IMPLEMENTING THE FEHBP DEMONSTRATION PROJECT FOR MILITARY RETIREES: GOOD FAITH EFFORT OR ANOTHER BROKEN PROMISE?

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON
GOVERNMENT REFORM

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IMPLEMENTING THE FEHBP DEMONSTRATION PROJECT FOR MILITARY RETIREES: GOOD FAITH EFFORT OR ANOTHER BROKEN PROMISE?

WEDNESDAY, JUNE 30, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:09 a.m., in room 2203, Rayburn House Office Building, Hon. Joe Scarborough (chairman of the subcommittee) presiding.

Present: Representatives Scarborough, Miller, Cummings, and Norton.

Staff present: George Nesterczuk, staff director; Garry Ewing, counsel; John Cardarelli, clerk; Tania Shand; minority professional staff member; and Earley Green, minority staff assistant.

Mr. SCARBOROUGH. Good morning. I would like to welcome everybody to this hearing before the Civil Service Subcommittee.

Today our subcommittee is going to examine the implementation of the demonstration project established in last year's defense authorization bill to allow Medicare-eligible military retirees and certain others to enroll in the Federal Employees Health Benefits Program. The purpose of this project is to test the FEHBP as an option for providing military retirees and others with high-quality, affordable health benefits.

This is a high priority for me since I represent more military retirees than any other Member of Congress. I have seen first-hand some problems that have plagued TRICARE, the military health care system for military families and some retirees, in my district and throughout the country. I know how hard I had to work to persuade doctors in my district to even join up in the TRICARE system and I know that many of them, even after our initial rounds of hearings, rejoined and then left again.

Military retirees who are eligible for Medicare are particularly ill-served by the current military health care system. The vast majority of them are locked out of TRICARE and the dwindling number of military treatment facilities. They are the only retired Federal employees who are expelled from their employer's health benefits program after a lifetime of dedicated service. Members of Congress are not, nor are retired civilian employees. In my opinion, this is unconscionable.

When I assumed the chairmanship of this subcommittee, I said early on that I hoped one of the my highest priorities would be to improve the health care available to the families of the men and women who serve or have served our Nation under arms. For that reason, this subcommittee will closely monitor the implementation of this demonstration project.

Unfortunately, the actions of DOD and of OPM, the two agencies charged with conducting this project, have raised serious concerns in some people's eyes. As a result of their decisions, many believe that it seems very unlikely that the demonstration project will be as large as the U.S. Congress had first intended. Congress intended that 66,000 military retirees would be able to participate in FEHBP. Whether to save money or for other reasons, DOD and OPM have limited the total population of eligible beneficiaries in the test site to about 69,000.

Few really believe that almost 100 percent of those eligible will alter their current health care arrangements to enroll in a temporary, 3-year program. As a result, we are likely to have a demonstration project that is much smaller than what the U.S. Congress originally expected it would be. The small size of the demonstration project may deprive military retirees of the wide range of choices available to civilian retirees and to Members of Congress. It may drive up the premiums they will have to pay.

As a result of these decisions, the demonstration project may not provide an adequate test of the FEHBP. Unfortunately, many retirees will conclude that, despite their years of sacrifice to serve this country, the government has broken yet another promise to them. I want to pledge to them, as I know other members of this committee want to pledge also, that we will continue to work with other Members, military organizations, and all interested parties to improve the quality of health care available for military families and military retirees. I believe this is going to be the first of many hearings and much effort by this committee to ensure that Congress does not break their promise to the men and women who have served this country so proudly for so many years.

[The prepared statement of Hon. Joe Scarborough follows:]

OPENING STATEMENT
THE HONORABLE JOE SCARBOROUGH
CHAIRMAN
SUBCOMMITTEE ON THE CIVIL SERVICE

Implementing the FEHBP Demonstration Project for Military Retirees: Good Faith Effort or Another Broken Promise?

June 30, 1999

Good morning, and welcome to this hearing before the civil service subcommittee.

Today, the subcommittee will examine the implementation of the demonstration project established in last year's defense authorization bill to allow Medicare-eligible military retirees and certain others to enroll in the Federal Employees Health Benefits Program (FEHB). The purpose of this project is to test the FEHB as an option for providing military retirees and others with high-quality, affordable health benefits.

This is a high priority for me. I represent more military retirees than any other Member of Congress. I have seen first hand the problems that have plagued TRICARE, the military health care system for military families and some retirees, in my district and throughout the country. I know how hard I had to work to persuade doctors in my district to rejoin TRICARE after they had left it in disgust.

Military retirees who are eligible for Medicare are particularly ill-served by the current military health care system. The vast majority of them are locked out of TRICARE and the dwindling number of military treatment facilities. They are the **only** retired federal employees who are expelled from their employer's health benefits program after a lifetime of dedicated service. Members of Congress are not. Nor are retired civilian employees. This is unconscionable.

When I assumed the chairmanship of this subcommittee, I said that one of my highest priorities is to improve the health care available to the families of the men and women who serve, or have served, our nation under arms. For that reason, this subcommittee will closely monitor the implementation of this demonstration project.

Unfortunately, the actions of the Department of Defense (DOD) and the Office of Personnel Management (OPM), the two agencies charged with conducting this project, have raised serious concerns. Perhaps most importantly, it seems very unlikely that the demonstration project will be as large as Congress intended.

Congress intended that 66,000 military retirees would be able to participate in the FEHB. Whether to save money, or for other reasons, DOD has limited the eligible population in the test sites to about 69,000. To meet Congress's intent, almost 100% of those eligibles would have to enroll. That is not a reasonable assumption, especially in a test program where enrollment is temporary and limited to 3 years. As a result, we are likely to have a demonstration project that is far smaller than Congress wanted.

The small size of the demonstration project may deprive military retirees of the wide range of choices available to civilian retirees, and it may drive up the premiums they will have to pay.

As a result of these decisions, the demonstration project may not provide an adequate test of the FEHB. And, unfortunately, many retirees may conclude that despite their years of sacrifice to serve their country, the government has broken another promise to them.

I pledge to them that I will continue to work with other Members, military organizations, and all interested parties to improve the quality of health care available to military families and military retirees.

Mr. SCARBOROUGH. With that, I would like to turn it over to the distinguished ranking member, Elijah Cummings from Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. And I—the last words you echoed, I agree wholeheartedly we cannot—I see so often where promises are made but not kept and I, too, agree that we must keep our promises. I also extend a warm welcome to the witnesses, particularly our congressional colleagues on the first panel who will be testifying before this subcommittee in a few minutes.

Non-active duty military beneficiaries, those over 65, are finding it difficult to get access to military health care system TRICARE. Retirees over 65 can obtain military health care only if space is available and after TRICARE enrollees and other active-duty members and their dependents receive care. In addition, when they are able to access TRICARE, they face high out-of-pocket costs and limited, if any, pharmacy benefits. Military beneficiaries are desperate for a solution to the inadequacies of TRICARE and want to be included in the FEHB Program.

The idea of improving access to health care for military families through the Government Employees Health Benefits Program has been around since 1995, when this subcommittee held its first hearing on this issue. During the 105th Congress, Representatives Moran and Thornberry, along with other Members of Congress, introduced legislation to address some of the difficulties with the military health care system.

Some of the bills would have authorized immediate nationwide access to FEHBP for Medicare-eligible military beneficiaries. Other bills propose establishing an FEHBP demonstration project to better determine government costs and beneficiary interest before deciding whether to implement the option nationwide. This is the approach that was taken in section 721 of the National Defense Act of 1999.

Section 721 of the National Defense Act calls for the Department of Defense and the Office of Personnel Management to implement a FEHBP demonstration project for Medicare-eligible retirees and dependents. The program should cover up to 66,000 military health systems beneficiaries, with DOD contributing to the premiums; 6 to 10 sites must be chosen with no more than 1 site per region. The statute also requires that a separate risk pool be maintained for military beneficiaries. The FEHBP demonstration project is one of three demonstration projects that is or will be on the way to examine different ways of improving the military health care system for military beneficiaries who are over 65.

Finally, we are here to discuss how the statutory requirements of section 721 are to be implemented and how the program will be evaluated once the FEHBP demonstration project is complete.

The demonstration projects that are on the way are temporary and were put in place to help us come up with a permanent solution to the problems facing the military health care system. I look forward to the testimony of today's witnesses and I thank you again, Mr. Chairman, for holding this hearing.

Mr. SCARBOROUGH. Thank you, Mr. Cummings.

Now it is with great honor we can introduce our first panel testifying today. We have Representative Jim Moran of Virginia. We have Resident Commissioner Carlos Romero-Barcelo of Puerto Rico. And we are expecting to have Representative Randy Duke Cunningham to testify before this committee very shortly.

They have all been very interested in this issue for some time. I know I have had numerous military retirees in my district telling me to go talk to Jim Moran, over and over again, about his FEHBP plan and we have done that. I want to thank these gentlemen for what they have done in the past. We certainly look forward to their testimony.

Mr. Moran, would you like to begin?

STATEMENTS OF HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA; HON. CARLOS ROMERO-BARCELO, A REPRESENTATIVE IN CONGRESS FROM PUERTO RICO; AND HON. RANDY "DUKE" CUNNINGHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. MORAN. Fine, Mr. Scarborough. Thank you very much, Mr. Chairman and Ranking Member Cummings, for—Hi, Duke; how are you—for letting us testify at today's hearing on implementing the FEHBP demonstration project for military retirees. And I look forward to reading the testimony of your other witnesses.

As you know, I introduced legislation last Congress which established the Federal Employees Health Benefits Program demonstration project for military retirees. And, with the help of some extraordinarily good original cosponsors, this measure received overwhelming bipartisan support, drawing 292 cosponsors ultimately and illustrating strong interest among all the Members in seeing this demonstration project move forward.

I got involved in this issue 4 years ago as a result of the difficulties faced by many of my constituents in finding access to quality, affordable health care once they retire from the military. And as you say, the same thing was happening within your constituency. I think that was pretty well experienced. I know you do have an extraordinarily large military retiree population, so we are particularly sensitive to it.

We are pleased to see DOD moving forward with the FEHBP demonstration project. But I am concerned that its limited scope and funding will preclude an accurate demonstration of the true effectiveness of the Federal Employees Health Benefits Plan to military retirees. I would encourage this subcommittee to continue to exercise its oversight of the program because we are going to be looking to you to ensure that a full and fair demonstration is conducted.

But the demonstration, I think, was just an attempt to bide time to avoid tough decisions and to save money and I think this feeling may be shared by many of my colleagues. The Congress and the Department of Defense really should be expanding FEHBP now to the larger military retiree population in this country because now is when the TRICARE program is being implemented, now is when military retirees are being rejected from military care at the military treatment facilities around the country, now is when they

need this. And, instead, what we have is a very limited demo project. And it may be so limited it is not going to give us information that is going to be particularly useful. That is why the representatives of so many organizations that have worked so hard on this are present today.

FEHBP, as you so very well know and your chief of staff on this subcommittee has been working on this program for a long time, this is a phenomenally successful health care program, when you consider that it covers almost 9 million participating Federal employees and their families. With 1.3 million military retirees over the age of 65 today and an expectation that we are going to have 1.6 million by 2005, FEHBP is the most viable program for military retirees who no longer have access to the military health care system.

But the problem with other approaches, even Medicare subvention, is that so few military retirees live within a military catchment area. So having Medicare subvention at military hospitals is just not a reasonable option for regular medical for them. The FEHBP is all over the country.

Now I have also cosponsored other related legislation to grant Medicare-eligible military retirees the option of participating in this program. There are a number of approaches. Randy Cunningham—we call you "Duke," I guess—has introduced the Health Care Commitment Act, H.R. 205. This provides health care once military retirees become eligible for Medicare and are prohibited from participating in TRICARE and shut out of medical treatment facilities if they are not willing to be last on the priority list for receiving care.

It just seems as though when people need care the most to then deny it to them is—what is wrong with this picture? And what is wrong is the absence of a program like the FEHBP that is available for all civilian retirees.

You know, when we recruit young men and women to go into the Nation's military, we promise them that they will get health care for life and that it will be quality health care. It may not have been a contract, but there was action as a result of that promise. There was a, if not a written contract, there was certainly consideration given. And I think you could make a strong case that, in fact, within our legal system, it could be considered a contract. There was never any mention that once they had served their country and turned 65, that DOD would ever consider reneging on this promise and turning them away from insurance programs and from military treatment facilities. DOD is the largest Federal employer in the Nation. So to kick its employees out of health insurance programs is an irony that cannot be sustained.

A lot of what I have to say is duplicative. I am not going to get into that any more because I am preaching to the choir. Everybody in this room understands this argument.

But in order to achieve a worthwhile demonstration of the FEHB Program, DOD and the Office of Personnel Management have to ensure that the actual enrollment is as close to 66,000 as possible. I think 66,000 is a minimal figure.

But with the limited scope of sights and, as the chairman said, when it is only for 3 years and there may be some disadvantage

to retirees and then going into subsequent health insurance programs if the DOD decides not to sustain this, there is a disincentive to go in. So I think it is a real stretch to think that we are actually going to get 66,000 people, based upon the way the demo project is constructed right now. I think we are going to need a larger mix of sites to the eight locations that were selected earlier this year. We need more ample information on the demo program provided for military retirees. And we need to incentivize. So that is the second thing I want to say.

The third thing is the Federal funding commitment. Last year's Defense Authorization Bill authorized the sale of assets from the national Defense stockpile. But now the proceeds of these sales, we understand, are not going to be available to fund the demonstration. The Federal Government and the Congress has an obligation to follow through on this project and ensure that it is properly tested. We have to insist that there be adequate offset funding and the fact that DOD has decided that it is not going to use the proceeds of these sales for this purpose, I think it is incumbent upon them to come up with some other offset. That should certainly not be an excuse not to follow through on this demo project.

We authorized it. We are anticipating it. There are hundreds of thousands of people who need it. So I trust that the DOD is going to work with us to ensure that it does go forward.

I addressed Medicare subvention. It works where it is possible, but I think we are only talking about less than half of the population, at best, even with expanded catchment area definitions that possibly take advantage of Medicare subvention. So I think we should have it. It is complementary to what we are talking about. We should proceed with it. But it certainly is not an option to what we are attempting to do in making FEHBP available to everyone.

I have said more than enough and you want to hear from my colleagues. But, again, let me conclude where I started. This is a needed program. I wish we had gone ahead with it without the demo project. It is going to require a great deal of oversight from this subcommittee. And I appreciate your having this hearing. Thank you, Mr. Chairman.

[The prepared statement of Hon. James P. Moran follows:]

Statement of Representative James P. Moran
Before the Subcommittee on Civil Service of the
House Committee on Government Reform
June 30, 1999

Mr. Chairman, I want to thank you and Ranking Member Cummings for allowing me to testify at today's hearing on Implementing the FEHBP Demonstration Project for Military Retirees. I look forward to the testimony of the other witnesses and appreciate your willingness to allow me to submit my statement for the record.

As you know, I introduced legislation in the last Congress which established the Federal Employees Health Benefits Program demonstration project for military retirees. This measure received overwhelming bipartisan support, drawing 292 cosponsors, and illustrated the strong interest among Members in seeing this demonstration project move forward. I got involved in this issue four years ago as a result of the difficulties faced by many of my constituents in finding access to quality, affordable health care once they retired from the military.

Today, I am very pleased to see the Department of Defense is moving forward with the FEHBP demonstration project. However, I am concerned that its limited scope and funding will preclude an accurate demonstration of the true effectiveness of the FEHBP for military retirees. For these reasons, I encourage this Subcommittee to continue to exercise its oversight of this program to ensure that a full and fair demonstration is conducted.

Additionally, I would advocate that Congress and the Department of Defense work to expand this program to the larger military retiree population in this country. I know I am joined by many representatives and organizations here today in supporting the extension of the FEHBP program to more of our nation's military retirees. FEHBP has been an enormously

successful federal health care program that covers 8.7 million participating federal employees and their families. With 1.3 million military retirees over age 65 today and nearly 1.6 million expected by 2005, FEHBP offers a viable program for military retirees who no longer have access to the military health system.

In the past few Congresses I have also sponsored legislation to grant Medicare eligible military retirees the option of participating in the Federal Employees Health Benefits Program. Joined by my friend and colleague Congressman Randy "Duke" Cunningham, I introduced the Health Care Commitment Act, H.R. 205, because I am deeply concerned that military retirees, particularly once they become eligible for Medicare, are being denied access to health care. Medicare-eligible retirees are denied access to and prohibited from participating in TRICARE. They are also effectively shut out of military medical treatment facilities because they are placed last on the priority list for receiving care. In effect, we have created a system where military retirees, once they reach the point in life where they need health care the most, are given the least from their former employer.

We recruit young men and women to serve in our nation's military with a promise that the government will provide them health care for life. While this is not a contract, many men and women enlist with the good faith belief that we will provide for their medical needs when they retire. After these men and women have served their country and turned 65, the Department of Defense reneges on its promises, turns them away from its insurance programs and effectively denies them access to its medical treatment facilities.

The Department of Defense is the only large federal employer in this nation that kicks its retirees out of its health insurance programs. But it does not need to be. Civilian employees in the same Department of Defense, and throughout the government, are given the opportunity to participate in one of the finest health insurance programs in the country. The Federal Employees Health Program is an established health insurance program that enables employees to choose from a range of health insurance packages. Federal

retirees, unlike their counterparts who served in the military, are not dropped from their insurance plans when they turn 65 and are not placed at the bottom or priority lists. Instead they are treated with the respect and dignity that they deserve. My legislation ensures that all federal retirees, whether they served their nation as a member of the armed forces or as a civilian employee, are treated with the same dignity and have an equal opportunity to participate in the Federal Employees Health Benefits Program.

In order to achieve a worthwhile demonstration of the FEHBP program involving military retirees, the Defense Department and the Office of Personnel Management must ensure that enrollment is closer to 66,000 beneficiaries and drawn from a larger mix of sites than the eight locations selected earlier this year. Furthermore, military retirees must be given ample information on the demonstration program and opportunities to enroll in it. If not, this demonstration will be too small in scale to yield enough data to properly analyze and assess the program.

Another issue that must be addressed is the federal funding commitment to this demonstration. Last year's Defense Authorization Act authorized the sale of assets from the National Defense Stockpile. It is my understanding, though, that the proceeds of these sales will not be available to help fund the demonstration. The Federal government has an obligation to follow-through on this project and ensure that it is properly tested. Without a similar structure and incentives as the civilian FEHBP program, the FEHBP demonstration will not offer military retirees the benefits and incentives to participate. I am hopeful that the Department and this Subcommittee can effectively address these issues and move forward with the demonstration as planned.

I introduced the Health Care Commitment Act to ensure that Medicare-eligible military retirees are provided access to quality health care. This legislation simply gives Medicare-eligible retirees the option of joining the FEHBP. It also establishes separate risk pools to ensure that military retirees and current FEHBP beneficiaries do not cross-subsidize one another. This involves only an accounting effort and will not affect the quality of coverage

for either group. If OPM chooses, the risk pools can be merged after 5 years.

It is important to remember that this legislation does not conflict with Medicare subvention. Medicare subvention is a system through which the Department of Defense can bill HCFA for the direct care it provides Medicare-eligible retirees. I support Medicare subvention, but I do not think that Medicare-subvention alone will address the needs of this population. The majority of Medicare-eligible military retirees do not live within the "catchment" areas surrounding a medical treatment facility. In addition, I do not believe Medicare-subvention alone will make available more resources to ensure that all who need care can be accommodated. The Health Care Commitment Act will ensure that every Medicare-eligible retiree is covered. The FEHBP is a nation-wide program with fee for service plans and HMOs available in every market. The Department of Defense can also benefit from this legislation because it has the ability to bill third party insurers for the direct care it provides to covered retirees in medical treatment facilities.

Mr. Chairman, it is not a coincidence that our nation's military organizations have endorsed the Health Care Commitment Act. They recognize that allowing the Medicare-eligible military retirees to join the FEHBP is a fair and efficient means through which we can live up to our prior promises. I hope you will also agree that this approach represents a solution to a serious health care problem and that the demonstration project is a critical first step to providing our nation's military retirees with high-quality, reasonably priced health care. I appreciate your consideration of my testimony and look forward to working with you, Members of the Subcommittee and the Department of Defense to ensure a fair test of the FEHBP demonstration project.

Mr. SCARBOROUGH. I appreciate your testimony and your efforts in this fight. I would like to recognize next—first of all, welcome, Congressman Cunningham and also Congressman Miller, both gentlemen who have fought for fairness for our military retirees since they have been up here. I would like to recognize next for testimony Representative Romero-Barcelo who actually represents one of the sites that was selected in this demonstration project. Welcome to our subcommittee.

Mr. ROMERO-BARCELO. Thank you, Mr. Chairman, Ranking Member Cummings, and Congressman Miller. I very much appreciate the opportunity to be here to testify at this oversight hearing.

As Congress and the Federal Government consider the alternatives to improve access to health and medical services while increasing the effectiveness and the efficiency of these services and striving to contain escalating costs, I believe that it is essential that we assess and determine the impact of the proposals on one of our most vulnerable populations, our military retirees. And these citizens have dedicated a substantial part of their lives in the defense of our Nation and, including those who are also veterans, have selflessly safeguarded American democratic values, often at the risk of their own lives.

We must fulfill our promises to them. It is the right thing to do. And it also happens to be in the best interests of the Nation.

And, in particular, I welcome the opportunity to appear before you today in this hearing to provide a voice for the thousands of military retirees in Puerto Rico, whose health needs have been neglected when compared with their fellow citizens in the 50 States. For instance, in Puerto Rico, it took over 12 years for the Veterans Administration to recognize that the hospital facilities of the Veterans Administration were inadequate, insufficient; and overcrowded. It was 12 years before we finally got the funding. I don't think this ever happened in any other State. We waited that long for the recognition. I think the retirees only have one hospital in Puerto Rico where they can go.

So, I consider Puerto Rico's selection as one of the demonstration sites as a most fortuitous and challenging opportunity. Indeed, I view it as a turning point in the availability of adequate and appropriate health services for this here-to-fore poorly served population.

The demonstration program as proposed would limit the total population of eligibles to the test sites to 66,000, of whom approximately 9,900 reside in Puerto Rico. And I believe that the Puerto Rico site enables the Department of Defense to evaluate issues that have not been considered previously.

The situation for military retirees and their beneficiaries in Puerto Rico is most unusual. It is unbelievably limited by the status of the territory, when viewed in the context of the rights and the benefits of military retirees in any of the 50 States. For instance, in the 50 States, retirees under the level of poverty would be entitled to Medicaid services. In Puerto Rico, we don't have Medicaid. We only get about one-tenth of what we would get if we were treated the same as a State.

Much can be learned from the selection of Puerto Rico as a demonstration site, including access to treatment for individuals in re-

mote locations and providing treatment to military retirees and their beneficiaries with limited English language proficiency.

Hearings in the 104th and 105th Congresses revealed serious deficiencies in the military health care system and it is the responsibility of the Congress to consider and develop alternatives that will improve services, especially in situations similar to those experienced by the retirees at home. Currently, the military retirees in Puerto Rico experience critical barriers to health services that are of grave concern to me. Retirees in the island are more likely to depend on the treatment and services offered at military hospitals, including free prescriptions. Why? Because, as I said before, the military indigent retirees do not have access to Medicaid.

I must point out that the only full-service hospital in Puerto Rico is in Roosevelt Roads Naval Station in Sabana Seca on the eastern coast. So even though military retirees reside at cities throughout Puerto Rico, they must travel to the remote site of Roosevelt Roads to be provided service on a space-available basis.

Travel from San Juan, the capital, to Roosevelt Roads may require anywhere from 1 to 1½ hours, but travel from Mayaguez on the western coast, would require a minimum of 3 to 4 hours of travel. By any standards, these are unacceptable amounts of time in a medical emergency. The remoteness of the location plus the availability of treatment strictly on a space-available basis, impose serious health hazards and an unacceptable risk to patients.

But it is also a challenge to provide medical care to a population that may have limited English language proficiency. The language barrier may limit the availability of enrollment documents and access to appropriate health services, particularly in the case of beneficiaries. I am pleased to note that the Department of Defense is developing materials for distribution in both English and Spanish.

An issue of particular concern is that—and I would like to point out here that some people object to the fact that they have to translate to Spanish. Well, those that served in the military, were never asked what language they spoke before they were asked to risk their lives. And I would also like to mention that, in the time of war, the volunteers have always been more than enough to cover the quotas in Puerto Rico.

An issue of particular concern that I would like to ask the Office of Personnel Management to address is the availability of the same level of benefits for military retirees in Puerto Rico as for retirees in the 50 States. I have been informed that the level of service provided to retirees in the island are not always comparable to retirees elsewhere in the Nation and would appreciate a clarification and detailed information on this issue.

For instance, only TRICARE standard plan is offered in Puerto Rico, whereas military retirees in the rest of the Nation have access to TRICARE Prime and TRICARE Extra.

The demonstration program will only be available to Medicare-eligible military retirees and their beneficiaries. Since there are some issues concerning Federal health programs that apply differently in Puerto Rico, I would also like clarification in terms of the impact of those programs on this demonstration group.

It is important to note that the U.S. citizens of Puerto Rico do not have access to some of the Federal health programs that are

designed to protect the neediest populations. For instance, in Puerto Rico, there is no Federal cost-sharing program under Medicare for eligible low-income individuals. This means that elderly, indigent individuals cannot receive assistance for their Medicare fees and deductibles as elsewhere in the Nation, where they would receive Part B assistance. In addition, Medicaid is, for all practical purposes, nonexistent in Puerto Rico.

I believe that this demonstration program is a step in the right direction and I wish to commend the Department of Defense for the opportunity to incorporate the needs of Puerto Rican-American military retirees and to consider the factors that limit their access to adequate health services. While I cannot estimate the number of retirees and their beneficiaries that will select this plan, I am sure that most will welcome the availability of more plan choices. As with any new program, there are areas of specific concern that must be considered and carefully monitored to ensure the successful implementation of a program of this magnitude.

Mr. Chairman, once again, I thank you for the opportunity to bring my concerns to your attention and consideration. Throughout the century, the American citizens of Puerto Rico have demonstrated their patriotism by upholding American democratic values whenever and wherever it has been necessary in the world and contributing to the national defense and national security concerns. Right now, as a matter of fact, there is one area in the whole nation where the Navy is bombarding with live ammunition close to where people reside and that is right in Puerto Rico at Vieques. No other citizens in the Nation are subjected to that kind of concerns and anxiety.

We recently had one bomb explode. It was off-target and a civilian guard was killed. He was working for the Navy, but he was a civilian. He was killed and three others were wounded.

