ Implementation of the Consumer Bill of Rights; and
- ◆ Other general areas of FEHBP administration.

The Consumer “Bill of Rights”

On February 20, 1998, President Clinton directed the heads of all federal agencies with jurisdiction over public health programs to come into substantial compliance with the

Consumer Bill of Rights recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Specifically, the Director of the Office of Personnel Management (OPM) was instructed to ensure that all health plans participating in the FEHBP come into contractual compliance not later than December 31, 1999 with respect to access to specialists, continuity of care, access to emergency room services, and disclosure of financial incentives. Further, OPM was directed to publish regulations within 90 days to prohibit practices that restrict physician patient communications about treatment options.

We who manage the Service Benefit Plan support initiatives that will improve the overall quality of healthcare and that seek to maintain affordability. I am pleased to report that the Blue Cross and Blue Shield Service Benefit Plan already complies with many of the rights and responsibilities advocated in the Bill.

Indeed, we believe that the entire FEHBP complies with much of the Bill. For example, the established appeal process provides the protections to the subscriber sought by the Consumer Bill of Rights and no further changes are needed.

There may be some areas of the FEHBP where minor changes would constitute an improvement, but we believe any policy changes must protect the value of the products that are now enjoyed by FEHBP enrollees. Much of the Consumer Bill of Rights is intended to address characteristics of a tightly-controlled network product such as an

HMO (Health Maintenance Organization), and is not generally applicable to our Service Benefit Plan, which is primarily a Preferred Provider Organization (PPO). Thus, we believe it is vital to assure that in making any changes to accommodate the Consumer Bill of Rights, the value of our PPO product is protected.

In analyzing the Bill of Rights, we were guided by the following facts and principles:

- ◆ Our PPO is an indemnity product that operates quite differently from an HMO. It encourages use of our very large network of preferred providers by requiring a lesser degree of cost sharing, but it does not restrict access to other providers.
- ◆ Our product is built on a network of pricing agreements, not a network of managers of care. These pricing agreements do not allow us to levy the type of requirements or restrictions on providers that some HMO contracts do.
- ◆ One of the fundamental economic principles of the FEHBP is the government's ability to take advantage of the private sector provider discount arrangements. With few exceptions, our provider contracts are not specific to the federal program. They are proprietary agreements, negotiated, administered, and leveraged in the local markets by the Plans;
- ◆ Compliance with the intent of the Bill should be cost effective and should minimize Program related costs that would increase the cost to the members;
- ◆ The health care provider plays a critical role in the fulfillment of the obligations of the Bill; and

- ◆ The needs of the business and the patient regarding disclosure of information should be balanced.

We analyzed each of the areas of the Bill against the principles enumerated above and have provided a detailed position paper to the Office of Personnel Management. A copy of our position paper is provided as an attachment to my testimony.

While we must await OPM's issuance of the Call Letter and the promulgation of proposed regulations to assess the extent to which the agency has considered our views, their report to the President and the Vice President on implementing the Bill in the FEHBP gives us some concern. Their report indicates, for example, that they intend to require PPO plans to compile and make available to enrollees information on providers, such as languages spoken and whether the office is accessible to the disabled, that is not currently captured or maintained by our Plans. Such information collection and disclosure may be important when potential enrollees are evaluating plans with narrow networks and severe restrictions on access outside the network, since it may impact their decision to select the plan. Collecting and publishing such information on the more than 400,000 providers in our PPO is another matter. We do not believe that it would add significant value, and it would be expensive to collect and nearly impossible to keep current and accurate. Moreover, the information is already easily available. The subscriber has only to call the providers listed in our directories that are of potential interest to him and ask.

In summary, in developing implementation programs, we hope OPM will consider the differences in the nature of the products being offered and in each instance balance the cost and burden on the carrier with the added value to the enrollee.

General Issues in Administration of the FEHBP

The FEHBP is the largest employer-sponsored health care program in the nation and it is successful, in our view, because of the critical--and delicate--balancing of the roles of Government, the private sector, and the enrollee. To maintain this balance, all parties must play their roles appropriately. Congressional oversight is crucial to ensuring that the proper roles are performed, so we commend you, Mr. Chairman, and Members of this Subcommittee for holding this hearing at this time.

In our view the government, although well intentioned, has expanded and continues to expand its role on a number of fronts. Its initiatives, e. g. Consumer Bill of Rights, when taken individually appear to pose little threat to the roles of the FEHBP stakeholders. However, collectively they erode the best attributes of this private, consumer choice program. The erosion is caused by increased regulatory control, mandates, and directives, and results in reduced flexibility, increased costs and reduced competition. Examples include:

Mandates

Your letter of invitation asked specifically about mandates and their costs. We are opposed to mandates, not because specific mandated benefits may not be worthwhile in themselves, but because a large number of mandates is incompatible with carrier flexibility and innovation. As I testified before your Subcommittee in October 1997, we estimate the cumulative effects of mandates imposed by OPM and the Congress through the 1990's have added about \$100 million, or about 1.5 percent to our annual benefit costs.

Flexibility

As we have testified in the past, we see a distinct and important role for the competing carriers in the FEHBP. 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. Carriers must perceive and assess the meaning of developing trends in utilization and costs and they must be permitted to make changes early-on to avoid dire consequences later. Similarly, each carrier must be allowed to offer innovative benefit designs and care management programs to the consumer, as new techniques become available. Carriers can only effectively play this role if they have flexibility in plan design.

As, perhaps, the most successful carrier in the program, we are especially sensitive to not becoming the one carrier that can "afford" to offer certain benefits or is required to

defer changes while other carriers are permitted to institute benefit designs or make changes deemed necessary to ensure their survival. In other words, we believe the long-range integrity and stability of the program depends on allowing the carriers to offer enrollees a variety of genuinely different products to choose from, while maintaining a level playing field on which all carriers compete.

Regulatory Controls

An additional area of concern to us is the imposition of rules and regulations that burden the carriers while adding little value to the program. A case in point is the Cost Accounting Standards, which have recently been made applicable to the FEHBP. While we acknowledge the government's legitimate interest in the cost accounting practices of its contractors, the current standards were developed with a manufacturing environment in mind and are not well suited to the health care industry. The vast majority of our costs are not labor and materials, but benefit expenses, which reflect commercial prices driven by the market place. The Cost Accounting Standards will be expensive and extremely burdensome for the carriers to apply and will yield no value of commensurate magnitude to the program. We believe the government's interest would be better served and the burden on carriers significantly reduced by the development of standards more appropriate to the health care industry.

Conclusion

In summary, the Blue Cross and Blue Shield Association supports the goals of the Consumer Bill of Rights and our Service Benefit Plan already incorporates many of them. We believe any further implementation -- and the administration of the FEHBP in general -- must be sensitive to the nature of the product being offered and should carefully balance added value to the customer with the cost and burden to the health plan. We are also concerned to protect and preserve what we believe is the secret to the FEHBP's long record of success -- carrier flexibility in anticipating and meeting customer needs, a level playing field, and enrollee choice among a variety of offerings.

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

Mr. MICA. Thank you and we'll hold questions until after we hear from Mr. Walton Francis. Walt Francis, you are recognized. Welcome.

STATEMENT OF WALTON FRANCIS, CONSULTANT AND AUTHOR OF "CHECKBOOK'S GUIDE TO HEALTH INSURANCE PLANS FOR FEDERAL EMPLOYEES"

Mr. FRANCIS. Mr. Chairman, committee members. I am honored and privileged to be here today. I'm particularly pleased, as a native of the District of Columbia and a lifelong resident of Washington, DC, who lives a stone's throw from Montgomery County, that Ms. Norton and Mrs. Morella are involved in this hearing.

I want to very briefly summarize my testimony, as you suggested, focusing on some of the points that are most salient today.

Let me start by making a general point about the framework of this program. There are other consumer choice programs in the health insurance market that do not allow benefit variation among plans. Notable among those is the CALPERS program in California. Consumers get to pick from a wide range of plans but the plans compete only on price and on quality.

The problem with that is that a major dimension of consumer choice is left out. The FEHBP, in contrast, actually lets plans vary in benefits like dental coverage, whether or not chiropractors, acupuncture, et cetera, are available to consumers.

As long as the core benefit package is a sound one, as OPM has developed with the help of the plans through a mutual process, these kinds of benefit variations are desirable and beneficial to the program.

They don't cause significant risk selection, a problem that is of great concern today in other context. There is a risk selection problem in the FEHBP, it's controllable, though it hasn't been controlled. It is primarily due to large groups of high-cost enrollees such as annuitants without Medicare, who are disproportionately enrolled in some plans and who bring with them a higher cost to those plans.

With that, by way of background, as to an essential, in my view, feature of this program, I just want to focus on a couple of key points here.

First, this program is preeminent in providing good information to consumers. It does a superlative job. As someone who gives consumers advice on how to pick health plans, my biggest competitor is OPM and they are a hell of a competitor. There isn't anybody else in the country doing a job as good as OPM.

Again, it's a partnership issue, but OPM's insistence on clear English, on consistent benefit presentations so people can compare plans from one plan to another and actually find things like maternity benefits on the same page, those are excellent practices.

Nonetheless, more and better can be done. I noticed, as I was preparing my testimony, I picked up this year's Blue Cross brochure and I rummaged through my files and went and found one from 4 years ago. It's doubled in size from 32 to 60 pages. That's too long.

I think there is some more good information that could be in that brochure. For example, for the HMO's numbers of providers is ex-

tremely important information for consumers, and all plan brochures don't present it.

