2009 BLUE CROSS BLUE SHIELD HEALTH BENEFIT: WHAT IT MEANS FOR FEDERAL EMPLOYEES

HEARING

BEFORE THE

SUBCOMMITTEE ON FEDERAL WORKFORCE, POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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2009 BLUE CROSS BLUE SHIELD HEALTH BENEFIT: WHAT IT MEANS FOR FEDERAL EMPLOYEES

WEDNESDAY, DECEMBER 3, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON FEDERAL WORKFORCE, POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m., in room 2154, Rayburn House Office Building, Hon. Danny K. Davis (chairman of the subcommittee) presiding.

Present: Representatives Davis, Norton, Cummings, and Sarbanes.

Staff present: Tania Shand, staff director; William Miles, professional staff member; Marcus A. Williams, clerk/press secretary; Jill Schmalz, minority counsel; Alex Cooper and Adam Fromm, minority professional staff members; Howard Denis, minority senior professional staff member; and Patrick Lyden, minority parliamentarian and Member services coordinator.

Mr. DAVIS. Never believing in punishing those who are where they should be at the time they had said they would be, we are going to go ahead and call the hearing to order.

It is my understanding that we do have, that Delegate Eleanor Holmes Norton is on the way momentarily and will be here. So, the subcommittee will now come to order. Unfortunately, Ranking Member Marchant will not be here.

Members of the subcommittee, hearing witnesses and all those in attendance, welcome to the Subcommittee on the Federal Workforce, Postal Service, and the District of Columbia's hearing to examine the changes in Blue Cross and Blue Shield's benefits and premiums for 2009 Federal Employees Health Benefits Program.

The Chair, ranking member, and subcommittee members will each have 5 minutes to make opening statements, and all Members will have 3 days to submit statements for the record. Hearing no objection, so is the order.

I will then go ahead with an opening statement. Other Members will have the opportunity to do so when and should they come.

The Federal Employees Health Benefits Program is arguably the gold standard for employee sponsored health insurance programs. It provides health insurance coverage to approximately 8 million people, including Members of Congress, and is the largest employer-sponsored health insurance program in the United States.

The Office of Personnel Management [OPM], negotiates plan benefits with the health plans and is responsible for ensuring that the Federal Government and its employees get good value for their health care dollars. Yet, the program still struggles with high premium cost and plan quality. Last week my subcommittee office received numerous calls from congressional staff members, Members' offices and plan participants about changes to the 2009 Blue Cross Blue Shield standard option benefit plan. Spurred by reports in the Washington Post Federal Diary column, Roll Call, and most recently U.S. News & World Report, all the callers expressed outrage about the changes.

One Blue Cross Blue Shield subscriber wrote in an e-mail to my staff, "I thought that OPM was supposed to represent the interests of Federal employees and retirees in negotiating coverage. The 13 percent increase in premiums coupled with the dramatic reduction in coverage for out-of-network surgical expenses makes me wonder, who indeed is at the helm? The 2009 proposed coverage would also expose subscribers to financial duress."

In addition to the 13 percent increase in premiums for the Blue Cross Blue Shield standard option, 2009 beneficiaries will be responsible for paying up to $7,500 for surgery performed by non-participating physicians, except in the case of medical emergencies or accidents. And for mail order brand name drugs, the co-payment will be raised to $65 per prescription for the first 30 prescriptions filled or refilled and $50 thereafter. This is of concern to many individuals because the current fee to fill a prescription is $35.

The question is asked, who indeed is at the helm? Are these changes emblematic of larger concerns and challenges? While plan participants can use in-network physicians or simply opt out of Blue Cross Blue Shield and into one of any number of other plans, we must question the structural framework of the program, plan negotiations, and what led Blue Cross Blue Shield to implement such drastic changes?

This issue deeply concerns me. Blue Cross Blue Shield is one of our Nation's oldest and most prominent nonprofit health insurance companies. When patients turn to name brand health insurers like Blue Cross Blue Shield, they do so for their physical, mental, and social well being. And while I understand that Blue Cross is reexamining its 2009 benefit option, and I am pleased that it is doing so, Americans, FEHBP participants included, can no longer assume that their current health insurer will perform in a reasonable fashion, especially as it relates to their ability to experience coverage at an affordable cost.

There is a lesson here for those seeking to reform America's health care systems. Expansions in coverage must mean more than simply paying for health insurance policies. At a minimum, this case shows us that we also need to consider appropriate regulations and oversight to ensure that Americans will actually get the care they need at affordable rates.

I look forward to the testimony of today's witnesses. It is my belief that today's hearing will not only assist plan participants in choosing a health plan before open season closes on Monday, but it will also assist the subcommittee in setting its hearing agenda for FEHBP during the next session. I thank you very much.

And I am delighted that Delegate Norton is here.
I ask if you have some opening comments.
[The prepared statement of Hon. Danny K. Davis follows:]

STATEMENT OF CHAIRMAN DANNY K. DAVIS
AT THE SUBCOMMITTEE ON FEDERAL WORKFORCE
AND POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA
HEARING ON

FEHBP and the 2009 BlueCross BlueShield Health Benefit Plan

December 3, 2008

The Federal Employees Health Benefits Program (FEHBP) is arguably the gold standard for employee sponsored health insurance programs. It provides health insurance coverage to approximately 8 million people, including Members of Congress, and is the largest employer-sponsored health insurance program in the United States. The Office of Personnel Management (OPM) negotiates plan benefits with the health plans and is responsible for ensuring that the federal government and its employees get good value for their health care dollars. Yet, the program still struggles with high premium costs and plan quality.

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In addition to the 13 percent increase in premiums for the Blue Cross Blue Shield standard option; 2009 beneficiaries will be responsible for paying up to $7,500 for surgery performed by a *non-participating physician*, except in the case of medical emergencies or accidents; and for mail-order brand-name drugs, the copayment will be raised to $65 per prescription for the first 30 prescriptions filled or refilled and $50 thereafter. This is of concern to many individuals because the current fee to fill a prescription is $35.

Who, indeed, is at the helm? Are these changes emblematic of larger concerns and challenges? While plan participants can use in-network physicians, or simple opt out of Blue Cross Blue Shield and into one of any number of other plans, we must question the structural framework of the program, plan negotiations, and what led Blue Cross Blue Shield to implement such drastic changes.

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Ms. NORTON. Thank you, Mr. Chairman.

Just a word or two. I want to thank you for responding to the concerns, particularly among Federal employees, who have tended to favor Blue Cross Blue Shield, so that we can get an explanation for what appear to be failures on the part of the two parties that employees depend upon, OPM and Blue Cross. The failure of transparency and clear explanation from the Blues seems to be clear. It is kind of search and ye shall find a very substantial cost change for enrollees.

And the failure on the part of OPM may be the honest broker failure. We depend upon OPM to keep the plan, which is much marketed as one of the best in the country because of its choice, transparent and understandable, and frankly, to be an honest broker with the plans. You know, Blue Cross Blue Shield may be about to squander the huge advantage it has had. It is a nonprofit health care plan. And one of its chief advantages is that it has seemed to offer people the ultimate choice, fee-for-service, while being a preferred provider. But this very unfortunate revelation casts—will make subscribers look very closely at Blue Shield and whether or not the almost automatic renewal has been worth it.

Obviously, this is a more expensive plan, but the very educated Federal worker has trusted Blue Shield—Blue Cross Blue Shield, and has been willing to pay for what seemed to be to many of them worth it. The cost of the standard option, however, has been increasing faster for Blue Cross Blue Shield and is now considerably more expensive than for others.

Particularly in these hard times, Blue Cross Blue Shield really stands to lose market share, and perhaps should. They shouldn't be making mistakes now. And they shouldn't be making mistakes in a plan that employees have favored, and now I think will make employees far more skeptical. Whatever the explanation, you don't bury this kind of potential cost increase in the fine print. You don't do it when you are dealing with Federal employees, because they do read. They finally get it. They perhaps got it too late, and I hope that there will be an opportunity for people to consider beyond December 8th whether or not they ought to stay in this plan, particularly since most people didn't get it, I bet. And to the extent that they get it at all, it is because the chairman has come all the way from Chicago to hold a hearing so that OPM and Blue Cross Blue Shield can explain themselves.

As for OPM, we are very disappointed. OPM seems not to be able to itself keep up with the complexity that attends health care plans today. I think everybody who is in a plan better take a much closer look at these plans. And the notion that the fine print may be burying costs is extremely troubling because transparency has been the hallmark of the FEHBP.

We hope that in the course of this hearing we will understand what was at the bottom of this, because we are left, you see, to speculate as to why this simply wasn't made clearer, particularly since it involves itself some complexity in order to be understood by one who is enrolled. And we need to know whether or not this kind of change is emblematic of what we can expect and what OPM intends to do about it. Again, I thank you very much, Mr. Chair-

man, for believing that this was important enough to come and hold this hearing this morning.

Mr. DAVIS. Thank you very much, Delegate Norton.

We will now go to our witnesses. I will introduce the first panel, and then we will swear them in and proceed.

Our first panel of witnesses: Mr. Walton Francis is a self-employed economist, policy analyst, and expert in the analysis and evaluation of public programs. He pioneered the systemic comparison of health insurance plans from a consumer perspective. And for 30 consecutive years, Mr. Francis has authored the annual CHECKBOOK's Guide To Health Plans For Federal Employees.

We thank you for coming, Mr. Francis.

And we will then also ask if Dr. Peter E. Petrucci will come to the table. Dr. Petrucci is board certified in general surgery and is a fellow in the American College of Surgeons. On several occasions, the Washingtonian Magazine has named Dr. Petrucci one of the top surgical specialists in the region. He also has been awarded distinction as one of the best doctors in America, having been selected by a consensus of physician colleagues as being among the top 4 percent of all physicians in his specialty.

Gentlemen, I want to thank you very much for coming. And if you would rise and raise your right hands, it is the procedure of this committee that all witnesses be sworn in.

[Witnesses sworn.]

Mr. DAVIS. The record will show that the witnesses answered in the affirmative.

Gentlemen, will you try and take 5 minutes? We don't always necessarily hold to that. But we try to have a 5-minute statement. The light sort of indicates the beginning, green go. Yellow means that you are down to 1 minute. And of course red is an indication that you stop. We try not to curtail witnesses' testimony, especially if they are wrapping up.

But if you would begin, and we will begin with you, Mr. Francis. Thank you very much.

STATEMENTS OF WALTON FRANCIS, AUTHOR, CHECKBOOK'S GUIDE TO HEALTH PLANS FOR FEDERAL EMPLOYEES; AND PETER E. PETRUCCI, M.D., PRESIDENT, MEDICAL STAFF, SIBLEY MEMORIAL HOSPITAL

STATEMENT OF WALTON FRANCIS

Mr. FRANCIS. Thank you, Mr. Chairman, Ms. Norton.

I think this hearing and the prior reporting in the Washington Post are examples of the bests of the private and public oversight in America. And I congratulate you on having this hearing. I think it is extremely important.

I am wearing two hats today, both as a consumer advocate and as a health care economist. And I am going to make some larger points about some of the problems of the FEHBP program that I think contributed not just to this particular benefit change that provoked this hearing, but as you already said, Mr. Chairman, there are a number of benefit changes and large premium increases in the Blue Cross plan. And the question is, why is that happening,

and is it necessary? And are there forces at issue that could have prevented some of this?

By the way, I am here speaking solely in my own personal capacity, not for CHECKBOOK magazine, and not for the Centers for Medicare and Medicaid Services, where I consult.

Focusing first just on the Blue Cross benefit changes this year, the key point is, the cutback in out-of-network surgery is not the only negative change. There are a number of others; increase in prescription drug co-payment, for example. There are also a few benefit improvements. But the benefit reductions greatly outweigh those.

Important to understand though, is, that had Blue Cross not cut back some of these benefits, its premium would have been greater, could have been several hundred dollars greater; could have been, instead of 13 percent, it might have been 20 percent.

The specific change that I think is most problematic this year is this ceiling on—it is not even clearly described in the Blue Cross brochure. Is it a deductible? Is it a co-payment? Or is it just a maximum? It is never fully described or categorized, which itself creates problems I will come to in a minute. But this increase of paying up to $7,500 for surgery using non-preferred providers presents—it is a massive benefit reduction, though there is an offsetting saving for some people because it does reduce potential balance billing problems. And I think that may have been a major factor in the decision to do this.

Second, it is a major reduction in catastrophic protection. The promised maximum you will have to pay out-of-pocket if you use nonpreferred providers of Blue Cross is $7,000. But actually, it is $7,000 plus $7,500. It is $14,500 with this change. And that is a big, big difference.

It is inconsistent I think with the promise and the premise that Blue Cross does remain fundamentally a fee-for-service plan and ought to have a good fee-for-service benefit. It is described on the cover its brochure as a fee-for-service plan with a preferred provider network. But it ought to have good fee-for-service benefits.

Finally, and most problematic, it is a gotcha trap. There has already been one clarification as to what happens in emergencies, because it wasn't clear earlier, if someone might involuntarily be exposed to the $7,500, not even realizing that was happening. I do a lot of consumer advice. Last night I answered e-mail, and it shocked me. A woman's 88-year-old mother is going to get surgery from a non-preferred provider, and she can't get a straight answer from Blue Cross as to whether or not—this mother has Medicare parts A and B—as to whether or not she will be exposed to this payment. I looked carefully last night at the Blue Cross brochure, which has a separate promise for people on Medicare, and it is unclear to me. But the better reading of it, it seems to be that, for the first time, there is not a hundred percent you-will-pay-nothing promise to people on Medicare parts A and B. I am not sure I am reading it correctly, but the point is this shouldn't be ambiguous. It shouldn't be debatable. Blue Cross representatives shouldn't be giving conflicting answers.

Most importantly, there are other alternatives that could have been used no matter what problem was being addressed. For exam-

ple precertification for certain kinds of surgery could have been used or prior approval. Let me stop there. That is sort of what happened here and my take on it.

Now let's talk about why it happened. There are some very important flaws. I go into these in great detail in my testimony. I won't belabor them here. But the aging of the Federal work force has created tremendous cost pressures, particularly and disproportionately on plans like Blue Cross that have loyal members who joined at age 30 when they were cheap; and they are still there at age 50 when they cost twice as much on an actuarial basis; and they are still there at age 70 when they cost twice as much again. So that is a tremendous pressure on Blue Cross.

The premium design of the FEHBP program is flawed in a particular way. When I pick a cheaper plan, I only get 75—I only get 25 percent of the savings. The government gets 75 percent. Medicare Advantage, it is the other way around. So my incentive to find a cheaper plan is greatly reduced. I don't get most of the savings. And the incentives of the plans to offer less expensive benefits is greatly reduced.

Then we have premium conversion added to this. Premium conversion, however nice it might have been as a little added twist to fringe benefits, and it did after all merely put the Federal work force in the same status as the Fortune 500 work force in terms of tax preferences on health insurance premiums, but premium conversion eroded all the incentives for cost saving on both plans and enrollees in this program. And it is no coincidence that the performance of the FEHBP has worsened dramatically in controlling costs in the last 10 years since premium conversion went in place. I think the Obama administration is going to deal with that issue in a broader context, but it is there.

There is a serious Medicare coordination problem. Neither program has addressed it appropriately. I think that the current legislative prohibition, statutory prohibition against plans paying the costs of the Medicare Part B premium should be lifted, and plans should be encouraged and maybe even required to pay part of that premium before they go into this you won't have to pay anything out-of-pocket mode, which is a huge cost driver. There's a lot of economic research that shows that situations where you pay nothing for medical care are situations where there is a great deal of waste and over-utilization, which costs the taxpayer a ton of money, and other enrollees in the program a ton of money.

There are solutions to all these things. I discuss them—I just want to talk a moment, though, and then I will end my testimony, about consumer information. There is a longstanding problem in the FEHBP consumer information relating to the statement and description of catastrophic protections. And it has gotten worse. It has gotten worse in part because plan complexity has grown. But the fact is, if you pick up a brochure today and it says this plan guarantees that you won't pay more than 5 or 6 or $8,000 out-of-pocket, that is not true. Buried in the small print you are going to find, oh, well, this didn't include the deductible, or this didn't include the $7,500 out-of-network surgery, or it didn't include your prescription drug co-payments. Whatever it doesn't include, and that varies from plan to plan, it makes it impossible for an ordi-

nary human being to compare those stated catastrophic limits. And it means there's lots of loopholes in them. There is no reason this has to happen. There is no reason OPM can't require that the catastrophic limits include all the significant costs to which you might be exposed that can be measured ahead of time. That doesn't include, unfortunately, balanced billing, but it includes just about everything else. There is no reason why prescription drugs shouldn't be in those catastrophic limits. We don't need a separate catastrophic limit, which to OPM's credit they have insisted that all the plans give you some protection against specialty drugs, that can reach tens or even hundreds of thousands of dollars, that should be in the regular catastrophic limit.

Then there is a question, do consumers even learn about this stuff? Every Medicare beneficiary in the country gets mailed to them "Medicare And You," a 100-page booklet written in clear English, big typeface, that explains Medicare benefits and describes in some detail the Medicare Advantage plans for which they are eligible. OPM publishes a similar booklet. I am holding up the one for annuitants, "Guide To Federal Benefits For Federal Retirees and Their Survivors." But this is not mailed. Nobody gets this. They can download it on the Internet, but it is not mailed to them. And of course, in the aging population, retired population, there is a very large fraction that don't use the Internet any way. Why isn't it mailed? Because OPM salary and expenses account won't—isn't big enough to pay for the postage costs. It is absurd. And there is no reason why retirees shouldn't get this information.

Then, however, if you look at what is in it, OPM no longer publishes the catastrophic limit on these plans in its summary description of benefits. That is probably a good thing, because until they fix it, those limits are misleading. But they do, and I will say this for them, the $7,500 maximum, you know, the surgery cutback is shown in this document, which nobody gets. The summary page of the Blue Cross brochure itself, the last page summary of benefits, does not show the $7,500 reduction for out-of-network surgery.

So let me stop there and simply say, there is—there are administrative actions that could be taken. There are legislative steps that could be taken within the jurisdiction of this committee, and there are legislative actions which may be primarily in the jurisdiction of Ways and Means, but they also could be taken relating to Medicare coordination. That concludes my testimony.

[The prepared statement of Mr. Francis follows:]

FEHBP FINANCIAL PROBLEMS AND BLUE CROSS BENEFIT REDUCTIONS AND PREMIUM INCREASES

Testimony of Walton Francis

Independent Consultant and Principal Author of
CHECKBOOK's Guide To Health Plans For Federal Employees

Before the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia

Committee on Oversight and Government Reform

U.S. House of Representatives

December 3, 2008

Mr. Chairman, and members of the Subcommittee:

I am pleased to testify before you today concerning the current status and performance of the Federal Employees Health Benefits Program (FEHBP).[1] The FEHBP is a vital component of Federal employee compensation—providing the majority of employees and annuitants a benefit whose cost for the government share of a family premium averages about $6,000. This is $6,000 in compensation that most employees and annuitants don't even realize they get because it never shows up in a pay stub or W-2 statement.

Total spending in this program in 2009 will be approximately $38 billion for premiums—both government and enrollee share—and $5 billion more in enrollee cost sharing. Eight million people depend on it for health care. It is a large responsibility for the Office of Personnel Management and for the Congress.

The FEHBP program is a remarkable success among Federal health insurance programs, both for its ability to control costs and for its ability to meet enrollee needs. It is perennially cited as a model for national health insurance reforms. It was the model for the Medicare Advantage program enacted in 2003 in the Medicare Modernization Act. I won't dwell on its successes because others and I have amply explained these in many previous evaluations. Important among these, however, is its continuing ability to hold down health care costs while meeting enrollee preferences for benefits and service. Until very recently, it had a record in holding down health insurance costs that clearly outperformed Original Medicare. It achieved this result through competition among plans to meet consumer needs, not through price controls and other top-down mandates.

Unfortunately, in recent years FEHBP performance has greatly slipped. In the ten-year period from 1989 through 1998, the average annual increase in per enrollee costs, adjusted for benefit improvements, was 7.5 percent in Medicare and 5.1 percent in the FEHBP. The FEHBP was outperforming Medicare, hands down. In the ten-year period from 1999 through 2008, the average annual increase was 5.6 percent in Medicare and 7.5 percent in the FEHBP, a complete reversal in relative performance (from Walton Francis, *Putting Medicare Consumers in Charge: Lesson from the FEHBP*, AEI Press, forthcoming).

Meeting enrollee health care needs through choice among plans is perhaps the program's strongest feature. Every fall I counsel hundreds of employees and retirees on health plan choices at seminars, on the radio, and by email. What constantly amazes and pleases these consumers is that there is a health plan to meet almost any need. Unlike almost all private sector employers, decisions on benefits are made by plans responding to consumers, rather than by faceless headquarters bureaucrats. In the FEHBP, enrollees who vote with their feet, not by fiat, make most final decisions.

However, before enrollees "vote," plans make marketing choices, sometimes to increase benefits and sometimes to decrease benefits. I am here today to talk to you about:

1. The surgical benefit limitation and other recent decisions of the Blue Cross plans,

[1] I am testifying in my personal capacity, not as the principal author of *CHECKBOOK's Guide to Health Plans for Federal Employees*, and not as a consultant to the Centers for Medicare and Medicaid Services. All views expressed are my own.

2. Underlying and potentially fatal trends and flaws that are increasingly crippling both the FEHBP as a program and the ability of plans to effectively manage both benefits and costs, and leading to decisions such as the ones made by Blue Cross, and
3. Essential reforms if the program is to regain its ability to contain costs while delivering quality services, and to thrive over the years ahead.

1. The Blue Cross Standard Option Benefit Cutback for Surgery Performed by a Non-Participating Surgeon.

Substantial controversy has arisen over one of the many benefit changes that the Blue Cross and Blue Shield plan (Blue Cross for short) has made for the 2009 plan year. I would like to comment on that change from the perspective of effects on enrollees, wearing my consumer advice hat.

This particular change should be put in a larger perspective. Over the last three years Blue Cross has made several dozen changes to its Standard Option benefits. Most of these have been reductions designed to reduce costs and hold the premiums down, but some have been improvements. For example, for 2009 the plan is reducing its coinsurance for generic drugs purchased at retail from 25 percent to 20 percent, and is providing the first four generic mail order prescriptions at no cost. As requested by OPM, and like most other plans, Blue Cross is also adding a hearing aid benefit for adults, one that will be particularly significant since about half of Blue Cross Standard enrollees are annuitants.

