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TO 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

HEARING ON FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) PREMIUMS

MAY 18, 2007

Mr. Chairman on behalf of our nation's 4.6 million federal employees, retirees and survivors, I appreciate the opportunity to express the views of the National Active and Retired Federal Employees Association (NARFE) on Federal Employees Health Benefits Program (FEHBP) premiums.

Chairman Akaka, NARFE commends you for requesting the Governmental Accountability Office (GAO) report we are considering today and for your leadership on trying to help federal employees and annuitants shoulder higher health care costs. Indeed, we were pleased that you specifically asked the nonpartisan GAO to determine how FEHBP premiums would have been affected had the Office of Personnel Management (OPM) applied for a payment provided under the Medicare Modernization Act of 2003 (MMA).

Section 1860D-22 of the Medicare Modernization Act provides that all employers who provide drug coverage to their retirees age 65 and older, at least as generous as the new Medicare Part D prescription drug plan, are eligible to receive a subsidy of 28 percent of the per enrollee cost for drug coverage.

GAO found that premium growth in one of the largest FEHBP plans with a high share of older enrollees could have been 3.5 to 4 percent lower in 2006 had the payment been accessed. Additionally, the payment would have lowered the growth in premiums across all FEHBP plans for 2006 by more than 2 percentage points on average, from 6.4 percent to about 4 percent. GAO also wrote that, "Absent the drug subsidy, FEHBP premiums in the future would likely be more sensitive to drug cost increases than would be premiums of other large plans [state and

local government and private employers] that receive the retiree drug subsidy for Medicare beneficiaries." The report said that prescription drug costs accounted for 34 percent of the increase in total expenditures per enrollee for the five largest FEHBP plans – the single largest cost driver between 2003 and 2005.

NARFE has long held that FEHBP is the best group health insurance plan in America today and should serve as a model for others. Even in years of double digit rate hikes, we have said that OPM – on behalf of the government as an employer-- does a better job negotiating premium increases than any other employer. The GAO report affirms this fact. But we can't say that everything is being done to contain premium growth if more than $1 billion is left on the table every year.

We are bewildered by the action (or, more appropriately, inaction) of the Federal Government as an employer not to take advantage of a $1 BILLION subsidy to which its health plan is entitled.

Are we to let politics trump sound public policy and practice – policy that was likely advocated by civil service career professionals charged with administering the Plan?

NARFE understands all too well "budget parlance". Our members, including your active and retired colleagues, have long been "parlanced" through the loss of benefits – delayed and eliminated COLAs, pay absorption, and alternative pay plans.

The goals of the Federal Government as an employer should be to attract and retain the best and the brightest to serve this country. In doing so, we must be a competitive employer. OPM, as the chief steward of the civil service must keep its focus on that goal in decisions affecting our competitive edge.

You, as leaders, have the power to promote the integrity of our civil service and our capacity to recruit and retain the workforce needed to inspect our ports, protect our food, air, and water, and support our seniors, our children, and our working families.

Most NARFE members, by tradition, are retirees. Our time in direct service to the nation has passed. Certainly, we will always be vigilant in our efforts to protect our earned benefits from our time of employment and to seek equity with our colleagues, retirees, and active civilian and military personnel.

But our responsibility, as yours, lies in the ability of our government to follow in our footsteps of not just competent, but superlative, support of our citizens and our government. Any and all actions should be taken with that mission in mind. We owe it to our legacy and we owe it to the American taxpayer.

Recognize that this decision also was denied the United States Postal Service, acting as a business with a quasi-governmental mission, access to the payment which would benefit its competitive status and its ratepayers, including you and me.

The government's action in this regard, repeated, does not support sound business practice. And we ALL suffer.

Federal workers, retirees and survivor annuitants, who often struggle to pay their steadily increasing premiums, cannot understand why the federal government has failed to do what so many other employers have done to reduce this burden, especially when state and local governments do not think twice about accepting the payment.

