UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

STATEMENT OF
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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"

April 11, 2013

Chairman Farenthold, Ranking Member Lynch and Members of the Subcommittee:

Thank you for allowing me the opportunity to appear before you today to discuss the Federal Employees Health Benefits (FEHB) Program.

Background

Established in 1960, the FEHB Program is the largest employer-sponsored health insurance program in the country, providing health insurance for approximately 8.2 million Federal employees, retirees, and their dependents. In 2012, approximately 90 percent of all Federal employees were enrolled and the FEHB Program provided $45 billion in health care benefits. The Office of Personnel Management (OPM) administers the FEHB Program through contracts with private insurers. On an annual basis, OPM issues a call letter to FEHB carriers soliciting benefit and rate proposals for the next contract term. In addition, new plan applications are

submitted to OPM each year and plans that meet the requirements specified in the statute and regulations may be accepted for participation. Carrier negotiations are conducted from June through August and OPM provides for an Open Season each November allowing enrollees to change plans.

Currently, there are 95 health plan contracts with 230 different plan choices government-wide. The FEHB Program statute specifies four types of plans: (1) the service benefit plan, which is one government-wide plan that is a fee-for-service plan and pays providers directly for services; (2) indemnity benefit plan; (3) employee organization fee-for-service plans; and (4) comprehensive medical plans. Currently, about 81 percent of total FEHB Program enrollment is concentrated in fee-for-service plans and 19 percent in HMO plans.

Under the statute, all FEHB plans must cover basic hospital, surgical, maternity, physician and emergency care. In addition, plans are required to cover certain special benefits including: prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity between mental health and medical care coverage; and child and adult screenings, preventive care and immunizations. To ensure the benefits provided under the FEHB Program are keeping pace with advances in medicine, OPM reviews treatments to determine if coverage or benefit changes should be implemented. For example, as a result of a recent review, in 2012, OPM concluded there is enough evidence to classify Applied Behavioral Analysis treatment for children with autism as a medical therapy. This reclassification allowed FEHB plans to offer such services where treatment is medically necessary and appropriate providers are available. For the 2013 plan year, 67 FEHB carriers in 22 states are now offering this coverage.

The FEHB Program uses market competition and consumer choice to provide comprehensive benefits at an affordable cost to both the Federal government and enrollees. FEHB premiums cover enrollees' health care costs, plans' administrative expenses, reserve accounts, and OPM's administrative expenses, which are approximately 0.078 percent of premiums. As set by statute, the government's share of premiums for employees and annuitants is the lesser of 72 percent of the weighted average premium of all participating plans or no more than 75 percent of the total premium for any one plan. However, enrollee premium contributions can be higher than 28 percent if their individual plan's premiums are significantly higher than the average FEHB plan. Average yearly premium increases have declined in each of the last four years, dropping from 7.4 percent in 2010 to 3.4 percent in 2013. In general, yearly changes in premiums reflect trends in the health care marketplace as well as specific policy initiatives negotiated with participating plans.

The remainder of my testimony will address the Subcommittee's interest regarding the relationship between Medicare and the FEHB Program, the impact of the Affordable Care Act (ACA) on the Program, and FEHB modernization.

Medicare and the FEHB Program

Currently, Medicare eligible active or retired Federal employees are not required to enroll in Medicare Part B. If an active or retired Federal employee enrolls in Medicare Part B and maintains coverage in an FEHB plan, Medicare law and regulations determine primary coverage. FEHB plans typically waive copayments, coinsurance, and deductibles for services covered by Medicare Part B. As a result, most annuitants have first dollar coverage. A growing proportion of FEHB enrollees eligible for Medicare Part B do not enroll in Part B. This means that FEHB

plans are the primary payer for all services that Part B covers, which includes physician services and many outpatient procedures. OPM is encouraging proposals for pilot programs where participating carriers offer a sub-option for Medicare eligible annuitants as an alternate choice. The sub-option may include premium pass-through accounts for plans to use solely to pay some or all of Medicare Part B premiums. Carriers may propose cost sharing changes for enrollees with Medicare Part B that are sufficient to encourage them to participate in the pilot program and also encourage appropriate utilization.

