BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

TESTIMONY OF

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

Before the

Subcommittee on Federal Workforce, U.S. Postal Service and the Census
Committee on Oversight and Government Reform
United States House of Representatives

On

"The Federal Employees Health Benefits Program: Is It a Good Value for Federal Employees?"

Presented by:

William A. Breskin
Vice President, Government Programs

Thursday, April 11, 2013

Mr. Chairman, Ranking Member Lynch and Members of the Subcommittee:

Good morning. My name is Bill Breskin, and I am Vice President for Government Programs at the Blue Cross and Blue Shield Association. Thank you for this opportunity to discuss the value of the Federal Employees Health Benefits Program (FEHBP) for federal employees. We look forward to working with members of the Subcommittee to ensure federal employees and retirees continue to have high quality, affordable health care coverage.

The Blue Cross and Blue Shield Association and participating independent local Blue Cross and Blue Shield Plans jointly administer the government-wide Service Benefit Plan in the FEHBP. We 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 5.2 million active and retired federal employees and dependents. Last year—for the second consecutive year—premiums for our most popular option increased by only two percent. We are proud that millions of federal employees select Blue Cross Blue Shield for our affordable premiums, high level of customer satisfaction, low administrative costs and constant innovation.

My testimony covers two areas: (1) the value of the FEHBP and Blue Cross and Blue Shield's strong track record in serving federal employees; and (2) our perspective on proposed changes to the program, including the addition of regional PPOs and proposals to consolidate contracting for prescription drug benefit management.

Value of the FEHBP

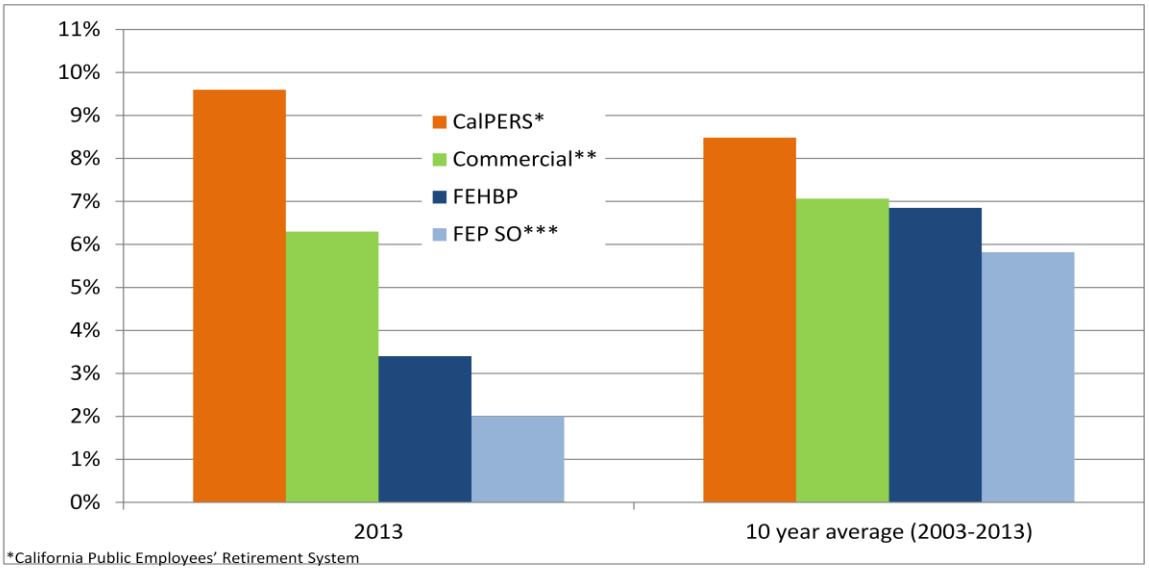
With robust plan offerings and high customer satisfaction, the FEHBP is often cited as a model for choice and competition. The FEHBP offers more plan choices than any other employer in the country. While most employers offer two or three insurance products through one or two carriers, 230 plans participate in the FEHBP—at both the national and local levels. The FEHBP offers active and retired federal employees many plan choices from national

preferred provider organizations (PPOs) to local health maintenance organizations (HMOs), high deductible health plans (HDHPs) and consumer-directed health plans (CDHPs).

The Office of Personnel Management (OPM), which administers the FEHBP, has increased the number of carriers in the program by double digits in the last two years—and more carriers have entered in the last two years than in the last five years. The beauty of the FEHBP is that no matter where they live, federal enrollees can choose from among a minimum of 13 national products offered by six different carriers—each with a uniform premium nationwide. In fact, 80 percent of federal enrollees select these nationwide options. Combined with local plan options, federal enrollees may have as many as 42 plan choices in some states.