However, the benefit reductions over the past several years have been far more significant. Taking the plan years 2007 to 2009, and focusing only on preferred providers, some (but not all) benefit reductions include:

- The deductible has risen from $250 to $300 per person (maximum of two per family),
- The per visit physician copayment has risen from $15 to $20,
- The hospital copayment per admission has risen from $100 to $200,
- The copayment for mail order brand name drugs has risen from $35 to $65 for a 90 day supply, and
- The catastrophic limit has risen from $4,000 to $5,000 (both self-only and family) when using preferred providers.

Some of these benefit reductions affect all enrollees, and most of them potentially impact most enrollees in important ways. Singly and cumulatively, they are far more important to most enrollees than reducing one fee-for-service benefit that is relatively rarely used.

Moreover, during this same period the enrollee share of the Blue Cross Standard Option premium has risen very substantially, considerably more than the average for other plans. In 2007 the total self only premium (both government and enrollee share) was near the enrollment-weighted average for all plans. However, by 2009 the total premium was well above the average for all plans. Because the FEHBP premium sharing formula is designed to reward more frugal plan choices, enrollees must pay the entire premium above 72 percent of the all-plan average. As a result, although the Blue Cross Standard Option total increase over the most recent two-year period was only about 13 percent, the enrollee share of premium jumped by about 22 percent.

Recent Blue Cross Standard Option Premium Increases

	2007	2008	2009	Increase 2007-2009
Total Annual Premium:				
Self Only	$5,180	$5,390	$5,870	13.3%
Family	$11,860	$12,340	$13,450	13.4%
Enrollee Share of Annual Premium:				
Self Only	$1,490	$1,620	$1,820	22.1%
Family	$3,490	$3,770	$4,280	22.6%

These premium increases occurred despite the rather significant benefit reductions I have already described. Had benefits remained unchanged, the Blue Cross premium increases would have been substantially higher. For example, assuming an average of about eight or nine physician visits, the combined effect of the higher deductible and per visit copayment increase would be about $100 on the enrollee share of premium, and the enrollee premium increase would have been about 25 percent for families, and about 30 percent self only, without these benefit reductions. In the latest edition of *CHECKBOOK's Guide to Health Plans for Federal Employees*, Blue Cross Standard Option rates as one of the most expensive half-dozen plans, usually one of most expensive three plans, in every comparison we make for employees and annuitants among the 29 plan options available in the DC metropolitan area.

In summary, the Blue Cross Standard Option is a plan in competitive trouble, and a plan that is trying to work out of its trouble. In the second part of my testimony I will address the causes of the problems that afflict this and other plans.

In this larger context, the reduction in benefits for using non-participating surgeons is arguably a small and relatively unimportant change. I do not know why the plan made this change, and you will learn the answer in other testimony. I suspect, however, that the primary purpose of this change was to deal with erosion of market share of preferred providers caused by recent growth in so-called "Specialty Hospitals" and "Ambulatory Surgical Centers." These provider types are putting great pressure on community hospitals because they have been able, on average, to deliver specialized surgical and other services at lower costs. To the extent that enrollees can find alternative providers at attractive rates, this puts great pressure on the ability of Blue Cross to build and retain its preferred provider network. Regardless of this or other factors that may seemingly justify this benefit reduction, I think the surgery benefit change that Blue Cross proposed, and that the Office of Personnel Management approved in contract negotiations, was not well considered.

The specific change that has attracted so much attention, as described in Section 2 of the 2009 Blue Cross brochure, "How we change for 2009," is that "**You now pay 100% of the billed amount up to a maximum of $7,500 for surgery performed by a Non-participating physician. Previously, you paid 25% of the plan allowance, plus any difference between our allowance and the billed amount.**" To take a concrete example, suppose an enrollee used a non-participating surgeon for an operation for which the charge was $5,000. Assume that the

Blue Cross allowance for this surgery was $4,000. Then under the old benefit the enrollee would pay $1,000 (25%) for coinsurance, and $1,000 for the difference between the allowance and the billed amount—a total of $2,000. This was a hefty penalty for not using a participating provider, but a rational consumer might well make that decision for any of a number of good reasons. However, under the 2009 benefit change, that same enrollee would have to pay the entire cost of the surgery—$5,000.[2]

There was a further potential problem, because there are emergency circumstances where the enrollee might not have a practical choice. So a surgery that might otherwise have cost only $400 (10 percent of the plan allowance was the coinsurance for "preferred" physicians in 2008) would unexpectedly and involuntarily jump to $5,000 in my example, and even more in other scenarios. This potential problem has been eliminated by a clarification issued just a few days ago by Blue Cross and OPM, so I will defer to other testimony and ignore it in the rest of my testimony.

For a prudent enrollee, who wisely and carefully uses "due diligence" to understand plan benefits and limits his use of physicians and other providers to those who are "preferred" or "participating," the entire matter seems unimportant. There is no issue, and no problem. To this enrollee, this is an irrelevant change. Almost all HMOs cover none of the costs for surgery or other medical care when using non-network providers and that even larger benefit limitation is well understood and accepted.

However, there are four important aspects of the $7,500 cost exposure that make it extremely consumer unfriendly and an arguably unreasonable benefit change.[3]

First, for an enrollee who has good and sufficient medical or other reasons for using a particular non-participating physician, this is a massive benefit reduction. One way to think of it is as an additional deductible (or copayment). If an enrollee has only one medical procedure in a particular year, and uses a network hospital but a non-participating physician for that surgery, under the old benefit he would pay the regular $300 deductible, and the $200 hospital copayment, for a total of $500, before cost-sharing kicked in. Under the reduced benefit he would pay that same $500, plus an additional $7,500 copayment or deductible, for a total of $8,000 before he saw a penny of plan payment. $8,000 is an extraordinarily steep set of deductibles.

Second, this massively reduces catastrophic protection under the plan. The 2008 catastrophic protection out-of-pocket maximum for Blue Cross Standard Option, using non-preferred providers, is stated to be $6,500. There are some categories of expense not included in this amount, most importantly the difference between the Plan allowance and the billed amount, but these are unlikely to empty anyone's wallet and in any event cannot be measured in advance (I assume no one would be foolish enough to use a non-participating hospital for a major medical procedure involving a lengthy stay). For 2009, that limit is raised to $7,000, and the $7,500 cost

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[2] Blue Cross distinguishes among three classes of provider: preferred, participating, and non-participating. Cost sharing for most benefits depends on which class is used. I try to avoid undue details on these differences wherever possible.

[3] In my discussion, I will ignore the almost unbelievable additional limitation imposed by Blue Cross, in charging the enrollee up to $7,500 for the surgery "per surgeon per surgical day." Whatever this language means exactly, it seems to suggest that (say) a burn victim being debrided might face many $7,500 penalties, not just one.

exposure is added as an additional exclusion. In other words, the enrollee's out-of-pocket exposure is raised from about $6,500 to about $14,500. This is a huge decrease in catastrophic protection. By far the most important purpose of health insurance is to limit exposure to catastrophic expense, and $14,500 hardly seems to be a reasonable level of protection.

Third, this is fundamentally inconsistent with the explicit and implicit premises underlying the Blue Cross Standard Option model. Enrollees understand and expect that Blue Cross will cover much and usually most of the cost of services even at non-preferred providers. The Blue Cross Standard Option, like all other national plans other than Blue Cross Basic, is technically and legally a fee-for-service plan that covers services from any licensed provider. As the brochure cover states in large type, it is "a fee-for-service plan ... with a preferred provider organization." One of the very important reasons consumers pay higher premiums to join such a plan, rather than an HMO, is to be able to use non-network providers without having to pay most or all of the cost. Whether described as a deductible of $7,500, or as a catastrophic limit of $14,500, this penalty is inconsistent with that role.

Fourth, this change creates a major "gotcha" trap for the unwary. Most enrollees do not study the brochure. They have no expectation that such a penalty exists. This is a very high price to pay for a failure in due diligence. Importantly, the summary descriptions of the program fail to disclose the existence of this trap. Page 132 of the official Blue Cross brochure for 2009 presents a "Summary of benefits" for the Blue Cross Standard Option. That summary contains no hint that surgery might cost not just the stated "30% of our allowance" and actually goes on to say that there is "no deductible for surgery." The summary further states that the catastrophic protection out-of-pocket maximum for PPO/Non-PPO costs is $7,000. Almost as an aside, it says, "some costs do not count towards this protection." Surgery is not just "some costs" but a major component of benefits, and an extra $7,500 is not just "some costs." Furthermore, the official OPM Web site at www.opm.gov/insure contains a plan comparison feature that shows the Blue Cross Standard Option deductible to be $300 and its catastrophic limit to be $7,000 when using non-preferred providers. A note says that "copayments for certain services may not count toward your ... maximum," which hardly warns the user that for surgery the catastrophic limit is more than doubled.

These issues and problems might be acceptable if unavoidable. But they are not. No other plan feels impelled to impose such a financial penalty, although there are gaps in catastrophic limits in other plans that should be closed, as discussed later in my testimony.

Most importantly, it is hard to believe that there weren't reasonable alternatives. For example, if a deductible is clearly the best approach to solve the underlying problem, surely a lesser amount such as $1,000 or $2,000, followed by 25 percent coinsurance and payment of all amounts above the plan allowance would have sufficed to eliminate most if not all of the problem. Enrollees already faced a substantial financial penalty for using non-preferred providers, and at some point additional penalty is overkill.

Other alternatives might have been possible. The catastrophic limit might have been raised to $10,000, without excluding the $7,500. Second opinions could have been required. Precertification or prior approval could have been extended from covering only non-emergency hospital stays to covering all non-emergency surgery whose costs exceeded a certain level, or all surgery of the specific types (whatever they may be) that seem to be causing the most network problems.

In considering the reasonableness of options that the Plan and OPM might have considered, it is important to consider the roll of Medicare. As shown in the table below, about one third of total Blue Cross Standard Option enrollment is enrolled in Medicare Parts A, B, or (overwhelmingly) both. These enrollees are not subject to the $7,500 deductible. They have 100 percent coverage for surgery whether or not they use preferred providers. Hence, the change in cost sharing had no effect on their incentives. However, alternative incentives, such as prior approval, or even a nominal copayment such as $100 might have been effective with these enrollees. Blue Cross added a prior approval requirement for surgery for morbid obesity for 2009, and could have expanded this to cover other types of surgery.

Blue Cross Standard Option Enrollment in 2008

	Self	Family	Total
Total	970	1,051	2,021
Employee	349	631	980
Annuitant	621	420	1,041
Annuitant percent	64%	40%	52%
Medicare percent (assumes program average of 2/3 of annuitants)	43%	27%	34%

2. Trends and Flaws that are Increasingly Crippling the FEHBP and Driving Blue Cross Costs Upwards.

The FEHBP program is showing its age. It has a number of important defects, some self-inflicted, but most simply reflecting a program design that has not significantly changed in almost 50 years. That design has withstood the text of time remarkably well, but is frayed around the edges in several areas. I am going to focus on four areas, though there are others:

- Complexity of Benefit Design and Catastrophic Protection
- Aging Work Force and Health Care Costs
- Premium Design
- Medicare and FEHBP Coordination

Complexity of Benefit Design and Catastrophic Protection. Over the years, plan design has gotten increasingly complex. Twenty years ago, three and six tier prescription drug benefits did not exist. High deductible plans did not exist. So-called "specialty drugs" were rare and relatively inexpensive. Few plans used provider networks. And so on.

As plans have used these and other tools to control costs, the numbers of gaps and loopholes in benefits have grown. For example, most national plans used to include prescription drugs in their catastrophic limits. Today, many do not, relying on relatively nominal copayments to limit enrollee cost exposure. But that has created problems when enrollees require "specialty drugs" that can cost thousands of dollars. OPM has worked diligently to close these gaps, but that has led to increased complexity in catastrophic limits. Some plans now have two limits, one for medical costs and one for drug costs.

This has led to serious inconsistencies in the ways plans determine as well as present their catastrophic limits. It is an important part of the issue regarding the Blue Cross surgery benefit

limitation, but it appears in many other plans. For example, here is a comparison table similar to one in *CHECKBOOK's 2009 Guide to Health Plans for Federal Employees*, showing how two plan's stated limits are calculated, but not clearly presented, in the plan brochure and in OPM's online plan comparison table:

Adjusting Catastrophic Limits to Make Them Comparable

Mail Handlers Self	HDHP	Standard Option
Limit Stated in Plan's Summary of Benefits and OPM Comparison:	$5,000	$4,500
Deductibles	Included	$350
Hospital, Physician, Drug Copays	Included	$2,560
Specialty Drug Limit	Included	$4,000
Actual Total Limit	$5,000	$11,410

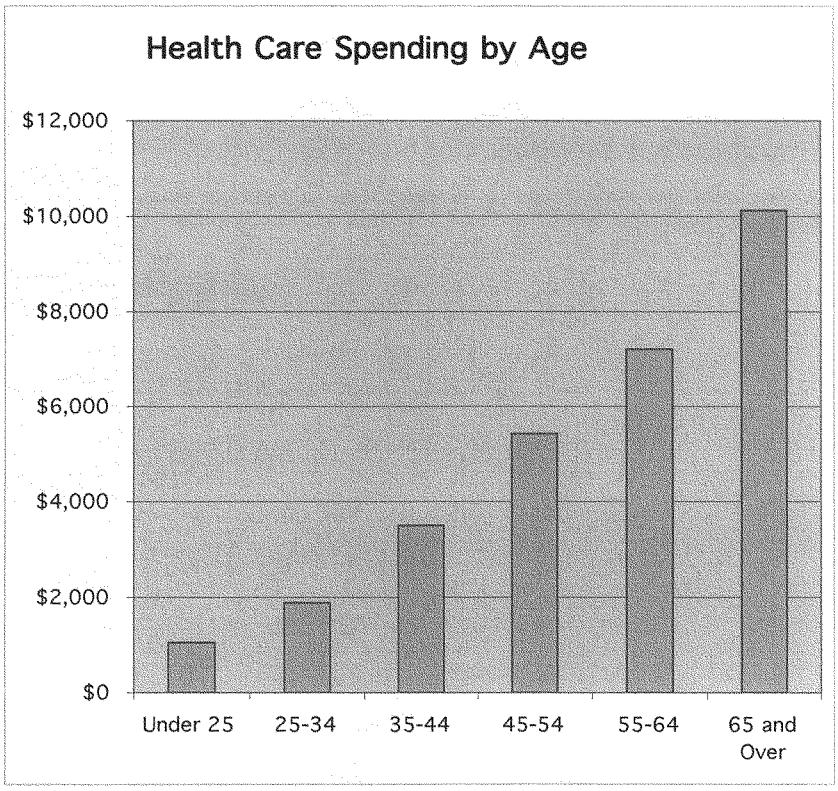
Here is another example:

Coventry Iowa Self	HDHP	High Option
Limit Stated in Plan's Summary of Benefits and OPM Comparison:	$5,000	$2,500
Deductibles	Included	Included
Hospital, Physician, Drug Copays	Included	$4,110
Specialty Drug Limit	Included	Included
Actual Total Limit	$5,000	$6,610
Note: certain assumptions about numbers of visits for very heavy users are used to calculate copays.		

What these tables show is that a plan that seems to have a far lower limit than another plan sponsored by the same company can actually expose enrollees to a considerably higher catastrophic maximum. In both of these cases the limits are included in the same brochure, but the same kinds of inconsistencies exist across many plans and many brochures.

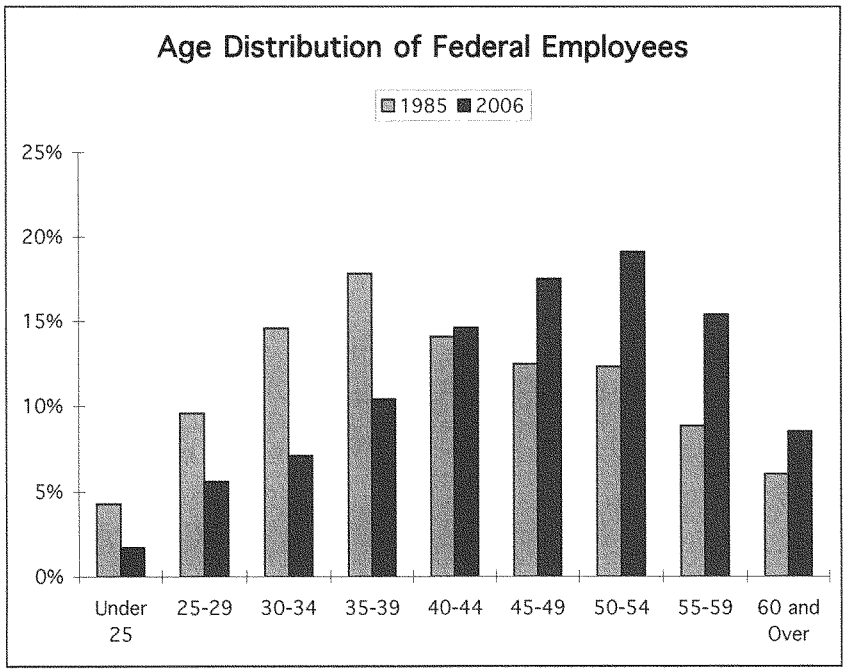
Aging Work Force and Health Care Costs. Federal employees and annuitants tend to stay in their plans, despite the multiple alternatives offered them every Open Season. While there are apparently no hard data, only about one enrollee in twenty switches plans in Open Season. This has benefits for program and plan stability, but penalizes the most popular plans. The problem is that as enrollees age, they get more expensive. The thirty year old that enrolled in Blue Cross Standard Option twenty years ago is very likely still in that plan today, but twenty years older

and correspondingly more expensive. While it is a commonplace that health care costs rise with age, it is always well to be reminded of the extent to which this occurs, as shown in the chart below.[4]



These differences are particularly important because the Federal work force has grown progressively and markedly older over the last two decades. Unfortunately, there are no extant age data that cover postal employees and annuitants as well as General Schedule employees. However, data from OPM on non-postal civilian employees show a massive deterioration in the relative proportion of lower-cost younger employees compared to older employees and retirees. From 1985 to 2006 the average age of these Federal employees increased from 42 years to 47 years, as shown by the data in the chart below.

[4] Source: Pooled MEPS data for 2003 through 2005, adjusted for inflation to 2007, provided to author by Agency for Healthcare Research and Quality



Source: Office of Personnel Management, Office of Workforce Information, at www.opm.gov/feddata/html/Age_Dist.asp
Note: Data include only full-time permanent civilian employees, and exclude postal employees

I think that these two charts tell us a great deal about why Blue Cross has faced the need to make such substantial efforts to hold premium increases down.

Premium Design. Under current law the government gets 75 percent (or more, for postal and FDIC employees) of the premium saving from frugal plan choices made by enrollees. More specifically, since the government pays 75 percent (or more) of the premium up to a premium amount close to the all plan average, neither the plans nor the enrollees face a strong incentive to set or choose premiums well below that all plan average. Moreover, the higher the government share of savings, the less incentive enrollees have to choose frugal plan designs. Paradoxically, the seemingly enrollee friendly "Premium Conversion" reform reduced the incentive to shop frugally by reducing the *de facto* employee share of employee premiums from 25 percent to about 17 percent (varying with the precise tax bracket of each employee). Therefore, the government now retains about 83 percent of the savings when enrollees choose plans whose premiums are substantially below the all plan average premium. As a result, plans now have correspondingly reduced incentives to keep costs and premiums down. (This is one of the major adverse consequences of Premium Conversion, but not the worst).

There is one key feature in existing premium design that prevents disastrous growth in costs and premiums. With the government contribution pegged to the average plan cost, and the government paying no more than 75 percent of premiums that are near the all plan average cost, enrollees pay the entire excess cost of plan premiums that exceed the average. High cost plans are not rewarded in the FEHBP. But frugal plans and frugal purchasing decisions have never been well rewarded, and are now poorly rewarded. Plan competition expert Alain Enthoven has argued pungently that current employer health insurance contributions generally reward the health care equivalent of expensive, bloated gas-guzzlers, but should instead reward "Honda" health plans (Alain Enthoven, "Where Are Health Care's 'Hondas'?" in *The Wall Street Journal*, October 24, 2002). In his words, what we "need is for most employers to offer multiple choice and expose employees to **full** responsibility for premium differences" (emphasis added).

I would put the matter another way. Why should an enrollee have to return to the government 75 (really 83) percent of the premium savings achieved if he chooses a lower cost plan? What sensible person would even choose a lower cost plan facing such a penalty? The Medicare Advantage program reverses the percentages, and lets the enrollee keep 75 percent of the savings from choosing lower cost plans in either reduced premium or enhanced benefits (as in the FEHBP, enrollees pay the entire cost of plans above a benchmark average). That is smart premium design.[5]

Medicare and FEHBP Coordination. All of the national fee-for-service plans in the FEHBP offer age-65 enrollees a seemingly wonderful benefit enhancement. The plans promise that if the enrollee has both Medicare Parts A (hospital) and B (physician), all hospital and physician care will be free—no deductibles, no coinsurance, and no copayments. Not only that, all this medical care will be free whether or not the enrollee uses preferred providers—network constraints go away.[6] What could be wrong with this wonderful benefit enhancement?

Medicare was created about 40 years ago, and the FEHBP about 50 years ago. The design of each has not significantly changed since its inception, with the major exception that Medicare has added private plan alternatives and a system of choice based on the FEHBP model in Medicare Advantage, as well as a prescription drug benefit. Original Medicare remains frozen in the time warp of vintage 1960 insurance patterns (e.g., the nonsensical bifurcation between hospital and physician costs, and the failure to use networks to control costs). The FEHBP has aged far more gracefully, with a market driven structure that readily adopts the latest and best insurance practices. But neither program has made any sensible accommodation to the existence of the other.

The great majority of retirees elect to pay the Medicare Part B premium at age 65, and enroll in one of the national fee for service plans. This wonderful coverage comes, however, at a high price. In 2009, the total premium cost for the most popular choice in combination with Medicare, Blue Cross Standard Option, will cost a retired couple $6,590 in premium. This is a "for sure" expense, whether or not they ever see a doctor (of course, total cost is far higher, with most hidden in the government premium subsidies).

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[5] It is not a coincidentally smart decision. The Finance and Ways and Means drafters studied both the strengths and weaknesses of the FEHBP quite carefully.

[6] Blue Cross Basic Option is a partial exception. It only provides this benefit within the network of preferred providers.

This same couple was most likely enrolled in Blue Cross until age 65, and was satisfied with its good benefits and reasonable premium. What changed upon turning age 65 that impelled them to pay an extra $2,300 a year for two Part B premiums? They do get that reduced cost sharing, and the ability to leave the network without penalty. However, *CHECKBOOK's Guide* estimates that in 2009 the net effect of joining Part B is to cost the average retired couple in Blue Cross Standard option an extra $670. The answer is that this decision is rational for that couple only because existing law is irrational.

