



# **AFGE** Congressional Testimony

**STATEMENT BY**

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**BEFORE THE**

**SUBCOMMITTEE ON FEDERAL WORKFORCE,  
U.S. POSTAL SERVICE AND THE CENSUS**

**HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM**

**ON**

**FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM**

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## **Introduction**

My name is Jacqueline Simon, and I am the Public Policy Director of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the 650,000 federal employees AFGE represents, I thank you for the opportunity to testify today. The Federal Employees Health Benefits Program (FEHBP), which covers more than eight million federal employees, retirees, and their dependents, is the nation's largest employer-sponsored health insurance program. FEHBP is affected by the Patient Protection and Affordable Care Act, and FEHBP is also a target of those who would force federal employees to forfeit their earned benefits to finance deficit reduction. The President's failed deficit commission, led by Morgan Stanley Director Erskine Bowles and former Republican Senator Alan Simpson recommended dismantling FEHBP and turning it into a voucher program. Within the next few years, when the tax provisions of Obamacare take effect, some FEHBP plans will be passing to enrollees the full amount of their new excise tax liabilities (40% of the premium that exceeds the law's threshold amounts), causing premiums to increase substantially. And now the Office of Personnel Management (OPM) is floating several highly controversial initiatives that would have a harmful effect on many of the most vulnerable enrollees.

OPM has provided stakeholders next to nothing in terms of analysis or justification for these proposed changes. That is one reason why we are asking lawmakers to withhold approval for any of the OPM initiatives. It is massively unwise to give OPM the authority it seeks to make enormous and consequential changes to FEHBP without requiring them to demonstrate the impacts of these changes on enrollees. In that context, we are also asking Congress to establish a statutory advisory council for FEHBP, modeled on the Employee Thrift Advisory Council and the Federal Salary Council, so that organizations representing federal employees and retirees will have a formal opportunity to gain access to information about FEHBP policies and administration.

With federal pay frozen for three straight years, a massive tax increase on FERS employees via increased retirement contributions, and furloughs of up to 14 days that may be repeated each year for the next decade, federal employees cannot withstand any more reductions in their compensation. Meanwhile, in spite of the freeze and the shift of retirement system costs that lower new employees' take home pay by an additional 2.3 percent in perpetuity; federal employees have had to pay more each year for health insurance. No federal employee can afford to pay any more than is absolutely necessary for health insurance, and there is certainly no justification for any more cost-shifting to federal employees. Unfortunately, all of OPM's proposals, except perhaps for one, would shift costs to enrollees without improving the program or lowering its overall costs at all.

We understand that the changes in FEHBP that OPM is proposing will produce both winners and losers, but that overall, they will shift costs for the program away from the government and onto the backs of federal workers. There are obviously numerous ways for the government to reduce deficits, but the worst possible way is to impose further cuts in benefits on its own workforce. As with the pay freeze and the retirement system cost shifting, the administration couches its proposals in the notion that it is following private sector practice, or “modernizing.” But the end result is the same: lower compensation for federal employees through cost-shifting. Thus, AFGE urges lawmakers to reject all proposals from OPM that would lead to higher costs or lower benefits for federal workers.

Our members currently pay an average of 30% of FEHBP premiums, in addition to sometimes substantial out-of-pocket deductibles and copayments. In some plans (New Jersey’s and Delaware’s Aetna Open Access Plans), the employee’s share of the premium is 64%. Yet despite shouldering this tremendous financial burden, we have neither access to information nor input into any decisions about expansions or contractions of benefits, changes in administration, or changes in program structure. We’re in the unenviable position of being expected to keep quiet and keep paying. That is another reason why we are so grateful for this opportunity to testify today. Hearings like this have become our sole opportunity to voice concerns about FEHBP and the direction OPM would like to take it.