But as a general proposition, we probably don't need a lot more length in brochures. I think this relates to the issue of the Patient Bill of Rights which calls for a lot of information to be given to consumers. It is possible to have too much information. So one of my concerns would be overloading consumers with relatively tertiary or, at best, secondary information, at the cost of the essential information they most need.

With respect to the PBR, the Patient Bill of Rights, it's hard to object to a document so exhortatory. It's hard to find a principle to which one would disagree in that bill of rights.

Nonetheless, it is not what one might term a very carefully constructed document aimed at practicality. So, while it contains on the one hand some excellent standards, such as the prudent layperson standard for emergency room access, which are vitally needed, it contains some other standards such as the 90-day continuity rule which I think will create incalculable problems in the real world.

For example, if an HMO were to leave the FEHB program at the end of the contract year, as a dozen or two do every year, with, say 10,000 or 20,000 enrollees, a significant proportion of whom could be characterized as having chronic diseases and then those people enrolled in various health plans, I guess the idea would be that those health plans would somehow have to arrange to pick up those same providers for this 90-day period. I can't quite imagine how that could be done. It is just not a practical option.

Let me give another example: access to the handicapped. The fact of the matter is that the overwhelming majority of medical care providers provide handicap access. I suppose in a context where plans produce literally telephone books of provider information, they could stamp on the cover all of them are accessible, but if one were going to try to rank each provider as to how accessible they were, you can imagine, and I'm not suggesting this is going to happen, but there are possible ways to interpret that Patient Bill of Rights that could lead to some very costly requirements.

Clinical quality is another example. The fact of the matter is that while everybody is in favor of clinical quality measures, they hardly exist in this Nation today.

For example, "The Hospital Quality Book" that the Health Care Finance Administration used to publish is now published by my publisher, Consumer Checkbook, and is the only such source of information on hospitals across the country. It's very complex to create a book like this, as far as case-mix adjustment, and all kinds of statistical techniques.

I think OPM will interpret the President's mandate sensibly. In the past they have been quite sensible, quite practical in the implementation of things, so I am relatively not worried about what will happen. Nonetheless, I commend the committee for its concerns over these matters and suggest you do pay particular attention to some of these implementation details.

One last point. There are future innovations which this program could accept. I discuss some of those in my testimony. They are not the focus of today's hearing, I won't get into them, but I commend

to you the possibility of adding other Federal dependents, such as military retirees and military dependents to this program. I think more national fee-for-service plans should be allowed to participate in this program. MSA plans are one type. There are some potential concerns over MSA's. I think they are probably easily controllable if any such legislation is appropriately drafted.

Thank you very much. If there are any questions, I will be glad to answer.

[The prepared statement of Mr. Francis follows:]

Mr. Chairman, and members of the Subcommittee, I am pleased to have the opportunity to testify before you today concerning the cost and quality of health care coverage under the Federal Employees Health Benefits Program (FEHBP), with particular attention to mandates imposed by OPM or the Congress, and to pending legislation.

I come to this hearing wearing two hats: one as the principal author of CHECKBOOK's Guide to Health Insurance Plans for Federal Employees, an annual book of consumer advice; and one as an economist and policy analyst who has spent most of his career evaluating government programs and policies. I have participated in literally hundreds of studies and analyses of Federal programs, both at the Department of Health and Human Services and at the Office of Management and Budget.

Based on my experience, I want to give you a summary conclusion: the FEHBP is one of the best run programs in the Federal government.

There are many reasons for this conclusion, but a simple comparison will suffice. During the last 20 years the FEHBP has painlessly and without controversy or fanfare steadily improved its benefits, particularly in the areas of catastrophic coverage and prescription drugs. In contrast, the Medicare program still lacks these key elements of coverage (except for those who enroll in HMOs). Likewise, the cost control exercised by the FEHBP is phenomenal in comparison to Medicare and considerably stronger than in the private sector. This cost control is largely a result of a competitive system in which health plans compete for consumer enrollments on the basis of cost, benefits, and service. (For an extended discussion of these issues, see my 1993 article "The Political Economy of the Federal Employees Health Benefits Program" in *Health Care Policy Reform*, edited by Robert B. Helms.)

So good is the FEHBP, and so widely recognized are its accomplishments, that it has been repeatedly urged as a model for other programs, including national health insurance, military dependents and retiree insurance, small business purchasing cooperatives, Medicare reform, and most recently as a substitute for Medicare in serving the below-65 retirees that the President proposed for a buy-in (See "President Clinton's Medicare Buy-in Right Goal, Wrong Program", by David B. Kendall of the

Progressive Policy Institute, February 1998). While these proposals vary widely in their feasibility and effectiveness, they testify to the deserved reputation of this program.

Before I turn to current policy issues, I would like to discuss one salient feature of this program: its handling of risk selection. Risk selection has become almost an obsession in recent years in the Medicare context. But the FEHBP as well is subject to this phenomenon. The basic idea is that if consumers are free to choose which health plan they join, and if many of the "good" risks with low health costs join Plan A with lower benefits and a lower premium, then Plan B will be left with the "bad" risks. In the next year, the Plan B premium will rise to cover its higher costs, the Plan A premium will drop further, and even more people with good health will join Plan A. Ultimately, Plan B will go into a "death spiral" where its costs shoot out of sight.

Risk selection is a real phenomenon. Some years back the State of Colorado experienced a death spiral in the more benefit rich plan in a two-plan system for its employees, and I understand that a Medical Savings Account option in Boise Idaho recently started such a spiral (the county dropped the MSA option to preserve stability). Risk selection has plagued the FEHBP for decades, and led to the demise of the Aetna fee for service plans as well as a number of union plans. However, whatever the experience of two-plan systems, which are obviously unstable, the plethora of plans in this program has tempered and ameliorated the worst aspects of risk selection.

There is a kind of risk selection that is good, and that is prominent in the FEHBP. I call it "feature selection". When plans with good basic benefits are free to offer variations in benefits, such as chiropractic or dental or mental health, the plans with the better version of each benefit will naturally attract persons who use those benefits. This will raise the plans' costs slightly. At the margin, employees in most cases pay the entire extra cost. Each employee, in effect, is offered the opportunity to pick the benefit package he wants, and to pay for the full cost of any extras.

I think that this model is far superior to the alternative approach, used in the CALPERS system in California, where each plan is required to offer a

“one size fits all” uniform benefit package. The reason that CALPERS does not offer that choice is that it wants to maximize price and service competition. And it does -- at the expense of allowing its employees to get the particular benefits they want.

If I can use an automobile analogy, the CALPERS system provides good basic transportation -- but everyone must buy the same car. Some of us really do prefer “four on the floor” or extra luggage space or even the baby boomer passion for off-road vehicles. Why not give us that choice?

The problem for the FEHBP is that this desirable features competition has been dominated by risk selection artifacts. The best mental health coverage in the program is in the Blue Cross High Option. That plan predominantly enrolls very elderly persons without Medicare coverage, a very expensive group. These elderly persons use almost no mental health benefits. Meanwhile, the persons who are willing to pay for extra mental health benefits are forced to subsidize an elderly group that has no interest in this benefit. (Of course, the problem is reciprocal).

Unfortunately, although there are ways to improve this situation, they would probably require legislation and would be controversial. For example, as I testified to OPM some years back, the elderly annuitants without Medicare, almost all now 75 years old or more, could carry a higher premium contribution to whatever plan they join, reflecting that their average cost is more than double that of other annuitants. If their premium were raised, the government contribution would have to be higher to hold them harmless. As I demonstrated to OPM, it is possible to set up a system of risk adjustment using the categories of active employees, annuitants below age 65, Medicare annuitants, and annuitants over age 65 without Medicare, without any net cost to the budget or any adverse effect on any group of enrollees. The program already creates several major premium distinctions, notably the self-only versus family distinction, and the special premium schedules used by the Postal Service, FDIC, and a few other agencies.

Unfortunately, getting any reforms through the suspicions of Federal employee and annuitant groups would be very difficult. I sometimes think that Federal employees are the most resistant to change of all interest

groups in America. I suppose this is because so many administrations have, over the years, proposed benefit cuts of one kind or another.

Although the FEHBP is a superb program, and extremely well managed, it has other opportunities for improvement as well. In the remainder of my testimony I would like to discuss these, starting with the simplest and moving to the more complex.

In what follows, I am mindful that the first maxim of medicine is "do no harm". No FEHBP reform should be adopted that carries a significant risk of damaging the program. On the other hand, perhaps the program's greatest strength is its dynamic stability over time. It is a robust vehicle.

I trust that all who read this testimony will understand that its focus on reforms does not imply major problems in this program.

1. Improved brochures. The program's brochures are a model of clarity compared to the private sector and other public programs. However, in recent years they have gotten more difficult to use, for several reasons. One of these is that the addition of preferred provider networks with more generous benefits to fee for service plans has greatly increased the number of pages needed to explain benefits. In the case of Blue Cross and other plans with both high and standard options, the brochure is essentially describing five different health plans -- standard option regular fee for service, standard option preferred provider, high option regular, high option preferred provider, and Medicare wraparound. The Blue Cross brochure is now about 60 pages long; as recently as 1992 it was only 36 pages long.

What is worse, some benefits, particularly those related to preventive care, have become almost indecipherable in a number of plans. This is due in part to OPM edicts discussed below. Other provisions are sometimes hard to understand, including in some plans the mail order drugs. The single worst case of which I am aware is the Blue Cross presentation on out of network providers. This bizarre section, replete with multiple cross references that only a lawyer could follow, seems to say that Blue Cross pays 75% of a non-preferred provider's bill. In fact, the program may pay less than half of the billed charge, and this should be stated in plain

English.

