

Federal Employees Health Benefits Program (FEHBP)

Introduction

The Federal Employees Health Benefits Program (FEHBP), which currently covers eight million active and retired federal employees and their dependents, is the nation's largest employer-sponsored health insurance plan. Together, taxpayers and federal employees paid insurance companies \$25 billion for FEHBP premiums last year, a price that does not include the additional enormous out-of-pocket charges paid exclusively by enrollees and their families. Despite the fact that it is routinely held up as a model for Medicare privatization, and was used in that capacity in the 2003 legislation that established the Medicare prescription drug coverage, those who must rely upon FEHBP know its flaws well. In the last six years, average premiums have risen by 60.1%, far faster than the average growth of national health care costs during the same period. In addition to out-of-control premium increases, FEHBP participants have suffered increased out-of-pocket costs, unpredictable shifts in covered benefits from year to year, the sudden disappearance of popular plans, and the introduction of new alternatives to insurance that promise to undermine standards in the program further. Finally, in spite of being forced to pay anywhere from 30% to 65% of premiums, federal employees have no meaningful voice in the program on issues such as coverage, quality standards, or the mix of benefits and costs.

FEHBP has both structural and political flaws. Each makes the program more expensive than it should be for both the government, and for federal employees. The changes in FEHBP sought by AFGE are aimed at lowering costs without reducing benefits, improving the accountability of both the plans and the Office of Personnel Management (OPM), and achieving parity with the benefits provided by large private and public sector employers.

High Costs and Uneven Coverage

The officially announced average 2007 FEHBP premium increase was 1.8%. This followed the pattern of 2001, 2002, 2003, 2004, 2005 and 2006 when the Office of Personnel Management approved average hikes of 10.5%, 13.3%, 11.2%, 10.6%, 7.9% and 6.6% respectively. Over seven years, premiums have risen by an average of 62%. These increases occurred at the same time that the general rate of inflation hovered between 2 and 3 percent, and health care spending nationally rose by 6% to 9% per year. A report from the Health Statistics Group in the prestigious journal *Health Affairs* compared annual per enrollee costs among those covered by private sector employers' health insurance plans, Medicare, and the FEHBP. While FEHBP's rate of growth was lower than either private plans or Medicare from 1991 to 1997, today FEHBP's per enrollee costs are rising 15.1% a year, while private plans' spending is going up by 8.6% and Medicare is rising by 7.1%.

But the real story in FEHBP is cost shifting from the government onto federal employees and retirees. Forget for a moment the 1.8% figure that OPM touts as the average premium increase. For federal employees, the numbers are much less positive. OPM took advantage of its ability to manipulate the formula for FEHBP premiums to engineer historic cost shifting maneuvers in both 2006 and 2007. They have claimed that since they had been putting aside too much in past years for reserves, they would dip into those reserves again this year to subsidize the government's share of premiums. As a result, again—for the second year in a row--federal employees and their families will be forced to shoulder far more of the increase in FEHBP premiums that the government will bear. Last year it was double the increase; this year the employee premium increase is 43% higher than the government's increase.

A recently published study by the Government Accountability Office (GAO-07-41) found that the average annual increase in premiums for enrollees between 2003 and 2006 was 8.8%, while the average annual increase over the same period was just 7.3%. Rate of growth in premiums is a much more telling statistic than comparing the published "average percentage increase in premiums" from the prior year. This difference in average annual growth - a 1.5 percentage point difference that is actually a 20.5% difference in growth rates, a huge measure of cost shifting from the government to enrollees.

Federal employees with family coverage who chose local, HMO-type plans are paying an average of 15.1% more in 2007 as compared with 2005, while those with individual coverage will pay an average of 15.5% more. Their employer, the federal government, will pay just 8.7% more for those with family coverage and 9.7% more for those with individual coverage as compared with 2005.

The financing formula for FEHBP is complex – it combines two types of caps on the government contribution: a dollar cap, and a percentage cap. The dollar cap is calculated on the basis of 72% of average premiums, weighted by enrollment among about 250 plans. The percentage cap is 75%, so that no matter what the premium actually is, the government will pay no more than 75% of the premium. For example, if the dollar maximum amounted to 80% of the premium of any given plan, the government would still cap its contribution at 75% regardless of the dollar amount of the weighted average formula.

