OVERSIGHT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND THE FEDERAL LONG-TERM CARE INSURANCE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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OVERSIGHT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND THE FEDERAL LONG-TERM CARE INSURANCE PROGRAM

WEDNESDAY, MARCH 24, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., room 2203 Rayburn House Office Building, Hon. Jo Ann Davis (chairwoman of the subcommittee) presiding.

Present: Representatives Jo Ann Davis of Virginia, Danny K. Davis of Illinois, and Van Hollen.

Also present: Representative Norton.

Staff present: Ron Martinson, staff director; Chad Bungard, deputy staff director and chief counsel; Chris Barkley and Shannon Meade, professional staff members; Reid Voss, clerk; John Landers, detailee; Mark Stephenson and Tania Shand, minority professional staff members; and Teresa Coufal, minority assistant clerk.

Mrs. JO ANN DAVIS OF VIRGINIA. A quorum being present, the Subcommittee on Civil Service and Agency Organization will come to order.

Thank you all for joining us today as we examine the Federal Employees Health Benefits Program and the very new Federal Long-term Care Insurance Program.

More than 8 million Federal workers, retirees, and their families are covered by the FEHBP, and more than 20 million people are eligible for long-term care insurance. And we want to look at several issues facing both programs.

The FEHBP is widely considered to be a model employer provided health insurance program. Yet there are pressing issues facing the program.

For one, there is the question of whether the cost accounting standards should be applied to the program and what effect that might have on Blue Cross/Blue Shield, its largest carrier.

There is also the possible addition to the program of health savings accounts which would allow individuals to use tax-free money to pay for qualified medical expenses. And I am interested to hear from our witnesses how they view the impact of HSAs on the Federal health program.

We will also discuss the Office of Personnel Management's long-term vision for the FEHBP, including the number and types of coverages offered, the level of government contributions, and how the addition of flexible spending accounts is working.

Our other subject is the Federal Long-term Care Insurance Program. Established by legislation in 2000, the Federal long-term care program is designed to cover injuries or conditions that prevent people from performing the task of everyday life.

While more than 20 million people are eligible for the insurance, I would like to know how many actually signed up. As of last year, the number was slightly over 200,000. So I wonder if that indicates any problem with the Federal coverage offered or whether people just do not know about the insurance.

There is also the question of whether the long-term care program should be opened up to more than one carrier. I look forward to our discussion, and now I will turn to our ranking member, Danny Davis for an opening statement.

Mr. DAVIS OF ILLINOIS. Thank you very much, Madam Chairwoman.

And I could not think of anything that is more important than health care benefits, and especially long-term care as people like myself begin to get older and look forward to the possibility of having that need.

So I want to thank you for holding this hearing because it focuses our attention on two issues that greatly impact the lives of Federal employees, the Federal Employees Health Benefits Program and the Federal Long-term Care Insurance Program.

A major problem facing Federal employees and retirees is rising FEHBP premiums. This year, the FEHBP premiums will climb an average 10.6 percent for the 8 million Federal employees, retirees, and family members who receive their health insurance through this system.

Representative Hoyer has introduced H.R. 577 which would help keep Federal employees' health care costs affordable by increasing the government's contribution to premiums. Currently the Federal Government pays 72 percent of the total cost of health insurance for Federal employees and retirees. H.R. 577 would raise this contribution to 80 percent.

Representative Hoyer's bill has been referred to this subcommittee, but unfortunately no action has of yet been taken.

In December 2003, the Office of Personnel Management Director, Kay Cole James, announced that OPM had begun to explore health savings accounts [HSAs], for Federal employees and retirees. HSAs, also known as medical savings accounts, are tax advantaged personal savings accounts for unreimbursed medical expenses.

Today I hope to hear what impact implementing HSAs will have on the FEHBP.

This is the first hearing the subcommittee has held on OPM's implementation of the Long-term Care Security Act, which was signed into law in September 2000. This subcommittee spent 2 years debating how best to fashion a Long-term Care Insurance Program for Federal employees. The debate centered around whether or not a single long-term care insurance carrier should be chosen to negotiate premiums and benefits on behalf of Federal employees, an

employer based group model, all where the multiple carriers would be able to sell individual long-term care insurance to employees.

That debate has been settled, and I look forward to hearing how Long-term Care Partners, LLC, which was awarded the long-term care contract by OPM in December 2001, is implementing the program.

And finally, Mr. Gammarino with Blue Cross/Blue Shield will testify extensively to why cost accounting standards should not apply to Blue Cross/Blue Shield. However, I would like to note for the record that there are many who are not represented here today that feel that it is financially prudent that cost accounting standards apply to all FEHBP carriers.

I look forward to hearing the testimony of the witnesses, and again, I thank you, Madam Chairwoman, for calling this hearing.

[The prepared statement of Hon. Danny K. Davis follows:]

**STATEMENT OF THE HONORABLE DANNY K. DAVIS
AT THE SUBCOMMITTEE ON CIVIL SERVICE
AND AGENCY ORGANIZATION
HEARING ON**

**THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND
THE FEDERAL LONG-TERM CARE INSURANCE PROGRAM**

March 24, 2004

I would like to thank the chair for holding this hearing, because it focuses our attention, on two issues that greatly impact the lives of federal employees – the Federal Employees Health Benefits Program (FEHBP) and the Federal Long-Term Care Insurance Program (FLTCIP).

A major problem facing federal employees and retirees is rising FEHBP premiums. This year, FEHBP premiums will climb an average 10.6% for the 8 million federal employees, retires, and family members who receive their health insurance through this system.

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That debate has been settled and I look forward to hearing how Long-Term Care Partners, LLC, which was awarded the long-term care contract by OPM in December 2001, is implementing the program.

Finally, Mr. Gammarino, with Blue Cross Blue Shield, will testify extensively to why Cost Accounting Standards should not apply to Blue Cross Blue Shield. However, I would like to note for the record, that there are many, who are not represented here today, that feel that it is financially prudent that cost accounting standards apply to all FEHBP carriers.

I look forward to hearing the testimony of the witnesses. Thank you.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Davis.

Ms. Norton, do you have an opening statement?

Ms. NORTON. Thank you very much, Madam Chairwoman.

Let me thank you for this particular hearing coming at this time, early enough so that there is some contribution we can make to the increasing troubles I see with the FEHBP model.

I also appreciate the opportunity to hear about experience thus far with long-term care insurance.

Madam Chairwoman, it is hard for me with a straight face to simply come here and criticize the increase in FEHBP premiums, you know, as we do each year. I know full well that what is happening to FEHBP is part and parcel of the never ending spiral, the virtual explosion of health care costs above and beyond any other item in our country.

I do regret that Congress is letting it happen. If we are letting it happen to virtually everyone, including people in Medicare, I do not know why I would expect that FEHBP would be any different.

If you look at Federal employees and what we could most do for them, the single most important thing we could do for them, of course, would be to increase the Federal contribution to FEHBP, and that is the single least likely thing to happen.

In fact, employers are doing just the opposite elsewhere. They are offloading part of the premium or entirely eliminating health care to their employees, and that will not happen, I am certain, in the Federal Government, and I am grateful that the Federal Government certainly would not set that example.

But I have to say that the much touted FEHBP model I no longer tout, and I am not sure exactly what Members have in mind when they say the way we could cure the health care increased problems of the country would be to have some giant FEHBP.

It is true that FEHBP gives choice, but I am not clear on what this model with its 8 million employees does for us on price, and the only way I think we could ever find that out is to compare our choice model with other choice models.

I mean, when we are the largest employer in the country and you still have premiums going up at a rate above 11 percent per year, that is nothing to write home about. That is something to complain about, and if that is what we do with a million in our risk pool, heaven help small employers, even Fortune 500 employers.

So I do not know what the largest pool in the country has brought to pricing or why it has seemed to invite so little to premium costs.

In that regard, Madam Chairwoman, I will be very interested. The burden is surely on those who want to add health service accounts to show that somehow such accounts would dare I say strengthen or even leave in place the FEHBP price structure we have now. If so, that is counterintuitive to me.

It seems to me that health service accounts may well be the one way to increase premiums at an even faster rate than they are going now. If you want to leave the least healthy retirees and workers in the FEHBP and tell everybody else they can get out and get the tax advantage, I invite them to get the tax advantage that is already available to them in the Federal flexible benefits plan, but don't where you are likely now to leave Medicare.

Look, we already have seniors in a number of districts as the guinea pigs for health service accounts in the country. That is enough guinea pigs for one time. I do not see why we should add Federal workers to that select group of Americans to try out this plan that would seem to work in exactly the opposite way we would want to work for the great majority.

I do not know whatever happened to the idea that we are all one community. The notion of community economically starts with insurance, and we put everybody in there. We put the healthy ones that will never use it, and we put the unhealthy ones that will never use it, and together we are a community. We are all helping one another, and, by the way, it makes economic sense.

You break up that idea. You break up the very bottom line notion of health insurance as an economic concept. FEHBP is already far from living up to its reputation as this grand model. I hope we do not make it even less of a model by marching forward with something that will fix it by hurting it.

Thank you.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Ms. Norton.

I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record and that any answers to written questions provided by the witnesses also be included in the record.

Without objection, it is so ordered.

I ask unanimous consent that all exhibits, documents and other materials referred to by Members and the witnesses may be included in the hearing record, and that all Members be permitted to revise and extend their remarks.

Without objection, it is so ordered.

On the first panel we are going to hear from Mr. Dan Blair, Deputy Director at the U.S. Office of Personnel Management.

It is a standard practice for this committee to administer the oath to all witnesses, and if all of the witnesses, both the first panel and the second panel, could please stand, I will administer the oath to all of you at one time.

If you will please raise your right hands.

[Witnesses sworn.]

Mrs. JO ANN DAVIS OF VIRGINIA. Let the record reflect that the witnesses have answered in the affirmative, and you may be seated.

Mr. Blair, thank you for being with us today. We appreciate you coming back to the committee for testimony, and we look forward to hearing your comments. We will recognize you now for 5 minutes.

STATEMENT OF DAN BLAIR, DEPUTY DIRECTOR, U.S. OFFICE OF PERSONNEL MANAGEMENT

Mr. BLAIR. Thank you, Madam Chairwoman. It is good to appear before the subcommittee. Ranking Member Davis, Ms. Norton, it is good to see you all this afternoon.

I am Dan Blair, the Deputy Director, and I am pleased to be here on behalf of the Office of Personnel Management and its Director, Kay James, to talk about the Federal Employees Health Benefits Program, as well as the new long-term care program.

I am assisted here today by Abby Block, who is OPM's Deputy Associate Director for Employee and Family Support Policy, and with your permission, I may ask Ms. Block to help me with more technical questions that the subcommittee may pose to me.

Mrs. JO ANN DAVIS OF VIRGINIA. Let the record reflect that Ms. Block also was administered the oath at the same time.

Mr. BLAIR. Thank you.

First, I would request that my full statement be included in he written record.

Mrs. JO ANN DAVIS OF VIRGINIA. So ordered.

Mr. BLAIR. I will be happy to summarize.

First, let me talk about the Federal Employees Health Benefits Program [FEHBP]. You talked about our vision. Our vision for the program is clear. We intend to keep FEHBP as a model for group health insurance purchasing in the private sector.

In order to do that, we must maintain or enhance competition, while at the same time effectively utilizing the purchasing power of the risk pool that is over 8 million people strong.

Further, to borrow from an ad line, an educated consumer is our best customer, and we intend to provide access to the best possible education in order to educate our enrollees.

We recognize the program is frequently cited as a model for the employer sponsored health insurance program. The program operates under a statutory framework enacted in 1959, which has permitted OPM to contract with multiple health plans to provide coverage for about 8½ million employees and retirees and independents.

The statute specifically defines the categories of plan sponsors that may offer plans in the program. HMOs may apply from year to year. New fee-for-service and preferred provider type plans may not.

Each spring we send our carriers our annual call letter which highlights particular areas of interest and provides broad guidelines for the upcoming negotiations. We have repeatedly expressed opposition to benefit mandates by opposing mandates in the call letters.

Rather, we encourage plans to be creative and responsive to consumer interests, especially in the areas of preventive services.

While enrollment in the program is generally relatively stable, with no more than a 5 percent fluctuation of enrollees, several plans have increased their enrollment of late, including Blue Cross/Blue Shield's Basic Option, and the National Association of Letter Carriers MD/IPA Plan, and the Foreign Service Benefit Plan.

Committee members recently spoke to flexible spending accounts, and in order to increase the value of the employees' hard earned dollars and give them greater control over their health care spending, we worked closely with the National Treasury Employees Union last year to make flexible spending accounts available to employees beginning last July.

We had our first full open season last November, and we are pleased to report that 123,187 employees are participating in the program. We have 117,950 accounts for health care, and a little over 18,000 for dependent care. So the total health care allotments add up to a little over $193 million.

Let me talk for a moment about health savings accounts which were referenced earlier. HSA's were made available by the Medicare Modernization Act, which was enacted last year. We estimate that there are 3.1 million individuals covered under FEHBP who would be eligible to have an HSA if they are enrolled in a high deductible health care plan.

The principle underlying HSA is to give consumers greater access to more of their pre-tax dollars for health care. In analyzing how best to approach the introduction of this new product, we must carefully consider the advantages of expanding the options available to Federal enrollees, along with the potential impact on the program overall and on specific groups of enrollees, like Federal annuitants.

While we believe there is a place for products like HSAs in FEHBP, our experience leads us to believe that the movement by large enough numbers of enrollees to raise a concern about the adverse selection is not likely. Rather, we will be providing guidance on HSAs to the FEHBP plans along with our general negotiating guidance through our annual call letter.

You also mentioned the cost accounting standards. Let me talk about that for a moment. The Congress, as you know, has waived the caps for FEHBP contracts in appropriation acts for fiscal years 2000, 2001, 2002, 2003, and 2004.

Further, Director James exercised her statutory authority to waive them as well, and we are proposing regulations to waive their applicability to experience rated contracts. We take these actions with the intent to do everything necessary to preserve the physical integrity of the program without placing an unnecessary and very costly burden on the plans that would ultimately be reflected in higher premium costs.

And on a final note, I would like to talk a little bit about the Long-term Care Insurance Program. We are pleased with the success thus far of the program. More than 200,000 individuals have enrolled, making it the largest employer sponsored long-term care insurance program in the country.

We are going to continue to work the Long-Term Care Partners to inform and educate employees and annuitants about the importance of this insurance for their own security and the future financial security of their families. Choice of plan design and options is a hallmark of the program. We offer 528 plan designs when combining the various components of the benefits package.

Further, the program is designed to meet long-term demands with an eye to keeping rates stable over the long haul.

That is my summary of my testimony. I am happy to answer any of your questions.

Thank you.

[The prepared statement of Mr. Blair follows:]

STATEMENT OF THE HONORABLE DAN G. BLAIR
DEPUTY DIRECTOR
OFFICE OF PERSONNEL MANAGEMENT

before the

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

on

OVERSIGHT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND
THE FEDERAL LONG-TERM CARE INSURANCE PROGRAM

MARCH 24, 2004

Madam Chairwoman and Members of the Subcommittee:

I am pleased to be here today on behalf of the Director of the Office of Personnel Management (OPM), Kay Coles James, to discuss the Federal Employees Health Benefits (FEHB) Program and the Federal Long Term Care Insurance (FLTCI) Program.

The FEHB Program is frequently cited as a model for employer-sponsored health insurance programs. The Program operates under a statutory framework enacted in 1959 which has permitted OPM to contract with multiple health plans to provide coverage for about eight and a half million Federal employees and retirees and their dependents. However, the statute specifically defines the categories of plan sponsors that may offer plans in the Program. While Health Maintenance Organizations (HMOs) may apply each year, new fee-for-service/preferred provider type plans may not. The only exception is the slot formerly occupied by the Indemnity Benefit Plan, a Government-wide plan. Aetna, which administered that plan, withdrew from the Program beginning in 1990. Since then, no insurer has indicated an interest in sponsoring a new nationwide open enrollment plan. But participating fee-for-service plans can and have introduced new products as options within their existing plans.

While plan participation rates have varied over the years due to changes within the healthcare industry, it has always been and still is OPM's intent to offer a broad range of competing plan designs and delivery systems so that consumers can choose the coverage that best suits their needs. Each spring we send carriers our annual Call Letter. The Call Letter highlights particular areas of interest to OPM as the plan sponsor and provides broad guidelines for the upcoming negotiations rather than specific benefits proposals. Director James has repeatedly expressed her opposition to benefits mandates and has consistently opposed mandates in the Call Letters. Instead, the Director encourages plans to be creative and responsive to consumer interests, especially in areas such as preventive services. OPM receives benefit and rate proposals from

participating plans on May 31 of each year and negotiates throughout the summer in preparation for the annual open season.

While enrollment in the Program is generally relatively stable, with no more than 5 percent of enrollees changing plans each year, several plans have increased their enrollment of late, including Blue Cross and Blue Shield in the Basic Option, the National Association of Letter Carriers Plan, MD-IPA, and the Foreign Service Plan. Although most of the participating plans in the program are either fee-for-service plans with a preferred provider network or health maintenance organizations, OPM has accepted proposals for several new products in recent years. In 2001, the Government Employees Hospital Association (GEHA) introduced a new Standard Option with a benefit package designed to be attractive to individuals covered by Medicare. In 2002, the Blue Cross and Blue Shield Service Benefit Plan introduced its new Basic option with coverage available only through network providers. This option has features of both a Preferred Provider Organization (PPO) and an HMO. In 2003, the American Postal Workers Union (APWU) introduced a consumer-driven option within a PPO structure. And in 2004, both Aetna and Humana introduced consumer-driven options within an HMO structure. The number of plan choices available in 2004 increased for the first time in five years, and represented an important addition to consumer choice.

Our vision for the future of the Program is clear. We appreciate the recognition of the underlying principles of competition and choice within the Program as a model for Medicare modernization, and we intend to keep it a model for group health insurance purchasing from the private sector. In order to do that, we must maintain or enhance competition while at the same time effectively utilizing the purchasing power of a risk pool over eight million strong.

In order to increase the value of their hard-earned dollars and give them greater control over their health care spending, Director James worked closely with Colleen Kelley of the National Treasury Employees Union to make flexible spending accounts available to Federal employees beginning in July of 2003. We had our first full-year open season last November for calendar year 2004. The Director is pleased to report that 123,187 employees are participating in the FSA Program. 117,950 accounts are for health care; 18,178 are for dependent care. Total health care allotments add up to $193,383,629. The average amount elected was $1,640. $65,217,574 has been allotted to dependent care accounts. The average amount elected was $3,594. Fundamentally, Director James believes that Federal employees, provided with clear information, are wise enough to make sound decisions with their money and purchase of health care for their families.

Director James also has been a strong advocate of care management programs. She believes that programs geared to educating members with chronic illnesses about appropriate life style changes and ensuring that they receive the necessary services for their conditions can mitigate the occurrence of costly complications down the road. We have urged participating FEHB plans to develop such programs and to design tools to measure the return on investment from their implementation. This approach is particularly desirable because it benefits patients while also controlling costs, a real win-win. The response from the plans has been very favorable. Several of them will be presenting information on their programs at our upcoming annual carrier conference on March 30.

As you know, the Medicare Modernization Act (MMA) created Health Savings Accounts or HSAs. HSAs are available to anyone under age 65 who has a qualifying High Deductible Health Plan (HDHP). The HDHP provides protection against high medical expenses, while the HSA empowers the consumer by providing an account for routine medical expenses, funded by pre-tax employer and employee dollars. Because the HSA belongs to the individual, it encourages greater attention to health care value. The account can accumulate funds tax-free from year to year, can help cover medical expenses and premiums when between jobs, and is portable across different employers. We estimate that there are about 3.1 million individuals covered by FEHB who would be eligible to have an HSA if they were enrolled in an HDHP.

In analyzing how best to approach the introduction of this new product, Director James instructed staff to consider carefully the advantages of expanding the options available to Federal enrollees along with the potential impact on the Program overall and on specific groups of enrollees. She has had conversations with several stakeholders and received comments from Members of Congress as well as from other stakeholder groups. She has instructed staff to carefully consider those comments as well as we develop our analysis and recommendations. The Director has a particular interest in both the desires for and concerns about HSAs, especially among Federal annuitants. We included in our analysis the enrollment experience of the Health Reimbursement Arrangements (HRAs), commonly referred to as consumer-driven plans, in the FEHB Program. In 2004, total enrollment in all three consumer-driven products is 13,151. While we believe there is a place for products like HRAs and HSAs in the FEHB Program, this experience leads us to believe that the movement by large enough numbers of enrollees to raise a concern about adverse selection is not likely. We will be providing guidance on HSAs to the FEHB plans along with our general negotiations guidance through our annual Call Letter. The Director will also conduct a comprehensive series of conversations with stakeholders prior to any formal announcement.

We have noted as well that the bill you introduced, Madam Chairman, H.R. 3751, with an amendment by Representative Danny K. Davis, was referred to the full Committee on Government Reform on March 17. That bill requires the Office of Personnel Management to study and present options under which dental, vision, and hearing benefits could be made available to Federal employees and retirees. At the request of Director James, we have been gathering information on dental and vision care programs so we can be aware of the practices of other employers and cognizant of industry trends. We also have looked at hearing benefits over the years in the context of proposals from Members of Congress to mandate coverage for those benefits. The Administration is currently reviewing the bill to develop a position.

I also would like to take this opportunity to bring you up to date on the status of the applicability of the Cost Accounting Standards (CAS) to experience-rated contracts under the FEHB Program. The Congress, as you know, has waived the CAS for FEHB contracts through appropriations acts for fiscal years 2000, 2001, 2002, 2003, and 2004. Director James used the authority given to agency heads by the Defense Authorization Act of 2000 to waive applicability of the CAS to FEHB contracts on September 11, 2002, because she was concerned that the legislative waiver would not be in place to ensure a timely open season. In addition, OPM has published, with the approval of the Office of Management and Budget (OMB), a proposed regulation that will

amend 48 CFR Chapter 16, the Federal Employees Health Benefits Acquisition Regulation, to enhance OPM's oversight of carrier contracts in various ways, and, at the same time, delete the CAS provisions of the Federal Acquisition Regulation from the list of clauses applicable to currently existing experience-rated contracts in the FEHB Program. Director James is confident that she has done everything necessary to preserve the fiscal integrity of the Program without placing an unnecessary and very costly burden on the FEHB plans that would ultimately be reflected in higher premium costs.

We know that proposals to open the FEHB Program to small business owners, as well as other non-Federal groups, are advanced from time to time in the interest of making health insurance coverage available to groups or individuals that are currently uninsured or can obtain coverage only at a very high cost. We believe that the FEHB Program can serve as a model for programs designed to address those needs, and we have always been willing to provide guidance and technical assistance to those seeking to develop such programs. However, since the FEHB itself is an employer-sponsored health insurance program developed and administered specifically on behalf of Federal employees and retirees and their families, we have concerns about the appropriateness of expanding eligibility to individuals with no direct relationship to the Federal Government, or requiring OPM as the Government's human resources agency to administer such a program.

I also would like to share with you Director James' interest in the success of the Federal Long Term Care Insurance Program. As you may know, she was the first person to join the Program at its inception. The Federal Long Term Care Insurance Program was designed specifically to give members of the Federal family the best value for their money. The enabling legislation took into consideration the composition of the Federal workforce, the underwriting practices of other employers and of the industry overall, and the need for continuity and stability over the long run. When evaluating the structure of this Program, it is important to remember that, unlike health insurance which covers current year costs, long-term care insurance accumulates funds for potential use many, many years down the road.

In drafting the enabling legislation, Congressional staff worked closely with OPM staff and a broad range of stakeholders to balance the need to make access to the coverage as broad as possible while at the same time keeping premiums competitive with other products available in the marketplace. Since there was agreement from the onset that a "one size fits all" approach would not satisfy the diverse needs of the various groups eligible for coverage under the Program, potential enrollees were given a range of pre-designed packages from which to choose and, in addition, had the flexibility to tailor a package based specifically on their own preferences for benefit and cost trade-offs.

While the Government does not underwrite the risk, all the parties involved in the process were acutely aware of the need to ensure the financial stability of the Program to protect the investments of the members of the Federal family. The Act provides specifically for periodic review by the General Accounting Office and consideration of whether to rebid the contract at the end of the first seven years.

Although the current enrollment in the Federal Long Term Care Insurance Program of over 200,000 is significant, we believe the Program has even greater potential for increased participation. We will continue to work with Long Term Care Partners, the administrator of the Program, to inform and educate employees and annuitants about the importance of this insurance for their own security and the future financial security of their families.

We believe that the FEHB and FLTCI Programs are both valuable components of the Government's benefits package and support the recruitment and retention efforts of Federal agencies.