Of greater importance to the program and to the United States Treasury, this decision is expensive. That retired couple has no incentive to be frugal in any way in making decisions about any kind of health care other than prescription drugs and dental care. Unlimited provider visits are free. The most expensive provider in the nation is free. The most discretionary surgical procedure is free. Durable medical equipment is free. Every conceivable medical test is free. Thousand dollar MRI and CAT scans are free. If an additional scan would show progress, the price is right for the second.

Based on robust research findings on the effects of cost sharing incentives, each person enrolled in a wraparound FEHBP plan and Medicare Parts A and B costs the Federal government somewhere on the order of 15 percent or more, or $1,500 or more, in unnecessary medical care utilization (for the source of this conservative estimate, see Jeff Lemieux *et al*, "Medigap Coverage and Medicare Spending: A Second Look," in *Health Affairs* Volume 27, Number 2, March/April 2008). With approximately 1.5 million Medicare enrollees (both single and couples), the Federal government loses more than $2 billion a year in increased utilization under the current system. Most of this cost falls on Medicare (which pays first) but as much as a half billion dollars a year falls on the FEHBP. And it falls disproportionately on plans like Blue Cross Standard Option, because they attract a disproportionate number of Medicare enrollees.

Meanwhile, it appears that increasing numbers of age-65 retirees are deciding not to sign up for Medicare Part B. They calculate, correctly, that they will save substantially in most years by not having to pay two sets of premiums. There are alternatives, such as suspending FEHBP enrollment, paying only one set of premiums, and enrolling in a Medicare Advantage plan. But very few even know this exists, and even fewer choose it. This trend will accelerate as more and more higher income retirees face the Medicare income-tested Part B premium penalty.[7] Every such decision actually saves the Federal government money by redacting incentives for wasteful overutilization, but those savings accrue primarily to Medicare. The effect on the FEHBP is to raise premiums overall, and especially in those plans that disproportionately attract retirees (e.g., Blue Cross Standard Option).

3. Useful and Necessary Reforms

There is a menu of potential reform opportunities to address these and other problems:

- Reducing or eliminated Premium Conversion and other tax subsidies for wasteful overpurchase of health insurance and overutilization of health care (something that will undoubtedly be addressed in a broader context when President-elect Obama presents his detailed reform proposals).
- Adding mechanisms to control risk selection in the FEHBP

[7] All or almost all GS-15 or higher-graded retirees will pay the higher income-tested premium if they enroll in Part B.

- Premium redesign to reward frugal enrollees
- Improving the coordination of Medicare and the FEHBP
- Eliminating arbitrary constraints on plan reimbursement for retirees on Medicare
- Admitting new plans to the program
- Expanding the program to cover military workers dependents
- Improving Information for enrollees to help and encourage them to make money-saving plan choices

Time does not permit in depth analysis of each of these issues and options today, but I would be glad to work with the Subcommittee or parent Committee in addressing any of these in more detail.[8] OPM acting on its own can address some. This Subcommittee can address others; and still others would require action by the Ways and Means Committee. The Subcommittee could easily enlist the Congressional Budget Office, the OPM actuaries, or the Office of Management and Budget, to assist it in exploring these and related options. I strongly recommend that it do so.

Improving Catastrophic Protection Limits and Their Presentation. I think that the Blue Cross decision to impose a $7,500 penalty for using non-participating surgeons in its Standard Option is best thought of as increasing catastrophic cost exposure of enrollees. This particular risk is unique to this plan. But there are many exclusions in other plans that have the effect of increasing maximum cost exposure far beyond stated limits. One set of plans, the High Deductible plans, all have essentially loophole-free and gap-free catastrophic protection. These plans follow Treasury Department guidelines in order to qualify as High Deductible plans.

I recommend that OPM undertake a comprehensive review of catastrophic limits, and include strong direction in next spring's Call Letter, to reform both the substance and presentation of these limits. The basic principle should be that all plans should to the extent reasonably feasible include all types of medical and prescription drug costs in one comprehensive catastrophic limit that is loophole-free (for plans that have both network and non-network benefits, each set of benefits would have its own limit). This does not mean that plans could not exclude such items as charges in excess of allowances, charges for visits that exceed specified numbers of visits, or noncompliance charges. But it does mean that separate catastrophic limits for drugs or surgery or mental health should either be eliminated, or included in a stated total limit on all benefit summaries. For example, it would be preferable if the NALC plan modified its benefits so that its total catastrophic limit was $6,000 dollars (or whatever amount was actuarially neutral), but if it persists in having what appear to the reader to be three separate limits, $4,000 for most medical expenses, $4,000 for prescription drug expenses, and $4,000 for mental health expenses, it should be required to summarize this is an overall limit of $12,000. The same requirement imposed on Blue Cross Standard Option would doubtless lead to a different decision on its surgical "deductible," as it is unlikely that the plan would choose to show a catastrophic limit of $14,500 in all summary materials.

I think it quite likely that this simple presentation change would have a salutary effect in leading plans to lower as well as combine limits, rather than have potential customers suffer potential "sticker shock."

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[8] I addressed more of these in testimony to a predecessor Subcommittee—Civil Service, Census, and Agency Reorganization—on December 11, 2002.

Equally importantly, limits should be presented and described in as standardized a method as possible. For example, currently many plans include, and many other plans exclude, deductibles from stated limits. Without making an actual benefit change in any of these plans, these disparate presentations can and should be eliminated. When a plan now says the most you can pay is $6,000, and states in fine print that you also pay $500 for the plan deductible that is excluded from that limit, that should be changed to say that the most you can pay is $6,500 including the deductible. There is no substantive change, but now it becomes possible to compare plan limits without poring over the small print to see what presentation gaming is going on in some plans, but not others.

The opportunity should also be used to eliminate some of the more bizarre maximums, exclusions, and calculation methods. It is highly misleading to say that a plan has a $6,000 limit if it excludes durable medical equipment or prostheses from that limit. Some HMO plans say that their limit is "the premium" without ever saying which premium: the total premium, the GS enrollee share of the premium, the postal enrollee share of the premium, etc. In every case the limit should be stated in dollars. Plans that claim a maximum based on dozens of "stated copays" scattered through their brochures should be asked to present a dollar number rather than sending enrollees on a "gotcha" hunt through a hundred page brochure. If "stated copays" are indeed small in all but the most exceptional cases, that dollar number can be small and the exceptional cases can be protected as well.

As a related presentation matter, some plans, especially some Consumer Driven plans, now obscure their substantial deductibles by use of clever and confusing nomenclature. This created a problem this year because one new plan, United Healthcare Consumer-Driven, was presented honestly and clearly in comparison charts and benefit summaries as having a deductible twice as high as its competitors, when the actual amount of spending before regular benefits kicked in was essentially identical. The correct solution is to show all these plans with the higher deductible, not to have them all mislead readers of their brochures.

These changes are simple and straightforward, will improve the program, and will greatly improve transparency and clarity for consumers. They can be accomplished without legislation or even codified regulation. They need not even include any actual benefit mandates. They require only an OPM decision to insist on clarity, honesty, and consistency in plan's descriptions of their most important benefit.

Providing More Information for Enrollees. OPM is severely constrained in its budgetary resources for administering the FEHBP. This shows up in many ways, but one of the most dramatic emerges from a simple comparison of Medicare's main information tool compared to OPM's. Every Medicare beneficiary receives annually an approximately 100-page publication, handsomely printed, entitled *Medicare & You*. This publication provides a wealth of information on the program and among other things summarizes the benefits of all available plans.

In contrast, every Federal annuitant receives annually a 10-page mailing that provides highly condensed information, in print that is so small as to be almost unreadable. It provides no information on plans except their premiums. Nothing it contains is likely to lead annuitants to compare plans or to realize how widely plans differ. As a consequence, Open Season plan movement among annuitants is negligible, and neither the annuitants themselves nor the FEHBP trust funds receive the substantial savings that could be generated if, for example, some fraction of annuitants migrated to Medicare Advantage plans or to Consumer-Driven plans.

The current information dissemination practice does minimize postage costs. It literally saves pennies while leaving on the table hundreds of millions of dollars in potential savings if enrollees switched to plans that better control costs and keep their premiums lower.

It should not be beyond the ingenuity of OPM or the Subcommittee to create a mechanism to enable the costs of a serious information dissemination effort to escape the penny-wise and pound-foolish constraints of the current annual budgetary and appropriation's processes. For example, building on approaches successfully used for brochure printing and dissemination, and for customer surveys of enrollees, plans could be required to purchase and mail to their enrollees a copy of OPM's *Guide to Federal Benefits for Federal Retirees and Their Survivors*.

Controlling Risk Selection in the FEHBP. The FEHBP is often accused of the dreaded "death spiral" through "adverse selection" by advocates who oppose consumer choice among competing plans. In reality, the FEHBP is remarkably stable. Although enrollees vote with their feet in Open Season, most of those who should change plans do not. This is despite my utmost efforts, through *CHECKBOOK's Guide* and through television, radio, and speaking engagements, to persuade enrollees to save themselves a lot of money by switching to plans that would lower their costs, often by thousands of dollars.

Most recently, the wise OPM decision to encourage Consumer-Driven and High Deductible plans to compete within the program was accompanied by wails of anguish and predictions that all the young and healthy employees would join these plans and leave annuitants stuck in expensive plans (why annuitants and those in ill health would not avail themselves of the same opportunity to join bargain plans with superb catastrophic protection was never explained). In the event, only about 40,000 enrollees, almost exactly 1 percent of total enrollees, have joined these plans during the five years they have existed. This is not exactly a stampede.

There is nonetheless a risk selection problem in the FEHBP, and the failure to risk adjust premiums interferes with orderly and effective plan competition and consumer choices. Suppose there had been a mass migration to High Deductible plans? With risk adjustment of premiums there would have been no deleterious effect on those few annuitants left behind, since government contributions to their plans would have risen. Again, the problems facing Blue Cross in competing against other plans are aggravated by the failure of the FEHBP to have any risk adjustment mechanisms that compensate the plan for attracting a disproportionate share of the oldest and sickest.

Under current law, the FEHBP program averages all risks and both contributes to and charges individual enrollees the same amount regardless of age, distinguishing only between self only and families of two or more. This seems to be a perfectly reasonable approach to "fairness" in compensation policy, though the resulting high premium charge for younger workers is doubtless one of the main reasons why about 5 percent or more of the Federal work force, mostly younger workers, has no health insurance at all. But it is a flawed approach to premium design in a market driven system. Furthermore, in practice it fails to achieve its equity objective because the plans that disproportionately attract older enrollees have to charge a higher premium to break even, and the older and sicker wind up paying more.

There is a simple fix that would preserve the "single pool" design of the program. Under this reform, the statute would be amended to require the government to pay differential amounts to

plans based on the age and Medicare status of enrollees. The share that enrollees pay in any given risk category would be "held harmless" on average.

Put another way, the current statute says, in effect, that the government should pay about 70 percent of the premium on average for all enrollees, taken as an average. But it could say, instead, that the government will pay (as an over-simplified example) 80 percent of a more costly average for those over age 55, and 60 percent of a smaller average for those under age 55, and still pay 70 percent on average. Amended to adjust for age-related risk, the FEHBP would allow enrollees to select the best plans without having to flee those plans that attract a disproportionate number of union shop stewards (older and more expensive), diabetics, annuitants age 55 to 64, and 85 year old annuitants without Medicare.

One very important risk factor, in this context, is Medicare status. With Medicare as the primary payer for the great majority of annuitants over age 65, FEHBP plans only have to pay residual expenses. These can be very high, and are made even higher by induced overutilization, but it appears that plans roughly break even by attracting this group. Medicare status should dictate the government share of premium paid.

Devising a risk-adjusted premium that will be fair to all groups, both in reality and as perceived by advocates, will potentially be politically and actuarially complex. But it can be done, without descending into a swamp of health status details.[9] Adjusting for nothing more than two age categories (above and below 55) and Medicare status (both A and B, A only, B only, or neither) would greatly attenuate the bizarre incentives to both plans and enrollees created by current premium sharing arrangements. The Congress need not (and in my view should not) attempt to write a rigid formula. For those with a long memory, the original design of the FEHBP called for a 60 percent government share of premium, but due to drafting myopia and a bizarre "big six" formula the government wound up paying about a 72 percent share of the average premium. Instead, the Congress could simply mandate that OPM devise an actuarially fair system that will not penalize any category group by more than a few percent in the amount of enrollee premium it pays.

There are alternative ways to reduce risk selection in the program. For example, the risks from enrollees with costs above $100,000 in a year could be pooled and reinsured, so that the smaller plans and those with disproportionate shares of older and more expensive enrollees did not face a disproportionate cost burden. I have heard that one of the better small plans left the program a decade ago because of a multi-million dollar premature birth disaster, and that another good but small plan left the program because of expenses from HIV-infected enrollees. Some form of reinsurance could be factored in as well, but would not suffice to replace a system based on age and Medicare status.

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[9] Medicare uses complex risk adjustors based on health status to determine contributions to Medicare Advantage health plans. The FEHBP cannot do this because, unlike Medicare, it doesn't have a database of medical records for all its enrollees. But it doesn't need to do so. Relatively crude risk adjustors would work reasonably well without the complexity of the more sophisticated Medicare system. In fact, because the underlying Medicare Advantage payment is based on complex and artificial geographic differentials that reflect waste and fraud as much as genuine differences in health care, even a simple FEHBP system would arguably be as good or better.

If the enrollee share of premium for each plan bore a reasonably rational relationship to plan benefits, without the artificial effects of differential by age and Medicare status, then plans could concentrate their energies on devising benefit and service reforms that best served their customers. In this regard, while the plans have often been accused of using benefit design decisions to "cherry pick" to get the healthiest enrollees, it is apparent that such behavior has been infrequent. Indeed, some of the plans with the strongest incentives to do so have not only not skewed benefits, but also gone out of business through "failing" to do so. Of course, this is due in part to OPM's stewardship in reviewing plan change proposals. Regardless, any reform that reduces risk selection or its costs also reduces incentives to plans to design benefits to discriminate against sicker enrollees.

Premium Incentive Redesign. It is possible and relatively easy to adjust the government contribution formula to improve the incentives for enrollees to choose, and plans to offer "Hondas" while remaining budget neutral. For example, if the government share were made 100 percent of premium up to a maximum of 70 percent of the all plan average, and nothing thereafter, the overall contribution would still be near 70 percent of the all plan average. However, incentives would change radically. Employees would now keep 100 percent of the savings from selection of lower cost plans, down to the maximum contribution level. The most important effect would occur over time: plans would selectively take cost-reducing steps to keep premiums down, and employees who became more frugal users of health care as copayments increased would help drive down the overall costs and premiums of the entire program.

Less drastic formula changes could achieve any desired mix of incentives and rewards. For example, a formula paying 90 percent of premium up to a maximum of about 80 percent of the all plan average would also result in an overall government subsidy of about 70 percent, but largely incentives for both plans and enrollees to go to even lower cost plans than those at the 80 percent maximum.

Under either of these options, plans would have greatly increased incentives to devise cost sharing provisions that, like their prescription drug benefits, would reduce overall utilization costs and hence unnecessarily large premiums.

Note also that under either formula suggested above, the enrollee premium share for a frugal plan would be reduced, and the incentive of healthy, young employees to enroll in the FEHBP significantly increased. These enrollees would, on average, reduce overall premium costs and help to reduce the premium creep created by a rapidly aging Federal work force. In other words, these are employee-friendly reform ideas, to be welcomed rather than feared.

Medicare and FEHBP Coordination. FEHBP plans individually and the program as a whole would benefit if many more Medicare-eligible enrollees sign up for Part B. Most of this saving would, however, be offset by wasteful overutilization if current benefit design remains unchanged.

There is a major alternative. Instead of enriching benefits so far as to eliminate all hospital and physician cost sharing, in a decreasingly successful effort to induce Medicare participation, plans could instead directly subsidize Medicare Part B premiums. Ideally (from a government-wide and taxpayer perspective) plans would be strongly discouraged or even prohibited from improving physician and other ambulatory cost sharing, but instead encouraged to add benefits that are not covered by Medicare, such as vision care, dental care, and improved hearing aid

coverage. (That the government's no-cost standalone dental plans would lose business, and that OPM's longstanding policy of discouraging dental benefits would be reversed, should be of no concern whatsoever since hundreds of millions of dollars in actual real savings to both enrollees and the taxpayer would be involved. Alternatively, the dental subsidy could be directed towards "free" enrollment in those plans.)

Viewed from a beneficiary perspective, the ideal result would be no-cost Part B coverage, no change in cost sharing for hospital, medical, and drug benefits (that is, most benefits would be identical pre- and post-65, and modest additional benefits (such as a dental fund or premium subsidy of several hundred dollars) not available pre-Medicare. Take-up would be near 100 percent (why would anyone decline a free benefit?), and all enrollees would directly gain more than they do under the current wrap-around scheme, as well as retaining the ability to go out of network should they so choose, using the Medicare Part B benefit.

Under such a reform, there would be a one-time amnesty from the Medicare penalty for delayed enrollment or, better yet, Medicare would adopt the Part D innovation of allowing penalty-free late enrollment for anyone who had been enrolled in comparable or better "creditable coverage." (This last innovation would benefit Medicare in all situations where employers such as State or local governments had rich benefits post-65, as many do.)

Among the other benefits of such a reform, it would encourage retirees to remain in HMO plans, since there would no longer be an advantage for enrolling in national fee-for-service plans. As a result, the FEHBP would benefit from the superior cost control exercised by HMO plans. (At present, about one third of employees enroll in HMOs, but most older retirees migrate to the "free" care of the national plans and less than one tenth of annuitants are enrolled in HMOs.)

For reasons lost in history, a quarter century ago the Ways and Means and Finance committees quietly inserted an unprecedented constraint on the FEHBP into the Medicare statute. Under Section 1840 of the Social Security Act, no FEHBP plan is apparently allowed to subsidize the purchase of Part B, unless the funds involved come from (nonexistent) sources other than FEHBP premiums.[10] The Federal government is now the only employer in America that cannot defray the cost of Medicare Part B for its retirees. This perplexing enactment costs Medicare far more than it saves, since the great majority of age-65 enrollees nonetheless pay for Part B and generate $2 billion a year or more in unnecessary spending. It certainly costs the taxpayer far more than it saves. Were FEHBP plans allowed, encouraged, or required to pay Part B premiums, reducing current wraparound coverage on an actuarially comparable basis, the plan budgets would benefit substantially from net increases in Part B enrollment, and from net decreases in health care utilization. This would in turn create the savings and additional benefits described above.

This reform would require legislation, and would be under the jurisdiction of the Ways and Means and Finance Committees.

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[10] Section 1840 (d) reads, in pertinent part: "A plan described in section 8903 or 8903a of title 5, United States Code [i.e., an FEHBP plan], may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part [i.e., the Part B premium] if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions [FEHBP premiums] described in section 8906 of such title."

Expanding the Program to Cover Military Personnel. The FEHBP does not cover almost half of all Federal employees and dependents: U.S. Military personnel and their dependents. This is particularly anomalous because the medical skills and equipment needed for military preparedness and operations, such as emergency medicine and surgery, are not those associated with pediatric, obstetrical, and other civilian-oriented services that comprise the overwhelming majority of DOD sponsored health care. While the tens of thousands of high ranking officers who constitute the military health establishment are unlikely to voluntarily relinquish their bureaucratic turf and give up their well paid administrative jobs, the Secretary of Defense has voiced concern over the huge resources devoted to DOD sponsored health care. The Tricare system is unpopular with military dependents. There is no reason that the FEHBP statute should not be amended to provide OPM authority to fold any or all military families into the FEHBP for non-service related health care, upon reasonable premium contributions by the Department of Defense. Providing legal discretion to OPM to implement this option in the future need not wait, or depend upon, the views of the uniformed service brass.

If such a reform ever came to pass, the DOD might well decide to fund a higher percentage of premium cost than received by most civilian employees, because military personnel pay no or very low premiums. This would not depart significantly from the current FEHBP model, which allows for higher government premium shares in the Postal Service and FDIC. A proper study of military health care costs (many of which are concealed within base budgets for facilities and equipment) would undoubtedly show that DOD could save a great deal of money by dismantling Tricare and buying into the FEHBP, even if it had to pay the entire cost of premiums.

A particular advantage to the FEHBP of such a reform is that it would bring a lower cost pool of enrollees into the program; thereby reducing average premiums for both employing agencies and, in the case of annuitants, OPM.

Premium Conversion. Premium conversion was a serious error in program design, whatever its advantages in terms of aligning Federal fringe benefits with those of the large private corporations. It greatly reduced incentives for frugality on the part of both enrollees and plans. In a perfect world I would recommend its elimination, with an appropriately large increase in the annual "cost of living" salary increase to offset the effects of its elimination. Assuming, however, that such a reform is either unlikely in the extreme or unlikely outside the context of a larger reform of the taxation of health insurance premiums, I would recommend that at the very least the Congress refrain from extending premium conversion to annuitants. That change would eliminate the strongest remaining enclave of necessarily cost-conscious enrollees in the FEHBP. Annuitants already receive a tax-free benefit of over $4,000 (self only) or over $9,000 (family) for health care insurance through the government contribution to their plan's total premium cost. No private sector retirees receive premium conversion. Enough is enough.

Conclusion. Every one of the reforms discussed above would advantage enrollees, plans, the FEHBP program as a whole, and taxpayers. All will particularly benefit enrollees in the long run, by holding down unnecessary spending and reducing premium costs. Every one of them would have ameliorated the kinds of pressures that led the Blue Cross plan to reduce benefits so sharply in the last several years. If some of these reforms are not made, the FEHBP is likely to see costs surge over time. I urge the Congress to think "out of the box" in assessing the current state of the FEHBP and possible reform options like these. There is plenty of practical and analytic help to be found in the CBO, OMB, GAO, and OPM itself. I wish you success in the coming session of Congress in making needed reforms to this vital program. It is not aging well.

Mr. DAVIS. Thank you very much, Mr. Francis.
And we will go to Dr. Petrucci.

STATEMENT OF PETER E. PETRUCCI, M.D.

Dr. PETRUCCI. Thank you, Mr. Chairman, distinguished members of the committee. Thank you for the opportunity to be here today. My name is Peter Petrucci.