However, despite this accomplished record of service, they are not receiving the same benefits as the rest of their fellow citizens. And particularly the colleagues with whom they serve. Puerto Rico's selection as one of the demonstration sites is most welcome and I believe that, as a test site, it will provide invaluable information concerning the provision of benefits to military retirees and the conduct of health programs in remote locations.

In addition, the military faces renewed challenges in the recruitment and retention of military personnel and has focused a great deal of resources on recruiting minorities. It is critical that the needs of that diverse force be foremost in Congress' consideration to ensure equality and to ensure that we keep our commitment and fulfill the promises made to all the men and women who serve our Nation. I urge you to remember that Puerto Rico has always responded to our Nation's call. Thank you very much.

[The prepared statement of Hon. Carlos A. Romero-Barcelo follows:]

HON. CARLOS ROMERO-BARCELO TESTIMONY BEFORE THE CIVIL SERVICE SUBCOMMITTEE OF THE COMMITTEE ON GOVERNMENT REFORM

JUNE 30, 1999

Chairman Scarborough, Ranking Member, and all the distinguished members of the Subcommittee on Civil Service, I very much appreciate the opportunity to present testimony at this oversight hearing on **Implementing the Federal Employees Health Benefits Program Demonstration Program for Military Retirees.**

As Congress and the Federal government consider alternatives to improved access to health and medical services while increasing the efficiency and effectiveness of these services and striving to contain escalating costs, I believe that it is essential that we assess and determine the impact of those proposals on one of our most vulnerable populations, our military retirees. These citizens have dedicated part of their lives in the defense of our nation, and in the case of those who are also Veterans, selflessly safeguarding American Democratic values above their own lives. We must fulfill our promises to them. It is the right thing to do and it also happens to be in the best interests of our nation.

In particular, I welcome the opportunity to appear before you today in this

hearing to provide a voice for the thousands of military retirees in Puerto Rico, whose health needs have been neglected when compared with their fellow citizens in the 50 states. I consider Puerto Rico's selection as one of the demonstration sites a most fortuitous and challenging opportunity. Indeed, I view it as a turning point in the availability of adequate and appropriate health services for this heretofore poorly served population. The demonstration program, as proposed, limits the total population of eligibles in the test sites to 66,000 of whom approximately 9,900 or 15 percent reside in Puerto Rico. I believe that the Puerto Rico site enables the Department of Defense to evaluate issues not previously considered.

The situation for military retirees and their beneficiaries in Puerto Rico is most unusual. It is unbelievably limited by the status of the territory, when viewed in the context of the rights and benefits of military retirees in any of the 50 states. However, much can be learned from its selection as a demonstration site, including access to treatment for individuals in remote locations and providing treatment to military retirees with limited English language proficiency.

Hearings in the 104th and 105th Congresses revealed serious deficiencies in the military health care system and it is the responsibility of Congress to consider and develop alternatives that will improve services, especially in situations similar

to those experienced by the retirees in Puerto Rico. Currently, the military retirees in Puerto Rico experience critical barriers to health services that are of grave concern to me. Retirees in the island are more likely to depend on treatment and services offered at military hospitals, including free prescriptions. Why? Because medically indigent retirees do not have access to Medicaid as they do in the 50 states.

I must point out that the only full service military hospital in Puerto Rico is located at Roosevelt Roads Naval Station, in Sabana Seca, on the eastern coast. Thus, even though military retirees reside at cities throughout Puerto Rico, they must travel to the remote site of Roosevelt Roads to be provided service on a space available basis.

Let me provided an example. Travel from San Juan, the capital, to Roosevelt Roads may require one to one and a half hours; but travel from Mayaguez, in the western coast, requires a minimum of three to four hours of travel. By any standards, these are unacceptable amounts of time in a medical emergency. The remoteness of the location plus the availability of treatment strictly on a space available basis, impose serious health hazards and unacceptable risks to patients.

It is also a challenge to provide medical care to a population that may have

limited language proficiency. The language barrier is another issue that may limit the availability of enrollment documents and access to appropriate health services, particularly in the case of beneficiaries. I am pleased to note that the Department of Defense is developing materials for distribution in both English and Spanish.

An issue of particular concern that I would like the Office of Personnel Management to address is the availability of the same level of benefits for military retirees in Puerto Rico as for retirees in the 50 states. I have been informed that the level of services provided to retirees in the island are not always comparable to retirees elsewhere in the nation and would appreciate clarification of this issue.

The program will only be available to Medicare-eligible military retirees and their beneficiaries. There are some issues concerning Federal health programs that apply differently in Puerto Rico and I would like clarification in terms of the impact of those programs on this demonstration group.

It is important to note that the U.S. citizens of Puerto Rico do not have access to some of the Federal health programs that are designed to protect the neediest populations, including Medicaid and that there are major policy differences in how Medicare is implemented in the island.

For instance, in Puerto Rico there is no Federal cost sharing program for Medicare-eligible low income individuals. This means that elderly individuals

cannot receive assistance for their Medicare fees and deductible as elsewhere in the nation. In addition, Medicaid is on all practical purposes nonexistent in Puerto Rico. We receive a block grant that is capped at $171.5 million, with limited annual cost of living increases. If we were treated as a state, we would have about $1.4 billion in Medicaid payments per year. Thus, the American citizens, including our veterans do not have the same access to federal health programs as the citizens and retirees in the 50 states.

I believe this demonstration program is a step in the right direction, and I wish to commend the Department of Defense for the opportunity to incorporate the needs of Puerto Rican-American military retirees and to consider the factors that limit their access to adequate health services. While I cannot estimate the number of retirees and their beneficiaries that will select this plan, I am sure that most will welcome the availability of more plan choices.

As with any new program, there are areas of specific concern that must be considered and carefully monitored to ensure the successful implementation of a program of this magnitude.

Mr. Chairman, once again thank you for the opportunity to bring my concerns to your attention and consideration.

Mr. SCARBOROUGH. Thank you, Representative. I appreciate you being here to help us better understand this issue and certainly do appreciate you stating for the record the sacrifices that the people of Puerto Rico have made in the past. Again, I appreciate your being here and look forward to asking you some questions later.

Mr. ROMERO-BARCELO. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. I would like to now welcome Congressman Randy "Duke" Cunningham, also a champion of military retirees and their dependents. I know this because I hear it from my grandmother who Duke represents in Solana Beach who tells me I need to be more like. [Laughter.]

So I say, thanks, Grandmom.

Mr. CUNNINGHAM. That is funny because my mom tells me I need to be more like you.

Mr. SCARBOROUGH. There you go. There you go. But, anyway, we appreciate you being here along with the other gentlemen who have been fighting for military retirees.

Mr. CUNNINGHAM. Thank you, Mr. Chairman. I would like to associate myself with the comments of my colleagues. I think they are right on the money. And I would also let my colleague, Romero-Barcelo, know that not many people realize when he talks about minding people talking in Spanish, there have been more Medal of Honor winners, Hispanic Medal of Honor winners, for representation and population, than any other group. And, yes, they have paid the price. And their values, their family values, their military patriotism is second-to-none. And I would like my colleague to know that and I would like to put it on the record, as well.

The subvention bill. When I came to Congress in 1990, it was my bill. I didn't write it. My veterans in San Diego had tried 4 years prior to that to get it through Congress and they couldn't. And we finally got that subvention bill through and then we had to even fight to get Balboa Naval Hospital in San Diego listed on the group and it was my bill. Somebody in the Senate wanted to steal the project, but we didn't allow that to happen.

But it is just a band-aid. And one of the terms that you hear from our military over and over again, that there are just band-aids out there. And I saw a movie once called Broken Arrow. Well, it was because of a broken promise. And for those of us that have been in the military that we were promised health care for life after that. Now these aren't people that are setting back not paying taxes, not working. They make the sacrifices and many times the ultimate sacrifice.

But people don't know that about every 2 years, military members are uprooted from their homes. They have to move. They can't make investments. That means that their spouses quite often can't get a job. Their children are ripped out of the schools and it is a very difficult situation for families.

And right now, there is a strong irony that we are having difficulty keeping people in the military. The No. 1 reason is family separation and all of the deployments from Haiti to Somalia to Bosnia to Kosovo to Iraq to all the rest of them. But the No. 2 reason is the erosion of what they consider promises made to them. In 1993, the White House cut both military and veterans COLAs. And, in a bipartisan way, I saw my own party, when we took the

majority, in the Budget Committee, try and cut veterans COLAs. We stopped that in our conference and we got bipartisan support to stop that, thank goodness.

But those kinds of things, our military that make all these sacrifices look back and that is why we are only keeping 23 percent of our enlisted, only 33 percent of our pilots. Our military experience, our quality of personnel is eroding, our equipment is being degraded. And, at the same time, while they are overseas, they are seeing their families not receive the health care that they were promised in active duty.

And then when they get out—we are losing, every year, great numbers of World War II veterans. They are dying. We are talking to people that are between 70 and 90 years old. And their life expectancy in the last few years, they want some health care above 65 years of age.

There are a lot of military brats that pass on, too. My wife is one of them. Her dad is retired Navy. But, usually, when those sergeants, when those enlisted and officers get out, they talk to their children about how good the benefits are in the service. That while they won't ever be rich, at least they can serve their country well and when they get out, the government is going to honor their pledge. That hasn't been the case.

For example, General Krulack is retiring today as commandant of the Marine Corps. He gets out at 65. Here is a guy that has been through war. Look at his chest, at the sacrifice that he has made. And, yet, General Krulack has served 30 years in the U.S. Marine Corps. A secretary in his office that works with him at 65 gets FEHBP. He does not. There is something wrong with that equation in the fact that, after you make all these sacrifices, that a civilian Federal employee or they don't get the same benefits that you and I do here in Congress. And that is wrong.

And Mr. Moran and Mr. J.C. Watts, myself, Mr. Romero-Barcelo have tried to sponsor a bill to make a level playing field for our military veterans in this. And it is something we feel very passionate about. I think it is very important to have a balanced budget. Most of us signed an agreement in 1997. The President signed it. And to stay and not break those agreements is important. But when we are moving money around in allocations, the one area that we ought to sacrifice for is for our veterans. And, down the line, by having a balanced budget, we are going to get them more money by reducing the debt, so we don't have to pay $1 billion a day on the national debt.

So, two important factors is to stay within a balanced budget but, at the same time, make those tough choices in the priorities. And those should be our veterans. Thank you.

Mr. SCARBOROUGH. Well, I appreciate it and certainly identify myself with your remarks also and everybody on the panel's remarks. I have been told the story before that my grandfather, who has since passed away, was a member of that World War II generation that you were talking about and after serving this country for 30 years and serving in World War II and the Korean War, he died a very bitter man toward his government whom he had given his whole life to, because of broken promises.

Mr. CUNNINGHAM. I would like to submit this for the record, my complete statement.

Mr. SCARBOROUGH. Without objection. I would like to have that.

Let me recognize Dan Miller. Any comments or questions?

Mr. MILLER. The only comment is we are preaching to the choir with our group. I am just interested to hear some of the other comments. And so I am just glad you are having the hearing. Thank you for having it.

Mr. SCARBOROUGH. Great. Appreciate your being here. Mr. Cummings, do you have any questions?

Mr. CUMMINGS. No, I don't have any questions, but I want to thank you all for your testimony and certainly we are all very, very sensitive to this issue. And I just hope that we can—I always say that we really have to put a face on policy and I think sometimes what happens is up on the Hill, we don't put the faces, sometimes, with the policy. And I think you all helped to bring that to light and we really do appreciate it. And so we will hear from these other witnesses and, hopefully, they will be able to shed additional light. Thank you very much.

Mr. SCARBOROUGH. Thank you. Let me ask one or two questions and if other Members have any followup, feel free to do it. Congressman Cunningham, let me ask you, what do you think the most important thing Congress could do right now to improve this demonstration project so when it is over we actually, in Congress, have a better understanding of what we have done and whether it is going to work in an expanded situation or not?

Mr. CUNNINGHAM. Well, many of us, when the demonstration project came out, said that the number of 66,000 is not enough. We said it has been interpreted so that you are not even filling the quotas that you have and that the numbers that you have will offset an unrealistic cost because those are the people that are in dire need of it and they are not living long and they need, you know, advanced medical care.

The best thing we could do is to put this across the board just like, you know, civilian Federal employees do. You know it has been very difficult to get this through. Mr. Moran and Mr. Barcelo and myself and I think over 260-some cosponsors criticized the project when it first came out, realizing that it was just a band-aid. And I think we need full implementation. I don't know if the panel agrees. And you are going to find cost savings in it because you are not going to have these people—just like where we are trying to give pharmaceuticals to Medicare recipients, which we support, those people that need it.

I think the only way to really enhance the project is to have full implementation of the program and either support Mr. Moran's bill or mine. We are both cosponsors of each other's bills. Because they add, I think, the best bang for the dollar for military active duty and retired personnel. But I think it is a little unrealistic what we have set up to make it work and I think the cost is going to come out high because of the way that it was set up.

Mr. SCARBOROUGH. Representative Romero-Barcelo, you had indicated before that you wanted clarification of the impact of other Federal health programs on the demonstration project. Can you expand on that about what issues you think need to be clarified as

we go through this project? Also, have you approached DOD or OPM to get answers?

Mr. ROMERO-BARCELO. No, I have not yet approached the DOD or OPM. What I think about is that, in Puerto Rico, I mentioned in my testimony, when the veterans or the retirees run into hard times and their pension is not enough and they are on the poverty line. They do not have access to the same health programs that they have in the rest of the Nation. For instance, as I mentioned, Medicaid. In Puerto Rico, we only get about $171 million in Medicaid. If we were to have the same formula, it would be about $1.4 billion.

Mr. SCARBOROUGH. You get $171 million in Medicaid, and what is your population?

Mr. ROMERO-BARCELO. 3.8 million.

Mr. SCARBOROUGH. OK, thanks.

Mr. ROMERO-BARCELO. What we would be getting would be about $1.4 billion. That means that the people, all of the veterans, any retiree under the poverty quideline does not have access to Medicaid because it is nonexistent. The State government gives services, but it cannot give services to the same extent as Medicaid because we lack the funding.

An example, for instance, this is a simple case, diabetes. Diabetes coverage under Medicaid, you get the equipment and the lancets and the strips for taking the blood samples. And, at home, that is not available. If you are diabetic, here you have access to podiatric services that are not available in their programs. A lot of the things that come with the Medicaid and are available, because of the funding are not available in the health care programs in Puerto Rico.

So how does that impact—all of that—the same people who serve their Nation the same way with the same loyalty and now they are retired and they have problems. Their families have problems. You have veterans whose children are not covered by any health care. So those are the situations which I think should also be analyzed at this time.

And problems with access, at times, that has been solved in the veterans hospital. I don't know, I have to find out, how that has been solved in the Naval Hospital at Roosevelt Roads. One time they had problems because of the language and because of the availability of the materials that were printed. Now the veteran's hospital has had all the materials for quite a few years now printed in both languages, but I am not so sure about the hospital being at one end of the island, the naval hospital. Those are the issues, I think, that are there and many others similar to those.

Mr. SCARBOROUGH. OK. Thanks. Anybody else? Any other followup questions?

Mr. CUMMINGS. Yes. Thank you. Representative Barcelo, let me ask you this. Is the FEHB Program—does it meet the needs of the civilian population in Puerto Rico now?

Mr. ROMERO-BARCELO. No. No. It is not, because of the lack of access. It is too far away. I mean, because you have some people who live in the west coast of Puerto Rico, as I said, it takes 3 or 4 hours because of transportation and everything else so they don't take advantage of it. They can't take advantage of it.

Mr. CUMMINGS. Do you expect the 9,000 Medicare-eligible participants to enroll in the demonstration?

Mr. ROMERO-BARCELO. I think there will probably be many more than that will try to enroll, if the program gets enough publicity. I am going to help it as much as I can in giving it enough publicity, but I don't know yet what the plans are for the publicity of the program.

Mr. CUMMINGS. You know, Representative Cunningham, Mr. Moran raised a very interesting issue when you said if you go through the demonstration project and it doesn't work, then you leave these people hanging. I mean, they have gotten used to certain things and then are sort of out there. And I guess what happens—and you all have been around here a little longer than I have, but I assume that what happens in these demonstration projects is that there is a presumption that they will be successful. I guess. And then—well, what happens when they are not?

Mr. CUNNINGHAM. Well, that is the reason many of us criticized just making it a pilot, that we want a full implementation. There are plans if it does fail, for those individuals on that particular plan to go back. But the problem is that we have closed or degraded over 75—just in the United States—military treatment centers. And so when you say go back, go back to what when there is already a substandard system for them and then they go back.

We are going to make this work, one way or another. There isn't any turning around. But what we are asking for is a more realistic evaluation and not a limit to the project like it is because of the inflated costs that will come out of it and the lack of enrollees.

What we are looking for is competition. Whether it is Medicare, whether it is IRAs, whether it is savings accounts, whether it is Medi-plus, whatever, you know, the things have. It is a competition and even TRICARE, someone is not eligible when they are over 65, so this system has got to work and we are going to make it work, but we would like a more realistic set-up to start with. It is like in a football game. And if you go out there and you know the referee is all pulling for the other side, you are kind of hesitant and say, we are going to win this game regardless, but it is tough. And we are asking just for a fair shake and I think that is what this committee can give us, Mr. Cummings.

Mr. CUMMINGS. Thank you very much.

Mr. SCARBOROUGH. Thanks a lot. I appreciate it, gentlemen. I would like to now call our second panel. We have four distinguished witnesses. We have Sydney Hickey of the National Military Families Association; Charles Partridge of the National Association of Uniformed Services; and Kristen Pugh of the Retired Enlisted Association. These three have been forceful advocates for this demonstration project and were instrumental in building support for its enactment.

Our fourth witness is Stephen Gammarino. Mr. Gammarino is a senior vice president for the Federal Employees Program and the Integrated Health Resources of Blue Cross and Blue Shield Association, who is, of course, the largest carrier in the FEHBP. I would like to welcome all four of you here. Why don't we start on our left by recognizing Ms. Hickey.

STATEMENTS OF SYDNEY T. HICKEY, ASSOCIATE DIRECTOR, GOVERNMENT RELATIONS, NATIONAL MILITARY FAMILIES ASSOCIATION; CHARLES C. PARTRIDGE, COL., U.S. ARMY (RETIRED), LEGISLATIVE COUNSEL, NATIONAL ASSOCIATION OF UNIFORMED SERVICES; KRISTEN L. PUGH, DEPUTY LEGISLATIVE DIRECTOR, THE RETIRED ENLISTED ASSOCIATION; AND STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, FEDERAL EMPLOYEE PROGRAM, BLUE CROSS BLUE SHIELD ASSOCIATION

Ms. HICKEY. Thank you very much, Mr. Chairman. Mr. Chairman and distinguished members of the subcommittee, the National Military Family Association is most grateful for your continued strong interest in providing quality health care to military beneficiaries. We are particularly appreciative of the subcommittee's leadership in examining the progress of the congressionally mandated FEHBP demonstration program.

As this subcommittee is well aware, NMFA would prefer that the FEHBP option be offered to all military families and retirees. Short of that, we firmly believe that at least the Medicare-eligible military beneficiaries, those who have been left out of TRICARE, the DOD health care program, should be offered this opportunity. Nonetheless, we have strongly supported the FEHBP demonstration because it was the only act in town.

The purpose of this demonstration is to test the extent to which Medicare-eligible military beneficiaries would participate in the FEHBP and, therefore, the potential cost to the Department of Defense by extending the option to all such beneficiaries. However, as implementation plans for the demonstration have emerged, NMFA has found cause for great concern. First, even though Congress authorized and funded 66,000 enrollees, DOD limited the selection to only 66,000 eligibles. Using the subvention demonstration as an enrollment model, probably less than 20,000 of the eligible population will enroll.

Second, the bingo drum method of choosing sites resulted in the selection of one site that has an FEHBP enrollment pattern significantly different than other areas of the country. The sole demonstration site has no military hospital, only a military clinic and, by far, the fewest number of eligible beneficiaries. Neither of these sites will be particularly useful in determining potential enrollment patterns when the program is offered worldwide.

Third, if the Office of Personnel Management requires a separate reserve fund for the demonstration, premiums for the Federal military beneficiaries may be significantly higher than those for Federal civilians. If such is the case, this will not be a test of enrollment in the FEHBP, but simply a test of enrollment in plans offered by some of the same carriers that participate in FEHBP.

Finally, NMFA strongly believes that a significant education effort must be made with Medicare-eligible military beneficiaries and others who are able to participate in the plan. At the present moment, DOD does not plan on publicizing even the names of the carriers, much less the rates, until the end of October. This short fuse approach for those who will not only have to decide whether to participate in the plan, but further choose among available plans seems extremely short-sighted.

While NMFA remains firmly committed to implementing the demonstration program this fall, we believe certain issues must be addressed. To overcome the extremely small number of expected enrollees and to more accurately test the FEHBP option, NMFA strongly urges the addition of other geographic areas, if not this year, then at least in the open enrollment season of 2000. In order to provide a true test of interest of Medicare-eligible military beneficiaries in the FEHBP, premiums must be kept in line with those of Federal civilians. DOD should accelerate its timetable for providing information and expend at least as much effort on marketing this program as it did for the subvention demonstration.

Many military associations and Members of Congress have been more than willing to significantly expand the numbers of those who can enroll in FEHBP. Many feel strongly that this country owes its most elderly and vulnerable military population some form of employer-provided health care. DOD wanted a more limited test. DOD, therefore, should bend over backward to ensure that the test is as fair and representative a demonstration as is possible. Thank you, Mr. Chairman.

[The prepared statement of Ms. Hickey follows:]

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Statement of

Sydney T. Hickey
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The National Military Family Association

Before the

CIVIL SERVICE SUBCOMMITTEE
of the
COMMITTEE ON GOVERNMENT REFORM

of the

UNITED STATES HOUSE OF REPRESENTATIVES

June 30, 1999

Not for Publication
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the Committee

The National Military Family Association (NMFA) is the only national organization whose sole focus is the military family and whose goal is to influence the development and implementation of policies which will improve the lives of those family members. Our mission is to serve the families of the Seven Uniformed Services through education, information and advocacy.

Founded in 1969 as the Military Wives Association, NMFA is a non-profit 501(c)(3) primarily volunteer organization. NMFA today represents the interests of family members and the active duty, reserve components and retired personnel of the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

NMFA Representatives in military communities worldwide provide a direct link between military families and NMFA staff in the nation's capital. Representatives are the "eyes and ears" of NMFA, bringing shared local concerns to national attention.

NMFA receives no federal grants and has no federal contracts.

NMFA has been the recipient of the following awards:

Defense Commissary Agency Award for Outstanding Support as Customer Advocates (1993)
Department of the Army Commander Award for Public Service (1988)
Association of the United States Army Citation for Exceptional Service in Support of National Defense (1988)
Military Impacted Schools Association "Champion for Children" award (1998)

Various members of NMFA's staff have also received personal awards for their support of military families.

NMFA's web site is located at http://www.nmfa.org.

SYDNEY TALLY HICKEY
Associate Director, Government Relations Department

As the spouse of a retired Naval officer and an Air Force daughter, Mrs. Hickey has been a military family member for most of her life. She attended Florida State University and was graduated from Johns Hopkins University in 1961 with a B.S. in Nursing. She pursued her chosen specialty of Public Health Nursing in the states of Washington and Florida - and several in between. "Retiring" from remunerated work on the birth of her first daughter, she became a full time wife and mother and part time volunteer.

Her volunteer positions included: Navy Relief interviewer, teaching assistant, Brownie and Girl Scout Leader, Red Cross pediatric nurse, Commissary, Exchange and Hospital Board member, President of four Naval Officers' Wives' Clubs. She continues her commitment to volunteer activities as a member of the Ecumenical Commission of the Episcopal Diocese of Virginia.

In 1983 she joined the Government Relations Staff of the National Military Family Association and served as the Director of the Department from 1987 to 1990. On January 1, 1990, she was competitively selected to become the Association's first paid professional staff member and currently serves as Associate Director, Government Relations. Mrs. Hickey supervises the preparation and delivery of the Association's dozen or so yearly Congressional testimonies, and travels extensively promoting the Association's mission of educating military family members about their rights and benefits.

The Military Chaplains Association of the United States of America selected Mrs. Hickey as the recipient of their 1992 National Citizenship Award. The University of Central Florida presented Mrs. Hickey with their 1993 Defense Transition Services Award for support to military families in transition. In 1998 Mrs. Hickey was presented the "Champion for Children" award by the Military Impacted Schools Association.

Mister Chairman and distinguished members of the Subcommittee, the National Military Family Association (NMFA) is most grateful for your continued strong interest in providing quality health care to military beneficiaries. NMFA is also very appreciative of this opportunity to express its views on the subject.

NMFA's Health Care Proposal

Background

As this Subcommittee is aware, in 1992 NMFA proposed what we believed then, and continue to believe today, was a fair and equitable solution to the health care dilemma facing both military beneficiaries and the Department of Defense (DoD). The proposal was the result of several years of research into alternatives to the escalating problems military beneficiaries were facing. The advent of the all volunteer force was producing a "married with children" force, and military retirees, along with their civilian peers, were living longer. The number of eligible beneficiaries was overwhelming the direct military care system, and the civilian alternative called CHAMPUS was costly both to the beneficiary and to the government. In addition, beneficiaries and providers often faced a bureaucratic nightmare attempting to get claims paid under CHAMPUS.

In an attempt to manage access to the direct military system, military hospitals and clinics instituted ingenious controls through the appointment system. For instance, gynecological appointments could only be made on the third Thursday of the month for the following month. When all appointments had been filled, a beneficiary had to wait for the third Thursday of the following month to attempt to gain access. Mothers often spent entire nights in military hospital emergency rooms in order to get care for their sick children, because they could not get appointments during regular clinic hours.

The drawdown of active forces and Base Realignment and Closure (BRAC) actions further exacerbated the access problem as military hospitals closed and the number of uniformed military medical professionals declined. NMFA believed it was imperative to

find a program within the civilian sector that could provide a guaranteed health benefit for military beneficiaries, as an augmentation to the direct military care system. We were aware that costs to the government had to be considered along with our primary focus of finding a program that met the needs of military beneficiaries. We looked for a program that did not include ingenious ways to control access, that did not include constant claims hassles, and one that was both affordable for military beneficiaries and offered them choice.

Suggested Solution

It appeared to NMFA that such a program already existed in the Federal Employees Health Benefits Program (FEHBP). The program had small government overhead costs, was available worldwide, continued to cover beneficiaries when they retired, offered a choice of plans and the opportunity to change plans once a year.