## **OPM’s FEHBP Proposals**

### ***Discounts for Wellness***

We first consider the proposal described as giving “discounts for wellness.” This Orwellian label barely masks its true purpose -- to impose surcharges on those deemed “unwell.” The unwell have relatively higher health insurance claims than those identified as “well.” Would OPM also propose lower salaries for those deemed “unwell”? Would OPM propose to charge those in “wellness programs” more for their retirement benefits on the belief that those with good health are likely to live longer, and therefore cost the retirement system more? Would it all come out even in the end? Lower pay and benefits now for the obese, but since they die earlier, they will be charged less for retirement?

The latest medical research strongly suggests that obesity is as much a function of genetics as is height. But illness is a misfortune, not a moral defect. Genetic traits do not respond to financial incentives. According to the latest data from the Centers for Disease Control, obesity rates vary tremendously by race and ethnicity, with 58.5% of non-Hispanic black women and 41.4% of Hispanic women classified as obese, while just 32.2% of non-Hispanic white women were labeled as such. The legal definition of discrimination involves disparate treatment on the basis of immutable characteristics, and one protected class has to do with physical disability. There

are numerous conditions that are physical disabilities that might make a federal employee ineligible for the “wellness discounts” related to obesity, rendering the initiative discriminatory. We understand that this form of discrimination is legal under ERISA and other laws, but it remains offensive to our sense of fairness. As such, AFGE urges members of the subcommittee to reject the so-called “premium differentials tied to “wellness”” initiative.

As an alternative, we propose requiring all FEHBP plans to cover up to \$750 per year for gym memberships, fitness classes, or fitness devices. This would provide a positive incentive to pursue fitness, and it is a practice that is far superior to penalizing those with obesity or other conditions that render them ineligible for preferred rates. This is the practice that AFGE uses for its employee health insurance program. For many of AFGE’s employees, this subsidy has been instrumental in the decision to pursue fitness classes that would otherwise have been unaffordable.

***Adding a new Premium Tier: Self plus one***

OPM has also proposed a “self plus one” category of premiums. This change would increase costs for families, and perhaps, contrary to the plan, might also increase costs for those who choose the “self plus one.” Self plus one would include many retirees or older couples, but it would also include some single parents of just one child. Those who currently choose family coverage include hundreds of thousands of parents and children under 26. Children under age 26 are the least expensive group to insure: the bulk of their health care costs come from primary care office visits, immunizations, and preventive care, which adds up to about \$900 per child per year. Other than that, their costs generally come from emergency room visits, and prescription drugs. Thus, families that include one or more children generally cost less to insure than two adults. That is why, currently, in FEHBP, among those with family coverage, those with more than one child subsidize the two-adult family. But all that could change with self plus one, to the detriment of both kinds of families.

FEHBP’s most serious structural problem is risk segmentation. FEHBP encourages those with similar risk to congregate in the same plans. Risk segmentation can occur when a program lets participants choose from plans that vary widely in terms of benefits, and when the program lets participants choose the number and age of individuals covered. Risk segmentation robs a large group of the benefits of minimizing average risk, and since premiums are based on average risk, risk segmentation produces higher aggregate health care costs for FEHBP than would occur if everyone were in the same pool. The “self plus one” proposal would exacerbate FEHBP’s risk segmentation problem, creating new disadvantaged groups of self-plus ones with similar risk profiles. Older or sicker couples would pay more, but so would those with larger families. Overall, the plan would have even more risk segmentation, which in turn raises aggregate costs and costs for some enrollees.

Interestingly, President Obama's Affordable Care Act went to great lengths to avoid the adverse consequences of risk segmentation. The rules for exchanges attempt to standardize benefits by allowing them to include no more than four benefits packages (60,70,80, and 90 percent of projected cost of "essential health benefits"), limiting the differentials plans can charge by age, and prohibiting differentials by gender altogether. Initially, Obamacare would have prohibited self plus one, but bowing to pressure from the states and insurance industry, state exchanges will have the option of charging by the number of individuals (up to a maximum individualized charge per family for three children).