OPM's latest letterhead proclaims itself to be "working for America" yet this unconscionable cost shifting shows that the opposite is true. OPM in this case is going against the working and middle class Americans who make up the federal workforce. Already an estimated quarter of a million federal workers and their families are uninsured because FEHBP premiums are unaffordable to them on their modest federal salaries. This move will only increase the ranks of uninsured and underinsured Americans. Undoubtedly, the continuation of cost-shifting and premium increases will force many more federal workers and their families to make the painful "choice" to go without health insurance.

As recently as seven years ago, the government's average share of premiums was 72%. The average share paid by the government has now dropped to 70% and the introduction of new types of plans threatens to reduce this amount further. This average, however, hides the fact that the government pays as little as 40% of the premium of some plans because FEHBP's financing formula caps the government contribution at 72% of the weighted average premium. In 2007, the maximum government subsidy for a plan in FEHBP will be \$8,369 for family coverage and \$3,690 for individuals.

Health Savings Accounts: The Administration's use of FEHBP as a Laboratory for Extremist Theories on Health Care

Health Savings Accounts have been pushed by President Bush as an alternative to the restrictions of managed care and yet another means for the affluent to shield their investment income from taxation. The trade-off for having a substantial portion of one's health care expenses uninsured was supposed to be freedom from managed care's restrictions on choice of provider and choice of treatment. However, neither goal has been served by FEHBP's High Deductible plans. The reality of HSAs under FEHBP is that they are not only as expensive or more expensive than traditional plans, but most of them include managed care restrictions on all covered services. And the only remotely affordable High Deductible plans in FEHBP are Health Maintenance Organizations (HMOs) that combine tightly managed care with \$2,500 of uninsured "deductibles." Predictably, they have been shunned by the middle class families who make up the federal workforce and its retirees, who stand to gain little from tax shelters and who value genuine protection from the high cost of needed health care services.

The introduction of High Deductible Plans into FEHBP, however, does make cost comparisons of different plans both confusing and misleading. Prior to the introduction of High Deductible/Health Savings Account plans, it was possible to compare plans on the basis of premiums and benefits, even though no two plans in FEHBP offer identical coverage. But it cannot be fairly said that a Health Savings Account plan like HealthAmerica Pennsylvania that charges an annual premium of \$4,709 per year, of which \$1,177 (25.0%) is charged to the employee, but which requires a \$2,500 deductible (part of which is supplied by the government's share of the premium) before any benefits are paid is more or less expensive than Blue Cross/Blue Shield Standard option which charges \$5,180 in total premiums for individual coverage, and \$1,396 to the employee (26.9%) but begins reimbursement after a \$250 deductible financed solely by the enrollee.

Further, what can be said of premium inflation when FEHBP's new plans are designed so that more than a third of the "premium" is a deposit in a Health Savings Account that rises by an amount determined by tax law rather than

health care costs? Has the government shifted costs when a family with a Health Savings Account must spend around \$5,000 before benefits kick in (HealthAmerica Pennsylvania) rather than maximum of about \$3,500 required by BlueCross/Blue Shield, when only the Health Savings Account holder has a shot of ending the year with thousands tax-free tucked away for another day?

The Administration included a vaguely-worded and obscure reference in its FY08 Budget to its intention to allow Blue Cross/Blue Shield to offer a Health Savings Account/High Deductible option in addition to the two plans it already sells to FEHBP participants. It is believed that the Blue Cross “brand name” will encourage more participation in Health Savings Accounts so that this laboratory experiment will yield more promising data. AFGE opposes allowing Blue Cross to add another plan to its FEHBP operation. Already the largest insurance contractor in FEHBP, Blue Cross has won for itself exemption from the Government’s Cost Accounting Standards (CAS), an exemption that makes it impossible for auditors to make sure that the company does not pass on to FEHBP costs it incurs in the course of providing services to other customers. Until the government is able to make sure that Blue Cross is not making improper charges to FEHBP by the application of CAS, AFGE believes that no additional contracts should be awarded to Blue Cross/Blue Shield under the FEHB program.

The fact is that the introduction of HSAs has not reduced average premiums. In fact, according to OPM only 6,000 people have signed up for the Health Savings Account or High Deductible plans since they have been an option within FEHBP, just 0.02% of the eligible population. And in spite of the fact that spending on FEHBP continues to rise at rates that exceed our nation’s overall health care inflation, and in spite of its foray into offering alternatives to insurance like HSAs, FEHBP fails the most important test of a group insurance program. It does not produce universal coverage for its target population—federal employees, retirees, and their families. Because of OPM’s collaboration in perpetuating the system’s flaws, it collects almost no data that would reveal the extent of the program’s failures. For example, it refuses to collect data on federal employees who are uninsured, the portion of the federal workforce that has no health insurance from any source, but is eligible to participate in FEHBP.

