FEHBP PREMIUM INCREASES 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

SECOND SESSION

SEPTEMBER 24, 1998

Serial No. 105–198

Printed for the use of the Committee on Government Reform and Oversight

U.S. GOVERNMENT PRINTING OFFICE

54–586 WASHINGTON : 1999

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-058431-0

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

DAN BURTON, Indiana, *Chairman*

BENJAMIN A. GILMAN, New York
J. DENNIS HASTERT, Illinois
CONSTANCE A. MORELLA, Maryland
CHRISTOPHER SHAYS, Connecticut
CHRISTOPHER COX, California
ILEANA ROS-LEHTINEN, Florida
JOHN M. McHUGH, New York
STEPHEN HORN, California
JOHN L. MICA, Florida
THOMAS M. DAVIS, Virginia
DAVID M. McINTOSH, Indiana
MARK E. SOUDER, Indiana
JOE SCARBOROUGH, Florida
JOHN B. SHADEGG, Arizona
STEVEN C. LATOURETTE, Ohio
MARSHALL "MARK" SANFORD, South Carolina
JOHN E. SUNUNU, New Hampshire
PETE SESSIONS, Texas
MICHAEL PAPPAS, New Jersey
VINCE SNOWBARGER, Kansas
BOB BARR, Georgia
DAN MILLER, Florida
RON LEWIS, Kentucky

HENRY A. WAXMAN, California
TOM LANTOS, California
ROBERT E. WISE, JR., West Virginia
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
PAUL E. KANJORSKI, Pennsylvania
GARY A. CONDIT, California
CAROLYN B. MALONEY, New York
THOMAS M. BARRETT, Wisconsin
ELEANOR HOLMES NORTON, Washington, DC
CHAKA FATTAH, Pennsylvania
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
ROD R. BLAGOJEVICH, Illinois
DANNY K. DAVIS, Illinois
JOHN F. TIERNEY, Massachusetts
JIM TURNER, Texas
THOMAS H. ALLEN, Maine
HAROLD E. FORD, JR., Tennessee

BERNARD SANDERS, Vermont (Independent)

KEVIN BINGER, *Staff Director*
DANIEL R. MOLL, *Deputy Staff Director*
DAVID A. KASS, *Deputy Counsel and Parliamentarian*
LISA SMITH ARAFUNE, *Deputy Chief Clerk*
PHIL SCHILIRO, *Minority Staff Director*

SUBCOMMITTEE ON THE CIVIL SERVICE

JOHN L. MICA, Florida, *Chairman*

MICHAEL PAPPAS, New Jersey
CONSTANCE A. MORELLA, Maryland
CHRISTOPHER COX, California
PETE SESSIONS, Texas

ELIJAH E. CUMMINGS, Maryland
ELEANOR HOLMES NORTON, Washington, DC
HAROLD E. FORD, JR., Tennessee

EX OFFICIO

DAN BURTON, Indiana

HENRY A. WAXMAN, California

GEORGE NESTERCZUK, *Staff Director*
JEFFREY SHEA, *Professional Staff Member*
JOHN CARDARELLI, *Clerk*
TANIA SHAND, *Minority Professional Staff Member*

CONTENTS

	Page
Hearing held on September 24, 1998	1
Statement of:	
Flynn III, William E., Associate Director for Retirement and Insurance, Office of Personnel Management	46
Gammarino, Stephen W., senior vice president, Federal Employee Program, Blue Cross Blue Shield Association; and Terry S. Latanich, senior vice president, Merck-Medco Managed Care, L.L.C.	13
Letters, statements, etc., submitted for the record by:	
Cummings, Hon. Elijah E., a Representative in Congress from the State of Maryland, prepared statement of	10
Flynn III, William E., Associate Director for Retirement and Insurance, Office of Personnel Management, prepared statement of	48
Gammarino, Stephen W., senior vice president, Federal Employee Program, Blue Cross Blue Shield Association, prepared statement of	15
Latanich, Terry S., senior vice president, Merck-Medco Managed Care, L.L.C., prepared statement of	22
Mica, Hon. John L., a Representative in Congress from the State of Florida, prepared statement of	4
Morella, Hon. Constance A., a Representative in Congress from the State of Maryland, information concerning premium rates	67

FEHBP PREMIUM INCREASES FOR 1999

THURSDAY, SEPTEMBER 24, 1998

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

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2203, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

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

Staff present: George Nesterczuk, staff director; Garry Ewing, counsel; Edward J. Lynch, senior research director; Jeffrey Shea, professional staff member; John Cardarelli, clerk; and Tania Shand, minority professional staff member.

Mr. MICA. Good morning. I would like to call this meeting of the House Subcommittee on the Civil Service to order.

This morning's hearing relates to the Federal Employees Health Benefits Program premium increases for 1999. I am pleased to conduct this hearing this morning, at the bipartisan request of Mrs. Morella, the gentlelady from Maryland, and also Mr. Cummings our ranking member, also from Maryland.

We expect, in just a few minutes, most of our subcommittee members on the minority side. They have been down at the White House and should return shortly. But, with their consent, we are going to proceed. I will start with an opening statement, as usual, and then will defer to other Members. Hopefully they will join us as we begin, for the sake of saving time and moving forward with the hearing.

This morning we have scheduled this hearing to examine the causes of increases in next year's health care premiums in the Federal Employees Health Benefits Program. The Office of Personnel Management announced on Friday, September 11, 1998, that FEHBP premiums will increase by an average of 10.2 percent for 1999.

This, in fact, is the second straight year in which FEHBP premiums have dramatically increased. As a result of these increases, premiums in 1999, on average, will be about 20 percent higher than in 1997. These steep increases in health care premiums confront our Federal workers, and in fact, will devastate Federal retirees who will, on average, see their COLA's nearly wiped out by these increases.

As I observed at last year's hearing, however, averages mask considerable differences among our various plans. For example, the

premium for one union-sponsored plan will be 34 percent higher than in 1997. Another will be up 29 percent. On the other hand, premiums for Alliance Health Plans are actually lower in 1999 than in 1997, and the Blue Cross Blue Shield high option plans are only up by 4 percent. The good news is that Federal employees and annuitants are still able to cushion these increases by choosing lower cost plans.

Around 9 million Federal employees and retirees and their families rely on our Federal Employees Health Benefits Program for affordable, high-quality health care benefits. The members of this subcommittee are acutely aware of the impact these increased premiums have on individual employees and annuitants. OPM has announced that the impact on individuals will be less in 1999 than in 1998. Largely, this is because, under the new fair share formula which Congress enacted in the Balanced Budget Act of 1997, the taxpayers pick up a higher percentage of premium increases.

But the reality is that, in actual dollars, the increases are, in fact, very significant. Average subscriber premiums rose $132 this year, and are going up an additional $88 next year. That means employees and annuitants spent $560 million more this year and will spend an additional $400 more next year. That's nearly $1 billion in extra costs in just 2 years for these folks. The Government's burden over those 2 years is another $2.2 billion, a staggering figure.

As we examine this issue, there are a number of questions that we should address. For example, OPM says the factors leading to higher premiums in FEHBP reflect overall trends in the economy. However, recent data suggest that last year's FEHBP increases, which averaged 8.5 percent, were substantially higher than other employer-sponsored plans. According to a recent article in the journal entitled, "Health Affairs," premiums for employer-sponsored health insurance increased by only 3.3 percent. In January 1998, CBO forecast single-digit increases in private health care insurance premiums through the year 2008.

I now have to wonder why this year's FEHBP premium increase was more than double the private sector rate. Are there factors peculiar to the FEHBP that account for this difference? I think we need to look at those differences.

Earlier this year, OPM testified that new plan requirements for 1999, including the President's so-called Patient's Bill of Rights, will add around $40 million to FEHBP costs. Almost half of this total, $17.5 million, would go toward producing paperwork—that's what our testimony indicated—and those efforts will have nothing to do with medical benefits or services. If FEHB premiums are rising so rapidly, do we need to be fueling the increases with irrelevant requirements? I think we have to ask ourselves some of these questions.

OPM cited a 22-percent increase in expenditures for prescription medicines as a primary culprit in next year's double-digit increase. Since the prescription drug benefit now represents about 20 percent of overall program costs, what are we to infer about future premium increases? What future steps can we take to rein in costs? We will hear from some of our witnesses in regard to the questions we have raised here.

I think these are some of the things we have to look at in the next few months here. I think that Congress, in fact, may need to redirect FEHB management away from overregulation and back to flexibility and choice. We also may need to roll back mandates that drive up costs and reduce choice.

Once again, I think we've got to look at options that lower costs, and I think we should revisit making medical savings accounts available to Federal employees and Federal retirees. Every instance where we have conducted hearings on this in Congress indicates that where they have had MSA's in the private sector, the premiums have been reduced for both the employer and the employee. MSA's, in fact, permit patients to take more control over their health care costs while lowering their insurance premiums. I think we have been remiss in again casting aside any options that provide us the opportunity for plans which will, in fact, lower premiums and costs.

Finally, I think we have got to get serious about tort reform. That is one Government reform that I also believe could significantly reduce the cost of health care, not only to our Federal employees and annuitants, but also to all Americans who see the costs of health care coverage increase. If Congress fails to act, I predict even higher future premiums and more problems for FEHBP.

Sixty-five plans, we have been notified, are dropping out of FEHBP. That's almost 20 percent of participating plans. Although they are mostly small HMO's, their departure means fewer choices for employees. The dropouts are telling us something about the business climate we are fostering in the FEHB program and in the health care industry.

I am today directing our subcommittee staff to conduct a complete review of the factors leading to the withdrawal of participation by this large number of plans. It is critical that employee groups, labor organizations, management groups, OPM, and this subcommittee work together to find ways to bring these premiums down, or, at least, to stem these dramatic cost increases.

However, I think we have to realize that more regulations, increased mandates, narrowing options, increased paperwork, high-sounding edicts, and a failure to stem litigation will only continue to increase health care costs.

My goal is to strengthen the ability of Federal employees to choose high-quality and affordable health care under this Federal health care program. Protecting consumer choice and encouraging competition, I believe, is the way to achieve both of these objectives, to help us keep the costs down and quality up.

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

DAN BURTON, INDIANA
CHAIRMAN
BENJAMIN A. GILMAN, NEW YORK
J. DENNIS HASTERT, ILLINOIS
CONSTANCE A. MORELLA, MARYLAND
CHRISTOPHER SHAYS, CONNECTICUT
STEVEN SCHIFF, NEW MEXICO
CHRISTOPHER COX, CALIFORNIA
ILEANA ROS-LEHTINEN, FLORIDA
JOHN M. McHUGH, NEW YORK
STEPHEN HORN, CALIFORNIA
JOHN L. MICA, FLORIDA
THOMAS M. DAVIS III, VIRGINIA
DAVID M. MCINTOSH, INDIANA
MARK E. SOUDER, INDIANA
JOE SCARBOROUGH, FLORIDA
JOHN SHADEGG, ARIZONA
STEVE C. LATOURETTE, OHIO
MARSHALL "MARK" SANFORD, SOUTH CAROLINA
JOHN E. SUNUNU, NEW HAMPSHIRE
PETE SESSIONS, TEXAS
MIKE PAPPAS, NEW JERSEY
VINCE SNOWBARGER, KANSAS
BOB BARR, GEORGIA
ROB PORTMAN, OHIO

ONE HUNDRED FIFTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225–5074
MINORITY (202) 225–5051
TTY (202) 225–6852

HENRY A. WAXMAN, CALIFORNIA
RANKING MINORITY MEMBER
TOM LANTOS, CALIFORNIA
BOB WISE, WEST VIRGINIA
MAJOR R. OWENS, NEW YORK
EDOLPHUS TOWNS, NEW YORK
PAUL E. KANJORSKI, PENNSYLVANIA
GARY A. CONDIT, CALIFORNIA
CAROLYN B. MALONEY, NEW YORK
THOMAS M. BARRETT, WISCONSIN
ELEANOR HOLMES NORTON
DISTRICT OF COLUMBIA
CHAKA FATTAH, PENNSYLVANIA
ELIJAH E. CUMMINGS, MARYLAND
DENNIS KUCINICH, OHIO
ROD R. BLAGOJEVICH, ILLINOIS
DANNY K. DAVIS, ILLINOIS
JOHN F. TIERNEY, MASSACHUSETTS
JIM TURNER, TEXAS
THOMAS H. ALLEN, MAINE
HAROLD E. FORD, JR., TENNESSEE

BERNARD SANDERS, VERMONT
INDEPENDENT

OPENING STATEMENT
Chairman John L. Mica
FEHBP Rate Hikes - What's Behind Them?

September 24, 1998

Good morning. We have scheduled this hearing to examine the causes of the increases in next year's health care premiums in the Federal Employees Health Benefits Program. The Office of Personnel Management (OPM) announced on Friday, September 11, 1998 that FEHB premiums will increase by an average of 10.2% for 1999.

This is the second straight year in which FEHB premiums have dramatically increased. As a result of these increases, premiums in 1999, on average, will be about 20% higher than in 1997. These steep increases in health care premiums confront federal workers and devastate federal retirees who will, on average, see their COLAs nearly wiped out by these increases.

As I observed at last year's hearing, however, averages mask considerable differences among the various plans. For example, the premium for one union-sponsored plan will be 34% higher than in 1997. Another will be up by 29%. On the other hand, the premiums for Alliance Health Plans are actually lower in 1999 than in 1997, and the Blue Cross Blue Shield High Option plans are only up by 4%. The good news is that federal employees and annuitants are still able to cushion these increases by choosing lower cost plans.

Around 9 million federal employees and retirees and their families rely on the FEHB Program for affordable, high-quality health benefits. The members of this subcommittee are acutely aware of the impact increased premiums have on individual employees and annuitants. OPM has announced that the impact on individuals will be less in 1999 than in 1998. Largely, this is because under the new Fair Share Formula Congress enacted in the Balanced Budget Act of 1997, the taxpayers pick up a higher percentage of premium increases.

But the reality is that in actual dollars the increases are significant. Average subscriber premiums rose $132 this year, and are going up an additional $88 next year. That means employees and annuitants spent $560 million more this year and will spend an additional $400 million more next year. That is nearly $1 billion in extra costs in just 2 years. The government's burden over those two years is another $2.2 billion.

As we examine this issue, there are a number of questions that we should address. For

example, OPM says that the factors leading to higher premiums in FEHB reflect overall trends in the economy. However, recent data suggest that last year's FEHB increases, which averaged 8.5%, were substantially higher than other employer-sponsored plans experienced. According to a recent article in the journal "Health Affairs," premiums for employer-sponsored health insurance increased by only 3.3%. In January of 1998, CBO forecast single digit increases in private health insurance premiums through 2008.

I now have to wonder why this year's FEHB premium increase was more than double the private sector rate. Are there factors peculiar to the FEHB that account for this difference? Earlier this year OPM testified that new plan requirements for 1999, including the President's so-called Patient's Bill of Rights, will add around $40 million to FEHB costs. Almost half of this total, $17.5 million, would go toward producing paperwork having nothing to do with medical benefits or services. If FEHB premiums are rising so rapidly, do we need to be fueling the increases with irrelevant requirements?

OPM cited a 22% increase in expenditures for prescription medicines as a primary culprit in next year's double-digit increase. Since the prescription drug benefit now represents about 20% of overall program costs, what are we to infer about future premium increases? What future steps can we take to rein in costs?

Congress may need to redirect FEHB management away from over regulation and back to flexibility and choice. We may also need to roll back mandates that drive up costs and reduce choice. Once again we must examine options that lower costs and revisit making Medical Savings Accounts available to federal employees. MSAs permit patients to take more control over their health costs while lowering their insurance premiums. Finally, we must get serious about tort reform. That is one government reform that could significantly reduce the cost of health care. If Congress fails to act, I predict even higher future premiums and more problems for FEHB.

Sixty-five plans are dropping out of the FEHB. That is almost 20% of participating plans. Although they are mostly small HMOs, their departure means fewer choices for employees. The drop outs are telling us something about the business climate we are fostering in the FEHB program and in the health care industry.

I am today directing our Subcommittee staff to conduct a review of factors leading to the withdrawal of participation by these plans. It is critical that employee groups, labor organizations, and management groups, OPM and this Subcommittee work together to find ways to bring these premiums down or at least to stem these dramatic increases.

However, we must realize that more regulations, increased mandates, narrowing options, increased paperwork, high-sounding edicts, and a failure to stem litigation will only continue to increase health care costs.

My goal is to strengthen the ability of federal employees to choose high-quality and affordable health care under the FEHB program. Protecting consumer choice and encouraging competition is the way to achieve both of those objectives -- keeping costs down and quality up.

Mr. MICA. I am pleased at this time to yield to the distinguished gentlelady from Maryland, who also is one of the requesters of this hearing today, and who does such a great job on behalf of our Federal employees.

Mrs. Morella, you are recognized for an opening statement.

Mrs. MORELLA. Thanks, Mr. Chairman.

Some of the comments you made, I noticed some of the people's ears perked up. I think they're going to be ready during the testimony and questioning to also respond in terms of what will be necessary. I appreciate very much your having this hearing.

I think it is important that we look at why all of a sudden we have such a tremendous increase. I was deeply concerned when I read the announcement from the Office of Personnel Management that, on average, premiums in the Federal Employees Health Benefits Program would rise by 10.2 percent in 1999, which ends up being an average increase of 7.4 percent in the employee and retiree share of the FEHBP premiums.

In fact, when you think about it, Mr. Chairman, without the amendment that this subcommittee approved, that I was able to offer in the first session of this Congress, creating that fair share formula, the impact on Federal employees would be even greater.

What accounts for increases of this magnitude, being so far above the 3.5 percent rate of medical inflation? The magnitude of this increase is even more surprising considering that a recent article in the journal "Health Affairs" reported that premiums in private employer-sponsored health plans will rise this year at the considerably lower rate of only 3.3 percent. Therefore, we on this subcommittee are very interested in knowing what the basis is for such a discrepancy.

Because my colleagues and I are committed to ensuring that the Federal Employees Health Benefits Program continues to deliver high-quality health care at reasonable costs well into the future, we need to listen to today's witnesses discuss the specific cost increases and efforts that are being made to avoid or to limit them.

For example, why are FEHBP prescription drug costs, which account for approximately 20 percent of FEHBP expenditures, rising by as much as 22 percent? We know that the FEHB Program is the country's largest employer-based health insurance program, serving the health needs of almost 10 million Federal employees, retirees, and their families. How are FEHBP plans using this leverage to implement meaningful cost containment mechanisms with the goal of passing on the savings to plan members? The answers to these questions need to be provided, and they need to be provided quickly.

Open season is now before us. I have annually a forum that I hold on open season, so that the Federal employees, retirees, and their families can make good decisions. I'm going to have my forum on December 4, and I know that these concerns will be raised. So I hope that today's hearing will give us the opportunity to discuss ways to help keep health care affordable for Federal employees, retirees, and their families.

Again, Mr. Chairman, I appreciated your opening comments, and I am especially grateful for your having this hearing. I yield back.

Mr. MICA. I thank the gentlelady, and thank her again for requesting the hearing. Mr. Cummings will be with us shortly.

I am going to go ahead and call the first panel and swear in our witnesses, if I could have Mr. Gammarino and Mr. Latanich come up.

Our hearing today is going to consist of two panels. First we will hear from Stephen W. Gammarino, senior vice president, Federal Employee Program, for the Blue Cross and Blue Shield Association. The second witness on our first panel will be Terry Latanich, senior vice president of Merck-Medco Managed Care.

The second panel will follow with one individual, who is no stranger to our subcommittee, Mr. William E. Flynn, Ed Flynn, Associate Director of Retirement and Insurance Services, Office of Personnel Management.