The sole rationale offered by OPM for the self plus one premium tier is that they consider it a "best practice" in the private sector. Although business buzzwords like "best practices" should always be approached cautiously, there is a clear sense of what one means by the term, and it is important to note that what private firms consider "best practice" is not necessarily desirable public policy. A private sector "best practice" is one that maximizes profits, and in the context of compensating employees, that increasingly means minimizing employer costs for health insurance by shifting costs on to employees, eliminating defined benefit pensions altogether and providing only nominal employer funding of defined contribution plans. Further, empirical evidence shows that the private sector does not have the "best" practices when it comes to health insurance; the public sector's practices are far superior. A 2011 Congressional Budget Office (CBO) analysis of Representative Paul Ryan's budget found that "average spending in traditional Medicare will be 89 percent of (that is 11 percent less than) the spending that would occur if that same package of benefits was purchased from a private insurer." ([http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan\\_letter.pdf](http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf))

An OPM document estimated that establishing self plus one in FEHBP would save the government \$6 billion over ten years. The proposal would shift some or all of this \$6 billion on to federal employees and retirees. Again, it is incumbent upon OPM to evaluate the impact that this change would have on plans and enrollees. OPM simply says premiums would not change ("there would be no overall impact on premiums"), but \$6 billion would be saved. What kind of assumptions did OPM use to produce that statement and the savings estimate? For many years, OPM's actuaries have told us that self plus one premiums would likely exceed family premiums in FEHBP, and that allowing this category would send family coverage premiums much higher. If past OPM actuarial estimates were so wrong, can OPM explain why they were wrong? Does OPM expect that all plans would offer this option, or would offering it be voluntary? The \$6 billion would be a massive compensation cut on top of the pay freezes, retirement cuts, and furloughs if it derives from cost shifting, as we suspect. Thus, AFGE urges the committee to reject this proposal as well.

## ***Regional PPOs***

The next idea from OPM for FEHBP is one its proponents call “expansion of FEHBP plan types.” In practice, this means allowing regional Preferred Provider Organizations (PPOs) to compete against the national PPOs such as Blue Cross/Blue Shield (BCBS) standard and basic options. The “Blues” are FEHBP’s most popular plans, and currently cover more than 60 percent of enrollees. Like other proposals that claim to lower costs by increasing competition, this one will deliver much less than promised by OPM. First, OPM has a miserable track record when it comes to “arms-length” negotiations with health insurance carriers. Indeed, the carriers are regularly referred to as OPM’s “partners” while we, the enrollees on whom OPM wants to shift more and more costs, are more like lepers. What OPM never seems to understand is that as a purchaser, they have a different set of interests from the carriers and it is not their role to follow and accommodate and approve any and all demands by the carriers. Thus their assurance that they would pursue a “negotiations” strategy “not only advantageous to the FEHBP Program but to carriers as well” does not bode well for enrollees, and neither does the \$600 million they think they will save from this initiative. Health care costs (prices and utilization) are not going down; if the government is saving \$600 million here and \$6 billion there in FEHBP, it can only mean that enrollees are paying the difference.

Like all of OPM’s proposals, this one would have both winners and losers. One question is who the winners would be and who would be the losers. Another is whether there are more losers than winners; the \$600 million savings estimate begins to answer that question in the affirmative. There is also the question of whether the amount of savings for the winners exceeds the losses of the losers. In short, what will be the impact on FEHBP? How many will migrate out of other plans into these regional PPO’s? How many will shift out of other plans that are affected by the migration to regional PPO’s? What will be the impact on premiums and benefits? *OPM has not answered any of these questions.*

OPM suggests that BCBS plans have too much market power, and that a dose of competition from regional PPOs will lower costs for both. But we know from experience that is not how things go in FEHBP. What will likely happen is that BCBS will end its national plan and the various state BCBS organizations will compete against the regional PPO’s, depriving federal employees of the most popular national plan. More risk segmentation will plague FEHBP. There may be less competition, not more, as a result of this change.