As you have heard, I am a board certified general surgeon and currently serve as the president of the medical staff at Sibley Hospital. I've practiced medicine in the District of Columbia since 1975, and am here today representing my patients and my colleagues. On January 1st, 4 million Federal employees, nearly half of the Federal work force, will face drastic changes to their health insurance policy. In addition to a 13 percent increase in premiums, out-of-network benefits for Federal Blue Cross Blue Shield standard option plan holders will be severely curtailed, affecting anesthesia, emergency, and surgical services, and placing a significant financial burden on patients.

These changes are particularly relevant for Federal employees already signed up with the Federal standard option plan as their health insurance provider, since they will automatically be renewed for 2009 unless they switch to another plan. With expiration of the open enrollment period on December 8th, there is little time to explore these options, and an immediate extension of the open enrollment should be implemented.

As a senior member of our medical community, I understand the need to control our large and growing health care costs. I also understand that establishing equitable and affordable care will be a complex process and will require compromise on the part of consumers, providers and insurers. But the new policy change by Blue Cross and Blue Shield adds an alarming wrinkle to cost containment by eliminating choice and putting the financial burden squarely on the patient. This is a denial of choice by deception.

Most egregious of the 2009 plan's so-called benefits has to do with patients' choice of physician. Effective January 1st, any patient who has surgery or any other of the so-called surgical procedures by an out-of-network or nonparticipating provider is 100 percent responsible for the first $7,500 of charges. This is not a one-time deductible. The $7,500 patient responsibility clock is reset with each surgery or procedure. More surprising, and buried in the 135-page plan document, is the policy's definition of surgery. It includes the treatment of fractures and dislocations, including casting, biopsy procedures, removal of tumors and cysts, treatment of burns, obstetrical care, including childbirth, and diagnostic colonoscopy, and other endoscopic procedures. This new policy change in effect converts the Federal standard program and point-of-service care plans to an HMO plan by making out-of-network costs prohibitive and limiting choice for the vast majority of patients.

Another disturbing provision of the new policy is a $350 deductible for emergency services when they are provided by a nonparticipating physician. Patients will be financially responsible for consultations rendered in an emergency even if the doctor was not chosen by the patient. Acutely ill patients do not usually have the lux-

ury of selecting their provider. Yet that is precisely what will be expected and required. This $350 fee is passed onto the patient for each consulting provider who does not participate in this plan.

Most importantly and with rare exception, patients are being caught unaware of the significant benefit cuts. Regrettably, the Office of Personnel Management appears to have contributed to this confusion by having abdicated their responsibility to the 4 million Federal employees and their families covered under this plan. The 2009 Blue Cross Blue Shield standard plan eliminates choice and transfers financial responsibility directly onto the patient, even during an emergency and without legitimate and transparent disclosure.

There are already a substantial number of patients who, finally informed about these changes, have become angry and frustrated. Only in the last few days, after mounting pressure from angry patients and concerned physicians, were minor clarifications posted on the Federal Blue Cross Blue Shield Web page.

On behalf of our patients, I would like to make the following recommendations: Restore to patients the right to choose their doctor without making it financially prohibitive. This can be achieved by Blue Cross and Blue Shield rolling back the changes for out-of-network providers to the 2008 standard option plan.

Immediately extend the open enrollment period to ensure the rights of Federal employees to explore and fairly exercise their right to choose a health plan that is best for them.

Have OPM establish a transparent and comprehensive outreach information program that ensures clear explanation of various plan benefits and the difference between plan costs and services.

Explore the process by which OPM, directly responsible for representing their employees, betrayed that charge by acting to negotiate and purchase as well as regulate the provision of health care benefits. These rules put OPM in a conflict of interest position. There should be a separate body, including consumers and physicians, which would oversee the products submitted to OPM and determine if they fairly represent the plan benefits and any changes, and ensure that all Federal employees are aware of proposed changes. Without such separation of purchasing and oversight powers, the opportunities for continued and future abuses remain.

Instead of legitimately engaging the medical community to explore ways of lowering costs, Blue Cross and Blue Shield has taken a hammer to this problem. In so doing, they will hurt the very patients they are supposed to serve.

Thank you for your time.

[The prepared statement of Dr. Petrucci follows:]

House Federal Workforce Subcommittee

Testimony

Regarding changes in Blue Cross Blue Shield Standard Option Plan

By

Peter E. Petrucci, MD

President, Medical Staff

Sibley Memorial Hospital

Past-President, DC Chapter of American College of Surgeons

December 3, 2008

Chairman Davis, Ranking Member Marchant and Members of the Subcommittee, I want to thank you for the opportunity to be here today. My name is Peter Petrucci. I am Board Certified in General Surgery and am currently serving a four year term as president of the Medical Staff at Sibley Memorial Hospital. I have practiced medicine in the District of Columbia since 1975 and am here today representing my patients and colleagues.

On January 1, 4 million federal employees (nearly half of the federal workforce), will face drastic changes to their health insurance policy. In addition to a 13% increase in premiums, out-of-network benefits for Federal Blue Cross Blue Shield Standard Option plan holders will be severely curtailed, affecting anesthesia, emergency and surgical services, and placing a significant financial burden on patients.

These changes are particularly relevant for federal employees already signed up with BCBS as their health insurance provider, since they will be automatically renewed for 2009 unless they switch to another plan. With expiration of the open enrollment period on December 8th, in less than one week, there is little time to explore options, and immediate extension of the open enrollment period should be implemented.

As a health care provider, I understand the need to control our large and growing healthcare costs. I also understand that establishing equitable and affordable care will be complex and require compromise on the part of consumers, providers, and insurers. But the new policy change by Blue Cross Blue Shield adds

an alarming wrinkle to cost containment, by eliminating choice and putting the financial burden squarely on the patient.

The changes to the Federal BCBS policy drastically reduce a patient's choice regarding their healthcare provider. These changes make it financially prohibitive for the majority of patients to obtain surgery and many commonly performed procedures from the doctor of their choice. They will instead be forced to obtain such services by "participating providers" who have contractual agreements with BCBS.

The most egregious of this plan's 2009 "benefits" has to do with patients' choice of physician for surgeries. Effective January 1, 2009, any patient who has surgery or any of the other listed procedures by an out-of-network (or non-participating) provider, is 100% responsible for the first $7,500 of charges.

This is not a one-time "deductible" expense. The $7,500 patient "responsibility" clock is reset with each surgery or procedure. More surprising, and buried in the 135-page plan document, is the policy's definition of "surgery". It is defined to include the treatment of fractures and dislocations (including casting), biopsy procedures, removal of tumors and cysts, treatment of burns, obstetrical care including childbirth, and diagnostic colonoscopy and other endoscopic procedures.

Another disturbing provision of the new policy is a $350 charge for emergency services when they are provided by a non-participating physician.

Patients will be financially responsible for consultations, rendered in an emergency, when performed by a non-participating provider, even if such a doctor was not chosen by the patient. Acutely ill patients do not have the luxury of selecting their provider in an emergency situation. Yet that is precisely what will be expected and required. This $350 fee is passed on to the patient for each and every consulting provider who does not participate in this plan.

This new policy change in effect converts the Federal BCBS Standard preferred provider option and point of service care plans to an HMO plan, by making the out-of-network costs prohibitive and limiting choice, for the vast majority of patients.

Unfortunately, with rare exception, patients will be caught unaware of the significant benefits cuts. Regrettably, the Office of Personnel Management (OPM) appears to have contributed to this confusion by having abdicated their responsibilities to the 4 million Federal employees and their families covered under this plan. There are a substantial number of patients, who informed about these changes, have become angry and frustrated. Without legitimate and transparent disclosure, the 2009 BCBS Standard plan eliminates choice and transfers financial responsibility directly onto the patient, even during an emergency, and all without being clearly disclosed. Only in the last few days, after mounting pressure from angry patients and concerned physicians, were "Important Clarifications" posted on the Federal Blue Cross Blue Shield Web Page.

To advocate on behalf of our patients, I would like to make the following recommendations:

- Immediately extend the open enrollment period to ensure the rights of Federal Employees to explore and fairly exercise their right to choose a health plan that is best for them.

- Restore to patients the right to choose their doctor without making it financially prohibitive. This can be achieved by BCBS rolling back their benefits plan with respect to out-of-network providers for anesthesia, surgery, endoscopic procedures and emergency room care to at least the 2008 Standard option plan.

- Have OPM establish a transparent and comprehensive outreach information campaign that ensures clear explanation of various plan benefits and the difference between plan costs and services.

- Explore the process by which OPM, directly responsible for representing their employees, betrayed their very charge by acting to negotiate and purchase, as well as regulate the provision of health care benefits. These roles put OPM in a conflict-of-interest position. There should be a separate body, including consumers and physicians, which would oversee that the vetted products submitted to OPM fairly represent the plans benefits and changes, and ensure all federal employees are aware of these changes. Without such separation of purchasing and oversight powers, the opportunities for continued and future abuse remain.

Instead of legitimately engaging the medical community to explore ways of lowering costs, BCBS has taken a hammer to the problem. In doing so, they will hurt the very patients they are supposed to serve. Thank you for your time.

Backgrounder on Testimony from:

Peter E. Petrucci, MD, President, Medical Staff, Sibley Memorial Hospital and Past-President, DC Chapter of American College of Surgeons

On January 1, four million federal employees (nearly half of the federal workforce), face drastic changes to their health insurance policy. In addition to a 13% increase in premiums, out-of-network benefits for Federal Blue Cross Blue Shield Standard Option plan holders will be severely curtailed, affecting both emergency and surgical services and placing a significant financial burden on patients. Current subscribers have not been made aware of these changes and have less than a week, until December 8th, to switch insurance plans.

➢ **What exactly is changing?**

The changes to the Federal BCBS policy drastically reduce a patient's choice regarding their healthcare provider. This new policy change in effect converts Federal BCBS Standard PPO and POS plans to an HMO plan by making the out-of-network costs prohibitive for the vast majority of patients.

Historically, BCBS has covered 70% of their allowance (their UCR, Usual Customary & Reasonable) for out-of-network surgical services, allowing patients to receive care from their physician of choice without prohibitive out-of -pocket expenses. The policy change increases a patient's deductible to $7500.00 for each procedure or surgery when using out-of-network providers. Patients are responsible for 100% of this charge.

Patients will also be responsible for 100% of fees related to emergency consultation services provided by any out-of-network physician up to $350.00 per physician. If emergency surgery is necessary, patients are responsible for 100% of the first $7,500 if performed by an out-of-network physician. In a true emergency, patients will not usually have any choice regarding the physician who evaluates and treats them.

➢ **How does this impact patients?**

These policy changes make it financially prohibitive for the majority of patients to obtain surgery and many commonly performed procedures from the doctor of their choice. They will instead be forced to obtain such services by "participating providers" who have agreements with BCBS. Patients will also be financially responsible for consultations rendered in an emergency when performed by a non-participating provider, even if such a doctor was not chosen by the patient.

➢ **How many federal employees are affected?**

More than four million federal employees (half of all employees covered by the Federal Employees Health Insurance Program) are enrolled in the BCBS Standard Option plan.

These changes are particularly relevant for federal employees already signed up with BCBS as their FEHBP health insurance provider, as they will be automatically renewed for 2009, unless they switch to another plan. The open enrollment period during which they can switch to another plan closes in less than two weeks, on December 8, 2008.

➢ **What medical procedures are impacted?**

- ✓ Operative procedures
- ✓ Emergency Room Care
- ✓ Treatment of fractures and dislocations, including casting
- ✓ Normal pre and post op care by surgeon
- ✓ Obstetrical delivery (delivery itself)
- ✓ Circumcision of newborn
- ✓ Colonoscopy – diagnostic
- ✓ Biopsy procedures
- ✓ Removal of tumors and cysts
- ✓ Correction of congenital anomalies
- ✓ Treatment of burns
- ✓ Insertion of internal prosthetic devices
- ✓ Voluntary sterilization
- ✓ Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures
- ✓ Gastric restrictive procedures
- ✓ Oral and Maxillofacial surgery

➢ **Are patients aware of these changes?**

With rare exception, no. Current and potential Federal BCBS Standard plan (PPO) enrollees have not been provided with an easy-to-understand disclosure of their benefit changes in the 2009 BCBS standard PPO option plan. The changes can be found on pages 10, 25, 51-55 of the 135 page manual of 2009 BCBS Standard benefits program, available online at http://www.opm.gov/insure/health/planinfo/2009/brochures/71-005.pdf.

➢ **What should federal employees do?**

Patients already signed up with BCBS as their FEHBP health insurance provider are automatically renewed for 2009, unless they switch to another plan within the remaining enrollment period, which closes in less than a week, on December 8th, 2008.

The four million federal employees who are currently enrolled in the Federal Blue Cross Blue Shield Standard plan should evaluate their choices of health plans thoroughly and consider coverage with a plan that will preserve their choice in healthcare.

➢ **Who administers BCBS and other health insurance products to Federal employees?**

The Federal Employees Health Benefits (FEHB) Program is run by OPM, the Office of Personnel and Management, a government agency.

2009 Changes to Blue Cross Blue Shield Standard (PPO) Option

Changes to benefits for BCBS Standard (PPO) option are listed in the benefits program, found on page 10 of the 135-page document, under section 2:

Until December 31, 2008	Beginning January 1, 2009
BCBS patients paid 25% of the Plan allowance, plus any difference between our allowance and the billed amount.	BCBS patients must pay 100% of the billed amount up to a maximum of $7,500 for surgery performed by a Non-participating physician.
BCBS patients paid 25% of the Plan allowance, plus any difference between our allowance and the billed amount.	BCBS patients must pay 100% of the billed amount up to a maximum of $800 for anesthesia provided by a Non-participating anesthesiologist or certified

	registered nurse anesthetist (CRNA).
BCBS patients paid any difference between the Plan allowance and the billed amount for care related to an accidental injury, and 25% of the Plan allowance, plus any difference between our allowance and the billed amount for care related to a medical emergency.	BCBS patients must pay 100% of the billed amount up to a maximum of $350 per visit for professional care provided in an emergency room by a Non-participating emergency room physician.

Source :http://www.opm.gov/insure/health/planinfo/2009/brochures/71-005.pdf

Mr. DAVIS. Thank you gentlemen very much.

Let me also acknowledge the presence of Representative Elijah Cummings, who has joined us.

Thank you very much, Representative Cummings.

Let me ask, listening to both of your testimonies, how important, and perhaps I will begin with you, Mr. Francis, how important is it that patients or consumers have the choice of selecting physicians for treatment?

Mr. FRANCIS. That is a great question, Mr. Chairman. And the answer is, it is extremely important for some and not important for others. And we don't know ahead of time which people are in which category.

For example, a very large fraction of the Federal work force, not of retirees but of the active workers, over a third, enroll in HMO's where the deal is you must use HMO participating physicians or we don't cover anything. That is a choice they make. They get certain benefits for that. They get typically a better benefit package, and they get lower premiums.

But for other people, it is vital that they be able to choose their physician without any constraint. So the FEHBP needs to provide plans that offer both kinds of packages. And I think the problem here, and it really is, is that the Blue Cross out-of-network benefit, and it is not significantly worse or different than those in most of the other national plans, they typically pay only 75 percent of an allowance. And that allowance is less by far than many physicians or surgeons charge. But at least the deal is sort of clear, and you are going to have something covered, typically half or more of your cost. But $7,500 is a mighty hefty penalty to pay to go out of network.

Mr. DAVIS. Dr. Petrucci.

Dr. PETRUCCI. I can't really improve on that statement. The choice really depends on the patient. Many patients choose to pick a physician that they have had a longstanding experience with. Some physicians choose to decide to become nonparticipating after patients have been with them for many years. And so that choice becomes one that they cherish.

Mr. DAVIS. There is a cost savings when individuals limit their choices in some way.

Dr. PETRUCCI. There is a cost savings to the patient, yes. There is no difference for the insurance company, however.

Mr. DAVIS. Well, given comparisons, given the changes that Blue Cross Blue Shield are making, are there other comparable plans that employees may want to consider?

Dr. PETRUCCI. The Federal panel, and you know this better than I do, certainly has other insurance companies in the program that allow the choice that patients want so that they can go out of plan easily and have a significant portion of their expenses covered.

Mr. DAVIS. Do they compare favorably, though, with——

Dr. PETRUCCI. I think so.

Mr. FRANCIS. In the Consumers' CHECKBOOK advice that we publish, we find that there are a number of plans, quite a number, that offer benefits as good or better than the Blue Cross standard option benefit and premiums that are considerably lower. Now, you know, no plan is better in every category. And no plan is worse in

every category, but there are lots of very good choices out there, including, by the way, Blue Cross Basic, whose main distinguishing characteristic is that you can't go out of the network and get any coverage. But people can make that choice and save a good deal on their premium.

So, yes, there are alternatives, and we always recommend people consider alternatives. That is the beauty of open season, a chance to think through your choices and consider options. I just wish the information that were out there were more available, especially to the retirees all over the country who don't get sort of the hot house attention that this issue gets in Washington, DC.

Mr. DAVIS. Well, Blue Cross has said that it will take another look or reexamine its 2009 benefit options. Do either of you have any idea of what that might mean? And if they were to reexamine, what other options or what changes might they want to look at?

Mr. FRANCIS. The suggestion, Mr. Chairman, I make in my testimony is that OPM and Blue Cross consider—whether or not they can do it now, I think probably they could, but I will leave that to them to address—that is right away could they change their 2009 situation—but certainly they could have put in a requirement for pre-approval of certain kinds of surgery, particularly where out-of-pocket expenses might be very high if people were balance billed. Or whatever problem they are after, they could require pre-approval. They did a—there is a pre-approval requirement for morbid obesity surgery that I believe was just added this year, if my memory serves. So it is not as if there aren't other tools in the arsenal that could be used that aren't so draconian in their financial impact.

Dr. PETRUCCI. Our concern is that there doesn't seem to be a clear benefit—I mean the patient understands when they come to us, that is nonparticipating providers, that they will have a cost outside of their plan. The issue is, this doesn't seem to save Blue Cross anything by just adding that deductible. They are basically saying, we are not going to pay anything for your—in other words, if they come to me now, they have an operation, I have a charge, Blue Cross will pay a percentage of that charge and the patient pays the rest. That costs Blue Shield nothing. And so the question is, why the change? What difference does it make to them to take away that benefit that is already there and not allow patient choice?

Mr. DAVIS. I will just ask a last one. Why would a patient want to go out of network say to have surgery?

Dr. PETRUCCI. Well, most patients are referred by their primary care doctor. And they also have patient family members, friends, who may have had operations by a certain physician, or they could be being taken care of by a certain physician. It has to do with a number of factors: Reputation, experience with a procedure. There are a lot of different reasons why a patient may choose to come to me rather than somebody else or somebody else rather than me. That is, again, patient choice. And that is really all we are saying is, they should be able to make that decision. They understand up front that they will have an additional cost, and we work with them on that process.

Mr. DAVIS. And the network activity is not coordinated in such a way that in all likelihood a primary care physician or primary provider would not necessarily refer someone to another member of the network, I mean to a surgeon that is part of the network?

Dr. PETRUCCI. It works both—it can work both ways. It can work either way or both ways.

Mr. DAVIS. Well, gentlemen, thank you very much. My time is up.

Delegate Norton.

Ms. NORTON. Thank you, Mr. Chairman.

Well, Mr. Petrucci, you say it doesn't save them anything. Why do you think they did it? If this large increase for consumers doesn't——

Dr. PETRUCCI. I am sorry, I didn't quite——

Ms. NORTON [continuing]. Doesn't save Blue Cross Blue Shield anything, why do you think they did what they did?

Dr. PETRUCCI. You know, I don't know. We've been—that is a question we would love to ask them ourselves. It is not something that is very clear to us.

Mr. NORTON. You know, people can understand some of the increases.

You spoke of some of them, Mr. Francis, increasing co-payment and the like. You know, I don't know if it has ever been tested, but certainly there is a policy rationale that people think before they run to the doctor.

The failure to even understand what is happening here is what bothers me most.

Now, and I ought to be clear, Mr. Petrucci, I am—is it Petrucci or Petrucci.

Dr. PETRUCCI. Petrucci.

Ms. NORTON. Petrucci. I believe that one of the problems with the American health care system is people can say, hey, you know, I want the same person who did your operation to do mine. So I am—the HMOs have managed to, in many ways, buildup some real prejudice against themselves, but one of the problems we have in this country, frankly, is that everybody wants Cadillac health care, and so we are leaving, you know, 50 million people with nothing, and an increasing number of people, including Federal employees who say, even though you are willing to pay part of it, I am sorry, this is even before we got to these hard times, I am going to have to take my chances. And so part of the problem—so I don't—when people say—when we see developing countries, for example, where everybody gets health care, do understand that when that happens it is because the society has agreed that, for the benefit of the many, some of us agree, unless we are going to pay for it, that we will not indeed demand what frankly in some ways Blue Cross Blue Shield looks like it wants to provide, because it is a preferred provider, something of an HMO-type saving there for the consumer. And yet there is fee-for-service. And here you have America writ large in health care: Hey, you can have it all.

Then what we get is this humongous increase. And of course, Blue Cross Blue Shield says it is not an increase at all. And they are going to have to explain themselves about that.

I want to ask you, Mr. Francis, because I am sympathetic with what you say, that Blue Cross Blue Shield—because you discuss very fairly, it seems to me, the pressures on Blue Cross Blue Shield, as of course is the case given the nature of the health care system in this country, the have-it-all system in this country. I understand that. And particularly for a provider that turns out to be preferred by many Federal employees throughout their work life, my question to you is does this huge advantage in volume or loyalty not make up in some way for the disadvantage which comes with the fact that the work force ages over time and therefore may cost you somewhat more?

Mr. FRANCIS. Yes, it does make up in a major way. For example, the plan, just being very narrowly business about it, it is to the advantage of the plans to have people who sort of don't exercise their right in open season to change plans, but stick with it, OK. That makes for predictability in expenses, predictability in enrollment.

Looked at from the consumer point of view, if I am in a plan for a long period of time, it is sort of like wearing an old shoe. I get comfortable with it. I understand the paperwork and the bureaucracy, and I understand the benefits.

And of course, that is one of the problems that leads to a situation where I know the benefits of my plan, I am not going to reread that 100-some page brochure every year. It is awful hard reading, let me tell you. I read them all. It is distressing. So people tend to get pretty lazy about it, with good reason, because they expect continuity, and they expect no surprises. That is my main concern here; it is the gotcha aspect of this change. Some people aren't going to realize what has happened to them until they go get that surgery.

Dr. Petrucci mentioned that he works with his patients to warn them and so on. And I often advise people when you go out of network, try to negotiate—I tell them to try to negotiate the Medicare rate. And sometimes it works with people who have no health insurance at all that I counsel.