In conclusion, Madam Chairwoman and Members of the Subcommittee, on behalf of Director James, I thank you for inviting the Office of Personnel Management to testify at this hearing. I will be glad to answer any questions you may have.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Blair.

I am going to turn first to our ranking member, Mr. Davis, for questions.

Mr. DAVIS OF ILLINOIS. Well, thank you very much.

Thank you, Mr. Blair.

In addition to providing long-term care insurance for Federal employees, the Long-term Care Security Act also includes provisions to help employees who had been placed in the wrong retirement system.

My question is: what is the status of the retirement error corrections provisions of the Long-term Care Security Act?

Mr. BLAIR. As you remember, that was a provision that was added during negotiations on the program, and that was an issue that both the House and the Senate took quite seriously.

I will be happy to provide you with an update for the record. I would have to go back and look, but I know we have been involved in making sure that those retirement corrections are, indeed, taking place.

I am reluctant to talk off the top of my head on this, but as I remember, we did not find many employees who were wrongly enrolled in the retirement system. However, any employee that is inaccurately enrolled does, indeed, face financial uncertainties when they reach retirement, and so we want to make sure that we get them in the right system.

Mr. DAVIS OF ILLINOIS. Then I would appreciate it if I could get that information, the number of people who have been placed in the wrong systems.

Mr. BLAIR. Certainly.

Mr. DAVIS OF ILLINOIS. And the number of corrections that have been made, as well.

Mr. BLAIR. Certainly.

Mr. DAVIS OF ILLINOIS. Also, let me ask you. I mean, we continuously talk about the increasing cost of health care. We continue to see premiums escalating, and this has been the order of the day now for many, many years. As a matter of fact, we have been talking cost containment in health care, to my knowledge, at least 30, 40 years, or at least as long as I have been involved in it.

Does OPM see any possible daylight or areas that can be pursued that would continue to provide the kind of coverage that our employees need, but at the same time be able to maintain or to handle cost as effectively as it can be handled?

Mr. BLAIR. Well, let's look first at what the cost drivers are. They are utilization, an aging population, increased pharmacy costs, and that is due to having a burgeoning number of new pharmaceuticals on the market. That is a good thing.

We have our population which is seeing its average life expectancy increase. That should be a good thing.

But all of those are going to be cost driving factors, and I think what we need to do with our program is find out what works best in the program. And what works best in our program is the competition among plans.

I wish that we had a silver bullet to say that, yes, we would reduce premiums next year by 5 percent, but we do not have that,

and as Ms. Norton noted, we reflect the economy at large in facing increasing health care costs.

We are going to continue to hone our competitiveness in this to make sure that what cost increases do take place should be the lowest possible for the enrollees.

Mr. DAVIS OF ILLINOIS. Is there anything that perhaps we could do in addition to the business model?

I am saying we are obviously interested in the business model, but are there any things that maybe we could suggest or do with our employees that might then translate into premium differentials or reductions on the part of those who provide——

Mr. BLAIR. We do have an emphasis on preventive medicine, and we do have am emphasis on wellness, and I think that those are two things that will become more and more essential as time goes on because we have seen that the benefits of a healthy work force translate into less cost in terms of the health care plan.

And so if there is anything that we can do with our employees, it is to promote activities and promote a work force that makes healthy life style choices.

Mr. DAVIS OF ILLINOIS. And so then as utilization changes, then that gets factored into negotiations?

Mr. BLAIR. It may be a little bit more complicated than that, but ideally if you have a healthy work force, you will not have as many claims, and then less claims would help restrain increasing costs.

Mr. DAVIS OF ILLINOIS. Thank you very much.

Mr. BLAIR. Thank you.

Mr. DAVIS OF ILLINOIS. Thank you, Madam Chairwoman.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Davis.

Mr. Blair, when you were just responding to Mr. Davis, you made a comment, and I think I heard you right, that you rely on the competition to keep the premiums down rather than, I guess, anything else.

I guess my concern is when I look at the charts, I think since the early 1990's, or the last 13 years, Blue Cross/Blue Shield has increased steadily, and the HMOs and the other plans have gone down. Is there any point you see where this may be a danger?

I mean, is the Director looking for competition? I mean, are we looking to go to a one source? You know, what is the direction that OPM is going on this, and does that concern you that it has gone up so much?

Mr. BLAIR. We want to strike a balance, and I think the balance that we want to strike is we recognize that Blue Cross/Blue Shield offers a very competitive product, and we see that because it has a large number of enrollees, but we also have other competitive plans as well.

We want to keep those plans in the FEHBP. We want to make sure the competition is strengthened. We want to keep the HMOs. I remember a point, 10, 12 years ago, maybe longer than that, when there was a perception there were too many plans in FEHBP, and that there possibly could be too much competition.

I think the question is how to reach the right balance. Remember that by Blue Cross/Blue Shield being so large, they reach economies of scale, and they can offer their competitive product that

way. We do not want to favor one plan over the other, however, and we want to encourage the other plans to be just as competitive.

And so if we are constantly pumping up one side, you have to keep the other side up, and it is a balancing act, and I think that is what we are going to have to maintain. One of the hallmarks of the program has been choice, and we want to keep that choice, and we have a commitment to that choice.

And so it is going to be an effort over the long haul to make sure that we keep competition and choice in plans intact.

Mrs. JO ANN DAVIS OF VIRGINIA. Does it concern you? When I look at the chart in 1990, Blue Cross/Blue Shield was 39 percent. Other fee-for-service plans was 35 percent. Today Blue Cross/Blue Shield is 53 and other service plans are 22.

Does that direction concern you at all?

Mr. BLAIR. I would not say it concerns me. Maybe, on one hand, you could argue that size can pose a problem. On the other hand, is that showing that they are offering a very good benefit, and Federal employees and annuitants and enrollees are recognizing that?

I just want to make sure that we are offering the best product, and so I would say it does not concern me, but it is an important trend to watch.

Mrs. JO ANN DAVIS OF VIRGINIA. Do you think the fact that people have heard of Blue Cross/Blue Shield as opposed to maybe some of these other plans makes a difference?

Mr. BLAIR. It could make a difference.

Mrs. JO ANN DAVIS OF VIRGINIA. When I sold real estate name made the difference.

Mr. BLAIR. Pardon?

Mrs. JO ANN DAVIS OF VIRGINIA. When I sold real estate name made the difference. Does Blue Cross/Blue Shield make the difference?

Mr. BLAIR. Well, I think it could make a difference, but at the same time, if you are a member of the National Association of Letter Carriers, you may come into the Postal Service and decide I want to go with my union plan, or if you are a member of the American Postal Workers Union, I may want to go with my union plan. So that can be influencing, too.

What I said earlier though is we will make sure that our consumers are educated and that name recognition is important, but you need to go beyond the name recognition. And an educated consumer does make the best choices. That has been one of the initiations that we want to see that we educate our enrollees to make the best choices for themselves.

Mrs. JO ANN DAVIS OF VIRGINIA. I agree with that. Choice should hopefully keep the competition going and keep the cost down.

On the HSAs, a lot of people when I talk to them, they say that the HSAs are much more attractive to the younger employees who view themselves as healthy, and that the fee-for-service plans and the HMOs will be more attractive to your older employees and annuitants who consider themselves more at risk.

Assuming that is so, how can the detrimental effects of adverse selection in the FEHBP program be avoided if the HSAs are readily available to the healthy or less at risk?

Mr. BLAIR. I am not so sure I agree with the assumption, but even if it does occur, I think we need to look at the experience we have in what we call our consumer driven plans now. Some have voiced concerns that these so-called consumer driven plans will exacerbate adverse selection.

We have seen those consumer driven plans. It's the ATWU plan. Abbie, if you could.

Ms. BLOCK. AETNA and ANGINANA.

Mr. BLAIR. Yes, there were three plans. We have not seen a mass migration to those three plans. We have 13,000 enrollees in those plans out of 4 million. Overall, Federal employees, I think, are not a group that goes for uncertainty; that's the case with HSAs being a new product on the market, and I think that should it ever be offered, it will certainly fill a market niche.

However, I think I do not share the view with those that say that this will lead to great adverse risk, the adverse selection. Rather, I see it as filling a market niche should it ever be offered.

Mrs. JO ANN DAVIS OF VIRGINIA. Should the assumption be a true assumption, does OPM have safeguards in place to modify the program?

Mr. BLAIR. We would be very concerned over any adverse selection taking place. We do not want to see that happen either, and so I think we all start from a common premise that, should it ever be offered, that it be offered within the context of making sure that we minimize any kind of adverse selection.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Blair.

Ms. Norton.

Ms. NORTON. Thank you very much, Madam Chairwoman.

That was an amazing response, Mr. Blair, that you just gave to the Chair. I take it that you who have nothing to do with the control of market mechanisms, you who have nothing to do with the choices that employees make would somehow make every effort to make sure adverse selection does not occur as a result of the availability of health service accounts.

Let me be specific. You are right that we ought to look at the evidence, and, sir, I submit to you that the Medicare bill is now in the process of providing us some evidence that ought to be instructive to us.

You, of course, recognize that it is counterintuitive, maybe even counteranalytical, to say that if you offer a more attractive package for younger people with a tax advantage to it that you almost seem to be saying you hope they do not take it because you are saying thus far, of course not with health service accounts, but what we have for the tax savings accounts we do have, there have not been a lot of people who have taken it.

So you are asking us to believe that if you split up, if you take away the one advantage that FEHBP has, I mean, because I have been unable to find what these other ones are, but there is this very large risk pool. Everybody fits. If you take that away, split it up, my question to you is: are you willing to say that on the basis of whatever evidence you are wiling to offer that you do not believe that splitting the risk pool up into various sections, particularly health service accounts, HRAs, and everybody else who cannot pos-

sibly eliminate the risk of going in, that would not have an effect upon those left in FEHBP?

Are you willing to say that there would be no effect in a greater or higher or more rapid increase in premiums if we opened the doors and said, "OK. Everybody wants an HSA. Just come on in?"

Mr. BLAIR. I am not saying that we are splitting up the risk pool, that HSAs would be part of that whole risk pool that enrollees will be able to access. I think it will fill an important niche, and what you are saying is that you are going to see a mass migration to HSAs.

Ms. NORTON. I am not saying that. I am saying how can you say anything about the migration. Are there not incentives, as the Chair said, for younger people——

Mr. BLAIR. Well, you are presuming that they will take those incentives.

Ms. NORTON. Yes, and you are assuming they are not.

Mr. BLAIR. I do not——

Ms. NORTON. And you are assuming they are not, and based on the way in which people respond to tax incentives, I do not know why your assumption is better than mine.

Mr. BLAIR. Well, I do not want to get into that, but I will say——

Ms. NORTON. Well, the burden is on you to justify the notion.

Mr. BLAIR. I will say——

Ms. NORTON. That it will have no effect and we ought to just be quiet.

Mr. BLAIR [continuing]. It is a new product, and as a new product, it does not have a track record yet, and without that track record——

Ms. NORTON. So what are you willing to do to safeguard?

In case premiums go up and you have already offered this new product, what are you going to do to safeguard FEHBP as we now know it?

Mr. BLAIR. I think that we will do everything that we can to ensure that adverse selection does not take place.

Ms. NORTON. Yes, and you have to be more specific than that. What is everything that you can?

Don't you think if you are going to do something as radical as introduce a product that could lure people away from what has given FEHBP what it has now to keep price down; don't you think you have a burden to say what everything you do, in fact, amounts to?

I am asking for specifics, Mr. Blair.

Mr. BLAIR. What I am saying is I do not see——

Mrs. JO ANN DAVIS OF VIRGINIA. Well, Ms. Norton, let him answer the question and maybe we can get somewhere.

Ms. NORTON. Well, he keeps saying everything—you know what? I am trying to make myself perfectly clear, Madam Chairwoman. I want to know specifically what he means by everything we can do. That is just an insult to keep coming back with same thing. That is why I keep interrupting him.

Mrs. JO ANN DAVIS OF VIRGINIA. Do you have safeguards in place?

Ms. NORTON. Give me some any things you could do. List them for me.

Mr. BLAIR. Well, let me just say this. I do not see the Federal populations as following the pied piper.

Ms. NORTON. So you are not listing them. You are saying they are not going to do it. I said list them for me, Mr. Blair. You said, "We are going to do everything we can do." Give me one.

Mr. BLAIR. One thing would be to review benefit designs in all the plans to make sure that adverse selection is not taking place.

Ms. NORTON. So after you review them, what do you do if adverse selection is taking place and you have already offered health service accounts out there?

Mr. BLAIR. Then we will start looking at how to redesign those benefits out there.

Ms. NORTON. Oh, my God. But it is already out there.

Mr. BLAIR. Remember we re-enroll every year.

Ms. NORTON. The toothpaste is out of the tube then, Mr. Blair. It is out of the tube. Are you going to put it back in the tube and say to all of those young people who are trying to save money that I am sorry we are not going to do this any more? We are going to cut it off?

Mr. BLAIR. I think that you are talking about a premise that there is going to be a mass migration out there, and what I am saying is I think that it will fill an important market niche if offered.

Ms. NORTON. No. 1, Mr. Blair——

Mr. BLAIR. And you are presuming that they are going to be offered. The Director has not made a decision on this issue.

Ms. NORTON. No. 1, Mr. Blair, and this will be the last thing I have to say, Madam Chairwoman; No. 1, Mr. Blair, you have not come forward with anything resembling a basis for saying that there will not be adverse selection, No. 1.

And, No. 2, I assume——

Mr. BLAIR. I said based on our experience with the consumer driven plans, we have seen 13,000 enrollees go to that, and what we are saying there is that if you look at that as a test for HSAs, we have not seen mass migration to those.

They definitely fill a market niche. That is what the FEHBP is about, being market driven, and I don't know why we would want to deny a very popular product out there. You are posing it as an either/or question. It is either in this basket or this basket.

I am saying it is a balancing act, and it is a balancing act every year that our folks go through.

Ms. NORTON. What do we get by the balance? What do we get by the balance?

Mr. BLAIR. You need to strike a proper balance between offering attractive market rates, attractive benefit designs, while keeping a broad risk pool. That is a balance.

Ms. NORTON. And if, in fact, these assumptions do not work out, you will do all you can for all of the rest of the employees who are left in that pool, and whatever that is, you cannot quite tell us at this time.

Mr. BLAIR. We have a pretty good track record of maintaining that balance thus far.

Ms. NORTON. You do not have a pretty good track record of keeping premiums down.

Mr. BLAIR. Better than the private sector.

Ms. NORTON. Is that your standard?

Mr. BLAIR. Better than any other governmental——

Ms. NORTON. You ask Federal employees what they think of that standard. What is the increase in the private sector, on average?

Mr. BLAIR. The average increase——

Ms. NORTON. For large employers.

Ms. BLOCK. The average increase last year was considerably higher than ours, and I do not want to give you an incorrect number.

Ms. NORTON. Yes, well, you give me some numbers and then—do not make general statements here that you are not prepared to back up.

Thank you, Madam Chairwoman.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Ms. Norton.

And just for the record, I think there are assumptions being made on both parts, on our part, as well as the witnesses, but I am wondering, Ms. Block, since we swore you in, do you have any examples of maybe some things that you have done in the past when there have been new programs and you were concerned about what was going on? Do you have any specific examples?

I think what Ms. Norton was trying to get to: do you have any specific examples of what you have done to try and head off the problem?

Ms. BLOCK. Yes, and I think if I may just say something preliminary to that, we do not have a single risk pool in the FEHBP program now. We have various types of plans with various delivery systems. And some of the concerns being expressed now about HSAs were expressed in the 1970's about HMOs when they first became an important new product in the market.

And there was great concern that younger employees were going to enroll in that type of plan, and the premiums tended to be lower than in the fee-for-service plans. And that has over time certainly leveled out and has not posed a major problem in the program.

But as Mr. Blair mentioned, one of the things that we always do in the negotiation process is look at overall benefit design and balancing benefit design so that there is not one type of plan that is unusually more attractive to one group of employees than another type of plan. And it is an ongoing process that is in place all the time of trying to strike that balance, as Mr. Blair suggested.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Ms. Block.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Madam Chairwoman.

I think we have covered the health savings accounts issue pretty well. I just do want to add my voice to the concerns that have been expressed.

And I want to note that when CBO looked at Senate bill 2230, the Patient's Bill of Rights legislation in the 105th Congress they concluded that, "offering high deductible health insurance with MSAs to Federal workers and annuitants would increase FEHBP premiums for comprehensive plans by siphoning off relatively healthy enrollees into MSAs. Higher premiums for comprehensive plans, in turn, would increase government contributions for all en-

rollees." That was CBO, which as we all know is a nonpartisan agency.

So I do think it is critical that we monitor this issue. I share the concerns that have been expressed, and I do think that before you really open it up, you should put in place some specific criteria. Whatever red flag it is going to be we know in advance, you know, what steps are going to be taken so that we don't have a problem on our hands and then later figure out that we are in the middle of a problem.

Mr. BLAIR. I did not want to leave everyone with the impression that this is a foregone conclusion because it certainly is not. In the spirit of discussion that we just had, I would like to just say that the Director understands the concerns expressed about adverse selection. No one wants that to take place.

Keeping that in mind, we will move forward. We will be keeping stakeholders, this committee, and others informed.

Mr. VAN HOLLEN. No, I understand you do not want it, and I am not an expert in this area. So all of us have to rely on people who are expert, and the CBO experts who looked at this very same issue just a number of years ago concluded that you would very likely have adverse selection, and that would have an impact on the premiums of other people.

So I just think that we have to understand clearly what we are getting into, and if you do proceed down that road, have in place in advance some kind of system that you can detect a problem early on and take action.

During the consideration of the prescription drug Medicare bill that was passed last year, you may recall Congressman Tom Davis from Virginia offered a piece of legislation on the floor. It was actually right after the House had passed its version, making clear that there should be no adverse impact on prescription drug benefits provided to Federal employees under FEHBP going forward.

That provision was never included in the final package. My question to you is: what impact, if any, do you foresee the prescription drug Medicare plan having on prescription drug benefits under FEHBP now or in the future?

Mr. BLAIR. At this point I do not think we see any impact, especially for this upcoming year, but it is still too early to tell. Remember we issue our spring call letter advising the carriers what the plans may look like, but I do not anticipate any impact from that legislation this year.

Mr. VAN HOLLEN. I mean, the purpose of that piece of legislation by Tom Davis of Virginia was not just for this year, but it was to ensure protection going forward, that this wouldn't have any impact on the package of prescription drug benefits.

Can you say categorically that it will not impact the benefits going forward?

Mr. BLAIR. I do not want to fall into that trap, but I would say that we are going to do everything we can to continue to offer a very competitive package to both current employees and annuitants, and we will do everything that we can to make sure that the program continues as a model.

As bumps come down the road, as Congress makes changes in laws, we are going to have to deal with that, and we understand

that and we know that is our job. The bottom line is that we want to offer the best product we can to our enrollees and the annuitants, and we intend to maintain that course.

Mr. VAN HOLLEN. All right. Well, I know the chairman of the full committee and maybe the chairman of the subcommittee agrees that the best protection of course, would have been the actual inclusion of that piece of legislation that was supported by, I believe, everybody here on this panel, and so I hope we will continue to pursue and I intend to work with others to pursue that, to insure that protection is there going forward.

Let me just close with a question regarding the Long-term Care Insurance Program because in your testimony, you noted that while the enrollment of over 200,000 members is significant, we believe the program has even greater potential for increased participation. What do you intend to do; what are your current plans for trying to better educate the people who are eligible to participate in the program about the benefits?

Mr. BLAIR. Congress recently broadened the eligibility to include deferred annuitants, Grey Reservists, some D.C. government employees, and we also have new hirees coming into the government. Our efforts are going to be focused on those new folks to make sure that they understand what the product is that we're offering, what the benefits of that product are and why it is important to them.

Two hundred thousand may seem low to some people, but actually that is something of which we are quite proud. With that, we are now the largest long-term care insurance offeror in the country, and we should be. With a relatively new product we had some startup difficulties. We could not get individual home addresses or things like that because of privacy concerns. We had to focus our education efforts in the work place, but we were proud that we were able to get that to the 200,000 folks.

And we are going to continue. We see the retirements in the Federal Government, new people coming in. There is a new pool of potential applicants, and we are going to go for them as well.

Mr. VAN HOLLEN. If I might, Madam Chairwoman, specifically, I mean, do you mail out to the new potential enrollees? What specific steps are you taking?

Mr. BLAIR. If they would request a package, I think that we would. What we do is we make sure that their H.R. offices in the various agencies make this kind of information available. We will make sure that it is available to them in the community role.

When you become a new Federal employee, you have the ability to enroll in the Federal Employees Group Life Insurance Program, the health benefits program. We make sure that the long-term care program is offered to them as well.

Mr. VAN HOLLEN. Thank you.

Mr. BLAIR. The Long-Term Care Program is part of our standard package of benefits.

Mrs. JO ANN DAVIS OF VIRGINIA. Are you satisfied with the 200,000?

Mr. BLAIR. We would have liked to have seen more, but I am told that this exceeded the normal participation rate when offered in the private sector, and if you look at it, you have to understand that not a lot of people understood the product and maybe that was

an education issue. If you read Consumer Reports, if you read the other consumer articles, they are saying most people should not look at it until their 40's or 50's, and so we do have a good population to draw from within the Federal Government. But remember we also offer into the Uniformed Services. They tend to be much younger than that.

In the Postal Service we did not see the participation rates within it that we would have liked to have seen. It is a new product, and most people do not even think they are going to need to use it. You do not see it widely enrolled in out in the private sector either, and so I think it is going to be an effort on the part of baby boomers and beyond to make sure that we are well protected when we confront what can happen to us as we grow older and have health care challenges.

And again, I think in 15, 20 years, you are going to see it much more standard than you do now. It is interesting. They call it a new product, but it has been offered since the 1970's, but you just have not seen it widely offered throughout the country.

We offered our product with an eye toward keeping rates stable for the long term. Some folks thought that our rates were a little bit too high. I would have liked to have seen them lower as well, but when we set our rates, we did so according to the National Association of Insurance Commissioners' rate setting policies, and now we are seeing other competitors out there having to do the same thing.

Our rates are looking much more competitive than they were, and they were still about 10 to 15 percent lower than what you could find in the private sector.

I think the most important piece of this is that our rates are going to stay stable. As I enrolled as a 44 year old, I can be certain that my rate was designed to be the same as when I am 60 or 70 or hopefully 80 years old, as I bought inflation protection, and I am very pleased with the product. I think I certainly did the right thing.

Mrs. JO ANN DAVIS OF VIRGINIA. What about the 60 and 70 year olds, our retired folks? What are you seeing in their enrollment?

Mr. BLAIR. You know, for some I think that it is a very individual choice. You have to look at a whole host of factors to see if this is something that you really need or not. If you have the money to cover these long-term care costs, you may not need the insurance.

On the other hand, if you want to leave a legacy to your survivors, you may, again, decide I really do need this. So it is a very individual call.

Mrs. JO ANN DAVIS OF VIRGINIA. Do you know the breakdown, Mr. Blair, on the retirees, how many of those have taken the long-term?

Mr. BLAIR. Could I provide that for you for the record because I don't think I have that information on the tip of my tongue?

Mrs. JO ANN DAVIS OF VIRGINIA. Because that is where I have heard the most complaints, is our retirees.

Mr. BLAIR. Our rates are age based, and so the retirees were going to pay more, and it was not like health insurance. They were going to pay more because they were older—because they were the

people who are most likely going to have to utilize the product much more quickly than someone who is 45 or 50.

Mrs. JO ANN DAVIS OF VIRGINIA. I look forward to hearing from our panelists on the next panel, but what I am hearing from the retirees is that they are not accepted, and I am not so sure that they are not accepted so much as they are not accepted because the rate would be sky high. You know, if they have diabetes or things like that, then they are not accepted or the rate is so high that they cannot get in.

Let me just echo what Mr. Van Hollen was saying about the legislation. I know that Tom Davis, and I think this is what Mr. Van Hollen was referring to, has the legislation that protected our Federal retirees, that they would not be treated any differently with the prescription drug plan than our active force.

And if I can send a message at all today, that is one I would really like to send back to Director James. I would certainly hope that even though it did not get into the legislation, that our retirees are not treated any differently than our active.

Mr. BLAIR. She has been a real protector of retirees and retiree benefits, and so I think that message will certainly be welcomed and was already there.

Mr. Davis, Ms. Norton, do you have any further questions? Mr. Davis.

Mr. DAVIS OF ILLINOIS. I think probably just one.

We know that choice costs. When individuals are part of a plan where they have more flexibility, there is more cost than in a straight-laced HMO or a straight-laced program. Is there anything that we could expect in terms of cost differential or that you would expect to pay for choice?

I am saying how much more should choice cost.

Mr. BLAIR. I am not sure. Abby, correct me if I am wrong here, but I do not think choice costs more. Actually it may provide the kind of competition you are looking for that can keep costs down.

