

**STATEMENT OF  
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**Before the**

**SPECIAL COMMITTEE ON AGING  
UNITED STATES SENATE**

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Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Federal Employees Health Benefits (FEHB) Program.

Our Health Benefits Program has been in operation for more than forty years. It is an employer-based program and forms an important part of the compensation package offered by the Government, enabling it to recruit and retain individuals who carry out the vital work of government. The operating philosophy of the Program is competition with a consumer focus, just as President Bush has highlighted in his framework for Medicare reform.

The Office of Personnel Management (OPM) has developed widely-recognized expertise in the complexities of arranging health care coverage with more than one hundred private sector health plans with a covered population of about eight and a half million people including 2.2 million employees, 1.9 million retirees, and members of their families. In 2002, the program accounted for \$24 billion in annual premium revenue. The Director of OPM, Kay Coles James, has made the FEHB Program a central focus of OPM attention, especially in terms of maintaining competition while ensuring that Federal employees and retirees and their families receive high quality services. Her strategy has been to encourage innovation from the health plans, support tough negotiations by her contracting staff, collaborate with the OPM Inspector General in his efforts to detect and control fraud and cultivate a culture of accountability within the FEHB Program at all levels, and finally to focus on the demand side by working with the health plans to make sure their members have the information they need to make the right choices about healthy life styles and appropriate utilization of services.

**FEHB Program Structure**

The Program relies heavily on market competition and consumer choice to provide our members with comprehensive, affordable health care. In 2003, 188 discrete options are being offered by 133 health plans.

An important and distinctive feature is nationwide availability. No matter where one lives, all members may choose from among a dozen options offered by nationwide fee-for-service/preferred provider organization (PPO) plans open to all. Some members may elect one of the six nationwide plans limited to members of sponsoring organizations, and many may choose a Health Maintenance Organization (HMO) in their geographic area. About 3 million Federal enrollees are in fee-for-service/PPO plans and 1 million in HMO's. There is an opportunity to enroll in the Program, change health plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November. OPM and the participating plans provide information on benefits and rates, provider availability, and quality indicators during the annual open season so that members can determine which plan best suits their needs and the needs of their family and make their plan election.

All of the FEHB national plans, except for the Blue Cross and Blue Shield (BCBS) Basic Option, offer their members access to all of the covered providers in their community. But for those providers that have not agreed to participate in a preferred provider network, the member does not get the advantage of reduced out-of-pocket costs. Since the fee-for-service plans introduced preferred provider networks into the Program in the 1980s, we have always made clear in our informational materials that the preferred provider benefit is an enhancement over the standard non-network benefit offered by the plans. In a typical network arrangement, the provider agrees to accept a rate of payment lower than billed charges in exchange for advantages such as more potential patients, expedited reimbursements, and other services provided by the plan. Often plans monitor the services provided in-network to ensure that their providers are well informed about current practice patterns and new developments in health care delivery. The plan, in turn, can pass on the benefits it derives from provider participation in the network to members in the form of lower out-of-pocket costs when they use a preferred provider. Those lower costs are offered as an incentive to members to choose in-network services when they are available. We have never guaranteed in-network coverage except in the BCBS Basic Option. Since Basic is an Option in a nationwide plan and it provides no coverage for out-of-network services, we negotiated special provisions to ensure that coverage would be available everywhere in the country.

While all participating plans offer a core set of benefits broadly outlined in statute, benefits vary among plans because there is no standard benefits package. Even where coverage is nearly identical, cost-sharing provisions may differ significantly among plans.

The design of the FEHB Program permits OPM to focus on three key elements: policy design, contract negotiations, and contract administration including financial oversight.

### **Benefit and Rate Negotiations**

While benefits and rates are negotiated annually, OPM does not issue a request for bids. Instead we issue a call letter to participating carriers in the spring that provides them guidance for the upcoming negotiations. The call letter is a strategic tool in setting the

stage for negotiations and highlighting the interests of the Director. In 2002, OPM highlighted coverage for colorectal screenings in the context of competition for members among the plans. In 2003, OPM highlighted coverage for preventive services, and sound oversight by the plans of their pharmacy benefits managers. Plans remain in the Program from year to year unless they choose to terminate their contracts for business reasons, including failure to reach agreement with OPM on benefits and rates for the coming year. Under current law, the window for new plans to enter the Program is limited to HMO's. Unlike the 1980s when we were flooded with HMO applications, in the current market, we average about 6 new plans a year.