NMFA also supported a robust military health care system: a system that provided for the health care and therefore readiness needs of the active force; and a system that offered both the Graduate Medical Education (GME) and the skill training necessary to care for the force in peacetime and when servicemembers went in harms way. We envisioned that this system would concentrate military health care professionals primarily in military medical centers. We recognized that some military community hospitals would also continue to exist when local civilian providers were unable to provide the needed care within acceptable time and distance standards. We believed a strong overseas presence was required as long as families were stationed in those areas, and therefore the system needed to provide an adequate rotation basis for military medical professionals.

Every study of married military personnel has shown that assured access to affordable quality health care for their families was a necessity for their peace of mind and therefore to readiness. NMFA believed much of this care could be provided in military facilities, but that access to the FEHBP was needed in order to provide a benefit for all

beneficiaries and to offer choice. NMFA suggested using the same government subsidy provided federal civilian employees and retirees with one exception. Since free or nearly free health care is touted as an employee benefit for both the member and the family, either a pay raise to cover the costs of FEHBP premiums had to be instituted or some other mechanism found to prevent what would otherwise have been a significant pay cut for the active force. NMFA suggested a Health Care Allowance, patterned after the Housing Allowance. Such an allowance would not increase the tax liability of servicemembers nor would it increase DoD's liability for retired pay, as would an increase in active duty pay. NMFA believed the allowance should be enough to cover the premiums of a moderate Health Maintenance Organization (HMO) within the FEHBP. If a member's family chose to use the direct military health care system, the allowance would be forfeited, just as a member does not receive a Housing Allowance when living in government quarters. On the other hand, if the member's family chose a more expensive FEHBP plan, the additional premium costs would have to be absorbed by the family.

NMFA was aware that good arguments could be made for continuing such a subsidy into retirement, based on the promise of free lifetime health care. However, the facts seemed to indicate that such a promise, along with the implied promise of a 20-year career and retirement if your work was satisfactory, both became casualties of winning the Cold War. In addition, our mail indicated that the majority of women in military families – those normally responsible for the family's health care decisions - were interested in choice, and guaranteed access to care, and they were willing to absorb some increased costs.

NMFA believed it was time to view the health care benefit as a personnel cost, a cost of doing business, just as it is considered in the civilian sector. We believed this view would easily translate into DoD providing the same benefit for its military employees and retirees as it did for its civilian employees and retirees.

The Birth of Tricare

DoD did not find our proposal to its liking and almost none of our brother military associations supported it. As a result Tricare was born. Tricare is a system of military direct care and managed care support contracts run by civilian contractors. Under Tricare a three fold benefit is supposedly offered: an HMO-like entity called Tricare Prime; a modified fee for service option called Tricare Standard; and Tricare Extra which offers some minimal savings in comparison to Standard. However, the less expensive Tricare Prime is not offered in many locations, and restrictions on where care can be received often leaves those in the more expensive Tricare Standard option with the same choices as those enrolled in the HMO. Tricare implementation began on the West Coast of the United States in early 1995. The last Tricare Regions started service in the early summer of 1998.

Problems

As each Tricare contract was implemented many of the same problems were repeated. Even the most successful Regions continue to have significant difficulties as providers drop out of the program and claims difficulties continue. There is no doubt that Tricare has increased access for many families and retirees who live near a military hospital. There is also no doubt that:

- services covered by one contractor appear not to be covered services under another
- the "rules of the road" change significantly from one contract area to another
- knowledge of the programs benefits, cost structure and rules vary significantly among military health care professionals and contractor personnel

The apparent differences in coverage and rules, the lack of accurate information, and claims problems have created an environment where few will praise Tricare.

However, the most egregious problem with Tricare was that it left out the oldest and probably the sickest military beneficiary population, the over 64 Medicare eligibles. These beneficiaries, many of whom had already lost their military hospital due to BRAC or downsizing, now had limited access to care even if they lived near a military facility! Some military hospitals made valiant efforts to provide care for these elderly beneficiaries by "empanelling" them to clinics and providers. Others have had to close certain specialty clinics to the Medicare eligibles or, at best, put these beneficiaries at the end of the line for access. Since the Medicare eligible military beneficiary is unable to enroll in Tricare Prime, there is no guarantee that care provided today in the military hospital will be available tomorrow or the next month or the next year. Often these beneficiaries are provided access depending on the type of health care they need. If their need matches the need of the military facility for GME or skill training, they may be granted access. If the needs do not match they may be invited to use their Medicare benefit downtown.

Medicare Subvention

DoD recognized early on that it needed at least some of the Medicare eligible population as patients for both GME and skill training. Some within DoD also felt uncomfortable about designing a plan that essentially left this group with little if any guaranteed access to their promised "free lifetime health care." In order to both address these concerns and to do so in an affordable manner, DoD turned to what is called Subvention. Subvention is when Medicare, or the Heath Care Financing Administration (HCFA), reimburses DoD a defined amount for the Medicare benefits DoD provides to the dual Medicare/military eligible beneficiary. After several years of intense negotiations with both HCFA and Congress, a demonstration program of Subvention, now called Tricare Senior Prime was

enacted. Ten DoD facilities are participating in the three-year demonstration program: Naval Medical Center, San Diego, CA; Fort Carson and the Air Force Academy, Colorado Springs, CO; Dover AFB, Dover, DE; Keesler AFB, Biloxi, MS; Brooke Army Medical Center and Wilford Hall Medical Center, San Antonio, TX; Sheppard AFB, Wichita Falls, TX; Ft. Sill, Lawton, OK; and Madigan Army Medical Center Ft. Lewis, WA. The first of these came on line in the late summer of 1988. And the last commenced services in January of 1999.

Some indications are already surfacing that the current program will not produce the financial bonanza DoD anticipated. All of the demonstration areas must first meet their prior level of effort before reimbursement can be received and retained; the level of reimbursement is less than that afforded "Medicare at risk HMOs" or "Medicare + Choice" plans; and many of the demonstration sites have yet to reach their capacity for enrollment as determined by DoD. The General Accounting Office (GAO) in its 5/28/99 report to Congress stated: "Portions of DoD's baseline costs may be understated, which could lead to Medicare overpayments if not adjusted." GAO was concerned that such understatement of costs inadequately reflected the true prior level of effort. The GAO report also stated: "DoD managers do not have sufficiently accurate or timely data to know whether Medicare capitated payments will cover DoD's costs to provide the full range of health care to beneficiaries or to determine whether it is more cost-effective to deliver care in DoD facilities or purchase it from network providers." It remains to be seen if DoD will realize any significant funds from Subvention.

The Associations Mobilize

The advent of Tricare and the "lock out" of the over age 64 Medicare eligibles, mobilized the military associations. The Military Coalition (TMC), the youngest, but most proactive of the various alliances of military associations, undertook a study in 1995, "Coalition's Health Alternative Reform Task Force" or CHART. CHART focused primarily on the dual Medicare/military eligible beneficiary. CHART found that the five

biggest civilian sector employers all provided relatively generous health care benefit plans to their Medicare eligible retirees. CHART looked at a variety of proposals including worldwide prescription coverage, Tricare as a second payer to Medicare, Subvention and the FEHBP. CHART concluded that while Subvention was potentially a "win-win" proposal for both beneficiaries and DoD, even full implementation would not cover the majority of the Medicare eligible military beneficiaries. Too many retirees no longer resided close enough to a full service military hospital to be able to access care under Subvention. FEHBP offered coverage for all such beneficiaries, with more benefits (primarily prescription coverage) and less beneficiary out of pocket expense than the more popular Medigap insurance plans. FEHBP was offered world wide, so the Medicare eligible military beneficiaries overseas would be covered. FEHBP has no preexisting condition prohibitions, offers a variety of plan choices, and an annual opportunity to change plans. Moreover, the plan was offered to all OTHER federal retirees.

CHART acknowledged that in supporting an FEHBP option for Medicare eligible military beneficiaries it was abrogating The Military Coalition's previous support of the "free health care for life" promise. Our brother associations had finally come to realize that the promise was not going to be, and could not be, kept. In the fall of 1995 CHART made its recommendations and The Military Coalition voted to support both Subvention and the FEHBP option for Medicare eligible military beneficiaries.

DoD's interest remained with the Subvention option, and it actually opposed the FEHBP initiative. TMC initially devoted the majority of its efforts to supporting DoD's Subvention proposal. When Subvention became a reality, TMC turned its energies to the final piece needed to provide an employer provided benefit to all Medicare eligible military beneficiaries, the FEHBP option. Despite current rhetoric, it took strong congressional support to overcome DoD's reluctance to participate in an FEHBP demonstration project. DoD's abiding concern was that offering FEHBP to Medicare eligible military beneficiaries would produce exorbitant costs to the Department. TMC

consistently questioned the costs DoD cited, as TMC did not believe that enrollment in the FEHBP would reach the high levels envisioned by DoD.

The FEHBP Demonstration Project

The demonstration project was to test the potential level of enrollment in the FEHBP of Medicare eligible military beneficiaries and hence the projected costs to DoD. The legislation, finally signed into law on October 17, 1998, provided for a three-year demonstration to commence with the fall enrollment period of FEHBP in 1999. Up to 10 sites could be selected with at least one in a Medicare Subvention site; one in a large catchment area of a military hospital; one in a small catchment area; one in a metropolitan area without a military hospital; one in a rural area without a military hospital; and only one site could be chosen in each Tricare Region. The funding level and the language of the law called for 66,000 enrollees in the program. Unlike the Subvention demonstration, which offers continuous enrollment up to a defined capacity, and "aging in" for Tricare Prime enrollees, the FEHBP demonstration has only one window of opportunity for enrollment. TMC was aware that language included in the provision required a separate risk pool for rating purposes, but were assured by congressional staff that nothing in the separate risk pool language prevented premiums similar to those offered federal civilian retirees.

A viable test?

Without regard to the demographics of particular areas, or to unique FEHBP enrollment patterns, DoD separated the country into areas to meet the requirements of the law. Since only one demonstration project could be carried out in a given Tricare Region, once a site had been selected in that Region, all others were no longer eligible for selection. The sites were then blindly drawn from a bingo drum. This process resulted in the least populous and most unique Subvention site to be selected, Dover AFB, DE. Dover's eligible population is only 3,900 and unlike the other Subvention sites which have full

service military hospitals, Dover AFB only has a clinic. Puerto Rico was chosen as one of the sites within a military hospital's catchment area. However, Puerto Rico's FEHBP enrollment pattern is unique when compared to other areas of the country. Ft. Knox, KY; Greensboro/Winston-Salem/High Point, NC; Dallas, TX; Camp Pendleton, CA; New Orleans, LA and Humboldt County, CA; were the other sites chosen.

In perhaps the most bizarre restriction, DoD limited the number of beneficiaries to a total ELIGIBLE population of 66,000. In order to reach the enrollment population as stated in law, all eligibles in each of the sites would have to choose to participate! Using the Subvention sites as a model, it would be difficult to envision that more than a third of those eligible would choose to enroll. Enrollment at several of the Subvention sites is still not at capacity, and several areas have done extensive marketing to increase participation. Since enrollment in Subvention can be continuous up to stated capacity, retirees who initially decided not to participate in Subvention, have the opportunity to change their minds. The FEHBP demonstration provides only one opportunity for enrollment, the open season of 1999.

NMFA and TMC became even more alarmed when rumors began floating that the Office of Personnel Management believed the legislative language requiring a separate risk pool also required the FEHBP carriers to set aside a separate reserve fund. Because DoD had so severely limited the number of possible enrollees, some of the smaller regional FEHBP carriers would have to charge exorbitant premiums simply to establish the separate reserve fund. Even national plans might have to significantly increase premiums to meet this requirement. The premiums would be higher not only for beneficiaries but also for DoD. NMFA can't help but wonder if foreknowledge of this "glitch" – though not shared by DoD with TMC – was the rationale for DoD's limiting the number of those who would participate in the program.

Where are we now?

Four months before the beginning of the FEHBP open enrollment season we have a demonstration program that includes:

• the Subvention site least likely to provide definitive information on a military retiree's preference

• a large military catchment area with an FEHBP enrollment pattern unlike that of any other area of the country

• a reduced pool of eligibles, with an enrollment anticipated to be no more than a third of what Congress allowed

• the possibility of a premium level which would discourage any but the most seriously ill from participating

When one remembers that the purpose of this demonstration is to ascertain the level of interest of Medicare eligible military beneficiaries in enrolling in the FEHBP and therefore the cost to DoD, one could be forgiven for wondering if there will be any validity to the test!

NMFA fully understands that the choice of sites and the limit on the number of eligibles can probably not be changed at this point, if the demonstration is to begin with services starting January 1, 2000. However, we believe that expanding enrollment to the 66,000 number is of extreme importance to a viable test. We believe such an expansion should be mandated in the second year of the demonstration program.

Our greatest concern is that significantly higher premiums will doom the test. Indeed, without premiums nearly the same as those paid by federal civilian retirees, the

demonstration program would no longer be a test of FEHBP. It would simply be a test of a program offered by some of the same carriers that offer plans within the FEHBP.

The Imperative

NMFA believes it imperative that the demonstration program begin with the open enrollment season in the fall of 1999. We believe premiums for the demonstration program must be almost identical to those offered federal civilian retirees. We believe that the current recruiting and retention problems of the Services can be laid, at least to some extent, to the plight of the Medicare eligible military beneficiaries. If the country cannot keep the promises – or at least some form of the promises – made to the veterans of three wars, how can it expect current and future military families to have the high level of dedication needed to endure the sacrifices of military life including sending their military member in harms way? Trust must be a two way street. The country must be able to trust that military members will respond to a call to arms, and military members and their families must trust that their country will keep its promises.

NMFA is extremely grateful to this Subcommittee for being willing in both the 104th and the 105th Congress to publicly recognize the shortcomings of the present military health care system and to explore the possibilities of an FEHBP alternative. NMFA would prefer that the FEHBP option be extended to all active duty families and to all retirees and their families and not just to Medicare eligible military beneficiaries. We continue to believe that such an option is the most prudent, cost effective and equitable way to provide a health care benefit for the uniformed employees and retirees of the federal government.

However, despite what we would prefer, we are cognizant of the immediate imperative to institute some employer provided benefit to the most vulnerable of the military population, the Medicare eligibles. Therefore, we are most appreciative for the

leadership of this Subcommittee in examining the progress of the Congressionally mandated FEHBP demonstration program.

In closing I would share with the Subcommittee an event that happened to me three years ago. I had just completed a presentation at a military installation on the West Coast. During the presentation and afterwards in the question and answer session, the subject of health care for Medicare eligible military beneficiaries had been discussed at length. Several people came up to me with further questions after the formal presentation had ended. At the end of the line was a very elderly military retiree. His age and I assume related conditions, had made his height less than would currently be accepted in active service. He held by the hand his white haired, blue eyed, petite wife. With fire in his eyes, and head and shoulders thrown back in a defiant position he stated, "Lady, as long as I live I will fight for the health care that I was promised for my wife and myself." Then with a slouching of his shoulders, a quaver in his voice and a tear in his eye, he asked, "But what will happen to her when I die?"

Mister Chairman and members of the Subcommittee, why did this retired soldier who had fought in two wars, have to ask this question?

Mr. SCARBOROUGH. Thank you. I appreciate your testimony.

Next we have Charles Partridge, and Mr. Partridge is of the National Association of Uniformed Services and has testified for us before. Good to see you again.

Colonel PARTRIDGE. Good to see you again, Mr. Chairman, Mr. Cummings, Mr. Miller. It was more fun testifying down in Pensacola.

This testimony, in addition to representing the views of my association and the Society of Military Widows, also represents that of the National Military Veterans Alliance, with some 20 military and veterans associations.

I would like to make four points regarding the FEHBP demonstration. But first I want to mention briefly why FEHBP is so badly needed for military retirees. And some of that has already been said, that they are the only Federal employees that lose the benefit at age 65. But, going along with that is that the Department of Defense does not have a plan that by a certain date all beneficiaries will be covered. There is nothing that they are doing now that will guarantee coverage at any time in the future by a specified date. There is no light at the end of the tunnel that our retirees can see, other than FEHBP.

TRICARE does not meet the needs of all of our beneficiaries. In addition to disenfranchising Medicare-eligibles, the reimbursement rates, the red tape, and the bureaucracy have not been solved. Therefore, the families need another option. The Secretary of Defense wants to close more bases. Sooner or later, there will be another round of base closures. We need FEHBP in place now so that when that happens, there are reasonable alternatives for people when they no longer have those military hospitals and clinics to go to.

Regarding the FEHBP demonstration, I want to underline what has already been said about the small size of the population. With 66,000 and 8 sites, it is just not big enough and we are not going to get 66,000 people signed up. We would like to go ahead and expand it to 10 sites, certainly by next year. And I believe the law would allow up to 70,000 eligibles enrolled and we would like to see the goal set at that maximum so that we end up with 70,000 enrollees rather than just having it as a target.

There is the risk pool and the reserve fund problem that we know is being worked between OPM, the Department of Defense, the carriers, and this committee. And we know it is a complicated issue. But in view, the concept is very, very simple. The legislation was certainly not intended to have this small risk pool as the only source of reserve funds. There is sufficient money to provide a reserve fund that would protect the carriers while still ensuring that we can use the same premium rates that are used by other enrollees in the Federal plan. If we don't have the same premium, then that is going to be perceived as a different program. It won't be a true test.

There are a couple of other points that will require a change in the law. One of them is that under the current law FEHBP enrollees will be locked out of military treatment facilities. We think this works against the program in this regard. First of all, occasionally some hospitals are overstaffed. They have extra appointments.

They should be able to invite those people in, give them their appointments, and bill the Federal plan for that so that it would, in effect, reduce the cost of the program to the Department of Defense.

And, finally, with the demonstration running from 2000 through 2002, individuals who enroll in the last year will have only 1 year in the program. We believe that should be extended for 3 years and that should be done next year so that people know that you have a minimum of 3 years in the program because asking people to enroll for only 1 year is not much of an incentive.

Mr. Chairman, we appreciate what this committee has done to take care of the medical needs of medical retirees and we appreciate your support for this program and I will be glad to answer any questions.

[The prepared statement of Colonel Partridge follows:]

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"The Servicemember's Voice in Government"
Established 1968

STATEMENT BEFORE

THE SUBCOMMITTEE ON CIVIL SERVICE

OF THE

COMMITTEE ON GOVERNMENT REFORM

U.S. HOUSE OF REPRESENTATIVES

ON THE

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

DEMONSTRATION

FOR

MILITARY RETIREES

BY

COLONEL CHARLES C. PARTRIDGE, U.S. ARMY, RETIRED
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5535 HEMPSTEAD WAY SPRINGFIELD, VA 22151

JUNE 30, 1999

Curriculum Vitae and Organizational Disclosure Statements

Charles C. Partridge
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National Association for Uniformed Services

Colonel Partridge, US Army, Retired, has been the legislative counsel for NAUS since May 1984.

Colonel Partridge's military career spanned 31 years of enlisted and commissioned services in the reserve and active forces. He served in Vietnam, Germany, Korea and in several installations in the United States. Colonel Partridge served three tours in the Pentagon as a staff officer dealing with personnel matters. He also served as the Chief of Staff of the Army Intelligence and Security Command, Arlington, Virginia and as the Executive, Office of the Chief, Legislation Liaison, Secretary of the Army, Pentagon. He is a graduate of the Army War College, the Army Command and General Staff College, and has a Masters in Public Administration from Pennsylvania State University.

Disclosure

Neither the National Association for Uniformed Services (NAUS) nor the Society of Military Widows (SMW) has received a grant from (and/or subgrant) or a contract (and/or subcontract) with the federal government for the past three fiscal years.

INTRODUCTION

Mr. Chairman and distinguished members of the Committee, The National Association For Uniformed Services (NAUS) and the Society Of Military Widows (SMW) appreciate the opportunity to testify on the demonstration project to extend the Federal Employees Health Benefits Program (FEHBP) to military retirees and their families.

The National Association for Uniformed Services represents all ranks, branches and components of uniformed services personnel, their spouses and survivors. Our nationwide association includes all personnel of the active, retired, reserve and National Guard, disabled and other veterans of the seven uniformed services: Army, Marines, Navy, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration.

Our affiliate, the Society of Military Widows, is an active group of women who were married to uniformed services personnel of all grades and branches and represents a broad spectrum of military society. From our membership of over 160,000 and 300,000 family members and supporters, or almost half a million voters, we are able to draw information from a broad base for our legislative activities.

We want to thank the committee for its long standing interest in military retirees and their health care. We also want to thank you for the opportunity to discuss the demonstration project for the Federal Employees Health Benefits Program for military retirees.

General

Medical care, including an adequate prescription drug program is a top concern of the military community. They were recruited and retained based on promises of a lifetime medical benefit which they have seen eroding year by year. Dissatisfaction with the failure of the US government to keep the medical care promise is having a serious impact on recruiting and retaining the current force. Retirees are a major part of the recruiting effort. Without their active support, recruiting suffers.

With base hospital closures, reduction in medical personnel, and perennial medical funding shortfalls the increasing lack of available health care continues to be a major concern to active and retired personnel alike. In fact, the situation will clearly get worse as additional hospitals are converted to clinics and medical personnel downsizing continues. Furthermore, each year the Secretary of Defense proposes additional rounds of base closures. Sooner or later, more closures will occur. This means hospitals will close and additional thousands of retirees will lose their health care benefit. After the previous round of closings DoD provided a BRAC prescription drug benefit; however most retirees do not benefit because they live in the wrong zip code or do not meet the prior use requirements to qualify.

Increasingly, we find that active duty personnel are also dissatisfied with their health care. Inadequate fee schedules, inflexible rules, red tape and slow bill payment discourage physicians and other providers from joining TRICARE- Prime networks. Medicare eligible retirees are not authorized to participate in TRICARE-Prime and the Administration opposes prompt expansion of the TRICARE Senior Prime demonstration. That demonstration would allow Medicare eligible retirees living near military hospitals to participate in a Military HMO.

With additional base closings, this option will serve fewer and fewer beneficiaries even if fully implemented. Our members remain concerned that the Department of Defense has no plan that will, by a date certain, provide the promised health care benefit. In fact, military retirees are the only Federal Employees that do not have a lifetime benefit.

That is why we support providing FEHBP as an option. It is available throughout the United States, there are a variety of plans and options, its availability is not dependent on troop deployment or base closures and it is widely accepted by physicians and other providers. FEHBP is cost effective for DoD, with low administrative costs. Military hospitals and associated managed care networks should remain the primary source of care for military personnel, their families and military beneficiaries who can be guaranteed care. However, the FEHBP option is badly needed to insure that all who served and were promised a Health Care benefit have access to a DoD sponsored health care program.

FEHBP Demonstration

Efforts last year to obtain a full scale FEHBP option for retired military personnel resulted in legislation authorizing DoD to conduct a demonstration of FEHBP for Medicare eligible military retirees at up to 10 sites and cover up to 70,000 eligible beneficiaries.

DoD selected eight sites with a total eligible population of approximately 66,000 beneficiaries. Since all eligibles will not enroll because they have other options or for other reasons choose not to do so, actual enrollment could be very low and not provide sufficient data on which to base a decision. The small size of the demonstration also makes it impracticable for regional HMOs and other smaller providers to participate. Therefore, the wide choices available to current FEHBP participants will not be available.

The requirement to establish a separate risk pool for such a small population could require higher premiums. This could be avoided by establishing the same rates for military retirees as other beneficiaries for purposes of the test. The test group could be monitored separately and the carriers indemnified against any significant adverse claims experience.

The current law requires that participants be denied access to treatment and the pharmacy in military treatment facilities. We believe that these beneficiaries should be given access on a space available basis but that their FEHB plan pay for any services received. This would allow DoD to use any excess capacity, bill for it and recoup part of the cost of the program.

With the demonstration running from 2000 through 2002, individuals enrolling in 2002 will have only 12 months in the program. We believe the demonstration should be extended to allow all enrollees three years access to FEHBP.

With four months to go before the first open enrollment period, we understand that the decision on establishing a reserve fund has not yet been made. We are concerned that continuing delays will not leave enough time for information and marketing efforts. This is particularly true for areas with no military treatment facility and no major military installations.

Mr. Chairman, the National Association for Uniformed Services and the Society of Military Widows thank you and this subcommittee for holding this hearing and for your continuing support for improving health care for military beneficiaries.

Mr. SCARBOROUGH. Thank you, Mr. Partridge. We appreciate you being such a strong advocate for this demonstration project from the beginning, as our previous speaker and our next speaker have also been.

Kristen Pugh, who is representative of the Retired Enlisted Association. Ms. Pugh.

Ms. PUGH. Good morning, Chairman Scarborough and distinguished members of this subcommittee. Thank you for the opportunity for the Retired Enlisted Association to discuss the implementation of the FEHBP 65-plus demo.

TREA has over 100,000 members and auxiliary, representing all branches of the Armed Services in which 61 percent of our membership are 65 and older and whose continued concern over accessing comprehensive, quality health care in the future stems from being dropped out of the military health care system at 65. With base closures, military treatment facilities downsizing, and demographics changing, the need to provide access to health care to our ever-growing number of aging retirees creates anxiety with those that "were promised lifetime health care."

One solution with the support, the strong support of this subcommittee, was the passage of the FEHBP 65 demo, a win-win to provide a benefit to the men and women who have patriotically served this country. The number of 65-and-over aged military retirees will not decline, but continue to grow in numbers to an estimated 1.6 million in 2004. Today I hope we find a solution to administering a "fair test" for FEHBP 65 demo in a timely manner so as not to delay implementation of this program this year.

OPM needs to finalize the operational guidelines with approved regulations by OMB for the test. This makes it extremely difficult to educate our members on rates, benefit guidelines, and participating carriers, as well as answer any questions they may have prior to the open enrollment season, beginning November 8. Also, this will jeopardize DOD's marketing time line for the demo.

OPM has not implemented regulations for carriers to access their own reserves to compensate for possible financial risk of enrolling service retirees. This access would control costs for the carriers, especially since this is a limited test with a limited number of enrollees in each site. Carriers will set high premiums over and beyond the costs of current FEHB programs in order to protect themselves until they have gathered some claims experience for this new group of beneficiaries. The consequence is OPM will be creating a completely new program, different from FEHBP, even though the legislation directs OPM to set up a risk pool as a new rating category for FEHBP.

The intent of title 10 in U.S.C. subsection 1108, "The director of OPM shall require health benefit plans under chapter 89 of title 5 that participate in the demo project to maintain a separate risk pool for purposes of establishing premium rates for eligible beneficiaries who enroll in such a plan," which means that, for the purpose of this demonstration program, OPM needs to set a new rating category in order to track the categories of beneficiary groups. This is no different than setting a risk category group for self/only and self/family under FEHBP, in which rates are based on access to service benefit plan reserves. The test should be no different

than one of the category groups in which premium rates are studied and set for that population for rating purposes only.

