

**TESTIMONY OF**

**Blue Cross & Blue Shield Association**  
An Association of Independent  
Blue Cross & Blue Shield Plans

Before the

Subcommittee on Civil Service and Agency Organization  
Committee on Government Reform  
United States House of Representatives

On

“Oversight of the Federal Employees Health Benefits Program and the Federal Long-Term Care Insurance Program.”

Presented by:

Stephen W. Gammarino  
Senior Vice President  
National Programs

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Good morning. Chairwoman Davis, Ranking Member Davis, and Members of the Subcommittee, thank you for the opportunity to appear before you today.

I am particularly pleased, Madam Chairwoman, to participate in the subcommittee's first oversight hearing on the Federal Employees Health Benefits Program (FEHBP) since you assumed the chair. I look forward to working with you, the Ranking Member, and the other Members of the subcommittee in addressing both the challenges and the opportunities the FEHBP presents.

The Blue Cross and Blue Shield Association administers the Government-wide Service Benefit Plan in the FEHBP on behalf of the 41 independent licensees that jointly underwrite the Service Benefit Plan. 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 high-quality, affordable health insurance to more than 4.3 million active and retired federal employees and their families. By their choice to enroll in one of the options we offer, the Service Benefit Plan has become the largest plan in the Program.

We are also pleased that in this era when keeping premium increases below double-digit is so challenging, we were able to hold our premium increases for both the Standard and Basic Option this year to single digits. The premium for the Standard Option rose by 9.9% and the premium for Basic by 8.3%. These increases are well below the 2003 national average of nearly 14% reported by the Kaiser Family Foundation and the Health Research & Educational Trust and

below the 2004 FEHBP average of 10.6%. We are also under the 12.6% increase Hewitt Associates has projected for 2004.

Your invitation letter asked us for our views on two topics in particular: (1) the FEHBP waiver from the Cost Accounting Standards and (2) cost-containment in the FEHBP. I welcome the opportunity to discuss these important issues with the subcommittee.

### **Cost Accounting Standards**

I cannot overemphasize how important the exemption from the Cost Accounting Standards (CAS) that currently protects FEHBP carriers is to the Blue Cross and Blue Shield Plans that underwrite and deliver the Service Benefit Plan. I am happy to explain why that is so.

#### **CAS Adds No Value to the FEHBP**

But I would also urge the subcommittee to consider a fundamental issue that is often overlooked: Why should *any* carrier be forced to comply with the Cost Accounting Standards? Put another way, would compulsory compliance add value to the FEHBP?

As the Office of Personnel Management (OPM) itself has attested, the agency has successfully monitored and audited the FEHBP for over 40 years without the Cost Accounting Standards. Therefore, those who want to impose them on the FEHBP should be required to demonstrate that it will confer concrete benefits. They should prove that taxpayers will be better protected. And they should show what benefits the millions who depend upon the FEHBP for health insurance will realize.

One would also expect that if the Cost Accounting Standards added value to the Program, they would be applied to all carriers equally. Yet that is not the case. Only experience-rated carriers (the fee-for-service plans and some HMOs) have been targeted, but not the community-rated plans (most HMOs). But community-rated plans are the overwhelming majority of the 205 health care plans that are participating in the FEHBP this year. I know of no logical basis for this distinction.

The Blue Cross and Blue Shield Association and its Participating Plans are confident that a careful cost-benefit analysis of requiring CAS compliance will reveal many added costs but no added value. That is the conclusion we reached after intensive analysis and numerous discussions with OPM. That is the conclusion that OPM Director Kay Coles James reached when she exercised her authority to waive the Cost Accounting Standards for experience-rated carriers, such as the Service Benefit Plan. And that is the conclusion we believe this Subcommittee would reach.

