CBO TESTIMONY

Statement of
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on
Premium Increases in
the Federal Employees Health Benefits Program

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

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Mr. Chairman and members of the Subcommittee, I am happy to be here today to discuss premium increases in the Federal Employees Health Benefits program and trends in private-sector health expenditures.

The Office of Personnel Management (OPM) recently announced that premiums for the Federal Employees Health Benefits (FEHB) program will increase by an average of 8.5 percent in 1998, after two successive years of decline. The announcement also stated that OPM expected the percentage increase in FEHB premiums to be significantly lower than the corresponding increase in the private sector.

OPM's statement has caused considerable concern among policymakers and raised several important questions about the future course of private-sector premiums in general and FEHB premiums in particular.

- Does the FEHB premium increase mean that we are about to return to double-digit increases in private-sector health expenditures?

- What factors drive the growth of premiums in the private sector and the FEHB program? In particular, are government actions to mandate health benefits responsible for an upsurge in health care costs?

- If cost pressures are beginning to grow, can FEHB premiums continue to grow less rapidly than private-sector premiums?

RECENT TRENDS

As is widely known, private-sector health expenditures have been growing much more slowly in recent years than in the 1980s. Surveys of employers show that the annual growth of premiums in employment-based plans dropped from double-digit rates at the beginning of the decade to 2 percent or less for the past three years—rates that are below the general rate of inflation (see Table 1). While demonstrating a similar trend, FEHB premiums have generally grown at rates lower than those reported by nonfederal employers, and average premiums actually declined in 1995 and 1996. The California Public Employees Retirement System (CalPERS), another major public purchaser of health care, has also reported premium reductions in recent years.

Health policy analysts generally agree that the 1990s have witnessed a fundamental transformation of health care markets that has helped to slow the growth of health spending, at least temporarily. The most visible sign of that transformation is the shift of workers from conventional fee-for-service coverage into various forms

TABLE 1. ANNUAL GROWTH OF PREMIUMS OR COSTS FOR HEALTH INSURANCE, 1990-1997 (In percent)

Source	1990	1991	1992	1993	1994	1995	1996	1997
FEHB	9	6	7	10	2	-4	a	3
CalPERS	17	11	6	1	-1	n.a.	-4	-1
Hay/Huggins	17	13	12	8	3	1	-3	n.a.
Foster Higgins	17	12	10	8	-1	2	2	n.a.
KPMG Peat Marwick	n.a.	12	11	8	5	2	b	2
Bureau of Labor Statistics	12	11	10	8	6	2	a	b
Memorandum:								
Consumer Price Index for All Urban Consumers	5.4	4.2	3.0	3.0	2.6	2.8	2.9	2.4

SOURCE: Congressional Budget Office based on the sources cited below.

NOTE: FEHB = Federal Employees Health Benefits program; CalPERS = California Public Employees Retirement System; n.a. = not available.

a. Decline of less than 0.5 percent.

b. Growth of 0.5 percent or less.

SOURCE NOTES

Office of Personnel Management, Federal Employees Health Benefits Program: The 1997 estimate is based on 1996 enrollment patterns and does not consider changes in enrollment during open season.

CalPERS, Health Plan Administration Division: Data for 1995 are unavailable because CalPERS changed the definition of its contract year. Before 1995, the CalPERS contract year ran from August 1 to July 31. In 1995, CalPERS began to switch its contract year to a calendar year basis. The 1996 data are for the contract year starting on August 1, 1995, and ending on December 31, 1996. Data underlying calculations for 1997 correspond to calendar year premium costs.

Hay/Huggins, *Benefits Report* (Washington, D.C.: Hay/Huggins, 1990 through 1996): The surveys use average premiums for all employers for the most prevalent plan, based on a sample of public and private employers that generally have at least 100 employees.

Foster Higgins, *National Survey of Employer-Sponsored Health Plans* (New York: Foster Higgins, 1990 through 1996): The surveys are based on a sample of private and public employers with 10 or more employees.

KPMG Peat Marwick, *Health Benefits* (Tysons Corner, Va., and San Francisco: KPMG Peat Marwick, 1990 through 1997): The surveys are based on a sample of private and public employers with 200 or more employees.