Delay in regulations will further delay military retirees to enroll in FEHBP November-December open enrollment season with reasonable premium rates, comparable to current FEHBP rates. As we have told this subcommittee in the past, we know that not all military retirees will enroll in this program, but we need to give them the option to make that choice in order to determine the viability of providing health care through FEHBP.

The Fiscal Year 1999 Defense Authorization Act defined the total number of enrollees for this test may not exceed 66,000. This was interpreted by DOD as 66,000 total persons eligible to enroll. TREA would like to see the sites expanded for more participants to enroll to meet the 66,000-enrollee cap, in the future of the test program. By limiting the number of beneficiaries eligible to enroll, this will create a scenario of more adverse selection, jeopardizing the viability of a "fair test."

In conclusion, in the past years, TREA has educated their members to the concept of FEHBP and that it was not a free benefit. The response was simple. TREA members wanted to have the option to participate and pay for a comprehensive health care benefit equal to their neighbor who served in the civil service. In order to accomplish this, the rate structure needs to be more in line with those civilian servants pay for their health care. If not, then yet again another program and inequity for these retirees would be created by the government, a program that looks like, smells like FEHBP, but is not FEHBP. Let us correct this wrong with a right and provide a fair test for FEHBP for those men and women who served in the uniformed services.

Thank you for your attention, by this subcommittee.

[The prepared statement of Ms. Pugh follows:]

STATEMENT OF

KRISTEN L. PUGH
DEPUTY LEGISLATIVE DIRECTOR

OF

THE RETIRED ENLISTED ASSOCIATION

BEFORE THE

CIVIL SERVICE SUBCOMMITTEE

GOVERNMENT REFORM AND OVERSIGHT COMMITTEE

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

JUNE 30, 1999

The Retired Enlisted Association (TREA) would like to thank the chairman and distinguished members of the Civil Service Subcommittee for the opportunity to come before you to discuss the implementation of the Federal Employees Health Benefit Program 65+ Demonstration project. TREA has over 100, 000 members and auxiliary representing all branches of the Armed Services, retired, active duty, guard and reserve, in which 61% of our members are 65 and older, and whose continued concern over accessing comprehensive quality health care in the future stems from being dropped out of the military healthcare system at 65.

With base closures, military treatment facilities (MTFs) downsizing and demographics changing, the need to provide access to health care to our ever growing number of aging retirees creates anxiety with those that "were promised lifetime health care." The fact remains that Department of Defense (DoD) has a responsibility to those men and women who have served in the Uniformed Services to provide a medical benefit to nearly 50 percent of the current retired military beneficiaries that were promised health care. The demographics have changed from the 1950's when retirees were only 7 percent of the military health care beneficiary population, therefore Congress needs to create a plan to administer a health care benefit to retirees. The support from this subcommittee for the FEHBP for Medicare Eligible Military Retirees Test program is very much appreciated, to expanding an equitable benefit to the men and women who have patriotically served this country.

Last year was a victory to the military retired community, when the FEHBP Test was included in the final passage of the Defense Authorization Act for FY99. "Yes," indeed a victory for the men and women who have served for this nation honorably. "No," I will agree it is not the free health care that they were quote and quote "promised" by recruiters, but it is access to health care. Accessing a complete health care benefit equal to Federal Employees was not only the right thing to do, but it was the equitable thing to do.

So here we are today debating the implementation of an equitable benefit. Due to the continued downsizing of MTF staff, base closures, and depleting dollars for DOD health care, the Medicare Eligible Military Retirees continue to be pushed out of military health care. We need solutions to these problems. And as we know, there is no one solution. Therefore, testing alternative options for those that live near MTFs or those residing outside the catchment areas, through the Medicare subvention test and FEHBP 65+ demonstration, will enable DoD to figure out how to administer health care to its aging heroes and heroines in the future. Even with full Medicare Subvention, TRICARE Senior Prime, we will only be servicing 33% of the overall population of military retirees over the age of 65. Some of our retirees have employer sponsored health care, 17%, and 10% already have Medicare Risk HMOs, leaving 33% to 40% of the 1.2 million population is 480,000 to access FEHBP. The number of 65 and over aged military retirees will not deplete but continue to grow in numbers to 1.6 million in 2004. Today, I hope we find a solution to administering a "fair test" for FEHBP 65+ demonstration project.

RESERVE ISSUE:

Currently, DoD and the Office of Personal Management (OPM) are in the process of implementing the FEHBP- 65 + test program for the open enrollment season to begin November 8, 1999. TREA is concerned that the rate structure set by the insurance carriers will deter our members from enrolling in the program, due to high cost premiums that will be set without access to a reserve fund (FEHBP reserve fund) by the carriers. OPM has not implemented regulations for various plans to use any of their reserves to compensate for possible financial risk of enrolling service retirees (even though this is the usual practice under FEHBP for federal civilian beneficiaries). This access to a reserve fund would control costs for the carriers, especially since this is a limited test with a limited amount of enrollees in each site. Carriers will set high premiums over and beyond the cost of current FEHBP programs in order to protect their groups, until they gather some claims experience for this new group of beneficiaries. The consequence of

this action is that OPM will be creating a completely new program different from FEHBP, even though the legislation directs OPM to set up a risk pool as a new rating category for FEHBP. The intent of Title 10 U.S.C. ss 1108 (h) (1) "the director of the OPM shall require health benefits plans under chapter 89 of title 5 that participate in the demonstration project to maintain a separate risk pool for purposes of establishing premium rates for eligible beneficiaries who enroll in such a plan," which means that for the purpose of this demonstration program OPM needs to set a new rating category in order to track the categories of beneficiary groups in this demonstration program. This is no different than setting up the risk category group for self only and self/family under FEHBP, in which rates are based on access to the Service Benefit Plan reserves. The demonstration program should be no different than one of the category groups in which premium rates are studied and set for that population for rating purposes only.

We are debating the language intent of a rating category as it pertains to accessing reserve funds. The House Armed Services Committee (HASC) subcommittee on military personnel staff had discussions with OPM to ensure that this issue of accessing the FEHBP Service Benefit Plan reserve accounts was clarified in language for the FEHBP 65+ test for the FY'99 Defense Authorization. In order to have a fair and equitable test of FEHBP for Medicare eligible military retirees, the intent of the language was to study this group of beneficiaries as a separate rating category for rating purposes only under FEHBP.

There has been discussion to using the OPM Administrative reserve accounts, which again creates a separate reserve for this separate risk pool resulting in a completely new program administered by OPM. Due to the small category that can even enroll, the number of participants will be low based on previous demonstration programs such as the Medicare Subvention Test. Again, increasing the chances for adverse selection without getting the cross section of military retirees to study the viability of this equitable benefit.

In order to have a fair and accurate test, we need to provide the opportunity for Medicare eligible military retirees to enroll in FEHBP in the November-December open enrollment season with reasonable premium rates. As we have told this subcommittee, we know that not all military retirees will enroll in this program, but we need to give them the option to make that choice in order to determine the future of providing care for those that have served in the military.

ENROLLMENT NUMBERS:

The FY 99 Defense Authorization Act subtitle C Section 721 ***Demonstration Project to include certain covered beneficiaries within Federal Employees Health Benefits Programs*** clearly defined the eligibility and number of enrollees for the test program. As printed in legislation the total number of enrollees may not exceed 66,000, this was interpreted by the DOD as 66,000 total persons eligible to enroll in the test program. We know that these designated 66,000 eligible participants will not all enroll because of the limited three year test program with a possible one time enrollment. Many of these participants may have employer provided insurance, Medicare Risk HMOs, Medigap policies, or have enrolled in TRICARE Senior Prime as in the case of the Dover, DE program. At best we are expecting around 20, 000 to enroll in the program this year, if we can correct the reserve issue to provide a comparable rate structure for FEHBP to current Federal employees for a population representing a cross section of military retirees.

TREA would like to see the sites expanded for more participants to enroll to meet the 66,000 enrollee cap in the future of the test program. We see that by limiting the amount of beneficiaries eligible to enroll, will create a scenario of more adverse selection jeopardizing the viability of a "fair test". GAO, OPM, and DOD need to be able to study this "separate rating category," to understand the needs of this population, as well as the carriers. TREA was discouraged by the limited eligible enrollees, but we feel that it is

necessary to emphasize getting this test up and running as soon as possible. We have run into roadblocks on the issue of the reserve accounts and have also learned the operational guidelines have not been put in place for the test program. Therefore, we need to focus on these two operational problems first in order to get educational material out to our members, as well as some sort of basis for how the premium rates will be set. This takes a priority over increasing enrollment at this point. Though, we would like this subcommittee to look at the option of increasing the number of participants in the second year of the test, as stated by the intent of the original law.

OPERATIONAL GUIDELINES:

OPM needs to finalize the operational guidelines through regulations to be approved by the Office of Management and Budget (OMB) for the test program. It makes it difficult to educate our members, as well as answer any questions they may have prior to the open enrollment season in November until the program rules are finalized. It is understood by TREA that rates from the carriers will not be negotiated until September, but we need time to provide the necessary information to our members prior to making a change in their health care needs. TREA in no way is in the position to advice their members on health care choices, we are merely an information resource.

The guidelines in the FEHB Program Carrier Letter dated April 9, 1999, lacked on ample information of the test program, which concerned TREA. The more delays to carriers the more delays to informing and enrolling our members into the program.

HISTORY:

On September 12, 1995, this subcommittee had the first hearing to look at an alternative option for military retirees to access health care, FEHBP. After that day, both the House and Senate members began introducing legislation in order to address the viability of this program to the military community. The military associations came

together to endorse H.R. 1766 and S. 1334, testing FEHBP for Medicare eligible Military retirees over 65. On May 21, 1998 , the House passed the Watts-Moran-Thornberry amendment to authorize DoD to test enrolling Medicare-eligible retired uniformed services beneficiaries in FEHBP, with a vote of 420-1 to support inclusion of this test in the FY99 Defense Authorization bill (H.R. 3616). The Military Coalition (representing 28 military association and 5 million members) and the Military Veterans Alliance (16 associations and 3 million members) saw success that day. After the final conference report, TREA and other military associations anxiously awaited implementation of this test program as their members began calling in asking for enrollment information.

In the past years, TREA has educated their members to the benefits of FEHBP as well as to the fact that it was not a free benefit. The response was simple, TREA members wanted to have the option to participate and pay for a comprehensive health care benefit equal to their neighbor whom served in Civil Service. In order to accomplish this FEHBP comparison, we need to keep the rate structure more in line with what these civilian servants pay for their health care. If not, then yet again another program and inequity for these retirees would be created by the government. We should always remember that Military retirees are the only group of federal workers who lose their employer sponsored health care when becoming eligible for Medicare. Let us correct this wrong with a right, and provide a "fair test" of FEHBP for those men and women who have served in the Uniformed services.

CONCLUSION:

TREA commends this subcommittee and staff in developing language for the FEHBP 65+ Test. We have come a long way from the first hearing on this issue, and in order to fairly test this program we must work together, OPM, DOD, Congress, and the military associations to study the viability of this option for military retirees for the future. The number one priority is to resolve the operational guideline regulations for the

FEHBP 65+ test program immediately not to further anymore delays in implementation of this program for Medicare Eligible retirees, especially accessing the service benefit plan reserves to create fair rates for enrollees. It would be another broken promise to deliver a health care benefit for military retirees which is not equal to retired federal employees. Not only not equitable but unjust for those that have honored this country with their patriotic service.

Mr. SCARBOROUGH. Thank you. I appreciate it.

Mr. Gammarino from Blue Cross, welcome back and we look forward to your testimony.

Mr. GAMMARINO. Good morning. I would like my written testimony entered into the record. I will be giving an oral summary.

Mr. SCARBOROUGH. No objection.

Mr. GAMMARINO. Mr. Chairman and members of the subcommittee, good morning. I am Stephen Gammarino, senior vice president at the Blue Cross and Blue Shield Association and, on behalf of the Association, I thank you for the opportunity today to discuss the demonstration project for military retirees to enroll in the Federal Employees Health Benefits Program. We are committed to doing our part to ensure the project's success.

As you know, Blue Cross and Blue Shield sponsors the governmentwide Service Benefit Plan in the program today. This plan is the plan of choice of approximately 45 percent of all Federal employees and annuitants, covering almost 4 million members. As the FEHBP's largest carrier, we bear a special responsibility to the program. We do not wish to create contention, but we must speak up when we have serious concerns about particular issues affecting this program. We have such concerns about the approach planned for implementing this demonstration project.

My testimony focuses on two areas specified in your letter of invitation. First, the difficulties posed by the limited size of the eligible population. And, second, the impact of the requirement for separate risk pools.

First, the size of the eligible population. Originally, we understood that as many as 66,000 military retirees and other qualified individuals would be allowed to enroll in this project. Therefore, we were surprised to learn that the total eligible population would be limited to only 66,000. With the other health coverage options available to these individuals, we estimate that fewer than 20,000 will enroll in this program.

A demonstration involving 66,000 enrollees, not eligibles, would have been preferable. Why? A larger group helps in spreading risk and increases the likelihood of attracting a broad cross-section of individuals. Additionally, the overall administrative effort and cost would be essentially the same for a larger group, but more people could benefit. Despite this projected small size, we believe the demonstration project can still be successfully implemented.

A much greater concern than the size of the group is the interpretation by OPM of the law's requirement for a separate risk pool and the subsequent determination of how reserves will be used to offset any resulting carrier liability. We understand that OPM, through an interim regulation, will be proposing to pay any deficits carriers incur under the project from the unused portion of the administrative reserve. This reserve, a 1 percent overlay on each carrier's premium, is meant to pay OPM's administrative expenses only. According to law, the unused portion is returned to carriers in proportion to their share of the total premiums paid.

We believe OPM is asserting authority to turn this into a fungible pool of money that would be returned to carriers based upon their operating results. What is wrong with this? First, we find no statutory basis for any such action. The statute is clear and direc-

tive on how moneys from the administrative reserve are to be paid to the carriers. Second, diverting reserves from one carrier to the competing carrier is totally inconsistent with a competitive program in which carriers are ultimately at risk.

The essential point of our objection is not that we may lose money, rather that the proposed reallocation among competing carriers sets a harmful precedent when it is without clear congressional mandate and in the face of contrary statutory directive. OPM's immediate purpose may well be benign, but its proposed action threatens the basic structure of this program. We've shared our views and legal opinions with OPM and we are prepared to take all necessary steps, including legal action, to protect the integrity of this program.

Our position is that the law need only be followed as written: Treat the DOD enrollees separately for rate-setting purposes, but for all other purposes, including carrier liability, they should be part of a larger group. Blue Cross Blue Shield premiums today for high-option versus standard option and for self versus self and family are determined in this manner. Each category is rated to stand on its own, but the plan's financial reserves are available, if needed, across rating categories. This is the only way of implementing the demonstration project that is both consistent with the law and likely to serve the purpose for which it was enacted.

Additionally, since January, we have received only oral guidance on the project during meetings with OPM. We still await the first formal guidance with respect to operational issues. Especially as we approach year 2000, details must be communicated immediately. Our window of opportunity continues to shrink as November's open enrollment period quickly approaches.

In conclusion, let me reiterate that we are committed to a fair test of the FEHBP as a viable option for the retired military community. As matters now stand, however, the fairness of the test is endangered by a course of action that is contrary to law and by a delay in addressing operational issues. There is still time, if all parties work together, to make the demonstration project a success. And we stand ready to do so.

Thank you and I will be pleased to answer any questions you may have.

[The prepared statement of Mr. Gammarino follows:]

TESTIMONY OF

BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

Before the

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

On

The FEHBP Demonstration Project for Military Retirees

Presented by:

Stephen W. Gammarino
Senior Vice President
Federal Employee Program
And Integrated Health Resources

June 30, 1999

Mr. Chairman and Members of the Subcommittee:

Good morning. I am Stephen W. Gammarino, Senior Vice President, Federal Employee Program and Integrated Health Resources, at the Blue Cross and Blue Shield Association. On behalf of the Association, I thank you for the opportunity to appear before you today to discuss the demonstration project for military retirees to enroll in the Federal Employees Health Benefits Program (FEHBP) that is scheduled to begin January 1, 2000. We are very supportive of the intent of this project and are committed to doing our part in ensuring its success.

As you know, Blue Cross and Blue Shield Plans jointly underwrite and deliver the Government-wide Service Benefit Plan. The Service Benefit Plan has been in the FEHBP since its inception in 1960 and is the plan of choice for approximately 45% of all Federal employees and annuitants, covering almost four million lives.

As the largest carrier in the FEHBP, we believe we bear a special responsibility to provide stability and integrity to the program. We have no desire to create contention and would greatly prefer to resolve all differences with regard to the administration of the program informally and amicably. But we believe it is our obligation to speak up when we have serious concerns about a particular issue or the direction in which the program appears to be heading. We have such concerns about the approach OPM is taking with regard to implementing the Department of Defense (DoD) demonstration project, and our concerns, despite many months of effort on our part, have not been resolved.

I will focus my testimony on the areas specified in your letter of invitation, which take us to the heart of the problem:

- The difficulties for the demonstration project posed by the limited size of the eligible population; and
- The impact of the requirement for separate risk pools for the demonstration project enrollees.

Size of the Eligible Population

When the legislation requiring the military retirees' FEHBP demonstration project was passed last fall, we understood the law to mean that as many as 66,000 military retirees and other qualified individuals would be allowed to enroll. We were surprised to learn, then, that the total eligible population would be limited to only 66,000 beneficiaries. Based on the size of the eligible population and our understanding of the health insurance options currently available to these individuals, we estimate that fewer than 20,000 individuals will choose to enroll with carriers in the FEHBP.

From our perspective, a demonstration involving as many as 66,000 enrollees would have been preferable. A larger group is helpful in spreading risk and increases the likelihood of attracting a broad cross-section of variously situated individuals. Additionally, start-up activities and the overall administrative effort would be essentially the same for a larger group as for a smaller one, but more people could benefit. Nonetheless, we are willing to proceed with the smaller group of eligibles and, pending the resolution of other issues, believe the demonstration can still be successfully implemented.

Separate Risk Pool Requirement

A much greater concern than the size of the participant pool is the interpretation of the law's requirement for a separate risk pool and the subsequent determination of how reserves will be obtained to offset any potential carrier liability resulting from the demonstration project. As you know, the law states that plans participating in the demonstration project must maintain a separate risk pool "for purposes of establishing premium rates." Our understanding at the time the project was being considered by the Congress was that this provision was intended to assure that the DoD enrollees "paid their own way" to the maximum extent practical, and to allow comparison of their costs with those of the larger group for the purpose of evaluating the merits of adding this population to the FEHBP on a permanent basis.

It is important to note that the law does not require maintenance of a separate risk pool for all purposes. If it did, entirely separate reserves would have to be maintained for this group. OPM initially communicated to us informally that it was interpreting the law to require entirely separate reserves. We objected on the grounds that we find no such requirement in the law and imposing one would vitiate the purposes of the demonstration project. The military retirees would not, in fact, be participating in the FEHBP, but in a parallel program that could not be as attractively priced, given the short duration and carriers' lack of experience with the DoD population. The result would be a diminished or highly skewed enrollment that would be useless for answering the fundamental question of whether participation in the FEHBP is a viable alternative for military retirees.

As distressing as OPM's initial interpretation of the separate risk pool requirement was, we understand that they have now decided on an even more troubling approach. While this approach would have the positive effect of mitigating carrier risk, we believe it is contrary to the plain language of the law, inconsistent with the nature of the FEHBP, and, if allowed to go forward, would set a very dangerous precedent.

As we understand from conversations and correspondence, OPM proposes to pay any deficits carriers incur under the demonstration project from the unused portion of the Administrative Reserve generated by the regular program, without regard to the allocation methodology that is plainly set forth in law. The Administrative Reserve is established to pay OPM's administrative expenses. It is created by a one-percent overlay on each carrier's premium and, according to law, the unused portion is returned to carriers in proportion to their share of the total premiums paid. We believe OPM is asserting authority to turn this into a fungible pool of money that they can return to carriers based on their operating results under the demonstration project.

We can find no statutory basis for any such action; in fact, the statute is abundantly clear and absolutely directive on how monies from the Administrative

Reserve are to be paid to carriers. Further, diverting money derived from and intended for use by one carrier to another carrier is totally inconsistent with a competitive program in which the competing carriers are ultimately at risk. With the safety net of other carriers' reserves, maintaining rating discipline among the carriers could become very difficult. We cannot believe that Congress intended that a demonstration project be used to alter the fundamental workings of the FEHBP, which is in essence what OPM proposes.

Thus, the essential point of our objection to OPM's proposal is not that we may lose money due to OPM's deviation from the statutory allocation methodology. It is that OPM's proposed reallocation among competing carriers—absent a clear Congressional mandate and in the face of a contrary statutory directive—sets a harmful precedent. OPM's immediate purpose may well be benign, but its proposed action is inconsistent with and threatens the basic structure of the program. The FEHBP must not be damaged as we experiment with making its many attractions available to additional populations. We feel so strongly about this matter that we are prepared to take all necessary steps, including legal action, to protect the integrity of the program.

We have repeatedly made our views, and the legal arguments supporting them, known to OPM. Further, we believe straining at farfetched interpretations of the law is entirely unnecessary. The purposes of the demonstration project can be served in accordance with current statutes by following the law as written. That is, the DoD enrollees should be treated separately for rate-setting purposes, with premiums set to reflect their costs to the maximum extent practicable, but for all other purposes, including ultimate carrier liability, they should be part of the larger group. This is the way we determine premiums for High Option versus Standard Option and for Self Only versus Self and Family enrollment. Each category is rated to stand on its own, but actuarial science is not exact, and the plan's financial reserves are available, if needed, across rating categories. We believe this is the only way of implementing the demonstration project that is both consistent with the law and likely to serve the purpose for which it was enacted.

Consultation with Carriers

Allow me to address one final issue that was mentioned in your letter of invitation, and that is the adequacy of consultation between the agencies and carriers. Since the announcement of the demonstration project in January, to date, the Blue Cross and Blue Shield Association has attended one OPM meeting during which the project was generally discussed, where very few answers were available. After requesting further guidance on the project, we met with OPM staff in mid-May and received oral direction on a number of issues. Nevertheless, we still await the first formal guidance with respect to the enrollment process, reporting requirements, cost allocation and other important operational issues for the demonstration project. Some of these details are required so that additional administrative costs, if any, can be accounted for in rate-setting. Additionally, requirements to account for the experience of the military retiree group separately may have claims and enrollment systems implications. Especially as we approach year 2000, it is critical that the details of the implementation and requirements of the demonstration project be decided and communicated immediately to all participating carriers. Our window of opportunity to prepare for this new population continues to shrink as November and Open Season for health plan enrollment quickly approaches.

Conclusion

The Blue Cross and Blue Shield Association is committed to conducting the demonstration project in a manner that constitutes a fair test to determine whether FEHBP participation is a viable option for the retired military community. As matters now stand, however, we believe the fairness of the test is endangered by OPM's insistence on a course of action that is contrary to law and by a general delay in addressing operational issues. We believe there is still time, if all parties work together, to make the demonstration project a success. We stand ready and willing to do so.

The Blue Cross and Blue Shield Association is very proud of the role it has played in helping to make the FEHBP the successful program enjoyed by civilian employees and retirees. Especially as our uniformed men and women have served and continue to serve our country in these heated times overseas, we welcome the opportunity here at home to, in return, serve America's retired military and their family members.

Thank you and I will be pleased to answer any questions you may have.

Mr. SCARBOROUGH. Thank you. I appreciate your testimony.

I wanted to ask all of you a question. To summarize very quickly, Mr. Moran stated that the way this project is being implemented is nothing more than an attempt to buy time and to cut costs. We have had testimony that the education approach was a "short fuse approach," and there was bad marketing. We heard testimony there is "no light at the end of the tunnel." Testimony about the "lack of fairness" and how we need a "fair program." And also testimony that the pool is so small that we are not going to have the broad pool necessary to see whether this works or not.

It goes back to what Congressman Cunningham said, that he felt like the referee was rooting for the other team. I think the question that is central right now to this hearing is do you all believe that this demonstration project has been set up for failure by DOD and OPM? Or, putting it in Duke's terminology, is the referee rooting for the other team? There is a referee speaking on the next panel—[laughter]—so you all don't be shy because the ref is not going to be shy. The ref will probably also accuse me of setting them up for failure with these first two panels.

But, is the referee rooting for the other team? This is very important, to get your gut feeling.

Ms. HICKEY. I don't know that I want to characterize that any one person, Admiral Carrato or anybody else, is rooting for the wrong team. But, from our point of view, when you take a look at the problems that are inherent at the moment in the demonstration, it certainly looks like you are creating a demonstration, for whatever reason and whatever motive, that may be doomed to failure. If you are looking at 20,000 enrollees, I don't know what you are going to find out. Particularly when two of the areas are not representative of what the test is supposed to be determining.

Mr. SCARBOROUGH. What are those two areas, again?

Ms. HICKEY. Puerto Rico because its enrollment pattern is significantly different than the rest of the country. As was mentioned, I think 45 percent of most people take the Blue Cross Blue Shield standard product. That is not true in Puerto Rico. They basically take the—it happens to be a Blues product—but it is an HMO product.

The other one, of course, is the subvention. I mean, Dover Air Force Base. Dover doesn't have a military hospital. It has only a small clinic. And it has only I think about 4,000 eligible people that live there. Half of whom or 1,500 of whom could enroll in subvention. How are you going to tell—we are looking at populations in San Diego of 34,000. That would have been a place to test it.

Mr. SCARBOROUGH. OK. Not to nail you down here and certainly we all understand—we have been in Washington long enough to know—that the people that come and testify aren't always the people that make the final decisions, but they are doing their job. So certainly you are not characterizing anybody in this room. But you said this project may be doomed for failure? Can you go back to your members and give them any scenario under which this project, as currently framed, is going to be a success? What I am saying is I think "may be a failure" is very generous. And I underline the word "may." Is it going to be a failure?

Ms. HICKEY. The only reason I use "may" is because I firmly believe that we have an awful lot of people out there in this age category who are literally desperate for health care. So it is conceivable that we may have a higher enrollment in some of these areas than enrolled in the subvention areas. I don't really know.

I think there are ways we could fix it. I think, currently in the law, we could go up two more sites. They could be picked tomorrow. We could go up to 66,000 enrollees by picking 2 sites with fairly good eligible populations. I don't think we need any legislation in order to do that. If you are really committed to a project and this is something that has been mentioned by both the carriers and the associations and the Members of Congress who worked on this legislation maybe this is something that needs to be done tomorrow.

Mr. SCARBOROUGH. OK. You said this may work because there are people that are so desperate for health care choices that, sadly, as Mr. Gammarino said, with approval this narrow, you are going to get the people that are the most desperate for it. You are going to have the sickest people in it, because it is not broad enough. It is going to be cost-prohibitive.