Ms. BLOCK. I think what we are talking about here is choice of providers within a health plan rather than choice of health plans, and the whole trend, as I know you know, has been away from the very restrictive model of the very closed HMOs, and that has been nationwide.

Even the HMO industry has moved more toward choice. Many of the HMOs have eliminated the requirement for a referral, for example, to see a specialist. So the consumers have really expressed a very strong interest in having that kind of flexibility in terms of how they get their health services, and it costs more because you cannot really control as much as you might in a more closed system inappropriate utilization or overutilization. That is one of the issues and one of the factors that goes into choice costing more.

There are some other issues in terms of provider reimbursements and so on. So it has typically been the experience that choice costs more, but more and more we are seeing plans now being offered where the premium really is close to or in some cases even less than the premiums of more restrictive systems.

Mr. DAVIS OF ILLINOIS. And the consumers, as I indicated, they are prepared to pay. I mean, if the cost is there, people are willing to pay for the flexibility.

Ms. BLOCK. People feel very strongly about having that flexibility.

Mr. DAVIS OF ILLINOIS. No further questions.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Davis.

Ms. Norton.

Ms. NORTON. Yes. Mr. Blair, I am looking at your testimony because you referred in answer to my question about HRAs to work you had already done, and you refer to 2004 where the total enrollment in these consumer driven plans was and the figure in your testimony is 13,151.

Now, how old are these plans that you are referring to, and when did they go into effect?

Mr. BLAIR. The APW plan went into effect in 2003, and the other two plans went in in 2004.

Ms. NORTON. Mr. Blair, that is very important information. We are talking about brand new plans, and you had testified here that one of the most important things FEHBP can do is to, "educate people about all of the choices that are available to them."

Again, looking at that figure with education just beginning, you're talking about one plan this year, one plan last year. I am not sure how you could then say on the basis of evidence of less than a year apparently this experience leads to believe that the movement of large numbers of employees to raise a concern about adverse selection is not likely. I thought that most of the time when people try to make statements like that they have a body of experience that they can rely upon, whereas you are talking about experience that has only just begun.

Mr. BLAIR. That is right, and the HSAs would be a new product as well. What we are saying is that, should they be offered, we do not anticipate a large migration to HSAs, especially in the first years.

Ms. NORTON. Well, I can understand in the first years when people barely know about the plans, and I think the burden on OPM, of course, is to indicate what the risk is to the pool over time. If the risk to the pool after 5 years or 10 years is great, the notion that it was not so great after a year would not be very impressive.

And, therefore, I think that at the very least, Mr. Blair, I would like to see you extrapolate this year or so experience so that we would have some sense of where this might lead in 5 years, in 10 years, at some point where we could say reliably, "Look, this is not going to mean a thing. People look like they are going to stay where they are despite what is a rather attractive economic incentive depending on your age and state of health to do just the opposite."

And of course, as an economic matter, we are taught to regard human beings as rational economic beings, and one wonders why a rational economic being, unless they thought ahead, way ahead, as you say that people do not do, for example, on long-term health insurance, why they would not respond to the immediate economic incentive that is planted right there precisely because you want them to respond.

Mr. BLAIR. I am not sure how I can say this again, but the way that we are viewing this, and I think that we do have the evidence

to show that we have not seen great trends of migration from one plan to another over a period of a year or even 2 years.

Ms. NORTON. I understand you, Mr. Blair.

Mr. BLAIR. Right.

Ms. NORTON. But you understand me, that I think 1 year or less, and certain we are now in 2004; this is, sir, not even April, and so all I am saying to you is I do not think the body of experience from which you are working is very impressive, and I am asking you to do something that is typically done in situations like that, and that is to try to figure out what it would be over a longer period of time based on what it is today.

Would you be willing to do that?

Mr. BLAIR. I think we are going to carefully look at these trends as they evolve over a period of time because we are all on the same page here. We do not want to see the program spiral into adverse selection. We do not want to take actions that are going to do that, and we want to make sure that we do everything we can, such as looking at benefit design over the long term. And so——

Ms. NORTON. I am asking you to do more than look at the benefit design. You know, again, I am trying to be specific, and that is why you see me being impatient with you. I am not asking you to look at the benefit design. I am asking you to extrapolate the figures, sir.

That is to say look at the figures you have now. Economists do this all the time. Assume that there would be greater knowledge and information and extrapolate out to what you think over 5 years or over 10 years, for example, would be the up tick in these plans. That is all I am asking.

Mr. BLAIR. We certainly can do that.

Ms. NORTON. Thank you. That is really all I am asking.

Finally, I asked because you heard my concern because we have 8 million employees and still the stuff goes up and Federal employees pay 11 percent a year, my heavens, and you say or at least your partner said, well, it is better than what it is in the private sector.

I would ask you to both look at, because I am sure these figures are readily available, at the let me say Fortune 1,000 companies, and would you give to the chairman and to me personally what the increase in health care has been? I am not even saying Fortune 500, but Fortune 1,000 companies so that we can get some sense of comparison.

I think we would more appreciate FEHBP if we could see those comparisons.

Mr. BLAIR. Oh, certainly.

Ms. NORTON. I am sure there must be something.

Ms. BLOCK. Over how many years would you want that?

Ms. NORTON. These 3 years that are in your testimony. You show the increases in the last 3 or 4 years, and so I think——

Mr. BLAIR. Since 2000?

Ms. NORTON. 2000.

Mr. BLAIR. Give a fuller figure and fuller flavor of what is out there.

Ms. NORTON. I would appreciate it. I am sure there is some difference, but it would be helpful to know what that difference is,

and of course, they would say that is no fair comparison because we are talking about 8 million.

Mr. BLAIR. Well, you have to remember when we are comparing what are we comparing. In FEHBP we have single and family coverage, and that is what we offer. Many private sector employers will cover a higher percent of an employee's premium, but not necessarily the family, or they may, but they may not carry people into retirement either.

So I am always cautioned that when looking at these kinds of figures that you keep in mind what we are actually comparing.

Ms. NORTON. That is a very good point, Mr. Blair. To the extent that you can, I am not asking for a whole lot of work here. Could you look at Fortune 1,000 companies that are most like us that kind of cover families the way the FEHBP does.

Mr. BLAIR. Certainly.

Ms. NORTON. And I recognize that many of them cover a greater percentage. So that would make that cost even more.

Ms. BLOCK. I think one of the other things though——

Ms. NORTON. A greater percentage of the cost for employees.

Ms. BLOCK. One of the other things that feeds into that comparison is whether there were or were not significant benefit reductions because we have looked at this very carefully, and very often the difference in the rate increase may be relatively small, but we got our rate increase with very minimal, if any, benefit reductions and the private purchaser got theirs with much more significant benefit reductions.

Ms. NORTON. With all due respect, when I asked the question before, what were we getting for the large risk pool we had, your answer, madam, was it is better than in the private sector. All I want to know, all I want to have is some comparisons so that I can better understand that, and you all can give me whatever figures are most convenient for you.

Thank you very much.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Ms. Norton.

And thank you, Mr. Blair and Ms. Block, and I think Ms. Norton shares the same concern that many of us have, and that is just to make sure that the HSA is a good concept, but we do want to make sure that there is no adverse effect on our Federal employees.

Mr. BLAIR. I think we all share that.

Mrs. JO ANN DAVIS OF VIRGINIA. But thank you so much.

Mr. BLAIR. Thank you. I appreciate it.

Mrs. JO ANN DAVIS OF VIRGINIA. We appreciate your being here, Mr. Blair and Ms. Block.

I would now like to invite our second panel of witnesses to please come forward to the witness table. First, we will open with a statement from Dr. Harvey Fineberg, president of the Institute of Medicine.

Next we will hear from Mr. Charles Fallis, president of the National Association of Retired Federal Employees.

Then we will hear from Mr. Stephen Gammarino, senior vice president of national programs at Blue Cross/Blue Shield.

After Mr. Gammarino, we will be hearing from Dr. Scott Smith, vice president and chief medical officer at First Health Group.

And finally, we will have the pleasure to hear from Mr. Paul Forte, chief executive officer at Long Term Care Partners.

Mr. Forte, did I pronounce your name correctly, or is it Forte?

Mr. FORTE. No, it is Forte.

Mrs. JO ANN DAVIS OF VIRGINIA. It is Forte. OK.

It is going to be tight. I do apologize. Can you all fit?

Mr. Forte, I was going to say you may be more comfortable at the end of the table if you would like. We can pull the microphone over there when it is time for you.

I want to thank you all for joining us here today, and the panel will now be recognized for an opening statement. We will ask you because there are so many of you to summarize your testimony in 5 minutes and your more complete statement will be included in the record.

And we will start first with Dr. Fineberg. You are recognized for 5 minutes.

STATEMENTS OF DR. HARVEY FINEBERG, PRESIDENT, INSTITUTE OF MEDICINE; CHARLES L. FALLIS, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES; STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, NATIONAL PROGRAMS, BLUE CROSS/BLUE SHIELD; DR. SCOTT P. SMITH, VICE PRESIDENT AND CHIEF MEDICAL OFFICER, FIRST HEALTH; AND PAUL E. FORTE, CHIEF EXECUTIVE OFFICER, LONG TERM CARE PARTNERS, LLC

Dr. FINEBERG. Thank you very much, Madam Chairwoman, members of the subcommittee. It is a pleasure for me to have this opportunity to testify before you today.

As president of the Institute of Medicine, I represent an organization that is an advisor to the Nation, to the agencies of government, and to the public about matters of health. The kinds of work that the Institute of Medicine undertakes ranges as widely as the health agenda of the Nation. We have worked on problems of the public health infrastructure. We have worked on problems of prevention of disease. We have worked on the science research needs of our Nation and problems of insurance.

Today I am going to refer specifically to some of our work that I think may be especially pertinent to your considerations of the Federal Employees Health Benefits Program, and that has to do especially with matters of quality and safety in our health care system. And I want to stress those in part because I believe they are not only very important in their own right, but I think they bear very directly on the concerns of cost that have occupied so much of the questioning and discussion in the early part of your deliberation today.

Before I get to that, it is worth, I think, reflecting for a moment on the extraordinary progress that we in our country have enjoyed in health over a long period of time. It is startling to imagine that in the time of our grandparents at the turn of the century when they were having children of which more than 100 per 1,000 newborns in the United States died before the first year of life was reached.

In the last century, life expectancy in our country increased from under 50 years to more than 75 years, and particularly in recent

decades we have seen dramatic deceases in major diseases that threaten the health of our citizens, and particularly older citizens, heart disease especially, but also stroke.

Now, with all of this success, we nevertheless have some serious problems. You've already been talking about the rise in cost which has become especially acute again in the last few years.

Incidentally, according to the figures that I have seen, in the year between 2002 to 2004, the increase in cost of the average employer based health plan in the United States was 13.9 percent, and that was a very significant blow, and led many, as has been alluded to earlier, to change the nature of the benefits that were offered.

But the problem with our system that I want to stress today is more around the problems of safety and the quality of care that our citizens and beneficiaries of the Federal employees plan and others receive in the care that they seek.

When the Institute of Medicine looked at the problem of errors in health care a few years ago, we found that every year tens of thousands of hospitalized patients were dying as a result of errors in medicine. In fact, if errors counted as a cause of death, it would rank in the top 10 causes of mortality in the United States.

Other studies that have looked at the quality of care received on average by our citizens—yes, I know, Madam Chairwoman, it is not a safe place to go, those hospitals—if other studies that have looked specifically at the quality of care find that on average only about half of the care requirements of those in care with chronic diseases are actually met.

So we have problems of misuse of care. We have problems of under use of needed care, and we have problems of overuse, of care that is not really beneficial to the individual recipients.

Now, with respect to the Federal Employees Health Benefits Program, I would like to make a few suggestions that are elaborated a bit more in my testimony that may be relevant to your considerations over time, and I would like to just briefly mention a few.

First, it would be, I think, very advantageous to do everything possible to ensure that high value services are, in fact, covered in the plans. Now, these types of services are those that return very high benefit for relatively low cost or can be done much more efficiently than typically is done, and they include preventive services, comprehensive care for common chronic conditions, which is a part of many of the programs today, coordination of care, especially for beneficiaries who have multiple chronic conditions, and very importantly an often neglected end of life care, alternatives for those at the end stage of life.

Second, it is worth considering what the FEHB program could do in what is sometimes called pay for performance. This is a reimbursement strategy, a kind of approach that says to the providers of care if you meet certain standards of quality, we will pay a premium for that benefit of service.

The advantage of reducing errors and actually insisting on and rewarding quality is that over time costs go down, while quality goes up for patients, but not because of, for example, medication errors and other ways that quality improves performance and can keep costs down.

Third, information technology, while it does have an expense at the outset, is an area that if made available can reduce errors on physician orders, particularly on medication and in the long term also save money.

I see that my time is exhausted. I would only like to add one final thought and that is around the area of what is sometimes called health literacy. It is shocking to realize how even educated people under times of stress and in their medical care are unable to understand and to follow effectively the instructions and advice that their physicians and other caregivers provide, much less to be able to find information they need to take care of themselves.

I believe that efforts to better educate and inform and empower the beneficiaries of the insurance program to make them more informed consumers for their own health would repay benefits for themselves and for the program in the long term.

Thank you very much.

[The prepared statement of Dr. Fineberg follows:]

Statement of

Harvey V. Fineberg, M.D., Ph.D.
President
Institute of Medicine

Before the

Subcommittee on Civil Service and Agency Reorganization
Committee on Government Reform
U.S. House of Representatives

March 24, 2004

Good afternoon, Madame Chair and members of the Subcommittee. I am Harvey Fineberg, president of the Institute of the Medicine of the National Academies. As an independent, scientific adviser to the nation for improving health, the Institute of Medicine seeks to provide advice that is unbiased, based on evidence, and grounded in science. We produce about 50 reports each year on health care and biomedical research policy, the majority of which are commissioned by federal agencies, sometimes under a mandate from the United States Congress. Our work ranges across the spectrum of our nation's health concerns, embracing, for example, the public health infrastructure, the conduct of biomedical research, the emergence of microbial threats, and disparities in health care and health outcomes among different races and between the rich and the poor. One major series of studies examines how to improve the safety and quality of health care received by Americans, and this work, I believe, is especially pertinent to decisions about the future of the Federal Employees Health Benefits (FEHB) program. I would like to share with you some reflections on the state of health and health care in our country, presenting a few ideas that bear on the FEHB program.

Advances in U.S. Health

The past century witnessed an unprecedented pace of progress in the health and well-being of the American population at every stage of life. The life expectancy of the average U.S. citizen—which only a century ago stood at a mere 47 years—has grown by almost two-thirds, while infant mortality has declined by more than 75 percent in the past 50 years alone.[1] These dramatic improvements in the scope of life have been accompanied by substantial progress in combating some of the most deadly and pervasive threats to the public's health. Death rates for cardiovascular disease, which rose through the first half of the 20th century, have been cut in half in the last 40 years, and even larger reductions have been seen over that period in deaths from stroke.[2] These two conditions account for nearly 40% of all deaths in the United States. Every year, three-quarters of a million persons survive who would have succumbed to these conditions if their previous high rates of mortality had prevailed.

While the mortality rate from cancer has proved more resistant to change, we have made significant strides in improving diagnostic practices, therapies, and survivorship rates for many major cancers, including breast cancer, prostate cancer, colon cancer, and leukemia. Public health campaigns to reduce tobacco consumption have driven down deaths from lung cancer in this country over the past 15 years. HIV/AIDS remains a serious public health threat, but preventive efforts can work, and advances in antiretroviral therapy have converted a diagnosis that was a nearly uniform death sentence into a frequently manageable chronic disease.

The U.S. continues to be a world leader in biomedical research and education. Many advances in understanding and combating heart disease, cancer, HIV, and other serious diseases are the fruit of decades of public investment in basic and clinical research, mainly

through the National Institutes of Health. The Centers for Disease Control and Prevention (CDC) leads in protecting the public's health within our borders, and CDC experts are called upon to confront diseases around the globe, such as last year's SARS outbreak. Meanwhile, U.S. academic health centers set world-class standards in biomedical education and research.

All of these substantial accomplishments and strengths, however, leave our nation's health care system with much room for improvement.

Causes for Concern

High costs and rising expenses. Americans spend on health care roughly one in every seven dollars they spend on everything. After remaining relatively flat as a fraction of GDP during much of the 1990's, U.S. health expenditures rose by 8.5 percent in 2001 and 9.3 percent in 2002 (the most recent years for which figures are available).[3] Between 2002 and 2003, the average cost of premiums for employer-based health insurance programs shot up by 13.9 percent.[4] Such costs are leading some employers either to cut health benefits or to pass on substantial portions of these costs to their employees, and they are also becoming a matter of concern for the affordability of federal health care programs.

Failure to insure all Americans for basic health care needs. The Census Bureau estimates that 43.6 million people, or more than 15% of the U.S. population, lacked health insurance for the entire year during 2002.[5] Other surveys suggest that over 15 million additional Americans typically have no health insurance for at least part of each year.[6] Beyond this high prevalence of uninsurance within the population, even many Americans who do have insurance are covered by plans that are principally designed to protect against catastrophic health emergencies. Such plans do not cover basic health care that may prevent far more dangerous and expensive conditions later on.

Sub-par performance. Although the U.S. spends more than twice as much on health care per capita as the median rate for the 30 members of the OECD, we rank in or near the bottom third in basic health indicators such as infant mortality and life expectancy.[7] The majority of Americans believe that there are some good things about health care in this country, but that fundamental changes are needed.[8]

Persistent problems in safety and quality of care. Several years ago, the Institute of Medicine reported that medical errors cause tens of thousands of deaths among hospitalized patients every year.[9] If counted as a "disease," errors would be among the top ten causes of death in our country. Most of these errors are preventable. The IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) presented a blueprint to improve the quality and safety of health care. Lessons can be learned from other industries that have achieved more consistent quality standards. This report stresses the importance of improvements in the processes and systems of care, and it calls for performance measures, data standards, newer technologies such as electronic health records, and a culture of care

committed to quality and safety. Action is required at many levels: health providers, care delivery institutions, payers, and the other public and private organizations that make up the U.S. health care system.

Recent studies confirm persisting gaps between the care that Americans receive and care that meets the best professional standards. One study of adults in 12 metropolitan areas found that respondents received only around half of recommended care for acute and chronic conditions as well as preventive services.[10] Fewer than half the patients with a myocardial infarction, for example, were treated with an inexpensive, life-saving drug that is indicated for nearly all of them. Only about sixty-five percent of patients with high blood pressure were appropriately treated. Other studies indicate that up to one-third of the care delivered for acute conditions and one-fifth of the care delivered for chronic health conditions is unnecessary or even harmful.[11] The National Committee on Quality Assurance estimates that nearly 50,000 Americans die each year simply because their known health conditions are not adequately monitored or controlled.[12]

Disparities in health care access and outcomes. Within the United States, there remain severe disparities in the quality and availability of health care. Some of this variation occurs along geographic lines, such as the sizable local and regional differences in infant mortality, child health insurance coverage, hospital quality, and the availability of health care practitioners. Other variations reflect disparities in the quality of care that is received by different racial and ethnic groups (even when controlled for access-related factors such as income and insurance status). To give one example, black Americans over the age of 35 are roughly twice as likely to die of heart disease as their white counterparts.[13]

Underinvestment in prevention. The leading causes of death in the United States stem from modifiable behavioral risk factors such as tobacco use, alcohol consumption, and poor diet and physical inactivity.[14] Deaths from overweight and obesity are on the rise and threaten to overtake tobacco as the leading cause of death in this country. The national resources we invest in prevention aimed at tobacco, alcohol, overeating, and inactivity are disproportionately small compared to the magnitude of the harm these public menaces produce. The diverse insurance plans in this country are inconsistent in their coverage for preventive care services.

Key Attributes of a Health System for the 21st Century

The American people deserve a better health care system, one that is built on the following principles:

A population perspective on health. As a population ages, chronic diseases take an ever increasing share of the burden of illness. Today 125 million Americans are estimated to have a chronic disease, and nearly half of them live with two or more such conditions.[15] Health interventions that target chronic conditions and meet the needs of these patients for

coordinated care are going to be increasingly important. Preventive interventions will have increased impact to the extent that they can focus on risks affecting a substantial proportion of the population (blood pressure, cholesterol levels, tobacco and alcohol consumption, diet and physical activity, exposure to toxic substances, etc.). Because a population's health is impacted by a broad range of interactions among biological, behavioral, socioeconomic, and environmental risk factors, attempts to improve health at the population level can achieve better outcomes through an ecological approach that recognizes the importance of these interactions and finds critical points at which to interrupt the causal chain leading to poor health outcomes.

A central role for preventive care. An efficient and effective strategy for a healthier population depends on preventing disease before it begins. For various reasons, including the fact that its success is typically invisible, prevention frequently gets shortchanged. Recent years have brought some positive trends in insurance coverage of services such as pre-natal care, immunizations, tobacco counseling, and screening for serious health conditions, but preventive care is still underfunded. For example, employer-sponsored insurance plans still often fail to cover immunizations, especially for adolescents and adults, even though these are among the most cost-effective measures in preventive medicine.[16]

Coverage that is universal, accessible, and affordable. Health care that is inaccessible or unaffordable cannot meet the needs of patients. As a recent series of reports from the Institute of Medicine demonstrated, failure to provide health insurance affects the health of the uninsured, the lives of their families and communities, and the well-being of the nation.[17] The lack of insurance leads to an estimated 18,000 premature deaths each year, and the value of health capital lost each year due to uninsurance is estimated to be $65-130 billion annually.[18]

Care that is person-centered rather than provider-centered. Patients' experiences of ill-health are governed by the nature of their illnesses and the care they receive and also by their ability to obtain needed information, to participate in decision making that concerns their health, and to have different aspects of their care appropriately coordinated to match their preferences. Patients rely on the quality of information they receive from their caregivers for making health-related decisions, and the degree to which their health is appropriately managed may also depend significantly on the successful coordination of case histories, test results, and therapeutic strategies among many different providers. The flow of both information and care delivery ideally would respond in a timely manner to the circumstances of each individual.

Care that meets the highest standards of medical evidence. It has been estimated that there is a lag time of around 15-20 years between the discovery of more efficacious forms of medical treatment and their incorporation into routine care for patients.[19] Even when new discoveries are made available more rapidly, adoption of recommended practices can be very uneven. The only way simultaneously to avoid errors of overuse, underuse, and misuse is to rely on evidence from controlled studies to guide practice. The volume of new clinical

research that is published each year far exceeds the ability of individual health practitioners to keep abreast of it on their own, and better decisions for patients will depend on better systems of data analysis and management.

A health care system that is driven primarily by quality and value rather than price. High expense is no guarantee of quality in health care. In fact, higher quality, over time, can save money by preventing inappropriate treatment and avoiding the consequences of errors, such as prolonged hospitalization. To make decisions governed only by price rather than by performance is short sighted, and ironically, may be more expensive in the longer run.[20] Value here refers to the level of quality achieved at a given amount of cost. If value is to be a driver of health care decisions, we will need accurate, transparent, and functional measures of health care performance.

Ideas for the Federal Employee Health Benefits Program

The Federal Employee Health Benefits Program serves a vital function and is not designed to solve all of the nation's health needs. However, the FEHB program is buffeted by the same economic and epidemiologic forces that act on the entire health system. In meeting its own clients' needs, the FEHB Program can also, I believe, serve as a model and a test bed for improving the performance of the U.S. health system as a whole. This notion of *Leadership by Example* was the subject of an IOM report, requested by the United States Congress, which examined the role of other federal health programs (Medicare, Medicaid, Department of Defense Tricare, State Children's' Health Insurance Program, the Veterans Health Administration, and the Indian Health Service) in demonstrating possible improvements in U.S. health care.[21]

I would like to suggest five areas where the FEHB Program may be able to enhance its service to government employees and contribute to improved performance of the health system as a whole.

1. **Incorporate coverage for high-value services**. Four areas that have potential for high-value services deserve special review for the availability of coverage. These are preventive services, comprehensive care for common chronic diseases, coordination of care (especially for patients with multiple conditions), and end-of-life care.

2. **Pay for performance**. A number of private insurers and foundations as well as the Medicare program are experimenting with various forms of payment enhancement for superior quality provided by health care organizations and practitioners.[22] These systems all depend on the definition of quality measures and vary in the specific forms of the programs of reimbursement. Here there may be an opportunity for the FEHB Program to participate along with others in promoting effective performance measures and in testing the effects of financial incentives to increase quality. A step beyond choosing among plans according to costs and menus of coverage would be

information to employees about the comparative performance of the various providers.