But some people don't do that, and some doctors don't warn them. So there are surprises. And it is unfortunate. And I think what we ought to worry about most in oversight of these plans is that those kinds of gotcha surprises be minimized. It is not that Blue Cross and the other plans shouldn't take cost-saving steps, it is just that the cost-saving steps should not be ones that lead to unfair and total surprises that are financially unfair.

Ms. NORTON. Dr. Petrucci, I was surprised; I am looking in your testimony now for the—here it is—for the list of so-called surgeries in your testimony. I would like you to explain to me whether or not perhaps they are trying to keep—perhaps they should—surgeons from doing some of these procedures. For example, it says "fractures and dislocations" in your testimony. Is that normally a matter for the surgeon?

Dr. PETRUCCI. Well, I think that is one of the problems we have is the term "surgery" is very loosely defined in this dialog. Technically speaking, there is no surgery involved in the setting of a fracture. Basically, the orthopedic surgeon sets the fracture, can sometimes do it in their office, put a cast on. And that is part of the care for that particular problem.

Ms. NORTON. So if a surgeon is present, then, of course, this would apply.

Dr. PETRUCCI. Well, this applies to all surgeons. So an orthopedic surgeon falls into the category of surgeon, even though that particular procedure does not actually involve an operation. And that is one of the problems we have with this, is the list of things that are included really aren't technically surgery in many respects.

Ms. NORTON. So it is going to be up to Blue Cross—so as far as you are concerned, if a surgeon does the—does any part of the work, this $7,500 cost increase applies?

Dr. PETRUCCI. Yes, any nonparticipating—patient goes to a nonparticipating physician surgeon and casts their fractured wrist, Blue Cross and Blue Shield will pay nothing, and the $7,500 deductible applies in that setting. Now, obviously, the charge won't be that high, but whatever it is, the patient will be responsible for.

Ms. NORTON. Mr. Chairman, I am through for the moment.

Mr. DAVIS. Thank you very much.

Mr. Cummings.

Mr. CUMMINGS. Good morning. You know, I am sitting here and I am listening to this, and I think the thing that bothers me more than anything else is when people think they have one thing with regard to coverage and then find out they have something else. Illness is nothing to play with. We are talking about people's ability to take care of their families, to take care of themselves, to go to work, to do the things they need to do on a daily basis, and to live a quality, a certain level of quality of life.

And I am just trying to figure out how concerned you are as to whether people are informed. We got people, we got busy people today that get—they are like me, and they get 50 pieces of mail, all kinds of stuff. And you separate some of it. You try to go through the most important stuff, and you might miss something. But I am just trying to figure out how informed do you think these Federal employees are and retirees with regard to these changes? I mean, do you have any clue?

Mr. FRANCIS. Yes, sir, I have a clue. Except for the publicity that attends to this hearing and the publicity that the Washington Post has chosen to put in its Federal Diary page and a couple of radio shows that I have been on, and you know, some people read the Federal Diary, but most people don't. Some people hear my radio show, but certainly most people don't. There is word of mouth. But by and large, people do not know about the benefit changes in their plans. They don't pay attention.

They rely, precisely, sir, as you said, we are all very busy. We get a ton of mail. We get a ton of documents. The thought of me as a sort of average Federal employee picking up this 134-page document and sort of reading through it, no one does that. Now, what they do in some cases, but only a minority of cases, is do what OPM advises them. And OPM is pretty good about most of this, right on the cover it says: Go to page 9 to see the changes in benefits. The trouble is, you go to page 9, and it is a long laundry list. And buried in that long laundry list is, to take this example, this $7,500 change along with a lot of others. And people tend not to do that.

So I think what is incumbent on the program as a whole—I am not blaming anybody; in fact, I think in general the program does very well at what I am describing—is to try to prevent people from having unpleasant surprises because something doesn't work the way it used to work or something doesn't work the way an ordinary person would expect it to work. And I think by and large this program does very well at that. So I think we all need to be a little bit careful taking Blue Cross to the wood shed here, I guess. But it is not all bad.

Mr. CUMMINGS. All right.

Let me ask you this. Let me just play the devil's advocate, because I think this is what OPM, maybe Blue Cross and Blue Shield, is saying: People have a choice. Cummings, why are you worried about folk when they have a choice? There are probably some things that are better out there, and so why are you so concerned? They will go—that is how, you know, the free market is. That is what competition is all about.

And but just let me give you this little footnote on the question on what they would say. I think Blue Cross and Blue Shield knows that people see them as the gold standard. And there are people who will say to themselves, if I get sick, I don't want to have to worry about anything. I don't want to have—I don't want to have to ask any questions. I just want to be able to go to the hospital, don't want any problems. Just want to get treatment. So the question becomes, how do we make sure that folk, I mean, if they want Blue Cross and Blue Shield, that they are informed and do you think we need to extend the time for them, the enrollment period so that they can hopefully become informed? What kind of procedures would you like for Blue Cross or OPM or whoever to go through to make sure people are informed of these things? Because there may be people that look at this and say this is fine. This is great. My problem is that if they don't know and then they end up in a situation where they have their back against the wall and there is no way that they can get around it and they are stuck. And see, it wouldn't bother me if you were talking about stuck because you are stuck in traffic, but I am talking about stuck with regard to your health. And so, I mean, what do you all recommend? Because I want the OPM and Blue Cross and Blue Shield people to be ready for this question, too. I mean, what do you all recommend? Again, there are people that probably may be fine with this.

Mr. FRANCIS. Well, if I may answer, Dr. Petrucci already did, he can speak for himself, but he already suggested extending open season. I'm——

Mr. CUMMINGS. For how long?

Mr. FRANCIS. I am inclined to recommend against that. I don't think that is the right answer to this problem. You can extend open season another week or 2 weeks, and still 90 percent of the people aren't going to know, you know, and they are still going to be potentially subject to the gotcha. I think reverse this around a little bit.

First, in general the choice among plans is extremely important in this program. OPM, the key to running the program is that all the plans, all the choices be good ones. OK. Then we don't have to

worry as much about competition. So OPM serves a regulator role, a cop role. And it serves it in general very well. I think this is just one of those blips. I think it is just one of those blips; I think it is one of those things that people, is sort of the forest and the trees. I don't think people quite realized what they were doing when they did it. That may be unfair, and I am sure OPM and Blue Cross can expand that better.

My suggestion, frankly, if I were Blue Cross, what I would do, if OPM would let me, is I would simply make a benefit change, and I would restore the outpatient—the out-of-network surgery benefit to what it was in the year 2008. A real simple change. Almost no financial consequence to the plan, if any. And a gotcha is gone.

And then over the next year, both parties could consider how in the future they want to handle whatever problem they are trying to deal with, whether it is balance billing, or network discipline problems, or just what was going on, because there are other and better alternative ways to deal with it.

Mr. CUMMINGS. Suppose they say no.

Mr. FRANCIS. You know, I don't know how to answer that. I don't think——

Mr. CUMMINGS. Which they probably will.

Mr. FRANCIS. The basic philosophy of this program is that the plans make their benefit choices. And as long as they are not sort of beyond the pale, the government is going to bless them. Government is not trying to set detailed benefit design—make detailed benefit design decisions. So I don't know the answer, sir. My guess is that one way or another, they are going to find a way to ameliorate this problem. OPM has already issued a clarification that there is not an emergency room gotcha. OK. I hope they could do a little more than that. And the simplest way, in my view, is simply to restore things to the status quo ante in terms of this particular benefit.

Dr. PETRUCCI. I think I would like to respond also, because I think you speak to a larger issue. And that is our experience in the office setting is that patients really don't know what their plans cover many, many times, even though they have signed onto this plan, they have had it for a long time. When they come to our office, it is very common for them really not to understand the nuances. And I think that is part of the problem. These plans have some very detailed nuances which are not easily spelled out, or they may be spelled out but they are not easy to understand, even for us and some of our staff. I think that needs to be clarified and improved.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. DAVIS. Thank you very much, Mr. Cummings.

Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

I am leaning over here to this mic, so hopefully you can hear me.

I wanted to pick up on what Congressman Cummings was saying about, you know, this is supposed to be the gold standard. And in fact, it is the one often pointed to in the debates about how we are going to improve the health care system. Everyone says, well, you know, we want to have the same system for everybody that Federal employees have and so forth. So to me the fact that Blue Cross is

resorting to, or having to resort to, and we will get their testimony on it, I guess, these kinds of changes may just be further evidence that the health care system and the coverage models that we have in place are continuing to break down. And I was curious to know if you know what percentage now of patients who are seeking surgical treatment are going outside of the network versus choosing the option of in-network surgery? Do you have any idea?

Mr. FRANCIS. I don't know the answer, sir. I am sure Blue Cross does. But it is a very small percentage, because I think the ordinary consumer advice I render to people is stay in the network. You join a plan, you use network physicians; it is kind of a no-brainer, if you possibly can. And but certainly use network physicians for anything very expensive. And I think, I don't know whether it is 98, 99 percent of the time, for the expensive stuff, people do that. For minor things, they may, you know, if you want to take your kid to a pediatrician who is not in the network, it is probably still just a hundred bucks, and people will do it. But the overall majority of the surgery in this program, I am sure, out of all the services of people who are enrolled in the Blue Cross plan or any of the other plans, they really all operate in the same way, they encourage you to use network physicians, and people do use network physicians. But it is this small percent who either—it might be ignorance. It might be a very important choice. OK, there are lots of important reasons people may choose to use a nonparticipating or non-network physician. But, as Dr. Petrucci said, you don't expect to have the particular medical procedure that is listed on page 87 of your brochure. Maybe you got hit by a truck. So people walk into their doctor's office, they are not going to know necessarily what faces them. That is unavoidable. What isn't unavoidable is that what faces them is not something disproportionate to the offense, so to speak. And that is the point here about this $7,500 cap.

Mr. SARBANES. So if, as you are speculating, the percentage is very small of people that would want to go outside for their surgery, then it translates, and I guess you have made this point already, that the savings aren't so great to the plan for implementing this new policy.

Mr. FRANCIS. I don't think there are any savings to Blue Cross that are—any direct savings that are consequential one way or the other.

It may be of some benefit to them in—remember, it's very important, the preferred provider system, part of the deal is, you're going to accept a lower rate that, the plan's allowance is going to be lower than we otherwise charge, but you're going to get more business because you are going to get people enrolled in the plan.

So all the plans have to make balancing decisions to attract enough physicians into the network to get some of the business going their way, and I think Blue Cross can answer this much better than I, but it's a small percent of people who go out of network for expensive procedures, but a small percent could be a lot of people in a plan like this which enrolls somewhere around 4 million of those 8 million lives in the FEHBP.

Dr. PETRUCCI. Well, I think—I would like to respond to that as well because I think that what happens is that, in the new plan,

Blue Cross Blue Shield pays nothing for that surgical procedure where currently they would be so that even if it's a small percentage, there is a significant savings in that setting. Now, I don't know whether that was intended or not, but that is certainly the outcome of that happening. So they pay nothing at all for that first $7,500 of service.

Mr. SARBANES. Well, we'll wait to hear from them, and I would just say that this line, this distinction between what happens to you when you go in or out of network, obviously, there need to be incentives to encourage people to stay in, but I don't think you want to create a situation where you're basically fencing people off from the kind of choice that they ought to be able to make. And when it's such a dramatic distinction, that can happen, and of course that is undermining this gold standard profile that the plan has had before now.

Thank you Mr. Chairman.

Mr. DAVIS. Well, let me just ask, how does one know whether or not they're using a physician or a provider that is out of network? I mean, let's say, if you are in surgery, and there might be three, four, five, six different people who will come into the surgery room, and they do different things?

Dr. PETRUCCI. Let's talk about two different circumstances. The first is in an emergency. And that is the one that is easiest to answer because the individual doctors who are involved in that emergency situation, whether it be an orthopedic surgeon, a general surgeon, a urologist, a thoracic surgeon, may or may not be in the plan. And the patient ahead of time usually doesn't know that. I think that I can speak for most of my colleagues, maybe not all of them, but most of my colleagues recognize that the patient is in a bad position in that situation, and therefore the charges are kept more in line with what the standard allowances are to a certain extent. There may be charges higher than what the standard allowances are, but the balance billing for emergency care is much less than it would be for a patient who comes to my office to have an operation scheduled.

Now in that setting, in most physicians offices, a patient will be told on the phone when they call that we do not accept your insurance but we will be happy to see you, we will file your insurance for you, we will do whatever you need to do for that, but we don't accept your insurance. That is the usual mechanism whereby they would find out that the physician is not participating.

Mr. DAVIS. Are you a——

Dr. PETRUCCI. I am a nonparticipating physician.

Mr. DAVIS. And was there any particular reason or reasons that you may have——

Dr. PETRUCCI. There were a number of reasons, and they go back a number of years. Part of it is that the current requirement for Blue Cross Blue Shield participation means that, based on the Care First oversight of that, is that you have to participate with all of their plans, including the HMO's, and we do not want to have to do that. Our choice is not to have to do that.

And second, the single most important point was that administratively these plans are a nightmare for us because they're all different. They all have different requirements for the physician.

Some require pre-certification for various tests and surgeries. Some don't. And it's impossible to keep track of that process as part of our regular office procedure. And as a busy group with five surgeons and a lot of patients coming for surgery, that was a nightmare for us.

Mr. DAVIS. Let me just ask my last question. For the last 40 years that I'm aware, much of the discussion around health care has been cost containment and everything has been driven in that direction, at least conversationally, and at least in discussions. Could it be that the costs are simply continuing to escalate to the extent that there is just no way around these increases?

Mr. FRANCIS. I think, Mr. Chairman, there are ways around these increases. They're painful. They're not going to happen over night. The Medicare trustees forecast dramatic insolvency for that program starting—actually, by some measures, it has already started. The Hospital Trust Fund is not collecting as much as much money as is going out. It's living off its balances right now.

There are ways, there are lots of ways to change the practice of American medicine and the mechanisms by which we insure and reimburse for treatment that can over time reduce costs. I mentioned earlier the tax treatment. I think every health care economist agrees that the current tax treatment of health insurance is a terrible mistake, not just because it encourages ever more increasing spending, but because it's—the rich get the bigger benefit, OK. The higher your tax bracket, the better benefit you get out of the current tax treatment of health insurance. And if you are someone who pays no or very little income taxes, you get almost none of the tax preference benefit. And there is no question in my mind that the Obama administration is going to look at that issue and propose some significant changes. But the Medicare wrap-around situation, it's not just the FEHBP that has this golden wrap-around where you get 100 percent coverage of, hey, you want two CAT scans? Go for three. Why not? It doesn't cost you anything and so on. This is just a continuing problem. It's not a problem when you break an arm in an emergency. It's a problem when there's all kinds of very expensive elective treatments out there and if they're free, "why not?"

Clearly, there are ways to deal with that. One of the ways, the economists favorite way is, charge people a little bit, but there are other ways, paying for the least costly alternative, for example, all kinds of ways to manage care, some of them unpleasant, but some of them not so unpleasant. Managing care can actually be good for the patient.

I think there's a lot of struggling, quality measures, another aspect of this, CMS where I consult is a leader in developing new and better measures of quality and increasingly trying to make reimbursement of both hospitals and physicians and other providers for that matter depend in part at least on the quality of their care. Quality of care includes not too much care or the wrong kind. I will stop my—I think there are methods, but they are not easy and they are not fast.

Dr. PETRUCCI. I would like to believe there is a system, and I don't know enough about the system to try and say that I could solve this problem today. I wish I could. But I will just comment

on one point that was made in terms of managed care. We've seen the managed care model. And it can be good, but it can be disastrous, because what it frequently does is it becomes an impediment for the patient to obtain care because there is a layer of bureaucracy between the patient and their care, which may be good, but it can often be bad. And so managed care by itself is clearly not an answer.

And I just want to reemphasize another point that I missed previously, and that is that—you picked up on it—and that is the issue of surgery. Surgery is a lot of different things as defined by the Blue Cross Blue Shield hand book. Most of them aren't actually surgery. They are procedures of various types required for good care. Thank you.

Mr. DAVIS. Delegate Norton.

Ms. NORTON. I had one further question, Mr. Francis, that I would like to ask you. There has been something of a debate raging for some years now about the fact that Blue Cross Blue Shield, which is very much unlike other companies inasmuch as it has tax advantages as a nonprofit, has notwithstanding the market today because I don't know the effect there, but has built, indeed required, very large surpluses of its members, huge surpluses. And since it's nonprofit, you have people looking to see, well, are you behaving like a nonprofit? Do you distribute any of that surplus?

And their standard answer is one that would convince me if you could show me. Their standard answer is that, well, we give this back to the subscribers. Well, if you were to ask any member of the public, even those who are concerned about the tax-exempt status and not getting very much frankly from Blue Cross from that status, they would say, well, if that is what you are doing with it, that is what we meant you to do with it.

Do you see any evidence that Blue Cross Blue Shield is using this huge surplus it has mounted and these requires—I'm not talking about reserves; I'm talking about sheer surplus—do you see any evidence that this surplus is plowed back to the benefit of consumers?

Mr. FRANCIS. I have to confess I don't know an answer; that is just simply beyond my knowledge.

Ms. NORTON. When you compare their value and their rates with other—with the commercial companies?

Mr. FRANCIS. I think I would say this with respect to—the issue you're raising I think has more to do with some of the Blue Cross plans have attempted to convert from nonprofit to for-profit status. That has been very controversial, and part of that controversy has been, what happens to those surpluses they have? That was a big issue in Maryland recently, for example.

Ms. NORTON. No, no. I'm not talking about that. I'm talking about, if you are a nonprofit and you do not distribute—and you mount a big surplus that is not distributed to where people can see it, then a question is raised, since you are exempt from certain kinds of taxes, whether in fact the public is benefiting from that.

Now the public could be, either the subscribers—I'm not talking about the conversion issue. Yes, we would have another issue if they then have to talk about how they get distributed. I'm talking about right now, if you're sitting in competition with commercial

providers who don't have a tax advantage, and because of that nonprofit status, typically the government expects that surplus will be used or at least some portion of it, no one knows how much, nobody is going to say that there is any percentage, but some portion, some significant proportion should be used for the public benefit. And I described—leave aside the conversion. I'm not talking about conversion. I'm talking about these people are not seeking now—they were at one point. They're not seeking now to become something else.

I'm saying, if you're sitting as a tax-exempt provider or a provider with some tax advantages, and you look, as you apparently do, at all of these plans, my question to you is, in your judgment, do you see such cost differences or other value, such that you could say that perhaps the surplus is of value to the subscriber because we can see it in the value or in the cost to the consumer?

Mr. FRANCIS. Couple of quick comments, and then I will defer to Blue Cross and OPM. First, it's very important, this program has a pretty rigorous degree of oversight in terms of the finances, and it is the case that the Blue Cross premium reflects the cost experience to the people enrolled in the plan. And there may be an issue of, you know, on the very margin as to sort of where one sets those rates exactly and how reserves and other funds are treated, but basically, I think people are getting value in terms of the—they're getting the services they're paying for, OK, in this plan and in the others.

Ms. NORTON. I'm not talking about that. Compare commercially, if they have—if they are nonprofit and they claim that money should not be distributed the way other nonprofits do but should in fact go back into their plan, you could say, for example, that it does because there are more people who have—because they're older, for example, you could say that their subscribers are older, as you indeed said. All I'm doing is looking for some evidence that the surplus which has become controversial in fact is having the effect they say it has. Sure you're getting value, but if the fact that you have a surplus, you would expect the surplus to get you more than value. You would expect that since you have money to put back, that money would in fact distinguish you from others or at least that is what they claim, that is why they don't want to distribute it elsewhere, something I would accept if somebody can just show me some evidence of it and simply to say, when you compare them to commercial guys, they are indeed reflecting the experience—then that of course doesn't show it because that is what everybody does. I'm just trying to find where this what I would amount to excess capital that commercial providers don't have, I'm trying to find where it goes and whether the subscribers of Blue Cross Blue Shield feel it in any way.

Mr. FRANCIS. I simply can't speak to the financial aspects of that. I will say that the Blue Cross program has over the years served a number of very important call them public good functions in this program that go sort of beyond what a narrowly conceived insurance program would have to do. I will give you two examples of that, and this was Blue Cross and OPM together making these calls, but a number of the union plans went out of business over the years. Plans closed down for various reasons. They just couldn't

hack it. Some of the people or options would close down. Some of the people enrolled in those plans were very old and weren't kind of with it mentally, and the question—if they made a mistake and let their membership, their enrollment in the FEHBP lapse, even for 1 day, they would be out of the program forever. OPM went to great lengths working with Blue Cross to make sure that people were what is called auto-enrolled in Blue Cross standard as a default, so they wouldn't lose their eligibility for the program, and those were expensive people. So that is an example——

Ms. NORTON. Well, that is a good example.

Mr. FRANCIS. Of the kind of service this plan provides.

I'll give you one other example, I'm not sure it is quite as good a one. It was the case for many years before we had mental health parity that the best mental health benefit in the program was in the Blue Cross plan, and that meant they were going to disproportionately attract the heavy users of psychiatric services, and of course, you know, those costs got reflected in the premiums, but the fact is people were taken care of who otherwise wouldn't have had a home. And I think, in general, Blue Cross is the plan of—we've been calling it the gold standard. I don't want to call it the plan of last resort, but it has been the plan that has provided the benefits and the coverage that people needed; if they had nowhere else to turn, they could always sign up for the Blue Cross plan. I think it has over the years been a great service to Federal employees and retirees in that respect.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. DAVIS. Thank you very much.

Mr. Sarbanes, do either you or Mr. Cummings have any other comments? Mr. Cummings.

Mr. CUMMINGS. I have a question Mr. Chairman.

Mr. Francis, you held up a book talking about the health plans. Do you have that book?

Mr. FRANCIS. I held up, Congressman, several books. I don't know if I held up my book.

Mr. CUMMINGS. This is something that describes the health plans.

Mr. FRANCIS. Yes, there is a Medicare book that describes the health plans in Medicare called "Medicare and You," and there is an OPM book. We call them booklets. It's called, "The Guide to Federal Benefits for Federal Retirees and Their Survivors." This is published by OPM. It's about 100 pages, plus or minus—yeah, it's exactly 100 pages.

Mr. CUMMINGS. Is that the one you said was difficult for you to understand and get through?