The most recent attempt to measure the size of this group, as well as its reasons for declining to participate in FEHBP, was 1992, when OPM contracted with Gallup to survey a small sample of nonparticipants. From that sample, it is estimated that approximately 250,000 federal employees who are eligible for the full employer subsidy under FEHBP not only do not use FEHBP, but they are entirely uninsured. The remainder of non-participants have health coverage from another source, predominantly from a spouse or from previous military service. There are no data on the number of uninsured federal retirees who are or were eligible for FEHBP coverage.

The reason most commonly cited by uninsured federal employees to explain their lack of participation in FEHBP was its prohibitive cost. The terms offered to

federal employees under FEHBP are substantially worse than those offered to the employees of other large, unionized employers, both in the private and public sector. While on average the government pays just 70% of premiums and not more than 75%, other large employers pay at least 80% and often 100%, according to recent data published by the Bureau of Labor Statistics (BLS), and the Kaiser Family Foundation.

AFGE's Legislative Solutions

The budget deficit that has accumulated under President Bush since 2001 has the potential to serve as an excuse to justify cutting employer support for federal employees' and federal retirees' health insurance. President Bush has proposed to reduce by half the government's financial support for health insurance premiums of "new annuitants" with fewer than ten years of service. This proposal, while consistent with his tax incentives to employers to drop coverage for their employees, is absolutely insupportable. In addition to the fact that there is no rationale for taking away an earned retirement benefit, reductions to this basic element of employee compensation are particularly ill-advised at this moment. The Government Accountability Office, the Department of Defense, and many other government-related organizations from AFGE to the Council for Excellence in Government to the National Association of Public Administrators to Senior Executives Association have all argued that the federal government must take bold steps to recruit a new generation of federal employees with the requisite skills and commitment to public service to replace the more than fifty percent of the federal workforce that is eligible to retire this year (OPM Director Linda Springer has referred to this as the coming "retirement tsunami"). Yet at the same time that the government's ability to achieve this is hampered by uncompetitive salaries and inferior health insurance benefits, the Administration decides to make things worse by reducing both.

The GAO's Comptroller General David Walker identifies the culprit as a two-decade insistence upon viewing federal employees as a cost to be cut rather than an asset to be cultivated. The government's approach to health insurance in FEHBP amply illustrates his point. Rather than try to set an example for the private sector, or even to meet prevailing standards in large firms and state governments, the federal government has tried to get by on the cheap. Not only is the government's 70% contribution to FEHBP premiums too low to produce universal coverage for the federal workforce, it amounts to more than \$1,100 less per employee per year than other large employers pay in both the private and public sectors.

Employees of the U.S. Postal Service bargain collectively over both wages and their employers' share of FEHBP health insurance benefits. Postal workers pay 15% of FEHBP premiums while the Postal Service pays 85%. The Federal Deposit Insurance Corporation (FDIC), a federal agency that regulates the banking industry, also negotiates with its employee union over health insurance

and pays 85% of premiums and provides employer-subsidized vision and dental insurance as well. In both cases, the employer does so not because of the overwhelming power of the union, but because it is a “best practices” business decision to do so. Simply put, employers who fail to pay an adequate or fair share of health insurance premiums are the ones facing human capital crises, and those who pay their fair share do not.

AFGE has long supported reforms that would allow the government to use the size of FEHBP, and its potential leverage over the insurance and pharmaceutical industries to produce savings which would render FEHBP more affordable for federal employees. For years, cost shifting onto federal employees has been the government’s only response to out-of-control premium increases. Forcing employees to shoulder a higher share of FEHBP costs has been justified as producing an incentive to be more diligent in restricting utilization and lowering costs. What’s good for the goose is good for the gander. With the government shouldering a higher portion of FEHBP’s costs, perhaps OPM and OMB will be motivated to do more than rubber-stamp the demands of these politically powerful industries.

In the last Congress, now Majority Leader Steny Hoyer (D-MD) introduced legislation that would have changed the financing formula for FEHBP so that agencies would pay 80% of the weighted average of premiums, with a maximum of 83% of any given plan. This legislation would have improved the affordability of FEHBP immensely. The current average contribution is 70% with a maximum of 75%, and moving to an average of 80% with a maximum of 83% would open the door to health insurance to many of the 250,000 uninsured federal workers who cannot afford coverage at today’s rates. This changes included in that bill would have been an important attempt to make FEHBP more affordable for federal workers and their families. It was also a smart response to the government’s much-discussed “human capital crisis.” Closing the gap between the federal government and other large, progressive employers in both the private and public sectors in the area of health insurance benefits would go a long way toward improving prospects for recruiting and retaining the next generation of federal employees.