If there is one thing FEHBP carriers oppose more than anything, it is the reform long championed by AFGC: one standard benefits package that would require plans to compete on the basis of cost and quality, rather than compete by segmenting the market. Without the national BCBS plans, the regional plans will construct dissimilar benefits packages designed to cherry pick, and the ensuing increase in risk segmentation will worsen FEHBP’s existing flaws.

We have surveyed our members who choose a BCBS plan and they report that they like the stability of BCBS, they like the large provider network, and they like the benefits package relative to other plans. In short, they like the fact that the Blues offer comprehensive benefits. They do not like the premiums, of course, or the fact that their rise seems inexorable. But they do like the idea and the reality of one national plan. They understand that purchasing power is maximized in a large group, and that average costs and therefore premiums are lowest in a diverse risk pool. The Blues are as close as FEHBP gets to having one big, diverse federal government plan with a standard benefits package. They know that the other regional plans try to lure away those with a particular need or preference, and are thus a worse deal. That is how BCBS became the biggest FEHBP plan, and that is why there is no appetite for yet additional breakaway plans that will further segment the market, and further dilute the purchasing power of the federal employee and retiree group.

### ***Direct Contracting with one Pharmacy Benefit Manager***

Another OPM initiative, put forth under the heading of “increasing contracting discretion” would involve carving out prescription drug benefits and allowing OPM to negotiate directly with one Pharmacy Benefit Manager (PBM). The logic behind this is identical to AFGE’s arguments in favor of reducing the number of carriers in order to consolidate buying power and encourage the kind of competition that drives down costs, rather than that which merely segments the market and shifts costs. AFGE would be supportive of this proposal if OPM had not let slip that it contemplated this in the context of full “voucherization” of FEHBP, as recommended by Messrs. Simpson and Bowles, but not endorsed by the commission they led. The notion that the carve out would mean a voucher to purchase prescription drugs, and would, eventually, be part of a fully-voucherized cafeteria-type structure for all of FEHBP makes AFGE extremely wary of OPM’s initiative.

In addition, since it seeks to save \$1.8 billion over ten years, it is not clear whether OPM’s strategy would lead to the adoption of a formulary (i.e. a list of covered drugs) that would leave out a particular drug or brand of drug that a patient needs. It is also far from clear that OPM would be successful in choosing a PBM that would provide the best prices. There is an almost inevitable trade-off between the restrictiveness of the formulary and the overall cost of the prescription drug benefit. Further, plans such as Blue Cross/Blue Shield may have more buying power than OPM, as they cover more than eight million when their non-federal customers are counted. It remains for OPM to demonstrate how it intends to lower its costs without a cost-shifting voucher or problematic restrictions on the formulary.

Alternatively, AFGE strongly supports H.R. 1367, introduced by Representative Stephen Lynch (D-MA), *the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act*. The bill is meant to lower FEHBP’s prescription drug costs by putting restrictions on the activities of

PBMs, the entities that negotiate with drug manufacturers and supply prescription drug benefits to health insurance plans of all types. The legislation prohibited PBMs from switching a person's prescription without prior approval from the prescribing doctor (currently PBMs do so if switching to a different drug is more profitable for them). It also required a PBM to return to insurance plans almost all rebates and incentive payments they receive from manufacturers, and creates disclosure requirements for information about such rebates and incentive payments.

### ***Domestic Partner Benefits***

Finally, OPM has indicated a willingness to allow domestic partners to be added to a federal employee's FEHBP enrollment. However, tax laws will require the government to include in the employee's taxable income the value of FEHBP benefits provided to a domestic partner and/or the child of a domestic partner unless they qualify as the employee's "dependents" for federal income tax purposes. In cases where the domestic partner and/or his or her children do qualify as dependents for federal income tax purposes, the value of the insurance under FEHBP will not be taxable to the employee. AFGE strongly supports the full coverage for domestic partners of both same- and opposite-sex couples and their children under FEHBP, as well as other law changes that would not impose a tax penalty on same-sex families.