Gentlemen, as you know, this is an investigations and oversight subcommittee of Congress. It is customary that we do swear in our witnesses, so if you would please stand and raise your right hand.

[Witnesses sworn.]

Mr. MICA. We will let the record reflect that the witnesses answered in the affirmative.

I see that we have been joined by the vice chairman of our subcommittee. I'm stalling a bit to see if we can get our ranking member and other minority members on the panel here. They are on their way in the car from the White House.

Mr. Pappas, did you have an opening statement or remarks?

Mr. PAPPAS. Thank you, Mr. Chairman. I'm glad I made it in time to see Terry, who is from a company that is based in my district. Welcome.

Thank you for holding this hearing, Mr. Chairman.

Mr. MICA. If you will just hold on here for a couple of minutes, we will stand in recess. I would like to have the other members of the panel to hear your opening comments. This is a very important issue. So if you will just stand in recess, we will wait until they arrive.

I apologize for the delay. We had originally scheduled this hearing for 10 o'clock, and then we moved it to 11 to accommodate the other Members. As you know, I try to be most accommodating.

Mrs. MORELLA. You are accommodating, Mr. Chairman.

Mr. MICA. We could call Ed Flynn up and I could ask him why OPM is opting for a study of the life insurance issue after 40 years of nonbidding on Federal employees' life insurance. We get an opportunity to lower the premiums and expand the options for Federal employees so they can have higher coverage at lower cost, and OPM is dragging its feet in the Senate. But I won't ask him that. [Laughter.]

I might when he comes up and he's under oath.

[Recess.]

Mr. MICA. The subcommittee will come back to order, as the ranking member, Mr. Cummings, takes his chair.

Mr. Cummings, we have had the opportunity to have our side give their opening statements. We knew you were going to be delayed, so we went ahead and gave the opening statements. We have our first panel of witnesses and they have been sworn.

I want to give you just a minute because I know you've been down at other meetings, but you are recognized, sir. Also, I did inform those attending that the hearing today is at the request of yourself and also a request from Mrs. Morella, to review the issue. So that's where we are.

As soon as you give your opening statement, and if we have any other Members from your side come today, they will be recognized. Then we will go directly to the testimony, which we have held up until you and the other Members were here. So you are recognized, sir. Thank you.

Mr. CUMMINGS. First, I want to thank you, Mr. Chairman, and I want to apologize, too.

Mr. MICA. No problem.

Mr. CUMMINGS. We were in a meeting with the President, and I think the other Members are probably just coming from that meeting.

Mr. Chairman, as you said a little bit earlier, it was at my request, and that of Mrs. Morella's, that brought about this hearing. I certainly again thank you.

As one can surmise from the debate on health care reform, health insurance is a necessity for a healthy and productive life. But many Americans either don't have access to it, or can't afford it.

This is the third hearing being held in the last year on Federal Employees Health Benefits Program premiums. The first hearing was held in September of last year, when OPM announced an 8.5-percent increase in the 1998 premium costs. The second hearing was held in March of this year, when Chairman Mica called a hearing to examine what impact the President's Patients Bill of Rights would have on 1999 premium rates. If nothing else, these hearings made clear the need for continued oversight by this subcommittee of the program.

At the March hearing, Walter Francis, author of "Checkbook's Guide to Health Insurance Plans for Federal Employees," testified that "FEHBP is one of the best run programs in the Federal Government. So good is the FEHBP, and so widely recognized are its accomplishments, that it has been repeatedly urged as a model for other programs . . . ."

This is certainly true. FEHBP has a stellar reputation for plan diversity and quality and customer satisfaction. For most of its existence, FEHBP has remained affordable to Federal employees and retirees, and we want to keep it that way, particularly at a time when Federal pay raises continue to fall short of what the Federal Employees Pay Comparability Act provides for. There are enough Americans suffering because they can't afford health care.

The Office of Personnel Management has a daunting task: keeping premiums affordable for Federal enrollees, while still being responsive to national trends and private market forces. OPM has done a commendable job, and this member has not lost sight of that.

At the same time, however, OPM must keep a close eye on factors that drive up premiums, and take the necessary steps to contain them. The reasons cited by OPM for the 10.2-percent premium increase next year—an aging population, technological advances,

fewer health plans, and an increase in prescription drug costs—will continue to affect premiums in the future. Many of these same reasons were cited for increases in this year's premiums.

The purpose of this hearing is to determine how OPM is attempting to contain costs. In addition, we need to determine the effect premium increases will have on enrollee retention.

As I have said on many occasions, we have one life to live. This is no dress rehearsal. This so happens to be that life.

I thank all the witnesses for appearing before this subcommittee today, and I look forward to your testimony on these subjects.

Thank you very much, Mr. Chairman.

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

OPENING STATEMENT OF THE
HONORABLE ELIJAH E. CUMMINGS

RANKING MEMBER

SUBCOMMITTEE ON CIVIL SERVICE

HEARING ON

"FEHB Premium Increases for 1999"

Thursday, September 24, 1998

Mr. Chairman, thank you for holding this hearing at my request. As one can surmise from the debate on health care reform, health insurance is a necessity for a healthy and productive life, but many Americans either don't have access to it or can't afford it.

This is the third hearing being held in the last year on Federal Employee Health Benefit Program (FEHBP) premiums. The first hearing was held in September of last year when OPM announced a 8.5% increase in 1998 premium costs. The second hearing was held in March of this year when Chairman Mica called a hearing to examine what impact the President's Patients' Bill of Rights would have on 1999

premium rates. If nothing else, these hearing made clear the need for continued oversight by this sub committee of FEHBP.

At the March hearing, Walter Francis, author of *Checkbook's Guide to Health Insurance Plans for Federal Employees*, testified that, "FEHBP is one of the best run programs in the Federal Government. So good is the FEHBP, and so widely recognized are its accomplishments, that it has been repeatedly urged as a model for other programs..." This is certainly true. FEHBP has a stellar reputation for plan diversity and quality, and customer satisfaction. For most of its existence, FEHBP has remained affordable to federal employees and retirees, and we want to keep it that way. Particularly, at a time when federal pay raises continue to fall short of what the Federal Employees Pay Comparability Act provides for. There are enough Americans suffering because they can't afford health care.

The Office of Personnel Management has a daunting task--keeping premiums affordable for federal enrollees, while still being responsive to national trends and private market forces. OPM has done

a commendable job and this Member has not lost sight of that.

At the same time, OPM must keep a close eye on factors that drive up premiums, and take the necessary steps to contain them. The reasons cited by OPM for the 10.2 percent premium increase next year: an aging population, technological advances, fewer health plans, and an increase in prescription drug costs, will continue to affect premiums in the future. Many of these same reasons were cited for increases in this year's premiums.

The purpose of this hearing is to determine how OPM is attempting to contain costs? In addition, we need to determine the effect premium increases will have on enrollee retention.

I thank all the witnesses for appearing before this sub committee today and I look forward to your testimony on these subjects.

Mr. MICA. I thank our ranking member.

I will return now to our panel, Mr. Gammarino, who is with Blue Cross Blue Shield Association, and Mr. Latanich, who is with Merck-Medco Managed Care.

Gentlemen, while we don't have two big panels today, we try to limit your oral presentation to 5 minutes. We can be a little bit generous with that, since there is only the two of you. We will withhold questions until we have heard both of you testify.

We will recognize first Mr. Gammarino with Blue Cross Blue Shield. Welcome. You are recognized, sir.

STATEMENTS OF STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, FEDERAL EMPLOYEE PROGRAM, BLUE CROSS AND BLUE SHIELD ASSOCIATION; AND TERRY S. LATANICH, SENIOR VICE PRESIDENT, MERCK-MEDCO MANAGED CARE, L.L.C.

Mr. GAMMARINO. Good morning, 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 to discuss the 1999 premium increases in the Federal Employees Health Benefits Program.

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 program since its inception in 1960, and is the largest plan in the program. Our plan covers over 1.9 million contracts and over 3.7 million lives.

I will focus my testimony on two areas: first, the principal factors affecting the 1999 premium increases for our plan, and second, the Blue Cross and Blue Shield perspective on the FEHBP generally.

First, the 1999 premium increase. About 95 percent of all enrollees in the Governmentwide service benefit plan are in our standard option program. For 1999, these enrollees will see a biweekly increase of $4.60 for self-only contracts and $5.74 for family contracts. Our premiums reflect the cost of providing a relatively stable benefit package compared to 1998, with no major reductions and a few modest enhancements. Thus, we are confident that our standard option continues to be a superior insurance product and continues to provide excellent value for our enrollees.

During 1998, the Governmentwide service benefit plan will pay over $7 billion in benefits for the health care needs of Federal employees, retirees, and their families. In 1999, that $7 billion will increase proportionately.

As you know, premium charges, generally speaking, are driven by benefit changes, changes in the cost of health care, changes in utilization patterns, and changes in the demographics of a particular group. The major task of an insurance carrier is understanding and coping with these changes and finding ways to mitigate their influence on premiums. It is a constant challenge, and one that we in the Blue Cross and Blue Shield system take very seriously, and to which we devote extensive effort and energies.

Like major private sector health plans, the Governmentwide service benefit plan is experiencing an increase in our health care trends. The cost of providing prescription drugs is by far the fastest growing component of this increase. We are now at a point where

prescription drugs are approaching 30 percent of total benefit costs in the service benefit plan, and are increasing at a rate that can fairly be described as alarming.

Of course, much of our drug cost is understandable and justified, given the large number of older people in our plan. The average age of the standard option enrollee is 60; in our high option plan, the average age is 70. And new drugs have revolutionized health care and made dramatic improvements in the quality of care.

In many instances, prescription drugs have become effective alternatives to hospital admissions and surgery. At the same time, we know that we cannot permit our prescription drug costs to rise unabated. Just as we have to look continually for new ways to keep all benefit costs under control, the cost of providing prescription drugs presents a particular challenge. As we seek more sophisticated tools to control these costs, we will also be forced to rely on existing techniques, such as benefit designs. Actually, greater flexibility in benefit design is an area offering a near-term promise and is an area of continuing discussion between Blue Cross and Blue Shield and the Office of Personnel Management.

Second, I would like to give you the general perspective on the FEHBP. The FEHBP is the largest employer-sponsored health care program in the world. Most observers agree that the program has been extremely successful in delivering affordable and high-quality health care coverage to millions of Federal employees and their dependents for almost 40 years.

We strongly believe that the FEHBP's success is due primarily to the critical and delicate balancing of the roles of the Government, the participating carriers and other entities in the health care industry and, of course, the all-important enrollees.

Clearly, the role balancing scenario requires candid exchanges of views and a great deal of communication. In that regard, we commend you, Mr. Chairman, and members of this subcommittee, for holding this hearing and for your very evident interest in maintaining the success of this program.

I would be remiss if I failed to take this opportunity to express our appreciation to the members of the subcommittee and your staffs, as well as the chairman and staff of the full committee, for your assistance in trying to obtain a resolution of the problem posed by the inappropriate application of the cost accounting standards to FEHBP contracts. Although we have had substantive and potentially productive discussions with OPM about this issue prior to congressional involvement, your intervention clearly has served to intensify these discussions, to secure the involvement of other interested parties, and to heighten the sense of urgency. While we do not have a resolution yet, we are much closer to that objective than we would have been without congressional assistance, so we thank you.

In summary, Mr. Chairman, the Blue Cross and Blue Shield Association is proud of our role in the FEHBP and we look forward to a continuing close relationship with the Congress and the Office of Personnel Management in maintaining and, indeed, enhancing the very successful Federal Employees Health Benefits Program.

Thank you. I will be pleased to answer any questions.

[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 the Blue Cross and Blue Shield Association. On behalf of the Association, I thank you for the opportunity to appear before you today to discuss 1999 premium increases in the Federal Employee Health Benefits Program (FEHBP) and related matters.

As you know, Blue Cross and Blue Shield Plans jointly underwrite and deliver the Government-wide Service Benefit Plan. This Plan has been in the Federal Program since its inception in 1960 and is the largest Plan in the Program. The Service Benefit Plan currently covers over 1.9 million contracts and more than 3.7 million lives.

I will focus my testimony on:

- The principal factors affecting the 1999 premium for the Service Benefit Plan; and

- The Blue Cross and Blue Shield perspective on the FEHBP generally.

1999 Premium Increase

About ninety-five percent of all enrollees in the Government-wide Service Benefit Plan are in our Standard Option. For 1999, these enrollees will see a bi-weekly increase of $4.60 for self-only contracts and $5.74 for family contracts. Our premiums reflect the cost of providing a relatively stable benefit package compared to 1998 with no major reductions and a few modest enhancements. Thus, we are confident that our Standard Option continues to be a superior insurance product and continues to provide excellent value for our enrollees. During 1998, the Government-wide Service Benefit Plan will pay over $7 billion in benefits for the health care needs of Federal employees, retirees, and their families. In 1999, that $7 billion will increase proportionately.

As you know, premium charges, generally speaking, are driven by benefit changes, changes in the cost of health care, changes in utilization patterns, and changes in the demographics of a particular group. The major task of an insurance carrier is understanding and coping with these changes and finding ways to mitigate their influence on premiums. It is a constant challenge and one that we in the Blue Cross

and Blue Shield system take very seriously and to which we devote extensive effort and energies.

Like major private-sector health plans, the Government-wide Service Benefit Plan is experiencing an increase in our health care trends. The cost of providing prescription drugs is by far the fastest growing component of the increase. We are now at a point where prescription drug costs are approaching 30 percent of total benefit costs in the Service Benefit Plan and are increasing at a rate that can fairly be described as alarming.

Of course, much of our drug cost is understandable and justified, given the large number of older people in our Plan. The average age of Standard Option enrollee's is 60; in High Option the average age is 70. And, new drugs have revolutionized health care and made dramatic improvements in the quality of care. In many instances, prescription drugs have become effective alternatives to hospital admissions and surgery. At the same time, we know that we cannot permit our prescription drug costs to rise unabated. Just as we have to look continually for new ways to keep all benefit costs under control, the cost of providing prescription drugs presents a particular challenge. As we seek more sophisticated tools to control these costs, we also will be forced to rely on existing techniques, such as benefit designs. Actually, greater flexibility in benefit design is an area offering near-term promise and is an area of continuing discussion between Blue Cross and Blue Shield and the Office of Personnel Management.

General Perspective on the FEHBP

The FEHBP is the largest employer-sponsored health care program in the world. Most observers agree that the program has been extremely successful in delivering affordable and high quality health care coverage to millions of federal employees and their dependents for almost forty years.

We strongly believe that the FEHBP's success is due primarily to the critical– and delicate– balancing of the roles of the Government, the participating carriers and other entities in the health care industry, and the all-important enrollees.

These roles, in brief, have the following attributes:

- The Congress must play a vital role in providing clear policy direction and vigorous oversight;
- The Office of Personnel Management, as the administering agency, must serve as an objective "market regulator", charged with maintaining a "level playing field" among competing carriers and an environment in which enrollees can make intelligent choices;
- Participating carriers and other health care organizations must come to the market each year with a product that provides quality coverage at an affordable price and must continually seek product improvements that will attract a broad segment of the FEHBP population; and
- Individual enrollees— as the ultimate arbiter of the marketplace— must study the offerings and make the selection most appropriate to their needs and family requirements.

Clearly, the role-balancing scenario I have outlined requires candid exchanges of views and a great deal of communication. In that regard, we commend you Mr. Chairman, and the Members of this Subcommittee, for holding this hearing and for your very evident interest in maintaining the success of this program.

I would be remiss if I failed to take this opportunity to express our appreciation to the Members of the Subcommittee and your staffs— as well as the Chairman and staff of the full committee— for your assistance in trying to obtain a resolution of the problem posed by the inappropriate application of the Cost Accounting Standards to FEHBP contracts. Although we were having substantive, and potentially productive, discussions with OPM about this issue prior to Congressional involvement, your intervention clearly has served to intensify these discussions, to secure the involvement of other interested parties, and to heighten the sense of urgency. While we do not have resolution yet, we are much closer to that objective than we would have been without Congressional assistance, so we thank you.

Conclusion

In summary, Mr. Chairman, the Blue Cross and Blue Shield Association is proud of our role in the FEHBP and we look forward to a continuing close relationship with the Congress and the Office of Personnel Management in maintaining— and indeed enhancing— the very successful Federal Employees Health Benefits Program.

Thank you and I will be pleased to answer any questions.

Mr. MICA. Thank you, Mr. Gammarino.

We will turn now to Mr. Latanich, who is with Merck-Medco. Welcome, sir. You are recognized.

Mr. LATANICH. Thank you very much. I will submit my longer written statement for the record.

Mr. MICA. Without objection, so ordered.

Mr. LATANICH. Good morning, Mr. Chairman, Congressman Cummings, and other members of the committee. My name is Terry Latanich and I am senior vice president of Merck-Medco Managed Care, which is a subsidiary of Merck & Co. We appreciate the opportunity to discuss the role of pharmaceuticals in contributing to the recently announced premium increases in the Federal Employees Health Benefits Program.

As the pharmaceutical benefit manager for several Federal Employees Health Benefits Program plans, we serve the prescription needs of more than 4 million Federal employees, retirees, and their dependents. Through better management on the use of prescription drugs, we work with patients, local pharmacists, physicians, and plan sponsors to improve the quality of patient care and reduce medical costs.

Our working relationship with the FEHBP provides us with a unique viewpoint on the committee's concerns about the rising cost of pharmaceutical benefits. Over the past several years, all health plans, whether public or private, within the FEHBP or outside of it, have experienced significant increases in the cost of the pharmaceutical benefit. For most health care plans, the pharmaceutical component has been increasing at an annual compounded rate of 15 to 20 percent, so the numbers that you're hearing and are being cited are, indeed, accurate on a compounded basis. But FEHBP's experience is not different from what we're seeing in other parts of the private sector that we manage.

In addition to the 4 million lives that we manage in the FEHBP, overall on a national basis we manage over 50 million lives in managed care plans, so we have a very broad base of experience.

The plans that we serve are experiencing pharmaceutical cost increases for a number of reasons. The first major factor, and really the principal factor, is the aging of the FEHBP population. As you can see from chart 1, which is attached to my testimony, which I think maybe is the single-most critical piece of what's driving costs here, is the increasing age of the population. Chart 1 demonstrates the increasing utilization and how rapid it is when associated with age. The curve, as you can see, is extremely steep in terms of the amount of medicine that is used by the average person as a function of age. That's very critical and is something we can and should talk about.

The second major factor is that physicians are prescribing drugs more frequently as new drugs have become available to treat a broader range of illnesses. We estimate that the increased utilization results in approximately a 10 to 12 percent increase in health plans on an annual basis. And that's on a compounded basis going forward.

But that 10 to 12 percent needs to be put in perspective. Today's prescription drugs are replacing more invasive medical procedures and treating diseases which formerly had no cure or effective ther-

apy. Utilization of many drugs translates into better health outcomes, improved quality of life, and in some instances, cost savings to the plan in the form of reductions in other medical expenditures, such as doctor visits and hospitalizations.

If you look back just a very short period of time, there were no cures and there were no treatments for ailments like HIV and AIDS. There are a number of conditions where breakthrough drugs have, in fact, done a remarkable job in improving the quality of life and productivity.

Chart 2, which I think is also really critical, shows that utilization is occurring at all ages across the age spectrum. While these data are not FEHBP specific, they are representative of our experience with the FEHBP. If you look at chart 2, what you see—and we have provided you with really 3 years' worth of data, with the 1998 data for a half-year extrapolated. But what you're seeing is, year by year, a person of the same age is using more medicine, and generally a function of more and better drugs available to treat conditions that previously did not have a medicine to treat them.

