

**STATEMENT BY  
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**TO THE SUBCOMMITTEE ON CIVIL SERVICE AND  
AGENCY ORGANIZATION  
COMMITTEE ON  
GOVERNMENT REFORM AND OVERSIGHT  
U.S. HOUSE OF REPRESENTATIVES**

**HEARING ON  
FEDERAL EMPLOYEES HEALTH BENEFITS  
PROGRAM (FEHBP)**

**MARCH 24, 2004**

Madam Chairwoman, on behalf of the nearly 400,000 members of the National Association of Retired Federal Employees (NARFE), I appreciate the opportunity to express our views on the Federal Employees Health Benefits Program (FEHBP).

We are aware that this hearing will also review the Federal Long Term Care Insurance Program (FLTCIP). As you know, NARFE played the leading role in writing and promoting the legislation that authorized the FLTCIP in September 2000 and we continue to work closely with the program's third party administrator – Long Term Care Partners – and the Office of Personnel Management (OPM). While my testimony today focuses on NARFE's concerns regarding FEHBP, we will submit additional views about FLTCIP later. I would be happy to answer any questions about the program.

But today I want to speak about an issue of equal importance to protecting our earned annuities. Indeed, ensuring that the FEHBP provides federal workers and annuitants with affordable health care coverage at predictable rates is one of NARFE's fundamental missions.

### Lessening the Burden

To make health care more affordable, NARFE has assigned priority support to H.R. 1231 and S. 623, legislation introduced by Representative Tom Davis and Senator John Warner to allow federal annuitants to use pre-tax annuities to pay their share of FEHBP premiums. Federal annuitants with family FEHBP plans could save an average of \$405 a year on their income taxes if federal annuitants – like federal employees – were allowed to pay premiums with pre-tax

dollars. We thank you, Madam Chairwoman, and members of the subcommittee, for approving H.R. 1231 last year and we request your ongoing assistance in persuading the Ways and Means Committee to do likewise.

### Prescription Drugs

As a cost-containment measure in FEHBP, NARFE supported the Special Agents Mutual Benefit Association (SAMBA) prescription drug demonstration program that was canceled by OPM in 2000 due to the pharmaceutical industry's refusal to participate. The pilot project would have allowed SAMBA to buy certain drugs for its enrollees at the discount mandated by the federal supply schedule (FSS), a procurement tool used by the Department of Defense and Veterans' Administration health care systems.

As you know, today drug reimportation continues to receive support and new converts in Congress. However, reimportation merely takes advantage of another country's willingness to negotiate drug discounts. NARFE believes we should not be forced to go elsewhere to get better drug prices when the FSS could directly accomplish this goal to reduce costs in FEHBP. For that reason, we urge the subcommittee and OPM to revisit the use of this procurement tool in our health care program.

### Shifting Costs to Enrollees

NARFE is concerned about any proposal that would end the present limit on the FEHBP government contribution to 75 percent. A similar initiative has been included in the FEHBP-

inspired “premium support” demonstration project that was authorized to begin in 2010 by the new Medicare reform law. Under FEHBP, 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 a particularly strong incentive to younger, healthier employees. Unintended risk selection occurs when enrollees leave plans where risk is more likely to be widespread, and leads more enrollees to congregate in the no-cost plans. Since the FEHBP "Fair Share" government contribution formula is weighted to the number of enrollees in each plan, no-cost plans that might attract large shares of enrollees would reduce the overall dollar amount of the maximum government contribution under the premium support proposal. Consequently, costs would be shifted to enrollees in all other plans, increasing enrollee costs and effectively limiting consumer choice.

A plan included in the Administration’s FY 2005 budget to formally coordinate Medicare and FEHBP coverage by “offer[ing] insurance plans tailored to the federal retiree...” is another proposal that could shift costs to enrollees – specifically annuitants. As you know, there is presently no difference between the FEHBP plans offered to federal employees, annuitants and Medicare-participating annuitants.

