

February 9, 2010

The Honorable Stephen F. Lynch
Chair, Subcommittee on Federal Workforce, Postal Service, and the District of Columbia
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Lynch and Members of the Subcommittee:

I understand that you are holding a hearing on Wednesday, February 10, 2010, on H.R. 4489, a bill to regulate the pharmaceutical marketplace in America by amending the statute authorizing the Federal Employees Health Benefits Program. This is to provide my analysis of that bill, and to request that these comments be included as part of the record on that hearing.

I am a long-standing consumer advocate, and an expert on the FEHBP program, on Medicare, and on prescription drug benefits in Federal programs. I am the author of *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, a book published by the American Enterprise Institute (AEI) last fall. For three decades I have been the primary author of the annual *CHECKBOOK's Guide to Health Plans for Federal Employees*. I was a consultant to the Centers for Medicare and Medicaid Services (CMS) on implementing the Medicare Advantage Program and the Medicare Prescription Drug Program. As a Federal employee, I headed staff work for an initiative that advised the Secretary of Health and Human Services on reforming the payment for prescription drugs in the Medicaid program. For many years I was responsible for reviews of all proposed HHS regulations to assure that they were both effective and minimally burdensome. Views expressed in this letter are my own, not those of AEI, CHECKBOOK, CMS, or HHS.

I have testified a number of times before this Subcommittee and other Congressional Committees on the FEHBP, on Medicare, and on health-related consumer information. In my recent book, I demonstrated that the consumer-driven FEHBP program has for five decades outperformed original Medicare in cost control, benefit generosity, fraud prevention, protection from catastrophically high health care expenses, avoidance of pork barrel earmarks, and customer service to enrollees. H.R. 4489 would jeopardize all these achievements. I believe it to be a sincere effort to improve the FEHBP program, but an effort fatally flawed by undue reliance on advocacy groups and alleged experts who fail to understand either the program or the legal, economic, and behavioral forces that affect the ability to control health care costs in America today.

I am concerned that in H.R. 4489 the Congress may enact legislation that would seriously damage the FEHBP and the 8 million Americans who depend on that program, with additional and serious adverse effects on other Federal programs and on all Americans who rely on a competitive marketplace for prescription drugs. I have grouped my analysis into three categories:

- The absence of credible evidence that there is a problem in FEHBP drug purchasing costs or drug management practices that justifies legislation, i.e. "if it ain't broke, don't fix it;"

- The burdens and damaging effects that a massive regulatory program would place not just on the FEHBP but also on other Federal programs and the private marketplace (and that would far exceed OPM’s ability to administer), without achieving any consequential savings or other benefits; and
- The availability of alternative reform options that address real problems in coordination of premiums and benefits between Medicare and the FEHBP, that would save billions of dollars to both taxpayers and enrollees without burdensome regulations (reforms that are well within OPM’s ability to administer).

A. There is no credible evidence that spending on prescription drugs in the FEHBP is wasteful or is higher than in other Federal programs, and hence no defensible rationale for enacting a “reform” to solve a nonexistent problem.

The FEHBP plans and their PBM contractors have successfully managed prescription drug benefits in recent years in ways that have generated major savings to the program and that have substantially outperformed programs such as Medicaid and TRICARE in containing prescription drug costs. The Medicare Part D prescription drug program was modeled in large part after the FEHBP, and has been an outstanding success in reducing spending on drugs by almost 40 percent from the original projections of the Congressional Budget Office and the Medicare actuaries. Both FEHBP and PDP have been successful in restraining costs through consumer-driven competition among plans, and the various techniques participating plans use to manage drug reimbursement, including tiered copays that reward selection of less of expensive drugs, use of mail order to reduce costs of maintenance drugs, judicious formulary decisions, and use of Pharmacy Benefit Management Firms to bargain aggressively with drug manufacturers, bargain with retail pharmacy stores, and handle the complexities of processing and paying millions of drug claims with near-perfect accuracy.