### **Federal Employees Need an Advisory Council for the FEHBP Program**

Federal employees and retirees pay at least 25% and as much as 64% of the premiums for health insurance under FEHBP. Yet in spite of this heavy financial obligation and the fact that FEHBP is the sole source of health insurance for many of its eight million participants, there is no formal mechanism for enrollees to have any input into any aspect of the program. We must rely upon OPM to negotiate contracts, set policy, and to decide what, if any, benefits beyond those specified in statute will be included or excluded. And we are forced to rely upon OPM to provide information, almost always after the fact, of what it has decided to do with this program. There is no formal mechanism for sharing of information prior to decision making. There is no formal mechanism for having federal employees' questions about FEHBP answered by OPM staff. In short, after paying, in the aggregate, 30% of the program's cost, there is no formal mechanism or opportunity for federal employees to have any involvement in its administration.

Federal employees have opportunity for input into administrative decisions involving the General Schedule pay system with the Federal Salary Council (FSC), a Presidentially-appointed advisory council required by law. The FSC includes outside experts in pay as well as representatives of the largest federal unions. Federal employees have an opportunity for input into administrative decisions involving the Federal Wage System with the Federal Prevailing

Rate Advisory Committee (FPRAC), an advisory council whose director is appointed by the Director of OPM and whose members include both management and labor representatives. And federal employees have the Employee Thrift Advisory Council (ETAC) which gives federal and postal employees and retirees and members of the uniformed services, all of whom participate in the Thrift Savings Plan (TSP), a chance to have input into administrative decisions involving the program. All of these bodies are established in statute, and all function well as avenues for dialogue and exchange of information, concerns, and advice. FEHBP would benefit greatly from the establishment of a similar statutorily required employee advisory council. AFGE will be seeking a sponsor for legislation to establish such an advisory committee.

### **Coverage of Applied Behavioral Therapy for Autism in FEHBP**

After years of pressure from AFGE and organizations representing the families of those with autism spectrum disorders, OPM finally agreed to allow FEHBP plans to cover the most widely used and most effective treatment for autism, Applied Behavior Analysis (ABA). Thirty-seven states require health insurance plans operating in their state to cover autism treatments and interventions. OPM's action still falls far short of this standard, because it only permits and does not require FEHBP plans to cover treatments such as ABA. Nevertheless, starting in January 2013, 67 of FEHBP's 230 participating plans offered ABA. In 19 states, coverage will be offered in some regions. All state-specific plans in Arkansas, Minnesota, and New Mexico will provide the coverage.

Neither of the largest FEHBP plans, Blue Cross/Blue Shield Standard Option or Basic Option, will cover ABA in 2013. These nationwide plans cover 62% of all FEHBP participants, and the regional plans that cover ABA do not begin to include the remaining 37%. Thus, if OPM is at all serious about providing coverage for the most effective and widely used intervention for autism, it must require plans to cover ABA. AFGE will continue to press OPM to require this coverage in every FEHBP plan.

### **Obamacare and FEHBP**

The enactment of the Affordable Care Act in 2010 has not yet solved all of our nation's problems associated with health care cost and insurance coverage, as 50 million Americans remain uninsured and we still spend almost twice as much per capita as other advanced industrialized countries with nationalized health care. This is true despite the fact that almost half of all American health care spending is funded by the US government through Medicare and Medicaid which are *not* drivers of cost. (Indeed, OPM should look to these government programs and the Veterans Health Care system for best practices). The country's problems with prices and coverage derive from the other "half" of health care spending, the portion controlled

by private insurers and pharmaceutical companies and where policies and rates are set by the private sector rather than government regulation.