Although there is coordination of coverage between traditional Medicare and FEHBP fee-for-service plans, less synchronization of benefits exists between managed care plans and Medicare. NARFE expressed concerns last year that a separately- rated FEHBP health plan for Medicare-

participating retirees and survivors might be suggested in response to the Administration's budget proposal.

One of the chief advantages of a large, employer-sponsored group health insurance program, like the FEHBP, is that the risk of health costs are spread across a diverse community. Segregating retirees from that community would destroy such risk sharing and significantly increase premiums. We are also concerned that coverage under a separate annuitant health plan would be inferior to benefits currently available to all FEHBP enrollees.

Additionally, NARFE and other retiree organizations are concerned that new costs could be shifted to older enrollees if employer-sponsored plans -- including the FEHBP -- reduce or eliminate prescription drug coverage currently provided in response to the new Medicare benefit. Indeed, Medicare-eligible annuitants could be forced to pay an additional monthly premium for a complex Medicare drug benefit that would be significantly inferior to what they currently receive through the FEHBP. The Congressional Budget Office estimated that one-third of retired workers with employer-sponsored benefits could lose their current drug coverage in response to the new Medicare drug benefit. We appreciate your assistance, Madam Chairwoman, in working with us to prevent the loss of our earned drug coverage by supporting H.R. 2631 and S. 1369, legislation to require FEHBP plans to provide a prescription drug benefit for Medicare-covered annuitants that would be at least of equal value to the drug coverage available to other FEHBP enrollees.

## Health Savings Accounts

Today, I want to specifically address NARFE's concerns with OPM's December 22, 2003 announcement that they are reviewing the possibility of offering the combination of Health Savings Accounts (HSAs) and high deductible catastrophic insurance in the FEHBP for 2005.

Provisions in the recently enacted Medicare reform law (P.L. #108-173), unrelated to either Medicare or prescription drug coverage, expand and rename Medical Savings Accounts (MSAs) as "Health Savings Accounts" (HSAs). In fact, HSAs are specifically unavailable to persons age 65 and older.

Like MSAs, HSAs combine a high deductible catastrophic insurance policy with a tax-exempt savings account dedicated for health care expenses. At the beginning of the year, health care costs are paid out of the HSA until the account balance is spent. Thereafter, enrollees are required to pay out-of-pocket for their medical expenses until they have satisfied the high deductible of their health insurance plan. Once the deductible is met, the plan covers health costs, except for any copayments or coinsurance, up to a catastrophic limit.

HSAs are likely to be attractive to healthier enrollees since the plans reward them with tax-free cash balances in subsequent years if they don't go to the doctor or to a hospital. Since less healthy enrollees would be uninsured for thousands of dollars each year, they would be well advised to remain in a comprehensive option in which their out-of-pocket costs would be significantly lower. As a result, healthy individuals are siphoned into the new option and premiums in the comprehensive plans they left increase in response. Consequently, HSAs could

circumvent the fundamental principles of group health insurance by dividing healthy persons and sick persons into different coverage options.

For these reasons, NARFE has historically opposed adding MSAs – and now HSAs -- to the FEHBP.

NARFE recognizes that HSAs are a politically sensitive issue, particularly in an election year when candidates will take sides for and against them. For that reason, I want to assure the subcommittee that NARFE's opposition to OPM's HSA proposal is based exclusively on ensuring that the FEHBP provides affordable coverage at predictable rates for federal workers and annuitants. In addition, NARFE is committed to this position by legislative resolutions approved by members at our four biennial national conventions held since 1996.

In previous testimony, we have cited the work of such respected and nonpartisan organizations as the Congressional Budget Office (CBO), the Academy of American Actuaries, the Urban Institute and others to support our concerns that MSAs could drive up premium costs in comprehensive FEHBP plans through risk selection.

For example, CBO said in their cost estimate of S. 2330, "Patients' Bill of Rights" legislation considered in the 105<sup>th</sup> Congress, that "offering high-deductible health insurance with MSAs to federal workers and annuitants would increase FEHBP premiums for comprehensive plans by siphoning off relatively healthy enrollees into MSAs. Higher premiums for comprehensive plans, in turn, would increase government contributions for all enrollees."