If there are suspicions that money is being wasted despite the record of overall success in these programs, *the first and only sensible step is to obtain expert and objective studies on the amounts and causes of waste, and useful remedies for any such waste before, not after, enacting legislation that would drastically alter the program in ways that might increase rather than decrease spending on drugs, and disrupt the entire prescription drug marketplace.* The General Accounting Office (GAO), the Congressional Budget Office (CBO), and the Office of the Inspector General (OIG) at HHS are all fully capable of comparing drug spending in the FEHBP to drug spending in other Federal programs that serve large numbers of enrollees through retail pharmacies, notably Medicare Part D, the Medicaid program, and insurance of civilian dependents and military retirees under TRICARE. (Neither the VA nor TRICARE procurement for Military Facilities should be used for comparisons, since these programs obtain their savings by using highly restrictive formularies that would never be accepted by Federal employees or retirees, and deliver their medicines at government facilities rather than through local pharmacies.) In this regard:

- The GAO has in recent years performed two general assessments of the methods used by FEHBP plans and their PBM contractors to manage drug costs (most recently the 2003 study “Federal Employees Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies”). *Both GAO studies found that the virtually unanimous opinion of the many stakeholders consulted was that the FEHBP was managing its drug benefits successfully and frugally, with substantial savings to the program and broad access of enrollees to needed medicines and convenient pharmacies. The importance of the latter factors is highlighted by the decision of some one million*

veterans eligible for free drugs from the VA to voluntarily pay premiums to Medicare Part D plans to improve their access. While these GAO studies did not provide the detailed research and analysis that would be needed in an authoritative cross-program and multi-year evaluation, *the GAO studies did provide persuasive evidence that current FEHBP pharmacy arrangements are effective and efficient.*

- The union partnership organization, Change to Win, has just published a study entitled “CVS Caremark’s Generic Rip Off.” This is neither an expert nor objective study. The study’s estimates of the total cost of alleged waste are badly flawed and greatly exaggerated because it erroneously assumes that all generic drugs are purchased at local pharmacies. In fact the great majority of generic drugs used by Blue Cross standard option enrollees are purchased through mail order, at prices to both enrollees and the plan that are significantly lower than at retail pharmacies. As another major failing, the Change to Win study fails to mention, let alone adjust its calculations to reflect, the Blue Cross standard option’s innovative benefit feature that provides free generic drug replacements for the first four prescriptions after switching from a name brand drug. Blue Cross standard is many times larger than Blue Cross basic option in the number and cost of prescriptions paid. *Hence, the overall conclusion of the study that hundreds of millions of dollars are wasted on drug purchases by the Blue Cross plans is completely unsupported by the analysis and clearly erroneous.* In addition, the study is artfully worded to mislead readers by implying that consumers are paying more than they should for drugs, when in fact Blue Cross enrollees need pay the regular copayment for prescription drugs only if it is lower than the pharmacy price. Hence, consumers who buy drugs at bargain CVS prices get just that—a bargain.

Most of the testimony to this Subcommittee at the Hearing held in June of 2009 and the Change to Win study commit another fallacy that is common to studies that focus only on ingredient costs of drugs. *The big savings in prescription drug management under programs that provide wide choices of drugs to enrollees come from either generic or therapeutic substitution, not from saving small fractions on drug acquisition costs.* Consider a plan that pays \$5 for a generic drug and \$100 for the name brand drug that is chemically identical. Another plan pays \$4 and \$80, a 20% saving on both versions. If the first plan succeeds in getting two thirds of its enrollees to switch to the generic, and the second plan succeeds with only one third, the first plan spends an average of about \$35 per enrollee and the second plan about \$55 per enrollee, almost twice as much. The seeming saving hides massive unnecessary waste. The strength of the FEHBP program and of the similar Medicare Part D program lie primarily in the ability of plans and their PBMs to provide incentives and mechanisms for such substitutions. *No analysis of drug costs in the FEHBP or any other program can be complete, or accurately calculate overall savings or excess costs, without dealing with actual utilization of lower cost drugs as replacements for higher cost drugs, or without focusing on total spending per enrollee over time.*

The Subcommittee’s hearing on FEHBP prescription drug costs in June of 2009 obtained *testimony from critics that, carefully read and properly interpreted, failed to provide any evidence of waste in FEHBP drug spending.* The hearing record shows that:

- A witness from the Department of Defense testified on drug costs in the TRICARE program. The testimony indicated that this program had engaged in a series of reforms in recent years to bring down the rate of increase in TRICARE drug spending. Those reforms notwithstanding, his testimony stated that during the period 2000 through 2008 total pharmacy program expenditures grew from \$1.6 billion to \$6.9 billion, more than

fourfold (Hearing page 77) and far, far more than the increase in drug prices in this period. During this period TRICARE enrollment rose very modestly, hence per enrollee spending also increased about fourfold. Yet the OPM Inspector General testified that from 1999 through 2007, per enrollee spending on prescription drugs in the Blue Cross plan had only doubled (Hearing page 27). While there are doubtless adjustments that would be needed for a fully accurate comparison, *the data provided to your Subcommittee last June demonstrates the overwhelmingly superior performance of the FEHBP's largest plan in controlling drug costs in comparison to TRICARE.* Moreover, the CBO in a recent study (June 2009, "The Effects of Proposals to Increase Cost Sharing in TRICARE") estimated that even after recent reforms, the program could actually have reduced its prescription drug spending by over \$1 billion dollars a year in 2009 had it used more aggressive cost sharing techniques to encourage substitution, similar to those used in most FEHBP plans.

- A supposedly expert witness testified that she was "surprised to see that your invitation letter to me stated that Federal [employee and retiree] costs for pharmacy benefits are 30 percent of total health care spending. Normally, I would see pharmacy costs as 20 percent of total health care, and I would conclude that your program is really, no deal" (Hearing page 32). Obviously, this witness was unfamiliar with the FEHBP program and unaware that the great majority of FEHBP drug costs are for elderly annuitants, a much larger group in the FEHBP than in private employer plans. Elderly people have many times higher drug costs than younger people, and the FEHBP has been by far the primary source of drug coverage for Federal annuitants. The great majority of retirees over 65 are covered by Medicare Parts A and B, which together pay roughly four-fifths of total hospital and physician costs. As a result, the major category of spending left for these enrollees in FEHBP plans is prescription drugs. *Accordingly, there should be nothing surprising about the 30 percent figure (actually, it is 25 percent) when comparing the FEHBP to private plans. That the figure is not far higher demonstrates the successful efforts to control the pharmaceutical costs of annuitants by FEHBP plans.*

In summary, the evidence that FEHBP drug spending is somehow wasteful or excessive is essentially nonexistent. No one has even performed the most important kinds of analysis, such as comparing total and per enrollee FEHBP spending over time on prescription drugs for age 65 and over enrollees, age 55 to 65 enrollees, and younger enrollees, with the corresponding enrollees in Medicare Part D, Medicaid, and TRICARE. Until such studies are conducted, there is no evidentiary basis for supposing there is any substantial waste in FEHBP drug spending.

B. The proposed bill would create a pervasive Federal regulatory program encompassing the entire prescription drug marketplace, with massive effects, most negative, not only on the FEHBP, but also on all public and private drug programs. The price control and other regulatory responsibilities it would place on OPM far exceed any present or likely future capabilities of that agency.

The proposed bill would require OPM to become an economic regulatory agency, with a scope of responsibilities for price controls and antitrust policy perhaps not seen in this country since World War II. Even were such a program otherwise justified, its proper locus is not the FEHBP and the Office of Personnel Management is manifestly unqualified to administer it. Moreover, each major section of the bill would create uniquely serious problems.

The bill would essentially prohibit CVS Caremark from doing business with the Federal government, by making it illegal for a firm that combines retail pharmacy with pharmacy benefit management to contract with any FEHBP carrier to perform PBM functions. Other Federal agencies and plans that operate under other Federal programs such as Part D would find it difficult to not to follow suit. This bill would appear to force either a corporate divestiture, a radical antitrust remedy that is rarely used in modern times and never used absent evidence of abusive monopoly powers, or to debar CVS Caremark from at least the FEHBP market. There is no apparent reason why such an extreme remedy should be imposed by the Federal government against this company or any of the smaller companies that are organized in this fashion. There are two Federal agencies, the Justice Department and the Federal Trade Commission, that have jurisdiction over antitrust issues. There are press reports that the FTC is conducting an investigation of CVS Caremark. *It would be a radical departure from good government and due process for the government to mandate such a divestiture or debarment while the responsible agency is investigating and before it has reached any conclusion as to either problems or appropriate sanctions, if any.* Banning this corporation from PBM arrangements with FEHBP plans would remove a major competitor to other large PBM firms such as Medco and Express Scripts. As a result, the FEHBP plans would likely face higher costs in their PBM contracts than they would if there were greater competition.