2. Data for Consumers. OPM pioneered the use of national customer service surveys, in partnership with Washington Consumers' CHECKBOOK, my publisher. While others merely talked, OPM got on with the job. However, some important data have been slighted, a problem that can be remedied at almost no cost. First, OPM collects data on "quit rates" or disenrollments from the plans during Open Season. These are extremely valuable data. It matters a great deal to know that one-third of the enrollees in a particular HMO quit last year, whereas another seemingly identical HMO lost only 1 or 2 percent. (A 1996 GAO report concluded that disenrollment data would be extremely valuable to Medicare clients.)

OPM needs to strengthen its collection of these disenrollment data, and consider publishing them more widely. I would like to see them in the brochures. Data on total number of physicians affiliated with the plan, both primary care and specialist physicians, should also be published in the brochures. Many HMOs present these data in the "about this plan" section of the brochure, but many do not. While these data are not a panacea, it makes a big difference to many people whether the provider pool is a few dozen, a few hundred, or a few thousand.

3. Consumer Protections. This program has a robust and effective set of consumer protections in place. The President's recent memorandum directs OPM to add protections so that participating carriers will come into compliance with the Patient Bill of Rights (PBR) issued by the President's Quality Commission. Most of what is in the Bill of Rights is sensible, and followed by the overwhelming majority of FEHBP plans. One provision that I particularly endorse is the use of the "prudent layperson" standard for use of emergency rooms. A patient should not have to worry that the plan will bill him for an emergency visit that turned out to be indigestion rather than a heart attack.

However, there are certain provisions that carry a potential for significant mischief, depending on how interpreted by OPM. For example, the PBR would require plans to allow patients with chronic conditions, or pregnancy, to retain a physician for up to 90 days after the plan has

dropped that physician or after the patient has switched plans involuntarily. That provision could wreak havoc with sensible plan management. For example, suppose a plan terminated its contract with OPM and the patient had to change plans. The apparent meaning is that the new plan would have to contract with that patient's physicians. Since chronic conditions are quite common, many plans might be required to add any number of physicians for the 90 day period. My guess is that most health plans could not readily add these physicians before most of the 90 days were up. Many other provisions of the PBR could, if unintelligently implemented, create massive red tape and confusion. I think that OPM will "get it right", but would respectfully suggest that this Subcommittee review any new directives or procedures before they are issued.

Actions under the President's memorandum have a high potential of creating unintended effects that go far beyond Federal employees. Health plans like to have uniform procedures, and if OPM and HCFA insist on new procedures for their clients, larger changes may follow. This isn't necessarily bad, but neither OPM nor HCFA has the responsibility for evaluating system-wide effects of their actions. And with all due respect to the Commission, its PBR has not had the benefit of Congressional scrutiny and appropriate redrafting.

4. Coordination with Medicare. The FEHBP has become, since 1984, a Medicare supplement system for hundreds of thousands of annuitants. The current system is something of a patchwork, and in some respects does not make much sense. For example, annuitants with Medicare don't get any advantage from using, or pay any penalty for not using, preferred providers in fee for service plans. With almost 100 percent coverage of hospital, doctor, and drug bills when dually enrolled in Medicare and the FEHBP, there are no incentives for cost containment for this group when they enroll, as 90 percent do, in fee for service plans. I have no specific proposal to make, but would like to see OPM explore options. For example, should OPM encourage fee for service plans to add enhanced dental benefits for Medicare enrollees who use preferred providers for other services? Shouldn't annuitants with Medicare who join HMOs get some additional benefits, even if not the 100 percent coverage enjoyed under the fee for service plans? Wouldn't this be particularly desirable to encourage annuitants to use intensively managed care?

5. **Mandated Benefits.** One of the best things that OPM has done over the years is to gradually steer all of the plans toward a set of core health insurance benefits that virtually eliminate, for example, the possibility of catastrophic expense. However, in recent years OPM has gone farther. Under the watchful eye of this very Subcommittee, certain preventive benefits of great importance to women have been mandated on all plans. Last year OPM attempted to mandate a significant expansion of mental health coverage (which was very unevenly implemented, reflecting the ambiguity of the statute). Some years back, OPM sought to mandate second surgical opinions in all fee for service plans (this was a faddish idea which most plans have since dropped). And the list goes on.

There are also benefits that OPM will not let plans add, primarily for budgetary reasons. Prominent among these are additional dental benefits.

Finally, there are benefits that OPM has not mandated that I think clearly should be added. The most important of these are good coverage of diabetic supplies and equipment. Plans that discourage diabetics from joining reap a substantial windfall in reduced cost. These medically necessary services are not the kind that are abused and no plan should be able to deny coverage for them.

I have mixed views on this record. On the one hand, OPM has overwhelmingly acted responsibly and prudently. On the other hand, the temptation to meddle can become addictive. One of the greatest weaknesses of Medicare is that every benefit change is both a budgetary issue and a political issue. In the FEHBP, the standard answer is that some plan covers X, even if all don't, so that nobody is necessarily denied any needed benefit. The closer that FEHBP comes to standardized, uniform benefits, the closer it comes to denying consumer choice and to politicizing benefit decisions that plans are probably better able to make than anyone else.

One important side issue is that in the preventive area benefits have become so messy and confusing that it takes the patience of Job to sort out which plan is better for what. This complicates consumer choices.

My conclusion is that this Subcommittee should continue vigorous oversight, and if necessary take OPM "to the woodshed" if it errs on either side -- neglecting vital benefits or mandating benefits for the fad disease of the month.

6. Allowing More Plans to Join. HMO plans may join this program virtually at will, simply by applying to OPM and demonstrating that they are responsible and sound entities. Fee for service plans cannot join without an act of Congress. This discriminatory treatment has no sound basis. In fact, in an era when about 99 percent of enrollees are in managed care plans, and Point of Service HMOs like Prudential and United offer opt-out benefits on schedules that are almost indistinguishable from those used by Blue Cross, it is not even clear that there is any meaningful distinction between HMOs and fee for service. I think that the relevant distinction is between national and local plans, and that the law should be changed to allow or require OPM to consider adding new national plans each year.

If this general reform were made, high deductible plans could join the program. I appreciate that there are additional issues involved in Medical Savings Accounts (MSAs), and that additional legislation might be needed to provide for these, such as H.R. 3166. However, the main point is that the structure of the program should allow for new national plans, and the Congress should not have to enact legislation each time a plan is added.

With respect to MSAs, I see no reason why an MSA should not be an option in the FEHBP. There is a theoretical possibility of risk selection, with many analysts concerned that the young and healthy would disproportionately join an MSA. On the other hand, if the middle-aged manager in a high tax bracket joins, risk selection may go in the opposite direction. There is only one way to find out ~~who~~^{how} an MSA option will work in the FEHBP -- try it.

OPM may be concerned that the risk of adverse consequences to the program is too great. I am not persuaded, if for no other reason than the extreme conservatism of Federal employees when it comes to benefit matters. A decade ago, only about 3 percent switched to FERS, when half

or more should have done so had they properly understood the financial benefits and costs of that decision. And the anticipated stampede to MSAs in the private sector has conspicuously failed to occur. But to assuage such fears, it would not be difficult to construct an option that restricts potential membership to some modest level or, even better, that gives OPM the right to adjust premium and contribution levels to reflect the actuarial experience of those who join.

7. Adding a Long-Term Care Option to the Federal Fringe Benefit Package. This is not, strictly speaking, an FEHBP matter at all. Nonetheless, I wanted to call to the Subcommittee's attention the possibility for a new fringe benefit -- long term care -- that can be entirely employee financed, and hence budget neutral, while significantly expanding one type of health protection in old age. The State of California has introduced such a benefit with great success. I understand that OPM and HHS have a joint task force working on this issue, and you may want in the future to consider legislation, to hold hearings, or both.

8. Expanding the FEHBP to More Enrollees. The many proposals to expand the program to more groups pose interesting problems and opportunities. I will restrict my analysis to two possibilities. First, just last month David Kendall proposed using the FEHBP, rather than Medicare, for the Clinton Administration buy-in proposal. That proposal would benefit persons in their 50s and 60s who are not yet eligible for Medicare. I think Kendall's real proposal is to reform Medicare in the direction of FEHBP, which is a reasonable idea though there are many devils in the details. The Balanced Budget Act goes a significant way in that direction.

The idea of enrolling individual citizens in the FEHBP makes very little sense. Most fundamentally, of course, this is a fringe benefit for Federal employees, annuitants, and dependents. If it is such a good model, and I think it is, why not create a "clone" of the program for additional groups? With appropriate risk pooling policies, such a program could be both effective and inexpensive.

But there is another issue that all such proposals must deal with: who will accept applications and process and collect premiums--the transactions costs of enrolling individuals? The FEHBP has only 150 full-time

equivalent employees for several reasons -- one of which is that the detailed work of enrollment and payment piggybacks on the payroll system. It would be a massive undertaking to create some additional mechanism for enrolling private sector individuals. Based on private sector experience, this could cost in the neighborhood of 5 to 10 percent of premiums.

Another proposal is much more viable, and seemingly within the mission of the FEHBP. H.R. 1631, the "Military Health Care Choice Act of 1997," would expand FEHBP coverage to military dependents and military retirees. These persons are, in fact, essentially as close conceptually to General Schedule dependents and annuitants as those of the Postal Service or Foreign Service. A great deal of evidence suggests that the present arrangements for giving them health care are unpopular and flawed. There is also a substantial equity issue involved. At present, military retirees over the age of 65 obtain Medicare, but no government arranged or subsidized wraparound to fill the major gaps in Medicare. In contrast, civilian retirees with Medicare obtain essentially 100 percent coverage.