CBO estimated that it would cost – not save -- taxpayers nearly \$1 billion over five years if MSAs were required in FEHBP.

HSA supporters have attempted to discount CBO and other organization's work on MSAs because they claim that HSAs are not MSAs. Some have also said real life experience with adverse selection in public employee health care systems -- like in Ada County, Idaho -- are not relevant for the same reason, or they attempt to re-write the facts by claiming that such risk segmentation never happened in the first place. But they fail to offer any credible evidence to support their revisionism.

#### HSAs vs. MSAs

Although there are some differences between old MSAs and new HSAs, their variation does not appear to significantly alter the outcomes estimated by CBO and other nonpartisan organizations. For instance, HSA enrollees will be allowed to contribute larger amounts to their savings accounts, but this change does not help those who cannot afford to deposit more money. Additionally, the government/employer contribution to an HSA is unlikely to be any greater than what it would have been for an MSA.

The newly authorized portability of the savings account might entice some less healthy and lower income enrollees to select an HSA. Nonetheless, they would be only one illness or injury away from learning about the high out-of-pocket costs of HSAs.

This “dark side” of HSAs was recognized by Federation of Americans Hospitals President Charles N. Kahn III (formerly President of the Health Insurance Association of American and Health Subcommittee staff director to Representative William Thomas) at the National Medicare Prescription Drug Congress on February 26 when he said that HSAs would saddle hospitals with increasing amounts of bad debt as a result of patients who are unable to adequately fund their accounts or who cannot afford to pay out-of-pocket. Kahn said that hospitals will be more vulnerable than other providers to incurring bad debt from patients with HSAs because their bills often are much larger.

Mai Pham with the Center for Studying Health System Changes (HSC) echoed provider concerns at a March 12 conference held by her organization on market competition. “In terms of extensive patient cost sharing, providers and especially physicians, we found, are wary of any process that requires more effort on their part to collect payments from patients. ...And the thought that this might increase their bad debt burden is really not appealing, nor is watching staff cost rise, as might be necessary to effectively collect payments.”

The minimum deductible for the catastrophic health insurance that is coupled with the savings account has been lowered to \$1,000 for individuals and \$2,000 for families. But lower deductibles increase the premium of the catastrophic insurance – resulting in less savings over comprehensive insurance. The lower minimum deductible does not change the fact that out-of-pocket costs for HSAs will continue to be substantially higher than comprehensive insurance. As a result, the risk for adverse selection is real, since enrollees with moderate-to-high health care needs would be ill advised to select an HSA.

In a February 16 commentary, HSC President Paul Ginsburg wrote that the \$2,000 minimum deductible for families in HSA/catastrophic plans might be too burdensome. “Usually no more than one family member has large medical expenses in a year, so families will be much less likely to exceed the deductible than will single people,” Ginsburg wrote. “While the current HSA might appeal to single healthy workers, most employers are unlikely to embrace a less-than-family-friendly change to their health benefits.”

### Consumer-Driven Health Plans

OPM has pointed to the so-called “consumer-driven” health plans (CDHP) that were first added to FEHBP in 2003 as evidence that related HSAs will not have an impact on FEHBP. We note with interest that consumer-driven plans are sufficiently similar for OPM’s purpose of promoting HSAs today while the agency defended its decision to roll-out consumer-driven plans in September 2002 by claiming the new option was nothing like MSAs.

A January 2004 American of Academy of Actuaries (AAA) paper on consumer-driven health plans found that “because CDHPs are so new, it is difficult to know what type of selection will take place until credible data becomes available.” But the actuaries also said the potential for adverse selection exists when they are offered with existing traditional plans, and that some enrollees could be worse off financially under CDHPs than with comprehensive insurance.

Although some may be willing to initiate an HSA experiment in FEHBP based on inconclusive consumer-driven plan findings, we believe it's premature to impose the option, particularly when the potential risks have not been acknowledged or addressed.