The mix of prescribed medicines is also changing in a way that increases costs. The introduction of new breakthrough drugs can have a substantial impact on the total cost of pharmaceutical benefits. One example is the introduction of a new, very effective medicine for migraines. Prior to the availability of this new medicine, the average daily cost of medicines to treat migraines was about $3.40. The new product, which shortens the duration and dramatically mitigates the intensity of migraines, costs $14 per day. We estimate that the current impact of the changing drug mix adds about 3 to 4 percent per year on the cost of pharmaceutical benefits.

The third principal factor in increases in the cost of the pharmaceutical benefit are increases in the price of pharmaceuticals themselves. Prescription drug price inflation has been relatively modest in recent years. According to the Bureau of Labor Statistics, drug price inflation in 1997 was about 2.5 percent. So if you look at the overall numbers in terms of what's driving that 15, 18, 20 percent increase, it's really being driven by utilization and new breakthrough drug therapies that are available to people to improve their medical condition and quality of life.

We continue to work with FEHBP plans to control the cost of pharmaceutical benefits. In fact, FEHBP plans, including the Blue Cross plan that Steve mentioned, which we serve, have been among the leaders in adopting new, innovative programs in health management that work with patients and physicians to improve health outcomes, while reducing costs.

We are pleased that the GAO, in its February 1997 report to this committee, cited the benefits of the activities of Merck-Medco and some of our competitors in controlling cost in the pharmaceutical benefit. That report cited savings of 25 to 27 percent in pharmaceutical costs as a result of the innovative programs that we use. So, absent those techniques, the trends that you're seeing would be even higher.

Among the most important techniques that we employ to control costs are aggressive use of generic substitution, the use of formularies, drug utilization review, the use of mail service phar-

macy benefits, and general health education and physician education. We will continue to find new ways to improve patient care as we reduce unnecessary prescription drugs and other medical costs.

But, looking ahead, we do not foresee change in the rate of cost increases in the prescription drug component of the plans' overall cost. We understand that OPM projects that the population in FEHBP plans will continue to age, and as they continue to age, they will continue to move to the right on that chart that I have provided to you. Even as older medicines come off patent and enable generic substitutes to meet the patient needs at lower cost, new medicines in the research pipeline will be introduced at a steady pace over the next several years. New medicines for mental health, pain, cancer, and a number of other diseases will place new demands on the pharmaceutical budget, while at the same time they improve patient health.

Finally, while we do not see a return to the levels of drug price inflation that we saw in the 1980's, we continue to project a modest price inflation factor for the actual cost of the pharmaceuticals themselves.

We feel fortunate to work with the FEHBP plans. We believe it is, in fact, an excellent model for delivering competitive, high-quality health care, while preserving the ability of members to choose the plan they want, the ability to "vote with their feet," if you will.

We are always aware that Merck-Medco has excellent competitors who are willing to replace us, to compete with us for this business, and we are pleased to compete for that business. We believe we have a corporate ethic for excellence, and that pushes us to try to do as much as we can to keep these costs down.

Again, I thank the committee for the opportunity to be here today and look forward to your questions. I will be happy to field them at your convenience.

[The prepared statement of Mr. Latanich follows:]

TESTIMONY OF TERRY LATANICH
SENIOR VICE PRESIDENT
MERCK-MEDCO MANAGED CARE, L.L.C.
BEFORE THE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON CIVIL SERVICE
U.S. HOUSE OF REPRESENTATIVES
SEPTEMBER 24, 1998

Good morning Mr. Chairman and members of the Committee. My name is Terry Latanich and I am Senior Vice President of Merck-Medco Managed Care L.L.C., a subsidiary of Merck & Co., Inc.. Merck-Medco appreciates the opportunity today to discuss the role of pharmaceuticals in contributing to recently announced premium increases in the Federal Employees Health Benefit Program (FEHBP).

Merck-Medco

Merck-Medco manages pharmaceutical care for more than 51 million Americans on behalf of more than 1,100 health plan sponsors. These sponsors include approximately 125 of the Fortune 500 employers, one-third of the nation's Blue Cross and Blue Shield plans, labor unions, and more than 100 local, state, and federal employee and retiree groups.

Merck-Medco works with patients, local pharmacists, physicians, and plan sponsors to improve the quality of patient care and reduce medical costs through better management of prescription drug use. Merck-Medco and its subsidiaries employ approximately 11,000 people working at 27 sites in the U.S. We operate eleven state-of-the-art mail service pharmacies and two pharmacies devoted solely to prescription medicine counseling. Through our subsidiary, Paid Prescriptions, L.L.C., Merck-Medco works with a network of approximately 56,000 community pharmacies, nearly all pharmacies in America. Merck-Medco employs more than 1,800 pharmacists, physicians, and nurses.

Merck-Medco and the FEHBP

Merck-Medco serves as the pharmaceutical benefit manager for several FEHBP plans. These plans include the two largest fee-for-service plans, the Blue Cross and Blue Shield Association's Federal Employee Program (FEP) and the plan offered by the Government Employees Hospital Association (GEHA). Merck-Medco also serves the American Postal Workers Union (APWU), Special Agents Mutual Benefit Association (SAMBA), American Foreign Service Protective Association (AFS), and the National League of Postmasters.

Through these plans, we serve the prescription needs of more than four million federal employees, their dependents, and retirees. Merck-Medco's working relationship with these plans provides us with a unique viewpoint on the Committee's concerns with the rising cost of the pharmaceutical benefit component of total FEHBP plan costs.

Analysis of Cost Increases

Over the past several years all health plans, whether public or private sector, have experienced significant increases in the cost of their pharmaceutical benefit. For most health care plans, the pharmaceutical component has been increasing at an annual compounded rate of 15 to 20 percent. FEHBP's experience is not different from what is occurring in other private sector plans. In the balance of my testimony I hope today to provide the Committee with some insight into the factors that contribute to these cost increases.

The FEHBP plans that we serve are experiencing pharmaceutical cost increases for a number of reasons. First, the average age of plan members is increasing and with increasing age comes the need for more prescription medicines. Second, plan members are using more medicines and a more costly mix of medicines. Third, and perhaps least significant, the price of medicines is rising.

I would like to review each of these trends in turn and estimate their impact.

Aging of the FEHBP Population

The first major factor in increasing costs is the aging of the FEHBP population. In Chart 1 we show the correlation between age and the days supply of prescription drugs used. For example, using 1997 data, the average 40-49 year old used 327 "days supply" of medicine. This means that an average patient used fewer than one prescription medicine each day. In contrast, the average 50-59 year old used 577 days supply or more than one and one-half prescription medicines each day -- 76.4 percent more. The same trend holds true for the retiree population.

As OPM stated in its press release announcing the premium changes, the average age of an FEHBP retiree is now 71. Again, using 1997 data, the 70-75 year old uses 1,016 days supply compared to the 903 days supply used by those in between 65 and 69, or a 12.5 percent difference. While the numbers we present are from Merck-Medco's overall experience with the plans we manage, they are consistent with the experience of the FEHBP drug plans we administer.

The Increased Use of Prescription Drugs

The second major factor is that physicians are prescribing drugs more frequently as drugs have become available to treat a broader range of illnesses. Today, prescription drugs are replacing more invasive medical procedures and treating diseases which formerly had no cure or no effective therapy.

Chart 2 shows the increase in utilization at all age levels. For example, the average 62 year old patient in a funded health benefit plan in 1996 used 711 "days supply" of medicine. This means that an average patient used approximately 1.9 medicines each day. In 1997 that number had grown to 757 days supply or an average of 2.1 medicines per day, an increase of 6.4 percent. Our figures for the first half of 1998 show continued increases. Again, while these data are not FEHBP specific, they are representative.

The reasons for increased utilization of drugs are many. Utilization of many drugs translates into better health outcomes, improved quality of life, and, in some instances, cost savings to the plan in the form of reductions in other medical expenditures such as doctor visits and hospitalizations. For example, studies document that the increased use of insulin as part of an intensive program to normalize blood sugar levels reduces the risk of complications by more than 50 percent. Similar studies show that improved drug therapy for asthma patients reduces medical resource consumption.

There are clearly instances where drug utilization can be decreased because it is inappropriate or is being used for too long a duration or at inappropriate dosage levels. But eliminating these problems will not, in all likelihood, reduce overall utilization in the long term. Many medical conditions for which there is effective drug therapy are underdiagnosed. Examples include hypertension, diabetes and congestive heart failure. Even where correct diagnosis has occurred, many physicians are not following the "best medical practice" guidelines adopted by NIH, AHCPR, VA or medical professional societies which often call for the addition of a drug as part of the optimal treatment strategy. Finally, the level of patient compliance with prescribed drug therapy is very low. It has been estimated that no more than 30 percent of persons who have been placed on medication for hypertension remain compliant with their prescribed therapy after just one year despite the fact that high blood pressure represents a leading causing of death in our nation. As "at risk" populations are better identified, physician knowledge increases, and patient compliance is improved, overall utilization can be expected to increase substantially.

Increased utilization results in approximately a 10-12 percent increase in health plan drug costs on an annual compounded basis.

The mix of prescribed medicines is also changing in a way that increases costs. The introduction of new, breakthrough drugs, can have a substantial impact on the total cost of the pharmaceutical benefit. For example, protease inhibitors for the treatment of HIV have resulted in dramatic improvements in both the quality and length of life for those affected. Another example is the introduction of new, effective, migraine medications. Prior to the approval of Imitrex, the average cost per day for medications to treat migraines was $3.40 per day. Imitrex, which shortens the duration and mitigates the intensity of migraines, costs $14.00 per day of therapy. Since Imitrex is the fastest growing drug in this category the average cost of treatment in this category is also increasing.

These are only two examples of a dynamic equation. In many classes, patented drugs are coming off patent and are becoming generically available. This trend will reduce costs. But other new, better drugs, will enter "generic" categories and increase costs. For example, many drugs used to treat arthritis have the side effect of causing peptic ulcers. New drugs are in development or in the approval process at the FDA which appear not to have this side effect. If approved, the cost of this class of drugs will almost certainly increase, but medical costs for treating peptic ulcer disease should decrease.

Depending on the age demographics of a specific health plan the impact of "mix" will vary, but in general, we estimate the current impact of the changing drug mix as a 3-4 percent increase in

health plan drug costs on an annual basis in addition to the estimates for increased utilization.

Manufacturer Price Increases

The third principal cause of increases in the cost of the pharmaceutical benefit is increases in the prices of the medicines used by FEHBP plan members. Unlike the period of the early 1980s, prescription drug price inflation has been modest in recent years. According to the U.S. Bureau of Labor Statistics, drug price inflation, measured by the pharmaceutical component of the CPI-U, was 2.5 percent in 1997. The CPI-U does not, however, measure rebates or discounts extracted by health plans or their benefit administrators, such as Merck-Medco, on their behalf.

Merck-Medco Efforts to Control Costs

Working with our plans, Merck-Medco is aggressively trying to constrain prescription medicine costs where that is consistent with improving patient care. We are pleased that the General Accounting Office, in its February 1997 report to this Committee, cited the benefits to the FEHBP of the activities of Merck-Medco and our competitor pharmaceutical benefit managers in controlling costs. That report cited savings of 25 to 27 percent in pharmaceutical costs as a result of the innovative programs we utilize.

Among the most important techniques that Merck-Medco employs to control costs are the use of generic substitution, formularies, drug utilization review, mail service dispensing, and health education. I would like to briefly describe each.

Generic substitution is the practice of dispensing a low-cost, generic form of a brand name prescription medicine. This is the same chemical as the original, brand name drug. Except where a physician specifically indicates otherwise, all states allow pharmacies to make this substitution without contacting the physician. In our own mail service pharmacies and the 56,000 community pharmacies in our networks, we work to ensure that generic drugs are used whenever possible. Where the physician indicates 'dispense as written' for a brand name medication, our mail service pharmacies often will contact physicians to discuss with them the possibility of using a generic. This year, our pharmacists will place more than 100,000 phone calls to physicians to encourage the use of generics.

Where there are no generic forms of a medicine, Merck-Medco uses formularies to create price competition that lowers drug costs in FEHBP plans. Formularies, or lists of preferred medications, have long been a common technique in the inpatient, hospital setting. All of our FEHBP plans use formularies. The preferred medicines on our formularies are selected based on the clinical evaluation of independent medical experts. Their work enables Merck-Medco to leverage the market power of the FEHBP plans to seek rebates and discounts from pharmaceutical manufacturers. To encourage the use of preferred medicines, Merck-Medco employs programs to contact physicians to alert them to formulary medicines that offer savings to the FEHBP plans. The physician always makes the final determination of the best medicine for the patient.

Through drug utilization review, or DUR, our mail service and cooperating retail pharmacists review prescriptions to ensure that medicines are not misused or abused. These techniques not only achieve better outcomes for patients, but are also proven to reduce unnecessary prescribing and unnecessary costs. We also review drug utilization retrospectively to look at physicians' patterns of prescribing. In this way, we can identify physicians who may lack the best current information on the use of medicines. Through educating these physicians, we can improve patient care and reduce costs.

Merck-Medco's eleven mail service pharmacies provide our FEHBP plans with a high quality, low-cost way to fill member prescriptions. Mail service dispensing is appropriate for many medications that patients need to take for chronic conditions such as high blood pressure, diabetes, and depression. Several of our plans encourage the appropriate use of mail service pharmacies by sharing with their members the savings realized through lower copayments.

Finally, through health education, we can better assure that patients take their medicines correctly and avoid adverse events that can worsen their health and increase health plan costs. Education can also reduce the use of medicines when that use is ineffective or actually harmful to a patient.

FEHBP Plans Lead in Innovation

As discussed above, the FEHBP is experiencing pharmaceutical cost increases roughly comparable to other non-FEHBP, private sector plans we administer, controlling for age and other factors. We have worked with our FEHBP plans to implement the cost control techniques I described earlier. In fact, FEHBP plans have been among the leaders in adopting new, innovative programs in health management that work with patients and physicians to improve health outcomes while reducing costs.

As new concepts are developed and tried, we will continue to find new ways to improve patient care as we reduce unnecessary prescription drug and other medical costs. One area we will continue to review with the plans is the remaining situations in which plan members continue to have no copayment for the purchase of medicines.

Future Projections

We do not foresee substantial changes in the rate of cost increase in the prescription drug component of health plans' overall costs. Specifically, even as older medicines come off patent and enable generic substitutes to meet patient needs at lower costs, new medicines in the research pipeline will be introduced at a steady pace over the next several years. New medicines in the areas of mental health, pain relief, and cancer prevention, to name just a few, will place new demands on pharmaceutical budgets at the same time they improve patient health.

We also understand that OPM projects that the population in FEHBP plans will continue to age. Finally, while we do not see a return to high drug cost inflation such a seen in the 1980s, we

project a modest inflation factor for each of the next several years.

FEHBP Plan Partners

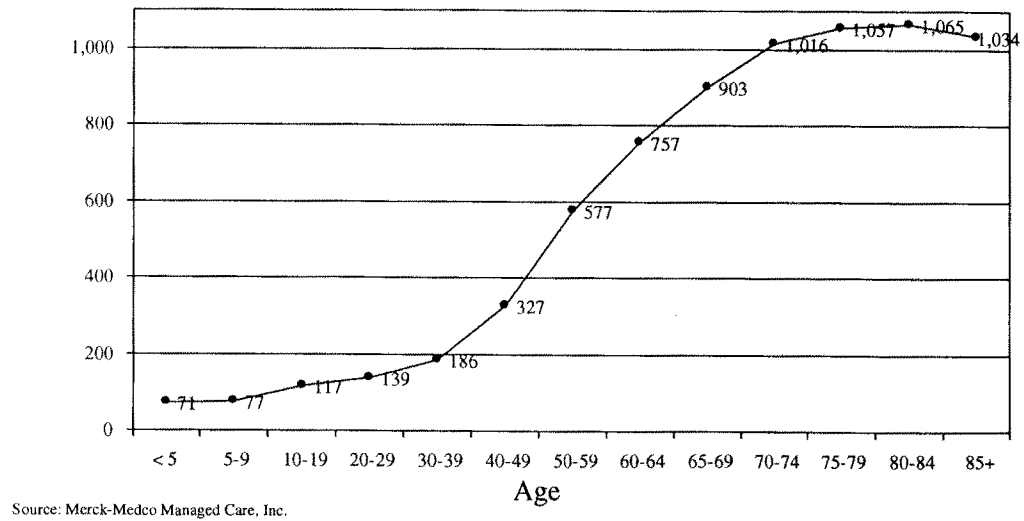
As a pharmaceutical benefit manager, we feel fortunate to work for FEHBP plans. The FEHBP's private sector plan managers have been able to work with us to swiftly adopt innovative programs for reducing costs and improving care. We are pleased that our services are appreciated by plan members who consistently give us high ratings in survey of member satisfaction.

The FEHBP is, indeed, a model for federal health care and the area of pharmaceuticals presents a good illustration of its successes. We are always cognizant that Merck-Medco has excellent competitors who are eager to win FEHBP business. This, along with a corporate ethic for excellence, pushes us on to provide FEHBP plans with quality service at the lowest possible cost.

Again, I thank the Committee for the opportunity to be here today and look forward to your questions.

Chart 1
Prescription Drug Utilization per Patient by Age Group
1997

Patients over 60 years of age consume 4 times more medication than patients below 40

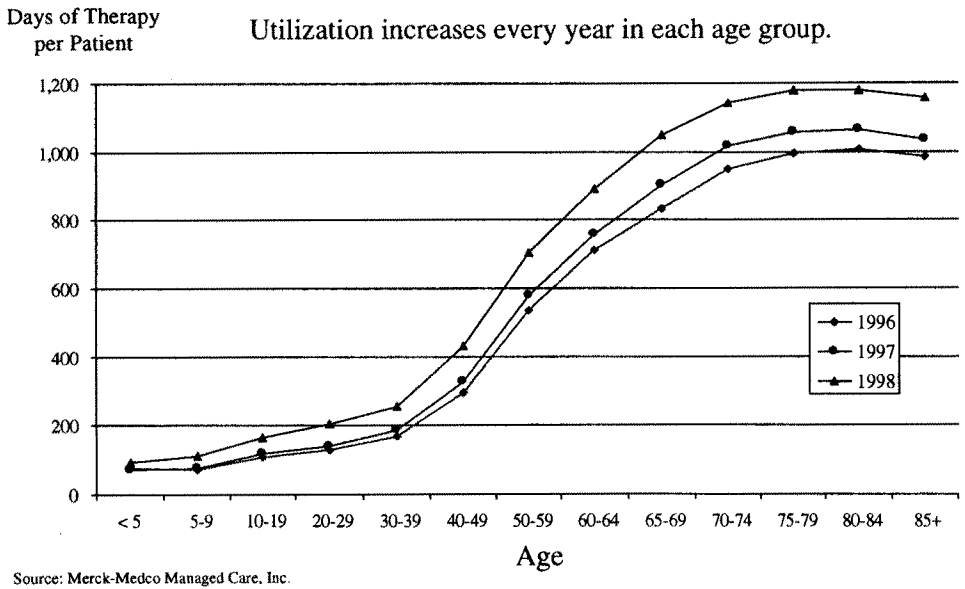


Source: Merck-Medco Managed Care, Inc.

Chart 2

Prescription Drug Utilization per Patient by Age Group

1996, 1997, 1998 (six months)



Source: Merck-Medco Managed Care, Inc.

Mr. MICA. Thank you, Mr. Latanich.