Mr. FRANCIS. No. The other one I held up was the Blue Cross Blue Shield brochure. This is the description of the Blue Cross benefits. It's 134 pages long, and it's very detailed and technical. OPM has set standards for these brochures. They try to get them written in pretty clear English. They have them organized the same way, so you can turn—for example, we've been talking about the surgery benefit. You can go to a certain page in every brochure and you will find the surgery section described. Another section is on the prescription drug benefit and so on. It's done pretty well.

Compared to the way private health insurance plans generally describe their coverages, it's a masterpiece of clarity and explanation. That said, it's 134 pages of very detailed small print, and nobody in the world reads every page or can understand every nuance, as Dr. Petrucci gave several examples of that and——

Mr. CUMMINGS. But is there anything that OPM can do to try to help simplify some of this? On the one hand, you said it's a great book. Then you come back and say it's not so great. So, help me with this.

In other words, can they make it more consumer friendly? I guess what bothers me is sometimes I think we don't have a realistic view of what people go through every day and how they live their lives. And to me, if I am, I tell my staff when we do an event, don't do it the way you like it done; do it the way the customer needs it done so we can be most effective and efficient, period. Other than that, I'm wasting my time. And time is short. So I'm trying to figure out, are there things that OPM can do to help employees to better understand and navigate this system so that they can come up with whatever is necessary, what they feel, deem appropriate and necessary for their family and for themselves? Do you have any—do you think it's fine just as it is?

Mr. FRANCIS. Congressman, I 100 percent agree with what you said. It's actually my main interest in this subject, is helping consumers to understand and benefit from their understanding in choosing health plans and in using those health plans.

I think, by and large, OPM has done a very good job on this. I would give them a B-plus. They have a very good and well organized and clear and useful Web site.

I think the brochures, as I mentioned, they're long and complicated. And I wish they were less long and less complicated, but under the circumstances, they do a pretty good job on those.

They do have these summaries of benefits, such as the one I held up. That isn't as good as it should be for the reason that, No. 1, it could present a little more information like what is the catastrophic benefit and, No. 2, because they don't standardize the way benefits are described. I want to emphasize, I don't mean you have to standardize the benefit itself, but because, for example, the catastrophic promise of each plan isn't—there is an apples and oranges comparison because they aren't actually defined the same way and they can be, I think there is work to be done.

And I think this example, this problem we were talking about today is a wonderful example of, if OPM had a rule in place that said any significant deductible copayment or other maximum, including this $7,500 whatever it is technically called, it's not very clear, must be included in our catastrophic promise. That is, you can't put it in a footnote that there is this $7,500; it has to be part of that number that everybody sees, so that number would have been in $14,000 instead of $7,000, I think they wouldn't have done it.

Mr. CUMMINGS. I've got to cut you off, because I want to ask Dr. Petrucci a question, but I'm sure OPM is listening to you, and we want a friendly, a user-friendly document for our employees.

Dr. PETRUCCI. We see it from the patient side as well. As I said earlier, patients will come to the office and think one thing about their plan, and it will be completely different.

Mr. CUMMINGS. Doctor, let me tell you what concerns me about what you just said. You were talking about the definition of surgery and how, I guess, it's Blue Cross and Blue Shield may or OPM—Blue Cross and Blue Shield I think it was defines surgery one way, and you see surgery another——

Dr. PETRUCCI. Well——

Mr. CUMMINGS. Wait a minute. Hold on, hold on, let me ask the question.

You're a surgeon, is that right?

Dr. PETRUCCI. Yes.

Mr. CUMMINGS. Oh, OK, and is there anything that OPM can do to straighten that out? Because where you were just about to go I think before I rudely cut you off, is you know we need—I mean, if there are things that we can clarify, and I'm sure—I'm not a doctor, and I know certain things get kind of murky and grayish maybe, but it seems to me surgeons ought to be able to figure out what surgery is. And I don't know who is making the decisions at Blue Cross and Blue Shield. I guess they're doctors. But my point is that sometimes it seems to me that there should be some kind of clear understanding, if that is possible and practical, of what surgery is, because it seems to me when I look at the information, if you have a dispute about what surgery is or is not, that is a problem.

Dr. PETRUCCI. I agree completely. I think the list of procedures, the list of conditions that are included under the surgery mantra, if you will, includes a lot of things, including procedures which are typically not considered surgery, but for example, childbirth obstetrical care and child birth is included in that list. There is usually not surgery there unless the patient has Caesarean section obviously. It's a definitional process which doesn't make any sense. It's certainly not medically the way we would think of surgery.

Mr. CUMMINGS. What would you recommend with regard to clearing that up? I mean, if you had a magic wand and if government worked the way you would like for government to work, what would you like to see government do on that issue?

Dr. PETRUCCI. Well, I think, obviously, the first thing here with that issue, I think Blue Cross has to be up front about what they're saying, and that issue, what they're basically saying is, there are a whole group of procedures here that we do not want patients to go out of the plan for, for whatever reason, and that includes all these various treatment types. They list them as surgery. They're not really surgery. So they need to be more up front about what this issue is.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. DAVIS. Thank you very much.

Gentlemen, thank you very much for your testimony. We really appreciate it.

And we will go to our next panel.

Our second panel will consist of, you have heard a lot about OPM, Ms. Nancy Kichak. She is the Associate Director for the Human Resources Policy Division for the Office of Personnel Man-

agement. In this position, she leads the design, development, and implementation of innovative, flexible merit-based human resource policies.

Thank you very much, Ms. Kichak, for being with us.

Mr. Stephen W. Gammarino is senior vice president of national programs for the Blue Cross Blue Shield Association, the Blues as they're called. Mr. Gammarino oversees the Blues Federal employee program, which administers the largest privately underwritten health insurance contract in the world, with premium income exceeding $18 billion. The Blues have approximately 50 percent of the Federal market.

Thank you all both for coming. And if you would stand and be sworn in.

[Witnesses sworn.]

Mr. DAVIS. The record will show that the witnesses answered in the affirmative.

Ms. Kichak, it's good to see you again. And thank you very much for being here. We will begin with you.

STATEMENTS OF NANCY H. KICHAK, ASSOCIATE DIRECTOR, STRATEGIC HUMAN RESOURCES POLICY DIVISION, OFFICE OF PERSONNEL MANAGEMENT; AND STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, NATIONAL PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

STATEMENT OF NANCY H. KICHAK

Ms. KICHAK. Mr. Chairman and members of the subcommittee, thank you for inviting me here today to discuss the benefit and premium changes for the Blue Cross Blue Shield benefit plan. The FEHB program annually provides $34.9 billion in health care benefits to over 8 million Federal employees, retirees, and their dependents. In January 2009, enrollees nationwide will have 269 health plan choices from which they may select their coverage.

At the end of this year's negotiations, Blue Cross and Blue Shield and OPM signed a contract that realigned benefits at no increase in cost to the program for nonemergency surgical procedures performed by nonparticipating physicians. The agreement was that enrollees would pay the full cost of the procedures up to $7,500, and then Blue Cross would pay the additional charges.

This provision was included in the plan because OPM's review of disputed claims over the last several years revealed a hardship to Federal employees and retirees. Time and again, disputed claims were submitted to OPM by patients with skyrocketing out-of-pocket costs due to the current policy for elective surgeries, which requires enrollees to pay 25 percent of the plan allowance plus any difference between the allowance and the billed amount. Because there was no limit on the amount that could be collected from Federal employees and because non-par doctors charged substantially in excess of allowable amounts for their out-of-network surgeon services, in some cases, the enrollees costs totaled tens of thousands of dollars.

For example, we reviewed a case in which one Federal employee who had back surgery ended up being responsible for paying the doctor over $55,000 of his own money. Now this would be a gotcha,

where you go to a non-par doctor and you have to pay the difference between the allowable and the billed amount.

Once the 2009 policy becomes effective, the maximum out-of-pocket will be defined for enrollees who obtain surgeries from nonparticipating doctors while reducing costs for Federal employees and annuitants using the most expensive services. The set copayment of $7,500 enables members to know, should they choose a nonparticipating provider, that they will be responsible for paying only up to that amount, Blue Cross Blue Shield pays any amount in excess of the fixed copayment.

Alternatively, Federal employees can choose to stay in network, and by far most do, at which point this policy does not apply, or they can enroll in a plan other than Blue Cross and Blue Shield. The $7,500 copayment does not apply to surgeries resulting from accidental or emergency situations, and it is not subject to the annual deductible.

Blue Cross's testimony suggests that these benefits should now be reconsidered. OPM stands behind the contract as agreed to. Continuous negotiations and benefit changes would create confusion in the program and make it virtually impossible to provide sufficient information for enrollees to make an informed open season decision. We remain committed to protecting the interests of the Federal employees whose disputed claims presented evidence of an overwhelming financial burden.

Also, from a competitive standpoint, it would be unfair to reopen negotiations with a single plan without making that same opportunity available to competitors. Each year, OPM works with insurance companies to negotiate a package of benefits that provides comprehensive coverage at the lowest possible cost. We work diligently to strike a balance of protection against catastrophic events without shifting a high premium burden to enrollees and firmly believe the negotiated copays for out-of-network surgeries achieve that balance by limiting costs for users of expensive surgeries without transferring more costs to enrollees who stay within network.

Mr. Chairman, we are 6 days away from the end of the time period for which Federal employees can choose their health care plan for next year. If changes are made at this late date, all of the information posted on our Web site, sent to the agencies' human resources benefit officers, and to the employees and retirees themselves, who need this information in order to make an informed decision about their health care options, would need to be revised. We encourage enrollees to take the opportunity during open season to review their health insurance coverage needs and any change in their plan's premiums and benefits, and then decide if they should consider a change in plans or options. I appreciate this opportunity to testify before the subcommittee on this very important issue, and I will be glad to answer any questions.

[The prepared statement of Ms. Kichak follows:]

STATEMENT OF

MS. NANCY KICHAK
ASSOCIATE DIRECTOR
STRATEGIC HUMAN RESOURCES POLICY DIVISION
OFFICE OF PERSONNEL MANAGEMENT

before the

HOUSE COMMITTEE ON OVERSIGHT AND
GOVERNMENT REFORM
SUBCOMMITTEE ON FEDERAL WORKFORCE,
POSTAL SERVICE AND THE
DISTRICT OF COLUMBIA

on

"2009 Blue Cross Blue Shield Health Benefit: What it means for Federal Employees"

December 3, 2008

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss benefit and premium changes for the Blue Cross and Blue Shield Service Benefit Plan.

Established in 1960, the FEHB Program is the largest employer-sponsored health benefits program in the United States, with about 8 million participants. The FEHB Program annually provides $34.9 billion in health care benefits. By law, participation of fee-for-service (FFS) plans is limited to one Service Benefit Plan, administered by Blue Cross and Blue Shield, one Indemnity Benefit Plan, and several employee organization plans. Health Maintenance organizations (HMOs) also participate in the program and

new HMOs may submit applications to participate in the program by January 31 each year without having to respond to a specific request for proposals.

OPM administers the FEHB Program on behalf of Federal employees, retirees, and their dependents. The FEHB offers competitive health benefits products for Federal workers, much like other large employer purchasers, by contracting with private sector health plans. In January 2009, enrollees nationwide will have 269 health plan choices from which they may select their coverage. There will be 14 fee-for-service (FFS) choices (ten open to all enrollees); 27 high deductible health plan (HDHP) choices; four consumer driven plan choices; and 224 local HMOs.

For five consecutive years, from 2002 to 2007, the rate of overall average premium increases in the FEHB Program declined from 12.1 percent to 1.8 percent. In 2008, rates increased slightly by 2.1 for 2008. In 2009, rate increases will be 7.0 percent. The increase is well within average increases predicted for other large employers which range from 4.3% to 10.6%, depending upon industry and type of health plan. In 2009, about 20% of enrollees will see an increase of less than 5% for their share of premiums. This year, however, enrollees in the BCBS Standard Option plan will see an increase of about 13%.

OPM annually negotiates benefits and rates with all carriers beginning each spring and continuing throughout the summer. Carriers are required to submit their proposals by May 31 and we act to conclude negotiations by August 31. During this time period, OPM contracting officials work with carriers to ensure that they offer a

comprehensive set of benefits and that any increases in premiums are necessary to protect the interests of enrollees and the Government. Once these negotiations have been concluded with all carriers, OPM issues a September press release announcing the Open Season event and health plan premium changes for the next contract year. Carriers are required to make copies of their brochures describing benefit and rate changes available to their members. OPM also publishes the brochures for all carriers on its web site prior to Open Season.

Now, I would like to discuss some of the benefit changes for next year. BCBS and other plans are expanding coverage for hearing benefits for adults, including hearing aids – most limit benefits to set dollar amounts (e.g. $1000 per year per hearing aid). Last year, BCBS and other plans added or expanded hearing benefits for children. Due to increases in drug costs and utilization, BCBS is increasing cost sharing for brand drugs and decreasing it for generics to encourage patients to seek lower cost generic alternatives. BCBS is also increasing physician office visit co-pays by $5.00 as well as other cost sharing for inpatient and outpatient facility care.

Last, beginning next year, enrollees in Blue Cross Blue Shield's Standard Option plan will have a $7,500 copayment for surgical procedures performed by a non-participating physician. The reason this provision was included in the plan was to lower expenses for certain members of the Blue Cross Blue Shield Standard Option who choose out-of- network doctors for non-emergency surgeries. Previously, for elective surgeries, enrollees paid 25% of the Plan allowance, **plus** any difference between the allowance and the billed amount. While we estimate less than three percent of surgeries are performed

by non-participating providers, in some cases this amount totaled tens of thousands of dollars. Patients could not predict their out-of-pocket costs when using non-participating providers until the health care expenses had been incurred, and benefits were provided by the doctors. Many members filed disputed claims because the balance owed was a large amount, in most cases larger than the new $7500 copayment, due to the difference between the allowed amount and the amount billed. For example, in 2007 a member filed a disputed claim concerning the costs for outpatient back surgery. In this case, the billed charge was $63,525. Blue Cross and Blue Shield paid about $5,700 leaving the member to pay the balance of almost $58,000. The new policy was negotiated to allow enrollees who elect to use these providers to know what they must pay. We also negotiated this change to hold benefits steady in total for enrollees who obtain surgeries from non-participating doctors while reducing costs those using the most expensive services. The set copayment of $7,500 enables members to know, should they choose a non-participating provider that they will be responsible for paying only up to that amount-- BCBS pays any amount in excess of the fixed copayment of $7500. Obviously, plan members can choose to stay in network, at which point this policy does not apply or they can choose another plan besides Blue Cross Blue Shield. Also, the $7,500 copayment does not apply to surgeries resulting from accidental or emergency situations, and is not subject to the annual deductible.

In switching to fixed copayments, we expect members will make informed decisions when selecting providers to ensure that out-of-pocket costs are not burdensome. Additionally, these fixed copayments will reduce the surprise of a larger

bill and will give members the information they need to make an informed choice of providers before having surgery. OPM encourages consumers to use in-network providers in order to reduce their out-of-pocket costs. Currently, enrollees who choose to use non-participating providers are at risk for paying any amounts the provider charges above the Plan allowance for the procedure.

One of OPM's Guiding Principles for FEHB carriers is "Strengthening information for consumers so they can be more involved and responsible for their healthcare decisions." All benefit changes are prominently described on the change page for each health plan brochure and which is available on OPM's web site. As I mentioned at the beginning of my testimony, there are 10 fee-for-service plan options as well as HMOs generally available for enrollees. OPM encourages enrollees to take the opportunity during Open Season to review their health insurance coverage needs and any changes in their plan's premium and benefits and then decide if they should consider a change in plans or options. A hallmark of the FEHB Program is "choice", meaning employees and retirees can use the Open Season to shop among plans and, perhaps, move to one that better meets their medical and financial needs.

Each Open Season, OPM also publishes the popular *Guide to Federal Benefits* and this year, OPM also unveiled a new Federal Benefits website which includes more information about all the Federal benefits programs available to employees.

Most enrollees in the FEHB are in plans whose premiums equal the cost of claims, allowable administrative expenses, and a small service charge. As claims

increase, the cost of health care increases, resulting in an increase in insurance premiums. Those premium costs are then shared by legislated formula between the enrollee and the government. Each year, OPM works with the insurance companies such as BCBS to negotiate a package of benefits that provides comprehensive coverage at the lowest possible cost. We work diligently to strike a balance of protection against catastrophic events without shifting a high premium burden to enrollees. We believe the high copayment for out–of-network surgeries in the Blue Cross Blue Shield Standard Option achieved that balance by limiting costs for users of expensive surgeries without transferring more costs to enrollees who stay within network.

OPM is proud of its record in administering the FEHB Program and believes it offers Federal employees and retirees a wide variety of options from which to select the health benefits and the premiums that best meet their needs.

Mr. Chairman, I appreciate this opportunity to testify before the Subcommittee on this very important issue. I will be glad to answer any questions you or other Members may have.

Mr. DAVIS. Thank you very much, Ms. Kichak.
And we will go to Mr. Gammarino.

STATEMENT OF STEPHEN W. GAMMARINO

Mr. GAMMARINO. Good morning, Chairman Davis and members of the subcommittee.

I'm Steve Gammarino, and I'm proud to represent the Blue Cross Blue Shield plans who make up the independent plans who both underwrite and administer Blue Cross Blue Shield governmentwide service benefit plan.

I'm also proud to indicate that we serve more than 4.9 million active and retired Federal employees and their dependents under this plan.

Through our participation in the FEHBP, we've made available to active and retired Federal employees and their families the deep provider discounts and broad networks that our local plans have developed on the basis of their extensive commercial business. An estimated 95 percent of eligible providers participate in our nationwide Blue Cross Blue Shield network. That is over 400,000 physicians today.

Mr. Chairman, today's hearing provides a welcome opportunity to address changes that we've negotiated for 2009 and to specifically address the benefit for surgery provided to standard option members by nonparticipating surgeons and to explain the problem that it intended to address.

Much concern has been generated about this change, even though it affects a relatively small population. It has become evident to me, however, that some of this concern is justified. And we do need to reexamine the benefit design for 2009.

The service benefit plan offers Federal employees and retirees two options from which to choose, standard and basic option, which have become the two most popular choices in the FEHBP today. I will continue my remarks today and focus on the standard option plan, because the issue before us does not relate to basic option.

Standard option covers professional services provided by three categories of professional: providers, preferred, participating and nonparticipating. Preferred and participating providers have agreed to accept an amount that we have negotiated with them as payment in full for their services. As a result, members cannot be billed for the difference between a negotiated amount or the allowances we call them and the providers' charge, a practice known as balance billing. Members can generally save the most money by using preferred providers, and we make them aware of this fact. When using either preferred or participating providers, service benefit plan members are responsible only for their deductible, co-insurance and copays.

Today, our experience shows that 96 percent of all medical services are provided by in-network doctors, and 98 percent of all surgeries are. Nonparticipating providers, on the other hand, have no contractual relationship with us so they're not obligated to accept our allowances for their services as payment in full. Instead, they are free to balance bill the member, and many do.

Ironically, it was to protect our members from having to pay exorbitant balances that we worked with OPM to negotiate a dif-

ferent benefit for surgery performed by nonparticipating providers. We reasoned that if we cap the members out-of-pocket costs, we could relieve some of the burden placed on members who choose nonparticipating providers for what is typically the most expensive type of professional service that they're going to receive. Members will pay 100 percent of the amount billed by nonparticipating surgeons up to $7,500 per surgeon, per day on which the surgery is performed. After that, we will cover the rest.

The benefit, as you already heard, does not apply to emergency surgery or surgery for accidental injuries. In reexamining the benefit initially negotiated for 2009 and in view of the express concerns that we've already heard, we will be pursuing an alternative that would allow us to administer the benefit in a way that is consistent with other services that are covered out of network. We would do this in a way to ensure that the alternatives do not result in an increase in our premiums.

Mr. Chairman, we take very seriously our obligation to offer Federal employees and retirees high quality affordable health insurance through the FEHBP. Blue Cross Blue Shield members have access to the deepest discounts and most extensive networks, and we strongly encourage standard option members to use preferred or participating providers to lower their costs. In order to keep our products competitive in the program, we are going to continue to make difficult decisions and develop benefit designs that meet the members' needs and keep our premiums competitive. We appreciate your interest in the program and look forward to working with you and the subcommittee to address this and other issues that are so important to Federal employees and retirees who rely on the FEHBP for their health care coverage.

This concludes, Mr. Chairman, my prepared statement. I look forward to answering any questions that you and the subcommittee may have.

[The prepared statement of Mr. Gammarino follows:]

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TESTIMONY OF

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

Before the

Subcommittee on
Committee on Oversight and Government Reform
United States House of Representatives

On

"2009 Blue Cross Blue Shield Health Benefit: What it means for Federal employees."

Presented by:

Stephen W. Gammarino
Senior Vice President, National Programs

Wednesday, December 3, 2008

Mr. Chairman and Members of the Subcommittee:

Good morning. Chairman Davis, Ranking Member Marchant, and Members of the Subcommittee, I am Stephen Gammarino, Senior Vice President, National Programs, of the Blue Cross and Blue Shield Association (Association).

Participating independent local Blue Cross and Blue Shield Plans jointly underwrite and administer the Government-Wide Service Benefit Plan in the FEHBP. The Association acts as the agent for these Plans for, among other things, communications with OPM. We are proud to 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 4.9 million active and retired federal employees and their dependents. By their choice to enroll in one of the options we offer, the Service Benefit Plan has become the largest plan in the Program.

Through our participation in the FEHBP, we have made available to active and retired federal employees and their families the deep provider discounts and broad networks that our local Plans have developed on the basis of their extensive commercial business. An estimated 95 percent of eligible providers participate in our nationwide Blue Cross and Blue Shield Provider Network.

Mr. Chairman, today's hearing provides a welcome opportunity to address the change we originally negotiated with OPM for 2009 to the benefit for surgery provided to Standard Option members by Non-participating surgeons and to explain the legitimate problem that it was intended to address.

Much concern has been generated about this change, even though it affects only a small percentage of our Standard Option members. It has become evident that this concern is justified and we have re-examined the benefit design for 2009.

The Service Benefit Plan offers federal employees and retirees two options from which to choose, Standard Option and Basic Option, which have become the two most popular choices in the FEHBP. I will confine my remarks today, however, to Standard Option, because Basic Option is not affected by the 2009 benefit change for surgery performed by Non-participating surgeons.

Standard Option covers professional services provided by three categories of professional providers: Preferred, Participating, and Non-participating. The member's cost for a provider's services varies, depending on the category of provider the member has chosen.

Preferred and Participating providers have agreed to accept an amount that we have negotiated with them as payment-in-full for their services. As a result, members cannot be billed for the difference between our negotiated amounts (or "allowances" as we call them) and the provider's total charge – a practice known

as "balance billing." Members can generally save the most money by using Preferred providers, and we make them aware of this fact. When using either Preferred or Participating providers, Service Benefit Plan members are responsible only for their deductible, coinsurance, or copayments.