Mr. Partridge, have we been set up for failure here?

Mr. PARTRIDGE. Failure in this sense: We are not going to get enough data to satisfy the statisticians and the actuaries to give them any answers. Our view has always been we are all people. And this program is designed for people. So the only possible reason for a test is money. There is absolutely no reason to test it other than that. Otherwise, why not make it an option and let the people who want it enroll in it and become part of the pool? So, in that sense, it is set up to say we don't have enough information so let us extend the test; let us not go forward. That is one of the points that concerns us.

There is institutional opposition to this. You know, the military surgeons general like to have their sheep pen with all the military retirees in that sheep pen. And then they reach in there and pull out the ones they want for their training programs and so forth and then the others get their care where they can. If you give people a real option, then they are going to have to guarantee care in those hospitals and guarantee that the service is top-notch. So you have an institutional problem as well.

Mr. SCARBOROUGH. Ms. Pugh, have we been set up for failure?

Ms. PUGH. I think Ms. Hickey stated it very clearly. I think it is a difficult statement to answer, but in three regards, we do feel that we are having difficulty implementing this program in a fair time. I look at my watch. It is June 30. We were going to have a hearing on this back in April. I looked at my testimony that I put together in April and none of those points have changed. That is frightening. That is frustrating.

We can debate the subject is it set up for failure. Well, we are on a one-way train to failure right now because one thing is I can't educate my members. I have members calling in on a daily basis trying to get some information.

I have members who want to enroll, but don't meet the zip code requirements because the eligible category they don't meet. I have people who are willing to move to those zip codes. I mean, I will be quite frank with you. They have heard about this. We have edu-

cated them. And it would just be a crime at this point that we haven't implemented it on a timely basis, that the enrollment season will come and go and I will be looking at you in the year 2000 and we will be having this same discussion and we will have not tested a viable option and we have yet failed my beneficiaries and your constituents yet again.

I think there have been a lot of road blocks. One thing is even getting the site selection done on a timely basis. How you define the eligible category has already been explained. And as well as the fact is marketing information. I have started to see some time lines from DOD which concern me, to be quite honest. But we are going to be educating people. October 30 we will be sending out a packet of information.

These are people who have been Federal employees. These are people that are watching the House floor going where is my pharmacy benefit? Medicare plus choice is changing. They need some more lead-in information prior to making a big decision, especially if you don't know how long the test program is going to last. You make a change—and we know this from experience from the Medicare subvention test program.

And, again, there has been—and I have not gotten this point clarified—but a one-time open enrollment season this year would further restrict the number of participants. And then, yet again, we would have adverse selection, high rates, and we wouldn't have the participants. And, yes, it would fail.

Mr. SCARBOROUGH. You know, you said something about people being so desperate they were talking about moving into zip codes. I saw some people sort of raise their eyebrows and chuckle; it is the truth. I mean, in Pensacola, FL, 32507, there are a lot of military retirees. Why? Because they all moved to be next to the Navy hospital.

People from my generation—don't realize that people served in the military and believed for 30 years that they were going to be taken care of. Some understand the scope of the human tragedy to these people who plan their whole lives around this only to have it yanked out from underneath them.

Mr. Gammarino, are we set up for failure? Would you invest in a company that set up a project like this?

Mr. GAMMARINO. I wouldn't have designed it quite this way. [Laughter.]

Mr. SCARBOROUGH. All of you are so diplomatic. God bless you.

Mr. GAMMARINO. I think we do need a bigger risk pool. 20,000 doesn't cut it. And it sounds to me, in the previous answers to your questions, you do have options to increase that pool to a full 66,000. And I would recommend not only that this be done, but that it be done in such a way that, demographically, you ensure a cross-section of individuals that will be representative of the whole eventual pool. And that way you can ensure that this small pilot will get the results that will provide you the answers about how to proceed going forward.

Mr. SCARBOROUGH. Mr. Cummings.

Mr. CUMMINGS. You keep talking about this 20,000. Can you explain that to me? You mentioned it also.

Mr. GAMMARINO. Yes. Our actuaries came up with that. And let me tell you what we did to provide you with that figure.

Mr. CUMMINGS. First of all, what is it?

Mr. GAMMARINO. Excuse me?

Mr. CUMMINGS. What does the figure represent? The 20,000.

Mr. GAMMARINO. The 20,000, in our estimate, is the number of individuals that are actually going to enroll in the FEHBP from the 66,000 eligible beneficiaries that have been allowed to participate.

Mr. CUMMINGS. That is what I thought. OK, now, go ahead.

Mr. GAMMARINO. There are a couple of things we looked at. First of all, we took a look at the actual sites and when we took a look at the sites, we took a look at what was available to those beneficiaries today in terms of military treatment facilities. What do they have available today? In terms of coverage, health care coverage. In terms of either MediGap or Medicare risk, what is there today? What rates do they pay today versus what rates would they expect to pay in this particular program?

So we took a look at each demographic site along those specific lines. Then we brought it up to the next level and said, one, this is a 3-year demonstration project. There is going to be some hesitancy in terms of people jumping into this program, not knowing if it is going to be there for them in the long run. And so those are some of the factors we used. And it is a guesstimate and I can assure you this: It will be either slightly higher or slightly lower.

Mr. CUMMINGS. But there is no way you will get up to 66,000? Not even close?

Mr. GAMMARINO. Not with the way it is designed right now. I don't see how that would happen.

Mr. CUMMINGS. So, I guess going back to you, Ms. Hickey, you were talking about increasing the sites. Is that right?

Ms. HICKEY. Yes, sir. I think that we have to get—first of all, we have one-fourth of our sites that are not representative of either DOD's population or the enrollment patterns of the FEHBP in general in this country. So you have 25 percent of your sites that are not going to tell you a lot when you want to overlay it on the rest of the country, that is one reason.

The second reason: We came at the same 20,000, or actually a little bit less, because we based it on the people, the same group of people, the Medicare-eligible military retirees, who were offered the opportunity to enroll in Medicare subvention and did not. Using that percentage and applying it to this population of 66,000 eligibles, we also came up with a little bit less than 20,000.

The law allows 10 sites; 8 were picked. The law allows 66,000 enrollees. There are only 66,000 eligibles in those 8 sites. I don't see why we couldn't extend it to two other sites.

Mr. CUMMINGS. Now, going back to you, specifically mentioned Delaware and I think Puerto Rico.

Ms. HICKEY. Yes, sir.

Mr. CUMMINGS. And said that they were not representative of the kind of—well, what you are looking for. I mean, of what you would expect, generally, throughout the country.

Ms. HICKEY. Yes, sir.

Mr. CUMMINGS. So I guess you have two problems. One, you have two sites that are not representative that have, I guess, a limited number of people that would even be eligible.

Ms. HICKEY. In the Dover site, that is correct sir. Yes, sir.

Mr. CUMMINGS. And then you also have the problem where you could pick up two sites that would be representative but we are not doing that.

Ms. HICKEY. Yes, sir.

Mr. CUMMINGS. So, basically, when you net it out—and I notice when you answered me you said the Dover site, but then you didn't mention the Puerto Rican site.

Ms. HICKEY. Puerto Rico is different because of the enrollment pattern for FEHBP. The enrollment pattern in FEHBP in Puerto Rico is that the majority enroll in HMOs. That is not true anywhere across the country. If the purpose of this is to test the number of people that would enroll and in what type of program they would enroll in within FEHBP if we opened it up to our entire beneficiary category across the United States, then overlaying Puerto Rico on the same type of population is not going to tell you whether they are going to enroll in a fee-for-service or an HMO, because the enrollment pattern in Puerto Rico is different.

Mr. CUMMINGS. So, therefore, if you net it out, you come up with six, right now, that probably pretty much fit the pattern.

Ms. HICKEY. Yes, sir. And one of those—excuse me, sir—but one of those——

Mr. CUMMINGS. No. No problem.

Ms. HICKEY [continuing]. Is the only site where there is any other competitive thing that DOD offers as an employer benefit and that is the Medicare subvention. And that only competitive site that is in this demonstration is Dover and it has a total of 3,900 beneficiaries. We are not going to even know, if you are offered subvention, would you rather have that then the FEHBP, when you are talking about a total of 4,000 people, some of whom probably have other health insurance any way.

Mr. CUMMINGS. So when the chairman talks about whether we are doomed for failure, all of you seem to indicate that this 20,000 problem is a major, major problem I guess because, one, it is not—I mean, you would think that you would have, if you are going to do a pilot, that the pilot is going to be representative because the reason why you do a pilot, as I understand it, is so that you can get a sample and see how it works and how it is going to be used as what we talk about up here costs—I mean, effective and cost-efficiency, looking at all those kinds of things. But if you don't have a true sample to start with, then you have a problem.

Ms. HICKEY. Yes, sir.

Mr. CUMMINGS. Is that a fair conclusion? Would that be the No. 1 problem, you think? When you talk about doomed to failure? This whole thing of the——

Ms. HICKEY. I think the first problem and I think we would all agree, at least the three of us, would be if the premiums were set significantly higher than they offer Federal civilians.

Mr. CUMMINGS. OK.

Ms. HICKEY. Because I think you would have two problems there. One would be the problem that the premium is higher, so there-

fore, somebody is going to choose not to enroll because of the premium. The other one which, in ways bothers me even more is that this group of people already feel they have been shot down by their country. They feel that a promise has been broken and probably it has. And then to say to them, because that is the way they are going to interpret it, you are not as good as a retired Federal civilian because we are going to charge you more for this program. I think in many ways it could do an awful lot of harm.

Mr. CUMMINGS. So No. 1 would be cost, the premium. No. 2 would be this whole issue of our numbers. And what is No. 3?

Ms. HICKEY. The fact that I think that this population, as Ms. Pugh mentioned, is going to need a lot of education. They are making two choices; Federal civilians and Federal civilian retirees make one: Which plan do I want to be in next year? Our folks are going to have to make two. No. 1, do I want to even look at this demonstration that is only going to last 3 years? And, No. 2, having made that decision, which one of these plans am I going to enroll in?

So there is a lot of education that has to go on. And if DOD is not going to get its brochures out until October 30th and open enrollment season starts November 8th, I think that is a problem.

Mr. CUMMINGS. Mr. Partridge, you put up a very good point about people possibly enrolling in the last year.

Mr. PARTRIDGE. Yes.

Mr. CUMMINGS. That is a problem. I guess so this thing is structured so that people might join in the first, second, or third year. Is that——

Mr. PARTRIDGE. Yes, sir. They will have an open enrollment season each year, just like Federal employees have, as I understand it. But the last year, since the program ends at the end of the last year, they have only 12 months in the program.

Mr. CUMMINGS. So your proposal is that you extend it so that everybody has at least 3 years. Is that right?

Mr. PARTRIDGE. That is it.

Mr. CUMMINGS. OK. You are not talking about the first year people having 2 additional years beyond the 3-years? Do you follow what I am saying?

Mr. PARTRIDGE. I understand what you are saying. I would say that the people who enroll the first year should be allowed to stay for the full length of the demonstration program.

Mr. CUMMINGS. OK.

Mr. PARTRIDGE. And the people who enrolled in the last year should be allowed to stay at least 3 years.

Mr. CUMMINGS. OK.

Mr. PARTRIDGE. So, yes, you could have people in there for—what—6 years.

Mr. CUMMINGS. I would hope that the next panel would—I mean, the reason why I am raising these questions is just so that the next panel can effectively, hopefully, can address these issues. Because I think you all have done a good job of punching holes in this thing.

But, now, do any of you all have anything good to say about it? And I am not trying to be smart. I am just curious. The fact that it is there.

Mr. PARTRIDGE. We are delighted it is there and we agree with Representative Cunningham, there is no reason why that we can't move this more quickly. Because the only thing we are talking about here is cost. That is the only thing that is holding it back. So we think it is going to be a very cost-effective program and we should look forward to expanding it quickly without waiting for the full time of the demonstration.

Mr. CUMMINGS. But we have a program, we have a demonstration project, I guess you could kind of summarize it by saying it probably could use a little fixing up and making a few changes here and there to make it the best that it could be so that it can accomplish what we all hope that it will accomplish. Is that a fair statement?

Ms. PUGH. Congressman, yes. It is a fair statement. The first thing is we have to fine tune the program as it is right now, but the second part is we don't want to delay it either. That would be the biggest concern. In response to your first question, yes, this is a big hope out there for the military retiree community. I will attest to the fact that last year when we published the fact that the House passed it 120 to 1 every one of my members was calling in happiness.

And even though we selected the sites and it wasn't in their State or their district, they said, I can't wait for this data to get together because I want to enroll. I had a woman who called from California 2 days ago who just read about this in one of the local newspapers. She said, you know, I signed up for the military career for my 20 years—and we are not debating about the free health care—but she said, my neighbors down the street have this great benefit. When can I see it. And I said, time. And she said, I don't have time.

Mr. CUMMINGS. I think one of the statements that you and the chairman, that you made and the chairman reiterated and I am going to certainly talk about it when I talk about wherever I go is this whole idea of people actually moving to certain areas so that they can get health care. I mean, that says a lot. And I think the chairman is right. I think a lot of people don't even realize how serious this whole question is of health care and people being able to get it. And so I want to thank you all for your testimony.

Mr. SCARBOROUGH. Thank you, Mr. Cummings. Mr. Miller.

Mr. MILLER. Thank you. I appreciate you all being here. It is very concerning these statements you have made because this is something that we all want to see succeed. I mean, we really do. I have a large number of retirees in my district, not military retirees, but close to, probably, in my area of southwest Florida. We have beautiful beaches by the way. But the concern is how do we make it succeed? And maybe it is something that we have to do in Congress. And then, you know, we have to look at this. And we still have time to do some things as our authorization bills and our appropriation bills go through, you know, in the next few months. And so we need to have the input for that.

How much input did you all have, the three military organizations plus Blue Cross, in the development of the plan to this stage? Have you all been able to provide input that you feel comfortable that they are listening to you?

Ms. HICKEY. We got invited to the bingo drum ceremony and several of us picked the sites after they rolled the bingo drum.

Mr. SCARBOROUGH. Is that your input?

Ms. HICKEY. We have seen, as of last week, I think, the potential marketing plan and time lines and have responded to that. In the normal scheme of things, I would say if we were going back and looking at when we first saw the subvention marketing plans, it was well over 6 months before they even were going to market on the first site. That is part of my concern, is there a commitment at the Department of Defense to put as much marketing and other effort in this program as they did in their own subvention program, the one that they wanted?

Mr. MILLER. Mr. Gammarino.

Mr. GAMMARINO. Well, we are sort of at the back end of this, as you can imagine. We are providing the care. I don't think we were significantly involved in the beginning. There have been some periodic meetings. We have initiated many meetings to get clarification both from the administrative perspective and also from the issue of underwriting risk.

And Mr. Cummings asked if there were anything significant that would hold this project up and I think, us being the largest carrier and I think many of the other carriers also see this as an issue as well, and that is ensuring that the underwriting risk is patterned after and follows what is there today and not to jerry-rig some other administrative mechanism. To do that really undermines the credibility of this program in the long run.

So we would have liked more participation. We would still like more participation today. And we do stand ready to assist both agencies in delivering this program.

Mr. MILLER. Well, thank you very much. You know, we are going to do everything we can to make sure this succeeds and if there is something we can do in the authorization or appropriation bill yet this year, we can do that. But I think we are all looking forward to the next panel.

Ms. PUGH. Can I interject one moment? And I apologize. What you could do this year is where we are today is there are no operational guidelines so no one can move forward on doing anything. So I guess that is my question. If it is being held up, so to speak, in OMB, then the rate issue definitely has to be figured out or solved. And it is this committee and the agencies need to work together because I think as we have already stated, that is a very big concern of creating two different benefits for two different populations, civil servants and retirees. Yet, again, it is a disconnect in benefits. Thank you. I apologize.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Thank you, Mr. Miller. The representative of the district that has the second most beautiful beaches in Florida and all of America. We have studies to prove that.

Ms. HICKEY. Aren't you happy Mr. Mica is not here.

Mr. SCARBOROUGH. Well——

Mr. MILLER. He doesn't have any beaches.

Mr. SCARBOROUGH. He doesn't. No. He is not even in the top 10.

I want to just followup very briefly two quick points. Mrs. Hickey, you keep talking about the short fuse and keep talking about

October being the time line to get some educational mailings out. I wanted to ask you. I have a time line here that talks about the first educational mailings going to be going out to eligibles and the deadline for that is tomorrow, July 1, 1999. And I understand that you actually saw—I think saw—copies of this about a week ago. Are they helpful?

Ms. HICKEY. That was the original time line that those of us in the coalition and the Veterans Alliance received as well, sir. But we had an updated one about 10 days ago that was e-mailed out to several of us to make comments on. And that one stated that they were not planning on putting stuff in the mail until October 30, correct?

Ms. PUGH. Yes. I have the time line right here, the most recent one. And the information to distribute out was starting July 15. That was a postcard. But the actual information wouldn't be until October 30, they would have the FEHBP enrollment and marketing and beneficiary information. This is the most recent that I received from DOD.

Mr. SCARBOROUGH. Really?

Ms. PUGH. I feel like I am on the sidelines sometimes.

Mr. SCARBOROUGH. Well, actually we are——

Ms. PUGH. Asking for information is a difficult thing in this city sometimes.

Mr. SCARBOROUGH. We are actually, I think, further out on the sidelines and maybe up in the stands rooting, because we have actually got this time line, June 28, 1999, which was a day or two ago. Ours is even more dated than yours.

Ms. PUGH. Well mine says DOD and maybe you had a different agency. I don't know if that is OPM's time line.

Mr. SCARBOROUGH. Yes, it is OPM's but they have gone ahead and been kind enough to put an X by July 1 for DOD to get it out. All right. Well, I want to thank all of you for coming and, Ms. Hickey, I want to, once again, take you to task for using "may" again. You said this "may" have been a broken promise. Let us be very clear right now. I talked to retiring General Charles Krulack and the other joint chiefs in a DOD hearing a year or two ago and all four of them testified that it was a broken promise.

Ms. HICKEY. I agree.

Mr. SCARBOROUGH. I agree with them and I will guarantee you every military retiree in my district believes that Congress and this administration and past administrations have not kept their promises. So I thank you all for what you do every day to make sure that we keep our feet to the fire. Thanks a lot.

Our final panel, and most popular one today, actually is going to be comprised of two distinguished witnesses. One is Rear Admiral Thomas Carrato, the Director of Military Health Care Systems and Operations at the Department of Defense's TRICARE Management Activity. And the second is Ed Flynn III, the Associate Director for Retirement and Insurance at the Office of Personnel Management, and a regular guest here at our subcommittee.

And I understand, Admiral, that you are going to be up for your second star very soon and we certainly congratulate you on that accomplishment and certainly know, coming from a Navy town, that that is a lifetime of commitment to excellence. So we commend you

on that and welcome you to our committee. I look forward to your testimony.

STATEMENTS OF THOMAS F. CARRATO, REAR ADMIRAL, USPHS, DIRECTOR, MILITARY HEALTH SYSTEMS OPERATIONS, TRICARE MANAGEMENT ACTIVITY, DEPARTMENT OF DEFENSE; AND WILLIAM E. FLYNN III, ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT

Admiral CARRATO. Thank you, Mr. Chairman. I appreciate the opportunity to discuss our progress in implementing the FEHBP demonstration program. The Department of Defense has worked closely with the Office of Personnel Management in preparing to implement the demonstration program. We have selected eight sites for the program and are preparing to notify eligible beneficiaries about the program this summer and conduct an open season in coincidence with the usual FEHBP open season in November for health care beginning January 2000.

The statute requires the Secretary of Defense and the Director of OPM to jointly identify and select the geographic areas in which the demonstration project will be conducted. Statute limits the size of the demonstration to no more than 66,000 participants, 6 to 10 locations, with not more than 1 site per TRICARE region. Sites must include a catchment area, one or more military hospitals, an area that is not located in the catchment area of a military hospital, and an area in which there is a Medicare subvention demonstration project. Our current best estimate is that there are approximately 70,000 persons eligible for the demo, based on their place of residence and their category of eligibility for military health system care.

Two principal factors influenced the Department's decision for sizing the demonstration at approximately 69,000 eligible beneficiaries. First, DOD wanted to avoid an artificial cap on enrollment in the demonstration. And, second, while the demo is authorized for up to 66,000 participants, no funding was provided. The Department's fiscal year 2000 budget includes funding of $79 million for this demonstration and two other demonstrations authorized in the Defense Authorization Act for Fiscal Year 1999. And this closely matches the CBO pay-as-you-go estimate for these demonstrations. Based on current government contributions and anticipated increases in the FEHBP rates, this could result in a cost in excess of $130 million for the FEHBP demo alone if 66,000 participated.

In summary, the Department believes the demo is sized to yield statistically relevant data, no requirement to artificially cap participation, and is in line with the cost estimates done by the CBO for this initiative.

The Department and OPM have been jointly developing an FEHBP demonstration marketing plan. The marketing plan describes our approach to educating our eligible beneficiaries about the demonstration program. Our strategy will include mailings to beneficiaries, which will begin actually July 15. A toll-free telephone call center to respond to beneficiary inquiries and distribute

materials. And this will start in September. And participation in health fairs during the open season in November.

During the open season, all eligible beneficiaries will be directly mailed a special guide. The guide will list important information about participating plans, health benefits offered, premium costs, and instructions for requesting individual plan brochures. As you can see, the Department has taken numerous steps to ensure timely and accurate information is provided to the demonstration-eligible population.

Mr. Chairman, I want to address specifically the issue of access to health care for military beneficiaries over the age of 65. TRICARE will always be incomplete until we have the capability to enroll retirees over the age of 65. Access to military health care is a benefit these people have earned, based on their years of service to and sacrifice for their country. Many of them were promised free care for life if they spent a career in the military. DOD feels a sincere and enduring responsibility for the health of our retired beneficiaries and will do all it can to meet its moral commitment to provide health care for our retirees and their families. We are committed to finding the best alternative for ensuring our older retirees and their families comprehensive health care delivery.

This concludes my statement and I, of course, would be happy to answer all of your questions. Thank you.

[The prepared statement of Admiral Carrato follows:]

Implementation of the Federal Employees Health Benefits Program Demonstration Program

Statement By

Rear Admiral Thomas F. Carrato, USPHS
Director, Military Health System Operations
TRICARE Management Activity

Submitted to the

Civil Service Subcommittee
Committee on Government Reform and Oversight
U.S. House of Representatives

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Mr. Chairman, Distinguished members of the Committee, I appreciate the opportunity to discuss our progress in implementing the demonstration program required by section 721 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999. The demonstration will make enrollment in the Federal Employee Health Benefits Program available to certain Military Health System beneficiaries, principally military retirees who are Medicare eligible and their family members.

The Department of Defense has worked closely with the Office of Personnel Management in preparing to implement the demonstration program. Pursuant to the statutory direction, we have selected eight sites for the program, and are preparing to notify eligible beneficiaries about the program this summer and conduct an open season coincident with the usual FEHBP open season in November for health care enrollments effective January 2000.

In its invitation to this hearing, the committee identified several issues it was concerned about, including:

1. the size of the demonstration
2. the impact of the size of the demonstration on FEHBP carriers and premiums
3. potential requirements for separate carrier reserve accounts for the demonstration
4. required participation by FEHBP carriers
5. the adequacy of our consultations with FEHBP carriers, and
6. the adequacy of our consultations with representatives of military families and military retirees.

My testimony will address items 1 and 6 on this list of concerns; while the testimony from the Office of Personnel Management will address items 2, 3, 4 and 5.

Sizing the Demonstration

The statute requires the Secretary of Defense and the Director of the Office of Personnel Management to jointly identify and select the geographic areas in which the demonstration project will be conducted, to include at least six, but not more than ten sites to include an area that includes the catchment area of one or more military medical treatment facilities, an area that is not located in the catchment area of a military medical treatment facility; and an area in which there is a Medicare Subvention Demonstration project area. Importantly, there cannot be more than one site in each TRICARE region. The statute limits the size of the demonstration to no more than 66,000 participants, or covered lives.

In its planning for site selection, the Department decided to size the demonstration project at approximately 66,000 eligible beneficiaries. Two principal factors influenced the Department's decision:

First, one of the biggest unknowns, which is to be analyzed in this demonstration, is the level of participation in the program by our eligible beneficiaries. Participation estimates by the Congressional Budget Office, the General Accounting Office, and others have ranged up to 83 percent of eligible beneficiaries. Given the level of interest by beneficiary groups in this program it must be assumed that a significant portion of the eligible beneficiaries may participate. The Department was concerned that imposing an artificial cap on enrollment in the demonstration (by sizing the demonstration so that the statutory limit could be reached) would make it impossible to draw conclusions about the most important issue being tested in the demonstration – the level of beneficiary participation.

Second, while the demonstration was authorized for up to 66,000 participants, no funding was provided. The Department's FY2000 President's Budget includes funding of $79 million for this and the Senior Supplemental demonstration in section 722 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999. This closely matches the CBO "Pay-as-you-go Estimate" for these demonstrations. In addition to unknown factor of participation rates there is no basis to predict the type (and cost) of plans selected by the beneficiaries. Government costs in this demonstration are limited to the amount of government contribution which would be payable if the electing beneficiary were an FEHBP eligible annuitant. Based on current government contributions and anticipated increases in FEHBP rate, if the maximum authorized population of 66,000 participated, the total government cost could exceed $130 million for the FEHBP demonstration alone.

Additionally, an important decision was to ensure that each of the sites selected would have a sufficient population to allow statistically sound analysis to be made of the results of this demonstration. We believe that the selection of sites has accomplished this.

Our current best estimate is that there are 69,663 persons eligible for the demonstration, based on their place of residence and their category of eligibility for Military Health System care. Up to 66,000 participants will be permitted to enroll from this eligible pool. The Department believes that the demonstration is sized to yield statistically relevant data without an artificial cap on participation, and is in line with the cost estimates done by CBO for this initiative.

Site Selection

In devising its site selection methodology, DoD had three goals. The first was to satisfy the legislative requirements of the demonstration. The second goal was to create a demonstration capable of validly testing FEHBP in a variety of settings. Because almost half of all dual-eligible beneficiaries live outside of catchment areas, DoD sought both catchment area and non-catchment area sites. Additionally, because health care options

are typically so different in urban and rural areas, DoD likewise sought both urban and rural non-catchment area sites. DoD's third goal was to make the selection fair: potentially available to all dual-eligible beneficiaries.