Department of Labor, Bureau of Labor Statistics, employment cost index: The index covers only the employer's share of premiums or costs. Growth rates measure changes in cost over a 12-month period from March to March.

of managed care. In 1997, fewer than 20 percent of employees are enrolled in conventional plans, compared with more than 70 percent just nine years ago.[1]

The shift to managed care reflects an increasingly competitive health care marketplace, for which both demand- and supply-side factors are responsible. On the demand side, employers have become considerably more aggressive in their price negotiations with health plans. A key force instilling competition in the marketplace has been their willingness to change health plans to obtain lower premiums.[2]

On the supply side, health plans have been focusing on expanding their shares of the market. With employers becoming more price sensitive, plans' market shares have depended increasingly on their relative prices. Thus, managed care plans—which are better able to control costs and, hence, premiums—have steadily gained market share at the expense of conventional fee-for-service plans. Not only have they sought to manage care more effectively, but they have also been able to take advantage of considerable excess capacity in the health care industry to drive hard payment bargains with providers.[3]

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1. KPMG Peat Marwick, *Health Benefits in 1997* (Tysons Corner, Va., and San Francisco: KPMG Peat Marwick, June 1997), p. 28.

2. Paul B. Ginsberg and Jeremy D. Pickreign, "Tracking Health Care Costs: An Update," *Health Affairs*, vol. 16, no. 4 (July/August 1997), pp. 151-155.

3. See, for example, Kathryn Saenz Duke, "Hospitals in a Changing Health Care System," *Health Affairs*, vol. 15, no. 2 (Summer 1996), pp. 49-61.

Managed care plans may not be able to continue to constrain premium growth, however, because of rising costs that are threatening their profit margins. Striking evidence of the upward pressure on premiums emerged in 1996 when the profits of health maintenance organizations (HMOs) fell by an estimated 60 percent and some plans were forced to use their capital reserves to meet their medical costs.[4] That erosion of profits reflects the recent pattern of premium increases that have not kept up with general price inflation.

Although premium increases remained low in 1997, they were higher than in 1995 and 1996, suggesting that the long downward trend may have come to an end. But because of the way in which insurers and health plans set those premiums, analysts did not expect the full impact of the 1996 profit squeeze to be felt until 1998. Considerable evidence suggests that health insurance premiums track changes in profits with a lag of about two years. That lag may reflect the time needed to collect and analyze the necessary data on claims experience, as well as the time needed to implement a premium change.

4. Julie A. Jacob, "HMO Profits Plunge in '96; Premium Hikes Likely Result," *American Medical News*, vol. 40, no. 35 (September 15, 1997), pp. 11-12.

Whether the recent slowdown in the growth of private-sector health spending will continue has been the subject of considerable debate. Once competitive forces have wrung inefficiencies out of the system, will the demands created by medical advances and new technologies drive spending back to the rapid growth rates of the 1980s and early 1990s? Or will continuing market pressures result in permanently lower rates of spending growth?

The Congressional Budget Office's (CBO's) most recent projections assume that private health expenditures will grow more rapidly over the next 10 years than they have in the past few years, with growth rates averaging 5 percent to 6 percent a year between 1998 and 2007.[5] At present we see no reason to modify those projections, which reflect the effects of several opposing forces within the health care system.

Upward pressure on premiums is coming from reduced profit margins, new requirements for health plans that the state and federal governments are imposing, and an overall change in the environment for managed care plans. That change reflects a growing backlash against some of the management practices that plans

5. Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1998-2007* (January 1997), Appendix H.

employ, causing plans to become increasingly concerned about their public image. But how far plans will voluntarily modify their practices in response to consumers' complaints is uncertain.

Moreover, there are indications that large employers may be modifying their market behavior, and some plans are beginning to find that raising premiums does not necessarily result in loss of market share. Although small employers still respond rapidly to price changes, large employers are apparently becoming less willing to change health plans when premiums rise, because of the resulting disruption in their employees' health care.[6] When employers were primarily offering conventional fee-for-service insurance, switching insurers did not have much effect on employees because they could generally see the same providers as before. But with most employees now enrolled in some form of plan with a restricted panel of providers, changing health plans may well mean changing physicians, which could cause considerable discontent.

Nonetheless, health care markets are still extremely competitive, and aggressive purchasing by employers is likely to continue. Although their concerns about quality of care and employee satisfaction may be growing, their concerns about costs will remain. Continued low inflation over the next several years is also

6. Jacob, "HMO Profits Plunge in '96."

expected to temper the growth of premiums; although price increases for medical services were greater than general inflation in the 1980s, rising prices in the overall economy certainly contributed to the rapid growth of health spending. CBO's projections assume that general inflation will remain at about its current rate for the foreseeable future.