### **CAS Is Not Required to Protect Program Integrity**

I would like to reassure the Members of this subcommittee that imposing the Cost Accounting Standards on FEHBP carriers is not necessary to protect the taxpayers or the federal employees and retirees who participate in the Program. FEHBP carriers are already subject to a broad array of cost accounting requirements. These include accounting requirements contained in the Federal Acquisitions Regulations (FAR), the Federal Employees Health

Benefits Acquisition Regulations (FEHBAR), and Generally Accepted Accounting Practices (GAAP).

In fact, the Blue Cross and Blue Shield Association and Participating Plans already comply with those Cost Accounting Standards that are compatible with insurance industry accounting needs because they are incorporated in the FAR and FEHBAR.

OPM has, and exercises, authority to conduct regular and rigorous audits of FEHBP carriers, including the Blue Cross and Blue Shield Association and Participating Plans, as the agency has previously testified before this Subcommittee and the CAS Board Review Panel.

We take seriously our obligations to the taxpayers and the employees and retirees who enroll in the Service Benefit Plan. The Association conducts its own internal audits to ensure adherence with all of these accounting requirements. And we have also worked closely with OPM on ways to strengthen FEHBP accounting requirements that are compatible with insurance industry needs.

As Director James wrote when she issued the administrative waiver, “The potential risk to the FEHB Program of waiving CAS requirements is nonexistent due to Program controls already in place.”

### **CAS Will Not Restrain Health Care Costs or Premiums**

FEHBP premiums are driven primarily by the cost of providing health care to our members: payments to doctors, hospitals, and other health care providers, as well as the costs of prescription drugs and other health care charges. These payments account for about 93% of Blue Cross and Blue Shield’s expenditures in

the FEHBP. Yet the Cost Accounting Standards would not apply to such expenditures, but only to the small segment attributable to administrative activities. Imposing CAS on the FEHBP is not an answer to rising insurance premiums.

To the contrary, the cost of administering the Service Benefit Plan would increase significantly if the Association and Participating Plans were to even attempt to implement CAS-compliant accounting systems. (In any event, we believe that any such attempt would be doomed to fail.) As Director James stated in the waiver, “Program costs would increase if health carriers determine they would need to develop discrete new accounting systems for their Federal group contracts.”

### **CAS Is an Intractable Problem for the Service Benefit Plan**

There are two interrelated reasons why the exemption from the Cost Accounting Standards is so important to our Plans. The first is the very nature of the Cost Accounting Standards themselves. And the second is our unique structure within the FEHBP.

### **Structure of the Service Benefit Plan**

Let me address the second issue first. Aside from HMOs, the Blue Cross and Blue Shield Association and its participating Plans are the only carriers sponsoring a FEHBP plan that also sell insurance in private markets. The 41 independent Blue Cross and Blue Shield licensees have come together to sponsor the Service Benefit Plan and provide to the government the same insurance products that they provide to commercial customers.

Blue Cross and Blue Shield Plans provide coverage under the Service Benefit Plan as an integral and inseparable part of the Plans' regular commercial health insurance business. The Plans' ability to provide FEHBP benefits depends upon the extensive networks of providers that each Plan develops and maintains to service underwritten commercial business. Because our FEHBP business is so tightly integrated with our commercial business, the Blue Cross and Blue Shield FEHBP contract is fully integrated into the various Plans' operational and accounting structures. This arrangement is fully consistent with the provisions of the original FEHBP Act, which established the Service Benefit Plan.

Collectively, Blue Cross and Blue Shield Plans insure nearly one in three Americans, about 88.3 million people. The FEHBP population of some 4.3 million is obviously a very small percentage – about 5% - of this overall book of business. Plan business decisions must be driven by what is best for their overall book of business. To put it another way, it would make no business sense for Plan's to make drastic and disruptive changes to their accounting systems that are necessary to serve their commercial accounts to accommodate a fraction of their business. Yet that is just what imposing the Cost Accounting Standards would require.

### **CAS Is Incompatible With Insurance Accounting Practices**

As we have noted many times before, the Cost Accounting Standards and insurance accounting systems are like two different and unrelated languages; the grammar is different and so is the vocabulary. One cannot be translated literally

into the other because they have so little in common. This is not surprising. After all, the Cost Accounting Standards were not designed to fit the insurance industry, but for manufacturers of goods for the Department of Defense.