Apparently, some employers are also wary of offering CDHPs. In their 12-community study, HSC found only incremental changes to traditional employer-sponsored health insurance, but a reluctance toward consumer-driven plans. "Their choice to not pursue this was not philosophical but really due to the devil in the details," said HSC's Sally Trude at their March 12 conference. She went on to say that employers "had done their homework; had their consultants do the numbers; and like the largest employers, didn't see savings."

And certainly, consumer-driven plan experience is not the definitive word for HSAs. While HSC's Ginsburg took the middle ground on the potential harm or benefits of HSAs, he was clear about the likelihood of adverse selection:

"There's little question that HSAs will transfer resources from the sick to the healthy. When a deductible is increased from \$500 to \$1,000 and the premium is lowered, those who need extensive medical care will pay more and those who do not will pay less. Higher-income people will benefit more from the accounts because they are more likely to have insurance and because of their higher marginal tax rates. Also, higher-income people will be more likely to fully fund their HSAs."

## Conscientious Consumers

HSA supporters claim that consumer driven health plans encourage individuals to spend their account balances more wisely. They also say the reverse is true – that enrollees in comprehensive plans are not sensitive to health care costs. Indeed, one doctor who testified before this subcommittee on October 16, 2001 remarked that: “The number one reason why seniors go to the doctor is they are lonely. What is a better deal, pay \$30 and go see your doctor.”

I think you can understand why federal retirees might be taken aback by this statement. When I travel to see our members all over the country, I find that many of them read, in great detail, their explanation of benefits statements, report false claims and are outraged by the high cost of health care. While we are not about to self-ration our earned health care, we certainly don't use it frivolously.

But the doctor's testimony and my personal experience only offer anecdotal evidence. A study published in the June 26, 2003 *New England Journal of Medicine* found that only 55 percent of Americans get indicated care. Others underuse or overuse health care, or there are errors made to their care.

Karen Davis with the nonpartisan Commonwealth Fund, who spoke at HSC's December 3, 2003 patient cost-sharing conference, discussed how Massachusetts General Hospital took these findings and extrapolated that about 100 million Americans underuse health services and about 30 million overuse them.

As a result of her review of several studies, Davis said “...the basic bottom line is that cost sharing reduces use of both appropriate care and inappropriate care. So, in other words, it would, if you increase cost sharing, you would have more than 100 million people underusing services, and you would have fewer than 30 million Americans overusing services, but you would affect both.” We do not believe the increased cost sharing required by HSAs will tackle the difference between underuse and overuse of health care.

HSA’s effectiveness to curb utilization and costs also depend on how consumers perceive buying health care as compared to other goods and services. As Barry Zallen with Blue Cross/Blue Shield of Massachusetts pointed out at the HSC March 12 conference, people do not make decisions about health care in the same way they would about purchasing a refrigerator. He said: “We, as patients, rely on a relationship with a physician. And we don’t think of choosing our rabbi or our pastor or our religion based on market forces. We don’t look it up in *Consumers [Report]* and make a decision or look for information about costs, because it’s an intimate relationship.”

### Design Issues

A potential design flaw in HSAs also weakens proponents’ claims that the plans save money. An open question is whether or not funds spent out of the savings account, or out-of-pocket, would enjoy the provider discounts negotiated by the catastrophic health insurance carrier. We believe that HSAs should use such discounts since insurance carriers can do a better job using the leverage of the millions of enrollees to negotiate lower costs with health providers and drug

companies than individual consumers. This will be particularly true if provider rates continue to be less than transparent and HSA participants are treated as private pay patients and charged higher rates than the insured. As a result, the ability of HSA enrollees to shop around for better prices may be illusory.

NARFE is also concerned about how OPM intends to pay for HSAs. If HSAs were offered in FEHBP, we presume that the current government and enrollee shares would be combined to first buy a catastrophic health insurance policy and whatever remains from that transaction would be deposited in an HSA. However, what we do not know is if the government would advance the full annual amount to the account at once or if this amount would be deposited in increments per pay or annuity period. That begs the question of how enrollees would pay for health care costs at the beginning of the contract year if the account held no more than a pro rated share of the anticipated annual government and enrollee contributions? If the full amount is advanced to enrollees at the beginning of the year, they could walk away from federal service with an unearned windfall. But if the decision is to make piecemeal contributions to HSAs, enrollees living from paycheck-to-paycheck will have difficulty absorbing health care costs, particularly if they occur early in the year when their account balances are low.