3. **Promote technology investment**. Recent reports of the IOM have stressed the importance of appropriate information technology to support programs of safety and quality.[23] Electronic health records can improve safety (for example in physician order entry systems that detect potential drug-drug interactions). Cost is certainly one obstacle to investing in information technology, but also deterring investment is the lack of standards for data definitions and interoperability.[24] Here, along with other federal and private insurers, the FEHB Program could promote data standards and appropriate deployment of information technology among providers.

4. **Measure comparative efficacy and value**. The key to making informed choices, as an individual patient and as an insurer, is reliable information on the comparative effectiveness and cost of alternative preventives and treatments. Oftentimes in medicine, what seems promising as a therapy turns out to be less good than anticipated or even harmful, and convictions about what should work may outpace the evidence. The use of bone marrow transplant for patients with breast cancer is a case in point. The recently reported study of comparative effectiveness of different lipid lowering drugs demonstrates how life saving differences may only be revealed by carefully conducted comparative trials.[25] The need for this type of information applies to every public and private insurer and to every doctor and patient. The FEHB Program could seek ways to participate and encourage a systematic approach to these needed studies.

5. **Stress health literacy**. Even well-educated adults may have difficulty interpreting and acting on the instructions from their caregivers, especially during times of acute illness and stress. A health-literate patient and family are also better able to prevent illness, to question their doctors, nurses, and pharmacists, and to obtain the health information they need from public and private sources. The FEHB Program may be well positioned to test and validate various approaches to increasing health literacy.[26]

Thank you for the opportunity to provide this overview and set of suggestions to the committee. If there are ways that the Institute of Medicine may be helpful as you proceed with your deliberations, we would be pleased to respond.

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[1] U.S. Census Bureau, *Statistical Abstract of the United States: 2003* (2003).
[2] Centers for Disease Control and Prevention, "Decline in Deaths from Heart Disease and Stroke – United States, 1900-1999," *Morbidity and Mortality Weekly Report* 48:30 (1999), pp. 649-656; cf. also American Heart Association, *Heart Disease and Stroke Statistics – 2004 Update* (2004).
[3] Katharine Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23:1 (2004), pp. 147-159.

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[4] Jon Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing," *Health Affairs* 22:5 (2003), pp. 117-126.
[5] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2002* (2003); Kaiser Family Foundation, *Health Insurance Coverage in America: 2002 Data Update* (2003).
[6] Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (2003).
[7] Data on infant mortality, life expectancy, and health care expenditures from OECD and WHO statistical tables; Gerard Anderson and Jean-Pierre Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs* 18:3 (1999), pp. 178-192; Gerard Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22:3 (2003), pp. 89-105.
[8] Humphrey Taylor and Robert Leitman, eds. "Attitudes toward the United States' Health Care system: Long-Term Trends," *Harris Interactive*, 2:17 (August 21, 2002).
[9] Institute of Medicine, *To Err Is Human: Building a Safer Health System* (National Academies Press, 2002).
[10] Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348:26 (2003), pp. 2635-2645.
[11] Elizabeth McGlynn and Robert Brook, "Keeping Quality on the Policy Agenda," *Health Affairs* 20:3 (2001), pp. 82-90.
[12] National Committee for Quality Assurance, *The State of Health Care Quality: 2003* (2003).
[13] Centers for Disease Control and Prevention, "Disparities in Premature Deaths from Heart Disease – 50 States and the District of Columbia, 2001," *Morbidity and Mortality Weekly Report* 53:6 (2004), pp. 121-125; Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (National Academies Press, 2002).
[14] Ali Mokdad et al., "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association* 291:10 (2004), pp. 1238-1245.
[15] Partnership for Solutions, *Chronic Conditions: Making the Case for Ongoing Care* (Johns Hopkins University, 2002).
[16] Institute of Medicine, *Calling the Shots: Immunization Finance Policies and Practices* (National Academies Press, 2000).
[17] Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (National Academies Press, 2004); ibid, *A Shared Destiny: Community Effects of Uninsurance* (National Academies Press, 2003); ibid, *Health Insurance is a Family Matter* (National Academies Press, 2002); ibid, *Care Without Coverage: Too Little, Too Late* (National Academies Press, 2002); ibid, *Coverage Matters: Insurance and Health Care* (National Academies Press, 2001).
[18] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (National Academies Press, 2003).
[19] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academies Press, 2001), p. 155.
[20] Sheila Leatherman et al., "Making the Business Case for Quality," *Health Affairs* 22:2 (2003), pp. 17-30.
[21] Institute of Medicine, *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* (National Academies Press, 2003).
[22] Meredith Rosenthal, "Paying for Quality: Providers' Incentives for Quality Improvement," *Health Affairs* 23:2 (2004), pp. 127-141.
[23] Institute of Medicine, *Patient Safety: Achieving a New Standard for Care* (National Academies Press, 2004); ibid, *Key Capabilities of an Electronic Health Record System* (National Academies Press, 2003).
[24] Robert Miller and Ida Sim, "Physicians' Use of Electronic Medical Records: Barriers and Solutions," *Health Affairs* 23:2 (2004), pp. 116-126; David Doolan and David Bates, "Computerized Physician Order Entry Systems in Hospitals: Mandates and Incentives," *Health Affairs* 21:4 (2002), pp. 180-188.
[25] Christopher Cannon et al., "Comparison of Intensive and Moderate Lipid Lowering with Statins after Acute Coronary Syndromes," *New England Journal of Medicine* 350:15 (2004), forthcoming.
[26] For more on the subject of promoting health literacy, see the Institute of Medicine's forthcoming report *Health Literacy: A Prescription to End Confusion* (National Academies Press, 2004).

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Dr. Fineberg.

Charlie Fallis, it is good to have you here with us today, and I look forward to hearing your testimony. You are recognized for 5 minutes.

Mr. FALLIS. Thank you, Madam Chairwoman.

Madam Chairwoman and honorable members of the committee, I appreciate the opportunity to express NARFE's views on FEHBP today and our concerns that HSAs might be introduced into the program perhaps as early as this year. NARFE historically has opposed adding MSAs and now HSAs. HSAs are likely to attract healthier enrollees since the plans reward them with tax free balances if they do not go to a doctor or to a hospital.

However, less healthy enrollees would, in our opinion, remain in comprehensive plans with significantly lower out-of-pocket costs, but with increasing premiums, costs of premiums that I believe and we believe would result from the addition of HSAs.

CBO, the Congressional Budget Office, has estimated that it would cost taxpayers an additional $1 billion over 5 years with the addition of HSAs and FEHBP. Although there are some differences between the old MSAs and the new HSAs, their variation does not appear to significantly alter the outcomes estimated by CBO and others.

For example, HSA enrollees will be allowed to contribute larger amounts to their savings accounts, but this change does not help those who cannot afford to deposit more money. Although some may be willing to initiate an HSA experiment in FEHBP, we believe it is premature and risky to impose that option.

Paul Ginsburg, president of Health Systems Changes, states, "There is little question that HSAs will transfer resources from the sick to the healthy. Higher income people will benefit more from these accounts because they are more likely to have insurance and because of their higher marginal tax rates."

HSA supporters claim that enrollees in comprehensive plans are not sensitive to health care costs, and that HSAs will encourage them to spend their health care dollars more wisely.

Well, a study in the June 26, 2003 New England Journal of Medicine found that only 55 percent of Americans get sindicated health care. Massachusetts General hospital took these figures and extrapolated that about 100 million Americans under-used their health care, where only about 30 million over used health care.

So we do not believe the claim that increased cost sharing required by HSAs will tackle the difference between under use and over use. HSAs savings might be illusory since HSA consumers acting on their own, as they would be required to do, will have less leverage than insurance carriers in negotiating provider discounts.

NARFE is also concerned about how OPM intends to pay for HSAs. For instance, how would enrollees pay for health care costs early in the year if the account held no more than a prorated share of the anticipated annual government and enrollee contribution.

And, on the other hand, if the full amount is advanced to enrollees at the beginning of the year and it is their account, they could walk away from that account, walk away from Federal service with a windfall.

NARFE recognizes OPM's interest in providing more health care choices. This makes sense when the only choice is a managed care plan, but that is not the case with FEHBP. We are confident that what Federal workers really want is to choose their own health care provider, something they can do very well without an HSA, and HSA catastrophic plans are not a choice for enrollees over 65 years of age, which of course excludes most of our members.

As a matter of fact, therefore, we question whether this age barrier conflicts with the Federal law that prohibits OPM from implementing contracts with plans that exclude enrollees based on age.

Given the risks and concerns that I have described, we are concerned that HSAs will be offered without any safeguards against adverse selection. For example, tax free savings accounts could encourage FEHBP enrollees to game the system by switching to a comprehensive plan during the annual open season for any year that they know their health care expenses will multiply.

We believe this problem could be mitigated if enrollees were forced to remain in an HSA for a period of, say, 5 years after making that selection. And since the FEHB fair share government contribution formula is weighted to the number of enrollees, catastrophic plans with lower premiums coupled with HSAs that attract larger shares of enrollees would reduce the overall dollar amount of the government contribution and we are very concerned about that.

To protect against this, OPM must disregard high deductible health plans in determining the government contribution. Otherwise it is a disaster. Most of my fellow annuitants and I started our careers in government when we were younger, when we were healthier, with a health care system whose premiums were never driven by age or condition.

And what gets NARFE members rankled today now that we are older is that HSAs could sabotage this contract between generations by introducing adverse selection based on health, wealth, age, and condition just at a time when those factors are most important to us.

For that and other reasons, Madam Chairwoman, NARFE members implore this subcommittee to insure that OPM's plan to impose HSAs into FEHBP be put aside.

Thank you very much.

[The prepared statement of Mr. Fallis follows:]

STATEMENT BY
CHARLES L. FALLIS
PRESIDENT
NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

TO THE SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION
COMMITTEE ON
GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

HEARING ON
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP)

MARCH 24, 2004

Madam Chairwoman, on behalf of the nearly 400,000 members of the National Association of Retired Federal Employees (NARFE), I appreciate the opportunity to express our views on the Federal Employees Health Benefits Program (FEHBP).

We are aware that this hearing will also review the Federal Long Term Care Insurance Program (FLTCIP). As you know, NARFE played the leading role in writing and promoting the legislation that authorized the FLTCIP in September 2000 and we continue to work closely with the program's third party administrator – Long Term Care Partners – and the Office of Personnel Management (OPM). While my testimony today focuses on NARFE's concerns regarding FEHBP, we will submit additional views about FLTCIP later. I would be happy to answer any questions about the program.

But today I want to speak about an issue of equal importance to protecting our earned annuities. Indeed, ensuring that the FEHBP provides federal workers and annuitants with affordable health care coverage at predictable rates is one of NARFE's fundamental missions.

Lessening the Burden

To make health care more affordable, NARFE has assigned priority support to H.R. 1231 and S. 623, legislation introduced by Representative Tom Davis and Senator John Warner to allow federal annuitants to use pre-tax annuities to pay their share of FEHBP premiums. Federal annuitants with family FEHBP plans could save an average of $405 a year on their income taxes if federal annuitants – like federal employees – were allowed to pay premiums with pre-tax

dollars. We thank you, Madam Chairwoman, and members of the subcommittee, for approving H.R. 1231 last year and we request your ongoing assistance in persuading the Ways and Means Committee to do likewise.

Prescription Drugs

As a cost-containment measure in FEHBP, NARFE supported the Special Agents Mutual Benefit Association (SAMBA) prescription drug demonstration program that was canceled by OPM in 2000 due to the pharmaceutical industry's refusal to participate. The pilot project would have allowed SAMBA to buy certain drugs for its enrollees at the discount mandated by the federal supply schedule (FSS), a procurement tool used by the Department of Defense and Veterans' Administration health care systems.

As you know, today drug reimportation continues to receive support and new converts in Congress. However, reimportation merely takes advantage of another country's willingness to negotiate drug discounts. NARFE believes we should not be forced to go elsewhere to get better drug prices when the FSS could directly accomplish this goal to reduce costs in FEHBP. For that reason, we urge the subcommittee and OPM to revisit the use of this procurement tool in our health care program.

Shifting Costs to Enrollees

NARFE is concerned about any proposal that would end the present limit on the FEHBP government contribution to 75 percent. A similar initiative has been included in the FEHBP-

inspired "premium support" demonstration project that was authorized to begin in 2010 by the new Medicare reform law. Under FEHBP, enrollees pay at least 25 percent of their health plan premiums. Absent this cap, the enrollee share of FEHBP premiums could be zero if enrollees select the lowest cost plans -- giving enrollees a "premium-free" option. That could have a significant effect on the rest of the program. The availability of a no-cost plan would serve as a particularly strong incentive to younger, healthier employees. Unintended risk selection occurs when enrollees leave plans where risk is more likely to be widespread, and leads more enrollees to congregate in the no-cost plans. Since the FEHBP "Fair Share" government contribution formula is weighted to the number of enrollees in each plan, no-cost plans that might attract large shares of enrollees would reduce the overall dollar amount of the maximum government contribution under the premium support proposal. Consequently, costs would be shifted to enrollees in all other plans, increasing enrollee costs and effectively limiting consumer choice.

A plan included in the Administration's FY 2005 budget to formally coordinate Medicare and FEHBP coverage by "offer[ing] insurance plans tailored to the federal retiree..." is another proposal that could shift costs to enrollees – specifically annuitants. As you know, there is presently no difference between the FEHBP plans offered to federal employees, annuitants and Medicare-participating annuitants.

Although there is coordination of coverage between traditional Medicare and FEHBP fee-for-service plans, less synchronization of benefits exists between managed care plans and Medicare. NARFE expressed concerns last year that a separately- rated FEHBP health plan for Medicare-

participating retirees and survivors might be suggested in response to the Administration's budget proposal.

One of the chief advantages of a large, employer-sponsored group health insurance program, like the FEHBP, is that the risk of health costs are spread across a diverse community. Segregating retirees from that community would destroy such risk sharing and significantly increase premiums. We are also concerned that coverage under a separate annuitant health plan would be inferior to benefits currently available to all FEHBP enrollees.

Additionally, NARFE and other retiree organizations are concerned that new costs could be shifted to older enrollees if employer-sponsored plans -- including the FEHBP -- reduce or eliminate prescription drug coverage currently provided in response to the new Medicare benefit. Indeed, Medicare-eligible annuitants could be forced to pay an additional monthly premium for a complex Medicare drug benefit that would be significantly inferior to what they currently receive through the FEHBP. The Congressional Budget Office estimated that one-third of retired workers with employer-sponsored benefits could lose their current drug coverage in response to the new Medicare drug benefit. We appreciate your assistance, Madam Chairwoman, in working with us to prevent the loss of our earned drug coverage by supporting H.R. 2631 and S. 1369, legislation to require FEHBP plans to provide a prescription drug benefit for Medicare-covered annuitants that would be at least of equal value to the drug coverage available to other FEHBP enrollees.

Health Savings Accounts

Today, I want to specifically address NARFE's concerns with OPM's December 22, 2003 announcement that they are reviewing the possibility of offering the combination of Health Savings Accounts (HSAs) and high deductible catastrophic insurance in the FEHBP for 2005.

Provisions in the recently enacted Medicare reform law (P.L. #108-173), unrelated to either Medicare or prescription drug coverage, expand and rename Medical Savings Accounts (MSAs) as "Health Savings Accounts" (HSAs). In fact, HSAs are specifically unavailable to persons age 65 and older.

Like MSAs, HSAs combine a high deductible catastrophic insurance policy with a tax-exempt savings account dedicated for health care expenses. At the beginning of the year, health care costs are paid out of the HSA until the account balance is spent. Thereafter, enrollees are required to pay out-of-pocket for their medical expenses until they have satisfied the high deductible of their health insurance plan. Once the deductible is met, the plan covers health costs, except for any copayments or coinsurance, up to a catastrophic limit.

HSAs are likely to be attractive to healthier enrollees since the plans reward them with tax-free cash balances in subsequent years if they don't go to the doctor or to a hospital. Since less healthy enrollees would be uninsured for thousands of dollars each year, they would be well advised to remain in a comprehensive option in which their out-of-pocket costs would be significantly lower. As a result, healthy individuals are siphoned into the new option and premiums in the comprehensive plans they left increase in response. Consequently, HSAs could

circumvent the fundamental principles of group health insurance by dividing healthy persons and sick persons into different coverage options.

For these reasons, NARFE has historically opposed adding MSAs – and now HSAs -- to the FEHBP.

NARFE recognizes that HSAs are a politically sensitive issue, particularly in an election year when candidates will take sides for and against them. For that reason, I want to assure the subcommittee that NARFE's opposition to OPM's HSA proposal is based exclusively on ensuring that the FEHBP provides affordable coverage at predictable rates for federal workers and annuitants. In addition, NARFE is committed to this position by legislative resolutions approved by members at our four biennial national conventions held since 1996.

In previous testimony, we have cited the work of such respected and nonpartisan organizations as the Congressional Budget Office (CBO), the Academy of American Actuaries, the Urban Institute and others to support our concerns that MSAs could drive up premium costs in comprehensive FEHBP plans through risk selection.

For example, CBO said in their cost estimate of S. 2330, "Patients' Bill of Rights" legislation considered in the 105th Congress, that "offering high-deductible health insurance with MSAs to federal workers and annuitants would increase FEHBP premiums for comprehensive plans by siphoning off relatively healthy enrollees into MSAs. Higher premiums for comprehensive plans, in turn, would increase government contributions for all enrollees."

CBO estimated that it would cost – not save -- taxpayers nearly $1 billion over five years if MSAs were required in FEHBP.

HSA supporters have attempted to discount CBO and other organization's work on MSAs because they claim that HSAs are not MSAs. Some have also said real life experience with adverse selection in public employee health care systems -- like in Ada County, Idaho -- are not relevant for the same reason, or they attempt to re-write the facts by claiming that such risk segmentation never happened in the first place. But they fail to offer any credible evidence to support their revisionism.

HSAs vs. MSAs

Although there are some differences between old MSAs and new HSAs, their variation does not appear to significantly alter the outcomes estimated by CBO and other nonpartisan organizations. For instance, HSA enrollees will be allowed to contribute larger amounts to their savings accounts, but this change does not help those who cannot afford to deposit more money. Additionally, the government/employer contribution to an HSA is unlikely to be any greater than what it would have been for an MSA.

The newly authorized portability of the savings account might entice some less healthy and lower income enrollees to select an HSA. Nonetheless, they would be only one illness or injury away from learning about the high out-of-pocket costs of HSAs.

This "dark side" of HSAs was recognized by Federation of Americans Hospitals President Charles N. Kahn III (formerly President of the Health Insurance Association of American and Health Subcommittee staff director to Representative William Thomas) at the National Medicare Prescription Drug Congress on February 26 when he said that HSAs would saddle hospitals with increasing amounts of bad debt as a result of patients who are unable to adequately fund their accounts or who cannot afford to pay out-of-pocket. Kahn said that hospitals will be more vulnerable than other providers to incurring bad debt from patients with HSAs because their bills often are much larger.

Mai Pham with the Center for Studying Health System Changes (HSC) echoed provider concerns at a March 12 conference held by her organization on market competition. "In terms of extensive patient cost sharing, providers and especially physicians, we found, are wary of any process that requires more effort on their part to collect payments from patients. ...And the thought that this might increase their bad debt burden is really not appealing, nor is watching staff cost rise, as might be necessary to effectively collect payments."

The minimum deductible for the catastrophic health insurance that is coupled with the savings account has been lowered to $1,000 for individuals and $2,000 for families. But lower deductibles increase the premium of the catastrophic insurance – resulting in less savings over comprehensive insurance. The lower minimum deductible does not change the fact that out-of-pocket costs for HSAs will continue to be substantially higher than comprehensive insurance. As a result, the risk for adverse selection is real, since enrollees with moderate-to-high health care needs would be ill advised to select an HSA.

In a February 16 commentary, HSC President Paul Ginsburg wrote that the $2,000 minimum deductible for families in HSA/catastrophic plans might be too burdensome. "Usually no more than one family member has large medical expenses in a year, so families will be much less likely to exceed the deductible than will single people," Ginsburg wrote. "While the current HSA might appeal to single healthy workers, most employers are unlikely to embrace a less-than-family-friendly change to their health benefits."

Consumer-Driven Health Plans

OPM has pointed to the so-called "consumer-driven" health plans (CDHP) that were first added to FEHBP in 2003 as evidence that related HSAs will not have an impact on FEHBP. We note with interest that consumer-driven plans are sufficiently similar for OPM's purpose of promoting HSAs today while the agency defended its decision to roll-out consumer-driven plans in September 2002 by claiming the new option was nothing like MSAs.

A January 2004 American of Academy of Actuaries (AAA) paper on consumer-driven health plans found that "because CDHPs are so new, it is difficult to know what type of selection will take place until credible data becomes available." But the actuaries also said the potential for adverse selection exists when they are offered with existing traditional plans, and that some enrollees could be worse off financially under CDHPs than with comprehensive insurance.

Although some may be willing to initiate an HSA experiment in FEHBP based on inconclusive consumer-driven plan findings, we believe it's premature to impose the option, particularly when the potential risks have not been acknowledged or addressed.

Apparently, some employers are also wary of offering CDHPs. In their 12-community study, HSC found only incremental changes to traditional employer-sponsored health insurance, but a reluctance toward consumer-driven plans. "Their choice to not pursue this was not philosophical but really due to the devil in the details," said HSC's Sally Trude at their March 12 conference. She went on to say that employers "had done their homework; had their consultants do the numbers; and like the largest employers, didn't see savings."

And certainly, consumer-driven plan experience is not the definitive word for HSAs. While HSC's Ginsburg took the middle ground on the potential harm or benefits of HSAs, he was clear about the likelihood of adverse selection:

> "There's little question that HSAs will transfer resources from the sick to the healthy. When a deductible is increased from $500 to $1,000 and the premium is lowered, those who need extensive medical care will pay more and those who do not will pay less. Higher-income people will benefit more from the accounts because they are more likely to have insurance and because of their higher marginal tax rates. Also, higher-income people will be more likely to fully fund their HSAs."

Conscientious Consumers

HSA supporters claim that consumer driven health plans encourage individuals to spend their account balances more wisely. They also say the reverse is true – that enrollees in comprehensive plans are not sensitive to health care costs. Indeed, one doctor who testified before this subcommittee on October 16, 2001 remarked that: "The number one reason why seniors go to the doctor is they are lonely. What is a better deal, pay $30 and go see your doctor."

I think you can understand why federal retirees might be taken aback by this statement. When I travel to see our members all over the country, I find that many of them read, in great detail, their explanation of benefits statements, report false claims and are outraged by the high cost of health care. While we are not about to self-ration our earned health care, we certainly don't use it frivolously.

But the doctor's testimony and my personal experience only offer anecdotal evidence. A study published in the June 26, 2003 *New England Journal of Medicine* found that only 55 percent of Americans get indicated care. Others underuse or overuse health care, or there are errors made to their care.

Karen Davis with the nonpartisan Commonwealth Fund, who spoke at HSC's December 3, 2003 patient cost-sharing conference, discussed how Massachusetts General Hospital took these findings and extrapolated that about 100 million Americans underuse health services and about 30 million overuse them.

As a result of her review of several studies, Davis said "...the basic bottom line is that cost sharing reduces use of both appropriate care and inappropriate care. So, in other words, it would, if you increase cost sharing, you would have more than 100 million people underusing services, and you would have fewer than 30 million Americans overusing services, but you would affect both." We do not believe the increased cost sharing required by HSAs will tackle the difference between underuse and overuse of health care.

HSA's effectiveness to curb utilization and costs also depend on how consumers perceive buying health care as compared to other goods and services. As Barry Zallen with Blue Cross/Blue Shield of Massachusetts pointed out at the HSC March 12 conference, people do not make decisions about health care in the same way they would about purchasing a refrigerator. He said: "We, as patients, rely on a relationship with a physician. And we don't think of choosing our rabbi or our pastor or our religion based on market forces. We don't look it up in *Consumers* [*Report*] and make a decision or look for information about costs, because it's an intimate relationship."

Design Issues

A potential design flaw in HSAs also weakens proponents' claims that the plans save money. An open question is whether or not funds spent out of the savings account, or out-of-pocket, would enjoy the provider discounts negotiated by the catastrophic health insurance carrier. We believe that HSAs should use such discounts since insurance carriers can do a better job using the leverage of the millions of enrollees to negotiate lower costs with health providers and drug

companies than individual consumers. This will be particularly true if provider rates continue to be less than transparent and HSA participants are treated as private pay patients and charged higher rates than the insured. As a result, the ability of HSA enrollees to shop around for better prices may be illusory.