In fact, I believe the subcommittee would find it instructive to ask all FEHBP carriers this question: “If you were charged with developing an accounting system to most effectively manage your insurance business, both commercial and federal, would you choose CAS?” I am confident each would say “No.” But if any truly believe that CAS is a superior accounting system for our industry, by all means they should be free to adopt it. They may do so today.

The Cost Accounting Standards divide all contractor costs into two basic types, direct and indirect costs. Indirect costs are then classified into three subcategories: “overhead,” “general and administrative,” and “home office,” which are grouped together into indirect cost pools. These pools are then allocated as a percentage to bases comprised of direct contract costs or combinations of direct and subsidiary indirect costs.

Insurance accounting is radically different. It employs none of these categories. Instead, the accounting systems used by insurers establish “cost centers,” sometimes as many as 1000 or more. These “cost centers” are allocated to various lines of business using up to forty different methods or statistics, such as number of claims processed, number of subscribers, or time studies.

The highly detailed system of accounting used in the insurance industry provides management with the business information it needs to effectively run

the business. Managers are able to see clearly how the various products the company offers are performing financially. The Cost Accounting Standards would obscure this clear vision because costs would be consolidated into what are, by the standards of the insurance industry, extremely large expense pools. In short, it would simply make no business sense for insurers to adopt a CAS-like accounting system in the first place, much less to revamp existing systems that serve them well to accommodate the demands of a small fraction of their business.

In addition any change in a cost center is arguably a change in accounting practices requiring agency approval. This could result in literally thousands of change approval requests each year for infinitesimally small adjustments in Plans' cost centers.

Because the Cost Accounting Standards are so ill-suited to the needs of the insurance industry, I could continue to discuss many other examples of incompatibility between them and insurance industry accounting practices, such as major differences in accounting periods. But to summarize, any attempt to overlay the Cost Accounting Standards on Blue Plans' accounting systems would result in irremediable mismatches. Plans would therefore be confronted with the unfortunate choice of revamping their accounting system in ways that make no business sense to accommodate a fraction of their business or leaving the FEHBP.

The rational business decision is obvious. That is why the Blue Cross and Blue Shield Association cannot sign any agreement that would impose the Cost Accounting Standards currently exempted by law on its participating Plans.

### **Sound Business Judgment, Not Arrogance, Drives Our Opposition to CAS**

There are also two criticisms of our position on the Cost Accounting Standards that I would like to meet head on for the benefit of this Subcommittee. The first is that Blue Cross and Blue Shield could implement those Standards, but as the largest carrier is throwing its weight around because it simply does not want to. This is simply not true.

We value our participation in the FEHBP, which has been cited frequently by many experts as a model employer-sponsored health benefits plan. When the government first announced that it would begin applying the Cost Accounting Standards to the FEHBP, we embarked on a painstaking, conscientious review of how to apply them to existing business structures and accounting systems. We retained outside consultants and lawyers to assist and advise us. It was only after completing more than a year-long analysis, that we concluded it was simply not feasible. Only then did we ask Congress for a statutory exemption.

### **FEHBP Is Not Like Medicare**

The second criticism is that because some Blue Plans comply with the Cost Accounting Standards in their Medicare and other government business, we could do it in the FEHBP. But there are critical differences between the FEHBP and those other lines of business that make compliance feasible in one but not the other.

Our Plans' Medicare and fiscal intermediary contracts are essentially service contracts. Unlike the FEHPB they are not integrated with our commercial business and do not depend upon our provider networks. In many cases those contracts are in fact distinctly separated and housed in wholly owned subsidiaries of individual Plans. In those circumstances, it is possible to develop distinct, CAS-compliant accounting systems without changing company-wide accounting systems. That is not true in the FEHBP.