The FEHBP has kept premiums affordable for federal employees and retirees while offering comprehensive, integrated benefits. In 2013, FEHBP premiums increased by 3.4 percent, while according to industry surveys, commercial plans rose by an average of 6.3 percent. (See Figure 1).

Figure 1. Premium Growth in CalPERS, Commerical Market, FEHBP and Blue Cross Blue Shield Standard Option, 2013 Benefit Year and 2003-2013



*California Public Employees' Retirement System
**Source: Aon Hewitt Health Value Initiative Database published estimates
***Blue Cross Blue Shield Federal Employee Program Standard Option

Blue Cross Blue Shield: A Strong Track Record Serving Federal Employees

The Blue Cross and Blue Shield Association and its member Plans are proud to have been dedicated, reliable and consistent participants in the FEHBP since the program's inception 53 years ago. We are committed to the federal market and are focused on serving federal employees, retirees and their families.

The nationwide Blue Cross Blue Shield FEHBP offerings include a Standard and Basic Option—both are popular with federal workers and retirees for their comprehensive benefits, competitive premiums and ongoing innovation. We are proud to have earned the loyalty of federal enrollees and retirees over our five decades in the program.

BCBSA knows that federal employees and retirees have a broad choice in coverage each year. That is why we strive to be the *best* choice for our members and for the FEHBP. We also understand the need to reduce federal spending has never been greater, and we are leading in care delivery innovation and other key strategies that improve health and attack health cost drivers. Blue Cross Blue Shield plans in the FEHBP leverage the innovations and provider relationships used by 85 of the Fortune 100 companies who turn to Blue Cross Blue Shield for their employee health benefits. Our Standard and Basic Option plans offer more than 25 innovative features, including wellness programs and incentives, online transparency tools and other management programs to improve the health of federal enrollees and the value of their benefits.

I want to highlight a few examples of specific Blue innovations that deliver quality, more affordable coverage options in FEHBP.

Patient-centered medical homes in 17 states plus the District of Columbia covered more than 250,000 FEHBP members at the close of 2012. CareFirst BlueCross BlueShield (serving D.C., Maryland and Northern Virginia) operates one of the largest networks of patient-centered medical homes (PCMHs) in the country, which have been available to Blue FEHBP

members since 2011. In a medical home, the patient and primary care practice are at the center of care, and patients have a continuing relationship with a primary care physician and care team that assures care is comprehensive, proactive and coordinated. This reinforces primary care's critical role in helping patients get the care they need, when they need it, with greater efficiency, less redundancy and fewer return trips to the hospital or physician's office—and it encourages teamwork and coordination across all of the clinicians involved in caring for a patient. By the end of this year, Blue Cross Blue Shield FEHBP plans are expected to include PCMHs in all 50 states plus D.C. These care delivery innovations are projected to serve almost 1.2 million federal members by the close of 2014.

Patient safety initiatives, including locally-tailored efforts to prevent medical errors and reduce hospital readmissions, are critical to ensuring our members receive the best possible care. A 2012 pilot with local plans reduced readmissions rates for our federal members in a matter of months, yielding estimated savings of over $3.5 million. The pilot is now being scaled nationwide.

Chronic disease management programs support BCBSA's FEHBP members with diabetes, congestive heart failure, chronic lung disease, coronary artery disease and/or asthma. In 2012, our 798,000 participating federal members had 11.9 percent fewer inpatient admissions and 8.29 percent fewer emergency room visits than those eligible but not enrolled. These reductions yield tangible savings for OPM and keep federal employees on the job and out of the hospital.

Transparency tools, which include Fepblue.org, MyBlue, and other consumer tools serve our members by helping them save money, make the best health choices and take action on these choices. In 2012, nearly 700,000 federal members signed up for the MyBlue Portal, which helps them to be more active, informed health care consumers. The MyBlue Annual Statement offers a summary of the benefits paid for medical and pharmacy claims for the past year, illustrates annual savings earned for medical and pharmacy services, shows member

utilization of in-network versus out-of-network providers and generic versus brand name medications, and provides information on the incentives available to each member. The MyBlue Treatment Cost Estimator helps members avoid surprises by utilizing the national cost estimation tool prior to receiving services. The National Doctor and Hospital Finder has information to help members assess the quality of the hospitals and physicians. Members can write reviews, read patient satisfaction surveys, and view safety and efficacy ratings for providers. These are only a few of the many consumer tools we employ to make health care transparent for our members.