The Administration's Objections

OPM has cited two reasons for the Administration's decision to forgo the payment.

First, they have said they did not need to take advantage of the payment since they had no plans to significantly change the drug coverage of federal annuitants age 65 and older. It is fair to say that other public and private employers who had no intention of reducing or ending their retiree drug benefits decided to apply for the payment anyway. Certainly, the Centers for Medicare and Medicaid Services (CMS) does not withhold the payment based on what they think an employer's behavior will be in response to the Medicare drug benefit and the employer payment. Stockholders and employees would be understandably furious if their company did not avail themselves of anything that could contain health care costs without sacrificing coverage.

Second, OPM claims that they do not believe it is appropriate for the federal government to be paying itself for this purpose. Nonetheless, what they do not say is that payments to OPM,

unlike other employers, would not result in a spending "outlay" under federal budget rules, since they remain within the government. Such "intragovernmental transfers" are not unusual. In fact, the federal government pays itself for the future retirement obligations when federal agencies make contributions from their appropriated salary and expense accounts to the on-budget retirement trust on behalf of their employees.

We also wonder why the Administration chose not to object to the payment much earlier in this process. NARFE announced on June 17, 2003 that we would oppose the version of the Medicare Prescription Drug bill that was about to go to the House floor because of concerns that employers, including the federal government, might dump retiree drug coverage in response to the creation of a Medicare drug benefit. Then-Ways and Means Committee Chairman Bill Thomas and Health Subcommittee Chairwoman Nancy Johnson responded by clarifying in the House-passed legislation that the federal government, as an employer, would be eligible for the prescription drug subsidy payment. Their change not only survived the legislative process, it was enhanced when state and local government also were made eligible for the payment.

At no point during the consideration of MMA did the Administration oppose including the federal government among the eligible employers. Indeed, OPM and CMS staff met in 2004 to discuss how OPM would receive the employer subsidy and made arrangements to ensure that payments to OPM would be considered an intragovernmental transfer. That is why OPM's announcement in the 2005 FEHBP "call letter," that the Office would not apply for the payment came as a surprise and disappointment to us.

OPM has also said that the payment is unnecessary since FEHBP is already "heavily subsidized".

NARFE objects to this characterization because it implies that the benefits federal employees and retirees earn is really welfare. The "government contribution," which is the statutory term used to describe the FEHBP employer premium share, is no different from any other form of earned compensation, like wages and retirement benefits. Moreover, we think that the government would want to exercise the option of lowering the worker share of health premiums to help attract a talented and skilled workforce, particularly as we respond to the human capital shortage precipitated by a growing wave of federal retirements.

NARFE is also concerned that the Administration's decision to forgo the payment further stacks the deck against federal workers whose jobs are considered for contracting out to the private sector. Contracting out decisions are based on an assessment of the cost of having the government continue to perform a specific function against moving that work to the private sector. For that reason, private contractors who use the Medicare employer payment to lower their health insurance costs have an advantage in such competitions over federal agencies, who by Administration policy, are barred from doing the same.

FEHBP "Fair Share" Premium Formula

Mr. Chairman, the GAO report you requested also attempted to evaluate the performance of the FEHBP "Fair Share" formula, developed by OPM, Congress and NARFE in 1996 and 1997.

Fair Share was intended to maintain a consistent level of government contributions as a percentage of total program costs, regardless of which health plan enrollees elect. For that reason, we have been concerned whenever the percentage increase in the enrollee premium share is disproportionately higher than the government contribution. For instance, in 2006 the enrollee share of a family Blue Cross/Blue Shield standard option premium increased by 14.85 percent while the government/employer contribution grew by only 5.76 percent. The formula should minimize the proportionate cost hikes between what enrollees and the government pays.

Under Fair Share, 72 percent of the program-wide weighted average of all 284 plan premiums determines the government contribution. The government as employer pays a larger percentage of any FEHBP plan (up to a 75 percent cap) with lower premiums and it pays a smaller percentage of plans with a higher rate.