Quite apart from due process, there is no apparent substantive reason why this corporation should be singled out and debarred from doing business with FEHBP plans. The Change to Win campaign cites many examples of corporate mistakes, but most of the claimed bad behaviors seem to be accidental mistakes, minor misdeeds, or in some cases nothing but normal practices of plan sponsors and the PBM firms they hire (e.g., in one of a number of You Tube film clips apparently sponsored by Change to Win, the alleged misdeeds are substituting a generic drug for a chemically identical name brand drug, and encouraging or possibly requiring use of mail order for repeat prescriptions, as shown at <http://www.youtube.com/watch?v=YAth43nhA6M>.). If these are misdeeds, then almost all FEHBP plans are “guilty” and their PBM contractors are the wrong targets. In the June Hearing (page 11), the National Community Pharmacists Association, an organization with a long history of opposition both to mail order pharmacy and to tight ceilings on ingredient prices (such as the AMP price ceiling proposed in H.R. 4489) makes a number of antitrust allegations, but those are precisely the issues under investigation by the FTC. If there is some compelling rationale as yet undisclosed, it is not clear why such a debarment should not apply equally to Medicare Part D plans and private insurance plans.

The bill would impose drug substitution restrictions. This would inject the Federal government into an area that has long been the exclusive regulatory domain of the States. It therefore raises major Federalism questions. Furthermore, State anti-substitution laws already prohibit pharmacists from making non-generic substitutions under all but rare circumstances. It is hard to believe that there is a problem so severe as to warrant Federal legislation that would encroach on States’ authority in this area. (The 2005 report of the FTC, “Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies,” found that therapeutic switching was rare, and that therapeutic interchange usually lowered costs to insurance plans.) *If there is such a problem it is not an FEHBP problem, but far broader. Again, it is hard to understand why any such legislation should, if justified, not apply to Medicare Part D and Medicaid, and arguably to private sector health insurance. And wherever a Federal oversight function for pharmacy practice might belong, it is certainly not with OPM.* Finally, the bill as drafted would prohibit PBMs from “proposing” therapeutic substitutions to physicians, an infringement not only on free speech, but also on one of the major expert functions performed by PBMs and one of the most

important methods of reducing drug costs as well as of educating physicians on both efficacy and side effects of alternative medicines.

The bill would mandate an immediate 99 percent pass through to carriers of all rebates, discounts, and other remuneration received by the PBM from drug manufacturers, to the extent such sums “relate to” the FEHBP carrier’s contract. This would be a major intrusion into the details of business arrangements. It would require the carrier, the PBM, and the manufacturer to follow this model without regard to their other legal or contractual obligations, or the practical realities of the marketplace. It would also encourage creative accounting to evade this straitjacket, and place OPM in charge of a massive set of accounting issues, far exceeding any existing OPM skills or responsibilities. Again, there is no reason to think that any such requirements, if justified, should be limited to the FEHBP and not extend to Medicare Part D and Medicaid under a common statutory scheme, particularly since these and other Federal programs have rebate policies that are not handled as proposed in this bill. Moreover, it is quite unlikely that this provision would reduce costs to the program, and it might even raise costs:

- *Such a pass through would reduce incentives of PBMs to bargain for discounts, offsetting possible savings to the FEHBP. In combination with the AMP price ceiling discussed below, FEHBP plans might effectively be forced into a “cost plus” mode of contracting, with predictable increases in prices paid.*
- Manufacturers could avoid these restrictions by selling to FEHBP carriers through wholesalers rather than PBMs, thus effectively forcing the plans to return to the antiquated and more costly business models of decades ago, and lose the efficiency and expertise provided by PBMs. The Congress could presumably modify the statute to close this way of escaping onerous regulation, but in doing so would risk even worse outcomes.
- *Because manufacturers have substantial discretion as to how they market to PBMs, including the ability to reduce rebates and compensate PBMs for this reduction through lower administrative fees, there is no reason to think that they would not make these adjustments to minimize or negate any losses and hence any FEHBP savings.*
- Again, there has been no credible showing from expert sources that there is a serious problem that would justify the Federal government intervening to create a “one size fits all” set of business practices for the prescription drug sector of the economy.