As an administrative matter, military dependents or retirees could be folded into the present system with simplicity. Their premiums would simply be handled through military payroll and annuity systems. Assuming that these individuals had appropriate risk pools or premium cost-sharing arrangements, there need be no financial downside for the FEHBP. In this regard, consideration should be given to constructing a new risk pool for family coverage with one adult and minor children, to occupy a spot between self-only and family coverage. Of course, enrolling all of these persons would involve a massive expansion of the program, by 50 percent or so.

In sum, from the perspective of the FEHBP, there would appear to be no crippling problem in enrolling all or most of these individuals or, as provided in H.R. 1631, a phased conversion of a group limited to several hundred thousand. In a phased approach, preference could be given to individuals who do not live near a military base with substantial medical services.

The problem with putting all of these individuals into the FEHBP lies in its potential cost to, and effect on, military medicine. A 1995 Congressional Budget Office Study, "Restructuring Military Medical Care," focused on the major issues that abolishing CHAMPUS/Tricare would involve. That study suggests that mission critical medical care could actually be improved with restructuring, although one-time costs would be significant. The CBO study concluded that the cost of FEHBP enrollment would be about \$7 billion annually, but that DOD could realize savings of \$9 billion annually through restructuring. The cost savings could be used to enrich the government premium share for this group, since most military dependents and annuitants do not now pay any premiums at all.

Clearly, an employer who sponsors both one fringe benefit health insurance program that does not work well and another with deserved rave reviews, should consider abolishing the former and placing all enrollees in the latter. Of course, the Subcommittee and the other Committee of jurisdiction would need to consider the entrenched opposition of the health care bureaucracy within DOD and the attendant likelihood of success, before making a great investment of time.

Based on the above analysis, I conclude that despite the performance of the FEHBP there are many opportunities both large and small for improving the program. I hope that both OPM and the Congress will select judiciously among these.

That concludes my prepared testimony. I would be happy to answer any questions.

Mr. MICA. Thank you, Mr. Francis and also Mr. Gammarino for your testimony. I have a few questions.

I think you heard the thrust of some of my concerns to Mr. Flynn and OPM, that they estimate this is going to cost us \$32 million. First Mr. Gammarino, you serve as the very large portion, you're the biggest provider aren't you, 40 percent, our biggest carrier?

Mr. GAMMARINO. That's correct, 43, 44 percent of the enrollees.

Mr. MICA. What's your estimate of their guesstimate?

Mr. GAMMARINO. I have no idea. I'd be afraid to guess.

Mr. MICA. Do you think it is high or low for compliance, based on what you've seen?

Mr. GAMMARINO. It's going to be millions, I know that. I think it depends on which level, as Mr. Francis pointed out. What level of information are you going to require, how often are you going to update it. To think that this information is going to be current by the time it gets to the consumer is a little naive. It's going to be outdated as soon as it hits the street.

Mr. MICA. So, we're providing a mandate for data which, you are saying is out of date, or will be outdated when it's available.

Mr. GAMMARINO. Well, you're going to have office hours, or whether or not they have an interpreter. All of those things can change weekly, daily, monthly.

Mr. MICA. The other thing too. Now you're big players and there are dozens and dozens and dozens of other small players. You are able to absorb some of the costs. Don't you think it is going to be difficult for some of the smaller players to absorb some of the paperwork or data collection costs?

Mr. GAMMARINO. We all are or will all have difficulty. You know, I have an administrative cap. I look forward to the OPM giving me an adjustment in my administrative cap to pay for this. I'm not sure I am going to get it. I'm not sure the other carriers are going to get relief either.

So you are going to have to figure out a way to pay for this, most likely—

Mr. MICA. So, indirectly if you don't increase the administrative cap, then something else has to give?

Mr. GAMMARINO. In my case it will.

Mr. MICA. OK. Mr. Francis. I was intrigued by what you said by the size of the brochure, I guess, that is provided now on some of these benefits. You said it went from, 32 to 64 pages?

Mr. FRANCIS. Sixty, I think.

Mr. MICA. I'm sorry?

Mr. FRANCIS. Sixty.

Mr. MICA. Sixty. If you were going to guess how many people read all 60 pages, what would you say? I mean I have to say I've never done it. I've been thinking about taking it home several times and reading it, may have even carried it home, but I don't think I've gotten too far into it.

What do you think? Am I atypical, maybe?

Mr. MICA. No, you're not, sir. I think, really, despite the example, and Blue Cross has a particular problem because they are one of the most complex plans and they really offer five different plans, they have to describe in one brochure because there is the high option, the standard option, the PPO, the non-PPO, the MediGap

wraparound, and so on, but the fact is it's gotten more complex, in part because of mandated benefits. It has gotten more complicated to describe because of the benefit structure in this program in recent years.

I think, in general, the program's done a pretty good job, I'm just saying it could do an even better job and one of the concerns over the Patient Bill of Rights would be that we grow those brochures unreasonably with less important information.

Mr. MICA. Well, one of the problems I think you're saying is the presentation of information is not really conducive to employees making good judgments or getting at the core of what they really need to know.

Is that correct?

Mr. FRANCIS. I think the goal of both OPM and the plans has been to make that information clear and direct and in a way that consumers can actually use to answer their questions.

Mr. MICA. Is it there in that form now?

Mr. FRANCIS. Pretty much. They do a good job.

Mr. MICA. And did I hear someone say, I wasn't sure which one, that patients can call and ask and get up-to-date, basically the kind of information that is being required under the bill of rights already. Did you say that, Mr. Gammarino?

Mr. GAMMARINO. Yes, sir. I mean how you implement this thing, I think, is critical. Why create a middle person in this transaction? For our product the consumer, the subscriber, can actually talk directly to the provider, believe it or not. So at any given time, if you want information, you can go direct. We do not salary our providers; we don't have a staff model HMO, we don't control these providers. That's part of the individual choice. In going to our product you get that direct access, so why create a bureaucratic, central information house that is going to be, I think, costly? The ability to keep it current is going to be almost impossible, when you can go directly to the source—the provider of care—and that is what people like about this program.

Mr. MICA. Mr. Francis, I think you indicated that there were some good ideas in the Patient Bill of Rights, but you thought there might be other ways that you could implement getting that information out, or compliance. I think you said there were some good requirements, but other ways to get the information out. Was that correct?

Mr. FRANCIS. That is correct sir. That is one of my points. I think the Patient Bill of Rights was written by a group of very well informed and very well intentioned experts in health insurance, and it addresses real and genuine concerns.

The problem is that it is not what I would call a good regulatory standard as written. There are certain problems that occur so rarely that there are different ways to approach it. For example, Mr. Flynn's testimony mentioned that he thought the drive-by mastectomy issue was simply a nonissue in this program and this program covers the majority of the HMO providers in the Nation.

I think that the Patient Bill of Rights has excellent ideas. I think that the general principles it espouses are excellent. Some of the particular proposals it makes are excellent, but that some of them will create substantial difficulty in the real world and ought to be

either amended, at some point as, I suspect, the Congress takes that up possibly as a piece of legislation, or at least implemented in a flexible manner.

Mr. MICA. Well, I am a little bit concerned. You know, sometimes you label things. I've always been for the bill of rights, I've never had anything against the bill of rights, and I want that to be part of the record. But if we relabel this the manifesto mandates for additional paperwork, we might get a different opinion about its value. Sometimes we title these proposals with a very nice cover, but their practical application implementation can be not what it was intended.

I am going to yield now to our ranking member, Mr. Cummings.

Mr. CUMMINGS. Thank you very much. You testified that your company already complies with many of the provisions of the health care Consumer Bill of Rights. Can you give me examples of what you are talking about?

Mr. GAMMARINO. Well, on the information side, providing benefit information, we comply through that 60-page document that Mr. Francis talked about.

Access to emergency room services. We don't have any limits. You can go directly to emergency rooms so we don't have any restrictions there. The appellate process, we believe that the process now that the Government has in effect that allows people to go to an external agency, their employer, complies with the intent of the law.

The confidentiality issue with information that we maintain and retain on our subscribers has been there for years with the Government, so those are a couple of examples.

Mr. CUMMINGS. What about ways that you don't comply?

Mr. GAMMARINO. Well, I think, the biggest one is the information that appears to be required on the provider itself. You know, the every waking moment of the provider; what I have to give in terms of his office hours; how he is compensated, and how many languages he or she may speak. Something I don't comply with today.

Mr. CUMMINGS. And I take it, just listening to your answer, you don't think it is a very good idea.

Mr. GAMMARINO. I don't think it is an added value. And I don't think so for \$17 million. I would propose we save the taxpayers that expense and allow the consumer to actually call that provider that they work with today.

Mr. CUMMINGS. You think they'd be able to get that kind of information by calling in?

Mr. GAMMARINO. I think they get it today. I don't—

Mr. CUMMINGS. Go ahead, I'm sorry.

Mr. GAMMARINO. I think they get it today, if you call your provider.

Mr. CUMMINGS. Well, I have Blue Cross and Blue Shield and I don't think I can get that kind of information. I have enough problems getting the doctor on the line, as I tried to do this morning, so I beg to differ with you.

You stated that it must be assured changes to accommodate the bill of rights must not undermine the value of your PPO product. How might full compliance with the bill of rights adversely affect the value of your PPO?

Mr. GAMMARINO. Well, let's make sure we have a common frame of reference. The Blue Cross and Blue Shield program is not one single company. We are a confederation of individual companies that carry the name and the mark. So among the almost 60 different corporations, they have secured local contracts with providers and that information is proprietary to the plans who negotiate that agreement with the providers. In many cases neither the plans or the providers want that information made public. It's confidential. And we and the taxpayer enjoy the discounts associated with those private agreements.

