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TESTIMONY OF

Blue Cross & Blue Shield Association
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Before the

Subcommittee on Oversight of Government Management,
the Federal Workforce, and the District of Columbia
Committee on Homeland Security and Governmental Affairs
United States Senate

On

"Up, Up, and Away! Growth Trends in Health Care Premiums for Active and Retired Federal Employees"

Presented by:

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Mr. Chairman and Members of the Subcommittee:

Good morning. Chairman Akaka, Ranking Member Voinovich, and Members of the Subcommittee, I am Stephen Gammarino, Senior Vice President, National Programs, of the Blue Cross and Blue Shield Association. Thank you for this opportunity to discuss premiums in the Federal Health Benefits Program with the members of the Subcommittee. We appreciate your interest in the FEHBP and look forward to working with you and the Subcommittee to address this and other issues that are so important to the federal employees and retirees who rely on the FEHBP for their health care coverage.

The Blue Cross and Blue Shield Association and participating independent state and local Blue Cross and Blue Shield Plans jointly administer the government-wide Service Benefit Plan in the FEHBP. 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 health insurance to more than 4.7 million active and retired federal employees and dependents. 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 believe we have been so successful in this program because, in large part, federal employees and retirees recognize our commitment to offering high-quality, affordable health care coverage. Our goal is to ensure that the right person gets the right treatment at the right time, and we work hard to do that while maintaining competitive rates.

Factors Affecting Premiums

There are a number of factors that affect FEHBP premiums. One factor benefiting federal employees and retirees is the very structure of this market-oriented, employer-sponsored program in which risk-bearing carriers compete with one another for each individual employee's or retiree's business. This retail competition and the fact that all of the competitors are at risk compel carriers to develop actuarially sound products that offer attractive benefits at competitive prices. Through their own choices, enrollees help to keep premiums in check.

Federal employees and retirees have also benefited from the Office of Personnel Management's responsible management of the Program. OPM's sound stewardship and its focus, as the employer's agent, on maintaining the FEHBP as an attractive employment benefit to assist the federal government in recruiting and retaining a well-qualified workforce, have contributed significantly to the FEHBP's reputation as a model employer-sponsored health benefits program.

Congress has also played an important role in the success of the FEHBP through its oversight role. I especially commend Congress for largely, and wisely, refraining from imposing too many mandates on the FEHBP. Each mandate

looks attractive when viewed in isolation. But as a whole, mandates deprive OPM and carriers of the flexibility they need to keep pace with the dynamic health care market and to deploy their resources in ways that most effectively respond to our customers' values and needs.

The FEHBP is, of course, integrally tied to our private health care industry. Federal employees and retirees see the same doctors and hospitals as their neighbors who work for private employers. Accordingly, the FEHBP is also affected by the same forces at work in health care in general.

These forces include increased utilization of prescription drugs and provider services, advances in medical technology and drug therapies, national demographic trends, and customer expectations.

One feature of the FEHBP that we should also keep in mind is that the nationwide fee-for-service plans, such as the Service Benefit Plan, offer uniform rates across the country. Any federal employee or retiree can enroll in any FEHBP plan and can switch to any other carrier during annual open seasons. All enrollees in a plan pay the same rates and receive the same benefits. The Service Benefit Plan also is required to be the insurer of last resort in the FEHBP.

The FEHBP is also affected by the demographics of the federal population. Retirees make up 46.1 percent of the FEHBP, and 47 percent of the Service Benefit Plan. In 2006, the average age of contract holders in the Service Benefit Plan's Standard Option, our largest plan, was almost 61, and Basic Option was over 45.

The Rate Setting Process

Each year OPM issues a call letter to all competing carriers in which the agency lays out its policies and expectations for the FEHBP in the coming year. Each carrier then develops its own proposals for rates and benefits. (In fact, we will be submitting our rate and benefit proposals at the end of this month.) In formulating those proposals, carriers will take into account the policies and expectations announced in the call letter, the values of its members, and its own projections for the costs of providing the benefits it is proposing. Carriers' projections are informed by its own analysis of historical utilization and costs, but carrier actuaries must also factor in assumptions about future prices of various health care services and expected utilization.

The carrier will also factor in its reserve position. In addition, of course, each carrier must keep a wary eye on the competitive landscape that it faces.