This year AFGE will work hard to advance legislation that will require FEHBP’s carriers to purchase prescription drugs at the discounted prices the government has negotiated for purchase off the General Services Administration’s (GSA) Federal Supply Schedule (FSS), as negotiated by the Department of Veterans’ Affairs. The negotiated drug prices available from the FSS are used by the Veterans Health System, the Department of Defense, the U.S. Bureau of Prisons, the Indian Health Service and other public health entities administered by the U.S government. It simply makes no sense for the federal government to pay one set of discounted prices for the prescription drugs it purchases for use in veterans hospitals and clinics, military hospitals and clinics, Indian Health Service facilities and federal prisons, and other drastically higher prices when it pays for

prescription drugs for its eight million employees, retirees, and their dependents who work in those agencies and programs. Why should taxpayers finance this inequity?

In 1999, one FEHBP carrier petitioned the government for permission to purchase the prescription drugs it provided to its federal enrollees off the FSS. Both OPM and OMB agreed that OPM had the authority to allow its FEHBP carriers access to the FSS discounts. After all, since taxpayers were paying for the prescriptions, every opportunity to minimize expenditures should be utilized, and the laws and regulations were already in place to allow the plan to operate. Those enrolled in the FEHBP plan would have access to the FSS discounts for the drugs on the schedule, and have a different and separate reimbursement rate and mechanism for drugs that were not. For about half a second, it looked like the first real cost-containment mechanism ever adopted for FEHBP would go forward.

Unfortunately, the major health insurance carriers joined with their friends in the pharmaceutical industry and their own pharmaceutical benefit manager subsidiaries and threatened a “strike” i.e. they told OMB that if FEHBP plans were permitted to purchase drugs off the FSS at discounted prices, they would no longer sell to FEHBP plans at all. The message was clear: Give us the higher prices we demand for FEHBP, or do without the drugs. In the face of this “your money or your life” ultimatum, OMB decided to hand over the money. Thus, legislation is needed that requires FEHBP carriers to purchase off the FSS, so that OPM and OMB are not able to back down in the face of industry threats of retaliation.

Prescription drugs now account for 11 percent of all health care spending, and 23 percent of all out-of-pocket costs for insured Americans. For 2003, the most recent year that national health care spending data are available, prescription drugs accounted for 50 percent of the increase in out-of-pocket costs for health care. OPM repeatedly cites prescription drugs as a major source of FEHBP’s own inflationary spiral; for 2006, they claimed again that almost a third of the average increase is directly attributable to drug prices, for 2007 OPM declined to analyze the source of premium differences. Thus, legislation to gain access to the real prescription drug discounts available to other federally-funded health programs would mark important cost-saving progress for both taxpayers and federal employees.

This effort coordinates perfectly with the proposal to bring the costs of the prescription drug benefit contained in the Medicare Modernization Act down through direct government price negotiations with the pharmaceutical industry. Since the Medicare prescription drug program is based on the FEHBP’s design, the issues are virtually identical. Apologists for the two programs’ structures believe that competition among plans is enough to bring down prices. Empirically that has been proven to be a false hope. In December 2005,

Families USA published a report comparing the lowest prices available under the various Medicare prescription drug plans to the prices the DVA negotiates for the FSS for the 20 most commonly prescribed drugs and found that in 19 out of 20 cases, the FSS price was lower. The median difference was 48.2% lower for FSS prices, i.e. if you compared the **lowest** price available under any Medicare plan, the median difference between that and the FSS prices was 48.2%. For half of the drugs, the lowest price under Medicare's private plans was 150% of the FSS price or one-and-one half times higher, and for a quarter the lowest Medicare price was double the FSS price.

These price differences amount to billions a year difference in costs for the government and for enrollees. Federal employees are no more able than most Medicare prescription drug insurance enrollees to shoulder expenditure differences of thousands per year, but the Families USA study shows that is exactly what the flawed structure of FEHBP and the Medicare prescription drug program requires.