Non-participating providers, on the other hand, have no contractual relationship with us, so they are not obligated to accept our allowances for their services as payment-in-full. Instead, they are free to balance bill the member. And many do. In order to address the potential for excessive balance billing, we explicitly warn our members in our Service Benefit Plan brochure that they may be balance billed and that their "out-of-pocket costs may be substantially higher" if they use a Non-participating provider.

Ironically, it was to protect our members from having to pay exorbitant balances that we worked with OPM to negotiate a different benefit for surgery performed by Non-participating providers. We reasoned that if we capped the member's out-of-pocket costs we could relieve some of the burden placed on members who choose Non-participating providers for what is typically the most expensive type of professional service that they receive. Members will pay 100 percent of the amount billed by Non-participating surgeons up to a maximum of $7,500 per surgeon per day on which surgery is performed, and we will pay the rest.

This benefit does not apply to emergency surgery or surgery for accidental injuries. For emergency surgery by a Non-participating surgeon, the member is responsible for 30 percent of our Plan allowance (subject to the calendar year deductible). In addition, the member would also have to pay the difference between our Plan allowance and the billed charges up to a maximum of $5,000 per episode of care. In the case of surgery performed within 72 hours of an accidental injury, the member is responsible for the difference between the Non-participating surgeon's bill and the Plan allowance up to a maximum of $5,000 per episode of care (deductible does not apply).

In re-examining the benefit initially negotiated for 2009 and in view of these concerns, we are working with OPM to pursue an alternative that would allow us to administer the benefit in a way that is consistent with other services that are covered out-of-network. The alternative will not result in an increase in our premiums.

Mr. Chairman, we take very seriously our obligation to offer federal employees and retirees high-quality, affordable health insurance through the FEHBP. Service Benefit Plan members have access to the deepest discounts and most extensive networks in the FEHBP. And, we strongly encourage Standard Option members to use Preferred or Participating providers to lower their costs. Yet some still choose to see Non-participating providers. In order to keep our products competitive in the FEHBP, we are continually called on to make difficult

decisions and develop benefit designs that meet our members' needs and keep our premiums competitive.

We appreciate your interest in the FEHBP and look forward to working with you and the Subcommittee to address this and other issues that are so important to the federal employees and retirees who rely on the FEHBP for their health care coverage.

This concludes my prepared statement. I look forward to answering any questions the subcommittee may have.

Mr. DAVIS. Thank you both for your testimony, and I will begin with the questioning.

One of the major concerns that has been expressed by enrollees, and of course we also heard that concern expressed by Dr. Petrucci and Mr. Francis, testified that the 2009 changes create this gotcha trap for people who just simply don't know, did not know, were not aware and are not aware. In addition to that, the brochure, that is the Blue Cross brochure summary description, nor the OPM Web site adequately discloses seemingly the 2009 benefit changes.

The question, actually, to both of you, as you look back at this or in hindsight, do you think that enrollees were adequately notified? And if they were not adequately notified, is there any way to correct this? Or does this give us some information for future negotiations and especially for ways of trying to make sure that the consumers are aware of what they're getting?

Perhaps, I will begin with you, Ms. Kichak.

Ms. KICHAK. First of all, the major change was described on the change page of the Federal employees benefit brochure. The Federal employees benefit brochure was standardized in a plain language initiative in which the change pages were moved to the front of the brochure so that they would be easily found by every Federal employee. They have, even when they were not in the front, even when they were the back page of the brochure, they have been known by Federal employees to be the source for looking at how every—how the plans are changed. And everybody gets a copy of the brochure for the plan they're in. That is provided to them. The $7,500 was also in the comparison chart posted on OPM's Web site.

Now, we have changed our Web site this year to make it more user-friendly. We are continuously working on improving the information, and we will continue to do so. But that information was there, and it was available.

I would also say that, again, this problem, this benefit was designed because of the folks who were subject to balance billing. I would expect that those folks who use—have been subject to balance billing would know to check for that in the brochure. The brochure is well indexed. I understand it's a very long brochure, but you can very easily find which section of that brochure deals with benefits that you're accustomed to using. So if you had been using nonparticipating physicians before, you can find that in the brochure by using the index.

So the material is good. Yes it can be better. We are working on it. We're working on it in our Web site, and we can also work and will work to make those brochures more clear. But it is a very, very complex program. It's complex benefits, we agree. And we're not just starting that. We've been working on that for a very long time.

And I think Mr. Francis mentioned that we've standardized the layout of brochures to help people do more comparisons.

Mr. DAVIS. Let me just ask quickly, though, new enrollees, individuals who are just coming in, will they get the benefit of the proposed changes that are being worked on?

Ms. KICHAK. Well, if they're new, the plan is new to them, so the change page won't matter. They can look at the comparison chart to see how a new employee gets to choose their coverage when they enter. And they can get the comparison chart. They can look at the

Web site. There are plan selection tools on the Web site that you can use to put your benefits in and get some recommendations. If you're new, you might miss the open season fairs we have at the agencies, but the agencies send—the plans send representatives to the agencies to discuss benefits also.

Mr. DAVIS. Mr. Gammarino.

Mr. GAMMARINO. Yes, I think OPM does an excellent job in terms of educating the changes, as Ms. Kichak has discussed.

I think, as the other panel has already indicated, although we educate and educate, that doesn't mean that everybody understands those changes. Because of this particular issue, we are mailing out to every one of our members clarification regarding this particular issue right now. So we recognize that everybody didn't quite understand what the changes were. And we're trying to improve the education by having increased information go out at this time.

Mr. DAVIS. Now, I think I heard Ms. Kichak suggest that if there were changes, that it would be very difficult to implement, and of course, if there are changes with one contract, then that necessitates taking a look, opportunities for other contracts. But I'm hearing you say that Blue Cross Blue Shield is open and is, in fact, looking at and working toward a different option relative to the surgery benefits and the way that is handled.

Mr. GAMMARINO. Yes, there are two tracks that we would like to pursue with the agency. One is, if no benefit changes can be made for 2009, that we take a look at how we're going to administer this. I think the previous panel indicated some issues associated with this, and I would like to followup with them and understand those issues better so that we can make sure if we do implement this the way it's defined right now, that we do it in a way that is sensitive to our members.

Additionally, I do think that what we traded off, we improved one part of the benefit in terms of these excessive billings by some of these nonparticipating providers, and we have a great protection now that we didn't have before. So from that advantage point, I think the OPM has done a very good job in terms of protecting their employees and their retirees.

As I look at it, I think you could say we could have done a better job associated with the other side of the coin, in terms of people that had costs that were—that weren't excessive, but there is an expectation. We talked about the gold standard, and I take that to heart. When you take a look at the program and you take a look at complexity, one thing that I will be looking at in terms of options, and there are primarily two, one is from the member perspective, could they readily understand this? And is it consistent with the overall intent of the product? And I think that is some of what you're hearing is everything else works one way; this works another. And no matter how much you educate, if you have those types of aberrancies, it's very difficult for the member to feel comfortable with the coverage that they have. So that is something I do intend to address, either through administration or some type of recommendation associated with 2010 benefits.

The other thing is cost. The tradeoff we made here results in less money going in one pocket and more in the other. And it's impor-

tant as we look through this that we do it in a way that doesn't raise premiums. Affordability is an issue we've already addressed. And it's my intent to ensure that as we look for ways to improve how we administer this particular area that we do it in a way that is sensitive to the cost of care.

Mr. DAVIS. Thank you very much.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

What changes are you considering, Mr. Gammarino?

Mr. GAMMARINO. What I'd like not to do here at the hearing is discuss the specifics behind that.

Ms. NORTON. That is a problem. Transparency has been a problem here. To the extent that we can't learn anything from you even about what you're considering, that problem remains, sir.

Mr. GAMMARINO. Let me try to help out there without negotiating here. Because that is what I don't want to do. If you just take a look at our benefit design, if you just take a look at the consistency of the cost sharing with in-network and out-of-network benefits, basically what you will find, you will see that the number in terms of the cost sharing is consistent regardless of the service rendered. And it's that type of—what would happen in this case is that consistency was broken. The cost sharing that is consistent with other medical services was broken. And it's that type of thing that I want to look at and try to restore that type of consistency regardless of the service.

At the same time, I think it's important to protect the member against egregious charges and billing for out-of-network services.

Ms. NORTON. One thing you might want to consider is the use of the word "surgery." We were stunned to see the across-the-board use of that word, some clarification there to limit——

Mr. GAMMARINO. That is exactly the type of thing I want to focus on relative to how we administer this.

Ms. NORTON. You know, if you cut somebody, that is surgery. You know, you put a cast on, and you still have the same $7,500 per, "surgery." That is going to give Blue Cross a really bad name, particularly since the language that was used and here I would like to hear you justify it since you, Ms. Kichak, you like it just the way it is.

OK since you're supposed to be the watchdog here, do you approve of the fact that the language used to reveal this change was as follows: Some costs do not count toward this protection.

Do you consider a $7,500 additional cost per surgery not worthy of some greater mention than that from Blue Cross Blue Shield.

Ms. KICHAK. First of all, most of the folks using the out-of-patient surgery—the nonparticipating provider surgeries will not pay $7,500.

Ms. NORTON. That is not my question. If you have to pay it once, and you didn't have to pay it before, Ms. Kichak, please don't minimize what it means to the consumer. That is not your role. You are not Blue Cross Blue Shield. You're supposed to be the person that monitors this for us all. So whether it's one, whether you have to pay $7,500 or $15,000, you know, it's what, it's a cost you didn't have last year and did not expect this year. So I wish you would

respond to my question. Do you think the language used was sufficient to inform consumers of an increase of this kind?

Ms. KICHAK. Can I ask which language you're reading? Are you reading from the change page or the brochure?

Ms. NORTON. I'm reading from the language, the only language that was used that gave people, reading from the summary, an indication of this cost increase.

Ms. KICHAK. I think we should work on the language.

Ms. NORTON. I appreciate that. If we can learn from this experience, we will be fine. But if the point is simply to justify what has happened, then, of course, we're not going to please consumers and we're going to think we're not getting anywhere.

Indeed, I was surprised, because it's not in your oral testimony, here you have Mr. Gammarino—this is a difference maybe between bureaucrats and somebody who has to be in business. And we're going to have to have government respond the way somebody in business has to. What Mr. Gammarino says, he is considering changes. You say you like it the way it is. At least you say it in the oral testimony. I had staff look. I said I don't see that in her written testimony.

If that is your view, I would like you to explain why you think it should remain. As it is, as best I could pick up, there were bureaucratic reasons that might be good and sufficient reasons.

Ms. KICHAK. I don't think protecting enrollees from $60,000 and $70,000 worth of costs is bureaucratic. I mean, we have numerous——

Ms. NORTON. $60,000 or $70,000 worth of costs in what way?

Ms. KICHAK. That is what our enrollees, our Federal employees and retirees, were paying under the benefit as it is today, because they were totally at risk between what is allowable and what the balance there was.

Ms. NORTON. So you think that the underlying change is a good change, and you prefer to let it remain that way.

Ms. KICHAK. We constructed it to protect the extreme, and in that process, the people with the lower-level, lower-cost surgeries are paying more and we——

Ms. NORTON. Do you believe surgeries should have been, a distinction should be made among surgeries?

Ms. KICHAK. I believe——

Ms. NORTON. Putting on a cast and doing a major surgery where you have to cut somebody, to be blunt about it?

Ms. KICHAK. We are using—surgery has been categorized the same way in all the plans using——

Ms. NORTON. That is what I mean by bureaucratic explanation. Because we have always done it that way, that is the way, that is the reason we did it even though there was a substantial increase in cost to the consumer. That is the source of my impatience.

Ms. KICHAK. But there is not, in aggregate, there is not a substantial increase in cost to the consumers. On average it works out. Some people pay more. Some people pay less. And we were trying to deal——

Ms. NORTON. But the person who has to pay more does not have all the people who have to pay less before them or care. So I am not taking issue at the moment with the underlying decision. I am

taking issue with your notion that nothing should be done even though the language did not warn consumers that there was a change that could have an effect and, if I may say so, a negative effect on them. And you have, I think, already conceded that the language needs to be used, if not looked at.

Ms. KICHAK. I did not mean to give the impression nothing should be done. I was addressing the benefit which was constructed, we thought, to provide a level of protection to our members. We are issuing additional information. We have sent things to the benefit officers. We have clarified the brochure. We have made Web changes. We are trying to improve the information.

Ms. NORTON. And I appreciate that, Ms. Kichak, nor do I have generally a problem with your materials. But then we haven't seen this kind of change for employees, the majority of whom are in this plan.

Indeed, I would like to ask you, Mr. Gammarino, and you, Ms. Kichak, in considering this, did you consider other ways? Because I am not, as you can see from the way I was questioning the last witnesses, I am not in favor of the American approach to health care, which is that we shouldn't worry about costs, we, the individual. And therefore, I'm very much for your network notion, your making people stay in the network and, to the extent that it is fair and possible, pay more for going out of the network.

Did you consider other ways, particularly given the figures that you have named, some 96 percent, virtually everybody stays in the network, did you consider other ways other than this cost? I don't know, second opinions or some kind of permission before you used someone outside the network, rather than to throw this very large payment on those accustomed to doing so, understand, and now are told they can't? Aren't there other ways to perhaps get the result you want other than through a large increase, per surgery, reset every time, per surgery, it goes up?

Mr. GAMMARINO. And those are the types of things I want to explore. Did we consider them through negotiation? I don't have any specific examples, but I can just tell you, normally what happens during the process is there are a number of things considered. In this case, the balance came down on the side of these egregious——

Ms. NORTON. But were second opinions considered?

Mr. GAMMARINO. Not to my knowledge.

Ms. NORTON. Would you agree to consider second opinions, if not now in the future?

Mr. GAMMARINO. I would like to consider any and all options because this, in my opinion, is not where I want to be in the long run on this coverage.

Ms. NORTON. Thank you, Mr. Chairman. I may have further questions, but I will pass on to others.

Mr. DAVIS. Thank you very much, Ms. Norton.

Mr. Cummings.

Mr. CUMMINGS. Mr. Gammarino, I have been around here a few years, and we get a lot of promises. And I have no—some of those promises are kept. Some of them are not. What happens is that, what I have noticed is that people will make promises, and then they wait, either for a new Congress and/or circumstances change, whatever, and the promises sometimes disappear.

But people still have problems, the people we represent. So I just want to nail you down a little bit here. What are we talking about timetable-wise? And by the way, your reputation is impeccable. But I am telling you, the people that I represent, they like to have answers, because they have to make decisions. In 6 days, I think, it is, a few days, a decision is going to have to be made. You talked about reconsidering, reexamining certain things. And I am just trying to figure out, what is your timetable? I mean, how do you see that happening?

Mr. GAMMARINO. Let me give you I guess what I would consider the outside time, OK? And that is if—remember that I can't act unilaterally.

Mr. CUMMINGS. I understand.

Mr. GAMMARINO. And so, in this regard, at a minimum, I am going to be seeking changes for the next calendar year when we go through benefit negotiations. That is a minimum, depending upon what I can achieve between today and in a very short time period. I do want to do something. This is not consistent with how we want to deliver products to our members. And I can just—I have been before you many times before. And this is something I want to change. In the short run, at a minimum, if the benefit cannot be modified for 2009, then I want to look at all I can do on the administrative front to ease the burden on members that are affected by this change.

Mr. CUMMINGS. Now let me—let's come to my constituents. Let's say these folks back here are my constituents here. And there is somebody here who is considering a non- network surgical service. They want to have that done within the next 6 months. How does—I mean, and they are looking at Blue Cross Blue Shield. They love you. They think you have done a great job, but now they are facing a decision. And this sounds nice, but they got to make a decision. So what do you say to them?

Mr. GAMMARINO. What they have to do is go by the brochure as it stands today. I would not expect them, with what I have put on the table so far, that they may get the type of change that they would expect. So I think you have to go by the negotiated brochure as it stands today. And at a minimum, you would expect something in 2010. And then, if we can pursue other options that are agreeable with the agency, I want to implement them.

Mr. CUMMINGS. Ms. Kichak.

Ms. KICHAK. Uh-huh.

Mr. CUMMINGS. Do you feel like your constituents, our employees, know about these changes?

Ms. KICHAK. We think that we are getting the information out, yes. And we think it is—again, because these claims with nonparticipating providers have been so damaging to people who use non-par doctors, not just in this instance, but this is the first time anybody has tried to deal with the balance billing problem; these folks are paying the full balance bill. And so we think, certainly if they have been subject to it, they are looking at this kind of thing. We are sending out more information. As Mr. Gammarino said, they are sending out more. We have changed our Web sites. The information is getting out.

Mr. CUMMINGS. Did you consider having an extension of the enrollment period?

Ms. KICHAK. No. 1, it is very difficult to extend the enrollment period. And the other thing is that creates extreme challenges for the operation of the program because we are already getting to mid-December. We are in the first week in December. Anybody who changes has to get their enrollment card, possibly get new doctors, learn new benefits. We have to get that information from the places where the changes occurred, whether it was in the HR office or on the Web site, out to the plans. And there is always a struggle at the beginning of the year around January if an enrollee needs new services and they don't have that enrollment card yet. And if you extend the open season, that jeopardizes that even further. So we don't think that is a good idea. Now, there is an opportunity for people who learn this over the next week to go to their HR office and say, I need to make a belated enrollment for this reason. But we do not want to extend the open season.

Mr. CUMMINGS. Mr. Chairman, I just have one last question.

Mr. Gammarino, I appreciate your testimony. And you talked about the surgery benefit charge with regard to the 2009 option plan. But let me just ask you about this. You know, that change was not the only thing that we were concerned about. Catastrophic out-of-pocket limits for 2009, for example, will increase by $500. Further, monthly premiums will increase 13 percent to $152.06 for individuals and $356.59 for families. These are real dollars. And you know, thank God, gas has come down, but people see their paychecks shrinking, shrinking, shrinking. And can you help me and explain to me why that is? I mean, that 13 percent increase is quite substantial. And I think it is a little bit above what it has been in the past. I think it was like around 8 percent in the past.

Mr. GAMMARINO. Well, it has actually been lower than that.

Mr. CUMMINGS. Yeah, so help us to understand that.

Mr. GAMMARINO. Sure.

Mr. CUMMINGS. Because you can imagine when people see that coming out of their paycheck, and they are used to—people that I represent, a change of that amount of money can throw their budgets completely off, or some of these young people getting their families started or whatever. So can you help us with that?

Mr. GAMMARINO. Right. I would like to just go back and level set, the increase we had this year was greater than our competition, and it was greater than what we had put through the last few years.

Mr. CUMMINGS. Your increase was greater than your competition?

Mr. GAMMARINO. Sure.

Mr. CUMMINGS. OK. I just wanted to make sure I understood.

Mr. GAMMARINO. So I appreciate your question, you know, why? Why did that happen? There is a couple of things going on. One thing that you will see in the FEHBP, you will see dynamics where carriers are going up and down and changing benefits. We don't do it in lockstep. Actually, if you just take a look at what our premiums have been on standard option, that is our flagship product, over the last 5 years, our average has been 5.8 percent, the last 4, 4. So we have—last 4 years, 5 percent, and in the last just couple

years, 3.5. So we were holding our rates down actually lower than our competitors on average in previous years. So, in one sense, we are catching up.

The other thing that was happening is our coverage really hadn't changed much over the last 5 to 6 years. Our copays on drugs, for example, really, if you just take a look back in previous years, they really hadn't changed since 2002. And what was happening is a lot of our competitors have been making changes. They have been making benefit modifications. They have been introducing new lower cost products.

And additional to that is the demographics of the standard option Blue Cross Blue Shield. And this is something that, you know, the country is seeing. The FEHBP sees even greater. And then the standard option Blue Cross Blue Shield sees it even more. And that is the aging of the American population. The average age in our standard option product now is 61. OK. That is not your typical plan. And the fact that we have been able to hold down our premiums and keep our coverage relatively stable for the last 5 years I think has been a great accomplishment. But that safety valve we had to let go of. The fact of the matter is the last couple years, our expenses are running at a rate that is slightly greater than the premium income.

And Ms. Norton, to your question about reserves, that is one thing that we do at Blue Cross Blue Shield. It allows us to stabilize things year to year. Normally we can draw down sometimes our reserves and sort of cushion some of the things that go on from year to year. So it is a combination of the demographics of the population. It is a combination of the dynamics of the FEHBP, where price is king in terms of people looking at benefit plans. People are very price-sensitive. And in many cases what you are going to see over probably the next couple of years is more and more cost-effective plans and probably enrollees making that choice through open season to go to lower cost plans. The Federal employee and retiree are very astute shoppers. You know, we talked about the educational issue. That is true. But I will put these shoppers in health care up against anybody in the country in terms of overall understanding of their benefits and in getting value for their dollar.

Mr. CUMMINGS. Just one real quick thing. Following that logic then, it seems to me then that you probably—I would almost have to predict that premiums will continue to sky rocket for Blue Cross and Blue Shield. And let me tell you why, based upon what you have just said. Younger people are going to probably go for the plans that are cheaper, figuring they are not going to get sick; they are not going to need whatever. Older people will go more I guess toward Blue Cross and Blue Shield because they feel like they can get the things that they need. So that 61 may go up even higher. That average age of 61 may go up even higher. Is that a reasonable assumption?

Mr. GAMMARINO. That is a hypothesis that might play out. What I think you are going to find is, No. 1, everybody in the FEHBP, if you want to play in this market, you are going to have to be able to service and manage an aging population. Nobody is going to get out from underneath that. If you just take a look at demographics, No. 1, it is one of the few employer groups now that also the retir-

ees get exactly the same coverage at the same price. So from that—you know, that is a little bit out of the—so when you take a look at, you know, other employers, a lot of them just cover their actives. In this case, the band is a lot bigger. And so it is just something I think we are in it for the long run, so we are going to find solutions and value propositions that even if they may be paying more for our plan, but they are going to get a value proposition in terms of what they need to navigate for their medical care that we believe that they are going to be willing to pay for.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. DAVIS. Thank you very much, Mr. Cummings. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

This is a great panel presentation, just because it shed a lot more light on the issue. What is intriguing to me is, normally when you have proposals for these changes in the benefits and the costs that go with them, it is driven by the plan's concern about, you know, protecting the economic model and solvency and so forth. And many of the changes proposed fall into that category. But it seems like the one having to do with the out-of-network surgery was based on a much different premise. And so my first question is, it sounds like OPM went to Blue Cross to initiate this change, not the other way around. Is that true?