The resulting methodology was a complex one. DoD selected demonstration sites at random from the following categories of sites: Large, Medium, and Small Catchment Areas; Metropolitan Non-Catchment Areas; and rural Non-Catchment Areas. The order of selection was important for two reasons. The first was to ensure compliance with the legislative provisions. Because of the one-site-per-region rule, the Medicare subvention demonstration site was selected first. The second reason was to ensure balance in the types of sites selected. After the Medicare demonstration site was selected, sites were selected at random by rotating category. The final order of selection was Medicare demonstration site, Large Catchment Area, Small Catchment Area, two Metropolitan Non-Catchment Areas, one Rural Area, a second Large Catchment Area, a third Metropolitan Non-Catchment Area, and finally, two additional Rural Areas. Site size was important. No site could be larger than 25,000 beneficiaries, in order to prevent any one site from dominating the demonstration. Similarly, no site could be appreciably smaller than 3,000 beneficiaries. This lower threshold was to assure that statistically valid conclusions could be derived about participation rates.

DoD selected 8 sites with approximately 69,663 eligible beneficiaries. In the final selection, there were 4 Catchment Areas and 4 Non-Catchment Areas. The Catchment Areas were the larger sites in terms of eligible population, so approximately two-thirds of the dual-eligible beneficiaries selected were from catchment areas.

DoD's threshold did not materially impact the site-selection process. The challenge was not to limit the selections, but to select enough. Achieving slightly more than 66,000 required eight drawings, and that was with the selection of Camp Pendleton on the seventh draw. The eligible population is spread out so diffusely in the non-catchment areas that achieving large numbers in such areas is difficult unless the sites become huge. For example, had a county in North Dakota or South Dakota been selected in place of Humbolt County California, the site would have had to include all of both states just to hit 3,000 eligible beneficiaries. Similarly, most Metropolitan Non-Catchment Areas provide fewer than 15,000 beneficiaries per selection. Typically even catchment areas sites provide relatively few eligible beneficiaries per site; three quarters of the catchment areas in the Continental United States have 14,500 or fewer dual eligible beneficiaries, and half have 8,000 or fewer eligible beneficiaries. Expanding the catchment area selections geographically offers only limited benefit; many sites are remote enough that population falls off precipitously much beyond the catchment areas, and selection rates in sites that are too large and heterogeneous will be hard to interpret. In sum, although two additional sites could be selected under the current legislative provisions (from TRICARE Central, Region 11, and Region 12, and Alaska), the prospect of drawing appreciably larger numbers of eligible beneficiaries appears limited.

Informing Beneficiary Groups about the Demonstration

Mr. Chairman, I would like to describe the commitment that the Department has adopted to educate those who are eligible to participate in the FEHBP Demonstration Program. The Assistant Secretary of Defense (Health Affairs), her Deputy Assistant Secretaries, the Executive Director of the TRICARE Management Activity, and many staff have conducted meetings with representatives of the beneficiaries since the demonstration statute was enacted last Fall. On January 14, 1999, the Department published an official news release from the Office of Assistant Secretary of Defense (Public Affairs) describing the FEHBP Demonstration site selection ceremony held by Assistant Secretary of Defense for Health Affairs. Beneficiary groups were sent copies of the news release. The Department also utilized the World Wide Web by posting the news release and the corresponding site zip codes, as well as frequently asked questions about the demonstration at http://www.tricare.osd.mil/fehbp.

The Department also will prepare and distribute several model news releases to the participating regional Lead Agents, military retiree organizations, service command information centers, and Lead Agent marketing officers. These releases will provide the eligible beneficiaries demonstration information.

The Department and OPM have been jointly developing an FEHBP Demonstration Marketing Plan. The Marketing Plan describes our "grass roots" approach to educating our eligible beneficiaries about the demonstration program. A draft copy of the Marketing Plan is located in Appendix A of my prepared statement.

Included within the Marketing Plan are several different avenues for educating eligible beneficiaries:

- **Program Fact Sheet**: TRICARE Marketing Office (TMO) and Service representatives, in coordination with OPM, will prepare a fact sheet on the FEHBP Demonstration Program, which will contain most frequently asked questions and responses. The fact sheet will be posted on the World Wide Web, and distributed to the Military Coalition and Alliance and the regional Lead Agent marketing and public affairs staff.

- **Comparison Chart**: The TMO, in coordination with OPM, will develop a comparison chart to help eligible beneficiaries understand the differences between the health benefits offered through the TRICARE Program and those offered through the FEHBP Demonstration Program.

- **Health Fairs**: The TMO, in coordination with Service representatives for participating FEHBP health plans and the Department's Information Processing Center (IPC), will conduct health fairs at the demonstration sites

during October and November 1999. Military Coalition and Alliance members will be notified when information is available.

- **Customer Service Call Center**: In September 1999, the general public were able to access the Department's IPC customer service call center by dialing 1-877-DOD FEHB. The customer service call center will answer questions concerning FEHBP plans marketing materials, FEHBP plans brochures, enrollment, disenrollment, and specific issues raised by eligible beneficiaries regarding the demonstration.

During the Open Season, all eligible beneficiaries will be directly mailed a special guide titled "The 2000 Guide to Federal Employees Health Benefits Plan Participating in the DoD/FEHBP Demonstration Program." The 2000 Guide will list important information about participating FEHBP plans, health benefits offered, premium costs, and instructions for requesting individual plan brochures from the Department's IPC. Furthermore, the IPC will be available to answer any questions from the eligible beneficiaries concerning information contained within the 2000 Guide.

Mr. Chairman, as you can see, the Department has taken numerous steps to ensure timely and accurate information is provided to our FEHBP Demonstration eligible beneficiaries. The Department is confident that the marketing materials described above, coupled with the customer service call center, will provide the eligible beneficiaries with the most comprehensive education available.

DoD's Commitment to Its Senior Beneficiaries

DoD recognizes its responsibility to offer a health program for military beneficiaries aged 65 and older, and is committed to maintaining access to care, and maintaining our level of space-available care to the maximum extent feasible, despite continuing reductions in medical infrastructure. For example, DoD mail order and retail pharmacy benefits are extended to Medicare-eligible beneficiaries who formerly relied on now-closed pharmacies.

We believe that significant efficiencies can be achieved in the Military Health System without reducing space-available care. Our strategy is to explore and test viable options for retiree health care, and to identify the best ways to meet our beneficiaries' needs in the future.

Among the programs that are now under way or being developed are the following:

- **TRICARE Senior** (Medicare subvention) is undergoing a 3-year test at six sites, as authorized by the Balanced Budget Act of 1997. Under the first component, called TRICARE Senior Prime, DoD may receive capitated payments from Medicare Trust Funds for beneficiaries enrolling in TRICARE. Under the Medicare Partners component, DoD will enter into agreements with Medicare Choice Plans, and receive

payments from the plans for care provided to dual-eligible beneficiaries enrolled with the Partner plan.

- A demonstration project at **MacDill AFB**, Florida involves enrollment of 2,000 seniors for primary care services at the MacDill hospital; when they need services beyond the capabilities of MacDill, they will obtain those services from civilian providers and use their Medicare entitlement. Annual DHP funding of $2 million has been allocated to this project.

- **Additional demonstrations** TRICARE as a supplement to Medicare, at two sites, and enhanced pharmacy coverage, at two sites, have been directed, along with the FEHBP Demonstration, in the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999. Health care under these projects will begin in FY 2000.

With full implementation of these demonstration programs next year, DoD will have in place projects in about 20 locations, affecting about 100,000 over-65 military beneficiaries. As information becomes available about beneficiary satisfaction, program costs and feasibility, and other factors, it will be vital to examine the options and come up with a well-reasoned approach to meeting the health care needs of the beneficiaries, to whom the nation owes so much.

Concerns About FEHBP and the Future of the Military Health System

In his testimony before this Committee last year, the Principal Deputy Assistant Secretary of Defense (Health Affairs) expressed several concerns about a new entitlement to FEHBP for military beneficiaries, including:

- increased costs to DoD, to Medicare, and to beneficiaries
- the potential loss of Medicare subvention, the keystone of DoD's initiatives to enhance access for over-65 beneficiaries, and
- the major threat that FEHBP poses to military medical readiness.

Cost of FEHBP

DoD has reviewed the results of two analyses of the Military Health System (MHS) and FEHBP conducted by the Congressional Budget Office, and the findings in the General Accounting Office report, "Military Retirees' Health Care – Costs and other Implications of Options to Enhance Older Retirees' Benefits" (June 1997).

In its July 1995 report, "Restructuring Military Medical Care," CBO evaluated alternatives to the current operation of the MHS. CBO focused primarily on a proposal to close all but 11 military hospitals, meet readiness training needs in alternative ways, care for active duty members in military or civilian facilities, and enroll all other military beneficiaries in FEHBP. CBO estimated the government cost of insuring DoD eligible beneficiaries under FEHBP would range from $7.3 billion to $12.1 billion, depending on

the level of government contribution to the FEHBP premiums. This includes increased Medicare trust fund expenditures estimated at $1.4 billion. CBO concluded that, given government and beneficiary premium contributions commensurate with those for civil service non-postal employees and annuitants, participation rates would range from 37 percent for family members of retirees under age 65 to 95 percent for Medicare-eligible beneficiaries.

The key implication of CBO's 1995 analysis is that replacing the peacetime military health benefit with FEHBP would result in a net added cost to the Government -- unless there is a major cost shift to beneficiaries. Average annual out-of-pocket costs per individual are about $1,250 under the most widely used FEHBP plan, Blue Cross and Blue Shield standard option. A comparable figure for TRICARE would range from $100 to $500, depending on beneficiary category and option selected.

In January 1998, CBO provided cost estimates for several bills that would provide coverage for certain MHS beneficiaries. Because of the provisions of these bills, CBO took a different approach than in its 1995 analysis: FEHBP is considered as an additional choice for beneficiaries, rather than as an alternative to existing coverage. CBO concludes that, given government and beneficiary premium contributions commensurate with those for civil service non-postal employees and annuitants, participation rates would be about 70 percent for beneficiaries over 65, about 5 percent for retirees, their families and survivors under 65, and nil for active duty families. These participation rates reflect the availability of cost effective alternatives to FEHBP. Overall, CBO estimates the net cost of offering an FEHBP option at about $2.1 billion annually. Most of this cost is attributed to Medicare-eligible beneficiaries, because CBO expects very low participation by other MHS beneficiaries.

These two analyses by CBO delineate two extremes: the 1995 report provides a high estimate, based an assumption that the MHS will be unavailable, and the 1998 report provides a low estimate, based on expected beneficiary response to an FEHBP option offered in addition to current options.

In its June 1997 report, the General Accounting Office assumed that 83 percent of Medicare-eligible retirees and family members would enroll in FEHBP if offered the choice, and estimated the cost to DoD at $1.6 billion. GAO did not estimate the cost to the Medicare Trust Funds of offering FEHBP.

The Administration also has concerns about how any expansion of this demonstration might affect the cost of the FEHBP to enrollees, the Federal Government, and taxpayers. The Office of Personnel Management will address this in its testimony.

Military Medical Readiness

In addition to the issue of cost, DoD has concerns about the military readiness implications of offering an FEHBP entitlement to MHS beneficiaries. These impacts

would be exacerbated if the CBO's alarming estimates for the costs for an FEHBP option prove accurate, and some of the costs must be borne out of the existing Defense Health Program. The inseparability of the twin missions of military medicine is, simply stated, the ability to care for the men and women of the uniformed services through a continuum of operations reaching from the "boots on the ground" to installations here in the U.S. A vital, and unique component is the ability to assess health risks associated with ongoing worldwide deployments. The MHS must have physicians, nurses, technicians, and medics who know what to do to save lives and prevent illness and disease. They learn how to operate in a field or shipboard environment by working within that military setting, and they maintain their professional, technical skills by working in a military **medical** setting. We need hospitals and clinics where our health care personnel can practice and provide a highly valued benefit to the families of our active duty personnel, our retirees and their families.

If substantial numbers of beneficiaries are removed from the Military Health System, then DoD's ability to recruit, train, and maintain the needed medical force could be seriously impeded or disrupted. Existing training programs in military facilities may be unsupportable; new arrangements with civilian facilities for training military personnel would have to be made. There are considerable overlaps in the resources needed to treat seniors in peacetime and the casualties of war – from intensive care and operating rooms, to radiology and pathology services, to physical therapy and dialysis. Keeping these resources on standby for war is impractical; using them to support peacetime care for military beneficiaries is the sensible approach.

Future needs for wartime combat medical capability, and the infrastructure to support it, are likely to change dramatically in the future. This depends on the outcome of current discussions of the role of the military in the post-Cold War era and our efforts to prepare America's armed forces for an uncertain future. The Report of the Quadrennial Defense Review (May 1997), the Defense Reform Initiative (announced in November 1997), and the National Defense Panel's report "Transforming Defense" (December 1997) all point to significant change in military medicine in the coming years. The existing infrastructure of military hospitals and clinics worldwide forms the basis of a cost-effective, high quality health care system for these beneficiaries – the TRICARE system.

Health care is an important aspect of quality of life, and DoD is committed to ensuring the quality and availability of medical care for all members of the military community including active duty personnel and their families, and retirees, their families, and survivors. FEHBP presents an alternative health care delivery option that could threaten the viability of our medical readiness infrastructure and would be dramatically more expensive for the Government and for beneficiaries than TRICARE for CHAMPUS-eligible beneficiaries and TRICARE Senior for Medicare eligible beneficiaries.

TRICARE Senior and FEHBP

Mr. Chairman, I want to address specifically the issue of access to health care for military beneficiaries over age 65. TRICARE will always be incomplete until we have the capability to enroll retirees over the age of 65. Within the continental United States, our retired beneficiaries, their families and survivors are eligible to receive health care benefits under the Medicare system when they become 65 years of age. They continue to be eligible for care in the MHS on a space-available basis, but they are no longer eligible for care under CHAMPUS and therefore, are not eligible to participate in the TRICARE program. The Medicare subvention demonstration is an important first step to determine if Medicare reimbursement can increase access for retirees to the Tricare program without increasing costs to the Medicare Trust Funds.

Access to military health care is a benefit these people have earned based on their years of service to and sacrifice for their country. Many of them were promised free care for life if they spent a career in the military. DoD feels a sincere and enduring responsibility for the health of our retired beneficiaries, and will do all it can to meet its moral commitment to provide health care for our military retirees and their families. At the same time, they understand the reality of fewer hospitals, fewer physicians, and less money. We are committed to finding the best alternatives for ensuring our older retirees and their families comprehensive health care delivery.

Our highest priority for keeping our commitment is TRICARE Senior. DoD worked closely with the Congress to achieve the Balanced Budget Act of 1997 provision authorizing a three-year demonstration of Medicare subvention, in which the Medicare program will treat the MHS similarly to a risk-type HMO for dual-eligible Medicare/DoD beneficiaries. The legislation also authorized Medicare HMOs to make payments to DoD for care provided by MTFs participating in the demonstration to HMO enrollees. This part of the demonstration, called Medicare Partners, will allow DoD to enter into contracts with Medicare HMOs to provide specialty and inpatient care to dual-eligible beneficiaries. The goal of the demonstration, TRICARE Senior, is to test cost-effective alternatives for delivering accessible and quality care to dual-eligible beneficiaries that does not increase the total federal cost for either agency.

We believe that by working closely with the Medicare program, alternatives can be developed which will offer comprehensive, as-needed, health care for our older beneficiaries. The demonstration of TRICARE Senior is an important first step.

Upon evaluation of a successful Medicare subvension demonstration, DoD and the Administration will work with the Congress to increase the availability of this demonstration to more military retirees.

A Note on TRICARE Progress

The Principal Deputy Assistant Secretary of Defense (Health Affairs), Mr. Gary A. Christopherson, testified before this committee one year ago about the status of the TRICARE program. As an update to that testimony, I am pleased to report that TRICARE has been implemented worldwide, and that many of the problems associated with initial implementation have been solved. We continue to work aggressively to address remaining concerns about TRICARE, to make it the best program it can be. The Department has made significant strides in ensuring strong consumer protections and enhancing access to high quality health care for its beneficiaries, both in military facilities and from contracted providers in TRICARE.

Thank you.

Appendix A

Marketing/Beneficiary Education Plan
DOD/FEHBP Demonstration Project
Draft - April 27, 1999

Objectives

- To inform Medicare eligible military retirees, their eligible family members, and other eligible beneficiaries residing in the demonstration sites, of their option to enroll in a health benefits plan under the FEHBP Demonstration project during the fall of 1999 Open Enrollment Season.

- To inform military personnel, eligible family members, the retiree population at-large, and their support groups, of the FEHBP Demonstration Project by mentioning this and other program initiatives for beneficiaries who are age 65 and older, in other TRICARE marketing materials.

- To educate eligible beneficiaries about the FEHBP Demonstration Project and the difference between the FEHBP Demonstration Project and the Military Health System.

Strategies

- Conduct an informative beneficiary multi-media education campaign to inform target audiences of program initiation and details.

- Prepare, print, and distribute educational materials, in accordance with the Office of Personnel Management (OPM) marketing guidance and guidelines, to educate and market this program to the primary target audience to facilitate their participation in the FEHBP Demonstration Project.

Target Audiences

Primary Target Audience:
- Certain dual eligible military retirees and their families
- Certain unremarried former spouses of military members
- Family members of deceased military members or former military members

Secondary Target Audience:
- Retirees not eligible for the demonstration project and active duty military and families
- Specialty media serving first two target audiences
- Elected officials, particularly in demonstration project states

- Military Coalition and Alliance groups

Positioning Statement

The FEHBP Demonstration Project, where offered, extends choices of an array of health plan options for the provision of comprehensive health benefits to Medicare-eligible military retirees, their families, certain unremarried former spouses of military members and eligible family members of deceased active or retired military members.

Messages

- The FEHBP Demonstration Project provides the opportunity for eligible military retirees, their family members, certain unremarried former spouses of military members, and family members of deceased members to receive comprehensive health care from an array of FEHBP Plans.

- The FEHBP Demonstration Project allows eligible military retirees, their family members, certain unremarried former spouses, and family members of deceased members to receive the same health care coverage available to Federal civilian employees and retirees.

- Eligible beneficiaries participating in the FEHBP Demonstration Project will be locked out of the Military Health System (MHS) during the period of their FEHBP participation. MHS services, including TRICARE benefits, space available health care, and pharmacy services will not be available to beneficiaries while they are enrolled in the FEHBP Demonstration Project.

- Eligible beneficiaries who are family members of deceased members or certain unremarried former spouses of military members, who choose to participate in the FEHBP Demonstration Project, do not have to be Medicare eligible.

- Initial enrollment in FEHBP Plans will occur during the Open Enrollment Season from November 8, 1999 to December 13, 1999; health care coverage will start January 1, 2000 and end December 31, 2002. Other opportunities to enroll or change enrollment will occur during open seasons in the fall of 2000 and 2001.

- Eligible beneficiaries participating in the FEHBP Demonstration Project must pay any applicable premiums to receive benefits.

- The amount of DoD government contribution will not exceed the amount of the contribution which would be payable for Federal employees under the FEHBP.

Concept

Central to the project's marketing and beneficiary education effort will be a trifold prepared by the TRICARE Marketing Office (TMO) in coordination with OPM, and provided to DoD's Information Processing Center, the Iowa Foundation, for distribution to eligible beneficiaries residing in those zip codes covered by the FEHBP Demonstration Project. The trifold will be available in PDF format for downloading from the HA/TMA and Services' web pages. It will also be available at TRICARE Service centers, retiree affairs offices, presentations and briefings provided by MHS/OPM staff, retiree days, retiree health care fairs, participating MTF marketing offices, and other appropriate locations such as the Military Coalition and Alliance offices, VFWs, etc. The trifold will contain information regarding the FEHBP Demonstration Project and how to participate in it.

OPM will also develop a special guide for the demonstration project Open Enrollment Season titled "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," which DoD will distribute to all eligible participants via DoD's Information Processing Center. The 2000 Guide brochure will include an enrollment form. It will also list information about participating FEHBP plans, health benefits offered, premium costs, and instructions for requesting individual plan brochures.

OPM will direct each participating plan to provide DoD's Information Processing Center with a supply of their plan brochures. These plan brochures will be distributed by the Information Processing Center to eligible program participants requesting them. The purpose of the plan brochure is to provide sufficient details about participating plans' health care benefits to enable eligible participants to make health plan choices.

Additional outreach and marketing activities will be pursued to ensure eligible beneficiaries residing in those selected sites are informed about the new opportunity for participating in the FEHBP Demonstration Project, as described below.

Tactical Elements

- ***Program Fact Sheet***. TMO and Service representatives, in coordination with OPM, will prepare a fact sheet on the FEHBP Demonstration Project, which will contain most frequently asked questions and responses. The information will be posted on HA/TMA and the Services' web pages, shared with the Military Coalition and Alliance members for inclusion in their written articles on the demonstration project, and disseminated to regional Lead Agents' marketing and public affairs staff where the 8 participating sites are located.

- ***A Comparison Chart***. To assist eligible participants in their decision-making process, TMO, in coordination with OPM, will develop a chart, which compares health benefits offered under the TRICARE program with those offered under the average FEHBP Plan.

- ***Military Coalition and Alliance Organizations.*** TMO and service representatives will encourage the Military Coalition and Alliance organizations to place provided marketing materials in areas frequented by their members.

- ***Additional Information.*** DoD will explore the possibility of developing standardized information about the demonstration project that could be used by interested parties.

- ***News Releases***. DoD and OPM will prepare and distribute several model news releases will be prepared and distributed to the participating regional Lead Agents and through other public affairs channels to inform target audiences about the details and dates for the FEHBP Demonstration Project. Distribution will be made, through public affairs channels, to military retiree organizations for inclusion in their publications. Distribution will also be made to service command information centers and to Lead Agent Marketing Officers in participating regions.

- ***Health Fairs***. In coordination with OPM, arrangements will be made by TMO, participating FEHBP Demonstration Project health plans service representatives, and DoD's Information Processing Center to conduct health fairs in the demonstration sites during the Open Enrollment Season. DoD and OPM representatives will be available to make presentations and answer questions. Military Alliance and Coalition members will be notified of these events. Where practicable, these health fairs should be in conjunction with or coordinated with other health fairs in the area open to FEHB enrollees.

- ***Information Processing Center***. DoD's Information Processing Center will be staffed with customer service specialists knowledgeable about the demonstration project to respond to enrollees' questions and inquires. Beneficiaries may also contact the Information Processing Center to request the "FEHBP 2000 Guide" brochure and plan brochures. The Information Processing Center will be responsible for enrollment/disenrollment application processing, and will mail enrollment and disenrollment confirmation letters to beneficiaries.

Measurement

This program employs time-proven marketing techniques. The success of each of the approaches to marketing and educating the eligible population about this FEHBP demonstration project will be assessed and "lessons learned" will be developed.

Timeline

April 28, 1999	Submit marketing/beneficiary education plan to IPT
June 15	Distribute most frequently asked questions, FEHBP Demonstration Project Fact Sheet, and Comparison Chart to Military Coalition and Alliance members, regional Lead Agents' Marketing and Public Affairs staff at the demonstration sites, and for placement on HA/TMA and Services' web pages
July 15	Distribute post card to all eligible beneficiaries describing the FEHBP Demonstration Project event schedule such as marketing material distribution dates, call center opening date, Open Enrollment Season duration, etc.
September 1	Distribute the FEHBP Demonstration Project trifold to the Information Processing Center for distribution to all eligible beneficiaries, and to TRICARE Service Centers, retiree affairs offices, participating MTF marketing offices, the Military Coalition and Alliance organizations, etc.
September 7	Information Processing Center Call Center becomes operational.
September 15	Distribute news/press releases to regional Lead Agent Public Affairs offices, Service command information centers, and to Military Coalition and Alliance organizations.
October 30	FEHBP Demonstration Project Open Enrollment Season marketing/beneficiary education materials distributed by the Information Processing Center to all eligible participants.
October - December	Conduct health fairs in the demonstration sites during the Open Enrollment Period.
November 8- December 13	Conduct Open Enrollment Season.
November – December	DoD's Information Processing Center will respond to requests from eligible participants for brochures.
December 99	Submit Press release for start of services.
January 1, 2000	Start of health services coverage

Mr. SCARBOROUGH. Thank you, Admiral. Welcome back, Mr. Flynn.

Mr. FLYNN. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Good to see you again. I look forward to your testimony.

Mr. FLYNN. Thank you very much, Mr. Chairman. I want to thank you for inviting me to testify today on the Federal Employees Health Benefits Program demonstration project for Department of Defense Medicare-eligible beneficiaries and dependents.

There has been a lot of testimony today and I will try and emphasize just a couple of key points, Mr. Chairman. But first let me say at the outset that I firmly believe the collaboration between the Office of Personnel Management and the Department of Defense on this project has been and continues to be strong. Further, our individual work with representatives of military retirees and their families, and with the health insurance plans affected by the demonstration project has been equally extensive. All of this work, in my judgment, will lead to an effective rollout of this project and will set the stage for a sound assessment of its potential for helping to address the health care needs of this particular group of military retirees and their families.

Second, our primary goal in this project has been to structure the health care delivery system in ways that mirror the Federal Employees Health Benefits Program, departing from those practices only where the nature of the demonstration project requires a change. We believe this is consistent with the intent of the project and will also contribute toward a solid evaluation of the project's potential for expansion.

Mr. Chairman, I would like to address two points that I know are of concern to you and other members of the subcommittee and which have been addressed in earlier testimony today. First, we have now received rate and benefit proposals from all of the health insurance plans that will be participating in the project in the different test areas. As you know, we are still negotiating with them and the other plans that will be offering health insurance in the Federal Employees Health Benefits Program during the year 2000.

Nonetheless, I can say to you today that in my judgment, military retirees and others who will be able to participate in the project will have an adequate number of health plans from which to choose. The number of health plan choices available in the different test areas will range between 8 and 15 and the average number of plans in each area will be 11.

This is the case for two reasons, one of which leads to my second point addressing one of your concerns as well. First, however, we deeply appreciate the cooperation we have received from the health plans that participate in the Federal Employees Health Benefits Program. For many of them, participating in this project was a new and somewhat uncharted experience. Through their cooperation and willingness to work through issues of concern, I believe we have a good number of health plan choices to offer affected individuals.

Second, since this is a startup program with no specific utilization experience and a statutory limit currently on its duration, we believe that premium rates can be kept competitive only if risk ex-

perienced by the health insurance plans is mitigated. If premium rates are not competitive, it will be impossible to accurately compare enrollment trends and otherwise assess the project. And I think that was borne out in the testimony, particularly by the previous panel. Therefore, absent some mechanism to protect health insurance plans that might experience smaller enrollments and higher utilization, insurers would add risk charges to their premiums. And these can produce major distortions in the demonstration project.

OPM has developed an approach to address this problem that we believe is reasonable, logical, and fully supported by the law establishing the project. Our proposal is to assure participating carriers that we will supplement premium revenues with money from the administrative reserve if necessary.