In sum, no one is more innovative and committed to bringing cutting edge innovation into the FEHBP than Blue Cross Blue Shield.

BCBSA Perspective on Proposed Changes to FEHBP

1. Regional PPOs

While the FEHBP has a long track record of success, some are calling for changes to the program, including the addition of regional PPOs into the FEHBP. We agree that there is always room for improvement, but believe a better approach would be to make statutory changes (if needed) to open up the FEHBP to any carrier willing to participate on a level playing field nationwide.

Adding regional PPOs to the FEHBP is neither innovative nor will lower the overall cost of the FEHBP. In fact, it will result in **higher** costs for both the federal government and federal employees and will jeopardize popular nationwide offerings. Instead of offering a uniform premium nationwide, regional PPOs would be allowed to "cherry pick" low-cost regions and charge a premium that reflects the cost of that region only. Since health care costs vary considerably across the country, regional PPOs will have a strong incentive to select only low-cost areas to offer coverage. This will lead to higher premiums in the nationwide plans or regions not picked up by the new PPOs, as more enrollees in the low-cost areas choose the regional PPOs. Within a few years, the nationwide plans will become non-competitive and will

likely stop offering nationwide coverage all together. This would leave certain areas of the country under-served or potentially not served at all.

Under the current FEHBP, a federal employee who works for a federal agency in California and is enrolled in a national PPO pays the same premium and has the same benefits as an employee working for that agency in New York or in any other state. This is especially important for federal employees and retirees who travel or are transferred to another area of the country. These nationwide plans provide access to in-network providers anywhere in the country, saving the member and the FEHBP money. However, if regional PPOs were allowed into the FEHBP, federal employees would pay different premiums based on the costs of each region. Assuming all PPOs were offered on a regional basis, 54 percent of federal employees and retirees are likely to see their premiums increase. An analysis by Avalere Health concludes that **federal spending would increase by $5.7 billion over ten years if all PPOs were offered on a regional basis**.

Instead of adding regional PPOs to the program, BCBSA recommends a two-pronged approach for making the FEHBP even better without disrupting the coverage millions of federal enrollees have selected today:

1. *Open up FEHBP to any carrier willing to participate on a level playing field nationwide.* The current statute allows for three categories of nationwide plans: (a) a Service Benefit Plan (BCBS); (b) employee organization or union plans; and (c) an indemnity insurance carrier slot (unfilled). To enhance competition without the negative impacts that regional PPOs would bring, Congress could authorize an unrestricted number of nationwide insurance carriers to offer products government-wide. This would encourage greater competition on a level playing field while preserving the nationwide coverage options overwhelmingly preferred by FEHBP participants. By maintaining the level playing field, the approach could also avoid cost increases expected under the regional PPO model.

2. *Give carriers additional flexibility to offer new products that more aggressively incorporate the latest private sector innovations for controlling costs.* Examples include[1]:

    - Premium discounts (currently not authorized by statute) that encourage tangible actions to improve health (*e.g.*, smoking cessation or weight loss).
    - Incentives for employees to choose high quality providers.
    - Coverage of new, technology-supported access points for health care (*e.g.*, e-visits, telemedicine, remote monitoring).

2. Prescription Drug Carve-out

Another change some are proposing is consolidating contracting for prescription drug benefit management in the FEHBP. Proponents of this "carve out" approach argue that streamlined purchasing of prescription drugs for FEHBP enrollees will save money by lowering administrative costs and using the government's purchasing power to secure better pricing than an individual insurance carrier could achieve.

BCBSA opposes any carve out of prescription drug benefit management in the FEHBP. Such an approach would harm enrollees and would not lower costs because it: (1) reduces beneficiary choice by limiting prescription drug benefits; (2) prevents effective integrated management of pharmacy and medical benefits; and (3) compromises care management and utilization management techniques that help ensure safety and adherence to best practices.

The pillars of the FEHBP have long been consumer choice and competition among carriers to offer affordable, high-quality health benefits that best meet the needs of their members. Carving out pharmacy benefit management from the current system would undermine these pillars and increase costs.

[1] Towers Watson and National Business Group on Health. (March 2013). Reshaping Health Care: Best Performers Leading the Way. Available at: http://www.towerswatson.com/DownloadMedia.aspx?media={BAD5FE64-62FD-492A-8F24-A3C6E5B075B8}.