The bill would make it onerous and costly for PBMs to sell utilization or claims data, and allow any state what amounts to a veto power over such sales. Quite apart from other legal, economic, and Federal role issues, this would disrupt one of the most valuable methods of obtaining vital information used by the Federal government itself. National aggregations of claims information are used in analyzing drug costs and patterns of usage by agencies such as GAO, CBO, and HHS, and in detecting and analyzing drug interactions and infrequent side effects not detectable in Phase 3 drug trials, by the Food and Drug Administration and a wide range of medical researchers at NIH and in academia. Again, OPM would become the regulator—tasked with approving each individual sale of such data from a PBM—despite no expertise or staffing to perform such a function. *Again there is no credible evidence that there is any serious problem requiring Federal regulation of any kind (other perhaps, than to prevent States from interfering with this valuable interstate market), and certainly no discernable connection to problems, if any, unique to the FEHBP.*

The bill would set “Average Manufacturer Price” (AMP) as a ceiling on carrier payments for drug ingredients. AMP prices are set by manufacturers, and can be lowered or raised by manufacturers to maximize revenues (higher prices lose sales, but may increase dollar revenues).

This is a stringent price ceiling and one that could make it difficult for independent pharmacies to participate in the FEHBP. It is yet another area in which other Federal programs use different standards, where laws and practices may conflict across programs, and where OPM has no expertise. A predictable effect of such a limitation (assuming that manufacturers did not evade it in ways discussed above) is that manufacturers would simply raise AMP prices to offset revenue losses. This is not a hypothetical outcome. A quarter century ago, the (Senator) Boren amendment to Medicaid drug payment rules tied Medicaid reimbursement levels to the lowest prices at which products were sold. Manufacturers promptly refused to continue to give VA such deep discounts, and the ensuing multi-hundred million dollar hit (in today's dollars) to the VA budget led an embarrassed Congress to rapidly exempt not just VA but also many other public entities from being included in the legislated formula. *If manufacturers find too many dollars riding on existing AMP prices, they can raise them, with potentially substantial cost increases to the Federal Supply Schedule, TRICARE, and VA.*

There are numerous other provisions that would create jurisdictional, administrative, and unintended side effects problems similar to those described again. Of special note, OPM would become a major arbiter of pharmacist wages, by setting dispensing fees. While these powers under the bill would apply only to FEHBP contracts, they would likely have major spillover effects. OPM would become an agency in charge of both wage and price controls affecting a large segment of a three hundred billion dollar sector of the economy, and subject to all the lobbying and political interventions that wage and price controls necessarily create. *Dispensing costs and pharmacy remuneration is yet another area of great complexity where OPM has no expertise.* Of special note, there are numerous defensible methods for allocating "joint" pharmacy costs to dispensing, and hence a wide range of essentially arbitrary outcomes for which OPM would become responsible. In Medicaid, where States set dispensing fees, these range from several dollars per scrip to ten dollars or more. (The economists' term for this problem is "joint cost allocation" and an Internet search will quickly disclose the complexities involved and the absence of any objective methods that are not arbitrary in practice—which explains the wide range of dispensing fee outcomes in Medicaid.)

Under the bill, *FEHBP enrollees would also be drowned in a sea of confusing information about prices charged from carriers to PBMs, and from PBMs to pharmacies, prescription by prescription.* This requirement is easily understood by analogy to groceries or clothing. Instead of the consumer getting only a sales slip with the price he paid for each item, he would get an additional sales slip by mail showing not only his price but also the price the store paid the wholesaler and the price the wholesaler paid the farmer (or manufacturer). This information would be required to be provided for every single drug purchase, many millions of times a year, to solve an undisclosed consumer information problem. The FEHBP program has far better options to spend tens of millions of dollars in postage to mail information to enrollees, not least of which is to require plans to mail annuitants a copy of OPM's annual *Guide to Federal Benefits for Federal Retirees and Their Survivors*. And consumers do not want this deluge of information. They already have the price information that matters to them for drugs, in sharp contrast to their inability to get price information for medical and hospital prices.