President Bush's Health Care Tax Proposal

President Bush has put forward a highly controversial plan to treat employer-paid health insurance as regular income for tax purposes, and allow a new standard deduction for health insurance of \$7,500 for individuals and \$15,000 for families. These standard deductions would rise with the Consumer Price Index (CPI), regardless of the rate of increase of health insurance premiums, which has far outpaced CPI growth for more than three decades. The President has said that the "logic" of his plan is to discourage "gold-plated" employer-paid insurance, and equalize the tax treatment of health insurance purchases between employers and individuals. He claims that this move will lead to a reduction in the number of uninsured Americans from 47 million to 43 million. The reduction in the number of uninsured would allegedly come about because more would buy individual insurance due to the tax deduction than will lose it because their employers stopped making it available. (President Bush would have the federal government join the latter group by taking away half of the current level of financial support for FEHBP premiums for some federal annuitants).

The proposal has been widely criticized by health care experts and members of Congress. First, as the dismal experience of FEHBP demonstrates, the price of health insurance is not necessarily a reflection of how comprehensive, generous, or "gold-plated" are the benefits. If the risk pool has many older, sicker people, even modest benefits will be expensive. Likewise, if the risk pool leaves out older, sicker people and concentrates on the young and the healthy, it might be "gold-plated" but relatively inexpensive. Regional differences in health care prices can also have a significant impact on insurance premiums. According to a GAO study conducted in 2005, several large U.S. cities have lower health care prices than rural areas or smaller cities because they include so many competing hospitals and doctors.

The President's plan can be seen as an effort to further his agenda of dismantling the post-World War II "social compact" which included government run health care programs for the elderly and the poor, and large government subsidies of employer-provided "fringe benefits" such as health insurance and pensions. In the Bush agenda, "personal responsibility" replaces social responsibility. The idea is to encourage individuals to consider health insurance a personal choice and responsibility, rather than one belonging to their government or their employer. President Bush has cloaked his proposal in economic jargon, claiming that the current tax treatment of employer-paid health insurance leads to high premiums. The only possible economic logic behind this is the conservative claim that having insurance leads to over-consumption and overspending. The fact is, however, that patients do not make most of the expensive health care consumption decisions, health care providers do, and high spending is as much a function of high prices as it is high demand.

The tax change strongly favors individual health savings accounts, and would be much more valuable to those in higher income tax brackets than those in low brackets or those who do not pay income taxes. For example, if Mr. Bush's plan were in effect in 2007, a federal employee household with FEHBP's Blue Cross and Blue Shield's (BCBS) standard option family coverage, would increase its taxable income by about \$11,900, the value of the government's contribution to the premium (the family pays the additional \$5,200 in premiums). But instead of having to pay income taxes on the \$11,900, the family would use the standard deduction of \$15,000 and actually reduce its taxable income by \$3,100 in that first year. The benefit in that first year to this family would be a tax cut of about \$1,000 if the family were in a 30% tax bracket, but just \$500 for lower-income families in a 15% bracket. In future years, when the premiums for BCBS go up by more than the standard deduction, the government's contribution/increase to the family's taxable income will exceed the size of the standard deduction, and President Bush's change in the tax treatment of health insurance will have turned into a tax increase.

Using the tax system as an incentive for employers to drop group coverage and for working families to purchase insurance on the individual market will produce neither a decrease in the number of uninsured nor a reduction in health care prices or spending. Individualized health insurance charges prices based upon individual risk; thus those who have pre-existing health problems will either be denied coverage or charged exorbitant prices. Higher prices will be charged to sicker people.

Conclusion

This Congress will be presented with stark choices regarding the direction the federal government should go with FEHBP. On the one side will be various proposals to shift costs further onto federal employees and retirees, including Cafeteria Plans and more Health Savings Accounts, which will only exacerbate

existing problems of coverage and affordability. On the other side may be the legislation like that introduced previously by Majority Leader Hoyer which improves the financing formula to make group health insurance—the most efficient means of delivering health care coverage—more affordable and more accessible. In addition, AFGE will work with members of Congress to take aim at one of the major causes of premium inflation—prescription drug prices. AFGE urges Congress to take the high road, and pass legislation to improve FEHBP affordability with an 80-20 financing split, and require FEHBP plans to purchase some prescription drugs from the Federal Supply Schedule. AFGE also urges the Congress to reject both the President’s proposals to cut support for certain federal retirees’ participation in FEHBP, and his effort to alter the tax treatment of employer-paid health care benefits. Neither move would produce any benefits to either the uninsured or those who struggle to afford even subsidized health insurance such as that offered through FEHBP.