NARFE is also concerned about how OPM intends to pay for HSAs. If HSAs were offered in FEHBP, we presume that the current government and enrollee shares would be combined to first buy a catastrophic health insurance policy and whatever remains from that transaction would be deposited in an HSA. However, what we do not know is if the government would advance the full annual amount to the account at once or if this amount would be deposited in increments per pay or annuity period. That begs the question of how enrollees would pay for health care costs at the beginning of the contract year if the account held no more than a pro rated share of the anticipated annual government and enrollee contributions? If the full amount is advanced to enrollees at the beginning of the year, they could walk away from federal service with an unearned windfall. But if the decision is to make piecemeal contributions to HSAs, enrollees living from paycheck-to-paycheck will have difficulty absorbing health care costs, particularly if they occur early in the year when their account balances are low.

Choice

NARFE recognizes OPM's interest in providing more health care choice to FEHBP enrollees and to empower them to use medical services with minimal limitations. Perhaps this point makes sense when workers' health care choices are limited to managed care plans. But that's not

the case with FEHBP. System-wide plans, that allow enrollees to select their own doctors and hospitals, continue to be the most popular FEHBP options and enjoy high customer satisfaction rates. We are confident that what federal workers and annuitants really want is to choose their own health care providers. That's something they can do today without HSAs.

But even if you were convinced of the choice argument, HSA/catastrophic plans would not be available to anyone age 65 and older. Consequently, HSAs are not a choice most of our members can make. This fact would add insult to injury if their comprehensive plan premiums jump in reaction to HSA-inspired adverse selection. In fact, we question whether this age barrier conflicts with Section 8902 (f) of Title 5 of the U.S. Code that prohibits OPM from contracts with plans that exclude enrollees based on age.

Protection Proposals

Given the risks, we are concerned that HSAs will be offered without any safeguards against adverse selection. Such protections would be easier to install now, before HSAs become entrenched, and insurance carriers block remedial action.

While we oppose HSAs, we offer two proposals to reduce the risks of offering these plans in FEHBP.

First, promising tax-free savings accounts to anyone who believes their health care costs will be low is a powerful incentive for enrollment. However, this incentive also could encourage FEHBP enrollees to "game" the system by switching to a comprehensive plan during the program's

annual "open season" for any year they know their health care expenses will multiply. This "gaming" will exacerbate the adverse selection anticipated from the introduction of HSA/catastrophic plans in FEHBP. Consequently, costs would be shifted to enrollees in all other plans – particularly comprehensive options. We believe that adverse selection, generally, and such gaming, specifically, could be mitigated if enrollees were forced to commit to remain in an HSA for at least five years once they selected that option.

Second, a significant migration of enrollees to HSAs could result in the overall reduction of the government/employer contribution for FEHBP premiums. Since the FEHBP "Fair Share" government contribution formula is weighted to the number of enrollees, catastrophic plans with lower premiums (coupled with HSAs) that attract large shares of enrollees would reduce the overall dollar amount of the government contribution available for any FEHBP plan. To protect against such unfair cost shifting to workers and annuitants, OPM must disregard high deductible health plans in determining the government contribution for FEHBP premiums in the "Fair Share" formula. This proposal is not without precedent since Representatives William Archer and Dan Burton first suggested it in H.R. 3166, legislation they introduced in 105th Congress to require MSAs in FEHBP.

In sum, FEHBP consumers did not ask for HSA/catastrophic plans, but we are concerned they will be imposed upon us. FEHBP is the best employer sponsored health insurance system in the country. NARFE wants to keep it that way and feel it is wrong to use it as a guinea pig by introducing risky schemes that are untested in a large, multiple option, group health plan.

Most of my fellow annuitants and I started our careers in federal service when we were younger and healthier. Indeed, most of us paid more into health insurance than we got out of it. Now that we have retired, our health needs have increased and some of us get more out of health insurance than we pay into it. What really gets NARFE members' hackles up is that HSAs now could sabotage this "contract between generations" by introducing adverse selection based on health, wealth and age.

For that reason, we implore this subcommittee to ensure that OPM's plan to impose HSAs in FEHBP is withdrawn.

Conclusion

For 44 years the FEHBP has minimized costs and provided a wide choice of comprehensive health insurance plans to nearly nine million federal employees, retirees and their families. OPM's ability to minimize expenses is now being challenged by significantly higher health care costs. I can assure this committee, that adequate, affordable health care coverage is of paramount importance to retirees. NARFE stands ready to work with this panel, others in Congress and the OPM to find ways and means of containing out-of-control health care costs without sacrificing quality, and to assure the federal family of access and coverage without resorting to proposals that only shift costs to enrollees, or that circumvent risk sharing in our group plan environment.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Fallis. You brought up some good points there. We are going to look into that one on the 65, whether it violates the Federal law there.

Mr. FALLIS. Title V.

Mrs. JO ANN DAVIS OF VIRGINIA. Got your point on that one.

Mr. Gammarino, you are recognized for 5 minutes, and thanks for being with us today.

Mr. GAMMARINO. It is nice to be here. Good afternoon. I want to thank the subcommittee for the invitation. I am please to testify at Chairwoman Davis' first FEHBP oversight hearing.

I ask that my written testimony be made part of the record, please.

Mrs. JO ANN DAVIS OF VIRGINIA. So ordered.

Mr. GAMMARINO. Blue Cross/Blue Shield, as you know, administers a governmentwide service benefit plan today. We are proud to be involved in the inception of the FEHBP since 1960. Today we are proud to serve over 4 million Federal enrollees and their families.

You asked us to address two questions: the cost accounting standards and cost containment. First, let me address the cost accounting standards.

For reasons given in much more detail in my written testimony, we believe first that the cost accounting standards referred to as CAS adds no value to the program. We do, however, believe that it will add unnecessary cost to the program, and therefore, we think the burden should be on CAS advocates to show concrete benefits to taxpayers and enrollees.

Second, CAS is not required to protect program integrity. The carriers today are subject to a broad array of cost accounting requirements, including compatible CAS standards that are in various Federal regulations, and as I am sure you are aware, the health plans are subject to regular and vigorous OPM Inspector General audits.

Third, CAS is a particular project to Blue Cross/Blue Shield. For reasons detailed in our written statement, CAS which was designed for the defense industry is incompatible with insurance accounting practices. Simply it is like fitting a round peg in a square hole.

More specifically, the Blue Cross/Blue Shield service benefit plan for Federal enrollees is tightly integrated into our commercial business. Let me explain.

Blue Cross/Blue Shield benefit plan serving over 3 million members represents about 5 percent of our overall business. Collectively, today Blue Cross/Blue Shield insures over 88 million people. Consequently Blue Cross/Blue Shield plans would have to either revamp our systems in ways that we feel are both detrimental and costly to our far larger commercial customers to be CAS compliant or leave this program.

We feel either choice makes sense. Therefore, we think CAS is a permanent problem that requires a permanent solution. We ask your support of a statutory exemption for all carriers just as Congress did for the Long-term Care Insurance Program.

The second topic you asked us to discuss is cost containment. Under that heading we are talking about insuring quality health care at affordable prices. As many people have already addressed,

we live in a challenging environment, and the FEHBP is subject to the same cost pressures as other health plans in the country.

Additionally, the FEHBP has a significant aging population. Blue Cross/Blue Shield's focus is to keep quality high while restraining cost.

First, we do think that the FEHBP, which is individual choice and promotes vigorous competition, promotes continual cost containment.

Second, in the plan itself, we have aggressive initiatives on two fronts. First, on economic cost controls, Blue Cross/Blue Shield negotiates significant provider discounts on the basis of our commercial business that save billions of dollars annually for the program. We also partner with at least two PBMs to provide significant savings on the prescription drug side as well.

The second area we focus on is what we call member centered programs. They are designed to help members make what we call cost effective use of benefits and/or adopt healthier lifestyles. Included in these programs are areas such as case management, disease management and health and wellness programs.

I cannot say that all of these member center programs lead to low cost in the short run. We do believe they are helpful in the long run. We are certain that members receive better care because of these programs.

This concludes my prepared remarks, and I would be happy to answer any questions.

[The prepared statement of Mr. Gammarino follows:]

TESTIMONY OF

Blue Cross & Blue Shield Association
An Association of Independent
Blue Cross & Blue Shield Plans

Before the

Subcommittee on Civil Service and Agency Organization
Committee on Government Reform
United States House of Representatives

On

"Oversight of the Federal Employees Health Benefits Program and the Federal Long-Term Care Insurance Program."

Presented by:

Stephen W. Gammarino
Senior Vice President
National Programs

Wednesday, March 24, 2004

Good morning. Chairwoman Davis, Ranking Member Davis, and Members of the Subcommittee, thank you for the opportunity to appear before you today.

I am particularly pleased, Madam Chairwoman, to participate in the subcommittee's first oversight hearing on the Federal Employees Health Benefits Program (FEHBP) since you assumed the chair. I look forward to working with you, the Ranking Member, and the other Members of the subcommittee in addressing both the challenges and the opportunities the FEHBP presents.

The Blue Cross and Blue Shield Association administers the Government-wide Service Benefit Plan in the FEHBP on behalf of the 41 independent licensees that jointly underwrite the Service Benefit Plan. We are proud to have offered the Service Benefit Plan from the very beginning of the FEHBP in 1960. Today, the Service Benefit Plan provides high-quality, affordable health insurance to more than 4.3 million active and retired federal employees and their families. By their choice to enroll in one of the options we offer, the Service Benefit Plan has become the largest plan in the Program.

We are also pleased that in this era when keeping premium increases below double-digit is so challenging, we were able to hold our premium increases for both the Standard and Basic Option this year to single digits. The premium for the Standard Option rose by 9.9% and the premium for Basic by 8.3%. These increases are well below the 2003 national average of nearly 14% reported by the Kaiser Family Foundation and the Health Research & Educational Trust and

below the 2004 FEHBP average of 10.6%. We are also under the 12.6% increase Hewitt Associates has projected for 2004.

Your invitation letter asked us for our views on two topics in particular: (1) the FEHBP waiver from the Cost Accounting Standards and (2) cost-containment in the FEHBP. I welcome the opportunity to discuss these important issues with the subcommittee.

Cost Accounting Standards

I cannot overemphasize how important the exemption from the Cost Accounting Standards (CAS) that currently protects FEHBP carriers is to the Blue Cross and Blue Shield Plans that underwrite and deliver the Service Benefit Plan. I am happy to explain why that is so.

CAS Adds No Value to the FEHBP

But I would also urge the subcommittee to consider a fundamental issue that is often overlooked: Why should *any* carrier be forced to comply with the Cost Accounting Standards? Put another way, would compulsory compliance add value to the FEHBP?

As the Office of Personnel Management (OPM) itself has attested, the agency has successfully monitored and audited the FEHBP for over 40 years without the Cost Accounting Standards. Therefore, those who want to impose them on the FEHBP should be required to demonstrate that it will confer concrete benefits. They should prove that taxpayers will be better protected. And they should show what benefits the millions who depend upon the FEHBP for health insurance will realize.

One would also expect that if the Cost Accounting Standards added value to the Program, they would be applied to all carriers equally. Yet that is not the case. Only experience-rated carriers (the fee-for-service plans and some HMOs) have been targeted, but not the community-rated plans (most HMOs). But community-rated plans are the overwhelming majority of the 205 health care plans that are participating in the FEHBP this year. I know of no logical basis for this distinction.

The Blue Cross and Blue Shield Association and its Participating Plans are confident that a careful cost-benefit analysis of requiring CAS compliance will reveal many added costs but no added value. That is the conclusion we reached after intensive analysis and numerous discussions with OPM. That is the conclusion that OPM Director Kay Coles James reached when she exercised her authority to waive the Cost Accounting Standards for experience-rated carriers, such as the Service Benefit Plan. And that is the conclusion we believe this Subcommittee would reach.

CAS Is Not Required to Protect Program Integrity

I would like to reassure the Members of this subcommittee that imposing the Cost Accounting Standards on FEHBP carriers is not necessary to protect the taxpayers or the federal employees and retirees who participate in the Program. FEHBP carriers are already subject to a broad array of cost accounting requirements. These include accounting requirements contained in the Federal Acquisitions Regulations (FAR), the Federal Employees Health

Benefits Acquisition Regulations (FEHBAR), and Generally Accepted Accounting Practices (GAAP).

In fact, the Blue Cross and Blue Shield Association and Participating Plans already comply with those Cost Accounting Standards that are compatible with insurance industry accounting needs because they are incorporated in the FAR and FEHBAR.

OPM has, and exercises, authority to conduct regular and rigorous audits of FEHBP carriers, including the Blue Cross and Blue Shield Association and Participating Plans, as the agency has previously testified before this Subcommittee and the CAS Board Review Panel.

We take seriously our obligations to the taxpayers and the employees and retirees who enroll in the Service Benefit Plan. The Association conducts its own internal audits to ensure adherence with all of these accounting requirements. And we have also worked closely with OPM on ways to strengthen FEHBP accounting requirements that are compatible with insurance industry needs.

As Director James wrote when she issued the administrative waiver, "The potential risk to the FEHB Program of waiving CAS requirements is nonexistent due to Program controls already in place."

CAS Will Not Restrain Health Care Costs or Premiums

FEHBP premiums are driven primarily by the cost of providing health care to our members: payments to doctors, hospitals, and other health care providers, as well as the costs of prescription drugs and other health care charges. These payments account for about 93% of Blue Cross and Blue Shield's expenditures in

the FEHBP. Yet the Cost Accounting Standards would not apply to such expenditures, but only to the small segment attributable to administrative activities. Imposing CAS on the FEHBP is not an answer to rising insurance premiums.

To the contrary, the cost of administering the Service Benefit Plan would increase significantly if the Association and Participating Plans were to even attempt to implement CAS-compliant accounting systems. (In any event, we believe that any such attempt would be doomed to fail.) As Director James stated in the waiver, "Program costs would increase if health carriers determine they would need to develop discrete new accounting systems for their Federal group contracts."

CAS Is an Intractable Problem for the Service Benefit Plan

There are two interrelated reasons why the exemption from the Cost Accounting Standards is so important to our Plans. The first is the very nature of the Cost Accounting Standards themselves. And the second is our unique structure within the FEHBP.

Structure of the Service Benefit Plan

Let me address the second issue first. Aside from HMOs, the Blue Cross and Blue Shield Association and its participating Plans are the only carriers sponsoring a FEHBP plan that also sell insurance in private markets. The 41 independent Blue Cross and Blue Shield licensees have come together to sponsor the Service Benefit Plan and provide to the government the same insurance products that they provide to commercial customers.

Blue Cross and Blue Shield Plans provide coverage under the Service Benefit Plan as an integral and inseparable part of the Plans' regular commercial health insurance business. The Plans' ability to provide FEHBP benefits depends upon the extensive networks of providers that each Plan develops and maintains to service underwritten commercial business. Because our FEHBP business is so tightly integrated with our commercial business, the Blue Cross and Blue Shield FEHBP contract is fully integrated into the various Plans' operational and accounting structures. This arrangement is fully consistent with the provisions of the original FEHBP Act, which established the Service Benefit Plan.

Collectively, Blue Cross and Blue Shield Plans insure nearly one in three Americans, about 88.3 million people. The FEHBP population of some 4.3 million is obviously a very small percentage – about 5% - of this overall book of business. Plan business decisions must be driven by what is best for their overall book of business. To put it another way, it would make no business sense for Plan's to make drastic and disruptive changes to their accounting systems that are necessary to serve their commercial accounts to accommodate a fraction of their business. Yet that is just what imposing the Cost Accounting Standards would require.

CAS Is Incompatible With Insurance Accounting Practices

As we have noted many times before, the Cost Accounting Standards and insurance accounting systems are like two different and unrelated languages; the grammar is different and so is the vocabulary. One cannot be translated literally

into the other because they have so little in common. This is not surprising. After all, the Cost Accounting Standards were not designed to fit the insurance industry, but for manufacturers of goods for the Department of Defense.

In fact, I believe the subcommittee would find it instructive to ask all FEHBP carriers this question: "If you were charged with developing an accounting system to most effectively manage your insurance business, both commercial and federal, would you choose CAS?" I am confident each would say "No." But if any truly believe that CAS is a superior accounting system for our industry, by all means they should be free to adopt it. They may do so today.

The Cost Accounting Standards divide all contractor costs into two basic types, direct and indirect costs. Indirect costs are then classified into three subcategories: "overhead," "general and administrative," and "home office," which are grouped together into indirect cost pools. These pools are then allocated as a percentage to bases comprised of direct contract costs or combinations of direct and subsidiary indirect costs.

Insurance accounting is radically different. It employs none of these categories. Instead, the accounting systems used by insurers establish "cost centers," sometimes as many as 1000 or more. These "cost centers" are allocated to various lines of business using up to forty different methods or statistics, such as number of claims processed, number of subscribers, or time studies.

The highly detailed system of accounting used in the insurance industry provides management with the business information it needs to effectively run

the business. Managers are able to see clearly how the various products the company offers are performing financially. The Cost Accounting Standards would obscure this clear vision because costs would be consolidated into what are, by the standards of the insurance industry, extremely large expense pools. In short, it would simply make no business sense for insurers to adopt a CAS-like accounting system in the first place, much less to revamp existing systems that serve them well to accommodate the demands of a small fraction of their business.

In addition any change in a cost center is arguably a change in accounting practices requiring agency approval. This could result in literally thousands of change approval requests each year for infinitesimally small adjustments in Plans' cost centers.

Because the Cost Accounting Standards are so ill-suited to the needs of the insurance industry, I could continue to discuss many other examples of incompatibility between them and insurance industry accounting practices, such as major differences in accounting periods. But to summarize, any attempt to overlay the Cost Accounting Standards on Blue Plans' accounting systems would result in irremediable mismatches. Plans would therefore be confronted with the unfortunate choice of revamping their accounting system in ways that make no business sense to accommodate a fraction of their business or leaving the FEHBP.

The rational business decision is obvious. That is why the Blue Cross and Blue Shield Association cannot sign any agreement that would impose the Cost Accounting Standards currently exempted by law on its participating Plans.

Sound Business Judgment, Not Arrogance, Drives Our Opposition to CAS

There are also two criticisms of our position on the Cost Accounting Standards that I would like to meet head on for the benefit of this Subcommittee. The first is that Blue Cross and Blue Shield could implement those Standards, but as the largest carrier is throwing its weight around because it simply does not want to. This is simply not true.

We value our participation in the FEHBP, which has been cited frequently by many experts as a model employer-sponsored health benefits plan. When the government first announced that it would begin applying the Cost Accounting Standards to the FEHBP, we embarked on a painstaking, conscientious review of how to apply them to existing business structures and accounting systems. We retained outside consultants and lawyers to assist and advise us. It was only after completing more than a year-long analysis, that we concluded it was simply not feasible. Only then did we ask Congress for a statutory exemption.

FEHBP Is Not Like Medicare

The second criticism is that because some Blue Plans comply with the Cost Accounting Standards in their Medicare and other government business, we could do it in the FEHBP. But there are critical differences between the FEHPB and those other lines of business that make compliance feasible in one but not the other.

Our Plans' Medicare and fiscal intermediary contracts are essentially service contracts. Unlike the FEHPB they are not integrated with our commercial business and do not depend upon our provider networks. In many cases those contracts are in fact distinctly separated and housed in wholly owned subsidiaries of individual Plans. In those circumstances, it is possible to develop distinct, CAS-compliant accounting systems without changing company-wide accounting systems. That is not true in the FEHBP.

A Permanent Statutory Exemption Is Necessary

Fortunately, as Members of this Subcommittee know, Congress has recognized just how serious a problem this is. Beginning with the Treasury-Postal appropriations bill for FY 1999, Congress has continuously exempted all FEHBP carriers from the Cost Accounting Standards. This statutory exemption remains in effect today, and I was pleased to note that President Bush's budget for FY 2005 proposes to continue it.

However, Blue Plans were almost forced out of the FEHBP in 2002 when the continued viability of that exemption was threatened because the House of Representatives voted to strike the exemption. That vote took place in an environment poisoned by various corporate accounting scandals. Opponents of the exemption falsely portrayed the Cost Accounting Standards as necessary to protect the integrity of the FEHBP.

Despite that setback, Blue Cross and Blue Shield Plans were able to commit to offering the Service Benefit Plan again in 2003 because OPM Director

James issued an administrative exemption for all experience-rated carriers in the FEHBP. We thank her for her decisive and courageous leadership.

The Blue Cross and Blue Shield Association and its Plans appreciate the support we have received in the past from this Subcommittee in securing and retaining annual exemptions through the appropriations process. However, our near death experience in 2002 has reinforced our belief that a permanent statutory exemption for FEHBP carriers is necessary to ensure stability in the Program.

As grateful as we are for the administrative waiver Director James issued, we recognize that new leadership at OPM could easily revoke it. The same would be true of any "permanent" regulatory exemption. And the annual exercise of continuing a statutory exemption through appropriations bills can needlessly disrupt the appropriations process and lead to a "Perils of Pauline" environment for those who depend upon the FEHBP for health insurance, OPM, and our Participating Plans.

This is not the best way to run a railroad or a health insurance program. That is why I am asking the Subcommittee to support a permanent statutory exemption from the Cost Accounting Standards for all carriers who participate in the FEHBP, just as Congress did when it established the Long Term Care program.

Ensuring Quality Health Care at Affordable Prices

The second issue your letter of invitation asked us to focus on is cost containment within the FEHBP. This is indeed a timely and important topic.

Almost daily, it seems, new reports and experts remind how difficult – but important – it is becoming to continue providing quality health care at affordable prices. The Blue Cross and Blue Shield Association and its Participating Plans never lose sight of our obligation to provide federal employees and retirees with quality health care at prices they can afford.

Challenging Environment

The FEHBP is not immune from the experience of the general health care market. It is subject to the same forces creating cost pressures in the wider market. These forces include increasing expenditures for prescription drugs; medical technology; higher payments to doctors, hospitals, and other providers; increased demand for medical services by aging "baby boomers" who expect the very best care; the malpractice crisis; government regulations; inflation; and waste, fraud, and abuse.

We are also increasingly realizing that the lifestyles we choose contribute to higher medical expenditures. For example, the Department of Health and Human Services (HHS) estimates that obesity and related problems adds $100 billion per year to health care expenses. According to HHS, more than 60% of adults in this country are overweight or obese, and the trends among young people are cause for real concern. HHS tells us that the number of overweight children between the ages of 6 and 11 has almost doubled, and it has nearly tripled for those aged 12 to 19.

Blue Plans and the Association are aggressively responding to these challenges.

Competition And Risk In the FEHBP Controls Costs And Promotes Quality

Before I turn to some of the things Blue Cross and Blue Shield Plans are doing to keep quality up and costs under control in the Service Benefit Plan, I would like to point out some features of the FEHBP itself that we believe contribute to both objectives. First, the FEHBP is a competitive market-oriented system centered on consumer choice. Carriers compete vigorously with one another for each individual's business. This alone provides a powerful incentive for each carrier to work hard to rein in costs and preserve competitive premiums without diminishing the quality of care.

Second, carriers, or their underwriters, are at risk in this market. They offer true insurance products to the ultimate consumer, not just administrative services. This reinforces carriers' incentives to ensure that benefit designs are actuarially sound.

The Service Benefit Approach

I would categorize the Service Benefit Plan's efforts to maximize the value of our benefit in two groups. In the first group, are such economic cost controls as the discounts we receive through our networks and by using pharmaceutical benefit managers (PBMs). The second encompasses what I would call member-centered programs that focus on helping the member achieve better health outcomes in cost-effective ways or adopt healthier lifestyles. We also maintain a vigorous and effective anti-fraud program.

Discounts

I noted earlier that our FEHBP business is integrated with the provider networks participating Plans have developed to service their commercial business. As a result, the Service Benefit Plan reaps the advantage of discounts that Participating Plans are able to negotiate on the strength of their commercial accounts. Those discounts far exceed what Plans could negotiate on the basis of their FEHBP business alone and generate significant savings for taxpayers and the federal employees and retirees who enroll in the Service Benefit Plan.

Contracting with PBMs to handle both retail and mail order prescription drug programs, helps the Service Benefit Plan control escalating expenditures for pharmaceuticals by taking advantage of substantial discounts they are able to negotiate with pharmaceutical companies and pharmacy networks. As the General Accounting Office has recently attested, these savings are shared by enrollees. (GAO, Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies (January 2003, GAO-03-196.)

Member-Centered Approaches

We also undertake a number of activities to ensure that our members are receiving high quality, affordable care.

- We monitor member satisfaction via surveys, focus groups, appeals/grievance process and devise local policies accordingly;

- We monitor provider safety and quality via provider network credentialing, provider contracting, fraud/abuse program, and member feedback
- We monitor clinical coordination in partnership with providers and members via case management, disease management, and pharmacy programs in varying degrees dependent upon initiatives designed for a local population;
- We provide health and wellness programs for Blue membership in varying degrees driven by local disease states; and
- We monitor clinical literature and provide staffing for health services research in local Blue Cross and Blue Shield Plans.

Let me give you some real-life examples of how these kinds of programs help our members achieve healthier outcomes.

- Our 24-hour nurse line, "Blue Health Connection," helps members assess their symptoms and find the right care at the right time.