Mr. Gammarino, I would like to start first with you. You have testified that the FEHBP premium increase reflects trends in the general health insurance market and are in line with what the private employers have experienced. The Congressional Budget Office has told the subcommittee that medical inflation has increased by only 3.5 percent between August 1997 and August 1998, and by 2.7 percent during 1998. Thus, medical inflation, while increasing somewhat, is still fairly modest, as has been cited.

A recent article in the "Journal of Health Affairs"—and I think I cited that in my opening statement—said that private employer-sponsored health insurance has risen at 3.3 percent in 1998. That was less than half the FEHBP's rise of 8.5 percent, even though expenditures for drugs have increased at double-digit rates throughout the economy.

Has your experience with rate increases for private sector employer-sponsored plans been different than these numbers would suggest?

Mr. GAMMARINO. Let's turn to a couple of the indices you mentioned. You indicated the medical CPI is in the low single digits, and that may be the case. I think the issue we're all feeling in the industry is that the cost pressures aren't necessarily driven by the price increases. They are driven by the utilization of services, and they are driven by the technology for new services that I don't think are included in the CPI.

As Mr. Latanich just testified on the drug for migraines, Imitrex, it was three to four times more expensive than the drug it replaced. That isn't calculated when they do the medical CPI because it's a new drug, a new product coming on the market.

Second, in terms of increases for the private sector, from my observation some of that business is being bought by insurance carriers. You only have to pick up any issue of the Wall Street Journal and see significant red ink associated with health care insurance carriers today. A lot of that is because they did not price their products appropriately, associated with the cost of utilization.

Third, the private sector may be more aggressive in some cases in modifying their benefits to reflect the changing patterns. I know in our own case we are attempting to modify our benefit structure to have more cost sharing associated with the drug area, and I think in the private sector they are a lot more aggressive in taking immediate action in that area.

Mr. MICA. As I recall, I think the biggest area of increase you experienced was in the drug area, and you attribute utilization as the primary factor for that.

Now, as I understand it, the drug component is 20-some percent of the total cost?

Mr. GAMMARINO. For our program, it's 30 percent. The average age of our enrollees is older than the average age within the FEHBP.

Mr. MICA. OK. But there is still a 70-percent residual cost. What are the biggest factors in the cost of that other 70 percent? It can't all be driven just by drug costs and utilization to get to that increase.

Mr. GAMMARINO. Primarily it is. Let me just give you our figures in that arena.

Overall we're seeing trends of about 7 or 8 percent. In other areas, like hospitalization, the hospital cost, and physician outpatient costs, we are seeing trends at or around the CPI, 2 to 4 percent, with the hospital cost being the lowest of those two.

Clearly, absent the pharmacy cost increases, you would be seeing rate increases in line with probably the medical CPI for our program. It is clearly the compounding trends on the drugs that are causing the type of increases that I think this committee is concerned about, and we are concerned as well.

As Mr. Latanich just indicated, what is scary, the trend lines aren't getting any better, with these new drugs coming on the market. As most of you know, today the FDA has what's called a fast-track way of approving drugs. There are over 50 new, high-tech drugs in the pipeline this year coming out on the market. That compares with the mid-80's of about 20. So you have those types of pressures being put on payers such as us. But, of course, these new technologies are also adding value to the population.

Mr. MICA. Then why would private sector health insurance have risen at 3.3 percent when they're going to be experiencing similar increases in drug costs? Is it particularly the utilization factor, or——

Mr. GAMMARINO. Utilization. I would have to research that figure. I can tell you, for Blue Cross Blue Shield, in general, our private business is seeing increases significantly higher than what you quoted. So that is not the norm in terms of what private payers are paying Blue Cross Blue Shield plans in the private sector.

Mr. MICA. Again, I'm just wondering if it can totally be attributed to drug costs.

Has Blue Cross Blue Shield instituted any measures to try to bring drug costs under control?

Mr. GAMMARINO. Well, we have a number of measures that we have in place. First, and foremost, is discounts that we get from manufacturers and from the retail pharmacy area. That is the primary area in which we enjoy savings in the pharmacy area today, and we're going to have to get more diligent in that area, particularly in the area of new breakthrough drugs, which are quite expensive.

We have a number of drug utilization review programs that provide intervention, where we think we can talk to a physician, intervene and work with the physician, to move a patient off a more expensive drug to a like-class drug that is less expensive.

We have disease management programs that look to secure overall higher quality for our patients while at the same time improving our costs. We have a number of areas that we look at today.

I can tell you some things that we don't do that we could, but we think it would inflict pain to our consumers that they do not want and are unwilling to accept. For example, our pharmacy network is one of the broadest in the country. We certainly could reduce the size of those networks and have them more restrictive, have less choice for our consumers, and probably obtain better discounts with fewer numbers. We have chosen not to do that.

We could have what is called a closed formulary, which means there would be a list of drugs that would be required, mandated, for use, and it would reduce the choice of our subscribers. So there are some steps we can take, and there are some steps we have taken.

The choices we have are difficult. There is no easy answer to this cost push right now. It's going to have to involve a number of players, the ones here at the table, people like Medco, Blue Cross Blue Shield, but we need to involve both the physicians, consumer, and the drug manufacturer if we're to rein in these double digit increases.

Mr. MICA. You talked about your mail order pharmacy benefit very briefly, and it stirred a lot of controversy several years back. We heard from the retail drug stores that said it was unfair for Blue Cross to charge a copayment when an individual fills a prescription at the local pharmacy, but not when he fills it by mail.

Have you considered instituting a copayment for mail orders, and if not, why?

Mr. GAMMARINO. We currently have copayments for our non-Medicare B population. We have tried for the last 2 years to add some form of cost sharing to our Med B population, without success.

We have not convinced the agency to this date about the value of this. We think it's of significant value because it puts the consumer as a key decisionmaker in this process. Certainly we think it would result in a more judicious type of decisionmaking in terms of the selection of drugs.

Mr. MICA. You are negotiating I know with OPM, and have been, to come up with a benefit package. Has OPM prevented you from modifying your benefit package for 1999 to help control costs in any way? What's your opinion? Are they providing roadblocks, or what they are doing to not help you control costs?

Mr. GAMMARINO. They certainly have provided a very high hurdle that we haven't been able to get over yet. We certainly might need your assistance.

Mr. MICA. Could you describe the hurdle?

Mr. GAMMARINO. Well, the hurdle is "No, you're not going to get your benefit design change."

Any other questions? [Laughter.]

Mr. MICA. Again, we're trying to find ways to help you reduce costs, and we're hoping the agency would work with you to find some measures that can be instituted to control costs. You know, you're on the firing line, so we look to you for direction.

Is there anything the committee can do to help open any doors, any specific areas?

Mr. GAMMARINO. Well, I think to encourage an open and objective review of this issue. Clearly, we're one of the few health care plans left in the country that has no cost sharing for drugs for a certain population. I know we have worked with our PBM's, such as Medco and PCS and others, and they've helped us support an objective assessment. This would help us reduce what we think would be in some cases overutilization and sometimes inappropriate utilization. It does put the consumer there with his physician saying, "Doctor, is this the most cost-effective drug for me, be-

cause I do have to pay a portion of it." That type of dialog doesn't have to occur today.

Mr. MICA. I understand there is also some controversy relating to the cost accounting standards language. Will Blue Cross sign the 1999 contract if it contains the cost accounting standards language?

Mr. GAMMARINO. We have told the agency that we cannot sign a 1999 contract with the clause they had in 1998. We are looking for what we think is fair relief in that area for us to continue participation in the program. Hopefully we're working with both the agency and the CAS Board to get that relief. If that relief isn't coming there, we do need congressional support in legislation to help us in that arena.

Mr. MICA. And if it doesn't work out, we'll just lose the carrier that provides coverage for 40 percent of our covered population?

Mr. GAMMARINO. If it doesn't work out, as I told the agency, we have 56 independent companies that make up the Blue Cross Blue Shield system, and they'll each make independent decisions, very much like some of the HMO's made them this year.

Mr. MICA. I have additional questions, but I want to give at least 5 minutes to start with to the ranking member for questions. I believe they've called a vote on us, so go ahead, sir.

Mr. CUMMINGS. I was just listening to your testimony and I was trying to figure out—we have savings by using prescriptions because we reduce our hospital stays, I take it, and we also save on perhaps a lot of procedures. But I guess the factor that kicks in, you would think that as one goes up, the other ought to be coming down. I guess what happens is, it's because the aging population keeps the hospitalizations and whatever going up.

Is that a fair—it just seems like one is saving so one would be coming down.

Mr. GAMMARINO. That's the argument that the drug manufacturers put on the table. The bottom line is, if that was a true 1-to-1 savings, you wouldn't be seeing the increases we're having today. The fact of the matter is there is not a clear offset in the enhanced drugs that are out there versus the reduced hospitalization and maybe other types of services.

Mr. CUMMINGS. In other words, you're saying you don't see that, that you don't necessarily agree with that?

Mr. GAMMARINO. No. Certainly there are individual drugs managing individual medical situations that do benefit in that area. But across the board, no, that's not the case.

Mr. CUMMINGS. Let's talk about generics. You make generics also, is that correct?

Mr. LATANICH. We ensure that they are widely used within the program. We don't make generics.

Mr. CUMMINGS. I'm sorry. Say again. I didn't hear you.

Mr. LATANICH. What we do is we encourage within our own pharmacies and plans other than FEHBP, we administer both mail and retail—we encourage, to the maximum extent possible, the use of generics.

Mr. CUMMINGS. You know, there was some controversy not too long ago where there was a question as to whether generics were as effective as the originals. Are we beyond that now?

Mr. LATANICH. My perspective, or my company's perspective, is that, in general, we are. I think the physicians are accepting of the comparability. From what we see, the patient population accepts the concept of comparability. In fact, we make 100,000 phone calls a year where doctors have not allowed generics, and in virtually all cases they agreed to it. It's more one of habit than any real medical concern.

There are some cases where the physicians do want brand name use, and that is always honored. But I think the rate of generic use is extremely high, and there is very little reticence to embrace it.

Mr. CUMMINGS. Mr. Gammarino, what is your policy with regard to generics?

Mr. GAMMARINO. It's the individual's choice. The way our benefit design is configured under the retail side, with coinsurance, the subscriber makes the choice of what he or she would prefer. They usually make that choice with their pocketbook in mind and that results in over 40 percent of the retail pharmacy drugs being generic. So we have almost 90 percent of the potential being met there without any mandates.

Similarly, on the mail side, our generic substitution rate is very high, because unless it's dispensed as written by the physician, we will intervene and switch the subscriber to a generic. In most of those cases, it is well received by both the physician and the subscriber population.

Mr. CUMMINGS. One interesting thing with regard to prescriptions, I was recently talking to a dermatologist who—you know, when you go to these doctors and they find out that you're a Congressman, you get the whole spiel.

But one of the things he was complaining about, he said that in his business, there are certain types of drugs that plans don't cover, won't cover. So what would happen is he has to give a weaker drug to the patient, and he has to use that drug for a much longer period of time. By the end, when you add all of it up, the patient has suffered longer and the ailment could have been cured much faster. It ends up that the plan pays more money.

You all may not have this problem, but he was very frustrated, because he said it ties his hands and with that longer period of treatment, that opens the door for other kinds of things to happen.

Mr. GAMMARINO. The Service Benefit Plan does not have that policy.

Mr. CUMMINGS. Thank you. I will wait for the second round.

Mr. MICA. We have a little less than 5 minutes to vote. Why don't we recess for 15 minutes. We will return at 12:30 sharp.

[Recess.]

Mr. MICA. If we could call the subcommittee meeting back to order.

Mr. Pappas has had to go to another meeting, but I'm going to ask a couple of questions for him and then we'll go back to the other side. These questions are for Mr. Latanich of Merck-Medco.

Congresswoman Lowey has introduced H.R. 1525, the Prescription Drug Benefit Equity Act, which has been referred to this committee. As I understand this bill, it would prohibit FEHBP plans from offering members lower copayments for prescriptions filled at mail service pharmacies.

What impact would the passage of this bill have on FEHBP premiums, in your opinion?

Mr. LATANICH. Thank you for the opportunity.

I think that we very clearly oppose the legislation. Our view is that the best health policy is to allow members to shop in an environment where they can manage their own cost and help improve the cost of the plan.

If, as is true in the Federal plans that we serve, we can provide a lower cost product and a lower cost delivery system to the plan sponsor, and the member wants to take advantage of that and help save the plan money, and the health plan wants to share part of those savings with the member through lower cost share deductibles or whatever, that that ought to be allowable. In fact, it ought to be encouraged, not discouraged, because that's one of the ways you help health plan members assume responsibility for their own health care. So we think that it's well intended but its result we think would be a substantial increase in the cost of the FEHBP drug component.

Mr. MICA. The second question he submitted was on another bill recently referred to this subcommittee, H.R. 4559, entitled, "The Prescription Drug Patient Choice Act." It is from Congressman Brown of Ohio.

Does Merck-Medco have any views on the impact of this legislation on FEHBP patients' access to pharmacies, and also FEHBP costs?

Mr. LATANICH. Well, as I understand Congressman Brown's bill, it would essentially eliminate the ability of FEHBP plans to use any pharmacy network in its program. Essentially every pharmacy would have a right to participate.

As Mr. Gammarino noted, one of the real strategies for getting better reimbursement is to limit the number of pharmacies and use that leverage to secure better pricing. In essence, if you can show a pharmacy that they're going to gain incremental use because they are one of fewer pharmacies participating, you have the ability to negotiate with them and obtain better pricing. If you can't do that, then you're really at the mercy of whoever the provider is. You have got to accept their price. They don't have to accept your price.

So the ability to maintain networks, whether it's in pharmacy medicine, or any element of health care, is really critical in your ability to negotiate with providers. So we are not at all supportive and would encourage this committee not to be supportive of that bill.

Mr. MICA. Thank you.

I will yield now back to our ranking member, and then we'll go to Mrs. Morella.

Mr. CUMMINGS. I was listening to what you just said. Of course, we have a lot of Federal employees in Baltimore, in my district, because we have the Social Security Administration there. One of the things that I have noticed is that more and more pharmacies have come back to the inner cities, everywhere. I used to be able to go a mile and maybe run into two pharmacies. I can now go a mile and run into six.

I guess the thing that concerns me, while there would be benefits, the leverage you just talked about, in maybe dealing with fewer, at the same time I guess the other side of that is making sure that companies are sustained. I just wanted to hear your view on that.

Mr. LATANICH. I can tell you our experience as Merck-Medco—and I was involved in negotiating, early on, most of our network contracts with pharmacies. Most health plan sponsors, when they ask you to put together a limited network, typically give you a requirement that there must be *x* number of pharmacies within an *x* number of miles of the location of each of the people.

Most of the plans will give you a list of all of their employees and use essentially a geomapping strategy. You are able to say, OK, for every member of this population, I'm going to have two pharmacies, three pharmacies, within 1 mile, 2 miles, 3 miles, whatever the standard is that is adopted by the plan.

I think our experience has been that it has not had a negative or more negative effect, if you will, on inner city pharmacies, rural pharmacies. In many cases, the principal impact has been, I would argue, on the suburban pharmacies, where there may be one on every corner and you don't need eight choices within 2 miles, if you want to try to cut your reimbursement. But most plans that we've dealt with have very explicitly required that we maintain coverage standards in rural areas, maintain coverage standards in inner-city areas.

Mr. CUMMINGS. You both talked about these prescriptions and doctors writing prescriptions. I'm just curious. Do you think there's a mindset now among doctors where they feel like prescriptions are the things to do?

I mean, as I look at my mother's and father's prescription cabinet, it looks almost like a pharmacy. They're 72 years old. I go through there about every 6 or 7 months and try to figure out—you almost have to have a chart to figure out what it's all about.

I'm just wondering, do you think there's more of a belief with regard to doctors, that they should be writing more prescriptions for every little ailment?

Mr. GAMMARINO. I think there's a lot of—if you would like for me to respond to that——

Mr. CUMMINGS. Yes; please do.

Mr. GAMMARINO. Just take a look at the pressures on the physician today. First of all, you have the new high tech drugs, and you have direct to consumer marketing. We didn't have that 4 or 5 years ago. Drug companies are spending over $1 billion a year to market those drugs, and they're not marketing it to anybody now but the consumer, and they're putting the pressure on.

Additionally, the drug industry is spending billions in what we call physician detailing. Thirty thousand drug representatives are meeting as we speak with physicians, touting the benefits of their drugs. So you have all that, in combination, I think exerting a lot of pressure on the physician, and I do think today in some cases it's the easy way to deal with certain conditions. But I think it's what the consumer wants, in many respects.

Mr. CUMMINGS. So when they hear these commercials—these commercials are fascinating to me, because it seems like half of

them tell you what's wrong with the drug, with all the precautions and things. So you're saying with that kind of advertising, the patient goes in and says, "Doc, they just said there's something for hair loss, and I heard about it. I've been hearing it over and over again. Prescribe that."

That's the kind of person you're talking about?

Mr. GAMMARINO. Yes. It's unrelenting pressure. I mean, they're getting it from the drug companies and they're getting it from the consumer about the value-added of a particular drug.

Then you couple that with—you know, to this day, it's relatively low cost sharing. The consumer wants it and they're willing to pay that low copay. They're not really tasked with the cost of that drug, which could be quite high.

Mr. CUMMINGS. My last question. You know, when you look at a drug like Viagra—and I understand what insurance companies are doing with regard to that—but I think Viagra put a spotlight on the issue of drugs which might be making life more enjoyable. A lot of people look at Viagra, but I'm sure there are many other drugs out there that have nothing to do with sex but just make people's lives better and is not necessarily dealing with a particular ailment.

Is that a part of the problem, too? I'm just curious. I mean, drugs that don't fall under that category, where you can say we're not going to pay for them, but I assume there are many other drugs, too, that are life enhancing and making people feel better, what have you. Is that a part of the problem, do you think?

Mr. GAMMARINO. For us, Viagra is not a problem, because we have an exclusion. But it certainly would have been a significant problem. It is an issue of what you call the life enhancement quality drugs. Consumers want them. If they are covered by a plan, you're going to have high utilization.

I think companies like ours are going to have to make choices, because where are you going to put that bucket of money? Is it evenly spread between life enhancements and those drugs that actually cure life-threatening diseases? You know, if we have to make those choices; I know we're going to put it in the bucket with life-threatening diseases and chronic ailments. We'll probably carve out—we may be carving out what are called life-enhancement drugs from coverage.

Mr. CUMMINGS. Thank you very much.

Mr. MICA. I thank the gentleman.

The gentlelady from Maryland, Mrs. Morella, is recognized.

Mrs. MORELLA. Thank you, Mr. Chairman.

Speaking of life-enhancement drugs, we passed on the floor of the House, and now passed in our appropriations bill, the concept of gender equity in prescriptions, which means contraceptives. I'm wondering, is this going to have any kind of a cost impact on premiums?

Mr. GAMMARINO. For Blue Cross Blue Shield, it's nominal. We have been gender equal for years. We have been paying for contraceptives, for example. It's already built into our premiums.

Mrs. MORELLA. You have been, all kinds, right. I don't know whether or not Mr. Latanich wanted to comment on that, or as we expand, what we're asking to have covered in terms of drugs.

Mr. LATANICH. I think that, generally speaking, the plans that we deal with are uncomfortable with mandates, because it eliminates their ability to control what's being used.

Congressman Cummings pointed out that there are life-enhancing drugs, there are life-saving drugs. Unfortunately, it's not usually that stark. One of the issues that most faces women today is that they are underdiagnosed for coronary disease. As you look at some of the different treatments—and I'll use hypertension as an example—the data showed that after 1 year, only 30 percent of the people who were taking hypertension medication are still compliant.

