STATEMENT OF
ABBY L. BLOCK
SENIOR ADVISOR FOR EMPLOYEE AND FAMILY POLICY
U.S. OFFICE OF PERSONNEL MANAGEMENT

Before the

COMMITTEE ON FINANCE
UNITED STATES SENATE

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Mr. Chairman and Members of the committee:

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

Our health benefits program has been in operation for more than forty years. It is an employer-based program and forms an important part of the compensation package offered by the Government, enabling it to recruit and retain individuals who carry out the vital work of government. The Office of Personnel Management (OPM) has developed widely-recognized expertise in the complexities of arranging health care coverage with more than one hundred private sector health plans with a covered population of about eight and a half million people including 2.2 million employees, 1.9 million retirees, and members of their families. In 2002, the program accounted for $24 billion in annual premium revenue.

Federal Employee Program Structure

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

An important and distinctive feature is nationwide availability. No matter where one lives, all members may choose from among a dozen options offered by nationwide fee-for-service/preferred provider organization (PPO) plans open to all. Some members may elect one of the six nationwide plans limited to members of sponsoring organizations, and many may choose a Health Maintenance Organization (HMO) in their geographic area. About 3 million Federal enrollees are in fee-for-service/PPO plans and 1 million in HMO's. There is an opportunity to enroll in the program, change health plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November.

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

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

Benefit and Rate Negotiations

While benefits and rates are negotiated annually, OPM does not issue a request for bids. Instead we issue a call letter to participating carriers in the spring that provides them guidance for the upcoming negotiations. Plans remain in the program from year to year unless they choose to terminate their contracts for business reasons, including failure to reach agreement with OPM on benefits and rates for the coming year. Under current law, the window for new plans to enter the program is limited to HMO's. Unlike the 1980s when we were flooded with HMO applications, in the current market, we average about 6 new plans a year.

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

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

Contract Administration and Financial Oversight

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

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

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

Policy Design

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

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

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

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

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

Conclusion

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

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

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

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