In response to several years of double digit increases, the demand for lower cost FEHBP plans has increased. This has been helpful to some workers and annuitants who want to cut costs. Lower wage and younger workers naturally gravitate to lower cost plans. However, since the government/employer contribution is set by a "weighted average" of all premiums, large enrollment shifts to less expensive plans could lower the overall amount the government pays and increase the percentage share which enrollees pay in moderate to high cost plans.

In many instances, the higher cost plans have more comprehensive coverage and better provider access than lower cost options. As a result, individuals with greater health care needs tend to remain in higher cost plans and the opposite is true for healthier persons. With fewer healthier

enrollees, consequently, greater claim experience with the higher cost plans contributes to higher premiums. In fact, carriers have withdrawn some “high option” plans when their premiums became too expensive. With the departure of high option, we fear that “standard option” (and with it, consumer choice) may suffer the same fate. While NARFE understands why more efficiency is necessary, we are troubled such a focus on cost consciousness could mean “a race to the bottom” where workers and annuitants are limited to plans with less coverage, smaller provider networks, and greater cost sharing in terms of more and more out-of-pocket costs in addition to plan premiums.

This situation would deteriorate more rapidly if the present 75 percent limit on the FEHBP government contribution were eliminated. Under Fair Share, 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 an even stronger incentive to younger, healthier employees and would lead more enrollees to congregate in the no-cost plans. Consequently, adverse selection costs would be shifted to enrollees in all other plans, increasing enrollee costs and effectively limiting consumer choice.

Health Savings Accounts

Although traditional lower cost managed care insurance could drive up the enrollee premium share, no option has more potential for separating healthy from sick enrollees than the

combination of a Health Savings Account and High Deductible Health Plan (HSA/HDHP). Healthier enrollees tend to be attracted to HSAs and other consumer-driven financing schemes because, as low health care users, they can be rewarded with unspent balances or credits at the end of each year.

Less healthy enrollees avoid HSAs and consumer-driven plans because they could pay thousands of dollars in out-of-pocket costs. As a result, higher volume health care users are more likely to stay in traditional comprehensive plans. This phenomenon, called "adverse selection," forces traditional insurance plan carriers to raise premiums, cut benefits or both. NARFE's concerns about HSAs were confirmed by a January 2006 GAO report, which found that HSAs tended to attract younger and wealthier FEHBP enrollees.

In addition, the nonpartisan Employee Benefit Research Institute (EBRI) December 2005 report found that individuals with HSAs are "significantly more likely to spend a larger share of their income on out-of-pocket health care expenses than those in comprehensive plans" and that they were "significantly more likely to avoid, skip or delay health care because of cost than those with more comprehensive health insurance."

In 2006, only 0.2 percent of FEHBP participants were enrolled in an HSA or similar plan. If HSA enrollment continues to be low, the controversial options will have minimal effect on comprehensive plans. However, without precautions against HSA-inspired "risk selection," the new plans could result in higher premiums and less benefits for the FEHBP's comprehensive

insurance if larger numbers of healthier enrollees migrate to HSAs. Ultimately, this would be the death knell for fee-for-service plans and many traditional HMO plan products.

The Administration's FY 2008 budget would give lackluster enrollment in HSAs a jump start by allowing Blue Cross/Blue Shield (BC/BS) to offer the controversial option in FEHBP.

In fact, the federal law which authorizes the FEHBP stipulates that one government-wide "Service Benefit Plan" offers two levels of benefits. BC/BS is the Service Benefit Plan. The budget recommends that the FEHBP law be amended to allow the Service Benefit Plan to offer three, instead of two, benefit levels which would enable BC/BS to offer a government-wide HSA/HDHP.

BC/BS's current health plans are the largest and most popular in the FEHBP. As a result, the insurance carrier's brand loyalty and considerable marketing resources could significantly increase HSA enrollment in FEHBP if they decided, and were allowed, to offer such an option.