ACA and FEHB Program

After enactment of the ACA, OPM reviewed its contracts and determined that FEHB plans were already in compliance with many of the ACA reforms to the health insurance marketplace. For example, denials of coverage to those with pre-existing conditions were already prohibited within the FEHB Program. However, there were some provisions in the ACA that expanded eligibility and benefits. For instance, effective plan year 2011, OPM extended dependent coverage by allowing adult children up to age 26 to be covered under their parent's FEHB plan. Almost 300,000 young adults between the ages of 22 and 26 now have FEHB coverage as a result of this provision. Another eligibility change included extending FEHB to employees of entitled Tribes, tribal organizations, and urban Indian organizations. Over the past three years, OPM has worked closely with Tribes, tribal organizations, urban Indian organizations, and national organizations to implement this provision of the ACA. As a result, approximately 16,000 tribal employees and dependents in 15 States are now enrolled in the FEHB Program. Additionally, effective with the 2011 plan year, all FEHB plans now cover in-network recommended preventive care, immunizations, and screenings without cost sharing.

Another provision in the ACA that impacted the FEHB Program was the medical loss ratio (MLR). Beginning in 2011, the ACA required health insurers to use at least a certain percentage of health insurance premiums to pay for medical claims or activities that improve the quality of health care. The ACA set the minimum required MLR at 85% for the large group market and directed health insurers that did not meet the MLR to pay a rebate to their consumers. For FEHB enrollees, by law, rebates are sent to OPM, which serves as the policyholder, and the rebate is used to adjust future premium rates. This method ensures that rebates will be shared between health plan enrollees and the Federal agencies that pay for the FEHB. In 2012, OPM communicated with health insurers and determined that three insurers out of the 91 insurers in the program would provide a rebate to the FEHB Program.

Modernization of the FEHB Program

The FEHB program was designed to offer Federal employees, retirees, and their dependents a range of health insurance choices that are reflective of the most competitive choices available in the commercial marketplace. As the health insurance market continues to change, OPM has done its best to keep pace with change; however, there are a number of areas where the structure of the program as configured by the original authorizing legislation passed in 1959, constrains OPM from responding to the changed marketplace. There are a number of challenges facing the FEHB Program including the need for more competition with more diverse health plan choices; affordability for enrollees; and limited opportunity to use best practices from the private sector. Presently, however, the FEHB Program lacks the flexibility to address these challenges and respond to the continuously changing market. OPM proposes to modernize the FEHB Program in the following ways: allow additional health benefits plan types; increase contracting

discretion; expand coverage options to include a "self plus one" premium tier and coverage for domestic partners; and allow premium differentials tied to wellness.

OPM proposes to expand its authority to contract with a greater variety of health plan types. The health insurance marketplace has changed significantly since FEHB began and the current contracting structure reflects largely outdated distinctions. As mentioned earlier, the statute only allows four plan types. Under the service benefit plan type, Blue Cross Blue Shield offers two government-wide benefit options (Standard and Basic). The indemnity benefit plan was held by Aetna until the late 1980s. Aetna's decision to leave as the indemnity benefit plan carrier was due primarily to adverse risk selection, which left Aetna in an uncompetitive situation. The third plan type consists of employee organization plans, which are sponsored by voluntary employee benefit associations or Federal employee unions. There are nine current sponsors and four of these plans are open to only certain Federal employees and retirees. The employee organization plans were grandfathered into the FEHB Program at inception or shortly thereafter and no new employee organization plans are permitted to join. The final plan type is made up of comprehensive health plans (HMOs) offered at the state level, which have no restrictions in the number of plans participating in the FEHB Program as long as they meet FEHB qualifying criteria and state licensure laws.

The FEHB model is built on robust competition and consumer choice that keeps costs affordable for enrollees and offers diverse health plan choices. The ability to contract with strong regional plan types currently available in the private market would enable OPM to increase competition and respond to changes in the health insurance market. FEHB enrollees would benefit from having greater choices that represent best practices in the private sector and more closely

resemble product combinations available in private industry as well as in state and local government employee programs.