  Earlier this year, one of our members was driving home when he developed symptoms which he thought were "the flu." His wife called the nurse call line, at which time the nurse advised him that he should go directly to an emergency room, since he might be having a heart attack. He did have a heart attack but, thanks to Blue Health Connection, he got the right treatment at the right time. When the Plan called the member, he was back at work, doing well, and attending cardiac rehab. It was a first

time event for him. He expressed appreciation for the nurse who gave him the correct direction.

- To encourage cost-effective use of prescription drugs, we manage drug cost and utilization with a continuous focus on quality. We incorporate a set of clinically aligned programs to review patient's medications. We continue to monitor new drugs that become available to determine if they are appropriate for inclusion in our programs, based on clinical studies and manufacturer's guidelines.

  One of our members was taking contraindicated migraine medication following a stroke. Following guidelines in our prior approval program and based on the pharmacist's review, the doctor was able to manage the patient's care, improve outcome, and avoid a potential threat to the patient's health or life.

  Another member's doctor was not aware that his patient was receiving medications from other doctors as well. After our review and notification, the doctor informed us "I will schedule a consultation with this patient and handle immediately. Notifications such as these are very beneficial".

I cannot tell you today that our programs actually led to lower costs in all of these incidents and the many others that our programs deal with. In the short term, our costs may have increased in some cases. We believe that in the long run, such programs will help control costs. But we are certain of one thing: the outcome for our members was better.

The Blue Cross and Blue Shield Association has established a Health Care Cost Containment Program that encourages our members to adopt healthier lifestyles. One example is the Association's "Walking Works" campaign to educate our members and others about the health benefits they can realize simply by walking more.

In short, we work hard to improve our members' health outcomes and control costs.

Anti-Fraud

In addition, the Service Benefit Program is protected by an effective anti-fraud program that fights fraud, and abuse. We estimate that in 2002 our anti-fraud program saved nearly $94.7 million. (Our estimate for 2003 is not yet complete.) On the medical side, our Participating Plans are required to integrate anti-fraud investigations under the Service Benefit Plan into their overall anti-fraud programs. With respect to prescription drugs, the Service Benefit Plan has established an anti-fraud program under which trained clinical personnel (e.g., registered pharmacists and pharmacy technicians) identify abusive practices and investigators search out and investigate fraudulent activities.

OPM's Office of Inspector General has repeatedly complimented our anti-fraud program. Our anti-fraud personnel participate in a number of training programs offered by such industry-related associations as the National Association of Drug Diversion Investigators in order to keep their skills at the cutting edge of industry practices.

Health Savings Accounts

In your letter of invitation, you asked us to be prepared to answer questions on several topics, and we are prepared to do so. However, I would also like to take a moment and address one of those issues, Health Savings Accounts (HSAs).

In general, we believe that HSAs are innovations that would enhance the Program. They offer an option that some federal employees and retirees (those under 65) might find attractive. Many have expressed concern about the risk of adverse selection, which could drive up premiums for others by enticing the best health risks to leave more traditional plans. While we agree that this is a potential development that must be guarded against, we also believe that OPM can minimize this risk by carefully monitoring the FEHBP marketplace and negotiating properly designed benefit packages. Nor are we concerned that there will be an immediate flood of employees into HSAs, which are a new and radically different approach to health care coverage. Thus, we believe there will be ample time to examine how they will actually affect the Program and take corrective action if necessary.

However, there is one aspect of this matter that does cause us immediate concern. Under an interpretation of the statute that OPM has followed for some years now, the agency believes that legislation is necessary to allow the Service Benefit Plan to offer more than the 2 options it currently does. In contrast, OPM has the authority to allow competing carriers to offer more than 2 options by regulation. We believe, though, that OPM currently has the authority to also

allow the Service Benefit Plan to offer additional options and that legislation is not required.

We will continue to discuss this question with Director James and her staff. But we are concerned that if legislation is required there may be a period – and possibly a very lengthy one – in which other carriers are able to offer an additional option, such as an HSA, while we are foreclosed. We are concerned that would establish an undesirable precedent for applying a separate set of rules to carriers that are otherwise similarly situated. We know that is not OPM's intent, but we fear it could be the consequence.

Pending Treasury guidance regarding HSA specifications is also of grave concern to us. The outcome of this guidance could render HSAs much less competitive products in the FEHBP.

Of particular concern is whether or not prescription drug coverage must be subject to the medical benefit high deductible in order to be "qualified" as HSA compatible. Many Blue Plans, including the Service Benefit Plan, use PBMs to manage pharmacy programs under which prescription drugs are exempt from the annual deductible. Systems changes to coordinate with PBMs would be required if prescription drugs are subjected to the deductible for HSA compatible products. These changes could be prohibitively expensive at a time when we are striving to reduce all administrative costs, and they could take at least a year to complete.

Conclusion

For the reasons I have elaborated, we believe the Cost Accounting Standards add no value to the FEHBP and present insurmountable obstacles to

the Blue Cross and Blue Shield Association and its Participating Plans. Imposing the Cost Accounting Standards would require our Participating Plans to revamp their accounting systems in ways that make no business sense to accommodate a small fraction of their overall business. The incompatibility of the Cost Accounting Standards with insurance industry accounting practices is a permanent problem that requires a permanent solution. Therefore, we ask the Subcommittee to support a permanent statutory exemption for all FEHBP carriers.

The Service Benefit Plan is dedicated to providing our members with high quality health benefits at affordable prices. Because the Service Benefit Plan is integrated with our Plans' commercial business, it enjoys the substantial discounts those Plans negotiate with health care providers. Our use of PBMs to handle the Service Benefit Plan's drug benefits also results in substantial savings for our members and the government. We maintain effective member-centered programs to assist them in making the most cost-effective use of their benefit, and we maintain a vigorous anti-fraud program.

I again thank the Subcommittee for the opportunity to appear before you, and I am prepared to answer any questions you may have on these important matters.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Gammarino.

Dr. Smith, thank you for being with us today. You are recognized for 5 minutes.

Dr. SMITH. Thank you very much, Madam Chairwoman and members of the committee. I apologize for my cold.

I am Dr. Scott Smith. I am the vice president and chief medical officer at First Health, and in the interest of full disclosure, a constituent of Mr. Davis' from Oak Park, IL.

First Health is a premier health benefit services company and provides integrated managed care solutions serving the group health, worker's compensation, State agency and Federal Government markets, a provider of managed care services in the FEHBP since 1985, and my remarks will focus on care management.

Since 2002, First Health has offered comprehensive care management services for Federal employees, including Medicare eligibles, in the Mail Handlers Benefit Plan, which is the second largest plan in the program. Care management services encompass an array of patient centered initiatives, including identification of patients with chronic conditions, patient self-management, education, and collaboration with attending practitioners.

Fewer people now account for the majority of health care costs than in the past. As an internal medicine physician and medical officer of the health benefits company, I am concerned about the prevalence of chronic disease and conditions in our country and the rising costs associated with these conditions due to uncoordinated care, as was previously referenced.

The Centers for Disease Control and Prevention estimate that 75 percent of the $1.4 trillion in annual health care costs in the United States is attributable to providing services for chronic illnesses. What used to be the 80–20 rule, in other words, 80 percent of the cost generated by 20 percent of the population, is now the 80–11 rule. Eleven percent of the population now accounts for 80 percent of health care costs. Included in this 11 percent are chronically ill patients, and these figures are illustrated in my written testimony, attachment 1.

For these chronically ill patients, our experience proves that care management can have a significant impact on cost, productivity, quality of life, and objective disease related outcomes. Effective care management requires early identification, the ability to identify at risk members at the earliest possible time so that we may work with the patient and the physician to achieve the best possible outcomes.

By the time a patient with a chronic condition is hospitalized, the condition is intensified and incurs the increased costs and complications of an unstable situation. First Health uses a predictive model, including medical and pharmacy claims to proactively identify patients in need of care management before their conditions deteriorate.

I want to share with you the story of Ethel. Ethel was one of our Mail Handlers Benefit Plan members, and her experience demonstrates the value of integrated care management services, particularly those that include pharmacy. Ethel was an elderly patient who was identified through a pharmacy system trigger, indicating she had congestive heart failure. When a First Health nurse case

manager contacted Ethel, she also learned that Ethel was diabetic. This real time pharmacy trigger led to our being able to support her in following her doctor's treatment plan. It allowed us to have an impact on both cost and clinical outcomes.

Ethel was not stable at this time. Trying to manage her condition on her own resulted in Ethel incurring medical costs that could have been avoided due to ER and hospitalizations. Our case manager sent Ethel a glucometer so she could monitor her blood sugar twice a day, and this same case manager was involved with the other co-morbid conditions referenced.

Care management intervention avoided further instability and costs, and Ethel is now able to manage her own condition in conjunction with her doctor, and improve her quality of life.

Financial results indicate decreased annual claim costs for patients enrolled in care management. In attachment 2 in the written testimony comparing patient costs before and after program participation, decreases are shown in each year. While pharmacy costs rose for the first 2 years due to increased patient compliance, total cost decreased.

In the third year pharmacy costs leveled off as well. This cost decrease is in the face of an industry trend that as has been noted, has risen dramatically each year.

One additional example in which care management resulted in significant savings for the plan is a recent situation of an elderly patient admitted to the hospital with pneumonia and complications. At the end of her in-patient stay, she was frail and weak, and the attending physician did not believe it would be safe for the patient to return home alone.

Rather than keep the patient in the acute care hospital, which we just discussed in terms of danger, at a cost of $1,800 per day, First Health obtained a daily rate of $450 for a skilled nursing facility which provided a safer environment for the patient's recovery.

The patient was in the facility 28 days to complete rehabilitation and fully recover. The plan cost was $11,000. The member cost was $1,200. At the acute care hospital the cost would have been more than $50,000 for the plan. First Health's involvement saved more than $39,000, and the patient received safer and better care.

This is a case where our clinical involvement had significant impact on cost and quality results.

In conclusion, First Health believes that the FEHBP can serve as an example to the private sector by adopting innovative care management programs for its participants. These care management programs are essential to achieving optimal cost in clinical outcomes for Federal employees and retirees.

Chairwoman Davis and members of the committee, I thank you again for the opportunity to share our views, work further with your committee, and would be happy to share with you video testimonials we have of Ethel herself and other members involved in our care management programs.

Thank you.

[The prepared statement of Dr. Smith follows:]

Statement of

Scott P. Smith, M.D., M.P.H., F.A.C.P.
Vice President and Chief Medical Officer
First Health Group Corp.

on

Care Management For Federal Employees

HOUSE GOVERNMENT REFORM COMMITTEE

SUBCOMMITTEE ON CIVIL SERVICE AND AGENCY ORGANIZATION

Wednesday, March 24, 2004

Introduction

Chairwoman and Members of the Committee, I am Dr. Scott Smith, Vice President and Chief Medical Officer of the First Health Group Corp. ("First Health"). First Health is the premier national health benefit services company. We specialize in providing large payors with integrated managed care solutions. First Health serves the group health, workers' compensation, state agency, and Federal Government markets. First Health, and its predecessor company, has been a provider of managed care – both broad-ranging, integrated medical management and Preferred Provider Organization ("PPO") – services in the Federal Employees' Health Benefits Program ("FEHBP" or "Program") since 1985, serving as a subcontractor to various employee organization carriers participating in the Program. In addition, since July, 2002, First Health has served as the plan administrator, underwriter, managed care service provider, and pharmacy benefit manager, fully integrating all those functions, for the second largest plan in the Program, the Mail Handlers Benefit Plan ("MHBP") sponsored by the National Postal Mail Handlers Union, a Division of the Laborers' International Union of North America, AFL-CIO.

First Health appreciates this opportunity to present testimony on health issues affecting FEHBP. Given our 20 years' experience with Federal employees' health plans we can offer learning and insights in this regard. Also, our extensive experience with in-house clinical management programs gives us a valuable perspective regarding the necessary elements and structure of care management programs.

Fewer people now account for the majority of health care costs

As a physician and Chief Medical Officer of a health benefits company, I am concerned about the prevalence and increasing incidence of chronic conditions in our country

and the rising costs associated with these conditions. The Centers for Disease Control and Prevention (CDC) figures estimate that 75 percent of the $1.4 trillion in annual health care costs in the U.S. is attributable to chronic illnesses. What used to be the 80/20 rule (meaning that 20 percent of the population accounts for 80 percent of health care expenditures) is now the 80/11 rule. Eleven percent of the population now accounts for 80 percent of health care costs. Included in this 11 percent are chronically ill patients. (Please refer to Attachment 1.) For these chronically ill patients, our experience proves that care management can have a significant impact on associated costs, productivity, quality of life and objective disease-related outcomes.

First Health's care management services for Federal employees

First Health has offered comprehensive care management services for MHBP since 2002. We have offered disease management services since 2000 as part of the **First Health**® Care Support Program. Care management services encompass an array of cost-control mechanisms and patient-support initiatives, including identification of patients with chronic conditions, patient self-management education and collaboration with physicians.

Early identification is critical to affecting outcomes

Effective care management is predicated on the ability to identify at-risk members at the earliest possible time so that we may work with the patient and physician to achieve the best possible outcomes. Waiting for a sentinel event, such as a hospitalization or emergency room visit, has minimal impact on patient outcomes. By the time a patient is hospitalized, the condition has intensified and incurs the increased costs and complications of a progressive condition. First Health uses a comprehensive system of data and events to proactively identify patients in need of care management before conditions escalate. We base our predictive modeling for care management on algorithms derived primarily from pharmacy and medical

claims. Other triggers include self-identification, clinical events and customer service interactions. Further, trigger algorithms are designed to identify those members at higher levels of risk for disease progression and utilization of services.

Integration is essential for a successful care management program

Sophisticated, integrated and systematic triggers are required for selective, yet aggressive patient identification. In addition, pharmaceutical data is critical to effective concurrent management of patients, specifically monitoring compliance, as well as measuring impact along the course of treatment and after treatment has concluded. Carve-out pharmacy services simply cannot meet the demands of this comprehensive approach, due to timeliness, data consistency issues and administrative complexity, not the least of which is HIPAA compliance. In fact, using a carve-out where these three components are critical may, and probably will, increase costs, likely arising from administrative expenditures required for system—technological and human—connectivity. Further affecting the cost equation will be missed opportunities due to delays in real-time analysis. An integrated approach, with all service components providing unified data offers the greatest opportunity to identify, monitor and assess the results of patients involved with care management. We find that clients using First Health's integrated product typically have five percent of their population identified for participation in care management: in the few circumstances in which First Health has attempted to work with external pharmaceutical carve-out programs that identification rate has not been met. More than 60 percent of care management participants are identified from triggers from prescription drug claims. Integrated data, particularly for prescription drug claims, create a comprehensive profile for the identification, ongoing management and measurement of the impact of care management that simply cannot be attained through multiple entities or carve-out approaches.

Increased Compliance does not increase costs

Financial results derived from the **First Health®** Care Support Program indicate decreased annual claim costs for patients enrolled in care management. Comparing patient costs before and after program participation, we found decreases for each year. While pharmacy costs rose for the first two years due to increased patient compliance, ten percent in 2000 and nearly 18 percent in 2001, overall costs decreased. In the third year (2003), pharmacy costs leveled off as well. (See Attachment 2). This cost decrease is in the face of industry trend that has risen each year.

Patient survey feedback reveals improved outcomes

Each year First Health gathers feedback through patient surveys mailed to a representative sample of members. We use survey feedback to measure process indicators, patient satisfaction and productivity. Survey results for 2003 include MHBP participants and indicate significant levels of satisfaction with the care management program along with increases in the patients' understanding of conditions, self-management, and productivity. Please refer to Attachment 3.

Personal interactions increase patient compliance

Personal interactions also influence the efficacy of a care management program. First Health nurse case managers work closely with patients to provide support and make outgoing phone calls to educate members, promote compliance and develop and maintain a strong connection with patients. We address comorbidities so common to chronic conditions by assigning a single nurse case manager to a patient with one or more conditions. Survey results demonstrate the connection between the number of interactions and patient satisfaction, medication compliance and productivity. Please refer to Attachment 4.

Essential elements for effective care management

The First Health model effectively addresses the critical issues of a care management program. Our model stems from the responsibility we assume on behalf of our customers and their members. Our mission is to direct members to the right provider at the right time, in the right setting at the right price—in short to facilitate the best outcomes. To have maximum impact on outcomes, we use proactive, integrated triggers to identify patients early for interventions and we use our integrated services to effectively monitor patients concurrently and retrospectively. One-on-one support from a single nurse case manager simplifies processes for patients and helps them become more compliant with their physicians' treatment plans. Increased medication compliance decreases complications and exacerbations of conditions and lowers overall health care costs.

Conclusion

First Health believes that FEHBP can serve as an example to the private sector by adopting aggressive care management programs for its participants. These care management programs are essential to achieving optimal cost and clinical outcomes for federal employees and retirees. As a model for employer-sponsored health plans, FEHBP can set a strong example and reap strong returns by promoting these programs for their employees, retirees and their families.

First Health thanks the Committee for the opportunity to make these comments.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Dr. Smith.

And finally, welcome, Mr. Forte. We are pleased to have you with us today, and you are recognized for 5 minutes.

Mr. FORTE. Good afternoon, Madam Chairwoman and members of the committee. I am Paul Forte, chief executive officer of Long Term Care Partners, the exclusive administrator of the Federal Long-term Care Insurance Program.

Long Term Care Partners is headquartered in Portsmouth, NH and employs 93 people. On behalf of Long Term Care Partners and of our parent companies, John Hancock and MetLife, I would like to thank you for this opportunity to participate in today's hearing.

We are mindful of the privilege of having been awarded the first contract to administer the Federal program which we believe is destined to become a critical development in the history of financial planning and an important resource to Federal employees, annuitants, and family members.

I am happy to report that the Federal program is off to a strong start. We have conducted a successful open season in 2002, developed policies and procedures for key functions, and begun paying long-term care insurance claims. The 2002 Federal open season featured a multi-phase, multi-media campaign, one of the most comprehensive education and marketing campaigns ever conducted for this product. This campaign reached more than 4 million Federal and U.S. Postal Service employees and members of the Uniformed Services and an additional 4 million annuitants, including retired members of the uniformed services.

The campaign was designed to help individuals access information, understand the risk of needing long-term care, and consider their options for financing such care. Less than 2 years after open season, the Federal program has over 200,000 enrollees. I am happy to note some 66,000 retirees.

This makes the Federal program the largest Long-term Care Insurance Program in the country, larger than the program sponsored by CalPERS, now in its 8th year and constituting roughly 15 percent of the total employer group, LTC Market, in the United States. Thanks to the passage of legislation last year, several newly eligible groups have been added, including Grey Reservists, D.C. government employees with Federal benefits, separated employees with title to a deferred annuity, Navy personal command, nonappropriated funds personnel.

These groups will be contacted in the coming weeks and are eligible to apply for coverage now.

The Federal program requires that certain underwriting conditions be met by prospective applicants. There are several levels of underwriting depending on the status of the individual, actively at work, say, or retired, and the window of opportunity in which the individual is applying, open season, say, versus post open season.

The aim of the Federal program underwriting is not to insist on perfect health—many people with a medical condition requiring treatment are approved for coverage—but rather to accept people who have average health for their age group.

Now, the overall approval rate for underwritten applications is 85 percent, which is in line with the industry. The Federal program has already assisted people with serious life threatening illnesses

that may be terminal in nature, as well as those for whom the program is principally designed, people with chronic and debilitating conditions requiring custodial help with the activities of daily living.

In addition, we are providing care coordination services to the qualified relatives of those who enroll. As of the end of February, our care coordinators had handled almost 6,000 calls for services.

These calls consist of evaluating service needs, assisting in the set-up of a plan of care to answer those needs, identifying and making referrals to appropriate local services and informal care providers, and answering questions about coverage under the program.

As Federal family members look forward, they can take comfort in the assurance that the Federal program is well poised for stability and growth. Those of us who have been involved in the industry for a long time believe that the full potential of the Federal program has not been capped; that there are tens of thousands, perhaps hundreds of thousands who may 1 day enroll.

We plan to take our message first to the many baby boomers who are beginning to plan their retirement. We are participating in about 50 retirement seminars per week with various agencies coast to coast, and we are continuing to contact annuitants who are now shopping for long-term care insurance, but have not yet made a decision.

We plan to continue working with NARFE and to extend our promotion efforts with large national associations with both active and annuitant members.

As we do, we will be sure to emphasize the Federal program's general and flexible informal care benefit, care coordination and information counseling services, third party claim appeal process, international benefits and other features which we strongly believe make the Federal program the best value in long-term care insurance today.

Thank you for your invitation to participate in this hearing. I would be happy to answer any questions.

[The prepared statement of Mr. Forte follows:]

The Federal Long Term Care Insurance Program

A Statement for the
House Subcommittee on Civil Service and Agency Organization
Committee on Government Reform
Congress of the United States

Washington, D.C.
March 24, 2004

Paul E. Forte
Chief Executive Officer
Long Term Care Partners, LLC

Good afternoon Madame Chairwoman and Members of the Committee:

I am Paul Forte, Chief Executive Officer of Long Term Care Partners, LLC (LTCP), the exclusive administrator of the Federal Long Term Care Insurance Program (FLTCIP), a long term care insurance program authorized by the Long Term Care Security Act of 2000 (P.L. 106-265). Long Term Care Partners is located in Portsmouth, New Hampshire, at Pease International Tradeport (formerly Pease Air Force Base), and employs 93 people from New Hampshire, Maine, and Massachusetts.

On behalf of Long Term Care Partners, and of our parent companies, John Hancock Life Insurance Company and Metropolitan Life Insurance Company, I'd like to thank you for this opportunity to participate in today's hearing and to comment on the Federal Long Term Care Insurance Program.

The FLTCIP is the result of more than three years of study into all aspects of long term care and long term care financing. During this time, the U.S. Office of Personnel Management (OPM) spoke with employees, retirees, and other stakeholders within the Federal Family, and then consulted with dozens of industry experts, from actuaries and underwriters to care managers and customer service specialists. OPM also consulted with large public and private sector employer sponsors of established group long term care insurance plans. The Request for

Proposal issued by OPM in June of 2001 was as challenging and thorough as any that has appeared, and the negotiations for the contract were tough. Since the statute allowed for the formation of consortia of insurers, who would bring diverse resources together, expectations were high. Emphasis was placed on both technical capabilities *and* price. The aim throughout was to secure not only the strongest possible plan design at the best possible price, but to ensure, through good administration, *that plan design would stay meaningful and rates would be stable into the future.*

The statute called for the contract to go to a single consortium of carriers. This was because participation in the FLTCIP would be voluntary, and therefore lower in relation to group health plans, and also because it was considered critical to establish a single credible risk pool. Such an approach was in keeping with insurance industry practice: virtually all employer sponsored group long term care plans have only a single carrier. After proposals were submitted and reviewed, and oral interviews were held, all competitors were asked to revisit their proposals and to sharpen their pencils. Best & Final offers were considered and a decision was made. This, in short, was the way the FLTCIP bid was structured and, I believe, the process was sound.

We are mindful of the privilege of having been awarded the first contract to administer the FLTCIP, which we believe is destined to become a critical development in the history of financial planning and an important resource to hundreds of thousands of Federal employees,

annuitants, and family members. I am happy to report that the FLTCIP has gotten off to a strong start. We have conducted a successful Open Season in 2002, developed policies and procedures for key functions, and begun paying long term care insurance claims.

I'd like to take a moment here to highlight the difference between conventional health insurance and long term care insurance. Most everyone understands the importance of health insurance. The need for it can arise suddenly, at any time. It is a cornerstone of financial security, and so it can be distributed without heavy marketing or promotion, although education about specific plan options is usually required. Long term care insurance, on the other hand, is relatively new and not fully understood. Many people think of long term care as something that will take place near the end of their lives, not in the midst of it. Further, they believe that Medicare pays for long term care expenses, fail to understand the eligibility requirements for Medicaid, and defer investigation of long term care insurance in favor of other or more pressing concerns. Successful distribution of long term care insurance requires education, repeat messaging, and personalized attention. It is hard to overestimate the importance of education to the promotion of the product. This is something that the framers of the enabling Statute recognized where they underscored the importance of "informed decision making" in FLTCIP marketing initiatives. See 5 USC Section 9008(d).

Accordingly, the 2002 FLTCIP Open Season featured a multi-phase, multi-media campaign on long term care and long term care insurance

–one of the most comprehensive education and marketing campaigns on the subject ever conducted. This campaign reached more than 4 million Federal and U.S. Postal Service employees, and members of the uniformed services, and an additional 4 million annuitants, including retired members of the uniformed services. The campaign was designed to help individuals access information, understand the risk of needing long term care, and consider their options for financing such care. Education efforts included a toll-free customer service line (1-800-LTC FEDS) that took over 1 million calls; a powerful web site that received more than 184 million hits; a five-month bulletin series that attracted 900,000 subscribers; and more than 2,300 program education meetings coast-to-coast. As a result of these efforts, more than 1 million people requested information kits. Of those who requested kits, more than 25% applied for coverage.