### Choice

NARFE recognizes OPM's interest in providing more health care choice to FEHBP enrollees and to empower them to use medical services with minimal limitations. Perhaps this point makes sense when workers' health care choices are limited to managed care plans. But that's not

the case with FEHBP. System-wide plans, that allow enrollees to select their own doctors and hospitals, continue to be the most popular FEHBP options and enjoy high customer satisfaction rates. We are confident that what federal workers and annuitants really want is to choose their own health care providers. That's something they can do today without HSAs.

But even if you were convinced of the choice argument, HSA/catastrophic plans would not be available to anyone age 65 and older. Consequently, HSAs are not a choice most of our members can make. This fact would add insult to injury if their comprehensive plan premiums jump in reaction to HSA-inspired adverse selection. In fact, we question whether this age barrier conflicts with Section 8902 (f) of Title 5 of the U.S. Code that prohibits OPM from contracts with plans that exclude enrollees based on age.

### Protection Proposals

Given the risks, we are concerned that HSAs will be offered without any safeguards against adverse selection. Such protections would be easier to install now, before HSAs become entrenched, and insurance carriers block remedial action.

While we oppose HSAs, we offer two proposals to reduce the risks of offering these plans in FEHBP.

First, promising tax-free savings accounts to anyone who believes their health care costs will be low is a powerful incentive for enrollment. However, this incentive also could encourage FEHBP enrollees to “game” the system by switching to a comprehensive plan during the program’s

annual “open season” for any year they know their health care expenses will multiply. This “gaming” will exacerbate the adverse selection anticipated from the introduction of HSA/catastrophic plans in FEHBP. Consequently, costs would be shifted to enrollees in all other plans – particularly comprehensive options. We believe that adverse selection, generally, and such gaming, specifically, could be mitigated if enrollees were forced to commit to remain in an HSA for at least five years once they selected that option.

Second, a significant migration of enrollees to HSAs could result in the overall reduction of the government/employer contribution for FEHBP premiums. Since the FEHBP “Fair Share” government contribution formula is weighted to the number of enrollees, catastrophic plans with lower premiums (coupled with HSAs) that attract large shares of enrollees would reduce the overall dollar amount of the government contribution available for any FEHBP plan. To protect against such unfair cost shifting to workers and annuitants, OPM must disregard high deductible health plans in determining the government contribution for FEHBP premiums in the “Fair Share” formula. This proposal is not without precedent since Representatives William Archer and Dan Burton first suggested it in H.R. 3166, legislation they introduced in 105<sup>th</sup> Congress to require MSAs in FEHBP.

In sum, FEHBP consumers did not ask for HSA/catastrophic plans, but we are concerned they will be imposed upon us. FEHBP is the best employer sponsored health insurance system in the country. NARFE wants to keep it that way and feel it is wrong to use it as a guinea pig by introducing risky schemes that are untested in a large, multiple option, group health plan.

Most of my fellow annuitants and I started our careers in federal service when we were younger and healthier. Indeed, most of us paid more into health insurance than we got out of it. Now that we have retired, our health needs have increased and some of us get more out of health insurance than we pay into it. What really gets NARFE members' hackles up is that HSAs now could sabotage this "contract between generations" by introducing adverse selection based on health, wealth and age.

For that reason, we implore this subcommittee to ensure that OPM's plan to impose HSAs in FEHBP is withdrawn.

### Conclusion

For 44 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 is now being challenged by significantly higher health care costs. I can assure this committee, that adequate, affordable health care coverage is of paramount importance to retirees. NARFE stands ready to work with this panel, others in Congress and the OPM to find ways and means of containing out-of-control health care costs without sacrificing quality, and to assure the federal family of access and coverage without resorting to proposals that only shift costs to enrollees, or that circumvent risk sharing in our group plan environment.