Finally, the bill would require PBMs to provide OPM voluminous information on sales prices, contracts, rebates, accounting methods, and much more, on every line of business. That is, OPM would request and receive essentially all financial information in the possession of each PBM firm not only on its FEHB contracts, but also on Medicare Part D, Medicaid, VA, TRICARE, and every private client (e.g., Fortune 1000 companies and tens of thousands of smaller

employers). What OPM could possibly do with this mountain of information is unclear. Presumably the purpose would be to audit the books to make sure FEHB rebates were properly calculated and allocated, on the grounds that OPM would have to see data on all rebates to make sure the FEHBP share was properly calculated. *Sorting through and actually analyzing every single piece of financial information for dozens of PBM firms, each with hundreds or thousands of clients would be a practical impossibility even if OPM hired hundreds of auditors.* Virtually any provision for collecting and using such data that the Subcommittee might craft would potentially conflict or overlap with audit provisions in the Social Security Act that apply to Medicare Part D, so again there are implications that go far beyond the FEHBP. In addition, despite the bill's prohibitions against disclosure of this sensitive and vital business information—vital because disclosure would undermine the ability of PBMs to bargain effectively by pitting one manufacturer against another to reduce the costs of drugs—the addition of OPM to the small group of agencies with access to such data would greatly increase the risk of disclosure. Most importantly, as I argue above, a focus on ingredient costs really misses the point. It is total drug spending per enrollee that should be the primary focus of evaluating prescription drug spending in a program such as the FEHBP. And drug spending is driven by many factors of far greater importance than ingredient rebates, or even total ingredient costs.

In summary, the cumulative burdens and problems created by these proposed provisions are immense, and the likely benefits small or nonexistent. One side effect seems almost a certainty: some PBMs would simply refuse to do business with the FEHBP rather than subject themselves to such massive and intensive interference, resulting in higher costs to the program as carriers increasingly found themselves unable to obtain attractive bids. Likewise, some health plans would likely leave the program, particularly those for whom the FEHBP is only a small part of their business. The responses of manufacturers are harder to predict, but if any appreciable number refused to sell under these conditions to FEHBP-participating PBMs, the entire regulatory apparatus would collapse. Most importantly, these provisions are certain to have substantial effects on other Federal functions, other Federal budgets, private health insurers, and the entire private sector pharmaceutical marketplace.

There is a larger issue here as well. The FEHBP model has for five decades produced impressive results in cost control, benefits, and access with only the lightest regulatory hand. Competing health plans make independent business decisions, and finding the right mix among lower costs, better benefits, better access, and better service is rewarded by success in attracting enrollees. This consumer-driven model works extremely well, despite design deficiencies which the Congress has neglected fixing, and the Congress should not lightly throw it away. The Congress should certainly not throw it away based on the anecdotal assertions and sometimes erroneous information it has received from a handful of witnesses and a handful of outside parties with vested interests at stake.

Variants of the regulatory scheme encompassed in this bill could be extended to physicians, hospitals, devices, dentists, and other health care providers and services doing business with FEHBP carriers. We already have a Federal program that operates under such a command and control system. It is original Medicare. And we know that despite all the ingenuity that the Congress and CMS have lavished on micromanaging this program over the years, original Medicare is outperformed by the FEHBP in all important respects. The new Medicare drug program, modeled on the FEHBP, has produced impressive results in controlling costs while responding to consumer preferences. Why on earth would the Congress want to take steps that might destroy this superior, proven, approach?

C. There are major FEHBP reforms that could produce genuine savings reaching billions of dollars annually. Prominent among these are better coordination with Medicare, not only for hospital and physician costs, but also for prescription drug benefits. CBO recently scored a Medicare coordination reform I proposed as saving one billion dollars a year. That reform, expanded, could reduce FEHBP costs for prescription drugs as well as for hospitals and physicians.

The FEHBP program is showing its age. Its design has withstood the test of time remarkably well, but is frayed around the edges in several areas. In testimony at a hearing of this Subcommittee in December 2008 on “FEHBP Financial Problems and Blue Cross Benefit Reductions and Premium Increases”

(<http://oversight.house.gov/images/stories/documents/20081203144040.pdf>) I dealt with a number of these problems and useful reforms to reduce them. In *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, I focused on those and additional reforms. In this letter I focus on one issue—Medicare coordination—and on proposals that would reduce taxpayer costs by improving Medicare coordination, similar to proposals made in those writings.