Less than two years after Open Season, the FLTCIP has over 200,000 enrollees, two-thirds of whom are active Federal civilians, U.S. Postal Service, and uniformed services personnel and their spouses, one-third of whom are annuitants and their spouses, and other qualified relatives. This makes the FLTCIP the largest long term care insurance program in the country – larger than the program sponsored by CalPERS (now in its 8th year), and constituting roughly 15% of the total employer group long term care insurance market in the U.S. Thanks to the passage of legislation in the last session of Congress, several newly eligible groups have been added, including Grey Reservists, DC Government employees with Federal Benefits, separated

employees with title to a deferred annuity, and Navy Personnel Command non-appropriated funds personnel. These groups will be contacted in the coming weeks and are eligible to apply for coverage now.

The FLTCIP offers a wide range of options to accommodate different budgets, including several "pre-packaged plans." There are, in fact, some 528 different plan designs available, all of which can be modeled on our web site (www.ltcfeds.com). During Open Season, most enrollees elected comprehensive coverage, which covers all levels of home health care as well as facility-based care. The most popular Daily Benefit Amount was $100 per day, followed by the $150 per day option. Almost half choose the 3 year benefit period, and a majority chose the 90-day waiting period. It is worth noting that a full two-thirds of enrollees decided to address inflation by buying Automatic Compound Inflation vs. one-third who chose the Future Purchase Option. This was largely due to special efforts made to explain the effect that inflation can have on benefits down the road. Those purchasing the Automatic Compound Inflation option will see their Daily Benefit Amount increase by 5% compounded each year, even if they are in claim status, and without a corresponding increase in their premium.

Reception of the FLTCIP has been positive from the beginning, both among Federal Family members and mainstream media. Articles and news briefs have appeared in the *Washington Post*, *Federal Times, New York Times, Wall Street Journal, CNNfn*, and *CBS*

Marketwatch.com. underscoring the appeal of the Program and its potential to serve as a model for employers throughout the country. The FLTCIP has also benefited the insurance industry, which has cited the FLTCIP rollout in 2002 and 2003 as instrumental in the growth of both the individual and employer-sponsored group markets. See LIMRA International, *U.S. Group Long Term Care Insurance Executive Summar*y, 3Q 2003, p.1. Indeed, long time industry observers view the FLTCIP's success as an important step in demonstrating the way that the public and private sectors working together can help individuals to become responsible for their long term needs, without relying on taxpayers and already strained government programs like Medicaid.

Long Term Care Partners is receiving very high marks for Customer Service. Based on recent customer satisfaction surveys, over 90% of those contacted have rated us good to excellent in customer service responsiveness. I should add that all LTCP Customer Service Representatives are well versed in the FLTCIP and in competitors' products.

It is important to note that the FLTCIP requires that certain underwriting conditions be met by prospective applicants. The Statute stipulates that no issue is "guaranteed," and that insurers have latitude as to how to provide a "fully insured" contract. See 5USC Section 9002 (d). During Open Season, active employees had to answer seven health-related questions; spouses of active employees had to answer an additional two questions; annuitants, spouses of annuitants, and

other qualified relatives had to furnish more detailed health information. After Open Season, all active employee applicants and their spouses must go through full underwriting, unless they are new or newly eligible. Annuitants and qualified relatives must go through full underwriting. For those applying with full underwriting, or for anyone applying for the unlimited benefit period, LTCP reserves the right to obtain medical records from attending physicians and to conduct telephone and face-to-face interviews to determine physical, functional, and cognitive health. The aim of FLTCIP underwriting is not to insist on perfect health – many persons with a medical condition requiring treatment are approved for coverage – but rather to accept people who have average health for their age group. Our overall approval rate for underwritten applications is 85%, which is in line with the industry.

Underwriting is required to ensure the stability and future growth of the FLTCIP. Since enrollees pay 100% of the premium (there are no Federal appropriations), it is critical to guard against the risk of anti-selection. Otherwise the Program would attract persons whose health is on average poor for their age, claims would mount, rates would have to be increased significantly, and the healthier enrollees would either not apply for coverage, or would terminate their coverage, leaving only the unhealthy people in the Program and causing the familiar rate spiral.

As of March 1, 2004, we have received about 500 claims, and have approved more than two-thirds for benefits. A significant number of

those not approved for benefits are the result of people recovering faster than expected, or people dying. Only about 12% of claimants have been actually denied. Of the claims that were denied, some 50% have been the result of people not understanding what the FLTCIP is designed to cover. The FLTCIP is designed to cover *long term care*, as opposed to *short-term care* (also known as acute care). We define long term care as being in need of personal assistance with at least two of the six activities of daily living (bathing, dressing, moving from bed to chair, toileting, maintaining continence, and eating) and requiring such assistance for an expected period of at least 90 days, or having a cognitive impairment arising from a degenerative condition such as Alzheimer's disease. Some claimants have acute muscular or skeletal problems resulting from injury but are not expected to be dependent in daily activities for 90 days. Others file claims upon receipt of a serious diagnosis like cancer that is not yet resulting in impairment. These people usually resubmit claims later and are often deemed eligible for benefits. Thus far we have not had any claimants who have availed themselves of the Third Party Appeals process. This unique provision allows for the submission of a claim to an independent board-certified physician specialist in cases where a claim determination is disputed. LTCP must honor the finding of the appeal reviewer if LTCP's denial is found to be incorrect.

The FLTCIP has already been of help to people with a serious life threatening illness that may be terminal in nature, as well as to those for whom the program is principally designed: people with chronic and debilitating conditions requiring custodial help with the activities

of daily living. In addition, we are providing care coordination services to the qualified relatives of those who enroll. As of February 29th, 2004, the Care Coordinators have handled 5,881 calls for services. These calls consist of evaluating the needs expressed by the enrollees or qualified relatives, assisting them to set up a plan of care to answer those needs, identifying and referring to appropriate local services and informal care providers, or simply answering questions about their coverage under the FLTCIP. The enrollees especially like the personalized service they get as they speak to the same Care Coordinator each time they or their qualified relatives call in. This facilitates a relationship with one nurse who will know their particular situation. As their needs change, the consistency of that nurse becomes a highly positive factor in their long term care plan.

With respect to financials, the FLTCIP is strong. All Program funds are put into separate accounts managed by John Hancock and MetLife. These separate accounts track all amounts received, as well as all investment income earned, separately and apart from other insurance company funds. The FLTCIP receives some $67 million in premiums each quarter, with an average of roughly $1,300 from each enrollee per year. The intent is to build up significant reserves in the early years of the Program to allow for large numbers of claims down the road. The assets backing these reserves are invested in a mix of bonds and other qualified securities matched to the expected commencement and duration of liabilities.

I would like to make a comment about the competitiveness of the FLTCIP. The current offering is the result of a bid submitted jointly in August and October of 2001 by John Hancock and MetLife, two of the market leaders in long term care insurance, with sizeable numbers of large group accounts. The bidding process attracted some of the best and largest carriers in the insurance industry. John Hancock and MetLife were awarded the contract on a combination of technical merit and net cost. Other criteria included the marketing expertise of the carriers, their ability to implement large national programs, and their financial ratings, as established by independent financial rating agencies. The FLTCIP is designed to be soundly underwritten. The assumptions that go into rates are conservative, following the National Association of Insurance Commissioners 2000 Model Act and Regulations on Pricing Stability. Nevertheless, the premium rates for the FLTCIP are competitive with those of any long term care insurance policies on the market, once varying benefit provisions are accounted for. Indeed, they appear more competitive each day, as insurers who in the past have offered heavily discounted policies and experienced losses are forced to withdraw those policies from the market in favor of new policies with higher rates.

Before I close, I'd like to take a moment to talk about marketing. During Open Season in 2002, we marketed the FLTCIP through Agency Benefit Officers, email, and direct mail, where we have home mailing addresses. We also set up a telephone unit staffed by specially trained and certified consultants. This unit is available five days a week to help prospective buyers determine the options that

might be best for their expected long term care needs, the benefits of certain features, and the choices that are right for their budget. We are currently receiving close to 1,500 phone inquiries per week.

In 2003, we began two new initiatives that are already bearing fruit.

- *Retirement Seminars* – 40% of the Federal workforce is eligible to retire in the next seven years. We communicate the importance of long term care insurance as a component of retirement planning. We are participating in more than 50 agency retirement seminars each month. These seminars are designed to help attendees understand the impact that long term care can have on retirement security and to explain the advantages of the FTCIP.

- *Outreach to National Associations* – There are a number of large national associations geared to the careers and special interests of Federal employees and retirees. We are working with senior officers of these associations to promote the FLTCIP. We maintain a close working relationship with NARFE, and will be continuing our outreach to NARFE members via magazine articles, exhibition booths at state and national conventions, and joint marketing initiatives.

As Federal Family members look forward, they can take comfort in the assurance that the FLTCIP is well poised for stability and future growth. Those of us who have been involved in the industry for a long time believe that the full potential of the FLTCIP has not yet

been tapped, that there are tens of thousands, perhaps hundreds of thousands, who may, one day, enroll. We plan to take our message first to the many baby boomers who are beginning to plan their retirements, and then to the annuitants who are now shopping for long term care insurance but have not yet made a decision. As we do, we will be sure to emphasize the FLTCIP's generous and flexible informal care benefit, care coordination and information counseling services to enrollees and family members, third-party claims appeal process, international benefits, absence of a war exclusion, and other features that make the FLTCIP what we strongly believe is the best value in long term care insurance today.

Thank you again for your invitation to participate in this hearing. I would be happy to answer any questions that you may have.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Forte.

And thank you, all of our witnesses, for being patient in being here with us today.

I am going to turn to my ranking member, Mr. Davis, for questions.

Mr. DAVIS OF ILLINOIS. Thank you very much, Madam Chairwoman.

I too want to thank all of the witnesses for their testimony.

Mr. Gammarino, you note in your written statement that the Federal cost accounting standards, even if they were applied to the FEHBP carriers would only apply to administrative costs and not to the payment of medical providers. For the record, could you tell us what your annual administrative costs are?

Mr. GAMMARINO. Our administrative costs are about $700 million a year.

Mrs. JO ANN DAVIS OF VIRGINIA. You need to use the microphone, Mr. Gammarino, for the reporter.

Mr. GAMMARINO. OK. I have got everything covered now.

They are approximately $700 million a year.

Mr. DAVIS OF ILLINOIS. And you also maintain that applying cost accounting standards would be prohibitively expensive, forcing Blue Cross/Blue Shield perhaps to withdraw from the FEHBP program. Could you elaborate on that?

Mr. GAMMARINO. Yes. Let me start with the value proposition. You mention that the costs only relate to administrative costs, which from a program point of view are well under 10 percent.

Additionally, what I want to make sure the committee understands is the way it was designed, it does not even apply to most of the carriers, and that is one reason why you probably just see somebody like myself sitting here today. Eighty percent of the carriers in the FEHBP are carved out of the requirement to be CAS compliant.

So specifically, again, about Blue Cross/Blue Shield, we are the only carrier left when you carve out the community rated HMOs, which are 80 percent of the health plans that have a product that we provide the program, the Federal enrollees, that is imbedded in our private business, and therefore, the existing accounting systems, which are designed for the insurance business rather than CAS, which is primarily designed around the defense industry. As I said before, is not comparable and would cause us to have to not only reengineer our existing systems, and not only affect this program, but every customer we have, all 88 million of them.

And the added cost and burden to those customers, as well as the Federal employees members, we just do not think is cost justified.

Mr. DAVIS OF ILLINOIS. I think all of us would probably agree that education, as we try to get to this whole business of cost and how everybody fits into the picture, that education becomes an essential party.

Could each one of you just briefly comment on what you think perhaps could be done to actually make that happen?

I mean, I hear us talk about lifestyle changes. I hear us talk about appropriate utilization. I hear us talk about missed opportunities, missed appointments. I mean, everything that we talk about that somehow contributes to the overall cost. What can we do?

Mr. Forte, perhaps we will start with you.

Mr. FORTE. Well, Congressman, I think for the long-term care program, education is primarily important because we need to educate people about the risk that long-term care poses to them. Many people are still in denial about it being something that could happen to them. It is a risk that all of us face because you can suffer from an accident, a tragic accident, as well as an illness in old age.

I think we have to do more to the problem of retirement security and make sure people understand that this is their problem, that at least it is something they need to give some thought to.

Now, whether they choose to buy private long-term care insurance under the Federal program or some other sources or not to buy it at all, they must look at the fact that this is a problem for them. People turning age 65 have a three in five chance of needing long-term care at some point, and right now we do not have any way of paying for it. You can try to save for long-term care, but it is very, very expensive.

Medicaid programs all over the country are suffering from the burden of people not having their own form of protection. People have had to turn to Medicaid for relief, and that is a huge problem for taxpayers.

That leaves private insurance, and I think what we need to do is more in the way of helping people understand how it can affect their retirement and to get them to plan for it, and that is exactly what we are doing for thousands of Federal employees now. We are going around the country participating in retirement seminars and trying to carry this message, trying to get them to understand so that they can take some steps to prepare for their future.

Mr. DAVIS OF ILLINOIS. Dr. Smith, if I had known, I cannot say I would have baked a cake, but I would have been pleased to introduce you. We are actually neighbors. I live right on the border of the city.

Dr. SMITH. Right on the border. Well, as it relates to chronic care, I think that the brief answer is that education is something that sounds easy and runs hard, and in discussions with the doctors in our network, they often say, "Well, you have all of the information. You have all of the data, the claims, the pharmacy. Why don't you use it more effectively?"

And so the system I described briefly is really designed to do that, to try to identify those patients, high risk patients, and reach out to them. Nobody calls us and asks us for chronic care management. They call us with problems. They call us with questions. They call us with issues.

And so fundamentally we want to make ourselves available to them 24 hours a day, 7 days a week with real people. We want to provide them with responsive information that is meaningful to them personally, not just general education, and target it at those people that need to make changes, and that is really what chronic care management is about.

As it relates to general lifestyle issues, that is another topic for another day. How do you teach people to do what is right and good for them? I wish I had the answer to that question.

Mr. GAMMARINO. At Blue Cross/Blue Shield, we have some of the very same programs, and one thing we have to deal with today is

that most of our programs are voluntary. So we do have so-called intervention programs for the provider or the member, but it is the member's choice.

Second, what I think we have to focus on with this particular population is that it is a significantly aging population, and they do require medical care. In our standard option program for Blue Cross/Blue Shield, which is our largest program, the average age is 60. They need medical care, and so I think when you deal with the cost issues that are formidable with this program, one thing I think you have to take your hats off to the agency and to the competitive nature of this program over is that it has held the premiums relative to what is happening elsewhere, relatively in check even with a population that requires in many cases significant medical care.

Mr. FALLIS. I think our 400,000 members are fairly well educated on health care, and quite frankly, everything we have in terms of retirement and health benefits come from the Congress. I think you probably will agree that we do a pretty good job at letting you know what we want. I guess our problem is in trying to get from you what we need. [Laughter.]

Mrs. JO ANN DAVIS OF VIRGINIA. We know what you want.

Mr. FALLIS. So I think our people are pretty well educated. It is a work in progress. We have new members coming in every year and so forth.

On Federal long-term care, NARFE took a very active role. As a matter of fact, we were leaders in getting the enactment of that legislation, and my sense is that our members who have an average age of about 74 saw sticker shock when this came out. They had a heightened expectation because the government was involved, albeit administratively, that this was going to be a great bargain for them, and they were disappointed when they finally realized that, you know, they are going to have to pay for all of this.

And so that has been a problem and a disappointment. I think probably most of the members are employees, but I do not know. I cannot tell you what percentage of our members of that 200,000 signed on, but our people understand quite well some of the things that are at risk here and are at stake. We really are very concerned about HSAs.

What it simply comes down to is after 44 years we are talking about changing the rules, and we do have one risk pool. Let anybody tell you differently. It is one risk pool. Universal employee and retiree premiums throughout the history of this program until now, a foot was put in the door a year ago with APWU, and consumer driven plans, and all of these things are nothing more than MSAs which we fought all the way down the line, and we know that once the healthy, the young are siphoned from the program, that one risk pool, what is left in it in those comprehensive plans is going to be driven by the free enterprise system which says the higher the risk, and it will be higher, the higher the premium.

Our people understand this very well. We need Congress to understand.

Dr. FINEBERG. In response to your question, Mr. Davis, I would add the idea of looking to priority conditions that have special promise for closing a gap between where care potentially could

make a difference and where we are delivering and failing to deliver on that potential.

Just a little over a year and a half ago, the Institute of Medicine released a report at the request of the Agency for Health Care Research and Quality identifying 20 conditions which it deemed to be especially promising as areas of attention for closing the quality gap and improving on the performance of the system, and I think it would be a good place to start for our educational objectives.

Mr. DAVIS OF ILLINOIS. Thank you very much.

Mrs. JO ANN DAVIS OF VIRGINIA. Thank you, Mr. Davis.

Mr. Fallis, let's go back to you on the HSAs. I think at least these members sitting up here on this side understand your concerns on the HSAs, and I guess my question to you is, and I think I probably already know the answer, do you believe that OPM has enough safeguards in place if there is any, you know, adverse selection to modify at the FEHBP.

Mr. FALLIS. If they have, I have not heard them. All I have heard, and I have talked to the Director of OPM directly, face to face, and she has said, and I do not like to violate confidences, but this was not given in confidence. She simply said that, you know, she would really fight for Federal retirees, those that are Medicare eligible retirees. That is what we are talking about here.

Our concern is for the long haul though. Who knows who will be Director of OPM 2 years, 3 years, 4 years from now? I do not know.

Mrs. JO ANN DAVIS OF VIRGINIA. I understand.

Mr. FALLIS. We need safeguards. We need statutorial. We need something in the law that covers the situation.

Mrs. JO ANN DAVIS OF VIRGINIA. To make sure the annuitants are not treated any differently than the active; is that what you are saying?

Mr. FALLIS. Pardon?

Mrs. JO ANN DAVIS OF VIRGINIA. You need safeguards to make sure HSAs never enter into the FEHBP or you want safeguards to make sure annuitants are treated the same as active?

Mr. FALLIS. Well, I just would want safeguards that would alleviate this problem that I just spoke of where our fears that the premiums for comprehensive plans would go through the ceiling once we have only left in the comprehensive plans those safe enough to take HSAs.

These are going to be the elderly, the sickly, the unhealthy.

Mrs. JO ANN DAVIS OF VIRGINIA. You know that in the Federal Government we have had hearings on recruiting and retention and so forth, of being able to bring in the best and the brightest into the Federal Government, and I think in our country today that a lot of the private sectors are offering similar things like the HSAs to their employees.

Do you not think that the Federal Government should offer the same thing as the private sector?

Mr. FALLIS. I am not saying they should not offer them, but they should have safeguards for those of us who have paid into the system for 44 years under rules that have existed for 44 years into one risk pool with universal employee/retiree premiums undriven by age and condition. We do not want to see the system changed here

at the 11th hour of our lives and suddenly be faced with insurmountable premium costs. That is our concern.

Mrs. JO ANN DAVIS OF VIRGINIA. I understand. I wanted to make sure I had you clear on the record there.

Dr. Fineberg, let me ask you. Do you believe that the widespread availability of the HSAs will over time endanger the health care system as we know it?

Dr. FINEBERG. Let me respond personally because this is not a subject that we have particularly studied at the Institute of Medicine.

My own belief is that HSAs introduce two types of incentives. As a matter of out-of-pocket expense, they exert a discipline on seeking medical care which is sometimes good, if it prevents over use, and sometimes bad if it prevents appropriate use. So there is a built in disincentive to use care which can have both good and bad effects. How much of each is the uncertainty.

And, second, by virtue of providing an alternative that is more attractive to healthier people or those who believe they are likely to be more healthy, it does provide a kind of adverse selection for the remaining pool who are not part of the HSA.

So from the point of view of effect on a health system, a challenge for a designer is how can you introduce into a system a kind of discipline for the individual in seeking care so as not to pursue frivolous care, keeping the barriers sufficiently low through education and access so that appropriate care can be accessed, and protect the overall affordability for those whose care needs are higher.

That is the trick and that is the challenge that is going to be faced by the FEHBP and every insurance plan that is trying to wend its way through these competing kind of incentives that an alternative like HSA provides.

Mrs. JO ANN DAVIS OF VIRGINIA. I think that has been the $64,000 question today, and everyone is making assumptions because we just do not know.

Let me go very quickly to the long-term care because that is an issue that I hear about. I have 36,000 Federal employees, about half retired and half active in my district, and I will tell you that when I am at NARFE luncheons and speaking to the retired folks there, Mr. Forte, they tell me that the plan is a failure; that they are not accepted, and I think out of—I am just going to throw the numbers out, but it was about this percentage—out of 10 that had applied, 1 was accepted.

Are you concerned? You said you presented the plan to 4 million retirees, 4 million annuitants, and 4 million active, and you said you had 200,000 that were in the plan, and 85 percent were accepted.

Well, if you take the number, and maybe I just have a district of people who are sick because if you take the number in the different luncheons that I have been to, there certainly have not been in those luncheons 85 percent of the people who applied accepted.

Mr. FORTE. It is a difficult subject. Let me see if I can shed some light on it. First of all, I would like to remind the committee that the statute section, 9002, expressly allows for and says that, in fact, no issue will be guaranteed. No coverage will be guaranteed

so as to avoid the occurrence of immediate claims, and furthermore, that higher standards may be applied down the road if it is deemed necessary.

Medical evidence underwriting is a standard feature of Long-term Care Insurance Programs, particularly for retirees. There are probably some 5,000 group plans in place across the United States, from very small ones to large ones. They are all medically underwritten, and if you start a program like this without having some underwriting standards, you will probably find that your experience will be poor. Word that that experience is poor will begin to travel, and you will lose the opportunity to capture larger amounts of people who have an average health profile as opposed to a poorer health profile.

I can tell you that the reasons for declinations stem from people who had serious conditions that would have predisposed them very much to the risk of stroke. Many had serious cardiovascular conditions, 19 percent. Some 27 percent of declinations had severe conditions that were likely to result in an immediate claim. Some people actually were in need of long-term care services at the time that they filled out their application, and there were some questions at the beginning of the application to try to get at that. Ten percent had neurological or several vascular or cognitive impairments.

So what we are seeing is, you know, tremendous pent up demand for the product. People want this product. They have followed the progress of the Federal program in some instances for several years, and I think the fact that it was sponsored by the Federal Government led to expectations that perhaps the underwriting qualifications would be waived or modified.

But if we had done that, we would not have had the opportunity to attract a lot of healthy people from the start source to establish a good, solid risk pool. We want to make sure that we can offer—this is the kind of thing you buy in. You might possibly not use the program for 20 or 25 years. You want to be assured of rating stability.

And so we wanted to make sure that we could get off to a good, strong start. I can tell you that in instances where people are declined, they will come back to us. There are reconsiderations, and a fair number are actually accepted upon reconsideration because a certain amount of time has gone by, and the underwriter feels more comfortable that perhaps he or she has made progress in recovering from some illness.

And there is even an appeal process, and there are numbers of people who actually are able to be accepted in the program after they go through that appeal process. Often it is because we get a vital piece of information that they did not make available to us in the original application process.

Mrs. JO ANN DAVIS OF VIRGINIA. Let me give you an example, one couple, and they looked as healthy as you and I. They were probably in their early 70's. Both had diabetes, but I mean, my sister-in-law has diabetes, and she is falling apart. These two folks looked perfectly healthy, but they were both declined.

Mr. FORTE. Yes. Well, diabetes is a tricky, tricky thing to talk about. You know, if it is insulin dependent diabetic from childhood, you know, that would be grounds for declination. If it is adult onset

and it is controlled by medication and there are not other complications such as heart disease, very high blood pressure, weight problems and so forth, that condition may be accepted.

And in fact, we do accept people who have diabetes, but you know, you have to look at all of the facts, and often when you read the reports that we read from attending physicians, a picture emerges that is different than the one that, you know, may have been described to you over the telephone or in passing and in the hallway.

And you know, we employ experienced nurses who have clinical experience, are soundly trained in underwriting. They understand these conditions. We have physician examiners who are consultants and are specialists in various families of conditions, and they review the applications. We have underwriters from both John Hancock and MetLife who have reviewed some of the tougher applications, and you know, if it is an appeal, our Director, who is very, very knowledgeable, is involved in every single one of those.

But I would just say in conclusion that, you k now, it is a shame that we cannot accept more, but there is a tradeoff between getting a brand new program like this off to a strong start and accepting so many people that you would put the program at risk, destabilize it early on, and then you would have to do something with the rates, and that is something that we all agreed from the start we wanted to avoid.