### **A Permanent Statutory Exemption Is Necessary**

Fortunately, as Members of this Subcommittee know, Congress has recognized just how serious a problem this is. Beginning with the Treasury-Postal appropriations bill for FY 1999, Congress has continuously exempted all FEHBP carriers from the Cost Accounting Standards. This statutory exemption remains in effect today, and I was pleased to note that President Bush's budget for FY 2005 proposes to continue it.

However, Blue Plans were almost forced out of the FEHBP in 2002 when the continued viability of that exemption was threatened because the House of Representatives voted to strike the exemption. That vote took place in an environment poisoned by various corporate accounting scandals. Opponents of the exemption falsely portrayed the Cost Accounting Standards as necessary to protect the integrity of the FEHBP.

Despite that setback, Blue Cross and Blue Shield Plans were able to commit to offering the Service Benefit Plan again in 2003 because OPM Director

James issued an administrative exemption for all experience-rated carriers in the FEHBP. We thank her for her decisive and courageous leadership.

The Blue Cross and Blue Shield Association and its Plans appreciate the support we have received in the past from this Subcommittee in securing and retaining annual exemptions through the appropriations process. However, our near death experience in 2002 has reinforced our belief that a permanent statutory exemption for FEHBP carriers is necessary to ensure stability in the Program.

As grateful as we are for the administrative waiver Director James issued, we recognize that new leadership at OPM could easily revoke it. The same would be true of any “permanent” regulatory exemption. And the annual exercise of continuing a statutory exemption through appropriations bills can needlessly disrupt the appropriations process and lead to a “Perils of Pauline” environment for those who depend upon the FEHBP for health insurance, OPM, and our Participating Plans.

This is not the best way to run a railroad or a health insurance program. That is why I am asking the Subcommittee to support a permanent statutory exemption from the Cost Accounting Standards for all carriers who participate in the FEHBP, just as Congress did when it established the Long Term Care program.

### **Ensuring Quality Health Care at Affordable Prices**

The second issue your letter of invitation asked us to focus on is cost containment within the FEHBP. This is indeed a timely and important topic.

Almost daily, it seems, new reports and experts remind how difficult – but important – it is becoming to continue providing quality health care at affordable prices. The Blue Cross and Blue Shield Association and its Participating Plans never lose sight of our obligation to provide federal employees and retirees with quality health care at prices they can afford.

### **Challenging Environment**

The FEHBP is not immune from the experience of the general health care market. It is subject to the same forces creating cost pressures in the wider market. These forces include increasing expenditures for prescription drugs; medical technology; higher payments to doctors, hospitals, and other providers; increased demand for medical services by aging “baby boomers” who expect the very best care; the malpractice crisis; government regulations; inflation; and waste, fraud, and abuse.

We are also increasingly realizing that the lifestyles we choose contribute to higher medical expenditures. For example, the Department of Health and Human Services (HHS) estimates that obesity and related problems adds \$100 billion per year to health care expenses. According to HHS, more than 60% of adults in this country are overweight or obese, and the trends among young people are cause for real concern. HHS tells us that the number of overweight children between the ages of 6 and 11 has almost doubled, and it has nearly tripled for those aged 12 to 19.

Blue Plans and the Association are aggressively responding to these challenges.

## **Competition And Risk In the FEHBP Controls Costs And Promotes Quality**

Before I turn to some of the things Blue Cross and Blue Shield Plans are doing to keep quality up and costs under control in the Service Benefit Plan, I would like to point out some features of the FEHBP itself that we believe contribute to both objectives. First, the FEHBP is a competitive market-oriented system centered on consumer choice. Carriers compete vigorously with one another for each individual's business. This alone provides a powerful incentive for each carrier to work hard to rein in costs and preserve competitive premiums without diminishing the quality of care.

Second, carriers, or their underwriters, are at risk in this market. They offer true insurance products to the ultimate consumer, not just administrative services. This reinforces carriers' incentives to ensure that benefit designs are actuarially sound.