The phase-in of benefits from Obamacare began in 2011 with extension of coverage to dependents up to age 26, no copayments for preventive care, and smoking cessation benefits, again without charging any copayments. Several other provisions of Obamacare affect federal employees and retirees who participate in FEHBP. Three will have a direct cost impact. The most promising is the rule on medical loss ratio limitations. Insurers will have to spend at least 80 percent of premiums on medical care or functions that improve the quality of care. For those covered by large group policies, insurers must spend an even higher amount -- 85 percent. Insurers who fail to meet this standard must provide policyholders with a rebate instead of pocketing the extra premiums as profit.

Those covered by Medicare and an FEHBP plan pay nothing for one annual well patient visit to a doctor, and can request a personalized illness prevention plan at no cost. Medicare beneficiaries are also able to get immunizations and screenings for cancer and diabetes without any copayments. Those who participate in Medicare Part D are eligible for a 50 percent discount on brand-name drugs and a seven percent discount on generic drugs if the plan has a coverage gap (also known as a "donut hole"). These discounts will increase each year until the donut hole is completely eliminated by 2020.

Beginning in 2018, the income-based government subsidies for individuals to purchase health insurance from state-run "exchanges" will become available. Unfortunately, because the incomes of hundreds of thousands of federal employees are so low, and FEHBP premiums are so high, the number of federal employees eligible for subsidized purchase through the exchange will be large. The numbers will be larger than originally anticipated because while FEHBP premiums continue to climb, the three-year pay freeze has impoverished growing numbers. The subsidies will be calculated partially to limit the share of family income paid out in premiums, and partially on the basis of family size.

2014 will also see the introduction of rules to prevent insurance companies from discriminating against those with a pre-existing or existing health problem. In addition, insurance companies will be prohibited from placing lifetime limits on the amount they will pay for benefits for a patient (the law raises the limit and eventually eliminates it). Restrictions on insurance companies' ability to cancel coverage when an enrollee falls ill also come into effect in 2014.

However, Obamacare also includes a time bomb provision, set to go off in 2018, that is likely to be very damaging to federal employees. The most punitive will be the 40 percent excise tax on "high cost" or "Cadillac" plans that will make FEHBP far less affordable for many federal employees and retirees than it already is. Most disturbing is the fact that this tax will fall on

many FEHBP plans whose high costs are not at all a reflection of a rich benefit package. In fact, the highest cost plans in FEHBP are not those with the most comprehensive benefits. The highest cost plans are those that exploit FEHBP's structural weaknesses by encouraging those with the highest health risks to congregate, and thus their costs reflect the risk group rather than the actuarial value of the benefits offered. Additionally, some FEHBP plans become high cost because of their political power and the Office of Personnel Management's long history of exempting them from cost accounting standards, and acceding to their demands for large annual premium increases.

FEHBP contracts are fixed price re-determinable type contracts with retrospective price redetermination. This means that even as the insurance companies receive only a fixed amount per contract year per "covered life", they are allowed to track their costs internally until the end of the year. The following year, they can claim these costs and recoup any amount they say exceeded their projections from the previous year. They are guaranteed a minimum, fixed profit each year regardless of their performance or the amount of claims they pay. The cost "estimates" on which they base their premium demands are a combination of what they report as the prior year experience plus projections for the coming year plus their minimum guaranteed profit. Clearly, there is no ability for federal employees to alter the "high cost" of these plans. It is in the FEHBP's insurance companies' interests to keep costs and profits high, and benefits low. And to subject the result of this inefficient system, one that propels FEHBP premiums ever-upward without regard to affordability or without any meaningful expansion of benefits to a "Cadillac" tax just adds insult to injury.

The excise tax is a heavily regressive tax on federal workers, especially those whose incomes are too high to be eligible for the exchange subsidies but are too low to afford employee premiums in excess of \$3,000 per year. While the 40 percent tax is levied on the insurance company and is paid on incremental costs over \$10,200 for individuals and \$27,500 for families, there are FEHBP HMOs whose rates already meet the 2018 thresholds.