This provision would require, depending on how you would interpret it, the details of that contractual relationship to be made public. And that could cause a significant problem and burden in terms of our contractual obligations that the plans have with their providers.

Mr. CUMMINGS. You know one of the things, I guess, that concerns so many consumers is when they need medical care that they have to jump through so many hoops to get it. You know it is real easy, I guess, when you are not in that situation, but you come to a point, as in my office, we find ourselves spending a lot of time negotiating, trying to help people who can't get the very treatment that they think they paid for. In many instances I think they have.

So I think there's a lot of frustration; I guess that is part of the reason why this bill of rights came forward. You've got a lot of very, very angry people. There is no issue that I, well, there may be one or two that rank about the same, but when it comes to this health care issue, it's just a major thing with a whole lot of people and it's greater than I ever even knew.

I mean when I go to my town hall meetings, I hear it. If I get 30 questions, I guarantee you, at least 12 of them are about somebody's complaining about being able to get access to service.

And that takes me to you, Mr. Francis.

You testified that the FEHBP suffers from competition dominated by risk selection artifacts and that the legislation to address this would be controversial.

Could you explain that to me?

Mr. FRANCIS. I'd be glad to, sir. In my written testimony, I focused at some length on risk selection issues as they affect this program. And I think that they do. There's almost no issue, reform, or practical aspect of this program, for which one doesn't have to at least ask: Is there a risk selection aspect to it?

I don't think it's a large problem in this program, and the point I was trying to make is that while it exists, it is not substantial. This program is dynamically stable over time, it's handled risk selection very well, despite the fact that it wasn't designed to do so, and it could be designed a little better.

The problem is that to do it right probably would require legislation and probably would require amending the benefit formulas and as I'm sure all of you know, if you're experienced with the fair share formula, that is not something lightly even to be considered. Therefore, I was not recommending that you seek to change the program at this time, but just that, to be aware that these issues lurk around. For example, the proposal to add more groups to the program could have an impact on risk selection.

Mr. CUMMINGS. Also complaints that the benefit standards tend to deny consumer choice and politicize benefit decisions. Can you explain that?

Mr. FRANCIS. Yes, sir. My best example is one from Medicare because I think it illustrates the difference between what I call politicize and a market-driven approach. I suppose I meant it pejoratively in this context, but of course, I don't mean there isn't a proper role for the political process. When the Medicare catastrophic coverage bill was enacted some years back it, among other things, added drug coverage to the Medicare Program, and was to be financed by a premium increase which, on couples, was going within a year or two to be about \$2,000. There was a famous incident when a lady in Chicago threw herself across then-Chairman Rostenkowski's—of the Ways and Means Committee—car in protest at this legislation that Congress had enacted.

The perceived pain far exceeded the perceived gain.

And, in fact, that law was repealed within a year. Well in this program, the program has been painlessly improved over the years, partly by competition among the plans, partly by guidance from OPM, and things like covering prescription drugs just don't arise as an issue. And there are other possible examples. Mental health coverage is a contentious coverage, and so on.

The problem is if you have to make a legislative decision as to whether every plan covers a benefit, it enters a whole different arena. Do we really want the Congress spending its time, for example, deciding whether or not acupuncture should be a covered benefit?

In this program, some plans offer acupuncture; some do not. And people who really want to use acupuncture for pain control can find a plan that gives them that benefit.

Mr. CUMMINGS. Let me ask you one other question. OPM has claimed that mandates have only minimal impact with regard to program costs, while Mr. Gammarino says that they cost his company over \$100 million. I think he said. Is that right?

Mr. GAMMARINO. Yes, sir.

Mr. CUMMINGS. What's your view?

Mr. FRANCIS. I believe they're both right. Remember, this is a \$17 billion program. A 1-percent change sounds like pretty small change. That's only 1 percent on the margin. But in this program, that's \$170 million. OPM, by the way, is very acutely sensitive to these issues. They agonize over these issues and they actually make cost calculations such as, if we did X, what would it cost, knowing that seemingly small changes can have big overall dollar consequences.

And Blue Cross, with 40 percent, roughly, of the program, feels those most acutely. So I'm not surprised at either way of characterizing the same phenomenon.

Mr. CUMMINGS. I take it you move around quite a bit and talk to various groups with regard to health plans, is that right?

Mr. FRANCIS. Yes, sir.

Mr. CUMMINGS. Have you received any feedback from the FEHBP consumers about the new coverage mandates that went into effect this year?

Mr. FRANCIS. Little or none. I think obviously there are always some individual consumers who feel particular need for something, and in fact, what I hear more feedback on are benefits that haven't been mandated, things that people want to see in this program they can't get. For example, artificially assisted reproductive technology is generally not covered in this program.

I think generally, there is little dissatisfaction with coverages in this program. In a way, it is not surprising precisely because people do get to pick their plan and do get some freedom on the margin to pick the benefit package that best suits them.

In comparison, when I occasionally hear from a person in CHAMPUS, the military dependents, I can't believe it. It's like they are on another planet; the pain that they express. You don't hear that in this program.

Mr. CUMMINGS. Overall, what's the complaint, I'm not just limiting it now to mandates but about complaints in general. What would you say is the No. 1 complaint that you hear about this program, if any?

Mr. FRANCIS. I'm going to answer that by saying they are two and they go together.

Mr. CUMMINGS. OK. That's fine.

Mr. FRANCIS. People often want to see more and better benefits; that's one reason they don't complain about mandates. And they want the premiums to go down, not up.

Unfortunately those two goals are in direct competition with each other and it is that tension which leads to that dual complaint.

Mr. CUMMINGS. Thank you very much. Thank both of you. I really appreciate it.

Mr. MICA. Thank you. Mr. Gammarino, in your testimony you said, we're especially sensitive to not becoming the one carrier that can afford to offer certain benefits but is required to defer changes, while other carriers are permitted to institute benefit designs or make changes deemed necessary to ensure their survival.

You have expressed here concern that your organization may not be permitted to add or drop benefits on the same basis as other carriers. Could you give us examples? Has this happened in the past?

Mr. GAMMARINO. We think it happened last year. We wanted to modify our pharmacy benefit design and we were not allowed to, and we noticed that some other carriers did make the type of design changes we were looking for. So it is a concern as we go forward that we be allowed to be flexible.

Mr. MICA. Well, I guess you have the tail that is wagging the dog somewhat; you being the dog, the others the tail? What do you think? Is that happening?

Mr. GAMMARINO. Well, from my end, it is. Yes.

Mr. MICA. Mr. Francis, you commented about military retirees and their families and dependents and benefits of CHAMPUS, and I think you said they might just as well be on another planet. And there is great criticism. One of the proposals that I've made and consistently advocated is that we open up FEHBP to some of these folks and replacing or substituting CHAMPUS or TriCare coverage.

If we offered this kind of an option to these folks, do you think it would do any harm to FEHBP?

Mr. FRANCIS. I don't believe it would harm FEHBP at all, sir. I think it would be, as these things go, easy to integrate those people into the FEHBP. I'm assuming that the legislation would be appropriately crafted and people had thought through, you know, all of the problems, but there is no inherent problem. This program almost runs itself and adding more enrollees is not, in and of itself, a strain on the program.

I think the big problems would be on the military side where they would be forced effectively to restructure military health care which now is predominantly focused on family care not on, if you will, battlefield care. There would be big changes to be made on that side of it.

Mr. MICA. Two other questions, one dealing with HMO's. Right now we have HMO's being eligible to enter the FEHBP and fee-for-service plans are basically locked out by statute. Some have suggested opening FEHBP to additional categories of plans that are now prevented from participating.

What's your opinion on this approach?

Mr. FRANCIS. I would recommend it. In the first place I don't think the distinction between fee-for-service plans and HMO's is even that big a distinction any more in these days of managed care. If you look at a HMO with what is called a point of service or opt-out benefit, it looks to me an awful lot like Blue Cross. In fact the main difference is almost that it is local and Blue Cross is national.

There is no particular reason, it seems to me, why additional plans shouldn't come into this program. I wouldn't expect great things to happen from that. Last time a group of plans came in, most of them exited pretty quickly.

But innovation is always to be desired, and if they are good competitors that can be offering good options to Federal employees, why not let them in?

Mr. MICA. Since you have also a rather broad prospective and viewpoint, what's your opinion about opening the program to MSA's?

Mr. FRANCIS. Same answer. I think MSA's were expected to do great things in the private sector and in Medicare and haven't done much. My own hunch is that they wouldn't do all that well if offered in this program, but by the same token they wouldn't be disruptive to the program. But they are a potential option, and some people would prefer them. Why not let them in?

Putting on my economist hat, there is a serious concern—and this is back to my risk-selection point—there's a serious concern that an MSA can cause risk selection to be destabilizing to a program. Alain Entoven, for example, is very concerned about that.

Really, any high-deductible plan, whether or not it's technically an MSA, could cause this phenomenon. On the other hand, as Mike O'Grady of the MEDPAC Commission said in a meeting the other day, there is good reason to think that a lot of Federal employees joining MSA's might be older people in higher tax brackets with higher medical expenses. And maybe the risk selection would go the other way. There's only one way to find out whether its going to be a problem and that's to try it.

The legislation could limit the number of people that enrolled as we've done in other contexts. I think there are plenty of ways to

make reforms prudently that don't risk damage to the FEHBP. I think it is extremely important not to break something that ain't broke. But that, by the same token, is no reason not to welcome carefully constructed reforms.

Mr. MICA. And I thought you did say that it could be done on a limited basis to see how—

Mr. FRANCIS. Sure, that would be a simple, prudent way to proceed.