### **The Service Benefit Approach**

I would categorize the Service Benefit Plan's efforts to maximize the value of our benefit in two groups. In the first group, are such economic cost controls as the discounts we receive through our networks and by using pharmaceutical benefit managers (PBMs). The second encompasses what I would call member-centered programs that focus on helping the member achieve better health outcomes in cost-effective ways or adopt healthier lifestyles. We also maintain a vigorous and effective anti-fraud program.

## **Discounts**

I noted earlier that our FEHBP business is integrated with the provider networks participating Plans have developed to service their commercial business. As a result, the Service Benefit Plan reaps the advantage of discounts that Participating Plans are able to negotiate on the strength of their commercial accounts. Those discounts far exceed what Plans could negotiate on the basis of their FEHBP business alone and generate significant savings for taxpayers and the federal employees and retirees who enroll in the Service Benefit Plan.

Contracting with PBMs to handle both retail and mail order prescription drug programs, helps the Service Benefit Plan control escalating expenditures for pharmaceuticals by taking advantage of substantial discounts they are able to negotiate with pharmaceutical companies and pharmacy networks. As the General Accounting Office has recently attested, these savings are shared by enrollees. (GAO, Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies (January 2003, GAO-03-196.)

## **Member-Centered Approaches**

We also undertake a number of activities to ensure that our members are receiving high quality, affordable care.

- We monitor member satisfaction via surveys, focus groups, appeals/grievance process and devise local policies accordingly;

- We monitor provider safety and quality via provider network credentialing, provider contracting, fraud/abuse program, and member feedback
- We monitor clinical coordination in partnership with providers and members via case management, disease management, and pharmacy programs in varying degrees dependent upon initiatives designed for a local population;
- We provide health and wellness programs for Blue membership in varying degrees driven by local disease states; and
- We monitor clinical literature and provide staffing for health services research in local Blue Cross and Blue Shield Plans.

Let me give you some real-life examples of how these kinds of programs help our members achieve healthier outcomes.

- Our 24-hour nurse line, "Blue Health Connection," helps members assess their symptoms and find the right care at the right time.

Earlier this year, one of our members was driving home when he developed symptoms which he thought were "the flu." His wife called the nurse call line, at which time the nurse advised him that he should go directly to an emergency room, since he might be having a heart attack. He did have a heart attack but, thanks to Blue Health Connection, he got the right treatment at the right time. When the Plan called the member, he was back at work, doing well, and attending cardiac rehab. It was a first

time event for him. He expressed appreciation for the nurse who gave him the correct direction.

- To encourage cost-effective use of prescription drugs, we manage drug cost and utilization with a continuous focus on quality. We incorporate a set of clinically aligned programs to review patient's medications. We continue to monitor new drugs that become available to determine if they are appropriate for inclusion in our programs, based on clinical studies and manufacturer's guidelines.

One of our members was taking contraindicated migraine medication following a stroke. Following guidelines in our prior approval program and based on the pharmacist's review, the doctor was able to manage the patient's care, improve outcome, and avoid a potential threat to the patient's health or life.

Another member's doctor was not aware that his patient was receiving medications from other doctors as well. After our review and notification, the doctor informed us "I will schedule a consultation with this patient and handle immediately. Notifications such as these are very beneficial".

I cannot tell you today that our programs actually led to lower costs in all of these incidents and the many others that our programs deal with. In the short term, our costs may have increased in some cases. We believe that in the long run, such programs will help control costs. But we are certain of one thing: the outcome for our members was better.

The Blue Cross and Blue Shield Association has established a Health Care Cost Containment Program that encourages our members to adopt healthier lifestyles. One example is the Association's "Walking Works" campaign to educate our members and others about the health benefits they can realize simply by walking more.

In short, we work hard to improve our members' health outcomes and control costs.

### **Anti-Fraud**

In addition, the Service Benefit Program is protected by an effective anti-fraud program that fights fraud, and abuse. We estimate that in 2002 our anti-fraud program saved nearly \$94.7 million. (Our estimate for 2003 is not yet complete.) On the medical side, our Participating Plans are required to integrate anti-fraud investigations under the Service Benefit Plan into their overall anti-fraud programs. With respect to prescription drugs, the Service Benefit Plan has established an anti-fraud program under which trained clinical personnel (e.g., registered pharmacists and pharmacy technicians) identify abusive practices and investigators search out and investigate fraudulent activities.