One of the major reasons is that those drugs often have side effects. So, if you have a new drug that comes out and is more expensive, but it eliminates some of those side effects, and encourages compliance, is that something which is life enhancing because it eliminates a side effect? Or is it something which is medically necessary in order to eliminate or help the medical condition?

I think what the plans face, and what Mr. Gammarino's plans face, all of them, is that they are all gray decisions, so they are very, very difficult. There is no magic bullet to control drug utilization or drug cost. You really have to look at every drug, at every class of drugs, and have a strategy that says what is my strategy in this class to control the use of drugs.

To your earlier question, Congressman Cummings, I think that patients have come to expect that the closing act with the physician is going to be the prescription. If you go to somebody and say to them what you need to do is eat less and exercise, the patient's reaction is "I didn't need to spend $70 to come in and have somebody tell me to lose weight and exercise." So I think there is a mindset that says that I, as a doctor, need to do that, but that's coupled with the fact that usually the drug will have a benefit. I mean, it is going to help that patient, and therein lies the difficulty.

Mrs. MORELLA. There's no doubt that these are difficult choices. I think they change with time. The more you learn, the more you know how they can save money in the long run, et cetera. So there is this evolving situation.

I think the gender equity concept that we passed is a good one. I think it's valid, and I don't think that's what you're responding to in terms of the differences.

But as one general question, since so many have been asked, my NARFE members, the National Association of Retired Federal Employees, and my other Federal employee at NIH and NIST, say "Why are these costs going up? You had a hearing. What did you learn from the hearing?"

Now, of course, Mr. Flynn is going to succeed you, and we'll have a series of questions for him. But I guess it's, "You're older, and you're getting older, and you're using more prescriptions, using more medicine. I don't see any end to it." Is that what I say to them, about why that increase is higher than it is with other groups?

Mr. GAMMARINO. Today that's the answer. Is it the answer for tomorrow? You know, I hope not. But there are a number of avenues that we hope will be taken.

The biggest one that I think we need—and it would be interesting to hear what your constituents would say about this—and that is, we need more accountability from the consumer. That means probably from their pocketbook. Because right now, without that involvement from them, the demand is excessive. That is fueling a lot of this, albeit very good in many cases. But the consumer has to be involved, in my opinion, from a financial perspective, and that means, from our perspective, we would like a modification in the benefit design that would put them in play with us in terms of paying for these drugs. Because I do not, Mrs. Morella, want to be in a position of saying, because of the spiraling increases, these drugs are in and these drugs are out. I would much rather the consumer make those choices. But in order to do that, I think they have to be financially involved.

Mrs. MORELLA. How do you get them—and I'm not talking about MSA's, but——

Mr. GAMMARINO. No; no. I'm talking about just simple cost sharing. As I mentioned earlier, our Med B population right now has come to expect free drugs.

It's like—I don't know. The last time I went to an all-you-can-eat buffet, I eat a little bit differently at those situations than I do when it's a la carte.

Mrs. MORELLA. More people get doggy bags than have doggies.

Mr. GAMMARINO. I think some of our subscribers are taking quite a few doggy bags home right now.

Mrs. MORELLA. I don't quite know how you handle that accountability or responsibility. Education, of course, is one, where you can point out that if you use the medical services as necessary, your costs will be lower. I'm not really too sure about how we do it, but we would be open to any suggestions you may have.

One final question. Since OPM is going to come before us after you, and you won't have a chance to say anything after Mr. Flynn talks to us, is there anything you would like to change in that partnership that you have? What's the process you go through? Do you submit annually to OPM what your requests are for premium changes? And then what happens?

Mr. GAMMARINO. Every year the Government sends what is called a call letter, providing what they would like in terms of changes from us, and then we respond to that with the changes we would like. In this case, for the last 2 years, we have wanted more cost sharing from the consumer, particularly the Med B subscribers, who get their drugs for free. That's the biggest thing, we think, in the short run that can start to mitigate these costs.

Will it be the "magic bullet," as Mr. Latanich said? No; it will not. There is a lot more we're going to have to do collectively. As I mentioned, there are a lot of stakeholders, when I say collectively, from the providers to the consumers and to the manufacturers, to the people here at this table, to work on this.

The most immediate thing we could do is to have a more realistic benefit design.

Mrs. MORELLA. Would you like to comment?

Mr. LATANICH. In general, we have no direct relationship with OPM. Ours is derivative through the plans that we serve. I think

that, in general, we're very supportive of our plans' efforts to have the maximum amount of flexibility in designing their benefits.

Certainly in the private sector plans, the non-FEHBP plans that we serve, there is a great deal of latitude in what they do. There is a great deal of latitude in terms of how much cost sharing they're willing to negotiate in their collective bargaining agreements, how much cost sharing they can impose in a nonunionized situation.

I think there is a greater ability and a greater willingness in the employer community to take more aggressive steps, because they're accountable only to their stockholders, their employees, and their ability to compete in the marketplace for good workers. So I think there's a different dynamic working in that market than there is in this market.

But, you know, clearly, my belief is that in the private sector, outside of the private plans and the FEHBP, there is a greater willingness to impose more pain, if you will, in terms of fewer choices, more difficult access to certain drugs. And those are hard decisions that you're going to have to face.

Mrs. MORELLA. They are hard. For instance, when you talk about accountability and talk about, let's say, diabetes, the consumer accountability for diabetes treatment—I mean, would it be that area, or would it be other areas? Do you see what I'm saying? This is a very difficult thing to appraise.

Mr. GAMMARINO. If I could respond, in those types of areas—first of all, I think cost sharing is needed, no matter what the condition. I really think there ought to be some financial involvement.

But I would let you know that we have a lot of programs today that we're working toward, on what we call disease management, and diabetes is one of those. In that respect, Mrs. Morella, we will probably have increased costs associated with managing that population, for the very reason that Mr. Latanich mentioned earlier, that some of these people are not taking their medication. So, from that perspective, we will see probably increased costs associated with managing those people. But we think that's an obligation we have for our members.

Mrs. MORELLA. Thank you, gentlemen.

Thank you, Mr. Chairman.

Mr. MICA. Thank you.

I have a couple of questions here. Back to this little impasse we have over the cost accounting standards language with Blue Cross. It is my understanding that Blue Cross can't send out, or you're not allowed to send out the 1999 brochures to the Federal employees and others who may participate, unless or until you sign a contract. I think open season starts on November 9.

What is going to happen as we approach this deadline?

Mr. GAMMARINO. Well, it is certainly something that none of us enjoy, and that is that we have a crisis brewing, associated with our ability to continue participation and get information out to our subscribers.

I mean, it is certainly our intent to be with the program next year, but at the same time, as you know, Mr. Chairman, we need relief from the cost accounting standards. The standards are not appropriate—many of them are not appropriate the way they're

written today. They're written for a different industry altogether. We cannot comply.

Quite simply, I have a responsibility to my board, which is made up of plan CEO's of the various Blue Cross Blue Shield plans, not to put them at risk associated with compliance as a Federal contractor. As a Federal contractor, we take the compliance associated with any contract provision very seriously, and we don't want to be out of compliance. In this case, we cannot be in compliance. So, until we get that relief in the contract, there may be disruption. Hopefully we can resolve the brochure issue in the short run, but the issues compound each other as we go forward if we don't get the relief we think we need.

Mr. MICA. We have heard both of our witnesses testify today about two things: one, that drug costs are driving up the cost of premiums and the cost to the Government for health care, that it's a major factor. We have also heard that both sides want some flexibility to deal with these problems. I think Mr. Gammarino has testified that they want flexibility in benefit design, to help control costs.

Mr. Latanich, do you believe that flexibility is going to help us control some of the increased drug costs that we're faced with?

Mr. LATANICH. I think our reaction to that is that it will. You know, the cost share issue for the Med B's is a very difficult, delicate, and political issue. In general, our advice to our clients is that the presence of a copay does involve the patient to a greater extent in decisions about their health care. So, to that extent, we have been supportive of the plans' efforts to look at this issue. But it's——

Mr. MICA. You've had experience in serving several FEHBP carriers. Do you believe those carriers have the flexibility that they need?

Mr. LATANICH. Well, they certainly have been able, for example, on the Med B's, to in most cases impose a copayment or coinsurance strategy. I think that the Federal plans in general have been less aggressive than their non-Federal counterparts in putting in very restrictive formularies and putting in some of the techniques. But if you're looking long term strategies that are going to be able to deflect the number of days of therapy used, you're looking at much more substantial—I don't say draconian, but very restrictive practices.

They're going to have to make some difficult choices about whether people are going to have access to medicines. That's a very difficult choice for a health plan to make, and I would suspect it's a very difficult one for the Congress to make. When a retired Federal person comes to a Member of Congress and says, "There's a new drug that will do *X* for me; are you going to cover it?" I think that health plans need the flexibility to deal with that. And yet it's very difficult in this environment.

I do think that the more discretion they have, the better, particularly since this is a market where the Federal employees—and I used to be one—have the ability every year to "vote with their feet."

Mr. MICA. Let me ask another question.

FDA policy certainly has an impact on drug costs. On June 30, I wrote to OPM to ask them about a proposed guidance published by the FDA in January on product promotion by managed care organizations. I understand that your organizations, along with the Blue Cross and Blue Shield Association, NARFE, and several FEHB carriers, have expressed strong concerns with that draft.

In a letter to me of August 5, Director of OPM Lachance stated her view, "We do not see how guidance, as drafted, could possibly adversely affect the FEHB, as long as our plans and their pharmacy benefit managers act responsibly."

Mr. Latanich, do you agree with OPM's, and if not——

Mr. LATANICH. No; not at all.

Mr. MICA. Why not?

Mr. LATANICH. The FDA's draft guidance essentially said, or could be read—and it was very ambiguous—but it essentially said that, if you accept rebates or discounts from a manufacturer, we're going to treat you as a manufacturer, and what manufacturers can say about their products is very, very limited, generally to the labeling that the FDA has approved.

In general medical practice, the best medical practice standards are very different than what's been approved by the FDA. For example, if a best medical practice standard says, after you have a heart attack, add a drug out of this class, a manufacturer can't say that because their drug is a specific drug and doesn't have what is called a class effect. Every one is slightly different.

But as a pharmacy benefit manager working with a plan like Mr. Gammarino's, we would try to educate doctors about the best way to treat people, the best way to manage their health conditions. But most of what we say would be outside of what a manufacturer would be allowed to say by the Food and Drug Administration. So you're faced with a very difficult choice if you're a health plan: either stop telling your physicians and your patients how to best manage their medical care, or give up the rebates and discounts you're receiving from the manufacturers.

Because essentially what the FDA is saying is that, by accepting these dollars for rebates—which we would argue are being negotiated by you because you have leverage over them, not leverage over you—that if you accept those rebates, you're acting on their behalf. So I would disagree very significantly. I think the plans are seriously at risk of losing their rebates if that FDA guidance is adopted.

Mr. MICA. Speaking of rebates, are the discounts and rebates you receive from drug companies passed on to FEHBP plans and their subscribers?

Mr. LATANICH. Yes. They show up in our pricing and they show up in rebate guarantees. They show up in—virtually all rebates are passed through.

Mr. MICA. A couple of quick final questions for Mr. Gammarino.

What do you believe is the single most important thing Congress could do to ensure that FEHBP remains affordable for our Federal employees and retirees?

Mr. GAMMARINO. Promote competition, have a healthy, individual choice market that allows a number of competitors to compete and allows them to deliver products that they think are necessary for

that constituency. So flexibility, in terms of benefit design, and the way we deliver products, and let the consumer, who is the ultimate decisionmaker here in terms of who stays and who provides benefits in the program, let them decide whether or not our benefit design, and our services are appropriate.

Let's not overregulate this great program that has thrived because of individual competition.

Mr. MICA. I guess my last question is a single thing that OPM could do, and I think you have probably answered that with your call for flexibility and competition; is that correct?

Mr. GAMMARINO. Yes; Mr. Chairman.

Mr. MICA. Did you have anything you wanted to add, Mr. Latanich?

Mr. LATANICH. No; I think that, in general, we agree with Mr. Gammarino's statements. We think the committee and the plans are facing some very difficult decisions, because technology is going to get better, new drugs are going to be introduced. There are categories of diseases being scrutinized now by the manufacturers that will increase productivity, improve health status, and the question is how much is society and Congress willing to pay to improve productivity, quality of life, and increase health status. So it's a very difficult choice.

Mr. MICA. Thank you.

Mr. Cummings, do you have any concluding questions?

Mr. CUMMINGS. Just two or three.

Mr. Gammarino, if we continue to go down the path that we're going down now, with no changes, then I guess in 5 years I imagine we could—basically from what I've heard this morning—there could be an increase from today's payment of at least 25 percent, at least 5 percent a year. Is that——

Mr. GAMMARINO. At a minimum. You're going to see higher trends than that, I'm afraid.

Mr. CUMMINGS. Thinking as a lawyer, if I were OPM, what would I be saying with regard to what you're saying? When you talk about flexibility—and you, Mr. Latanich, you talked about how difficult the decisions are, and I agree with you; they've got to be very difficult—taking all of that into consideration, I'm trying to figure out how much we have to beat up on OPM. I don't mean that in a negative sense. In other words, both of you are sort of throwing it in their lap, saying OK, we need more flexibility.

But, on the other hand, they're in a situation where they're trying to keep Federal employees satisfied. That's a heck of a balance. I guess I want to put you all in their shoes, if you don't mind, just to be fair to them.

If you were in their shoes, understanding all that you know, and listening to your testimony this morning, what would you do? Would you do the things you have suggested?

I'm not trying to put you on the spot. But that's where we find ourselves.

Mr. GAMMARINO. No. 1, there's no magic cure for these trends. When you said we would want to put it in OPM's lap, I'm not looking to do that, in terms of responsibility. We do need flexibility; we do need competition; we do need the consumer involved.

I don't think it's right to overregulate this benefit program. For almost 40 years it has thrived because it hasn't been overregulated. I do think, when you continually regulate and add mandates, add the regulatory environment that we see today, add standards such as the cost accounting standards, through no thoughtful thinking of the consequences, I think you stifle competition and you stifle choice.

No; it's not a magic cure for the trends, but it certainly will allow us the opportunities to develop ways to respond to these issues.

Mr. CUMMINGS. With this accounting stuff, do you feel that the discussions and negotiations have been fair to you all?

Mr. GAMMARINO. Initially, no. I think today we have a lot better objective assessment by the Government in terms of the issues we have. We're not there yet, though. I know the agency has asked the CAS Board for what we think is reasonable relief, as we both look at ways to make these standards apply reasonably, where appropriate. But we're not there yet, and I don't know what the agency and the CAS Board are going to be able to do in the long run.

If that doesn't come through, we do need legislative relief. We would very much appreciate the support of this committee as we go through this because, believe me, Blue Cross Blue Shield wants to be in this program in the long run. It's the carrier of choice of the enrollees and we're very serious about our commitment to them. But we do need a reasonable playing field in order to compete.

Mr. CUMMINGS. I want to say to you both that your testimony has been very, very helpful. I really appreciate it.

Mr. GAMMARINO. Thank you.

Mr. MICA. Thank you, Mr. Cummings.

Mrs. Morella.

Mrs. MORELLA. Just briefly.

The President announced the Patients Bill of Rights in my district, and it was for Federal employees and retirees and I was there. Would you like to comment on what impact that may have for you as a carrier?

Mr. GAMMARINO. In the short run, it's not going to be too significant for us. The agency has worked with the carriers to a level where I think we're applying reasonable standards to implement this.

Our program is not an HMO. It's a preferred provider program. Therefore, many of the restrictions that the Patients Bill of rights was getting to don't exist in our program. What we do have to worry about is the rush to implement the Patients Bill of Rights, Mrs. Morella. They have tarred the whole industry with the same way of interacting with the patient. Therefore, you do have potential regulatory burdens on us as a PPO that don't really need to be there because we don't act that way. But they will add cost to the program unnecessarily.

Are they going to make a big difference in the rates? Not significantly. But it is an added regulatory burden that is being placed on all carriers. You know, we have always intended, and I think we have proven to the market and our consumers, that we have their rights served today in most cases.

Mrs. MORELLA. It appeared to me that most plans already did have contained within it, the elements of the Patients Bill of Rights.

I was also curious because the chairman, in his opening statement, said that it would cost like $40 million more, and that a tremendous percentage of that, Mr. Chairman, was going to be administrative and regulatory——

Mr. MICA. That was testimony from our hearing, not my calculations. It is what was testified to in hearings on the——

Mrs. MORELLA. Right.

Would you like to comment on that, Mr. Gammarino?

Mr. GAMMARINO. I haven't put a price tag on it. As you indicated, Mrs. Morella, we are in compliance with most elements of the bill of rights.

There is going to be some administrative burdens. Our program is approaching $8 billion, so every time we add $5 or $10 million, it's not going to show up in anybody's pocketbook. But they do all add up.

I think my feedback to you is that we have to watch out, in terms of regulating this and other areas, that we don't, in the name of good intentions, add burdens that are going to compound the administrative requirements that we have, and actually, in some cases, reduce the level of services that we give today and then tangentially add administrative costs.

Mrs. MORELLA. A final question, Mr. Chairman.

Do you ever meet with any of the unions, any of the Federal employee and retiree unions? Do you consult or have kind of a partnership liaison?

Mr. GAMMARINO. They're competitors. No, we don't meet with the unions. They have their own health plans. We do meet with NARFE as a constituents group. We do meet with our union members who are subscribers to provide services and——

Mrs. MORELLA. I understand competition. But sometimes we find, as we enter the 21st century, that we've got competition and we've got cooperation. Both of them go hand in hand. You want to compete, but you also have to cooperate.

Mr. GAMMARINO. And we have the Department of Justice, which is always looking at how we cooperate.

We do talk—certainly, they do have a group, their own organization, that we're invited to participate sometimes in discussions. The agency is there as well. So we do get good discussion on those group settings.

Mrs. MORELLA. Thank you. I thank both of you. I really appreciated the testimony.

Thank you, Mr. Chairman.

Mr. MICA. I thank both of our witnesses. Hopefully this will be good information that we can utilize to assist you in bringing down health care costs for both our Federal employees and retirees.

If we have any additional questions, we will leave the record open for at least a week and submit them to our panelists.

There being no further questions at this time, I will dismiss our panelists and call forward our second panel. Our second panel is one individual, William E. Flynn III, also known to his friends and family and members of this committee as "Ed" Flynn, Associate Di-

rector for Retirement and Insurance Services, Office of Personnel Management, who is entering from the ring on the right and now taking his last bit of liquid refreshment. [Laughter.]

Please stand and raise your right hand.

[Witness sworn.]

Mr. MICA. Mr. Flynn, welcome back. You know the ground rules. We look forward to your testimony and response to the two previous witnesses comments. You are recognized, sir.

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

Mr. FLYNN. Thank you very much, Mr. Chairman. I apologize if I do some coughing and wheezing here today.

With all of the representatives of the health care industry here, I was hoping that some free samples might be passed out. [Laughter.] Apparently I'm just going to have to endure here. I apologize for making you endure as well.

On behalf of OPM Director Lachance, thank you very much for the opportunity to discuss the 1999 program for the Federal Employees Health Benefits Plan. As we begin this morning, I would like to summarize several points from my prepared statement.

First, the significant news for Federal employees and retirees in 1999 is that the projected increase in their share of health plan premiums for next year is about one-half the 1998 rate increase that we announced last fall. While premium rates for the Federal employee program are projected to rise an average of 10.2 percent next year, the impact on the average person will be considerably less, 7.4 percent, compared to the expected increase of 15.4 percent last year.

Under the new fair share formula, enrollees will pay an average of $3.39 more every 2 weeks, next year, compared to an average $5.08 increase in 1998. Depending upon choices they make during the open season, they may pay even less.