Mr. MICA. So, you're basically endorsing my proposal?

Mr. FRANCIS. Absolutely.

Mr. MICA. Thank you. [Laughter.]

It took a while to get it out of you. And we're going to have MSA's in some fashion in the program. Not that Mr. Mica or Mr. Cummings mandated it, but it has been mandated at a much higher authority and pay-grade level, and will come to pass. So we'll try to do it in a responsible fashion.

Let me go back to Mr. Gammarino for a second. You were with us in October, and you said at that time that your plan might suffer from adverse selection during open season. Can you report to us today what's taken place? Do you have any comments?

Mr. GAMMARINO. I can't report definitely. Going back to October, I told you we did anticipate, because of how we rated and the changes occurring, that we would have some adverse selection. It's too early to say what the results are. We did rate for some adverse selection, and given what I know about the results to date, I would say right now that we are probably OK. In terms of whether we rated properly and whether or not we did better or not, we won't know that for a few months—until we get some type of experience with these new enrollees.

Mr. MICA. Well, if you find out that you did better than you anticipate, is there the potential for looking at reduced premiums?

Mr. GAMMARINO. Well, certainly, that would factor into how we would rate the program for 1999.

Mr. MICA. Overall, based on your experience to date, this year, what are we looking at as far as potential increase or decrease in premiums?

Mr. GAMMARINO. I think it's going to be hard to have any decrease in premiums. I don't have a crystal ball, but you only have to pick up the Wall Street Journal every week and see the health plans that are in trouble; the health plan that didn't rate properly; the health plan that lost money last year, and didn't rate for that loss in 1998. So I think for a lot of plans, health plans, both inside and outside of this program, you are going to see rate increases that have been higher than in recent years.

Mr. MICA. And based on what you've heard from the proposed call letter and the administration's proposal for Patient's Bill of Rights. Is that going to increase or decrease your costs?

Mr. GAMMARINO. Well, it will increase our costs.

Mr. MICA. And any estimate? Again, do you think this is something you can analyze at this point?

Mr. GAMMARINO. It's too early.

Mr. MICA. Mr. Flynn estimated, I think he broke it down to pennies per week.

Mr. GAMMARINO. We have not received the call letter, so we have not had the opportunity to do our own cost analysis?

Mr. MICA. But there will be some substantial costs due to paperwork and other compliance in what has been proposed in the Patient's Bill of Rights?

Mr. GAMMARINO. The way it's been described by OPM, yes, we think that's the case.

Mr. MICA. Well, I don't have any further questions at this point. Did you have anything Mr. Cummings?

I do want to thank both of you. I do have some additional questions I'd like to submit, particularly to Mr. Gammarino and also to Mr. Flynn. We will be doing that. We will keep the record open for a period of 2 weeks for additional comments. There being no further business before the House Subcommittee on the Civil Service, this meeting is adjourned.

[Whereupon, at 3:07 p.m., the subcommittee adjourned subject to the call of the Chair.]

[Additional information submitted for the hearing record follows:]

**BLUE CROSS BLUE SHIELD FEDERAL EMPLOYEE PROGRAM
SUGGESTED VOLUNTARY COMPLIANCE WITH
THE CONSUMER BILL OF RIGHTS**

Statement of the Right	Suggestion for FEP Voluntary Compliance	Suggested Compliance Schedule and Issues
<p>I. INFORMATION DISCLOSURE</p> <p><i>Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.</i></p> <p>HEALTH PLAN INFORMATION</p> <p>A. Benefits, Cost Sharing, and Dispute Resolution</p> <p>Consumers should receive the following information about a health benefits plan:</p> <p>(1) A general summary of all covered benefits, including: General limits on coverage, including any annual or lifetime limits, as well as limits for specific conditions Whether preventative services are covered. Whether a drug formulary is used and, if so, how decisions are made pertaining to inclusion of drugs, particularly new drugs (including a process to consider exceptions). How drugs, devices, and procedures are deemed experimental.</p> <p>(2) Enrollee cost-sharing, including employee or beneficiary premium contributions, deductibles, copayments, and coinsurance.</p> <p>(3) Type and extent of dispute</p>	<p>Information is already disclosed in the brochure, except for disclosure of use of formulary and determination of experimental drugs.</p> <p>Additional information regarding use of formulary and determination of experimental drugs can be disclosed in the brochure</p>	<p>Suggested Compliance Schedule:</p> <p>Additional information can be included in the 1999 brochure.</p>

Statement of the Right	Suggestion for FEP Voluntary Compliance	Suggested Compliance Schedule and Issues
<p>resolution procedures available in the event of a dispute.</p> <p>B Health Plan Characteristics and Performance Information.</p> <p>Consumers joining or considering whether or not to join a health plan should receive information about:</p> <ol style="list-style-type: none"> (1) State licensure status, Federal certification, and private accreditation status (including publicly available reports). (2) Consumer satisfaction measures (3) Clinical quality performance measures (4) Service performance measures (e.g., waiting time to obtain an appointment with primary care providers and specialists). (5) Disenrollment rates (adjusted for involuntary disenrollment and other relevant factors). 	<p>Suggested compliance:</p> <ul style="list-style-type: none"> • (1) Provide consumers with a brochure or fact sheet regarding Plans' State licensure and any Federal certification or accreditation status; • (1) Inform consumers where they can obtain publicly available accreditation reports; • (2) OPM consumer satisfaction survey can be used to satisfy this requirement. • (5) Provide disenrollment rates by product line 	<p>Suggested Compliance Schedule</p> <ol style="list-style-type: none"> (1) Develop for distribution for 1999 season. (5) Data available for 1999 season once issue resolved. Data would be provided by FEPCO (see issue below). <p>Compliance Issues:</p> <ol style="list-style-type: none"> (3) In measuring quality, different measurements will be required for the different products: POS and PPO. Each product has different controls for monitoring and managing costs. The POS product generally has greater controls designed to manage care, control costs, effect outcomes, and manage provider networks. Such controls are limited under the PPO/indemnity product. The PPO product is not designed as a managed care product and is merely a network of pricing agreements between Plans and providers. This product is distinguishable from HMO-type products and cannot be measured for quality and performance in the same manner. <p>Currently, clinical quality measures are not measured for the PPO product across the industry. Without such industry standards, performance would be impossible to measure.</p> <ol style="list-style-type: none"> (4) Consumers are the best evaluators for what constitutes quality and good service for customers. OPM currently uses a survey tool. In the absence of standardized clinical and service

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Statement of the Right	Suggestion for FEP Voluntary Compliance	Suggested Compliance Schedule and Issues
<p>Additional information that should be made available upon request includes:</p> <ol style="list-style-type: none"> (1) Number of years in existence. (2) Corporate form of the plan (i.e., public or private; nonprofit or for-profit ownership and management) (3) Whether the plan meets requirements (State and Federal) for fiscal solvency. (4) Whether the plan meets standards (State, Federal, and private accreditation) that assure confidentiality of medical records and orderly transfer to Caregivers 	<p>Suggested Compliance: Statement describing the Service Benefit Plan in the context of the FEHBP. FEHBP is administered by the Office of Personnel Management and is governed by its own laws and regulations which address relevant issues including confidentiality and preempts state laws.</p>	<p>(5) Need to clarify what type of adjustments will be required and define "other relevant factors."</p> <p>Compliance Schedule: Include broad statement in the 1999 brochure as standard information</p>
<p>C. Network Characteristics. Consumers should receive:</p> <ol style="list-style-type: none"> (1) Aggregate information on the numbers, types, board certification status, and geographic distribution of primary care providers and specialists (2) Detailed list of names, board certification status, and geographic location of all contracting primary care providers; whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether facilities are accessible to people with disabilities. 	<p>Suggested Compliance:</p> <ul style="list-style-type: none"> • (5) (6) (7) The Brochure currently contains information regarding rules about coverage of out-of-network services and applicable cost sharing; whether referrals are necessary to access specialty care, and what options exist for 24 hour coverage and whether enrollees have access to urgent care centers. • (1)(2) Information on contracting POS PCPIs is currently updated annually in the provider directory, containing information on geographic location. However, information regarding board certification, whether the 	<p>Compliance Issues:</p> <ol style="list-style-type: none"> (2) To maintain database of this information would be costly and administratively burdensome to maintain on a current basis, which would be required in order to provide value to the consumer. Where information is currently not obtained, suggest consumer be directed to provider for information to avoid costly and administrative burden of collecting and maintaining information. <p>This information includes:</p> <ul style="list-style-type: none"> • board certification status • acceptance of new patients • languages spoken • availability of interpreter services • accessibility for people with