Mrs. JO ANN DAVIS OF VIRGINIA. One more question, and then Mr. Van Hollen, I was going to go to you. Do you need to go?

Mr. VAN HOLLEN. No, that is OK.

Mrs. JO ANN DAVIS OF VIRGINIA. OK.

Mr. VAN HOLLEN. Thank you very much.

Mrs. JO ANN DAVIS OF VIRGINIA. My ranking member alluded to the fact that at the beginning it was apparently all hashed out a great deal as to the fact you would go with one carrier. That was before my time, obviously.

Do you think that having more than one carrier would make a difference? You know, we heard earlier talking with OPM that, you know, you have all of these choices which keeps the competition and, you know, keeps the rates down, and it is probably not a fair question to ask you.

But if there were more carriers other than you, would it bring the price down? Would there be competition? Would it give choice to the folks and would it be a better program?

Mr. FORTE. At the risk of this statement appearing counterintuitive, I would say no. I do not see how——

Mrs. JO ANN DAVIS OF VIRGINIA. That is what I expected you to answer, but OK.

Mr. FORTE. The making available of another officially sponsored Long-term Care Insurance Program would strengthen what we are doing right now, and the reason is that you want to build a large risk pool coming right out of the gate. You do not want to have separate smaller sort of pods of risk pools that are being independently managed by various consortia. If you do that, then everybody who is doing that will have—there will be more volatility, and I do not think that you would get the same very robust program that

is being offered in the Federal Long-term Care Insurance Program today.

We have one of the most generous informal care benefits on the market, whereby you can have friends and neighbors and family members take care of you, and we will reimburse them.

We have a third party claim appeal process where if you do not like our decision on a claim, you have the right to go to an expert who is an independent reviewer, and that decision, if it goes against us, is ultimately binding on us.

You can get coverage anywhere in the world. There is no war exclusion. There are features. This is the engineering that is beneath the hood that people do not always see on this program. And what I would submit to you, Madam Chairwoman, is that if there were to be a number of smaller risk pools, HMO type arrangements, no one would be able to match the terms that are currently being offered here.

Now, let me just say——

Mrs. JO ANN DAVIS OF VIRGINIA. Because you are new and there is a smaller pool. But down the road if there were 8 million people in it, it would be a different story.

Mr. FORTE. That is right. That is a different story. You know, altogether there probably are not more than about 7 million people who have private long-term care insurance across this vast country, even though products have been available, as representatives from OPM noted earlier, for some 15, 20 years. So you know, there are relatively small numbers of people who have this, and there is no Federal subsidy of any kind.

So people must pay 100 percent of the cost of this, and the challenge is to educate them about the importance of long-term care, the risks that they are under, the difficulty of trying to save on your own, and how much value you can actually get, how this would really be the difference between your being able to maintain your financial security or not at some later point in your life.

Now, if there were to be millions of people who were enrolled in the program, that would be a different thing, and the only other thing I will just close with and say is that we have a lot of competition. There are dozens and dozens of top quality insurers competing for people in your district and all over the country. In fact, many of those agents have reported some good results because we are generating a lot of discussion and a lot of awareness.

I would say that people do have options, but to get the program that they have today would not be possible if you were to break it up and have a dozen separate sponsored plans.

Mrs. JO ANN DAVIS OF VIRGINIA. Mr. Davis, do you have a question?

Mr. DAVIS OF ILLINOIS. Well, just one. Let me make sure that I understood Mr. Gammarino.

Did you actually say that most of the FEHBP carriers are carved out from the cost accounting standards?

Mr. GAMMARINO. Right now we are all carved out, but prior to the administrative waiver by Director James, the intent was that it would only apply to a small minority of carriers which are called the experience rated carriers. That is not the majority of carriers.

The majority are what we call community rated HMOs, which were about 80 percent of the carriers, and they were excluded from the cost accounting standards, and they, like Blue Cross/Blue Shield, have their systems for the FEP program imbedded in their private insurance products as well.

Mr. DAVIS OF ILLINOIS. Thank you.

Thank you, Madam Chairwoman. That is all.

Mrs. JO ANN DAVIS OF VIRGINIA. I just have a couple more questions, and we may have some questions for the record that we may want to submit to you all to get you to answer.

Dr. Fineberg, I am not sure. You have to leave in 5 minutes. So let me ask you real quickly, and you may not know the answer to this. But how do you think the life expectancy—you know, we are living so much longer—how do you think that will affect the Long-term Care Insurance Program? Is that something you could answer?

Dr. FINEBERG. Well, I think actuarially what is interesting about the length in survival, contrary to some earlier expectations is people are also living healthier longer so that actuarial projections about the burden of long-term care and when it occurs, on average, have been improving over time.

Mrs. JO ANN DAVIS OF VIRGINIA. You mean later on in life?

Dr. FINEBERG. Later in life and on average, and, therefore, that is all to the good for the idea of a pooled insurance scheme, but the premise that ultimately a substantial fraction of us will require some form of long term care remains valid, and the only real challenge in this is putting together the kind of attractive package that people in their own interests can find it within their means and sensible for them early on to make that investment. That is the trick.

Mrs. JO ANN DAVIS OF VIRGINIA. I am going to try to get you out of here by 4:15.

Dr. FINEBERG. Thank you. I will try to be brief, too.

Mrs. JO ANN DAVIS OF VIRGINIA. One quick question. Doctors now are practicing defensive medicine, if you will, ordering more tests and things that are really not necessary just to try to avoid potential lawsuits. What do you think that is doing to the cost of our health care system?

Dr. FINEBERG. It is driving costs up, and I believe that our current system of malpractice serves neither the interest of the patients who may be injured nor the interests of medical care very well. This is a separate area obviously, but it is another huge potential area of improvement.

Mrs. JO ANN DAVIS OF VIRGINIA. Well, I am very concerned about our health care system and the cost, and I am going to let you go because I know you have to go, and I am going to see.

Mr. Gammarino, I do not want to do anything to make those other, I forget how many million you said, 88 million folks that are with Blue Cross/Blue Shield, because I am one of those. I am not under FEHBP. We are under a separate one. So I do not want your costs to go up to those folks either.

Mr. GAMMARINO. Thank you.

Mrs. JO ANN DAVIS OF VIRGINIA. That does not mean that I agree with you but—no, just kidding.

I am going to give any of you a chance to say anything else you want to say before we close out.

Dr. FINEBERG. Thank you, Madam Chairwoman.

Mrs. JO ANN DAVIS OF VIRGINIA. Anyone else? Mr. Forte.

Mr. FORTE. I would just like to make one more comment. It is important to note we have established an experienced fund for this program, and if it turns out down the road that, you know, there is, you know, excess premium because of ratings; we have been conservative, it will be possible to enhance benefits or make modifications of one kind or another.

The same thing goes for claims. The carriers cannot benefit because there were fewer than anticipated claims. We are strictly reimbursed according to certain measures for our expenses and for our profit and other elements of experience stay in the fund and ultimately belong to the fund and belong to all of the participants.

Mrs. JO ANN DAVIS OF VIRGINIA. I want to thank you, Mr. Forte. You have given me a lot of answers to questions that I had today that I will be able to carry back to my constituents and be able to explain the situation.

And, Dr. Smith, I thank you for being here today and Mr. Gammarino and, Charlie, it is always good to see you, and with that the hearing is adjourned.

[Whereupon, at 4:14 p.m., the subcommittee meeting was adjourned.]

[Additional information submitted for the hearing record follows:]

OPM Responses to Questions from the House Subcommittee on the Civil Service and Agency Organization Following the Hearing of March 24, 2004, "Oversight of the Federal Employees Health Benefits Program and the Federal Long-Term Care Insurance Program"

I. Federal Employees Health Benefits Program

A. OPM's Long-Term Vision for the FEHBP

- **Please articulate OPM's long-term vision of the FEHBP, in other words, does OPM prefer competition among the fee-for-service plans or just one fee-for-service plan?**

  Our vision for the future of the Program is clear. We recognize the underlying principles of competition and choice within the Program as a model for Medicare modernization, and we intend to keep it a model for group health insurance. In order to do that, we must maintain or enhance competition while at the same time effectively utilizing the purchasing power of a risk pool over eight million strong.

B. Health Savings Accounts

- **At the hearing, Eleanor Holmes Norton asked OPM to provide projections for 5-10 years on participation in health savings accounts. Please provide the subcommittee with this information.**

  Based on the assumption that Health Savings Accounts (HSAs) will be more successful than consumer-driven plans but less successful than the Blue Cross Blue Shield Basic Option, we would estimate an initial enrollment of about 50,000 in the first year. We estimate that there will be some growth in the next few years, possibly bringing enrollment up to 100,000. If the experience with HSAs is similar to the experience with the Basic Option, enrollment will level off after 2 or 3 years. We believe that will be the case because experience has shown that less traditional product types have a limited market in the Federal Employees Health Benefits (FEHB) Program.

- **As discussed at the hearing, many are concerned that HSAs will negatively affect the FEHBP through adverse selection or some other means. Please describe what specific safeguards are in place, or will be in place, in the case of a negative impact upon the program.**

  As you know, the Office of Personnel Management (OPM) sends a Call Letter to the participating plans in the FEHB Program each year giving them guidance for the upcoming negotiations on benefits and rates. The Call Letter clearly establishes the parameters for the upcoming contract negotiations. The guidance we provide in the Call Letter and the positions we take regarding both benefits and rates during the negotiations are based on our perception of how the Program is performing overall, as well as how individual plans within the Program are performing. Because contracts are renegotiated

each year, we are able to seek solutions to problems or concerns that we have identified.

C. Federal Flexible Benefits Plan

- **How many employees have health care FSAs and how much money do they have in their accounts on average?**

  As of March 20, 2004, 117,950 employees have health care Flexible Spending Accounts (FSA). The average account is $1,639.

- **What is OPM doing to heighten employee awareness of the benefits of using a health care FSA?**

  OPM has worked closely with SHPS, the FSA program administrator, to get the word out to employees. Each year there is a section in each health plan's brochure about FSAs and how they can be used to coordinate with the plan's benefits package. SHPS representatives participate in health fairs and agency FEHB service days where they are available to talk directly with employees and answer their questions. In addition, the FSAFeds web site has extensive information on the program along with a calculator to help employees determine an allotment amount.

- **How much money has the Government "lost" in health FSAs to date, that is, in the case of employees who incurred a covered expense and then left the service before their allotments to the Program covered that expense?**

  The Government has not lost any money as a result of employees withdrawing more from their health FSA than they put in. That liability is assumed by SHPS in accordance with their contract. In 2003, 6,172 people withdrew in total $74,314 more than was covered by their allotments.

- **Is the recent increase from $4 to $7.50 for health care FSA administration fees in line with private sector fee increases that other FSA administrators may have put in place, as you have, due to the addition of OTC medicines and products to FSA?**

  There is no basis for comparison to private sector fees. Other employers are responsible for paying all eligible claims as presented. Since they assume all of the risk themselves, there is no need for a risk surcharge. The Government has transferred the risk to the program administrator but indemnified it via the risk surcharge.

- **How much of the $7.50 health care FSA administrative fee does SHPS receive each month and how much is set aside in a reserve fund?**

  SHPS receives $4 a month. The additional $3.50 is a risk reserve surcharge that is

available to SHPS only after OPM's explicit approval.

- **Is SHPS meeting your expectations in providing services for FSA? Has OPM received serious complaints? Praise?**

  SHPS is generally meeting expectations in providing services. Our contract with SHPS includes specific performance standards. Feedback from customers overall is favorable.

- **What percentage of health care FSA claims does SHPS reject? What is the process for appealing such a rejection?**

  In the initial plan year (July 1-December 31, 2003) SHPS processed 111,100 claims for approximately 31,000 participants. SHPS received 12 appeals in 2003.

  There is both an informal and a formal appeals process. Informally, a participant calls or emails FSAFEDS questioning why a claim was partially or totally denied. The Benefits Counselor reviews the claim online. If the Counselor notices an error in how the claim was adjudicated, the Counselor reprocesses the claim.

  If the Benefits Counselor determines that the claim was denied for medical necessity, not covered under the plan, or for services provided before or after the plan year, the Counselor advises the participant of their appeal rights. Formal appeals must be in writing (email and faxed letters are both accepted). There are specific timelines for both parties written into the contract. An independent arbitrator is used for final appeals, and his or her determination is final.

D. Cost Accounting Standards

- **Please explain OPM's position on whether Cost Accounting Standards (CAS) should be applied to the fee-for-service health plans participating in the FEHB.**

  OPM has determined that there are sufficient reasons to grant a waiver for the fee-for-service health plans participating in the FEHB Program. We also have proposed a regulation that would specifically exempt existing fee-for-service contracts from CAS coverage. We have taken those actions because we believe that the CAS should not be applied to contracts under the FEHB Program.

- **If it is your position that CAS should not be applied to such plans, do you believe that the FEHBP already has adequate financial requirements in place to protect the interests of the government?**

Yes, we believe that the FEHB Program already has adequate financial requirements in place to protect the interests of the Government.

We have had statutory oversight and regulatory requirements in place for more than 40 years.

Cost accounting requirements are included in the Federal Employees Health Benefits Acquisition Regulation, which supplement the Federal Acquisition Regulation.

FEHB carriers are required to file annual accounting statements signed by a certified public accountant and certified by the carrier's Chief Executive Officer and Chief Financial Officer, as well as a responsible corporate official of the underwriter, where applicable.

Experience-rated FEHB carriers and their third party servicing agents must adhere to financial and related standards, comply with an FEHB audit guide, and submit to audits by Independent Public Accountants.

OPM has contracted with the experience-rated carriers for at least 20 and in some cases more than 40 years and maintains extensive data on each carrier. Adequate benchmarks are available in the existing systems. Disclosure statements would be superfluous and not cost effective.

The OPM Office of the Inspector General audits health plans on a regular basis.

Carrier contract rates are negotiated annually and are subject to adjustment for audit findings.

- **The percentage of enrollees in Blue Cross and Blue Shield has increased fairly steadily over the past twenty years, is there any point that this might become a danger to the program? Is competition an important facet of the program?**

  Competition is an important facet of the FEHB Program. The increase in Blue Cross and Blue Shield enrollment reflects the marketplace decisions made by the employees and annuitants enrolled in the Program. OPM has made every effort to provide enrollees with viable choices. Two years ago we accepted a proposal to offer a consumer-driven or HRA-based product. Last year we accepted two additional plans based on that model. We have announced our intention to entertain proposals for an HSA/HRA-type product for 2005. Within the provisions of our statutory authority, we will continue to seek ways to give consumers choices so they can determine how best to spend their healthcare dollars and meet the needs of their families.

E. Cost Containment

- **What can Congress do to help OPM to enhance cost-containment and improve the quality of the FEHB Program?**

  OPM and the Congress have worked together throughout the history of the FEHB Program to enhance cost-containment and improve quality. However, the structure of the Program relies primarily on the market to drive both effectiveness and efficiency. One of the Program's strengths is the breadth of the statutory requirements, mirrored in regulations that are prescriptive to the minimum extent feasible. We have no specific proposals for legislative changes at this time but will continue to be alert to any opportunities.

- **Would you like to have authority to carve out specific benefits from the comprehensive plans?**

  OPM is not considering any program-wide benefit carve outs at this time. Many of the health plans carve out the administration of certain benefits such as prescription drugs or mental health. However, this is an individual plan decision and is plan specific.

- **Would you like increased authority to terminate the participation of plans that do not meet quality and enrollee satisfaction criteria and to reward those plans that do meet the criteria?**

  We are aware of the extensive purchaser interest in pay for performance and are researching the various approaches. The incentive systems that we are aware of are generally in the pilot/demonstration stage. We will continue to monitor these programs to determine which approaches might be viable in the FEHB environment. We think it is premature to ask for any specific authority at this time.

F. Miscellaneous FEHBP Issues

- **What percentage of Federal employees and annuitants are NOT insured under the FEHB Program? And what percentage of them do you estimate have not enrolled because they are unable to afford coverage, as opposed to being covered by a spouse, for example?**

  The percentage of those eligible but not enrolled has remained consistent at 15 percent for many years. The data we have available indicate that less than 3.5 percent are not enrolled because they say they cannot afford the coverage.

- **Does OPM have any analysis, to date, of the effect on the FEHB Program of offering consumer-driven plans? Has it saved money, has it led to adverse selection, or have**

participants been happy with these plans?

The consumer-driven plans have not been offered long enough to reach any conclusions about their impact on the Program. At this time their enrollment is too small to generate savings or lead to adverse selection. Overall, participants appear to be satisfied for them. Those who are not can change plans during the upcoming open season.

- **At the hearing, Eleanor Holmes Norton requested that OPM provide the subcommittee with information regarding the increases in health care premiums for Fortune 1000 company employees since 2000. Please provide the subcommittee with this information.**

Attached is a 5-year FEHB premium chart, as well as aggregated data from other employer sources. We do not have information broken out by size of employers, as the question was phrased. However, the surveys and reports we use (for instance those by Milliman, Hewitt, Hays, and others) are industry-wide and nationwide and serve the same purpose. You will see in each of the last 5 years that the FEHB Program has seen smaller increases in all years, often by significant percentages.

FEHB Rate Increases for the Past 5 Years

Year	(%)
2004	10.6
2003	11.1
2002	13.3
2001	10.5
2000	9.3
1999	9.5

2000

Watson Wyatt Worldwide - 12.2% for employees, 13.3% for Medicare retirees
Hewitt Associates - 14%
Corporate Research Group - 11 to 12%
California - 12.9% (9.2% HMO, 20% PPO)
Maryland - 9.6% HMO, 12% PPO
New Jersey - double digit
Eagle County, Colorado - up to 57.5%
Wisconsin - up to 17.5%

Minnesota - 19%
North Dakota - 24%
New York Times (Sept 6) - 10 to 30%

2001

California Public Employees Retirement System (CalPERS) - 15.5%
Midwest Business Group on Health - Increases between 10% and 20%
Texas state employees - HMO increases between 22% and 25.5%
Minnesota state employees - 14%
Large automobile manufacturer - HMO increases betw/ 15.2% and 17.5%
Large telecommunications company - 13%

2002

California Public Employees Retirement System (CalPERS) - 15.5%
Hewitt Associates – 15.3%
Washington Business Group on Health – 14%
Mercer Human Resources Consulting – 12.7%
Kaiser Family Foundation -- 12.7%

2003

California Public Employees (CalPERS) HMOs- 25.1%
Texas state employees – HMOs – 16%
Large automobile manufacturer – HMOs – 13.99%
Hewitt Associates average HMO increases - upwards of 20%
Milliman USA HMO plans - 17% Nationwide and 19% in the DC area
Mercer Human Resources Consulting – 12%-15%
Washington Business Group on Health – insured plans - 18% in DC area
Pacific Business Group on Health -- HMOs – 25%
Midwest Business Group on Health – HMOs – 18.7%

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California Public Employees Retirement System (CalPERS) HMOs - up 16.7 % to 18.4%
Large manufacturer – 11%
Hewitt Associates average HMO increases – 18%
Milliman USA HMO plans - 14% Nationwide
Hay Group -- 15%
Midwest Business Group on Health – HMOs – 16%

II. Federal Long-Term Care Insurance Program

- **Competition among carriers for new customers is one of the defining features of the FEHBP, yet there is no competition in the Federal Long Term Care Insurance Program since there is essentially only one carrier (Long Term Care Partners). Why did OPM establish a contract with only one carrier when the FLTCIP was created in 2000? Is long term care insurance significantly different from standard health insurance, such that a non-competitive program is the best option?**

  The Federal long term care insurance program (FLTCIP) is significantly different from health insurance in several ways. Because of those differences, our research of insurance industry practice clearly demonstrated that virtually all employer sponsored group long term care insurance plans are offered by a single carrier. Since participation in the Program is voluntary, with no Government contribution toward premiums, and based on the experience of others, we anticipated correctly that the participation rate would be far lower than for the health insurance program. Therefore, we determined that to leverage the buying power of the group as well as to establish a viable risk pool, a single contract would provide the best value for the Federal family.

- **Has OPM considered opening up the FLTCIP to competition by including another carrier in the program besides Long Term Care Partners? What about adding two or more carriers? Should we open up the competition every two to three years?**

  We do not believe that it is a good idea to open up the FLTCIP to competition by including another carrier in the program besides Long Term Care Partners, nor do we believe it would be a good idea to add two or more carriers or to open up the competition every two to three years. The most critical element in a long term care insurance program is stability. Unlike health insurance which, for many people, is used to some extent every year, long term care insurance generally is purchased many years before its anticipated or actual use. Rate stability and the continued integrity of the product are key to ensuring

that members receive good value in the long run. However, we and Long Term Care Partners recognized from the very beginning that the FLTCIP could not be a "one size fits all" Program but had to be flexible to meet the very diverse needs of the very broad and diverse group of eligibles. As a result, the Program's single carrier offers over 500 different plan designs and facilitates modeling the various combinations of benefits levels and premiums on its web site.

- **With just Long Term Care Partners in the FLTCIP, how does OPM ensure that federal employees are receiving high-quality service for long-term care insurance?**

  Performance standards were incorporated into the contract between OPM and Long Term Care Partners. OPM monitors performance against those standards on an ongoing basis. The FLTCIP provides some services that are unique. For example, Long Term Care Partners provides care coordination services not only to enrollees but also to the qualified relatives of those who enroll. This benefit is invaluable to those members of the Federal family who are beginning to assume responsibility for the care of the older generation. Our contract with Long Term Care Partners also includes a unique independent appeals process that ensures that claims are adjudicated properly in accordance with the contract.

- **How are federal employees benefiting from participation in the FLTCIP rather than through purchasing long-term insurance on their own in the private sector?**

  They have the advantage of participating in a group contract administered by OPM. In addition to the extensive educational campaign required under the statute and the contract, OPM oversight has ensured financial stability, quality service, and choice of benefit levels. They also benefit from the exceptional care coordination services available under the FLTCIP. Finally, unlike most competitive plans, the FLTCIP includes international benefits and does not have a war exclusion.

- **At the hearing, Danny Davis requested an update on the corrections under the Long Term Care Security Act for people placed in the wrong retirement program. Please supply the subcommittee with this information.**

  As of June 24, 2004, we received approximately 11,000 applications. Out of the 11,000 about 6,000 were found to be eligible under the Federal Erroneous Retirement Coverage Corrections Act. The Center for Retirement and Insurance Services at OPM is in the process of correcting about 1,500 retirement cases which should be completed in the next 5 to 6 months. OPM has recently issued a RFP to solicit a contractor to process about 4,500 employee cases. The employees' caseload will probably be completed by March 2005.

III. What are the number of annuitants enrolled in FLTCIP? What about active enrollment in FLTCIP?

As of the end of February 2004, the FLTCIP had over 201,000 enrollees. Annuitant enrollments constitute a full third of all FLTCIP enrollments. As of the end of February, we had 69,300 annuitant enrollees, with an average age of 64. Of those, 62 percent are annuitants, 31 percent are annuitant spouses, and 7 percent are surviving spouses. Of note, the high interest of annuitants in the FLTCIP is gratifying and somewhat atypical of employer-sponsored group long term care insurance enrollments, where annuitant participation is usually under 10 percent.

Active employee enrollments constitute 63 percent of all FLTCIP enrollments. As of the end of February, we had 127,600 active employee enrollees, with an average age of 52. Of those, 74 percent are active employees (Federal Employees, US Postal Employees, and Members of the Uniformed Services); 26 percent are active employees' spouses.

IV. What is the number of rejections (declines) due to underwriting in FLTCIP?

Unfortunately, not all annuitants who want to enroll can be accepted for coverage due to health conditions that put them at a greater than average risk of needing long term care services in the immediate future. A number of applicants suffer from serious health conditions that could result at any time in stroke, paralysis, cognitive impairment, or other conditions that would affect their ability to function independently. LTC Partners does not employ a single underwriting standard. Rather, an individual's health status is assessed relative to the expected health status for individuals in the same age group. Perfect health is not required; persons with serious conditions like diabetes and arthritis can be accepted. But such persons must demonstrate that they do not suffer from co-morbid conditions or have other conditions that put them at a higher than average risk of needing benefits in the foreseeable future.

The approval rate for FLTCIP for those filling out abbreviated underwriting applications is 99 percent. (Abbreviated underwriting was available to all actively-at-work employees and active members of the uniformed services and their spouses during Open Season in 2002. It is also available to all newly eligible persons and their spouses and newly married spouses of employees for 60 days.) The FLTCIP approval rate for those filling out the full underwriting form, which is required for all other eligible groups, including annuitants, is 63 percent. The Program's combined approval rate for all applicants, both those subject to abbreviated underwriting and those subject to full underwriting, is 84 percent. This compares favorably with long term care insurance industry approval rates.

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