Now, Mr. Chairman, both you and Congressman Burton expressed some concerns about this strategy in a recent letter to Director LeChance. Perhaps if I lay out exactly how we plan to implement our proposal, we can begin to put these concerns to rest.

By law, the Office of Personnel Management has the discretion to distribute excess administrative reserves to the contingency reserves of health plans based on their market share. Should it be necessary in this project to supplement a health plan's revenue from the administrative reserve, we would go first to that plan's proportional share of the reserve itself. Only if that share were exhausted would we intend to use funds that might ultimately go to others and we would maintain strict accounts of which plans received what amounts. We believe this approach is consistent with the law establishing the demonstration project.

The bottom line, Mr. Chairman, is that our action on this matter does three important things. First, it ensures competitive premiums. Second, the affected population will have more health plan choices than would have been the case otherwise. And, finally, it enables the Office of Personnel Management and others to see clearly the cost of carrying out the demonstration project in order to assess its effectiveness.

In summary, both the Department of Defense and the Office of Personnel Management have worked hard to make this project a success and to lay an effective foundation for its assessment. We have collaborated with a wide range of interested parties to ensure that the design of the project addressed concerns. And we are about to embark on a major educational effort leading to an open enrollment period this fall for health benefit coverage beginning next January. We are excited about the project's potential and eager to move forward to carry it out.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions you or other members of the subcommittee have.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN III
OFFICE OF PERSONNEL MANAGEMENT

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

ON

FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM
DEMONSTRATION PROJECT FOR DEPARTMENT OF DEFENSE
MILITARY ELIGIBLE BENEFICIARIES

JUNE 30, 1999

MR.CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR INVITING OPM TO SPEAK TODAY ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM DEMONSTRATION PROJECT FOR DEPARTMENT OF DEFENSE MEDICARE ELIGIBLE BENEFICIARIES AND DEPENDENTS.

BACKGROUND

THE NATIONAL DEFENSE AUTHORIZATION ACT FOR 1999, PUBLIC LAW 105-261, SIGNED BY PRESIDENT CLINTON ON OCTOBER 17, 1998, AMENDED CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE. THE AMENDMENT SPECIFIES THE CONDITIONS UNDER WHICH MEDICARE ELIGIBLE RETIREES AND CERTAIN OTHER DOD BENEFICIARIES, AND THEIR DEPENDENTS, MAY ENROLL IN HEALTH BENEFIT PLANS IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. THE DEMONSTRATION PROJECT WAS AUTHORIZED FOR 3-YEARS. IN ACCORDANCE

WITH THE LEGISLATIVE REQUIREMENTS, DOD SELECTED EIGHT DEMONSTRATION SITES WITH A COMBINED ELIGIBLE POPULATION OF 66,000. ELIGIBLE BENEFICIARIES MUST RESIDE IN A DEMONSTRATION AREA IN ORDER TO ENROLL.

OPEN SEASON FOR DOD BENEFICIARIES WILL RUN CONCURRENT WITH THE REGULAR FEHB OPEN SEASON. THE FIRST OPEN SEASON WILL BE IN THE FALL OF 1999, WITH COVERAGE BEGINNING ON JANUARY 1, 2000. THOSE ELIGIBLE WILL BE ABLE TO ENROLL OR CHANGE HEALTH PLANS DURING THE ANNUAL OPEN SEASON AND AFTER OTHER QUALIFYING LIFE EVENTS LIKE ANY OTHER FEHB ENROLLEE.

INDIVIDUALS ENROLLED IN THE DEMONSTRATION PROJECT WILL NOT BE ELIGIBLE TO RECEIVE CARE AT A MILITARY TREATMENT FACILITY OR TO ENROLL IN A HEALTH CARE PLAN UNDER TRICARE. IF THEY TERMINATE COVERAGE AT ANY TIME DURING THE DEMONSTRATION PERIOD, THEY WILL NOT BE ELIGIBLE TO RE-ENROLL IN THE PROJECT, BUT WILL AGAIN BE ELIGIBLE FOR ANY BENEFITS PREVIOUSLY AVAILABLE TO THEM THROUGH DOD.

THE LEGISLATION REQUIRES THAT WE USE SEPARATE RISK POOLS TO ESTABLISH PREMIUM RATES. THE GOVERNMENT CONTRIBUTION FOR ENROLLEES WILL BE PAID FOR BY DOD AND CANNOT EXCEED THE PERCENTAGE THAT THE GOVERNMENT CONTRIBUTES TOWARD REGULAR FEHB ENROLLEES IN

THE SAME HEALTH PLAN AND LEVEL OF BENEFITS.

REPORTS

THE LEGISLATION REQUIRES OPM AND DOD TO COLLECT AND ANALYZE DATA AND REPORT TO CONGRESS ON THIS PROJECT. THE FIRST REPORT IS DUE IN APRIL 2001 AND THE SECOND AT THE END OF THE DEMONSTRATION PROJECT. WE WILL EXAMINE DIFFERENT ASPECTS OF THE PROJECT SO THAT WE CAN CONSIDER WHETHER AND HOW ACCESS TO THE FEHB PROGRAM COULD BE EXPANDED TO INCLUDE ALL MEDICARE ELIGIBLE MEMBERS OF THE UNIFORMED SERVICES AND THEIR DEPENDENTS. WE WILL LOOK CLOSELY AT WHAT EFFECT ANY EXPANSION MIGHT HAVE ON THE COST OF THE FEHB PROGRAM TO ENROLLEES, THE FEDERAL GOVERNMENT, AND TAXPAYERS. TO ENABLE THE ANALYSIS TO PROVIDE ACCURATE AND SOUND COMPARISIONS, WE ARE MAKING EVERY EFFORT TO KEEP THE EXPERIENCE FOR THE DEMONSTRATION GROUP AS SIMILAR AS POSSIBLE TO THE FEHB PROGRAM EXPERIENCE.

GEOGRAPHIC AREAS

DOD CONDUCTED A PUBLIC RANDOM DRAWING ON JANUARY 13TH OF THIS YEAR TO SELECT THE EIGHT DEMONSTRATION SITES. IN ACCORDANCE WITH THE LEGISLATIVE REQUIREMENTS, SITES WERE SELECTED FROM A CATCHMENT AREA OF A MILITARY TREATMENT FACILITY, A NON-CATCHMENT AREA, AND A MEDICARE SUBVENTION DEMONSTRATION AREA IN WHICH MEDICARE IS

REIMBURSING DOD A THE PRIMARY PAYER. ALSO, NOT MORE THAN ONE SITE WAS SELECTED PER TRICARE REGION.

THE EIGHT AREAS ARE:

- DOVER AIR FORCE BASE, DELAWARE
- THE COMMONWEALTH OF PUERTO RICO
- FORT KNOX, KENTUCKY
- GREENSBORO/WINSTON-SALEM/HIGHPOINT, NORTH CAROLINA
- DALLAS, TEXAS
- HUMBOLDT COUNTY, CALIFORNIA AND SURROUNDING COUNTIES
- NAVAL HOSPITAL, CAMP PENDLETON, CALIFORNIA
- NEW ORLEANS, LOUISIANA

THERE ARE ENOUGH FEE-FOR-SERVICE PLANS AND HMOS PARTICIPATING IN THOSE AREAS TO GIVE DOD BENEFICIARIES AN ADEQUATE CHOICE OF PROVIDERS.

REGULATIONS

THE INTERIM REGULATIONS ARE AT THE FEDERAL REGISTER PENDING PUBLICATION. THESE REGULATIONS WILL AMEND PART 890 OF TITLE 5 CFR AND CHAPTER 16 OF TITLE 48 CFR TO AUTHORIZE CHANGES TO EXISTING PROGRAM POLICY THAT ARE NECESSARY BECAUSE OF THE LIMITED SCOPE AND SPECIFIC PARAMETERS OF THE DEMONSTRATION PROJECT. KEY PROVISIONS OF THE REGULATIONS DEFINE CRITERIA FOR EXEMPTING CARRIERS FROM PARTICIPATION IN THE DEMONSTRATION PROJECT, AND ESTABLISH A MORE APPROPRIATE BENCHMARK FOR THE RATES OF COMMUNITY-RATED HEALTH PLANS THAN SIMILARLY SIZED SUBSCRIBER GROUPS, THE BENCHMARK UNDER

THE FEHB PROGRAM. THE REGULATIONS ALSO ALLOW EXPERIENCE-RATED CARRIERS TO DRAW FUNDS FROM THEIR EXISTING FEHB LETTER-OF-CREDIT ACCOUNTS TO PAY CLAIMS AND ADMINISTRATIVE EXPENSES, BUT REQUIRE THEM TO ACCOUNT SEPARATELY FOR THOSE CLAIMS AND DIRECT EXPENSES.

FINALLY, THE REGULATIONS DESCRIBE THE MECHANISM THROUGH WHICH OPM PLANS TO MITIGATE CARRIER RISK THAT MIGHT RESULT FROM THE LIMITED SCOPE AND DURATION OF THE DEMONSTRATION PROJECT.

PREMIUM DEVELOPMENT AND RESERVES

THE ENABLING LEGISLATION CALLS FOR SEPARATE RISK POOLS FOR PURPOSES OF PREMIUM RATE SETTING. SELF ONLY AND SELF AND FAMILY PREMIUM RATES FOR PLANS WITHIN THE DEMONSTRATION AREAS WILL BE SET BASED ON THE DEMOGRAPHICS OF THE DOD POPULATION. OPM WILL CREATE AND MAINTAIN SEPARATE CONTINGENCY AND ADMINISTRATIVE RESERVES FOR THE PARTICIPATING DEMONSTRATION PROJECT CARRIERS.

DOD PROVIDED DEMOGRAPHIC INFORMATION ON ITS ELIGIBLE POPULATION FOR EACH DEMONSTRATION AREA. WE GAVE THIS INFORMATION TO OUR PARTICIPATING CARRIERS SO THEY COULD FORMULATE THEIR DEMONSTRATION PROJECT RATE PROPOSALS FOR THE YEAR 2000. WE UNDERSTAND THAT THE MAJORITY OF ELIGIBLE PARTICIPANTS ARE ENROLLED IN MEDICARE A AND B. BARRING OTHER FACTORS, THIS SHOULD HELP KEEP

THE RATES FAIRLY COMPARABLE TO FEHB RATES. THE COST TO BENEFICIARIES OF ENHANCED COVERAGE, INCLUDING RETAIL AND MAIL ORDER PHARMACY BENEFITS, MAY WELL BE LESS THAN THE COST OF AN AVERAGE MEDIGAP POLICY.

USE OF RESERVE ACCOUNTS TO MITIGATE RISK

SINCE THIS IS A START-UP PROGRAM WITH NO SPECIFIC EXPERIENCE AND A STATUTORY LIMIT ON ITS DURATION, WE BELIEVE THAT PREMIUM RATES CAN BE KEPT COMPETITIVE IF CARRIER RISK IS MITIGATED. IF PREMIUM RATES ARE NOT COMPETITIVE, IT WILL BE IMPOSSIBLE TO ACCURATELY COMPARE ENROLLMENT TRENDS OF THE DOD GROUP OR OTHERWISE ASSESS THE IMPACT OF THE DEMONSTRATION ON BOTH OPM AND DOD.

ABSENT SOME MECHANISM IN PLACE TO PROTECT CARRIERS THAT MAY EXPERIENCE SMALL ENROLLMENTS AND HIGH UTILIZATION FROM SEVERE ADVERSE IMPACT, CARRIERS WILL ADD RISK CHARGES TO THEIR PREMIUM RATE CALCULATIONS THAT WILL CAUSE MAJOR DISTORTIONS IN THE DEMONSTRATION PROJECT RESULTS.

OPM HAS DEVELOPED AN APPROACH TO ADDRESS THIS PROBLEM THAT WE BELIEVE IS REASONABLE, LOGICAL, AND FULLY SUPPORTED BY THE AUTHORIZATION ACT LANGUAGE. OUR PROPOSAL IS TO ASSURE PARTICIPATING CARRIERS THAT WE WILL SUPPLEMENT DOD PREMIUM

REVENUES WITH MONEY FROM THE FEHB PROGRAM ADMINISTRATIVE RESERVE FUND IF NECESSARY. MR.CHAIRMAN, YOU AND CONGRESSMAN BURTON EXPRESSED SOME CONCERNS ABOUT THIS STATEGY IN A RECENT LETTER TO DIRECTOR LACHANCE. ONE OF OUR MAJOR CARRIERS HAS EXPRESSED SIMILAR CONCERNS. PERHAPS IF I LAY OUT EXACTLY HOW WE PLAN TO IMPLEMENT OUR PROPOSAL, THOSE CONCERNS CAN BE PUT TO REST.

CHAPTER 89 OF THE UNITED STATES CODE GIVES OPM THE DISCRETION TO DISTRIBUTE EXCESS MONEY IN THE ADMINISTRATIVE RESERVE FUND TO THE CONTINGENCY RESERVES OF FEHB PARTICIPATING CARRIERS BASED ON THEIR MARKET SHARE. SHOULD IT BE NECESSARY TO SUPPLEMENT A CARRIER'S PREMIUM REVENUE FOR THE DOD DEMONSTRATION GROUP FROM THE ADMINISTRATIVE RESERVE, WE WOULD GO FIRST TO THAT CARRIER'S PROPORTIONAL SHARE OF THE ADMINISTRATIVE RESERVES. ONLY IF THAT SHARE WERE EXHAUSTED, WOULD WE USE FUNDS THAT MIGHT ULTIMATELY GO TO OTHER CARRIERS. WE WOULD MAINTAIN STRICT ACCOUNTS OF WHICH CARRIERS RECEIVED WHAT AMOUNTS. NO CARRIER WOULD BE FACED WITH A SIGNIFICANT REVENUE SHORTFALL DURING THE PROJECT. SINCE THE AUTHORIZING LEGISLATION GIVES OPM UNLIMITED ACCESS TO THE FEDERAL EMPLOYEES HEALTH BENEFITS FUND TO IMPLEMENT THE DEMONSTRATION PROJECT, THIS APPROACH IS CLEARLY IN KEEPING WITH CONGRESSIONAL INTENT. FURTHER, THE WAY WE PLAN TO IMPLEMENT IT, WE WOULD FOLLOW BOTH THE SPIRIT AND THE LETTER OF CHAPTER 89.

TO ENSURE THAT ADMINISTRATIVE RESERVE FUNDS ARE PROPERLY ACCOUNTED FOR, WE WILL REQUIRE AN ANNUAL ACCOUNTING OF REVENUE AND COSTS ATTRIBUTABLE TO THE DOD POPULATION. AT THE END OF THE 3-YEAR DEMONSTRATION PERIOD, CARRIERS WITH A SURPLUS WILL RETURN IT TO THE FEHB ADMINISTRATIVE RESERVE FUND.

HOPEFULLY, MY EXPLANATION HAS CLARIFIED OPM'S INTENT. WE, OF COURSE, ARE AVAILABLE TO DISCUSS THE ISSUE WITH ALL CONCERNED PARTIES.

SIZE OF DEMONSTRATION GROUP

THE AUTHORIZING LEGISLATION LIMITED PARTICIPATION IN THE DEMONSTRATION TO 66,000 MILITARY BENEFICIARIES AND DEPENDENTS. DOD IS OFFERING AN ENROLLMENT OPPORTUNITY TO 66,000 ELIGIBLES TO ASSURE THAT TOTAL ENROLLMENT WILL NOT EXCEED THE STATUTORY MAXIMUM. OPM IS CONFIDENT THAT BENEFICIARY PARTICIPATION WILL BE ADEQUATE TO EVALUATE THE DEMONSTRATION PROJECT AS REQUIRED BY CONGRESS.

OPM'S IMPLEMENTATION EFFORTS AND STAKEHOLDER INTERACTIONS

WE HAVE COMMUNICATED WITH CARRIERS THROUGH CONFERENCES, MEETINGS, CONFERENCE CALLS, AND CARRIER LETTERS ABOUT SELECTED SITES, PARTICIPATION CRITERIA, AND RATING REQUIREMENTS. THE ONLY OUTSTANDING ISSUES AT THIS TIME ARE THE RATING ISSUES I JUST DISCUSSED.

OPM AND DOD HAVE MET FREQUENTLY ON ALL ASPECTS OF IMPLEMENTATION. WE ARE WORKING COLLABORATIVELY WITH DOD TO ENSURE A SMOOTH AND SUCCESSFUL OPEN SEASON FOR ALL ELIGIBLE INDIVIDUALS. DOD IS WORKING WITH GROUPS REPRESENTING MILITARY RETIREES AND THEIR FAMILIES WHO ARE EAGER TO ASSIST IN EDUCATING THEIR MEMBERS. OPM AND DOD ARE JOINTLY DEVELOPING GUIDES, FACT SHEETS, AND OTHER INFORMATION THAT WILL INFORM ELIGIBLES OF THEIR OPPORTUNITY TO ENROLL AND THE DIFFERENCES AMONG THEIR HEALTH PLAN OPTIONS.

WE ARE IN THE MIDST OF NEGOTIATING BENEFITS AND RATES WITH FEHB CARRIERS AND DEVELOPING INFORMATIONAL MATERIALS IN PREPARATION FOR THE UPCOMING OPEN SEASON. WE WILL BE TRAINING DOD PERSONNEL ON POLICY AND PROCEDURES SHORTLY, AND WILL BE ATTENDING HEALTH FAIRS AT DOD FACILITIES IN THE FALL.

THIS CONCLUDES MY STATEMENT. I WILL BE GLAD TO ANSWER ANY QUESTIONS THE SUBCOMMITTEE MAY HAVE.

Mr. SCARBOROUGH. All right. Thank you, Mr. Flynn. Appreciate it.

I want to start, Admiral, by saying that I certainly appreciate in your opening testimony that you did say that your belief is and DOD's belief is that these men and women and their families were promised health care for life. That is a great place for us to start. I also was pleased that you saw it as a moral commitment. Unfortunately many people in past administrations have not felt that way.

I want to start with a couple of clarifying points. First of all, there was some question on the first educational mailing. We had seen something that said that it was going to be July 1. There was also some testimony earlier that they received an e-mail saying it wasn't going to be until October. You have now stated that it is going to be on July 15. Tell me what is going out on July 15 and who is it going to? Will it go to all 69,000? How extensive will that be and can this committee get a copy of that as soon as possible?

Admiral CARRATO. Yes, absolutely. In my written testimony, which I have submitted, I have attached a time line which lays it out. Just to start with, I think we recognize what a complex educational effort this will be for our retirees, given that they aren't Federal employees. So we do have a fairly steep learning curve.

We actually have started in mid-June by posting some information on our TRICARE website, some basic information. And I apologize for the confusion as to when the first mailing will go out. But we are going to distribute the postcard to all eligible beneficiaries, a description of the project, and lay out information regarding scheduling of the various marketing activities, some information on the open enrollment season.

In September—if you will permit me, I will just walk through a couple of the key points which I think are important.

Mr. SCARBOROUGH. Sure. Go ahead.

Admiral CARRATO. In September, September 1, actually, we have prepared a trifolder. It is in draft and we are coordinating it. September 1, we will distribute an FEHBP demo trifold to our information processing center which will then go out to all eligible beneficiaries. It will go out to our TRICARE service centers at our facilities. It will go to retiree affairs offices, public affairs, et cetera.

On September 7—and I think this is a very, very key activity—is we actually are setting up a 1—and, actually, they have exhausted 800 and 888—we have a 1–877 FEHBP number and there will be a phone system dedicated to answering questions, providing information to all our beneficiaries. So I think that is actually an excellent effort. Mid-September, we will distribute additional press releases. And then on October 30, we will submit more, fuller information on plans, prices, et cetera. And then we will conduct the open season with health fairs, beginning in November.

Mr. SCARBOROUGH. So July 15 you are going to be sending out a postcard.

Admiral CARRATO. Yes, sir.

Mr. SCARBOROUGH. Just a generalized postcard, explaining time lines and what is going to happen.

Admiral CARRATO. Yes, sir.

Mr. SCARBOROUGH. And who is going to be eligible. Your trifold is going out in September.

Admiral CARRATO. Yes, sir.

Mr. SCARBOROUGH. Is that going to be something that is going to be extensive enough that—and let me get the clarification, because you said you are actually going to start distributing that on September 15. When are military retirees going to be able to get that in their hand and understand what is going to be happening within a month's time?

Admiral CARRATO. I guess there are two pieces to it. One is the trifold, which will provide some general information. We think in this program, premarketing is critical. For example, if you enroll in FEHBP, you are not eligible while you are enrolled for services at a military treatment facility. That is a real important point to make sure people clearly understand that. So we have some—the trifold will have some good information about all the aspects of the program.

I think what you may be asking is when will we have specific information on the plans and the premium costs? And that will not be until the guide goes out in October.

Mr. SCARBOROUGH. That exclusion is statutory, just for the record. That exclusion that you are speaking of is statutory, not something that you all dreamed up in the middle of the night.

Admiral CARRATO. Yes, sir. That is by statute, sir. Helping us.

Mr. SCARBOROUGH. A little bit.

Admiral CARRATO. If it wasn't by statute, I probably wouldn't have mentioned it.

Mr. SCARBOROUGH. Yes, exactly. Let me ask you—well, actually, let me make a statement just for the record and just tell you that I guess it was July 1, back in 1996 that TRICARE was implemented and they had an 800 number at that time. Unfortunately, they didn't spend enough money and man enough people on that phone to make that happen. I know that because I received a stack of letters about this big from my district.

Admiral CARRATO. Yes, sir.

Mr. SCARBOROUGH. It was an absolute nightmare and Humana came down and testified and DOD came down and testified talking about this wonderful 800 number. And it was of no practical effect other than it made our military retirees and dependents even more frustrated. I would just urge you to make sure that you all spend enough money on the people who are answering those questions, whether it is in Topeka, KS, or Washington, DC, or wherever that when somebody calls up they are not put on hold for 3 hours or they don't get a recording. First of all, are you aware of the problems that we had with the TRICARE 800 number?

Admiral CARRATO. Yes, sir. Absolutely.

Mr. SCARBOROUGH. OK. I don't want that to happen.

Admiral CARRATO. I am painfully aware of them.

Mr. SCARBOROUGH. OK.

Admiral CARRATO. And, unfortunately, in our most recent startups, we also had some similar concerns with telephone response rate.

Mr. SCARBOROUGH. Fine.

Admiral CARRATO. Which I am happy to report we cleared up in a hurry. But one of the things, I, too, when we have a 1–800 number, it probably stands to reason that people will call that number.

Mr. SCARBOROUGH. Oh, sure.

Admiral CARRATO. And we need to make sure that we do have the phones answered. We have paid particular attention to that and made it perfectly clear. The phone actually is in Des Moines, IA, is where it is going to be.

Mr. SCARBOROUGH. I knew it had to be somewhere in the Midwest. I commend you. And I am going to be forwarding all the positive responses I get from my constituents when they tell me how successful that 877 number is.

Let me ask you this question. You have heard from the previous two panels that a lot of people do not believe that we are going to have any more than 20,000 or so participants in the program. Do you agree with the testimony of our other two panels that we are not going to get anywhere close to the 66,000 number that Congress originally intended?

Admiral CARRATO. I don't agree with the estimate as low as 20,000. As we looked to size the program, we relied on a couple of reports, actually three reports. Two by CBO, one by GAO. CBO in a 1995 report estimated—and, again, it is not completely analogous—but as they looked at a nationwide FEHB Program, in the 1995 report, CBO estimated that the enrollment, the take rate, would be 95 percent for the over 65s. In 1997, GAO estimated the enrollment rate at about 83 percent for military over 65s. And then in 1998, CBO actually revised their estimate and they thought it would be about 70 percent participation rate.

So we actually believe it will probably be in the 83 percent range is what we believe. I think one of the reasons of the demonstration and actually one of the reasons for actually keeping the enrollment level at the eligible level at 66,000 is we want a true test of who will participate. If we had substantially more than that, it could lead to a situation where we would have to cutoff enrollment. We wouldn't have a true and valid test of the enrollment rate. So I think the enrollment rates will be much more significant than 20 percent.

Mr. SCARBOROUGH. Really. Or 20,000.

Admiral CARRATO. Yes, 20,000. I am sorry. 20,000.

Mr. SCARBOROUGH. So you think 85 percent. That is, I think, a higher percentage than what FEHBP gets right now from—is it about 85? Yes, from their employees. Do you understand what the concern is about it being a one-time project? A 3-year project?

Admiral CARRATO. Yes, right.

Mr. SCARBOROUGH. You think 85 percent of the people are going to say that they are willing to give up their current health plan for a program that may not be around 2 or 3 years from now?

Admiral CARRATO. I think they will. And I know in one of the earlier panels there was a concern about looking at our experience with the TRICARE Senior program, the Medicare subvention program. And the fact that there was some speculation that enrollment would exceed all expectations. And in some locations, the enrollment was below what was expected. Now keep in mind that TRICARE Senior was conducted within catchment areas. And that

some of those areas, on a space-available basis, large medical center, they have access to the MTF and I think that factored into the decision. You know, if you have access to a military treatment facility, then perhaps you don't have to enroll in a demonstration program. The FEHBP sites are in areas where we don't have as robust an MTF as we do in some of the TRICARE Senior sites.

So I expect that we will have significant enrollment, given that it is a demonstration program, even given that.

Mr. SCARBOROUGH. Boy, if it is up to 85 percent—and I know this sort of puts you in a no-win situation—but if it is up to 85 percent, isn't that a heck of an indictment against the military health care system, as it is right now? That DOD believes 85 percent of the people would choose to bail out of that system?

Admiral CARRATO. Well, I don't think it is bailing out of the system. If you look where these demonstration sites are, you know, they are for non-catchment so, by definition, there is no MTF in that location and in the sites where we do have military treatment facilities, I think, as Mrs. Hickey indicated, much smaller capacity and capability of those facilities. So I think the judgment that a Medicare eligible is making is do they want to continue on a space-available basis getting what access they can or would they like to enroll in a program and upfront know what benefit they are eligible for and it is a little more predictable.

Mr. SCARBOROUGH. One final question before I turn it over to the ranking member. I wanted to ask you this because you suggest that we could approach that, but in the written statement, you say that 66,000 participants in the FEHBP could cost the DOD more than $130 million. Now the President budgeted about $79 million for this demonstration project and the Senior Supplemental Administration project together. So, obviously, that is a shortfall of about $50 million.

I want to ask you, because, again, from my understanding, the Senior Supplemental is going to be taking at least as much money as this project. How much of the $79 million is budgeted for FEHBP for that demonstration project, and the budget for Senior Supplemental?

Admiral CARRATO. Sure. And I will round numbers so it won't add up exactly, but we have actually budgeted, in the President's budget, we have $79 million for three demonstration programs that were authorized. For FEHBP, it is about $62 million that we have allocated. For the TRICARE Senior Supplement, it is about $14 million. And for the over 65 pharmacy, it is about $4 million.