Almost all of the national fee-for-service plans in the FEHBP offer age-65 retirees a seemingly wonderful benefit enhancement. The plans promise that if the retiree has both Medicare Parts A (hospital) and B (physician) as primary insurance, all hospital and physician care will be free under the FEHBP plan—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. What could be wrong with this wonderful benefit enhancement? It comes at a high price. In 2010, the most popular plan choice in combination with Medicare, Blue Cross standard option, will cost a retired couple \$7,130 in FEHBP and Medicare premiums. This is a “for sure” expense, whether or not they ever see a doctor.

This same couple was most likely enrolled in that same Blue Cross option until age 65, and was satisfied with its good benefits, despite its “pricey” premium. What changed upon turning age 65 that impelled them to pay an extra \$2,300 a year for two Part B premiums? The answer is that this decision is sensible for that couple only because the existing system for coordinating premiums and benefits is irrational.

Of great importance to the FEHBP, Medicare, and the United States Treasury, that couple’s decision is expensive. That retired couple and the providers they use have 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 to expensive specialists are 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 might add just a touch of reassurance, the price of zero is just right amount to justify the second scan. A recent *New Yorker* article (June 1, 2009) by Atul Gawande probed the costs of medical care in McAllen, Texas. His main example of bad decisions was a medical condition that could almost always be cured by inexpensive drugs over a period of several months, or cured immediately by a safe but moderately expensive surgical procedure. He thought the inexpensive drugs should be tried first. But for most FEHBP retirees (and apparently many other McAllen patients) the surgical procedure is a free as well as a fast cure, the drugs a modestly costly and a slow cure. Why would any enrollee, or any physician, opt for more cost and lesser benefit? The cumulative effect of such perverse incentives, whose algebra is created by “free” care under immensely

generous insurance benefits, has been estimated to cost the nation more than \$500 billion a year in unnecessary health care spending.

Based on research findings on the effects of cost sharing incentives, on average each person enrolled in a wraparound FEHBP plan and Medicare Parts A and B costs the Federal government somewhere on the order of 25 percent or more in spending than a person without such “free” care and facing significant cost-sharing, according to CBO estimates. With approximately 1.5 million individuals enrolled in both Medicare and the FEHBP, the Federal government loses as much as \$3 billion a year or more in wastefully increased utilization under the current system. Most of this cost falls on Medicare (which pays first) but half a billion dollars a year or more 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 enroll in Medicare Part B. They calculate, correctly, that they will save substantially in most years by not having to pay two sets of premiums. This trend will accelerate as more and more higher income retirees face the Medicare income-tested Part B premium penalty. Every such decision actually saves the Federal government money by reducing 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. FEHBP plans individually and the program as a whole would see reduced costs if 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 that would not only reverse this trend, but reduce unnecessary spending substantially. Instead of enriching benefits 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, paying half or more and possibly the entire cost. 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 limited to premium subsidies or allowed only to add benefits that are not covered by Medicare, such as vision care, dental care, and hearing aid coverage. That OPM’s longstanding policy of discouraging dental benefits in health plans would be reversed should be of no concern since hundreds of millions of dollars in real savings to both enrollees and the taxpayer would be involved. Alternatively, the dental subsidy could be directed towards paying premiums for OPM’s standalone dental plans.

Viewed from a beneficiary perspective, a better result than the current system would be no-cost Part B coverage, generous hospital, medical, and drug benefits that are identical pre- and post-age 65, and modest additional benefits (such as a dental subsidy) not available pre-Medicare. Take-up would be near 100 percent (why would anyone decline a free benefit?), and almost 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, either using the Medicare Part B benefit or, if plans so chose, receiving regular benefits without network restrictions.

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 HMOs. (At present, one third of employees enroll in HMOs, but most retirees migrate to the “free” care of the

national plans, so that only one tenth of annuitants are enrolled in HMOs.) Even more importantly, it would reduce the risk segmentation problems that plague HMOs such as the Kaiser plans and national plans such as Blue Cross standard option, and let them compete more fairly and evenly with plans that have fewer elderly enrollees, thereby improving the workings of the competitive FEHBP system as a whole.

For reasons lost in history, a quarter century ago the Congress quietly inserted an unprecedented constraint on the FEHBP into the Medicare statute. Under Section 1840 of the Social Security Act, no FEHBP plan is allowed to subsidize the purchase of Part B, unless the funds involved come from (nonexistent) sources other than FEHBP premiums. (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.”) The Federal government is now perhaps the only employer in America that cannot defray the cost of Medicare Part B for its retirees. 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 unnecessary health care utilization.