Ms. KICHAK. That is correct.

Mr. SARBANES. OK. You said that there is an exception with respect to this change for emergency surgery and another category. What was the other category?

Mr. GAMMARINO. Accidental injuries.

Mr. SARBANES. So how come? Why is there an exception for those two?

Mr. GAMMARINO. I think the thinking is the member had very little choice in terms of where they had to go for the care. And therefore, we weren't going to—we were going to safeguard their interest because they are in an ambulance; they are going to the nearest facility, being treated by the best available physician at that time. And——

Mr. SARBANES. So they might have to go out of network——

Mr. GAMMARINO. They might.

Mr. SARBANES [continuing]. Is the point.

Mr. GAMMARINO. Yes, it happens.

Mr. SARBANES. That is the reason, right?

Mr. GAMMARINO. Yes.

Mr. SARBANES. OK. But if they go out of network, then they are still going to get hit with that balance billing issue that you are trying to protect all the other people from. So I don't understand, if that is the underlying rationale, why you are not trying to protect those people, too, Ms. Kichak.

Ms. KICHAK. Yeah, I think, first of all, this is the first time that balance billing has been addressed in any way, frankly, I think in any of our plans. And we have been trying to get our hands around this for a couple of years. This was not a casual, easily arrived at benefit. And yes, we initiated it, and we worked with Blue Cross, and we have been trying to deal with this issue. So I think one of the reasons it started this way is this is where we saw the most egregious claims, and so we were starting to address what we saw

the most of, which was elective surgeries with nonparticipating providers; balance billing is a concern, but nobody is addressing that.

Mr. SARBANES. I understand. I am just pointing out it seems a little bit contradictory, because you could say that the person who is in the most gotcha position is the person who, through an accidental injury and an emergency, went to a nonparticipating provider and then ends up with this huge balance billing issue again, which if that is the basis for your concern and wanting to push this change, it is a little odd that you exempt them from it. That is all I am——

Ms. KICHAK. We get at OPM about 2,000 what we call disputed claims a year. And that is where we start to see where our enrollees are having difficulty. And we were not getting those disputed claims on the emergency side. And you heard the doctor earlier say that, on emergency conditions, he was saying that their balance billing is not as large because they recognize it is an emergency. So maybe the doctors haven't been balance billing in those situations. We were not experiencing—we were not getting the concerns from our enrollees. And so that is not where we started with this.

Mr. SARBANES. OK. So let me ask this question. You know, again, this is not a change that is being forced by the economics, which is what I——

Ms. KICHAK. Right, it is not.

Mr. SARBANES. And I apologize because I hadn't read ahead to some of the testimony, but was the assumption I was going on when the first panel was before us. But if it is not forced by the economics, then there is much more flexibility to try to fix this problem, maybe rethink it as others have been suggesting.

One question I had, and this would follow on the observation that the Federal employees are astute shoppers, had you thought about making it an option? Because it is about protecting the consumer here. That was your goal. When I say an option, in other words, that you would say to people, if you go out of network, there are two options that could be available to you. One is the one you have had, which was the 25 percent plus the exposure to the balance billing, or you could pick this option, which would be a cap at $7,500 through the deductible, where you won't have any exposure to the balance billing. Beyond that, and you being astute shoppers and trying to judge, particularly if it is applicable to elective surgery only, where presumably you could try to ascertain ahead of time what the costs might be and the charges might be, you can choose as a consumer. Now, I understand you might end up in a situation which you don't want to have, which is where you have people with different results hollering at each other and hollering at you because they are wondering, well, how come the person over here made out better than I did? And I didn't realize when I picked one that I was getting foreclosed from this better scenario over here. But I just wonder if that was considered at all.

Ms. KICHAK. That wasn't considered. I don't think in the past we have ever had an option for allowing folks to choose their benefit at point-of-service. And that has some negatives in that people are obviously going to choose what is financially the best interest to them. And then it is hard for us to predict the costs. But we are

trying to find the right solution to provide the broadest protection for our Federal employees. And we will definitely work with Blue Cross on examining a multitude of options.

Mr. SARBANES. Again, the only reason I offered that, and I will close my questioning, but the only reason I offered it is because you alluded to the costs, you can't predict the costs.

Ms. KICHAK. Right.

Mr. SARBANES. But this particular change, as we have all agreed, has not been driven by the cost concerns on the plan's side. It is being driven by a desire to protect the consumer in some instances from him or herself is what I am hearing. So if that is what is driving it, then you could offer the option to the astute shopper to decide, well, you know, I want to take the chance on the balance billing thing because I think this is where I am going to end up, or I want that comfort of knowing I will be capped out at the $7,500 if I have to go for this out of network. And there may be other reasons why that is not a good idea. But it seems to me that it at least is something to look at, given what is driving the proposal here.

Ms. KICHAK. Of course, the better thing for the enrollee is to try to find a participating provider. Since participating providers were introduced into the program, there has always been a financial incentive for people to use them. And that affords them the most protection in these instances. Because those charges that are not covered then are part of the catastrophic, too. But again, we are willing and happy to explore as many options as possible. Because we did not like to see what was happening to our enrollees.

Mr. SARBANES. Thank you, Mr. Chairman.

Mr. DAVIS. Thank you very much, Mr. Sarbanes.

Mr. Gammarino, let me try and make sure that I understand why the Blue Cross premium for the standard plan increased more significantly than other plans and why that increase took place.

Mr. GAMMARINO. The experience of this group over the last couple of years exceeded the premiums coming in. So we were drawing down the reserves. And we got to a point where we had to not only increase, but for the long run health of the product that so many people rely on, we had to make benefit changes and actually keep this product in line with a lot of the competitive products out there. We don't stand on an island alone. So when other people have products that allow them to price a product lower than ours, and this is a very price-sensitive market, that type of alignment can't go on too long. And that is part of the reasons why you saw the types of changes that we put in place for 2009.

Mr. DAVIS. Do you know how much reserve you had to draw?

Mr. GAMMARINO. Our reserves right now stand at about 4.7 months, about $8 billion. And for the comfort of our enrolled population, particularly for these troubled times we are in, it should be noted for the record that these reserves are held by Uncle Sam and are dedicated only to this product and can only be used for this. And they are held in U.S. Treasuries, so it is a very safe financial instrument.

Mr. DAVIS. Ms. Kichak, we are up against the wall in a sense in terms of there only being six additional days for employees and beneficiaries to know what they are facing. Are there any statutory reasons that we cannot extend the enrollment period?

Ms. KICHAK. Well, there is a process to go through. I mean, it is not—and not created by me—but we are required to do public notice to extend it. So there is a process, but there is no statutory bar from extending the open season.

Mr. DAVIS. And do you know how long the public notice——

Ms. KICHAK. No, I don't. I think—I don't know. I could certainly get that information for you quickly.

Mr. DAVIS. It would appear to me that while there isn't much that could be done, that it could be very beneficial and very helpful if the enrollees had additional time to really look at the instruments that they were going to be buying into and where they had as much information. And I would suspect that many people are just beginning to take notice. I am saying, prior to now, they probably had not given much thought to it, and they were more than likely ready to re-up. I am just thinking of my own situation, where my primary care physician is making some changes. And we have been together for 15 years. And I have some considering to do before I decide if I am going to follow with him or if I am going to maintain what I already had. I knew that he was leaving, so at least in my case, I have had some time to think about it. But I am not sure that, you know, hundreds of thousands of our enrollees have had that opportunity. I think if we could look at that. And I am trying to determine what harm, if it is possible, might actually——

Ms. KICHAK. The harm is, and there is harm, the harm is trying to get the information out to the carrier, to the carriers as to who they are covering in 2009. And we want to make sure that if something happens on January 1, 2009, and the person needs to go to the hospital, they have that card that says this is the coverage I have. And by extending open season, that is what we jeopardize. Particularly for our annuitants, a lot of this, they are not in the office, they have to get information, and it is a risk to extend the open season.

Mr. DAVIS. But would not the enrollees maintain the same coverage that they had until they exercised the option to change?

Ms. KICHAK. No. The effective dates for coverage are in the contract. Coverage for any open season change becomes effective on January 1st for retirees. And I believe, and we have talked about—I believe it is the Monday of the first pay period of the new calendar year for employees.

Mr. DAVIS. I think I would certainly, as chairman of the subcommittee, appreciate a hard look at any possibility that there might be to give employees and retirees as much of an opportunity to be as informed as they could possibly become. And I would certainly appreciate that.

Ms. KICHAK. We will get back to you very quickly.

Mr. DAVIS. Ms. Norton, do you have any——

Ms. NORTON. Yeah, Mr. Chairman, I think that I would like to question Mr. Gammarino about other ideas, too. This would seem to be the easiest idea.

Of course, you are covered if you choose before January 5th. Even if you don't, as you indicate, have your enrollment card, you are covered.

Ms. KICHAK. You are covered. It is just very stressful for the enrollee if they go someplace for service, and they don't have that card, and there is a question. You are definitely covered.

Ms. NORTON. I can understand. The problem, Ms. Kichak and Mr. Gammarino, comes from what amounts to a huge reliance on the carrier to not do these kinds of increases very suddenly. And so that you depend upon your carrier, because your carrier has a good reputation for not putting large charges on you quickly, then you have a reliance problem and a reliance trust I may say, Ms. Kichak, which could be broken, which is something I don't think we want to have happen. And we do want a solution that takes into account all concerned, the government as well as, of course, the provider.

Now, it is important that it has come out that you initiated this idea. And I can understand your concern if there were what amounts to, I understand it a rather small number, but some providers who found themselves with a bill very much larger than they expected. You would want to somehow prepare them for this up front rather than have this come after the surgery. Did you suggest a large amount might be in fact in order?

Ms. KICHAK. Did——

Ms. NORTON. Did you, who brought this idea to Blue Cross Blue Shield, suggest that, in order to get the attention of the subscriber, a large amount per surgery might be in order?

Ms. KICHAK. No, we did not suggest a large amount to get people's attention. This was strictly, when I answered the question, it wasn't cost driven; we did not make this change to increase costs or to save money. But what we did was we priced from an actuarial point of view how much it would cost to cover these charges over X amount and how much would be saved by billing under X amount. And $7,500 was where the people at the low end were contributing enough money to fund the people in the catastrophic situation.

Ms. NORTON. I see.

Ms. KICHAK. So we did not——

Ms. NORTON. It is important to understand where this amount came from.

Ms. KICHAK. Right. And we probably——

Ms. NORTON. As you looked at this, if you are not in business, but you are looking at this simply by doing the math, you may not consider that there might be other ways to do it. Did you consider, Ms. Kichak, in your discussions with Gammarino, that there might be alternatives to simply pricing the amount in light of the figures that were before you?

Ms. KICHAK. Absolutely. This was—I do not know all the back and forth, but this was not a simple, how about this, and let's do it. This was a negotiation in which we asked for proposals to resolve this question. They responded. We went back and forth.

Ms. NORTON. But you looked like you knew exactly what the amount was, because you said it was about $7,500 per——

Ms. KICHAK. Well, that was when we came to the let's do the cost-neutral within this benefit.

Ms. NORTON. Yeah, again, there is a difference between somebody who doesn't have to worry about customers and providers and

somebody who can sit in the government and say this is what the figures are.

I mean, Mr. Gammarino got the point, Ms. Kichak. You showed him some figures, and it sounds to me as though those figures were highly suggestive and did not in fact encourage Mr. Gammarino to think of other ways that might have accomplished—and I have no idea—but might have accomplished something of the same purpose. And I really do think it is going to be very important, particularly for OPM, if this is what you are in the business of doing. The one thing that I have learned from my work in chairing another subcommittee is what I don't know about business. And my approach would certainly not have been to say here is the cost, you come up with what you are going to do about it. It would have been to say, here is the cost, now how can we make sure that cost is not borne across the——

Ms. KICHAK. This was a bilateral negotiation back and forth.

Ms. NORTON. All negotiations are by definition bilateral. I think you get my point, and I want to go on. I think the fact that a concrete figure from the government is before the provider sends a very strong message. And I am suggesting that you play a dual role here that more and more I find in conflict with one another. Because you are—I am not sure who you are in fact representing here. When all the alternatives, which in a real sense isn't your job—you don't know how to consider all the alternatives. That is what Mr. Gammarino is in business for. And if he were made to show why some alternatives he might suggest would or would not accomplish the same end, then I would be convinced. That is what I call a bilateral negotiation, where I am in the position of the government, I am not in business, and I know that anybody who is in business does not want to raise anything. He doesn't want to raise a cent. So if it looks like the government's giving him permission to do it, then of course, it makes it far easier than it would be if the government said, look, I know you don't want to put what people will see as additional cost. This, however, is what it costs your network, therefore show me how you might accomplish the cost saving for all involved, because I am with you on that, through either imposing a cost up front so people know in advance or through an alternative you might name. That, in my judgment, where one side knows a whole lot more than the other, you know a whole lot more about what it is costing across the network; he knows a whole lot more about alternatives that might be useful.

Mr. Gammarino, I don't know, I am not convinced that extending the time would be catastrophic. I think it would be something that is not in your hands. I think it would, if I were OPM, I wouldn't like to be the government here saying I, the government, who did not in fact—who in fact allowed this summary to go forward, which said that there will be some additional costs, I, the government say, because I have saved you money, be happy, and to ignore the transparency matter, which is what the government is there for.

So I don't understand her role, but I do understand your role. And I do understand the difficulty this raises for you. It seems to me that there are a number of things you could do. You could go back to the status quo ante right now. Because I am only interested in remedies here. You could say, OK, we are going to try to

make up for at least some of this next year, but there wasn't the kind of fair notice that subscribers are used to from Blue Cross. So, OK, I don't think that makes you less competitive. You could do it after it closed, and not throw everything up for people trying to shift everything one way or the other. You could distinguish among kinds of surgery very sharply, keeping in mind what we in the law call the reasonable man theory: What does the average person mean by surgery? And you could, if there are costs, and you go back to the status quo ante, you could, in 2010, try to make up for those costs in a more transparent way. Do you find any of those unreasonable suggestions?

Mr. GAMMARINO. I think they are all something that we should evaluate. I mean, I think I have been pretty clear that I don't want to stick with the status quo. And I think I have been clear about the reasons for that. And they are focused on the member. This is not how I want our members to see our product going forward. And it is not what I want the brand to stand for.

Ms. NORTON. And of course, we didn't—we don't see that it is going to save you a lot of money.

Mr. GAMMARINO. This is not a money issue for me.

Ms. NORTON. I am just looking for some sense that anybody in business is looking for—you got a lot of goodwill out here.

Now, you know, Ms. Kichak doesn't care about your goodwill. She is doing her job. And she does it very well but in my judgment quite too bureaucratically. You got to care about that. And therefore, I am looking for some way to send a message to the consumer that the reliance you have had on Blue Cross Blue Shield is still intact.

I do want to ask you something about your surplus. You mentioned reserves. My question did not go to reserves.

Mr. GAMMARINO. OK.

Ms. NORTON. It went to surplus and your nonprofit status. I don't touch the notion of reserves, especially for health care insurance companies. And frankly, I don't touch much the notion of surplus. But of course, Blue Cross Blue Shield is unique in the business as a nonprofit. And there have been some concerns. Let me ask you, would you prefer to be a nonprofit—the company had some issues with that before—or not, and why not? Or why?

Mr. GAMMARINO. Well, the plans that are independent companies that are licensed for the brand, there are 39 independent companies, they have chosen to collectively underwrite the cost—underwrite the FEHBP product we have. But outside of that, they are independent companies. Most of them are not-for-profit. There is one for-profit. So the brand itself doesn't dictate one or the other.

Ms. NORTON. By the way, which one is the for-profit one?

Mr. GAMMARINO. It is WellPoint. WellPoint is the parent company. When you see it aligned with Blue Cross Blue Shield, you normally see it aligned with Blue Cross Blue Shield Anthem of Ohio or Blue Cross Blue Shield——

Ms. NORTON. Isn't it true that Blue Cross Blue Shield sought to get rid of its nonprofit status in recent years?

Mr. GAMMARINO. Which? Was there a particular plan when you say Blue Cross Blue Shield?

Ms. NORTON. CareFirst, for example.

Mr. GAMMARINO. I think CareFirst a couple of years ago went down that path, but I think they clearly didn't——

Ms. NORTON. Why was that? Why is that better for some plans?

Mr. GAMMARINO. I think that—and I am not a proponent on either business model, because they both work under the brand. The brand licensure requires fiscal accountability——

Ms. NORTON. So why would some prefer one and——

Mr. GAMMARINO. I think, from what I see, a lot depends upon your market. A lot depends upon your need for capital. A lot depends upon the competitive models up in your particular market that are successful. And certainly depending upon sometimes your relative financial health, capital may be easier if you are a for-profit to obtain.

Ms. NORTON. There has been some testimony before from the prior witness and from you about the use of, you indicated, reserves. I need to know whether the surplus, the very large surplus that—and by the way, I am agnostic on a surplus, particularly since there are no standards for how much surplus or not surplus a company like yours should have. But you know, as it continues to grow and to get very large, then people began to look at Blue Cross Blue Shield because it is nonprofit. And if you had a large surplus, you are supposed to distribute some of it. And then people got hungry about your surplus, and they had their hands out for your surplus. And the standard answer, as I have indicated, is, well, we use it to keep down the costs for our subscribers. That is a perfectly satisfactory—in fact, that is the best use of it, as far as I am concerned. Is, in fact, your answer—I mean, when you referred to my question before you mentioned reserves. I am asking you, is the surplus being used, instead of being distributed the way nonprofits do it, is the surplus being used, let us say in this region, for example, to keep down the cost of health care here relative to what other companies face?

Mr. GAMMARINO. I think you are talking outside of the FEHBP, is that correct?

Ms. NORTON. Yeah.

Mr. GAMMARINO. You are talking about outside of that?

Ms. NORTON. Yes, I am speaking about the surplus.

Mr. GAMMARINO. And I am not prepared really to address that. You know, every Blue Cross Blue Shield plan is regulated by the State that they are licensed in. And those definitions, as you just pointed out, Ms. Norton, they probably vary in terms of what is considered a surplus. I think also the economic times probably may cause people to rethink what a surplus is. I know today collectively Blue Cross Blue Shield is very proud of the fact that our 100-plus members nationwide can feel very secure in the fact that financially, collectively and independently, we have sufficient capital to ride out with our members this economic downturn.

Ms. NORTON. Yeah. It is hard to be an enemy of surpluses, even before the present turn down. But what of course Blue Cross Blue Shield has to be aware of, as a nonprofit, it gets more scrutiny from government because of it. And just this year——

Mr. GAMMARINO. Sure it does.

Ms. NORTON [continuing]. There was a big controversy involving CareFirst here when a large payment to an executive who was

leaving was paid, and the Maryland insurance commissioner required that it be cut in half, citing the inconsistency of such a large payout of severance, the inconsistency with the nonprofit mission. So I just remind you of this not to beat up on the surplus; I am where you are. I am not even sure what the surplus, anybody's surplus is today. But to say that one of the reasons we are looking at Blue Cross Blue Shield is that so many Federal employees, but the other reason is that you are very different because of the nonprofit status you enjoy or not, considering whether or not you would rather be a commercial company.

Thank you very much, Mr. Chairman.

Mr. DAVIS. Thank you very much. And it appears to me that maybe you are being warned that there are individuals who are seeking ways to tax everything that may not be taxed, including religious institutions, including hospitals, including probably Blue Cross Blue Shield. Hopefully, we won't get to the point where, you know, Russia got one time when they didn't have anything to tax, and they ended up wanting to put a tax on the air. But we wouldn't want to get to that point I am sure. Thank you both very much.

Yes, Mr. Gammarino.

Mr. GAMMARINO. Mr. Chairman, I was wondering if I could just clarify one thing that I heard. There was a question of Mr. Francis related to Medicare B and the issue with the nonparticipating physicians, the $7,500, and where does that fit? If they have Medicare B, are they still required to pay that? And I did want to indicate that when our members have Medicare B as primary and we are secondary, any type of cost-sharing, whether it be deductibles, coinsurance or copayments would be waived. So, specifically in the case of that $7,500, it will be waived. So I wanted to make sure the committee understood that.

Mr. DAVIS. Thank you very much. Thank you both. And thank all of those who attended.

This hearing is adjourned.

[Whereupon, at 12:47 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Elijah E. Cummings follows:]

CONGRESSMAN ELIJAH E. CUMMINGS OF MARYLAND
OPENING STATEMENT

"2009 BLUE CROSS BLUE SHIELD HEALTH BENEFIT PLAN"

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON FEDERAL WORKFORCE, POSTAL SERVICE AND THE DISTRICT OF COLUMBIA

WEDNESDAY, DECEMBER 3, 2008

Mr. Chairman,

Thank you for holding this critically important hearing to examine changes to the Blue Cross Blue Shield Health Benefit for federal employees.

As you know, more federal employees are enrolled in the BCBS standard option plan than any other plan the government offers.

Changes to the 2009 plan will have a significant impact on these employees, and I am concerned that many of them will be unaware of these changes until they wind up with the bill.

That is why it is so critically important that we hold this hearing now, when the Open Enrollment season is still ongoing, so that federal employees will have the opportunity to change their plan if they are not happy with the service they can expect to receive from BCBS in the coming year.

Several matters raise concerns for BCBS standard option customers. Specifically, they can expect a premium increase, changes in payment for services provided by non-participating providers, catastrophic coverage limits, copayments and coinsurance for covered services, and increases and decreases in coverage.

While many of the increased costs can be avoided by utilizing preferred or participating providers, other costs will be passed on to the consumer regardless of where they get their care.

The catastrophic out-of-pocket limits for 2009, for example, will increase by $500.

Further, monthly premiums will increase 13 percent—to $152.06 per month for individuals and $356.59 per month for families.

Mr. Chairman, I understand that [redacted] the failing economy has affected the Blues' bottom line—and some of those losses must be passed along to the consumer.

But the American people are also suffering in this economic climate, and they simply cannot keep up with the rising costs to maintain their basic needs.

At the least, I want to make sure that BCBS is offering a competitive plan that offers its customers [redacted] comparable service to federal employees enrolled in other plans.

If this is not the case, it is our purpose here to either work with BCBS to ensure that they change their policy—or inform federal employees of the alternatives.

Time is of the essence, as Open Enrollment ends on Monday, December 8, 2008.

I appreciate your leadership in bringing this matter to the attention of the U.S. Congress, and indeed the general public as well.

Thank you and I yield back the remainder of my time.

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