Second, these increases are not unique to the Federal employee health program. They reflect what is occurring throughout the health care marketplace and are in line with increases facing large- and mid-sized employers. I think ample evidence of that was demonstrated by the two witnesses who appeared earlier. Health care costs are going up, and the fact that they are is well documented throughout the industry.

Cost increases in the industry are attributable to several key factors. The expanding role of prescription drugs in the overall health equation, the need for insurers to maintain adequate levels of reserves in the context of overall financial performance, and the fact that people are older, on average, and living longer, are all major drivers in the health care economy. These are the very same factors that account for most of the increase in our program premiums this year.

Third, we are actually quite pleased with our ability, in collaboration with the health plans, to have taken major steps in ensuring implementation of the President's Patients Bill of Rights. In 1999, everyone in the program will benefit from uniform assurances of: direct access to women's health care providers for routine and pre-

ventive services; use of the prudent lay person standard for emergency room visits; direct access to network specialists for patients with complex or serious medical conditions requiring frequent care; extensive information about health plans, providers and care; and finally, an assurance of full and open communication between doctors and their patients about medically necessary treatment.

In addition, the classification of "pharmacotherapy" under the general medical benefits structure means increased coverage for mental health care. These enhanced patient protections and increased mental health benefits account for less than $1 per year in individual out-of-pocket costs.

Finally, Mr. Chairman, I don't want to leave the subcommittee with the impression that we are not concerned about increases in the cost of health care. We are. The Federal Employees Health Benefits Program is a recognized leader in the provision of quality, affordable health care, and OPM is committed to maintaining that position. We will continue to look for ways to moderate cost increases, while ensuring quality of care.

Like other large employers, we believe that strategies that promote value-based purchasing can achieve these results, and we intend to examine approaches that have been used effectively by others in the purchaser community to see if and how they might be applied in this program.

I think that pretty much summarizes what I would like to start with, Mr. Chairman. I would be available to answer any questions you and the other members of the subcommittee may have.

[The prepared 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

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
1999 PREMIUM RATES

SEPTEMBER 24, 1998

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR THIS OPPORTUNITY TO DISCUSS THE RESULTS OF OPM'S RECENTLY CONCLUDED NEGOTIATIONS ON 1999 BENEFITS AND RATES UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. AS YOU KNOW, 1999 WILL BE THE PROGRAM'S FIRST YEAR USING THE NEW GOVERNMENT CONTRIBUTION FORMULA, WHICH CONGRESS APPROVED AS A PART OF THE BALANCED BUDGET ACT OF 1997.

THE SIGNIFICANT NEWS FOR FEDERAL EMPLOYEES AND RETIREES IS THAT THE PROJECTED INCREASE IN THE ENROLLEE SHARE OF HEALTH PLAN PREMIUMS FOR 1999 IS ABOUT ONE-HALF OF THE 1998 RATE INCREASE THAT OPM ANNOUNCED LAST FALL. WHILE PREMIUM RATES FOR THE FEDERAL

EMPLOYEE PROGRAM ARE PROJECTED TO RISE AN AVERAGE OF 10.2 PERCENT NEXT YEAR, THE IMPACT ON THE AVERAGE ENROLLEE COST WILL BE CONSIDERABLY LESS-7.4 PERCENT. BY COMPARISON, THE EXPECTED AVERAGE INCREASE IN ENROLLEE COSTS FOR 1998 WAS 15.4 PERCENT.

FOR NEXT YEAR, THE IMPACT OF PREMIUM INCREASES ON PROGRAM PARTICIPANTS WILL BE SUBSTANTIALLY MITIGATED BECAUSE THE GOVERNMENT WILL ASSUME A LARGER SHARE OF PREMIUM COSTS UNDER THE NEW "FAIR SHARE" GOVERNMENT CONTRIBUTION FORMULA THAN WOULD HAVE BEEN THE CASE UNDER THE "BIG 6" PHANTOM FORMULA. THE FAIR SHARE FORMULA WILL MAINTAIN A CONSISTENT SHARE OF GOVERNMENT CONTRIBUTIONS, PEGGED AT 72 PERCENT OF THE PROGRAM-WIDE WEIGHTED AVERAGE OF SELF ONLY AND SELF AND FAMILY PREMIUM CHARGES.

WHILE THE PROJECTED COST INCREASE TO ANNUITANTS AND NON-POSTAL EMPLOYEES IN 1999 WILL AVERAGE 7.4 PERCENT, THE INCREASE IN THE GOVERNMENT CONTRIBUTION WILL AVERAGE 11.4 PERCENT. IN DOLLARS RATHER THAN PERCENTAGES, ENROLLEES SUBJECT TO THE FAIR SHARE FORMULA WILL PAY AN AVERAGE OF $3.39 MORE BIWEEKLY IN 1999 (COMPARED TO AN AVERAGE $5.08 INCREASE IN 1998) WHILE THE AVERAGE BIWEEKLY GOVERNMENT INCREASE WILL BE $12.07 IN 1999 (COMPARED TO

$5.02 THE PREVIOUS YEAR).

THE COMPARATIVELY LARGER INCREASE IN GOVERNMENT CONTRIBUTIONS WILL BE A ONE-TIME OCCURRENCE CAUSED BY THE MOVE FROM THE BIG-6 TO THE FAIR SHARE FORMULA. IN FUTURE YEARS, WE EXPECT RATES OF CHANGE IN AVERAGE CONTRIBUTIONS FOR BOTH THE GOVERNMENT AND THE ENROLLEES TO CLOSELY APPROXIMATE THE RATES OF CHANGE IN THE OVERALL PROGRAM.

IT IS IMPORTANT TO NOTE THAT OPM'S PROJECTION OF AVERAGE PREMIUM COSTS AT THE CONCLUSION OF CONTRACT NEGOTIATIONS ASSUMES THAT ENROLLEES WILL STAY IN THEIR PRESENT HEALTH PLANS DURING THE UPCOMING YEAR. BUT, ALL ELIGIBLE PARTICIPANTS HAVE THE OPTION OF CHANGING HEALTH PLANS DURING THE ANNUAL OPEN ENROLLMENT PERIOD--WHICH IN 1998 WILL RUN FROM NOVEMBER 9 TO DECEMBER 14. CHOICE AMONG A WIDE VARIETY OF HIGH QUALITY HEALTH COVERAGE, AND CAREFULLY DESIGNED MATERIALS THAT HELP ENROLLEES COMPARE HEALTH PLANS AND SELECT AN AFFORDABLE PLAN TO MEET THEIR NEEDS, ARE HALLMARK FEATURES OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. AS A RESULT OF THE OPEN SEASON PROCESS FUNCTIONING AS INTENDED, THE ACTUAL 1998 AVERAGE INCREASE IN INDIVIDUAL ENROLLEE COSTS WAS 12.5 PERCENT, CONSIDERABLY LOWER THAN THE PROJECTED

INCREASE OF 15.4 PERCENT. ENROLLEE SELECTION OF MORE COST EFFECTIVE PLANS HAS BEEN A COMMON OPEN SEASON OCCURRENCE, AND WE EXPECT TO SEE THIS TREND CONTINUE FOR THIS YEAR'S OPEN SEASON, MAKING THE ACTUAL 1999 AVERAGE INCREASE LESS THAN 7.4 PERCENT.

THE 1999 FEDERAL EMPLOYEE HEALTH PLAN PREMIUM INCREASES REFLECT WHAT IS OCCURRING THROUGHOUT THE HEALTH CARE MARKETPLACE AND ARE IN LINE WITH INCREASES FACING LARGE AND MID-SIZED EMPLOYERS. HEALTH COSTS ARE GOING UP. THIS PAST JUNE, A MANAGEMENT CONSULTANT FIRM, WATSON WYATT WORLDWIDE, RELEASED THE RESULTS OF A SURVEY THAT LOOKED AT EMERGING COST TRENDS FOR 1999 FOR ORGANIZATIONS WITH 500 OR MORE EMPLOYEES IN MAJOR METROPOLITAN MARKETS NATIONWIDE. THE SURVEY PREDICTED DOUBLE DIGIT INCREASES FOR FEE-FOR-SERVICE PLANS AND SOMEWHAT LOWER INCREASES FOR HMOs. IT ALSO PREDICTED THAT HEALTH CARE PROVIDERS WOULD BE LESS WILLING TO NEGOTIATE FEES.

THE STUDY STATED THAT COST INCREASES WERE DUE TO CIRCUMSTANCES THAT AFFECT BOTH THE NATIONAL AND THE FEHB HEALTH CARE MARKET PLACES. IN THE FEHB PROGRAM, STRONG MANAGED CARE EMPHASIS SINCE THE EARLY 1990'S HAS RESULTED IN THE VAST MAJORITY OF ENROLLEES ACCESSING CARE VIA HMO OR PREFERRED PROVIDER NETWORKS. DEEPER

DISCOUNTS ARE DIFFICULT TO OBTAIN AND HAVE LESS IMPACT ON RISING MEDICAL COSTS.

NATIONALLY, TECHNOLOGICAL ADVANCEMENTS ARE DRIVING COSTS HIGHER. THE FEHB PROGRAM IS STRUCTURED TO ALLOW BENEFITS TO EVOLVE IN RESPONSE TO MEDICAL PRACTICE SO THAT PROGRAM PARTICIPANTS ARE ASSURED ACCESS TO QUALITY AND UP TO DATE HEALTH SERVICES.

NATIONALLY, AN AGING POPULATION IS PUTTING EVER MORE PRESSURE ON THE HEALTH CARE DELIVERY SYSTEM. THE AVERAGE AGE FOR ENROLLEES IN THE FEDERAL EMPLOYEE PROGRAM (EXCLUDING DEPENDENTS) HAS INCREASED FROM 56.18 IN 1996 TO 57.08 IN 1998.

FINALLY, THE WYATT SURVEY IDENTIFIED PRESCRIPTION DRUG BENEFITS AS A MAJOR COST DRIVER, LARGELY DUE TO USAGE AND MANY NEW AND EXPENSIVE DRUGS COMING TO MARKET. FOR 1999, IT PREDICTED PRESCRIPTION DRUG INCREASES OF UP TO 22 PERCENT. THE MOST RECENT FEHB EXPERIENCE IS 17 PERCENT, WITH ABOUT 20 PERCENT OF TOTAL FEHB PREMIUMS EXPENDED FOR DRUG BENEFITS.

SUBSEQUENT TO THE INVITATION TO TODAY'S HEARING, THE CHAIR ASKED

FOR A HISTORY OF RESERVE LEVELS FOR OUR PARTICIPATING FEE-FOR-SERVICE HEALTH PLANS AND AN EXPLANATION OF HOW THE RESERVES HAVE INFLUENCED RATES. THIS INFORMATION HAS BEEN FURNISHED. BUT, I WANT TO CLARIFY FOR THE RECORD, THAT WHILE OPM REGULATIONS SPECIFY MINIMUM RESERVE LEVELS FOR EXPERIENCE-RATED PLANS, THE RATE-SETTING PROCESS INVOLVES VERY JUDICIOUS USE OF RESERVES RATHER THAN MECHANICAL DECISIONS TO DRAW DOWN OR REBUILD RESERVES TO TARGET LEVELS IN THE SHORT TERM. IN 1999, OUR USE OF RESERVES IN LIEU OF PREMIUM INCREASES SLOWED, CONTRIBUTING TO THE AVERAGE PREMIUM INCREASE. WHILE OPM DOESN'T REGULATE RESERVES HELD BY COMMUNITY-RATED HMOs, MAINTAINING APPROPRIATE RESERVES IS AN IMPORTANT ISSUE THERE AS WELL, AND WE PAY CLOSE ATTENTION TO THIS IN CONTRACTING WITH THEM.

A MAJOR INITIATIVE TAKEN FOR 1999 IN COLLABORATION WITH CARRIERS WAS THE IMPLEMENTATION OF PRESIDENT CLINTON'S PATIENT BILL OF RIGHTS. AT AN ADDITIONAL PREMIUM COST OF LESS THAN 25 CENTS A YEAR, SHARED BY THE GOVERNMENT AND ENROLLEES, ALL FEHB PARTICIPANTS WILL BENEFIT FROM THE FOLLOWING:

- DIRECT ACCESS TO WOMEN'S HEALTH CARE PROVIDERS FOR ROUTINE AND PREVENTIVE WOMEN'S HEALTH SERVICES;
- USE OF THE "PRUDENT LAYPERSON" STANDARD WHEN DETERMINING THE NECESSITY OF EMERGENCY CARE VISITS FOR COVERAGE;

- TREATMENT PLANS PROVIDING DIRECT ACCESS TO A QUALIFIED SPECIALIST IN PLAN PROVIDER NETWORKS FOR INDIVIDUALS WITH COMPLEX OR SERIOUS MEDICAL CONDITIONS REQUIRING FREQUENT CARE;
- EXTENSIVE INFORMATION ABOUT PLAN CHARACTERISTICS AND PERFORMANCE, PROVIDER NETWORK CHARACTERISTICS, AND CARE MANAGEMENT; AND
- A REGULATORY PROHIBITION ON "GAG" CLAUSES IN PROVIDER CONTRACTS THAT COULD LIMIT COMMUNICATION ABOUT MEDICALLY NECESSARY TREATMENT.

ALSO, PLANS WILL TAKE ANOTHER STEP FORWARD IN COVERING SERVICES RELATED TO MENTAL HEALTH CONDITIONS LIKE SERVICES FOR OTHER HEALTH CONDITIONS. ALL PLANS WILL NOW COVER PHARMACOTHERAPY FOR MENTAL HEALTH CONDITIONS UNDER GENERAL MEDICAL BENEFITS RATHER THAN MENTAL HEALTH BENEFITS, WITH NO REDUCTION IN EXISTING COVERAGE FOR MENTAL HEALTH SERVICES. PHARMACOTHERAPY INVOLVES THE PRESCRIPTION OF MEDICATIONS, OFFICE VISITS FOR OBSERVATION OF PATIENT RESPONSE AND REGULATION OF DOSAGES, AND LABORATORY TESTS TO MONITOR THEIR EFFECT. OPM CONCLUDED THAT 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. THIS CHANGE WILL INCREASE AVERAGE 1999 PREMIUMS BY A TOTAL OF 3/100 OF 1 PERCENT--OR ABOUT 80 CENTS A YEAR FOR SELF ONLY COVERAGE AND ABOUT $1.82 A YEAR FOR SELF

AND FAMILY COVERAGE. ENROLLEES PAY ONLY A PORTION OF THIS AMOUNT.

NEXT YEAR A TOTAL OF 285 HEALTH PLANS WILL PARTICIPATE IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, DOWN FROM 350 PLANS OFFERED IN 1998. THE DRIVING FORCES BEHIND THIS DECLINE WERE THE SHAKE OUT OF PLANS UNABLE TO ATTRACT SUFFICIENT NUMBERS OF FEDERAL ENROLLEES OR MAINTAIN COMPETITIVE RATES, PLAN CONSOLIDATIONS, AND OTHER CHANGES IN MANAGED CARE AND POINT OF SERVICE PLANS. NONE OF THE PLANS WHICH WITHDREW DID SO IN RESPONSE TO OPM'S INITIATIVES ON MENTAL HEALTH COVERAGE OR PATIENT PROTECTIONS. THIS REDUCTION IN PARTICIPATING PLANS REFLECTS NATIONAL TRENDS IN THE HEALTH INSURANCE MARKET AND WILL NOT ADVERSELY AFFECT FEDERAL ENROLLEES.

ONLY ONE FEE-FOR-SERVICE PLAN-BENEFICIAL ASSOCIATION OF CAPITOL EMPLOYEES WITH ABOUT 1,200 ENROLLEES-WILL CEASE PARTICIPATION IN 1999. THE OTHER PLANS WERE HEALTH MAINTENANCE ORGANIZATIONS AND POINT OF SERVICE PLANS AND ALSO WERE AMONG THE SMALLER PLANS PARTICIPATING. ALTOGETHER, LESS THAN 2 PERCENT OF OUR ENROLLED POPULATION WILL BE AFFECTED BY THESE PLAN CHANGES.

WHILE ANY INCREASE IN COSTS IS ALWAYS A CONCERN FOR US, OPM BELIEVES THAT THIS YEAR'S AVERAGE INCREASE WILL LIKELY BE LOWER THAT THE AVERAGE INCREASE IN PRIVATE SECTOR EMPLOYER PROGRAMS, AS HAS BEEN THE CASE FOR MOST OF THIS DECADE. OUR PROGRAM IS A RECOGNIZED LEADER IN THE PROVISION OF QUALITY, AFFORDABLE HEALTH CARE AND OPM IS COMMITTED TO MAINTAINING THAT POSITION.

OPM WILL CONTINUE TO LOOK FOR WAYS TO MODERATE COST INCREASES WHILE CONTINUING TO MONITOR THE QUALITY OF CARE DELIVERED TO FEDERAL ENROLLEES. LIKE OTHER LARGE EMPLOYERS, WE BELIEVE THAT STRATEGIES THAT PROMOTE VALUE-BASED PURCHASING CAN ACHIEVE THESE RESULTS. WE WILL BE EXAMINING APPROACHES THAT HAVE BEEN USED EFFECTIVELY BY OTHERS IN THE PURCHASER COMMUNITY TO SEE IF AND HOW THEY MIGHT BE APPLIED IN THE FEHB PROGRAM.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU HAVE AT THIS TIME.

Mr. MICA. Thank you. I would like to go ahead immediately with some questions. I wanted to talk first about the impact of the fair share formula.

In the Balanced Budget Act of 1997, Congress enacted a new formula for determining the maximum Government contribution to FEHBP premiums. I would like to examine how that new formula affected the calculation of this year's contribution and how it might affect future premiums.

First, what are the maximum Government contributions in 1999 for self alone and family coverage, and what would they have been if we had not passed the fair share formula?

Mr. FLYNN. Mr. Chairman, I think I know where you're going with that. If I might answer it in a slightly different way, if that's satisfactory——

Mr. MICA. Go ahead.

Mr. FLYNN [continuing]. And then perhaps we can provide some additional information for the record.

In 1999, use of the fair share formula means that there is an average increase for the enrollee of 7.41 percent. Now, I can tell you how we got there, but let me compare that to what the average increase would have been under the previous Big 6 formula, the old phantom formula that we've been operating under for a number of years or, in its absence, a Big 5 formula.

As I mentioned, in 1999, the average enrollee cost will go up 7.4 percent. Under the Big 6 formula, it would have gone up 13.11 percent, and under a Big 5 formula, it would have gone up just under 36 percent.

Mrs. MORELLA. Wow.

Mr. FLYNN. So you can see the impact that the implementation of this formula has had in this program, particularly with respect to its impact on the individual.

Mr. MICA. Somebody's paying the difference, and I guess it's the Federal Government. What's it going to cost the Federal Government in the transition to this new formula?

Mr. FLYNN. Well, there's only a 1-year transition to the new formula.

Mr. MICA. Right.

Mr. FLYNN. Let me try and handle it this way, because I think you can isolate the transition difference actually quite easily.

The new fair share formula calls for a distribution of the premium between the Government and the employee: 72 percent for the Government and 28 percent for the individual employee.

In 1997, the phantom formula, had a distribution of about 71.3 percent versus 28.7 percent, if I have done my math correctly. So the cost increase to the Government resulting from the transition amounts to 0.7 of 1 percent of the premium differential this year.

Mr. MICA. Which is what, about $2.2 billion?

Mr. FLYNN. Well, the Government's cost this year, in fiscal year 1999, will be about $803 million.

For purposes of comparison—yes, sir?

Mr. MICA. It doesn't seem like that figure is correct.