OPM's Office of Inspector General has repeatedly complimented our anti-fraud program. Our anti-fraud personnel participate in a number of training programs offered by such industry-related associations as the National Association of Drug Diversion Investigators in order to keep their skills at the cutting edge of industry practices.

### **Health Savings Accounts**

In your letter of invitation, you asked us to be prepared to answer questions on several topics, and we are prepared to do so. However, I would also like to take a moment and address one of those issues, Health Savings Accounts (HSAs).

In general, we believe that HSAs are innovations that would enhance the Program. They offer an option that some federal employees and retirees (those under 65) might find attractive. Many have expressed concern about the risk of adverse selection, which could drive up premiums for others by enticing the best health risks to leave more traditional plans. While we agree that this is a potential development that must be guarded against, we also believe that OPM can minimize this risk by carefully monitoring the FEHBP marketplace and negotiating properly designed benefit packages. Nor are we concerned that there will be an immediate flood of employees into HSAs, which are a new and radically different approach to health care coverage. Thus, we believe there will be ample time to examine how they will actually affect the Program and take corrective action if necessary.

However, there is one aspect of this matter that does cause us immediate concern. Under an interpretation of the statute that OPM has followed for some years now, the agency believes that legislation is necessary to allow the Service Benefit Plan to offer more than the 2 options it currently does. In contrast, OPM has the authority to allow competing carriers to offer more than 2 options by regulation. We believe, though, that OPM currently has the authority to also

allow the Service Benefit Plan to offer additional options and that legislation is not required.

We will continue to discuss this question with Director James and her staff. But we are concerned that if legislation is required there may be a period – and possibly a very lengthy one – in which other carriers are able to offer an additional option, such as an HSA, while we are foreclosed. We are concerned that would establish an undesirable precedent for applying a separate set of rules to carriers that are otherwise similarly situated. We know that is not OPM’s intent, but we fear it could be the consequence.

Pending Treasury guidance regarding HSA specifications is also of grave concern to us. The outcome of this guidance could render HSAs much less competitive products in the FEHBP.

Of particular concern is whether or not prescription drug coverage must be subject to the medical benefit high deductible in order to be “qualified” as HSA compatible. Many Blue Plans, including the Service Benefit Plan, use PBMs to manage pharmacy programs under which prescription drugs are exempt from the annual deductible. Systems changes to coordinate with PBMs would be required if prescription drugs are subjected to the deductible for HSA compatible products. These changes could be prohibitively expensive at a time when we are striving to reduce all administrative costs, and they could take at least a year to complete.

## **Conclusion**

For the reasons I have elaborated, we believe the Cost Accounting Standards add no value to the FEHBP and present insurmountable obstacles to

the Blue Cross and Blue Shield Association and its Participating Plans. Imposing the Cost Accounting Standards would require our Participating Plans to revamp their accounting systems in ways that make no business sense to accommodate a small fraction of their overall business. The incompatibility of the Cost Accounting Standards with insurance industry accounting practices is a permanent problem that requires a permanent solution. Therefore, we ask the Subcommittee to support a permanent statutory exemption for all FEHBP carriers.

The Service Benefit Plan is dedicated to providing our members with high quality health benefits at affordable prices. Because the Service Benefit Plan is integrated with our Plans' commercial business, it enjoys the substantial discounts those Plans negotiate with health care providers. Our use of PBMs to handle the Service Benefit Plan's drug benefits also results in substantial savings for our members and the government. We maintain effective member-centered programs to assist them in making the most cost-effective use of their benefit, and we maintain a vigorous anti-fraud program.

I again thank the Subcommittee for the opportunity to appear before you, and I am prepared to answer any questions you may have on these important matters.