

STATEMENT OF THE HONORABLE DAN G. BLAIR
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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.