Mr. FLYNN. The cost to the Government for the increase associated in 1999 is $803 million. Last year, the cost to the Government was $831 million.

Mr. MICA. Well, we will go back and look at those figures. I'm not sure if they jibe with what we had calculated.

Mr. FLYNN. Well, there may be several reasons for that difference. First of all, remember that a very significant proportion of the population that is in this program is in the Postal Service. We don't count increased costs to the Government resulting from the increase to the Postal Service.

Mr. MICA. That's the difference. I see what you're calculating. All right.

We have gone through some of the figures before, and you've heard them, about what the private sector medical care cost increases have been in similar periods of time. They appear to be approximately half of what we're experiencing.

Why are FEHBP premiums rising faster than private sector employer-sponsored plans?

Mr. FLYNN. I don't think they are rising faster than employer-sponsored private plans, Mr. Chairman. I think you heard Mr. Gammarino before we began this morning indicating that the experience we're having in the Federal Employees Health Benefits Program precisely mirrors the experience they're having in their private sector lines of business.

You did quote several studies that suggest that they might be different, and I might provide a couple of general comments.

First of all, I am sort of reminded of the adage, "liars figure and figures lie." You have to make sure that you're looking at the same numbers when you make these comparisons.

A June 1998 report by Watson Wyatt, the benefits consulting firm, suggested that, in 1998, premiums increased in the low double-digit range, and that they're expected to be even higher for 1999. That, quite honestly, is troubling to a number of people. But if you look at what we had last year and what we're projecting for next year, it continues to put us among the cost leaders in the area.

The second thing that I would just quickly mention is that if you look at average premiums in the private sector and compare it to average premiums in the Federal Employees Health Benefits Program, the average premium, irrespective of who pays it, is about $200 less per year in the Federal Employees Health Benefits Program than it is in the private sector.

So I think the thing I would say is that what's happening in this program is precisely what is happening with other private sector, employer-sponsored programs. We continue to have a cost advantage and we want to continue to look for ways in which we can maintain that.

That doesn't mean that we're not concerned. There are things that we need to consider, in cooperation with you and others, to see if there are ways that we can preserve the quality and value of this program, and at the same time, if not hold health care costs level, at least slow the rate of increase to something that is sort of less eye-popping from 1 year to the next.

Mr. MICA. I know that we have 1.9 million active Federal employees, and 2.2 million Federal retirees. Those who are in active service probably are going to be able to absorb this a little bit easier. But this is going to be pretty startling to our retirees, who are

going to probably experience one of the smallest increases in their cost of living, and a second big hit. Many of those people retired with low salaries some years ago, so it's going to be a significant shock to them and adjustment.

What can we do—and you heard the two witnesses. They keep coming back to mandates, regulation, inflexibility. What is OPM going to do to help us bring the costs down, or at least assign the costs, where we can, in an equitable fashion? Give me one, two, three.

Mr. FLYNN. I would be happy to, Mr. Chairman.

Let me comment just for a moment on the impact of this premium increase on Federal retirees. We are as concerned as you and every other member of this committee, and, I'm sure everybody sitting behind me, about the impact of premium increases on people who are on fixed incomes. Even if you assume for a moment that the cost-of-living adjustment for Federal retirees next year will be just over 1 percent, on average, that amounts to about $17 a month, and this will cost them about half of that. So, it is significant, and I appreciate very much the attention that you have brought to that.

Second, which gets to the larger part of your question, Mr. Chairman, let me just simply say, that it is not overregulation; it is not mandates; it is not inflexibility that is driving the experience of this program. I said earlier that what we're seeing in the Federal Employees Health Benefits Program mirrors essentially what is going on in the private market. I think we can see very clearly that there are not things that are going on in the Federal program that are unique, that somehow or another contribute to added costs.

Let me offer what I think are some thoughtful, useful suggestions as to how we might work cooperatively to deal with the kinds of issues that we're seeing from the perspective of a purchaser of health care.

Now, I'm going to mention two things. The first thing I'm going to mention is the increasing knowledge and awareness of the ability to track and report on quality outcomes resulting from health care experiences. We know today, for example, how to effectively treat asthma, and we know today how to ineffectively treat asthma. We can collect and organize and report data that tells us where physicians are doing it effectively, and where they're doing it ineffectively. I just use that as one example.

The science of knowing what effective treatments are is getting better, and the technology of collecting information, analyzing it, and using it for purchasing decisions, is getting better. We've got a long way to go, but purchasing based on quality outcomes in health care can have a very significant impact on health care costs.

The second thing that I want to talk about are things that purchasers—and OPM, as an employer-sponsor, is a purchaser of health care, just like General Motors or General Electric or AT&T—things that purchasers have done in the past and that I think warrant our looking at again as a way of adding some measure of control to the cost of health care. We might create differential employer contributions based on quality health care outcomes, so that we reward health plans that have a good track record in health outcomes, and we give individual employees and retirees a

break on their share of the premium if they join up with those health plans. That's one idea, one example of the types of things that can be done.

A second thing that can be done was referred to, in general, by Mr. Latanich, having to do with limiting choices. Limiting choices can come about in a number of ways. In this program, we have almost 300 plans. Last year, we had 350. Plans come into this program on the basis of being able to meet certain financial, licensing, and other kinds of requirements.

We could impose other types of requirements, such as minimum standards of performance, minimum levels of health care quality outcomes, and by limiting plan participation, create larger insured populations. Where the expense of health care is spread over a larger population, you can have some moderation in costs.

Another area has to do with carving out benefits. We have talked a lot this morning about prescription drug benefits. Prescription drug benefits, believe me, are a great concern to us. It may be that instead of having 285 prescription drug benefits programs in the Federal Employees Health Benefits Program, we ought to have one. And it may be we ought to have one pharmacy benefit manager and use the purchasing power collectively of almost 9 million people to keep costs under control. That's one example.

Another example of where carve outs might be effective is in mental health.

Finally, things that others have talked about have to do with standardizing benefits, so that people make cost decisions from one plan to another on the basis of exactly equal benefits.

Now, each one of those suggestions, Mr. Chairman, deals with some important conceptual underpinnings of the Federal Employees Health Benefits Program that have served it well over its history. But if we are concerned about increases in the cost of care, then I do believe that the integration of a focus on quality health care outcomes and some of these other ideas is, in fact, necessary today to see if there's not a way to move this to a higher level and continue to provide quality care at an affordable price.

Mr. MICA. Well, I guess that was a pretty long answer. I guess we have to get back to the specific questions. The testimony that we've had here today has called for more flexibility, less regulation, and more choices, and you're saying less choices and more regulation will solve the problem, is that it?

Mr. FLYNN. No, sir; I'm not saying that at all. In fact, the panel before me suggested that one of the ways to deal with this was less choice. I was simply saying that, from the standpoint of plans and their participation in the program, I was essentially agreeing with the point that they made. That limiting plan participation is one way of looking at controlling costs in the program.

I'm not here espousing that. I'm saying there is a range of things that we need to look at if we want to hold level or slow down the rate of increase in this program.

Mr. MICA. We have an immediate crisis facing us. The largest carrier, the Blue Cross folks, it doesn't appear that they intend to sign a contract with the current cost accounting standards language that is being required by OPM.

What's going to happen there? Why is this so important?

Mr. FLYNN. First of all, Mr. Chairman, let me make clear that the application of the cost accounting standards to the Blue Cross Blue Shield Federal Employee Program, and several others in the Federal Employees Health Benefits Program, was not a decision of the Office of Personnel Management. It was a decision of the Cost Accounting Standards Board.

We, Blue Cross Blue Shield, and other carriers, have been working very hard in an effort to come to a resolution of this that will work for everybody. I'm certain we will do that this year and for the future.

Mr. MICA. We also heard the call for more flexibility, for the ability of these other carriers to design—to have more flexibility in the design of their offerings.

What does OPM plan to do in that regard?

Mr. FLYNN. Well, Mr. Chairman, all of that discussion on flexibility actually had to do with one subject and one subject only, and that was the imposition of a copayment on Medicare Part B retirees who purchase prescription drugs from the mail order program run by Blue Cross Blue Shield.

I would think, if you look across the entire spectrum of the Federal Employees Health Benefits Program, you will find that flexibility is, in fact, evident in virtually every nook and cranny.

But let me talk about this drug benefit just for a moment. First of all, let's be clear about who it is we're talking about. Earlier today you heard the beneficiaries in this program who are affected by this issue of flexibility called Med B retirees. What that means, Mr. Chairman, is that these are retirees who are over the age of 65, who are living on fixed incomes, and as Mr. Latanich so amply demonstrated, more and more today rely on prescription drug therapies for their continued health and well being.

Two years ago, Medicare Part B retirees were given an incentive, under the Blue Cross Blue Shield program, to use mail order for their appropriate prescription drug needs. They were given the incentive of no copayment requirement whatsoever. As Mr. Gammarino has indicated, the very next year Blue Cross Blue Shield suggested that a copayment was necessary for this population.

Our response to them then, and now, was we understand the issue that you have raised with us. But since we have so recently made this change, we want to ensure that if we accept another, we are accepting it because there is demonstrated overuse of prescription drugs by that over-age-65 population.

So far we have not seen evidence that would suggest to us overuse of prescriptions. We have seen evidence, as again the charts amply demonstrate, that people use drugs more and more as they get older. But we have not seen any evidence that drugs are being overused.

I think we want to be very careful about imposing a copayment so quickly, after having brought these individuals into the mail order program with the enticement of no copayment whatsoever.

The debate on this is not over, Mr. Chairman, but I think we need some more evidence that demonstrates why this would be warranted.

Mr. MICA. I have additional questions, but I will yield right now to our ranking member, Mr. Cummings.

Mr. CUMMINGS. I have just a few questions.

I have listened to your suggestions on trying to contain these costs. I guess when I hear proposals, the question that first comes to mind is practicality and, in dealing with the Federal Government, how fast can things get done. You've heard me say it before, that sometimes I get a little frustrated with the Federal Government and that it seems like it takes so long to do so little. But a lot of times those little things are the things that make a difference in people's lives.

With regard to your suggestions, first of all, let's talk about practicality; and second of all, let's talk about time; and third of all, let's talk about whether we'll be talking about these same things 5 years from now. That concerns me.

Mr. FLYNN. And it concerns me as well.

Let me just be very candid with you, Mr. Cummings. We can put proposals on the table very quickly. Reaching consensus and agreement on those proposals, in a political, consensus-building process, can take and will take time. But I think those are the kinds of proposals that hold out the most hope, quite honestly, for achieving cost containment in ways that respect and build on the traditions of this program and the strength that it exhibits.

Other things that can be done more quickly, quite honestly, are a lot more rough around the edges, if I may say that, and often can have some unintended side effects.

Mr. CUMMINGS. I guess the suggestion that I found most interesting is the one about trying to reward those companies that have effective treatment.

Mr. FLYNN. Absolutely.

Mr. CUMMINGS. I want to make sure I understand it.

First of all, you take a look at various plans, is that it?

Mr. FLYNN. Yes.

Mr. CUMMINGS. Just take me through it.

Mr. FLYNN. Let me try and do it very quickly for you.

As I said, in creating the ideal, we've still quite a ways to go. But if you look at this in terms of objective characteristics, process characteristics, and outcome characteristics, in the first two areas—objective and process characteristics—we're pretty far along. Things like accreditation by a nationally recognized health care accreditation organization, things like the degree to which individual patients understand how to get treatment for certain kinds of things—you can pretty much measure those kinds of things.

Employers today create incentives for their employees to enroll in plans that have accreditation, that score above a certain level on a whole series of process measures and things like that. And the direction, the trend, is to add health care quality outcome measures and to create incentives, combining those as well.

Those things can be done. Some of the measures today are a little rough, but they do, in fact, moderate the increases that employers face in their health care costs from one year to the next.

Mr. CUMMINGS. I think you heard Mr. Gammarino talk about what he predicts in costs 5 years from now. I said 25 percent and

he said more than that, if we continue to go down the road we're on now. Do you agree with that?

Mr. FLYNN. Well, I think it's hard to know, but it could certainly be that. It doesn't have to be.

Mr. CUMMINGS. You know, they say when you do the same things that you've been doing, you shouldn't expect any different results.

Mr. FLYNN. Right.

Mr. CUMMINGS. So I'm a little bit confused about your answer. I mean, if we continue to do what we're doing, it seems only logical that 5 percent here, 3, 7, whatever, add up, and in 5 years you have Federal employees paying quite an increase. So I'm trying to figure out—maybe I'm just trying to plant something in your computer, that we have to do something different or else we're going to get the same results. I guess that's what I'm kind of trying to push for.

I don't know what that is. I have looked at the things you have suggested, and I think you're right on track. But I am concerned that we'll be sitting here 5 years from now talking about an increase far greater than where we are now.

Mr. FLYNN. And I would be equally concerned. The only point I would make there is that you could look 5 years from now and see 25 percent inflation not just for Federal employees but for America, OK?

Mr. CUMMINGS. Right, all the way around.

Mr. FLYNN. And our ability to influence that is a function of how we act as a purchaser.

Mr. CUMMINGS. You mentioned briefly mental health twice, and you mentioned it in one of your suggestions. Can you talk about that a little bit?

Mr. FLYNN. Well, we have been concerned for several years now about the availability of mental health benefits in the Federal Employees Health Benefits Program. Generally speaking, if you look at what private sector plans offer, we are not particularly attractive in that comparison. So over the past couple of years we have tried to do things that incrementally add benefits.

The creation of mental health benefit networks, that parallel in many respects the medical service networks that were so effective in controlling health care costs over the past 6 or 7 years, seems to us to be a direction we want to move in. It's one that we have encouraged our plans to undertake. We have had some limited success in this area, but we want to continue to do that.

Now, the suggestion that I made was that you might want to look at this as a benefit that you would manage on a nationwide basis as part of a carved out program. We don't currently have that ability, but that's another way that you might be able to enhance the benefit and still control its cost.

Mr. CUMMINGS. Have you seen an increase in the use of mental health benefits over the last 2 or 3 years?

Mr. FLYNN. I'm really not in a position to answer that knowledgeably. If you don't mind, I would like to go back and have our actuaries look at that across the program and provide a response to you.

I wouldn't think so, but I would like to look to make sure.

Mr. CUMMINGS. The reason why I asked is because when I was in the Maryland Legislature, it was a big deal for me, because I spent a lot of time trying to bring some parity, some equity, with regard to mental health benefits, because I just believe that mental health benefits have been a stepchild, while mental health certainly can be directly related to physical health.

I was just wondering whether people are using it. It used to be almost taboo to deal with mental health, and I think that that trend is beginning to change because people are beginning to understand how significant it is. I was just wondering about that.

Mr. FLYNN. I do think, Mr. Cummings, we have got a ways to go to make mental health benefits in this program what they should be.

The only other thing I would add is that, just as we have seen drug therapy operate so effectively in the area that we traditionally regard as medical benefits, it is also operating very effectively in the area of mental health as well, and that's a good thing.

Mr. CUMMINGS. If you could change something with regard to this whole prescription situation that was just talked about—about 40 percent of the testimony we've had was on prescriptions—what would you change, if anything? In other words, if there was something that you could do, putting yourself in the place of these doctors and the drug companies and whatever, is there something you would do? It seems to me like prescriptions are having a drastic effect.

Mr. FLYNN. Right. Mr. Cummings, the only easy thing to do is the thing that I hesitate to do, and that is, introduce greater copayments. That doesn't affect health care costs; that simply redistributes it to different pockets.

The hard thing to do is to create an awareness among plans, providers, pharmaceutical companies, and individual consumers and employer sponsors, about drugs and their effect and their utilization and their effectiveness, so that people become responsible purchasers, if you will, of that. But that's a much longer road to go down, and it doesn't offer immediate payoff like a copayment would.

But I worry about the effect of copayments on the population, the very population that we are trying to serve here.

Mr. CUMMINGS. Just one last question.

Mr. Gammarino implied it, but I'm not sure it was implied, that when you have a copayment, people might think twice about prescriptions. In other words, if you get things for free, you know, you possibly open the door for abuse. That argument makes a lot of sense. I was just wondering what your feelings are on that.

And I want to make it real clear, because I know the media gets things mixed up. I am not advocating getting copayments for the people who don't presently have them.

Mr. FLYNN. And we have copayments existing in virtually every plan—I'm sorry, in all plans in the FEHB, at the retail level, at the mail order level, at the brand name level, and at the generic level. So we have copayments that are widespread throughout this program.

Yes; it does cause people to think about whether or not they should purchase a prescription drug. What I'm trying to get at for

the group that we talked about a few minutes ago is, whether or not that thinking causes them not to purchase a drug that they need, as opposed to overpurchasing a drug that perhaps they don't need as much of. That's what I'm trying to get at as we answer that question about whether a copayment should be imposed.

Mr. CUMMINGS. I may have missed your answer to Mr. Mica's question, about how you predict this whole accounts issue is going to work out. That certainly would cause a lot of people—I mean, we have Blue Cross Blue Shield sitting here saying we're making progress, but if x, y, and z don't happen, we may not be in the program. That sends a very alarming message to Mrs. Morella's constituents and mine and many others.

That's my last question.

Mr. FLYNN. And it alarms Ed Flynn as well, Mr. Cummings.

I am confident that we will work this out administratively for this year, and continue to work together on a resolution of this for the future. I don't intend to act in any way to threaten Blue Cross Blue Shield's participation in the program for next year.

Mr. CUMMINGS. Thank you very much.

Mrs. MORELLA [presiding]. Thank you, Mr. Cummings.

Mr. Flynn, I know we're going to have a vote soon, and I have another committee that I must go to, so I want to submit questions to you, if I may. But I wanted to ask you a couple of questions.

One, I am curious about to what degree does OPM challenge and verify the experience data that comes from health plans which they use to justify their premium increases. Do you have staff in place, some designation where they have the responsibility to monitor and to audit the FEHBP plans and their costs?

Mr. FLYNN. Mrs. Morella, we have extensive monitoring of the plans in the Federal Employees Health Benefits Program to assure ourselves that the medical costs they're experiencing and that they are charging to this program are, in fact, covered, appropriate, audited, and the like.

We have a number of people who work directly for me in Retirement and Insurance Services who receive regular reports from all of our participating carriers. We have all of our health actuaries in the Office of Actuaries who are really expert in this data, who know what to look for, how to look for it, how to analyze it, and what questions to ask. Finally, in the independent Office of the Inspector General, we have that same type of expertise.

I don't think there's any question, Mrs. Morella, that we have good oversight of the medical trend and medical costs in this program, and on that basis, we can make independent judgments and do not have to rely solely and exclusively on what we hear from plans.

Mrs. MORELLA. So you feel pretty comfortable feeling that your cost accounting apparatus is in place?

Mr. FLYNN. I believe, when it comes to this issue of the cost accounting standards, that we currently have a wealth of information which enables us to make judgments about whether or not the indirect costs charged by these health plans are, in fact, appropriately charged to the Federal Employees Health Benefits Program, that they're not overcharging us at the advantage of someone else and that sort of thing. Yes; I am comfortable.

Mrs. MORELLA. A question I would like to ask you, that I also asked Blue Cross Blue Shield, has to do with whether or not you bring into the deliberations Federal employees. I'm not talking about the union plans, but Federal employees and retirees.

Do they have any role to play?

Mr. FLYNN. They certainly do, Mrs. Morella, and we do bring them in.

We talk to the unions in their roles as representatives of employees; we talk to the National Association of Retired Federal Employees. Last year we conducted focus groups with Federal retirees across the country, and we're engaging in a similar process this year.