What is new about this recycled proposal is that, in addition to BC/BS, the Administration says that the "Indemnity Benefit Plan" should provide HSAs as a system-wide option.

Despite being named in the law which authorizes FEHBP, the Indemnity plan has not been available since the Aetna left the FEHBP in 1990. Legislation would be necessary to enable the long dormant plan to offer HSAs.

The entry of a second large insurance carrier with an HSA option available to most enrollees could also boost participation in HSAs.

NARFE opposes further expansion of HSAs because they could increase premiums for comprehensive plans since relatively healthy enrollees with higher incomes would be siphoned off into HSAs.

Mature and Older Enrollees

While GAO found that prescription drug cost and utilization of services were the highest cost contributors in all FEHBP plans, they reported that demographics had a greater effect on higher cost plans than less expensive options. We believe that trend is true for two reasons.

First, as individuals age and use more health care, they have a greater need for access to the physicians of their choice and comprehensive coverage than younger enrollees. That means they tend to enroll in fee-for-service plans which usually cost more than managed care options. Second, some annuitants age 65 and older join a higher cost plan, even when a more moderately priced option is available which would provide the same level of benefits when their FEHBP plan is coordinated with Medicare coverage. For example, some retirees stayed in what used to be Blue Cross/Blue Shield "high option" despite the fact, that when it was combined with Medicare Parts A and B, high option offered no added value over the less expensive "standard option". That is why for years NARFE has helped Medicare-participating annuitants determine whether their level of coverage is appropriate.

Age is rarely a determining factor regarding whether individuals make the best decisions about their health plan choices. Indeed, the turnover rate in FEHBP plans continues to remain about two percent a year. Some enrollees remain in plans even though they might be able to find other options with lower premiums and equivalent coverage and provider access.

In any event, the higher utilization of health care by older enrollees is a well-documented reality of what happens to us as we age. Most annuitants started their careers in federal service when they were younger and healthier and paid more into health insurance than they got out of it. Now that they have retired, some of them get more out of health insurance than they pay into it. This "contract between generations" has been a fundamental principle of group health insurance for decades. For that reason, we must accept the reality that an aging workforce and 2.3 million annuitants will have a definite impact on premiums. And, we honor this obligation because it was, and is, earned by federal workers who served their country.

NARFE strongly believes that the cost of providing health care to older enrollees could be mitigated if: (A) the Administration agreed to apply and accept the Medicare employer payment and (B) FEHBP plans were finally allowed to buy prescription drugs for their enrollees at the discount mandated by the federal supply schedule (FSS).

Indeed, OPM proposed in 2000 that the Special Agents Mutual Benefit Association (SAMBA), an employee organization FEHBP plan, be allowed to buy drugs off the Federal Supply Schedule for their participants, as part of a two year demonstration program to determine if the

arrangement was feasible for other FEHBP carriers. The agency cancelled the pilot project, not long after it was announced, due to the pharmaceutical industry's refusal to participate. Drug companies argued they did not have to provide SAMBA drugs at the Federal Supply Schedule discount because, unlike Department of Defense and the Department of Veteran's Affairs, the employee organization plan, while part of FEHBP, was not a government agency.

Given substantial congressional support for allowing Medicare to directly negotiate drug prices, it is time for this committee to revisit using the same leverage to make prescription drugs less expensive in the FEHBP.

Conclusion

For 47 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 continues to be challenged by persistently higher health care costs. I can assure this committee that adequate, affordable health care coverage is of paramount importance to workers and retirees. NARFE stands ready to work with this panel, others in Congress, the OPM and the FEHBP insurance carriers to find the ways and means to contain out-of-control health care costs without sacrificing quality, and to ensure that the federal family has access and coverage, without resorting to proposals that only shift costs to enrollees, or circumvent risk sharing in our group plan environment.