Mr. SCARBOROUGH. So that is $62 million for over what time period?

Admiral CARRATO. Fiscal year 2000.

Mr. SCARBOROUGH. Fiscal year 2000. OK. And what number of participants or participation rate is the President's budget based on?

Admiral CARRATO. We looked at about 80 percent, we estimated.

Mr. SCARBOROUGH. 80 percent. So you would agree with our friends on the previous panel that if it is lower than that and the risk is not as spread out, that those costs could skyrocket. Would you agree with that?

Admiral CARRATO. If the participation rate is less?

Mr. SCARBOROUGH. Right. If we have 20,000 instead of, say, 60,000.

Admiral CARRATO. I think the issue is where will the participating plans set their premiums. And I think the largest concern is information on our beneficiary population. Now, to the extent we have it, we have provided that information to OPM and I think they, in turn, have supplied that to the plans. But there is some concern on the part of the plans, so I think that is the issue, you know, what is the risk level? There is some possibility, if it is a lower enrollment rate, that there could be some adverse selection. And, you know, I don't know. I don't know.

Mr. SCARBOROUGH. Thank you, Admiral. Mr. Cummings.

Mr. CUMMINGS. Admiral, I have to tell you, when you mentioned the 85 percent, people in the audience began to smile and I think they share with me—and I can really begin to kind of understand their cynicism. If the FEHBP is doing—what did you say? 85 percent? And then we look at this program. I mean, I don't care what kind of studies we look at. Logic just tells you that that doesn't—unless I am missing a factor or some factors that you haven't talked about today, I don't see how a program that has a big question mark is going to draw the same kind of numbers as the FEHB Program. And I think that if somebody said that to you based upon what we know, I don't—maybe I am missing something and you can help educate me. I don't see how you would come to that same conclusion either.

Admiral CARRATO. OK.

Mr. CUMMINGS. I mean, let us set the reports to the side.

Admiral CARRATO. OK.

Mr. CUMMINGS. Let us just deal with the logic.

Admiral CARRATO. OK.

Mr. CUMMINGS. I mean, am I missing something?

Admiral CARRATO. Yes. And, setting the reports aside, because that was one big factor we looked at, I think some factors you have to consider. For our over 65 military retirees, they are not eligible to enroll in the TRICARE program. They are eligible for space-available care at our military treatment facilities. And, as I mentioned with downsizing and with the implementation of the TRICARE program, some of the capacity is not as readily available for the over 65s. Plus our over 65 population is growing. It is increasing dramatically. So a lot more over 65s. We have less care available.

Now, some of our over 65s, recognizing that limitation, have made other arrangements. A large majority have Medicare part fee, so they have a Medicare program available to them. Some are enrolled in Medicare risk plans. But I think a large percentage of them would like to have a predictable health plan. The FEHB Program offers a good benefit. So I think there will be—based on all those factors—I think there will be significant enrollment, even given that it is a demonstration program.

Mr. CUMMINGS. I will come back in a moment. Now, Mr. Flynn, you heard the concerns, right? And I am sure you tried to address them in your testimony. I didn't hear it all. I apologize. I will have to review your testimony.

Those three problems, you remember them? They talked about the premiums.

Mr. FLYNN. Premiums.

Mr. CUMMINGS. They talked about the information getting out. And there was one other thing. The measure—the number, right. Thanks. I call these senior moments. [Laughter.]

So, I mean, just real briefly, can you address those three real quick? I mean, without——

Mr. FLYNN. Yes, Mr. Cummings, I will try and do that. In the remarks that I made, I tried to indicate that we have taken steps that, for this demonstration project, will ensure competitive premiums for the military retirees and other eligible beneficiaries.

And, if I might, I want to relate that statement to the question that you asked of Admiral Carrato and that had to do with the numbers of people who would sign up. Let us just assume for a moment that we offered the Federal Employees Health Benefits Package of benefits for no cost to the individual. I would suspect that if there were 69,000 eligible individuals, 69,000 people would line up at the door to be able to gain access to that health care.

The only reason I say that is because, whether it is in the Federal Employees Health Benefits Program or anywhere else, people are price sensitive—very much so, about the cost of their health care. So the fact that premiums are going to be competitive, I think, does help in attracting higher numbers of people to participate in this demonstration project than might otherwise be the case or if there were not a competitive premium.

The other thing that I would say that I think has some influence is that when you think of an individual participating in the Federal Employees Health Benefits Program, on behalf of herself or himself or the family, what they tend to look at is what is my out-of-pocket cost? Now, keeping in mind for a moment that the typical participant is going to be someone who has Medicare, Part A and B, and who pays the $42 a month Part B premium, for all practical purposes, what the Federal Employees Health Benefits Program enrollment means to them is it wraps around Medicare, which is the primary payer.

Since the typical cost of a MediGap policy for a couple runs from roughly $750 to as much as $3,000 a year, and the average participant share of the FEHB Program runs from roughly $370 to $1,750, you can see that if someone has Medicare and a MediGap policy, it is more likely than not that the out-of-pocket comparison is going to favor joining the FEHBP and having it coordinate benefits with Medicare.

So, again, I think that speaks to the potential for a higher number of enrollees than some might have predicted. The end of the day, though no one really knows and you have to be prepared for the number of people that do enroll, subject to whatever statutory limit there is.

I have listened to the issues about information, and I think Admiral Carrato has helped clarify a great deal, the information strategy and the information steps that will be taken over the course of the next several months to help these potential beneficiaries participate in this program. As Mrs. Hickey mentioned, there are really two questions that these individuals will be asking:

(1) Do I want to move to this option, compared to the other options that I have? And, (2) Assuming I do, what are the choices of health plans that I have available?

And I think the staggered plan for information, the ability to get information from a variety of sources that we have worked on with the Department of Defense is based on our own experience, a reasonable approach to that we are giving people information in the order of: What you need to know today is whether or not you might want to join; what you will need to know just prior to the start of the open enrollment period is what choices do you have and of those choices, which seems best for you? And I think that is a reasonable approach to the information issue.

Mr. CUMMINGS. Can we hold on that point?

Mr. FLYNN. Sure.

Mr. CUMMINGS. Assuming you weren't finished.

What are we doing—and maybe you should—you might want to answer this, Admiral—are we working with the National Military Families Association? I mean, are we in contact with the stakeholders as we process this? I mean, these are the people who have folks who they are dealing with every day. I mean, that is their job. They do it 60 hours a week. You know? And so I am just wondering how much contact we have with them in getting the information out. What is the status of that?

Admiral CARRATO. Right. We jointly have met with the coalition and alliance organizations and we have shared the draft materials with them and they have provided their input, comments on those materials. And they have been very helpful in all of these demonstrations. They were very instrumental in identifying some enhancements we could make to the TRICARE Senior program. So they have been involved.

Mr. CUMMINGS. And you all do listen?

Admiral CARRATO. Yes, sir.

Mr. CUMMINGS. And the reason why I asked that is that, I mean, it gets very frustrating and I am sure Mr. Scarborough would agree with me. I mean, we go to these town hall meetings. And if people feel that we don't listen to them, then they get kind of cynical. And next thing you know, you don't have people that would normally participate participating because they don't want to waste their time. They would rather be home doing something else. And so that means, just from a very practical matter, I just was curious.

And I am curious about this Mr. Flynn. DOD said the 100 percent enrollment would cost $230 million. The President budgeted it at $62 million. Does that create a problem?

Mr. FLYNN. Well, it doesn't create a problem for us. We send a bill to the Department of Defense and expect them to pay it. [Laughter.]

Admiral CARRATO. Sir, that was——

Mr. CUMMINGS. Good answer. It is what you call passing the buck.

Admiral CARRATO. Yes, sir. The figure we quoted was if we had full enrollment at 66,000, that would be the cost of the program. And we don't believe we will have, you know, full enrollment. We think we will have very significant enrollment. But we just added that number just to show you what the 66,000 at an average pre-

mium and with the government's contribution, of about, you know, 74 percent, that would be the Department estimate.

Mr. CUMMINGS. Now you know I have to ask you this question. You said that you anticipated somewhere in the 80, 85 percent range, right? And so I am just dealing with percentages now. Let us assume we have 80 percent.

Mr. SCARBOROUGH. 85 percent is $112 million.

Mr. CUMMINGS. Are you serious? [Laughter.]

Thank you.

Mr. SCARBOROUGH. I didn't add that. I went to Alabama.

Mr. CUMMINGS. This is what you call bipartisan cooperation.

Mr. SCARBOROUGH. That is right.

Mr. CUMMINGS. So, help me. I mean, we have 100—based upon your own testimony. I guess we come up with about somewhere in the area of $112 million bill and we have—we are dealing with—now, again, that is a percentage. We are just dealing with percentages. Yes, your percentages. So, help me.

Admiral CARRATO. The fiscal year starts this October and then we wouldn't actually start enrollment until—our health care delivery begins in January. So that accounts for all of it. And the averages of the premiums. We were using averages. So that accounts for the difference.

Mr. CUMMINGS. Let me just say this in summary. I think that you—I think that the people who—I mean, I could take that a step further, but I am not going to do that. I think you get the point.

Admiral CARRATO. Right. [Laughter.]

Mr. CUMMINGS. The problem is that we have people who really feel like they have been set up for failure. And that is not a real good feeling. I mean, for us, we don't—and we don't want to be a part of that process. We don't want to go to our constituents and our constituents say, you know, we thought you were doing A but really it didn't turn out to be A, it turned out to be something much less. And so we have a responsibility and a duty to get into these kinds of issues. And when we have the stakeholders' representatives here and they are sitting here and they are shaking their heads, I think what it does is it causes us a little bit of anxiety. And, you know, they have listened to all of this and they are going to go back to their folks and say this is what we believe.

Admiral CARRATO. OK, can I respond?

Mr. CUMMINGS. I am almost finished. But they have set a bar and they basically said we don't believe this is going to work. And that is what I am hearing. And I believe that, in the end, when all the dust settles and everything, it probably will work. But right now there is a presumption that it is not going to. And, to be frank with you, some of the testimony here today hasn't helped. It hasn't helped. I think they will go out feeling probably just as they did or worse. And they can speak for themselves at some other time. But I do want to hear what you have to say, but I just want you to see——

Admiral CARRATO. Sure.

Mr. CUMMINGS [continuing]. See it from our perspective, too. I mean, we want success. That is why we are here.

Admiral CARRATO. OK.

Mr. CUMMINGS. And I am not saying you don't.

Admiral CARRATO. Yes. And that is basically what I was going to start with is that we clearly, and OPM clearly believes this, is we want to have a valid demonstration. I don't want to be involved with a demonstration program that is set up to failure. I just wouldn't operate that way. I think the issue we are talking about is participation rates.

And just to set that aside for a moment, but I think we, working closely with OPM, I think we have developed a demonstration program that I think will be a very valid test of this program. I think we have taken steps to education is a big piece. And I think we have taken great steps to educate the beneficiaries and educational material never comes out fast enough and you can never get enough educational material out for any new program. I agree with that.

The question of take-up rates. I don't think the success of this demonstration hinges on, you know, whether we have 60, 70, 80 percent enrollment. I really don't. I think we have designed this, as we went through the site selection, we designed it that we would have—and our statisticians, our actuaries have also looked at this. And I am confident that we will have a statistically valid demonstration program and one that we can learn great lessons from.

So I do not think it is set up to failure. I think it is actually going to be very, very successful and I am anxious to get the answer to the question of how many people will participate. I told you what, you know, our estimates are. We have heard others. And so I think that is going to be one of the results of this demonstration.

Mr. CUMMINGS. I think Ms. Pugh said it best. I think she said something to the effect that we don't want to be sitting here a few years from now looking backward and basically having not accomplished what we needed to accomplish. And, in the meantime, so many people will have suffered. You see, that is the bottom line.

Admiral CARRATO. I agree. I agree.

Mr. CUMMINGS. Thank you very much.

Admiral CARRATO. Thank you, sir.

Mr. SCARBOROUGH. Thank you, Mr. Cummings. I want to followup, briefly, on a few points. Let me say, Admiral, I do believe you want this to succeed. It was very interesting when you were testifying about working with the groups that you did take their input. I looked at them and they were agreeing that you had and I commend you for that.

I will just say this, though. You know, our ranking member talked about cynicism. I think we can sit here all day and talk about how we are not setting this up for failure and how we want this to succeed, but, unfortunately, the people who sent you over here to testify in this administration—certainly not your doing and Mr. Flynn's doing—set you up for failure today by telling you that they believed and the DOD believed that there was going to be an 85 participation rate and yet they only funded you for 50 percent. And that is about $50 million short of that—let us see. You had $112 million for 85 percent of what was projected. And then the $62 million cost. So, we are about $50 million short and the percentages aren't adding up right.

Now I am confident that we can work together to make this a success, but I think we all need to recognize today—and certainly

I recognize today—that right now the numbers don't add up. They don't add up for an 85 percent participation rate. And if we do have an 85 percent participation rate, we could have the chaos that we had with TRICARE.

If you want to respond to that, you can, but if not, let me just say, again, certainly, I know that you want this to succeed. And I am looking forward to all of us working together to make sure it does.

Mr. Flynn, I wanted to ask you a couple of questions. First of all, when do you expect that your regulations on the project are going to be published and available to carriers and others? What is your date?

Mr. FLYNN. I expect they will be available today, sir.

Mr. SCARBOROUGH. Today?

Mr. FLYNN. Yes, sir.

Mr. SCARBOROUGH. Now that is efficiency. Not only do you know how to pass the buck on a tough question, you know how to give the right answers. Let me ask you this also. We were talking before about other deadlines regarding your negotiations. According to your guidelines, OPM is going to be completing negotiations with the carriers regarding benefits and rates by August 15. Are you going to be able to meet that deadline?

Mr. FLYNN. We should be able to, Mr. Scarborough. Generally speaking, we conclude those between August 15 and the first of September. That has been our practice for years. I see no reason to think they will be any different.

Mr. SCARBOROUGH. Certainly, well, you certainly don't see any circumstances under which that would move into September, then?

Mr. FLYNN. Not this year. No, sir.

Mr. SCARBOROUGH. OK, good. As soon as you get those rates, could you provide those to this subcommittee?

Mr. FLYNN. Yes, sir. Absolutely. I think, actually, we do a pretty big announcement and provide Members of Congress with advance notice of that just before that is concluded. Typically, that occurs around the first of September.

Mr. SCARBOROUGH. Great. Let me also talk to you very briefly about the reserves issue that you talked about in your testimony regarding the letter that we sent to you. We expressed our strong reservations about the proposed use of the administrative reserves because we didn't think it was legal. And, in fact, we got a legal opinion from CRS that I would like, without objection, to submit for the record.

[The information referred to follows:]

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Memorandum June 25, 1999

TO : House Subcommittee on Civil Service
Attention: Gary Ewing

FROM : Thomas J. Nicola
Legislative Attorney
American Law Division

SUBJECT : Whether the Office of Personnel Management Has Legal Authority to Transfer a Contingency Reserve It Holds for One Health Benefits Plan to a Different Plan and Whether It May Transfer Unused Funds for Administrative Expenses to a Plan Because of Incurred Losses

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This memorandum responds to a question regarding whether the Office of Personnel Management (OPM) has legal authority to transfer a contingency reserve or portion of a reserve that it holds for one health benefits plan to a different plan in the Federal Employees Health Benefits Program (FEHB). Our research indicates that except in two circumstances permitted by statute, mergers and discontinuances of certain plans, OPM does not appear to have authority to transfer reserves from one plan to different plan.

It also responds to a question regarding whether OPM has legal authority to transfer unused funds for administrative expenses to a plan because of losses that plan incurs. Our research indicates that OPM does not appear to have legal authority to transfer these unused funds on the basis of incurred losses.

Section 8909(a) of title 5 of the United States Code establishes in the Treasury of the United States the Employees Health Benefits Fund which is administered by OPM. Portions of contributions paid by enrollees and the government regularly must be set aside in the Fund as follows: A percentage, not to exceed one percent of all contributions, determined by OPM to be reasonably adequate to pay administrative expenses; and *for each health benefits plan,* a percentage, not to exceed three percent of the contributions toward the plan, determined by OPM to be reasonably adequate to provide a contingency reserve.

OPM, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with it. When funds are so transferred, each contingency reserve, *i.e.*, the contingency reserve of each plan held by OPM, shall be credited in proportion to the total amount of the subscription charges (premiums) paid and accrued to the plan for the contract term immediately before the term in which the transfer is made. Income derived from dividends, rate adjustments, or other refunds made by a plan must be credited to its

contingency reserve. Contingency reserves may be used to defray increases in future rates, applied to reduce the contributions of enrollees and the government to the plan, or increase benefits provided by a plan from which the reserves are derived, as OPM from time to time shall determine. 5 C.F.R. § 8909(b).

The statute prescribes two circumstances under which a contingency reserve or portion of it held by OPM for one plan may be transferred to different plan. It provides that a contingency reserve of a plan described in statute may be transferred to a plan sponsored or underwritten by a successor organization when assets, liabilities, and membership of employee organizations sponsoring or underwriting certain plans are merged. 5 U.S.C. § 8909(d). A contingency reserve of a plan described in statute also may be credited to contingency reserves of other plans when a plan described in the statute is discontinued. Each reserve is credited in proportion to the amount of subscription charges paid and accrued to the plan for the year of termination. 5 U.S.C. § 8909(e). The statute does not appear to authorize transfers of a contingency reserve that OPM holds for one plan to a different plan in situations other than mergers and discontinuances.

Under the FEHB law, a portion of the premiums OPM collects for each health benefits plan is designated to be placed in the contingency reserve account that OPM holds for each plan. Experience rated plans (fee-for-service plans) whose premiums are based on actual claims experience of the plans hold their own special reserves in which they maintain funds that were in excess of the amount needed to pay claims in prior contract years. These reserves provide a "cushion" in the event that a plan's actual claims experience exceeds the projected claims experience on which its rates were based. Experience-rated carriers also hold their own "incurred claims" reserves for paying claims that have been incurred but have not yet been paid by the plans. *See* 51 *Fed. Reg.* 30068 (Aug. 22, 1985) for this description. To avoid confusion, the special reserve and the incurred claims reserve collectively may be referred to as the carrier's reserves to distinguish them from the contingency reserve that OPM holds for each plan.

Section 890.503 "Reserves" of title 5 of the Code of Federal Regulations states that the enrollment charge (premium) consists of the rate approved by OPM for payment to the plan of each enrollee, plus four percent, of which one part is for an administrative reserve and three parts are for a contingency reserve for the plan. The contingency reserve that OPM holds *for each plan* is credited with (i) three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from enrollment charges for employees and annuitants enrolled for that plan; (ii) amounts transferred in accordance with law from other contingency reserves [in a merger or discontinuance of another plan] and the administrative reserve; (iii) income from investment of the reserve; (iv) its proportionate share of the income from investment of the administrative reserve; and (v) any return of reserves from the plan.

This section of the Code of Federal Regulations also prescribes minimum balance and target level requirements that carrier reserves must meet and conditions under which transfers may be made between the contingency fund that OPM holds for each carrier and the carrier's reserves. When, as of the end of a contract period, the total of all carrier-held reserves including the special and incurred claims reserves for an experience-rated (fee-for-service) plan falls below the prescribed target level, a carrier is entitled to payment from the contingency reserve that OPM holds for it. When, as of the end of a contract period, the total of all reserves of an experience-rated plan exceeds the plan's target level, the excess over the

plan's target level must be credited to the contingency reserve that OPM maintains for the plan. OPM may, by agreement with the carrier, approve community rating for a comprehensive (non-fee-for-service) plan. If the contingency reserve of the carrier of a community-rated plan exceeds the preferred minimum balance, the carrier may request OPM to pay to the plan a portion of the reserve OPM holds for it not greater than the excess of the contingency reserve over the preferred minimum balance. 5 C.F.R. § 890.503(c)(2)-(4).

In addition to amounts transferred under previous paragraphs of section 890.503(c) of the Code of Federal Regulations, OPM may authorize such other payments from the contingency reserve as in its judgment may be in the best interest of employees and annuitants enrolled in the program. A carrier for a plan may apply to OPM at any time for a payment from the contingency reserve when the carrier has good cause, such as unexpected claims experience and variations from expected community rates. By agreement with the carrier and where good cause exists, OPM may accept payment from carrier reserves for credit to the contingency reserve in an amount and under conditions other than those specified in subsection (c). 5 C.F.R. § 890.503(c)(5).

Use of the article "the" contingency fund may raise a question whether 5 C.F.R. § 890.503(c)(5) implicitly may grant OPM authority to transfer funds from the contingency fund it holds for one health benefits plan to a different one in circumstances other than those that the statute allows, mergers and discontinuances of certain plans. A review of the *Federal Register* which explains this subsection indicates that paragraph (5) does not appear to authorize such interplan transfers. "This provision is intended to allow carriers to request funds from *their* contingency reserve when good cause exists. ... The final regulations include language to clarify that carriers may make application to OPM for funds from *their* contingency reserve any time they have good cause." 51 *Fed. Reg.* 7430 (Mar. 4, 1986) (emphasis supplied). "...in addition to the end of year reserve transfers, the regulations [5 C.F.R. 890.503(c)(6), now (5)] will continue to allow carriers to request a transfer from *a plan's* contingency reserve anytime the carrier has good cause, such as an unanticipated increase in benefit claims." 52 *Fed. Reg.* 3211 (Feb. 3, 1987)(emphasis supplied).

As noted earlier, OPM has legal authority to transfer unused funds for administrative expenses to the contingency reserves of plans then under contract with it "from time to time and in amounts it considers appropriate." 5 U.S.C. § 8909(b). Congress has constrained the authority of OPM to make these transfers. Section 8909(b) adds that, "When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made." This language does not appear to authorize OPM to transfer unused funds for administrative expenses to a plan on the basis of the losses it incurs.

Conclusion

This memorandum has addressed whether the Office of Personnel Management has legal authority to transfer a contingency reserve or portion it holds for one health benefits plan to a different plan. Section 8909 of title 5 of the United States Code authorizes interplan transfers in two circumstances, to a successor plan described in statute when plans merge and to all other plans when one plan described in statute is discontinued. Neither the statute nor the regulations appear to authorize interplan transfers in other circumstances.

It also has addressed whether OPM has legal authority to transfer unused funds for administrative expenses to a plan because of losses it incurs. While section 8909 authorizes OPM to transfer unused funds for administrative expenses to contingency reserves of funds "from time to time and in amounts it considers appropriate," it limits this authority to transfers in proportion to the total amount of subscription charges paid and accrued to a plan for the contract term immediately before the contract term in which the transfer is made. It does not appear to permit OPM to transfer unused funds for administrative expenses to a plan because it has incurred losses.

Mr. SCARBOROUGH. That says that they concluded the proposal was not authorized by statute. I wanted to ask you about do you have any documentation with you here or any information regarding the legal testimony or the legal information that you all received that suggested this would be legal?

Mr. FLYNN. Mr. Scarborough, you ask a very important question. We have looked at this from a number of perspectives, including a legal perspective. It is, without question, and the agency and I know it was part of OMB's review of our proposed regulations, something that we do believe is legal. And, moreover, it is in the interests of making this demonstration project successful. You mentioned an opinion from the Congressional Research Service. This is the first I have become aware of it. We would certainly like to take a look at that—take it back to our legal staff and do our own analysis of that. And I know that, in our Office of the General Counsel, we have some information that I am sure we can provide for the record regarding our own review of the matter.

Mr. SCARBOROUGH. That would be great. I will get this CRS opinion to you. We got it June 25. I am sorry I didn't get it to you before this hearing. But if you could just see whatever legal memos you have and provide that to this committee, that would be great.

I wanted to ask you also if you felt comfortable guaranteeing to the subcommittee that your proposal was not going to create a moral hazard in the FEHB Program that Mr. Gammarino fears. You heard Mr. Gammarino's testimony before. How do you feel you could prevent that occurring?

Mr. FLYNN. Well, providing an absolute guarantee against a moral hazard is something I would not hazard to predict about, but let me say this. First of all, this is a demonstration project. And, as I said in my prepared statement, we have tried to parallel the FEHBP, Federal Employees Health Benefits Program operations, every step of the way so that we could have a good test. There are several areas where that is just simply not possible. You have a situation here where you have a special group of individuals who are able to participate in selective areas around the country and we had the health plans who are planning to participate in this program come to us and demonstrate the degree to which they felt they were facing potentially adverse risk and that they needed to provide for that in their premium.

And so we looked at the authorizing legislation and, as I say, from a variety of standpoints, came up with this as a way to deal with it. I think it has been very effective in doing that because all of those plans expressing those concerns have decided—virtually all of them—have decided to participate. So we will have good choice. And we will have competitive premiums.

The second thing that I would say is that, as our actuaries have looked at what is the total amount of risk that we are potentially facing here, in terms of the size of the program, it is quite small, about two-tenths to perhaps three-tenths of 1 percent. In dollar terms, Mr. Chairman, that amounts to perhaps $50 million a year in a program that runs between $18 billion and $20 billion a year.

So I don't think we are creating a dangerous precedent, a moral hazard, in this program. I think what we are trying to do is make competitive premiums available to eligible beneficiaries and to give

those beneficiaries the widest choice of health plans available. That has been our objective all along and that is the way that we will continue to work at this.

Mr. SCARBOROUGH. OK. Well, I appreciate your testimony and I have some more questions but I would prefer to submit them in writing to you all if you all could respond within 30 days. If that is OK, that would be great. I appreciate your testimony and appreciate everybody that has been here to help us out on this difficult issue. This hearing is adjourned.

[Whereupon, at 12:35 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

AUG - 3 1999

Honorable Joe Scarborough
Chairman, Subcommittee on
Civil Service
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter of June 4, 1999, regarding our approach in implementing the Military Retiree Federal Employees Health Benefits (FEHB) Demonstration Project.

The matters you have raised are presently the subject of litigation. The regulations were promulgated upon careful thought and analysis, and following consultation with counsel. Similarly, they were promulgated following discussion with and approval of the Office of Management and Budget. We are confident that our regulation meets both the letter and the spirit of the National Defense Authorization Act for 1999 (the Act), enacting the Demonstration Project, in a manner that is fair and practicable.

The legal analysis memorandum from the Congressional Research Service (CRS) dated June 25, 1999, that was provided to my staff at the hearing of the Subcommittee of the Committee on Government Reform on June 30, 1999 is not to the contrary. That memorandum does not address the effect of the Act and its amendments to chapter 89 of title 5, United States Code.

If we can help in clarifying any aspect of the Demonstration Project that is not presently in litigation, please do not hesitate to contact us.

Sincerely,

Janice R. Lachance

Janice R. Lachance
Director

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