In addition, over the space of the next 6 weeks, we will conduct a series of focus groups, facilitated by the Gallup organization, with families, Federal employee families, active and retired, to ask them questions about the degree to which we are meeting the needs of the family as we administer this program.

Finally, Mrs. Morella, as you know, we do a customer satisfaction survey each year, where individuals not only have the opportunity to tell us how they feel about the individual plans that they're a part of, but they also have the opportunity to tell us about what they think of the services they get from OPM.

Input from our customers—a broad term—but from Federal employees, retirees, members of their families, is important to us. We listen in a lot of different ways.

Mrs. MORELLA. Indeed, it should be. I do know that the customer satisfaction rate has been pretty high, and we comment on that.

Would you in some way change that system of receiving the input from the Federal employees, the retirees, the union representatives? I mean, is it to your total satisfaction, or would you streamline it?

Mr. FLYNN. I doubt that you could ever get me to say something is to my total satisfaction.

The way in which we get input has evolved over the several years that I have been fortunate to run this program, and will continue to do so, and not only on the basis of things that we think might make it better, but suggestions that we get from others. We would invite that all the time.

Mrs. MORELLA. I would like to ask if you could submit to this subcommittee the documentation that each plan submits to justify its premium increase request, and maybe cost containment measures. I think the other members of the subcommittee would like to see that, too.

[The information referred to follows:]

Documentation To Support Premium Rates Under The FEHB Program

The rate-setting process in the Federal Employees Health Benefits (FEHB) Program begins in March of each year when the Office of Insurance Programs in the Office of Personnel Management (OPM) sends all qualified health plans the annual Call Letter to advise them on goals and procedures for negotiation of contracts which will take effect the following January. In conjunction with the Call Letter, OPM's Office of Actuaries sends each health plan a package of rate instructions which asks for the plan's proposed biweekly premium charges for self only and self and family coverage and includes discrete documentation requirements based on whether a plan uses experience rating or community rating. Plans must complete and return contract proposals by May 31.

An important factor in FEHB rate negotiations is the position of a plan's FEHB reserves. The cost of each FEHB enrollment includes a three percent payment to fund a contingency reserve account for the plan in the Employees Health Benefits Fund in the U.S. Treasury. Applicable law makes contingency reserve accounts available, subject to minimum balance requirements and other conditions reflected in OPM regulations, to defray future premium increases, to increase benefits, or to reduce contributions of enrollees and the Government for the plan from which the contingency reserves are derived.

Moreover, OPM regulations require experience-rated plans to maintain a "special reserve" representing the cumulative difference between income to the plan from FEHB enrollments (premiums, plus interest on investments) and plan expenses (benefit costs, plus administrative expenses, and retentions). If at the end of a contract year, total reserves credited to an experience-rated plan (for incurred-but-unpaid benefit claims and the "special reserve") exceed target levels OPM regulations specify, any excess must be credited to the contingency reserve maintained by OPM.

Experience rated Health Plans

Premium rates for the fee-for-service plans, and the few health maintenance organization (HMO) plans which are also experience-rated, are a reflection of the plan's actual FEHB claims experience. The most important consideration in rate negotiations is protection for individual enrollees against plan failure due to inadequate funds. OPM rate instructions for experience-rated plans prescribe a reserve goal that provides a cushion equal to two months of claims and expenses in excess of the reserves necessary to satisfy all incurred liabilities to date. (The sum of the reserves held for all incurred liabilities to date and the reserve cushion in excess of that amount are an integration of the total reserve holdings for the plan either with

the insurer or in the Employees Health Benefits Fund in the U.S. Treasury.) The setting of appropriate rates to achieve the preferred reserve goal must be tempered by such considerations as rate stability, plan attractiveness and value, the size and demographics of the plan, plan growth or shrinkage, and the long range viability of the plan.

As each experience-rated plan's proposal comes into OPM, actuaries first price out benefit changes to determine if they are in compliance with guidance given in the Call Letter. For example, the actuaries must determine that any carrier-initiated changes are cost-neutral or that changes in the plan's mental health benefits amount to a realignment but not a reduction in benefits. Usually benefit changes are settled upon and the rate setting process is then begun, however it is sometimes the case that because of rating or other considerations benefit changes are revisited.

The purpose of the completed rating package for experience rated plans is: to quantify the historical experience of the plan, to estimate the plan's present position, and to project the plan's future experience in the context of the proposed changes in benefits and rates.

Quantification of Historical Experience:

For purposes of quantifying a plan's historical experience, the actuaries compare enrollment demographics for the present year and for several prior years. This gives an accurate picture of trends in premium income and enrollment. The actuaries also evaluate the impact on claim costs associated with recent benefit changes under the plan, and any other factors that bear on benefits costs, such as the expansion of a preferred provider organization (PPO) network. Next, the actuaries analyze the correlation between the plan's enrollment trend and the trend in average benefit utilization.

Based on a plan's historical patterns of claims payments and the most recent actual claims data (e.g., a plan's data may show that as of July 31, incurred claims for the prior year are 97 percent complete and claims for the second previous year are 99.5 percent complete), the OPM actuaries calculate prior year incurred claims. The trend in these claims numbers, along with the trends for enrollment and average utilization, allow determination of the historical trends for a plan.

Estimation of Present Position:

At the time OPM and FEHB plans negotiate rates for the upcoming contract year, complete claims data for the present year is unavailable until approximately 18 months later. Therefore, the OPM actuaries must estimate the plan's gains or losses in relation to current FEHB premiums through the end of the current year and the plan's reserve position at the end of the year. The estimate relies on a combination of the most recent claims data and historical and projected trends for both the specific plan and the overall program.

Projection of Future Experience:

Based on trend projections for both the particular plan and for the FEHB Program as a whole, and the other factors which would affect claims experience such as proposed benefit changes and enrollment characteristics, the OPM actuaries project each plan's claims for the upcoming year (the year for which rates are being set). The actuaries scrutinize the plan's proposed premium rates to determine if they satisfy the requirements for adequate funding of benefits and OPM reserve targets.

The actuaries also evaluate the plan's rate proposal in relation to past premiums and anticipated future premium requirements, to ensure that the plan's premiums will be reasonably stable, represent good value for the benefits provided, and remain competitive with other FEHB plans. To achieve these multiple goals sometimes requires OPM actuaries to work closely with the plan to reach consensus on what additional actions are necessary. This may be as simple as an adjustment to the proposed premium, but may involve additional measures such as benefit changes, cost saving measures, or insurance arrangements.

OPM's actuaries continue discussions with the plans throughout the summer, until negotiations on rates and benefits are finalized by the middle of August. This deadline is essential to allow sufficient time for the printing of brochures and the dissemination of other informational material so that enrollees may make an informed decision when choosing a health plan during the open season.

Community Rated Health Plans

The majority of FEHB plans are HMO plans and use community rating. OPM accepts three different types of community rating. The first is "traditional community rating" which requires the HMO to charge the FEHB group rates that are essentially the same as rates it charges all other groups the plan does business with.

The second community rating method is "community rating by class" which allows a bit more flexibility than traditional community rating. Specifically, under community rating by class, the rate the HMO charges the FEHB group (and all of the plan's other groups) may be adjusted on the age-sex composition of the group.

The third community rating method is "adjusted community rating" which allows the HMO to base the FEHB group rate on the actual experience of the group. This method differs from the type of experience rating OPM uses for its "experience rated" plans in that it is a prospective rating method. That is to say, although the HMO may use the experience of the FEHB group to set rates, once rates are set for a year, there is will be no retrospective adjustments. The

HMO may not request additional payments from its contingency reserve to recover losses due to an under-estimation of the rates.

The FEHB rating package for HMOs requires the plan to complete an extensive questionnaire which asks for detailed documentation of the proposed community rates.

If an HMO uses traditional community rating or community rating by class, the main concern for OPM actuaries is that the FEHB Program receives a rate equivalent to the rates the plan charges other groups who contract with the plan. Each HMO must provide written certification that this is the case. Further, HMOs with more than 1500 FEHB enrollees must include, as part of their rate proposal, detailed documentation for how it derives rates for the two groups it contracts with that are closest in size to the plan's FEHB group. These two groups are known as "similarly sized subscriber groups" (SSSGs). OPM actuaries carefully analyze the rate derivations of the SSSGs for conceptual soundness and technical accuracy. The OPM audit staff subsequently verifies all SSSG data HMOs submit.

An HMO using the complex adjusted community rating methodology must also submit detailed documentation of its rate derivation. The HMO must indicate the experience period it used to derive the FEHB group rates and show precisely how the proposed rate follows from the stated experience. OPM actuaries scrutinize all assumptions and calculations.

The FEHB rate package also requires each HMO to provide details on rate loadings for any additional benefits (above and beyond the plan's community benefit package for other groups) that OPM requires the plan to offer FEHB enrollees, such as, including dependent children as family members to age 22. Finally, all HMOs must compute rate loadings to account for the fact that the FEHB Program offers Medicare-eligible retirees the same health plans as other enrollees. Each HMO coordinates its benefits with Medicare benefits in cases of retired FEHB enrollees with Medicare eligibility and must include adjustments to the community rates, if appropriate. The Office of Actuaries analyzes all rate loadings for accuracy and conceptual soundness.

The purpose of the FEHB contingency reserve for a community rated HMO is to enable OPM to mitigate rate fluctuations for FEHB enrollees. If a plan's contingency reserve exceeds the preferred minimum balance, OPM may make the reserve available to pay any amounts owed the plan for any reason (e.g., to cover variations from expected community rates for the plan's other group contracts that occur subsequent to FEHB negotiations, to comply with audit findings in the plan's favor). Access to the FEHB contingency reserve for the HMO avoids increases in the plan's FEHB premium rate to cover prior payment deficiencies.

Mr. FLYNN. I think we can do that without any difficulty.

Mrs. MORELLA. Is there any other comment you would like to make?

Mr. FLYNN. I know you're ready to go, and I'm about to lose my voice. So I appreciate very much the opportunity to be here.

Mrs. MORELLA. We very much appreciate having you here. I've often wondered if maybe we should have had the three of you together, as was originally planned, so that we could have had a back-and-forth kind of discussion. You are kind of spread out here, so I apologize for that.

You've been great to be here. We look forward to continuing to work with you as we have in the past, and thank all of you.

I will now adjourn the Subcommittee on the Civil Service. Thank you very much.

Mr. FLYNN. Thank you.

[Whereupon, at 1:55 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Mr. Chairman and Members of the Subcommittee. The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to present testimony for the record regarding prescription drug benefit programs under the Federal Employees Health Benefits Program (FEHBP), and our perspectives on the recent announcement made by the Office of Personnel Management (OPM) that that FEHBP premiums would increase on average by 10.2 percent next year.

Founded in 1933 and based in Alexandria, Virginia, the National Association of Chain Drug Stores (NACDS) membership consists of 135 retail chain community pharmacy companies. Collectively, chain community pharmacy comprises the largest component of pharmacy practice with over 91,000 pharmacists. The chain community pharmacy industry is comprised of 19,000 traditional chain drug stores, 6,300 supermarket pharmacies and nearly 5,000 mass merchant pharmacies. The NACDS membership base operates more than 30,000 retail community pharmacies with annual sales totaling over $135 billion including prescription drugs, over-the-counter (OTC) medications and health and beauty aids (HBA). Chain operated community retail pharmacies fill over 60% of the more than 2.7 billion prescriptions dispensed annually in the United States. Additionally, NACDS membership includes more than 1,300 suppliers of goods and services to chain community pharmacies. NACDS international membership has grown to include 86 members from 20 foreign countries.

NACDS shares concerns expressed by you and Members of the Subcommittee regarding the FEHBP premium increases for 1999. We are particularly concerned by the fact that a significant portion of these premium increases is being driven by increases in the prescription drug benefit component of the program. As you know, the agency attributed part of this premium increase to a 22 percent rise in total prescription drug expenditures, which included increases in the **price of drugs**, an increase in the **use of drugs**, and the costs of **expensive new drugs**. About one-fifth of all total FEHBP expenditures are for prescription medication costs.

1996 COPAYMENT CHANGE HAD NEGATIVE IMPACT ON PROGRAM EXPENDITURES, RETIREES, PHARMACIES

Under the FEHBP program, each of the approximately 300 FEHBP plans is responsible for providing their own prescription drug benefit program. Many of the plans contract with private-sector pharmaceutical benefit management companies (known as PBMs) to arrange for the delivery of a prescription drug benefit. These plans use various cost containment mechanisms, such as drug formularies, and negotiate discounts and rebates with drug manufacturers to reduce overall costs. They also negotiate the dispensing fees that retail pharmacies are paid by the PBM to provide prescriptions and pharmacy services to FEHBP enrollees. There are no OPM guidelines, however, on how these drug programs should be structured or how costs should be controlled.

Most disturbing about these recently-announced prescription drug cost increases is the fact that OPM made a high-profile change in 1996 in their largest prescription drug benefit program - the Blue Cross/Blue Shield program - which was designed to reduce escalating prescription drug program costs.

Until 1996, Federal retirees paid a 20 percent copayment on a prescription whether it was obtained from a retail or mail order pharmacy. The 20 percent copayment helped to control overall utilization and manage costs. The 1996 change ***waived*** the 20 percent copayment if the prescription is obtained through the mail order pharmacy service, which is operated by Merck-Medco. The ostensible purpose of this change was to generate savings for the program by encouraging the use of mail order prescription services, which some perceive to be less costly than obtaining prescriptions at retail pharmacies.

At the time of the copayment change, many Members of Congress and retail pharmacies questioned the wisdom of this policy move. That is because patient copayments are time-tested method to encourage appropriate utilization of health care services, and help to involve patients in making decisions about their care.

Many expressed concerns that the lack of copayment on mail order prescriptions would encourage overutilization of prescription medications. Moreover, there were concerns that most of any program savings from the change would result from copayments made by many Federal retirees who would want to continue to obtain their prescriptions from local retail pharmacies, not the mail service provider. Finally, while OPM and Blue Cross/Blue Shield contended that retirees still had the "choice" of using their retail pharmacy, many viewed the copayment change as nothing less than "economic coercion" to encourage the use of the mail order service, which has not proved to reduce costs.

COPAYMENT CHANGE HELPED FUEL INCREASE IN PRESCRIPTION DRUG COSTS, BURDENED RETIREES OBTAINING PRESCRIPTIONS AT RETAIL PHARMACIES

NACDS believes that many of the original concerns it expressed about this copayment change have been validated. For example, instead of helping to better manage overall prescription drug costs, the copayment change may have helped fuel the explosion in these costs that the program is now experiencing.

NACDS strongly supports the appropriate use of prescription medications and pharmacy services, and believes that these are among the most cost-effective therapy in the health care system. Study after study documents the value of pharmacy services in reducing the inappropriate use of medications, which is estimated to result in up to $100 billion in additional and unnecessary health care costs.

However, appropriate and reasonable patient cost sharing helps to discourage unnecessary utilization, which is as significant a problem to the health care system as is overutilization, and helps to control overall costs. In short, in order to better control utilization and manage care, an increasing number of public and private prescription drug benefit plans are implementing reasonable cost sharing amounts, not eliminating them. Waiving the mail order copayment defies this logic and marketplace trends.

Data presented by Merck-Medco at the September 24th hearing demonstrate a significant increase in utilization of prescription medications for the FEHBP retiree population since 1996, the first year that the copayment was waived for retirees obtaining their prescriptions through the mail. While it is not possible to conclude from these data that these increases resulted solely from the copayment change, or that these increases in prescription drug utilization were unnecessarily or medically unjustified, it can be realistically concluded that the lack of a mail service prescription copayment contributed to part of the significant utilization increases. Moreover, to compare utilization patterns before and after the copayment was implemented, Merck-Medco should have also presented pre-1996 utilization trend data for this retiree population group, not just post-1996 data.

The concerns about the impact of this copayment change on out-of-pocket payments for retirees obtaining their prescription drugs at retail pharmacies were confirmed in a letter that OPM sent to Chairman Mica in April 1996. In that letter, OPM stated that **63 percent of the $200 million savings projected for the program in 1996 from the copayment change resulted from beneficiary copayments**. Only 37 percent resulted from use of the mail order program. This demonstrated that many retirees continued to opt to use local retail pharmacies rather than send their prescriptions to a mail service provider. This copayment unfairly penalizes those retirees who want to use their local retail pharmacy.

In the same April letter, OPM attributes these mail order savings to volume discounts that plans are able to negotiate with drug manufacturers and savings from using lower-cost generic substitutes. Other reports issued by the GAO indicate that using mail order pharmacy services may not generate any significant savings from increased efficiency.

Taken together, these data suggest that a disproportionate share of the cost containment burden resulting from this copayment change has been placed on Federal retirees that use local retail pharmacies and the pharmacies themselves, not drug manufacturers. This seems unfair, given that drug manufacturer product costs usually represent about 75 percent of total drug program spending. At this point, we are unsure about the exact nature and amount of savings being realized by the use of this mail order prescription program.

In response to these collective concerns, the FY 97 Treasury/Postal Appropriations bill recommended that the OPM take actions to help reduce the costs of FEHBP prescription drug benefit programs. The language says that OPM should continue to "encourage all FEHBP plans to find alternative savings and hold down premiums." In referencing the new 20 percent retail pharmacy copayment in the Blue Cross/Blue Shield FEHBP program, the language said that "much of the savings from the new prescription coverage comes directly from retail copayments.

OPM and its carriers should consider other commonly-used management options such as full utilization of drug manufacturer rebates and generic drug substitution." It is unclear whether OPM actually took these actions, which could have helped reduce the magnitude of the current premium increases which the agency and Federal employees and retirees are now facing.

NACDS RECOMMENDS EQUAL COPAYMENT FOR MAIL ORDER AND RETAIL PHARMACY PRESCRIPTIONS

Mr. Chairman, we believe that recent information supports the position taken by NACDS in 1996 regarding this copayment change. That is, eliminating the copayment for mail order prescriptions was and is inappropriate medical and economic policy for Federal retirees, and the retirees who choose to utilize retail pharmacies should not be forced to shoulder most of the cost savings burden from this change.

At the September 24th hearing, both Blue Cross/Blue Shield and Merck-Medco suggested that they be allowed by OPM to reinstate some form of cost sharing requirement in the mail order component of the program to better manage utilization and control costs. However, OPM stated that it does not believe that such a change is warranted at this point in time.

NACDS believes that such a move would represent sound medical and program management policy. For example, **a 10 percent copayment on both mail and retail would serve multiple purposes**. It would:

- maintain some form of appropriate and realistic patient cost sharing for both programs;
- not impose an unfair economic impact on Federal retirees who want to continue to use retail pharmacy;
- improve quality of care by facilitating Federal retiree interaction with the local pharmacy provider, and;
- help to reduce expenditures from any unnecessary utilization of prescriptions that have resulted from the lack of a mail service copayment.

We believe that there should be no differential in the copayment amounts between mail order and retail pharmacy paid by Federal retirees, and urge that this policy be implemented as soon as possible. However, we also encourage the Committee and the OPM to investigate other opportunities for cost savings that focus on the drug product expenditure component of the program. We do not believe that OPM has taken steps to implement the report language included in the FY 97 Treasury/Postal Appropriations bill that encourages OPM and its carriers to more fully utilize drug manufacturer rebates and generic substitution to hold down program costs.

In summary, implementation of equal copayments on mail order and retail pharmacy prescriptions, as well as more aggressive implementation of the 1997 report language, would go a long way toward helping better manage these escalating prescription drug costs and avoid the magnitude of premium increases that Federal retirees will experience next year.

We appreciate the opportunity to present our views on this issue, and look forward to working with the Subcommittee and its staff, and the staff of OPM to continue to assure that FEHBP prescription drug benefits are effectively and efficiently managed care delivered. Thank you.