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<p>(3) Provider compensation methods, including base payment (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withhold, etc.).</p> <p>(5) Rules regarding coverage of out-of-network services, and applicable rates of cost-sharing.</p> <p>(6) Information about circumstances under which primary care referral is required to access specialty care.</p> <p>(7) Information about what options exist for 24-hour coverage and whether enrollees have access to urgent care centers.</p>	<p>PCP is accepting new patients, and language(s) spoken is currently not obtained. Suggest information be made available by provider.</p> <ul style="list-style-type: none"> (1) (2) In instances where information is currently not obtained by the Plans, we would direct the consumer to the provider. To gain the support of the providers and to encourage active participation, we would engage in a provider-directed education program to educate and to inform providers of their obligations under the Bill. To obtain the most current information available, we would direct the consumer to either call the Plan directly and/or to the Website. The Website would be utilized for up-to-date information. Provider directories would continue to be updated annually. 	<p>To protect the proprietary market information, we suggest compensation information be communicated generically. For example, in the 1989 and future Brochures and/or the provider directory, a general statement can be included such as:</p> <p>Our network of providers are typically reimbursed using reimbursement methodologies such as percent of charges, DRG's, capitation, withhold, bonuses, case rates, fee schedules, and UCR.</p> <p>(3) Detailed compensation methodologies considered proprietary information. Disclosure of such information could jeopardize competitive position in local Plan areas. Provider contracts typically prohibit disclosure of such information.</p>
<p>Additional information that should be made available upon request includes:</p> <p>(1) Detailed list of names, board certification status, and geographic location of all contracting specialists and specialty care centers;</p> <p>(2) Whether they are accepting new patients; language(s) spoken and availability of interpreter services; and whether facilities are accessible to people with disabilities.</p> <p>(3) Detailed list of names, accreditation status, and geographic location of hospitals,</p>	<p>Suggested Compliance</p> <p>The provider directory currently includes the list of all participating providers in the network. The information includes the geographic location and specialty. We would continue to provide this information. For up-to-date information, we would utilize the Website.</p> <p>Additional information required by the Bill is best provided by healthcare professionals. We would direct the consumer to the provider for this information.</p>	<p>Compliance Issues:</p> <p>Would impose substantial cost and administrative burden on Plans to collect and maintain information.</p> <p>While provider contracts can not compel provider to disclose information, the most practical solution is to direct consumers to the provider for specific detailed information.</p>

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<p>home health agencies, rehabilitation and long-term care facilities, whether they are accepting new patients; languages spoken and availability of interpreter services; and whether they are accessible to people with disabilities.</p>	<p>To gain the support of the providers and to encourage active participation, we would engage in a provider-directed education program to educate and to inform providers of their obligations under the Bill.</p>	<p>Compliance Issues:</p> <ul style="list-style-type: none"> (2) Clinical protocols, practice guidelines and utilization review procedures are considered proprietary by Plans. <ul style="list-style-type: none"> • in some cases, information may be copyrighted and Plan would be barred from disclosure. <p>Suggested Compliance Schedule:</p> <ul style="list-style-type: none"> (1)(3)(5) Information available upon request. (2) Suggest current practice to release high level general information upon request be preserved and continued contemporaneously. (4) Modify 1999 brochure
<p>D. Care Management Information Information in this category that should be available upon request includes:</p> <ol style="list-style-type: none"> (1) Preauthorization and utilization review procedures followed (2) Use of clinical protocols, practice guidelines, and utilization review standards pertinent to a patient's clinical circumstances. (3) Whether the plan has special disease management programs or programs for persons with disabilities. (This information should indicate whether these programs are voluntary or mandatory or if a significant benefit differential results.) (4) Whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers. (5) Qualifications of reviewers at the primary and appeals levels 	<p>Suggested Compliance:</p> <p>Upon request, the following information would be disclosed verbally. Should written information be requested, appropriate communication would be used (correspondence, available pamphlets, Brochure).</p> <ol style="list-style-type: none"> (1) (2) Disclose general description of how such procedures are used in the decision making process (3) Disclose and describe disease management program where applicable, how used and objectives of the program. Indicate that participation is voluntary and is designed to help the consumer manage the disease (4) The Brochure would be modified to include additional disclosure of the use/description of the open formulary. The Brochure currently includes a disclosure on the Preauthorization requirement. (5) The general qualifications of the reviewers for reconsiderations and internal appeals at the Plan would be communicated to the consumer upon request. The appeals process is currently described in the Brochure. Because the 	<p>Compliance Issues:</p> <ul style="list-style-type: none"> (2) Clinical protocols, practice guidelines and utilization review procedures are considered proprietary by Plans. <ul style="list-style-type: none"> • in some cases, information may be copyrighted and Plan would be barred from disclosure. <p>Suggested Compliance Schedule:</p> <ul style="list-style-type: none"> (1)(3)(5) Information available upon request. (2) Suggest current practice to release high level general information upon request be preserved and continued contemporaneously. (4) Modify 1999 brochure

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<p>HEALTH PROFESSIONAL INFORMATION</p> <p>All consumers should receive information on:</p> <p>(1) Whether the health professional's ownership or affiliation arrangement with a provider group/institution would make it more likely that a consumer could be referred to a particular specialist or facility or receive a particular service.</p> <p>(2) How the provider is compensated including base payment method (e.g., capitation, salary, fee schedule) and types of additional financial incentives (e.g., bonus, withhold).</p>	<p>Suggested Compliance:</p> <p>(1) This information should be provided by health professionals. The health professional should disclose their affiliation with other provider/institutions/facilities. As well as to disclose any preference for a particular referral location. To the extent that a local Plan has an affiliation arrangement with a health professional, this information could be disclosed in provider-related literature.</p> <p>To gain the support of the providers and to encourage active participation, we would engage in a provider-directed education program to educate and to inform providers of their obligations under the Bill.</p> <p>(2) This information would be disclosed in general information in the provider directory/Brochure as described above. Detailed and specific information by provider would not be disclosed.</p>	<p>Compliance Issue:</p> <p>(2) Detailed compensation methodologies considered proprietary information. Disclosure of such information could jeopardize competitive position in local Plan areas. Provider contracts typically prohibit disclosure of such information.</p> <p>To protect the proprietary market information, we suggest compensation information be communicated generically (see page 4)</p>
<p>Consumers should receive upon request the following information on CBR0224 doc 3/5/97</p>	<p>Suggested Compliance</p>	<p>Compliance: No obligation</p>

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<p>health professionals:</p> <ol style="list-style-type: none"> (1) Education, board certification, and recertification status. (2) Names of hospitals where physicians have admitting privileges. (3) Years of practice as a physician and as a specialist if so identified (4) Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity. (5) Consumer satisfaction measures. (6) Clinical quality performance measures. (7) Service performance measures (8) Accreditation status (if applicable). (9) Corporate form of the practice (i.e., public or private, nonprofit or for-profit, ownership and management, sole proprietorship or group practice). (10) The availability of translation or interpretation services for non-English speakers and people with communication disabilities. (11) Any cancellation, suspension, or exclusion from participation in Federal programs or sanctions from Federal agencies; any suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges. 	<p>This information should be provided by health professionals. We will promote and educate providers on their requirements under the Bill.</p>	
<p>HEALTH CARE FACILITY INFORMATION Consumers should receive the following information from a health care facility:</p>	<p>This information should be provided by health professionals.</p>	<p>Compliance: No obligation</p>

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<p>(1) Corporate form of the facility (i.e. public or private nonprofit or for profit, ownership and management, affiliation with other corporate entities)</p> <p>(2) Accreditation status</p> <p>(3) Whether specialty programs meet guidelines established by specialty societies or other appropriate bodies (e.g., whether a cancer treatment center has been approved by the American College of Surgeons, the Association of Community Cancer Centers, or the National Cancer Institute).</p> <p>(4) The volume of certain procedures performed at each facility.</p> <p>(5) Consumer satisfaction measures.</p> <p>(6) Clinical quality performance measures.</p> <p>(7) Service performance measures.</p> <p>(8) Procedures for registering a complaint and achieving resolution of that complaint.</p> <p>(9) The availability of translation or interpretation services for non-English speakers and people with communication disabilities.</p> <p>(10) Numbers and credentials of providers of direct patient care (e.g., registered nurses, other licensed providers, and other caregivers).</p> <p>(11) Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.</p> <p>(12) Whether the facility has been excluded from any Federal</p>	<p>This information should be provided by health professionals. We will promote and educate providers on their requirements under the Bill.</p>	<p>health programs (i.e., Medicare or Medicaid).</p> <p>This information should be provided by health professionals.</p> <p>Suggested Compliance:</p> <p>This information should be provided by health professionals. We will promote and educate providers on their requirements under the Bill.</p> <p>Compliance: No obligation</p>

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 Health Programs (i.e. Medicare or Medicaid)

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<p>health programs (i.e., Medicare or Medicaid)</p> <p>CONSUMER ASSISTANCE PROGRAMS</p> <p>The bill of rights does not include a specific requirement for consumer assistance programs but describes the desirable characteristics of such programs as follows:</p> <p>• There are reasons to believe that consumers and other stakeholders would benefit from greater availability of consumer assistance programs that:</p> <ul style="list-style-type: none"> • Inspire confidence. • Consumers want to know that they will be treated fairly. • Provide a safety valve. Even in the best of systems, there will be individuals who fall through the cracks. Assistance programs provide a resource that can help such individuals resolve problems quickly and efficiently, often bridging communication failures between the consumer and the provider or health plan. • Foster collaboration. • Assistance programs should work with the array of available resources to best meet the needs of consumers. 	<p>FEP does not interpret this section of the Bill to impose a requirement on Plans at this time and recognizes that the Bill sets aside this issue for future study and consideration</p>	<p>Compliance: No obligation.</p>
<p>II. CHOICE OF PROVIDERS</p> <p>Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care. To ensure such choice, health plans should provide the following:</p> <p>(1) Provider Network Adequacy. All health plan networks should provide access to sufficient</p>	<p>Suggested Compliance:</p>	<p>Compliance Issues</p> <p>While accessibility standards are currently defined, most continue to recognize exceptions in communities where the supply of providers may be limited. In</p>

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<p>numbers and types of providers to assure that all covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day, seven days a week. If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of socialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers. Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members.</p> <p>(2) Access to Qualified Specialists for Women's Health Services: Women should be able to choose a qualified provider offered by a plan—such as gynecologists, certified nurse midwives, and other qualified health care providers—for the provision of covered care necessary to provide routine and preventative women's health care services.</p>	<p>Accessibility standards already defined for FEP. We currently meet all standards as defined except where noted in rural communities.</p>	<p>While accessibility standards are currently defined, must continue to recognize exceptions in communities where the supply of providers may be limited. In such cases, provision of benefits would be consistent with brochure.</p>
	<p>Suggested Compliance: Currently we are in compliance with this requirement. Routine and preventative services currently defined in the Brochure meet these requirements.</p>	