For the FEHBP to achieve significant savings, OPM would have to adopt a single, restrictive formulary, which would limit member and provider choice to potentially narrow selection of drugs (as in the Department of Defense [DoD] or Veterans Administration [VA] health programs that use a limited formulary/supply schedule[2]). The Congressional Budget Office (CBO) has stressed on numerous occasions that similar consolidation of "purchasing power" for Medicare Part D enrollees would not achieve significant savings unless an extremely restrictive formulary was adopted for all beneficiaries.[3] In addition, this single prescription drug benefit design is likely to shift costs from pharmacy to medical expenses by preventing the integrated management of medical and prescription drug benefits. Overall program costs would almost certainly increase as a result.

Full integration of medical and pharmacy benefits allows carriers to design products that incentivize members to make safe, appropriate and cost-effective drug choices. Maintaining an integrated medical-pharmacy benefit provides members with better quality health care management as a result of total management and oversight of members across the continuum of care. Studies have found that annual medical expenses for plans with an integrated pharmacy-medical benefit design have been reduced by up to 6.2 percent as compared with plans without integrated designs.[4]

Under a pharmacy benefit carve-out, health plans have limited access to pharmacy claims that would otherwise help identify members who may benefit from case management and coordination of care. This leads to increased costs and poorer health outcomes.

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[2] The VA uses both the FSS and national contracts to purchase drugs. DoD also allows beneficiaries to purchase drugs from retail pharmacies and then negotiates with the manufacturers for additional savings under the FSS. *See* Government Accountability Office. (June 1997). Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain, Available at: http://www.gao.gov/assets/230/224182.pdf.

[3] CBO estimates that striking the non-interference provision from the Medicare Modernization Act (*i.e.*, permitting the federal government to negotiate drug prices) would have a negligible effect on federal spending. *See* Letter from Douglas Holtz-Eakin to Sen. Bill Frist. (January 23, 2004). Available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/49xx/doc4986/fristletter.pdf.

[4] Culley, E.H., Williams, L.C., & Thomas, L. (2010). Pharmacy Benefit Carve In: The Right Prescription for Cost Savings. *Benefits and Compensation Digest*, 47(2), 22.

In 2011, OPM issued a carrier letter that required FEHBP fee-for-service carriers to alter the way in which they contract with pharmacy benefit managers (PBMs). Specifically, the PBMs must now pass through all drug claims at their actual acquisition cost, and all rebates/discounts must be passed back at 100 percent to the carriers. This has the effect of making certain proposed legislation that would carve out pharmacy benefits unnecessary since carriers are already receiving all the discounts that this legislation hopes to achieve. I would also point out that any savings that have been attributed to a prescription drug carve-out in past budget proposals were predicated on numbers prior to OPM issuing its 2011 carrier letter and are inaccurate.

Integrated medical-pharmacy models allow for more comprehensive and effective management of patients with complex pharmacy needs. The ability to access pharmacy as well as medical claims information also helps decrease the risk of drug abuse and diversion. Prescription drug abuse and diversion is the fastest growing, most widespread substance abuse issue facing our society. Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers. Drug abuse and diversion increases prescription drug costs as well as costs related to provider and emergency room visits, rehabilitation services and other health care needs.

Conclusion

Blue Cross Blue Shield has been in the FEHBP since its inception in 1960, and we are committed to working with OPM and Members of the Subcommittee to make the FEHBP even better without disrupting the coverage millions of federal enrollees have selected today.

Blue Cross and Blue Shield has incorporated a diverse set of innovations in both of our FEHBP plans, Basic Option and Standard Option. Whether it is in care delivery and payment, care management, or member engagement, these innovations leverage the Blues' local presence and nationwide strength to meet the needs of our federal members and our client,

OPM. As the choice of 85 of the Fortune 100 companies, the Blues are constantly innovating and are committed to delivering the best value to our members, whether in the FEHBP or in the commercial marketplace. We focus our services on each member, one at a time, to provide the best products to both the federal workforce and OPM.

I appreciate the opportunity to discuss the value of the FEHBP, and I look forward to your questions.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: William A. Breskin

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

None.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Blue Cross and Blue Shield Association

Vice President, Government Programs

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

(1) The Blue Cross and Blue Shield Service Benefit Plan's contract CS 1039 with the U.S. Office of Personnel Management (OPM) for participation in the Federal Employees Health Benefits Program:

2011 - $26.7 Billion*

2012 – $27.7 Billion*

2013 – TBD*

* These numbers represent the premiums attributed to the Service Benefit Plan. BCBSA does not receive the premium dollars; they are deposited in the U.S. Treasury and Blue Plans withdraw funds from a letter of credit account as needed to pay claims and other expenses. These total amounts do not include statutorily required premium loads to defray OPM's administrative costs and to deposit in the Service Benefit Plan's contingency reserve, which is maintained in the U.S. Treasury. It is not possible to calculate the total receipts for 2013 at this time because the total amount attributed to the Service Benefit Plan depends on the number of individuals who enroll in it and the mix of enrollment tiers they choose (self or self and family).