It is important to emphasize that this proposal would not require that OPM contract with every health plan that applies to participate in the FEHB Program under this expanded authority. As with standard contracting procedures, each health plan would still need to meet the qualifying criteria like that currently in place for all plans in the FEHB Program. This proposal would simply provide OPM with the ability to consider additional plan types and contract with plans only when it is in the best interests of the FEHB Program and its enrollees. The introduction of a wider selection of market-driven plans would increase competition within FEHB Program, and thus lead to more choice for enrollees. OPM estimates the expansion of FEHB plan types would result in estimated mandatory cost savings of $260 million in direct spending over ten years.

Next, OPM proposes increasing its contracting discretion, which would allow us to more efficiently leverage the Federal government's purchasing power for its 8.2 million FEHB enrollees and allow greater flexibility in negotiating benefits by allowing for direct contracting with vendors for pharmacy and other benefits. Many FEHB Program carriers contract with Pharmacy Benefit Managers (PBM) to purchase prescription drugs and manage benefits on behalf of their enrollees. However, current law precludes OPM from directly negotiating with PBM contractors to purchase prescription drugs. With the ability to contract directly for PBM services, OPM would be in a position to obtain better discounts by leveraging the size of the population, providing for more consistent performance across the FEHB, and allowing a more consistent formulary structure and patient care management. Allowing OPM to pursue direct

negotiations with PBM contractors would result in scored mandatory cost savings of approximately $1.6 billion over ten years.

OPM also proposes authorizing the FEHB Program to offer a “self plus one” enrollment option. Allowing the FEHB program to offer a "self plus one" enrollment option, places the program in line with other large private employers as well as state and local governments. Currently, the FEHB Program is only authorized to offer self-only enrollment and self and family enrollment. By adding a third tier, the “self plus one” option, an employee or retiree who does not need a family plan - for example, because they need only to cover a spouse or one child - can choose the “self plus one” option rather than the self and family option. OPM also proposes allowing FEHB enrollees to add a domestic partner to their FEHB enrollment. This proposal would align the FEHB Program with best practices in the private sector as larger employers competing for talent are increasingly offering domestic partner benefits. Together, the proposals would result in a savings in mandatory spending of approximately $5.2 billion over ten years.

Finally, OPM proposes allowing premium differentials tied to wellness. This proposal provides OPM with the authority to approve a limited differential adjustment to rates charged for enrollees based on their health status and participation in health and wellness programs. For instance, this proposal would allow OPM to increase the enrollee share of premiums for those who use tobacco products and do not participate in tobacco cessation programs (which FEHB plans offer tobacco cessation programs at no cost share to enrollees). This proposal aligns the FEHB Program with current trends in the commercial market, increases the use of preventive services, and encourages enrollees to make improvements to their health status resulting in a reduction of long-term

chronic costs. OPM estimates that this this proposal would result in estimated mandatory cost savings of $1.3 billion over ten years.

Overall, these proposals would result in net mandatory cost savings of $8.4 billion to the Federal government over a 10 year period. In addition to cost savings, the proposals would improve efficiency, and directly support OPM's mission of recruiting, retaining, and honoring a world-class workforce to serve the American people.

Conclusion

I want to thank you for this opportunity to testify today and I am happy to address any questions you may have.

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BIOGRAPHY

Jonathan Foley

Jonathan Foley is director, Planning and Policy Analysis, U.S. Office of Personnel Management (OPM). In that role, he manages a team that provides advice to the OPM Director on human resource management policy, the Federal Employees Health Benefits program, health reform, and workplace wellness. From 1999 through 2008, Jon worked for the New Zealand Ministry of Health assessing health system performance and developing and implementing primary health care policy. His prior experience included developing and managing public health and primary care programs in the State of Maryland; consulting on hospital financing in Sierra Leone; and managing a community health center in the State of West Virginia.
Jon graduated with a masters degree in public administration from the Syracuse University's Maxwell School of Citizenship and Public Affairs and received his B.A. from Colgate University.