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<p>(3) Access to Specialists: Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.</p>	<p>Currently we are in compliance with this, but specifics vary by Plan.</p>	
<p>(4) Transitional Care: Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or through completion of postpartum care) to allow for transition of care. Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.</p>	<p>We are currently in compliance with this requirement. Benefits currently address continuity of care issues. Such issues are normally handled at the individual consideration level and should continue to be as the needs and interests of the patients vary from case to case. On an individually determined basis, a transitional plan should be developed and time frames established based on the particular circumstances of the case.</p> <p>Transitional plans may require patient to work with case managers and may need to be negotiated with OPM. (For example, in situations where involuntary termination of patient's plan)</p>	<p>Compliance Schedule: Currently in Compliance</p>

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<p>Public and private group purchasers should wherever feasible, offer consumers a choice of high quality health insurance products. Small employers should be provided with greater assistance in offering their workers and their families a choice of health plans and products.</p>	<p>Portfolio of Products available to federal subscribers determined by OPM. Not an issue for the FEP.</p>	<p>Not Applicable</p>
<p>III. ACCESS TO EMERGENCY SERVICES</p>		
<p>Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a “prudent layperson” could reasonably expect the absence of medical attention to result in placing that consumer’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. To ensure this right:</p>		
<p>(1) Health plans should educate their members about the availability, location, and appropriate use of emergency and other medical services; cost-sharing provisions for emergency services; and the availability of care outside an emergency department</p>	<p>Currently in compliance. Additional information can be added to existing subscriber education materials, and to the Website.</p>	<p>Suggested Compliance Schedule: Additional information will be added to 1999 subscriber education materials.</p>
<p>(2) Health plans using a defined network of providers should cover emergency department screening and stabilization services both in-network and out-of-network without prior authorization for use consistent with the prudent layperson standard. Non-network providers and facilities should not bill patients for any</p>	<p>Currently in compliance.</p>	<p>Compliance Issue: Plans cannot obligate non-contracting providers to accept Plans’ payment rates and hold the consumer harmless against balance billings.</p>

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<p>charges in excess of health plans' routine payment arrangements.</p> <p>(3) Emergency department personnel should contact a patient's primary care provider or health plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care.</p>	<p>Suggested Compliance:</p> <p>The appropriate protocol is for the emergency department personnel to contact the patient's primary care physician and a stabilization plan developed between the healthcare professionals. The health plan should not be involved in this manner. Voluntary compliance by provider will be promoted. Will educate providers on their responsibilities of this right.</p>	<p>Suggested Compliance Schedule:</p> <p>Incorporate into provider-directed education/promotion program for the 1999 benefit season.</p>
<p>IV. PARTICIPATION IN TREATMENT DECISIONS</p>		
<p>Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.</p>	<p>Nothing in the FEP prohibits this form of exchange with our providers.</p>	<p>Suggested Compliance Schedule:</p> <p>Incorporate information in a provider-directed education program for 1999.</p>
<p>In order to ensure consumers' right and ability to participate in treatment decisions, health care professionals should:</p> <ul style="list-style-type: none"> Provide patients with easily understood information and opportunity to decide among treatment options consistent with the informed consent process. Specifically, <ul style="list-style-type: none"> Discuss all treatment options with a patient in a culturally competent manner, including the option of no treatment at all. Ensure that persons with disabilities have effective communications with members of the health system in making such 	<p>Plans will continue to generally cooperate with and encourage professionals to ensure an environment conducive to the consumers' right to become educated on their health related issues and to participate in decisions regarding their treatment as specified in the Bill of Rights.</p>	

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<p>decisions.</p> <p>Discuss all current treatments a consumer may be undergoing, including those alternative treatments that are self-administered.</p> <p>Discuss all risks, benefits, and consequences to treatment or nontreatment.</p> <p>Give patients the opportunity to refuse treatment and to express preferences about future treatment decisions.</p> <p>Discuss the use of advance directives—both living wills and durable powers of attorney for health care—with patients and their designated family members.</p> <p>Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process.</p>		
<p>To facilitate greater communication between patients and providers, health care providers, facilities, and plans should</p> <p>(1) Disclose to consumers factors—such as methods of compensation ownership of or interest in health care facilities, or matters of conscience—that could influence advice or treatment decisions.</p>	<p>Provider contracts do not inhibit or pose a barrier to the subscriber's participation in treatment decisions.</p>	<p>Compliance Issue:</p> <p>Disclosure of methods of compensation considered proprietary and in some cases prohibited by provider contracts. Suggest information be communicated through general disclosure.</p>

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<p>(2) Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options.</p> <p>(3) Be prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients.</p>	<p>Plans do not include in their provider contracts provisions that restrict or appear to restrict physicians or other healthcare providers from advising and communicating with patients about medically necessary treatment options.</p> <p>Plans will inform providers on appropriate activities to serve as patient advocates through communication pieces directed at providers, provider relations activities, workshops or other in-service programs offered by plans to educate providers.</p>	<p>Suggested Compliance Schedule</p> <p>Incorporate information in provider directed education program for 1999</p>
<p>V. RESPECT AND NONDISCRIMINATION</p>		
<p><i>Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.</i></p>		
<p>Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.</p>	<p>The Service Benefit Plan is required by contract to, and does, provide benefits to all enrolled members whose enrollment is determined by the federal government. Any complaint of discrimination should be addressed through the appeal process as outlined by federal regulation.</p>	<p>No further action required</p>
<p>Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.</p>	<p>The Service Benefit Plan is required by contract to, and does, provide benefits to all enrolled members whose enrollment is determined by the federal government. Any complaint of discrimination should be addressed through the appeal process as outlined by federal regulation. To the extent not already discussed in the Brochure, the Service Benefit Plan's nondiscrimination policy and appeal process could be included in its Brochure.</p>	

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<p>VI. CONFIDENTIALITY OF HEALTH INFORMATION</p> <p>Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records, in order to ensure this right.</p> <p>(1) With very few exceptions, individually identifiable health care information can be used without written consent for health purposes only, including the provision of health care, payment for services, peer review, health promotion, disease management, and quality assurance.</p> <p>(2) In addition, disclosure of individually identifiable health care information without written consent should be permitted in very limited circumstances where there is a clear legal basis for doing so. Such reasons include: medical or health care research for which an institutional review board has determined anonymous records will not suffice, investigation of health care fraud, and public health recording.</p> <p>(3) To the maximum feasible extent in all situations, nonidentifiable health care information should be used unless the individual has consented to the disclosure of individually identifiable information. When disclosure is required, no greater amount of</p>	<p>Confidentiality is currently addressed in CS 1039 and establishes compliance standards which meet the concerns raised by this chapter.</p>	<p>No further action required.</p>

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<p>information should be disclosed than is necessary to achieve the specific purpose of the disclosure.</p>		
<p>VII COMPLAINTS AND APPEALS</p>		
<p>All Consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers and the institutions that serve them. Including rigorous system of internal review and an independent system of external review.</p>		
<p>A. INTERNAL APPEALS Internal appeals systems should include:</p>		
<p>(1) Timely written notification of a decision to deny, rescind or terminate services or deny payment for services. Such notification should include an explanation of the reasons for the decisions and the procedures available for appealing them.</p>	<p>Currently in compliance The Brochure explains the OPM Claims Appeals process; in our opinion the current process meets the requirements of the Bill.</p>	<p>No further action required</p>
<p>(2) Resolution of all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).</p>		<p>No further action required</p>
<p>(3) A claim review process conducted by health care professionals who are appropriately credentialed with respect to the treatment involved. Reviews should be conducted by individuals who were not involved in the initial decision.</p>	<p>Currently in compliance The qualifications of the reviewers vary from Plan to Plan. However, reviewers generally have a clinical background and are competent to conduct the review. Where necessary, additional expertise is sought.</p>	<p>No further action required</p>
<p>(4) Written notification of the final determination by the Plan of an internal appeal that includes information on the reason for the determination and how a consumer can appeal that decision to an external</p>	<p>Currently in compliance</p>	<p>No further action required</p>

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<p>(5) Reasonable processes for resolving consumer complaints about such issues as waiting times, operating hours, the demeanor of health care personnel, and the adequacy of facilities.</p>	<p>Currently in compliance Plans have an established subscriber appeal process to deal with a myriad of issues. However, complaints over wait times, hours of operation and adequacy of facilities generally are not issues under a PPO type arrangement. Providers run independent practices</p>	<p>No further action required</p>
<p>B EXTERNAL APPEALS: External appeals systems should</p>	<p>An external review process is established for the FEHBP and in our opinion meets the requirements of this Bill</p>	
<p>(1) Be available only after consumers have exhausted all internal processes (except in cases of urgently needed care)</p>		<p>No further action required</p>
<p>(2) Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized.</p>		<p>No further action required</p>
<p>(3) Be conducted by health care professionals who are appropriately credentialed with respect to the treatment involved and subject to conflict-of-interest prohibitions. Reviews should be conducted by individuals who were not involved in the initial decision.</p>		<p>No further action required</p>
<p>(4) Follow a standard of review that promotes evidence-based decision making and relies on objective evidence, and</p>		<p>No further action required.</p>
<p>(5) Resolve all appeals in a timely</p>		

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manner with expedited consideration for decisions involving emergency or urgent care consistent with time frame's consistent with those required by Medicare (i.e., 72 hours)		No further action required