(2) The Blue Cross and Blue Shield FEP BlueVision contracts with OPM for participation in the Federal Employees Dental and Vision Insurance Program:

2011 – $76.5 Million**

2012 – $82.9 million**

2013 – TBD**

** These numbers include total premiums. It is not possible to calculate the total receipts for 2013 because the total amount received by FEP BlueVision depends on the number of individuals who enroll in it and the mix of enrollment tiers they choose (self or self and family). In addition to paying for vision and other expenses, a portion of the premiums is also used to defray OPM's expenses in administering the program. (Continued on attached sheet)

I certify that the above information is true and correct.

Signature: [signature]

Date: 4/8/13

(3) Health Insurance for the Aged and Disabled (Medicare Part A Prime contract) from the Centers for Medicare & Medicaid Services:
FY 2011 - $4,533,100 (contract no. 87-001-1)
FY 2012 - $4,533,100 (contract no. 87-001-1)
FY 2013 - $4,533,100 (contract no. 87-001-1)

(4) Resident FTE Assessment Program for the Children's Hospitals Graduate Medical Education (CHGME) Payment Program from the Health Resources and Services Administration:

FY 2011- $1,262,753 (contract no. HHSH230200732003C)
FY 2012 - $1,313,946 (contract no. HHSH230200732003C)
FY 2013 - $1,141,113 (contract no. HHSH250201200006C)

(5) Legal Representation in Arbitration Hearings for the Home Health Third Party Liability Demonstration from the Centers for Medicare & Medicaid Services

FY 2011 and FY 2012 - $1,363,780 (contract no. HHSM-500-2010-00056C)
FY 2013 Stop Work Order Issued (contract no. HHSM-500-2010-00056C)

(6) Evidence-based Practice Centers (EPC III) (Contract no. HHSA 290 2007 100581) with the Agency for Healthcare Research and Quality***

2010 - $3,684,000
2011 - $3,396,000
2012 - $2,477,000

*** Under this contract, which extended from October 2007 to September 2012, receipts actually depend on the number and value of task orders issued to BCBSA. The amounts above represent revenues received from the Agency for Healthcare Research and Quality during that year and include some funds received under a previous contract EPC II.)

(7) Evidence-based Practice Centers (EPC IV) (Contract no. HHSA 290 2012 000101) with the Agency for Healthcare Research and Quality****

**** Under this contract, receipts actually depend on the number and value of task orders on which BCBSA bids successfully. To date, BCBSA has received two task orders, totaling $245,000.

(8) BCBSA subcontracts with Cahaba Government Benefit Administrators®, LLC, to provide the services of a Hearing Officer, on behalf of Cahaba, to conduct certain intermediary hearings:

Start Date August 3, 2011 - $70,000 (contract no. CGBA-C-09-0020, Amendment 3)
Start Date August 3, 2012 - $70,000 (contract no. CGBA-C-09-0020, Amendment 4)

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William A. Breskin

Vice President of Government Programs

William A. Breskin is the Vice President of Government Programs for the Blue Cross and Blue Shield Association (BCBSA), a national federation of 38 independent, community-based and locally operated Blue Cross and Blue Shield Companies. The Blue System is the nation's largest health insurer covering more than 99 million people – one-in-three of all Americans. It is the largest single processor of Medicare claims in the nation, and holds the world's largest privately underwritten health insurance contract – the 5.2 million-member Federal Employee Program (FEP).

In Bill's current role, he directs the activities of the FEP and Medicare programs for BCBSA. Prior to being Vice President of Government Programs, Bill served in many roles within the Legal and Governance area of BCBSA, most recently as Vice President, Deputy General Counsel and Assistant Corporate Secretary. Bill worked for many years as BCBSA Chief Washington Counsel, exhibiting a broad range of expertise advising clients on contracting with the Federal government in the health insurance arena (including both FEP and Medicare), as well as advising BCBSA's Office of Policy and Representation. He has worked for BCBSA since 1995.

Before working at BCBSA, Bill was in private practice as a lawyer for eight years, specializing in issues related to doing business with the Federal Government and labor and employment law.

Bill graduated from Georgetown University in 1979, earning a B.A. in History and Art History, cum laude. He received his law degree in 1987, cum laude, from the National Law Center of The George Washington University.