### **The 2011 Deficit Commission's Proposal to Dismantle FEHBP**

The recommendations of the co-chairs of the President's National Commission on Fiscal Responsibility called for "transforming the Federal Employees Health Benefits Program (FEHBP) into a defined contribution premium support plan that offers federal employees a fixed subsidy that grows by no more than GDP plus 1 percent each year." Although the commission failed to achieve the supermajority vote necessary to send its recommendations to Congress for fast track consideration, the recommendations remain alive in current attempts to reduce the deficit on the backs of federal employees.

The voucher plan would change FEHBP by having the government provide a fixed amount of cash each year that employees could use to buy insurance on their own, instead of paying a percentage of average premiums charged by the insurance companies, as is currently the case. Under the existing statutory system, if premiums go up by 10 percent, the government's contribution goes up by around 10 percent. The FEHBP financing formula requires the government to pay 72 percent of the weighted average premium, but no more than 75 percent of any given plan's premium. Under the Commission proposal, the government's "defined contribution" or voucher would go up by an amount totally unrelated to the rise in premiums. For example, between 2011 and 2013, FEHBP premiums went up by an average of 3.5 percent (3.4% for 2013), and so did the government's contribution. If the voucher proposal would have been in effect, the government's "contribution" or voucher would have gone up by GDP + 1%. The annual growth rate of GDP in 2011 is estimated to have been 2% (through the third quarter, the most recently available data). Adding an additional percentage point to that and the voucher would have risen by 3%, not enough to cover the average rise in premiums.

This proposal originated in a Heritage Foundation "backgrounder," published in 2001 which criticizes FEHBP's "artificial restrictions on plan options, including less expensive plans" and recommends getting rid of all legally "mandated benefits," removing the 75 percent cap on the government's contribution to a plan, and allowing rollovers of any unspent funds. To make matters worse, Heritage recommended allowing plans selling to federal employees to charge different premiums to different individuals, based upon age or health risk. Differential premiums combined with the voucher approach would spell disaster for federal employees, no matter what their age or health status.

Why did co-chairmen Bowles and Simpson propose this drastic change? The proposal was presented as a "pilot program" in health care vouchering. The co-chairs planned to use federal employees as guinea pigs to see what happens if you de-link the government's financing of health care from actual health care costs. If they liked what happened to federal employees under the voucher plan, they said they would advocate extending the same approach for Medicare. Following the description of turning FEHBP into a voucher, they say many on the commission wanted to "offer seniors a fixed subsidy, adjusted by geographic area and by individual health risk to purchase health coverage from competing insurers." They went on to say that "if this type of premium support model successfully holds down costs without hindering quality of care in FEHBP," they would apply it to Medicare.

House Budget Committee Chairman Paul Ryan (R-WI) and the House Republicans who voted for his budget did not wait for the FEHBP pilot, and voted to voucherize Medicare. Of course, the voucher plan only holds down costs for the government, shifting the burden to federal workers

or the elderly. Clearly the objective is to reduce government spending and impoverish workers and retirees.

## **Conclusion**

During the three year pay freeze, federal employees' health insurance contributions have grown by more than thirteen percent. The cost to employees of participating in FEHBP continues to rise by more than either the general rate of inflation or the rate of growth of their ability to pay (i.e. cola growth for retirees or pay adjustment rates). While the consumer protections included in Obamacare have allowed all Americans to enjoy some of the positive elements of the FEHBP, federal employees' main benefit has been the extension of coverage to dependents up to age 26. AFGE supports efforts to lower FEHBP's prescription drug prices, but will closely monitor any sense that efforts to do so are part of a voucherization project or would negatively affect the formulary. Finally, AFGE will seek to protect federal employees from the new taxes Obamacare will impose starting in 2018, because they punish enrollees for the failure of OPM to negotiate premiums that are a fair reflection of the benefits contained in FEHBP's plans.

The establishment of an FEHBP Advisory Council, similar to the FSC, FPRAC, or ETAC, would allow representatives of federal employees the opportunity to voice their many concerns about the adequacy of the program to OPM, the federal agency with the responsibility of administering the program fairly.

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