OPM will analyze those proposals, and then the carrier and the agency will negotiate the final benefit package and premium rates. A carrier's final rates also include statutorily required contributions to the contingency reserve maintained in

the U.S. Treasury for that carrier and to defray expenses OPM will incur in administering the FEHBP.

2007 Rates for the Service Benefit Plan

I am very pleased that this year, for the third consecutive year, there was no change in the premiums for our Basic Option. Additionally, the individual's share of the premiums for our Standard Option, which covers almost 4 million people, actually declined slightly, and the total premium increased by only 1 percent.

I am even more pleased that we accomplished this while maintaining generous benefits. In fact, we have added significant enhancements to our benefits. For Standard Option, these include better coverage for chiropractic services and acupuncture, more generous ambulance coverage, and improved coverage for routine physicals and cancer screenings. For Basic Option, we have eliminated $40 co-payments for diagnostic or psychological testing related to mental illness or substance abuse and diagnostic tests at outpatient hospital or surgical centers, and we improved maternity benefits.

As the members of this subcommittee know, the FEHBP Act expressly provides that funds in a carrier's contingency reserve may be used to stabilize premiums. We were able to use our reserves to stabilize our premiums for 2007.

Quality Initiatives

I would also like to review for the Subcommittee several initiatives designed to improve the quality of health care our members receive.

Care Coordination

Working closely with OPM, we are developing a member-centric program, called Care Coordination. Care Coordination applies health information technology to an integrated database in order to improve our members' ability to receive higher quality health care.

Care Coordination focuses on those with chronic conditions, diabetics for example. Under it, we will use claims data, including prescription drug information, and information from enrollment forms to identify those members who would benefit from our Plans' disease or case management programs. We will then work with our local Plans to educate those members about the benefits of such programs and, we hope, persuade them to take advantage of the appropriate program.

We anticipate that all Plans will be part of the Care Coordination program by 2008. Our objective for this program is to enhance the health care received by

those who need it most by strengthening their ability to manage their medical conditions.

Blue Distinction[SM]

Blue Distinction is a nationwide program of the Blue Cross and Blue Shield companies to help foster the development of a more consumer-centered, knowledge-driven health care system. Blue Distinction is an important step toward providing health care consumers with cost and quality information similar to what they expect before buying most other goods and services.

By encouraging a much deeper level of transparency, Blue Distinction intends to (1) encourage and empower consumers to make more informed decisions about their health care; and (2) collaborate with providers to make health care more affordable and enable members and providers together to improve quality outcomes.

Consumers will have access to the information necessary for sound decision making through Blue Distinction's:

- special care centers (bariatric surgery, cardiac care, and transplant services), which are leading institutions identified in collaboration with providers across the country that meet clinically valid standards and deliver better outcomes;

- nationwide hospital measurement and improvement program, which draws together data from the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality on common conditions such as heart attacks, heart failure, and pneumonia; and

- transparency demonstrations in which Blue Plans work with hospitals, physicians, and medical groups to test the most effective ways of bringing information on health care quality and costs to consumers.

Blue Distinction, we believe, will lead to healthier lives and, over time, lower healthcare costs as patients and doctors interact with one another.

Comparative Effectiveness

One of the most fundamental drivers of cost increases is the fact that almost 30 percent of expenditures in our current health care system is for ineffective, inappropriate or redundant care. The dearth of evidence based medicine results in patients receiving suboptimal care – and paying more for it. Only about 54

percent of acute care delivered and 56 percent of chronic care delivered by physicians follows guidelines from medical literature.

BCBSA believes this root problem is causing many of the headliner issues of today: increasing uninsured levels and decreasing affordability for those with insurance. To address these core problems, BCBSA has proposed a legislative initiative to create a new independent institute to support clinical research comparing the effectiveness of medical procedures, drugs, devices, and biologics. The institute would disseminate its findings to providers, and in reader-friendly form to consumers. Providers that follow the institute's findings would receive special malpractice protections. BCBSA believes this approach would ultimately be the best path to assuring that affordability returns to health care while maximizing quality of care. We believe the institute should be funded by both public payers – like Medicare and Medicaid – as well as private payers.

Conclusion

Let me assure the Subcommittee that we are committed to providing federal employees, retirees, and their families affordable coverage so they may obtain high-quality healthcare. We look forward to working with OPM and Congress in order to achieve that goal.

This concludes my prepared remarks. I would be pleased to answer any questions you may have.