Rates are negotiated with the national plans based primarily on their claims experience. About 93 percent of premium, or 93 cents out of every dollar, reflects benefit costs. The remaining 7 percent covers the plan's administrative costs.

For the community-rated plans, rate negotiations are based on a per member per month community rate. Adjustments may be negotiated to the base rate for a variety of reasons, including changes to their standard benefits package, the demographics of the Federal group, and the utilization of benefits by the Federal group.

We, along with all purchasers of health insurance, have experienced significant rate increases over the past few years. Our increase in 2003 was 11.1 percent, which was high, but well below the industry average. The increase for CalPERS, the second largest employer-based program in the country, was 25 percent. In 2002, our increase was 13.3 percent. In 2001 it was 10.5 percent.

### **Contract Administration and Financial Oversight**

Our oversight focuses on key areas of plan performance, including attention to quality, customer service, and financial accountability. Measures and expectations regarding quality assurance, patient safety, prevention of fraud and abuse, and compliance with accounting standards are built into our contracts. Some measures, such as the results of the industry standard consumer satisfaction survey conducted annually, and the accreditation of health plans and providers by independent accrediting organizations, are reported to our members in both print and electronic format. Members use the information, often in conjunction with decision support tools that we provide on our web site, to choose their health plan during the annual open season.

We began recently to centralize plan performance data in a data repository that facilitates analysis by contracting staff. All of our contracts include mechanisms through which profits can be adjusted based on performance.

In addition to oversight by the contracting office, all carriers are subject to audit by the independent OPM Inspector General (IG). As a result of the close collaborative relationship between the contracting office and the IG, the Program recovers on average more than one hundred million dollars a year based on defective community rate findings and unallowable administrative expense or benefit cost findings. Director James views

the OPM IG as a central partner in maintaining the creditability of the Program in the eyes of employees and retirees. She has supported successive increases in the IG's budget to expand his oversight capacity. This year, our call letter telegraphed specifically the Director's interest in working with the IG to review costs associated with the operation of pharmacy benefits managers in the Program.

## **Policy Design**

We administer the FEHB Program in a way that mirrors other employer-based health insurance programs. We also are in compliance with all applicable Federal laws and meet all the standard Federal accountability requirements.

While the Program has a statutory and regulatory framework, key aspects of plan design, such as coverage or exclusion of certain services and benefit levels are in neither law nor regulation.

Within broad parameters set by OPM, plans have the flexibility to determine both their benefits package and their delivery system. Because policy guidance is developed by OPM and provided to the plans annually prior to the start of negotiations, policy changes can be made quickly in response to market factors. For example, this past year we accepted a proposal from one of our plans for a consumer-driven option that reflects the development of new products in a fluid market.

Because our policy is to encourage innovation and private sector initiatives, plans use business-based processes to achieve desired results. For example, when Blue Cross and Blue Shield introduced its basic option a couple of years ago, they had to make adjustments to their provider arrangements to ensure members access to a nationwide provider network since the plan does not cover out-of-network services. Other plans take a different approach and guarantee out-of-network benefits only in parts of the country where they cannot develop a strong provider network, such as rural areas.

While plans have considerable flexibility to deal with specific issues such as access to services, the FEHB Program, by statute, has a provision for Medically Underserved Areas that ensures that Members have access to health care providers. Our fee-for-service plans must pay for covered services provided by any licensed provider practicing within the scope of his or her license, even if that provider is not considered a covered plan provider.

## **Conclusion**

The FEHB Program uses a hybrid approach that shares practices with both public sector and private employer health insurance programs. While we believe the Program has been very successful over its long history in offering Federal employees, retirees, and their families quality coverage for a reasonable price, we are always looking for ways to ensure that it continues to reflect the current health care environment, meets the needs of its members, and serves the Government in its recruitment and retention efforts. While

our survey results are relatively good – about 80 percent of those enrolled in our national plans are satisfied – our work with the participating plans on quality improvement is ongoing.

We have benefited from close collaboration with the participating health plans and with other purchasers. We also work closely with the Center for Medicare and Medicaid Services (CMS), particularly on issues affecting the population we serve jointly, our Medicare-covered retirees.

We think that the FEHB Program is an excellent example of effective public-private partnerships.

Thank you for inviting me to be here today. I will be pleased to answer your questions.