In 2008 I suggested to the CBO that it take a look at this idea. CBO agreed that my proposal would save the government a good deal of money—approximately \$1 billion a year and \$11 billion over ten years. The CBO analysis of its version of my proposal (not exactly the same as I propose here) can be found as Option 94 in *Budget Options Volume 1: Health Care*, December 2008. CBO estimated that almost all the savings would accrue to Medicare. My own estimate is that the FEHBP would retain about 20 percent of the savings, roughly in line with the proportion of spending that the FEHBP plans pay as secondary insurers.

This reform can be substantially improved by adding prescription drugs to the mix. At present, only GEHA among FEHBP plans offers a concrete incentive to retirees to enroll in the Medicare Part D Prescription Drug benefit. GEHA combines a relatively weak drug benefit in its own plan with a guarantee that if the retiree enrolls in Part D, which pays first, GEHA will pay 50 percent of whatever costs are not covered by the Part D plan. As a practical matter, this means that enrollees choosing this combination of benefits typically pay only token sums for generic drugs, no more than 15 or 20 percent for most name brand drugs (depending on the specifics of the Part D plan’s benefits), and never more than half. For almost all other FEHBP plans, enrollees are told only that “you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage ... however, if you choose to enroll ... your FEHB plan will coordinate benefits with Medicare” (found in brochures on the inside front cover). This namby-pamby language actually discourages dual enrollment, since the plans make no firm benefit commitment.

My present proposal is that FEHBP plans be encouraged or required to offer a benefit similar to GEHA’s, and in addition be required to pay the entire Part D premium, up to \$30 a month, for any enrollee who signs up for any Part D plan. For couples, the subsidy would be doubled. Wherever enrollees live, \$30 a month is enough to pay the entire 2010 Part D premium for one (or usually many more) low cost Part D plans. The effect of this would be to shift about \$1,000 per enrollee of prescription drug costs (net of premium payment) from FEHBP to Medicare. From a government-wide, taxpayer perspective this is essentially a wash. However, assuming a

50 percent take up rate, it means that *the FEHBP would save perhaps a half billion dollars a year in drug spending*. Taken together with the Part B change, and depending on exact design details, the Medicare and FEHBP programs would share roughly equally in the overall savings from improved coordination. Enrollees would often but not always gain, and never lose (they could refuse to enroll in Part D). This reform could be implemented in part without legislation, and in time for the 2011 plan year, if OPM were to require this spring that all plan bids include concrete improvements in prescription drug cost sharing for enrollees who joined Part D.

(A similar payment of the Parts B and D premium could also be offered to age 65 military retirees, with some differences in benefit supplementation reflecting the particular structure of TRICARE for Life. Since current copayments for drugs are very low in that program, retirees would need an additional incentive to enroll in Part D. One option might be government payment of the dental premiums that the program otherwise requires of enrollees, along with payment of the Part D premium, in return for modest Part D supplementation leaving retirees with higher out of pocket costs for drugs than under present arrangements. According to CBO estimates, increasing the enrollee share of drug benefits is vital to increasing substitution that would reduce overall drug costs to the TRICARE program (recall that TRICARE drug spending has quadrupled in recent years, and that CBO estimates show that at least a billion dollars a year is wasted under present cost sharing arrangements). CBO estimates of savings from proposals to introduce modestly higher cost sharing for hospital and physician costs in TRICARE are also in the billions of dollars. But past proposals were “dead on arrival” because there was no quid pro quo for military retirees. Paying the Part B premium offers a very substantial “for sure” monetary benefit to offset modest increases in cost sharing.)

The FEHBP coordination reforms proposed above would advantage enrollees, plans, the FEHBP program as a whole, and taxpayers. All will benefit both employees and retirees in both the short and long run, by holding down unnecessary spending and thereby reducing premium costs for the entire program. I urge this Subcommittee 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, as well as from the FEHBP carriers. I wish you success in crafting useful reforms that would actually succeed in improving the performance and reducing the costs of this vital program. The FEHBP needs genuine reform, not regulatory schemes of doubtful efficacy and great cost, promoted by outside parties whose expertise and vision are both limited, and whose interests do not coincide with those of FEHBP stakeholders.

Sincerely,

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cc: The Honorable Jason Chaffetz, Ranking Member