FUTURE GROWTH IN FEHB PREMIUMS

Health plans offered by the FEHB program consist of a few large managed fee-for-service plans that operate nationwide and several hundred smaller point-of-service plans and HMOs that serve local markets across the country. All of those plans are subject to many of the same forces as private-sector plans more generally, as well as to the unique and varied pressures that exist in local markets. Thus, just as one sees wide variations in levels and rates of growth of private-sector premiums across the country, one would also expect to observe similar patterns in FEHB premiums.

The projected 8.5 percent increase in FEHB premiums should therefore be interpreted carefully. Because of the large market share of the national fee-for-service plans, especially the Blue Cross-Blue Shield standard-option plan, average premium increases in local markets may appear deceptively similar. Family

premiums in that plan will rise by 7.5 percent throughout the country, an increase that does not reflect the conditions in any particular local insurance market.

The regional pattern of rate increases appears to be consistent with conditions in local markets. For example, changes in premiums for the three local plans in California with the largest family enrollments range from a slight drop to an increase of less than 5 percent. That performance is consistent with the overall increase of less than 3 percent projected by CalPERS for 1998. In contrast, family premiums in the three local plans in the District of Columbia with the largest enrollment will all increase by more than 10 percent.

THE ROLE OF MANDATES

One factor that contributes to the growth of health insurance premiums is mandates on health plans that expand benefits or modify the way in which those plans are operated. Such mandates are not a new phenomenon. States have traditionally regulated health plans, resulting in a complex pattern of requirements that plans must meet. But self-insured plans are exempt from most of those requirements under the provisions of the Employee Retirement Income Security Act (ERISA). In the past two years, however, the federal government has enacted several mandates relating to the portability of insurance coverage and covered benefits that will affect all health

insurance plans, including those that are self-insured. Several other federal mandates are under consideration.

Although health insurance mandates generally increase the cost of providing health coverage and result in an increase in premiums, the magnitude of such increases for the recent federal mandates has not been large. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) made it easier for people who change jobs to maintain health insurance. According to CBO's estimate, the act's provision for insurance portability will impose mandate costs on the private sector of $440 million in fiscal year 1998, or about 0.1 percent of the more than $300 billion spent annually on private health insurance. In contrast, HIPAA did not impose any additional costs on the FEHB program, which already covers new employees without restriction.

Other recent federal health insurance mandates, however, are expected to increase the costs of both FEHB and private plans. As a result of legislation passed last year, all health plans must cover at least a 48-hour hospital stay for normal deliveries (96 hours for a cesarean section) and meet certain parity requirements for mental health coverage. In addition to those legislated mandates, OPM will now require that FEHB plans cover at least a 48-hour hospital stay for mastectomies. According to CBO's estimate, the requirement for maternity stays will increase federal spending for the FEHB program by $4 million (subject in part to

appropriations) in fiscal year 1998, and mental health parity would increase federal FEHB spending by $10 million in that year. Counting both the federal and employee shares of the premium, FEHB spending will rise by almost $20 million in fiscal year 1998 as a result of those mandates. That amount is extremely modest compared with the $17 billion in total spending for federal employees' health benefits projected in CBO's baseline. The impact on private-sector costs is somewhat more significant. CBO estimated private-sector mandate costs of $180 million for the requirement for maternity stays and $1.2 billion for mental health parity in fiscal year 1998.

By themselves, those mandates should not add significantly to the growth in health insurance premiums between 1997 and 1998. Nonetheless, as more state and federal mandates are imposed, their cumulative effects on premiums could become considerable. That issue, which affects both private and FEHB plans, is one of the factors causing uncertainty about future growth in premiums.

CONCLUDING THOUGHTS

The recently announced 1998 premium rates for the FEHB program represent a significant rise in health care costs for federal employees. Although an 8.5 percent

increase is somewhat higher than CBO and other observers have projected for the growth of private insurance premiums for 1998, it does not appear to be out of line with developments in the private market. Moreover, that increase does not mean that a return to double-digit rates is inevitable or even likely in the foreseeable future.

The geographic pattern of FEHB premium increases for local health plans suggests that OPM is obtaining premium offers that are consistent with conditions in those markets. The low increase for FEHB premiums in California, for example, is consistent with the experience of CalPERS. The FEHB program may be able to negotiate rate increases below the average increase in private insurance rates in some markets, primarily those in which there is already substantial competition among health plans and in which the FEHB program has a large share. But even in those areas, FEHB rates would not be immune to the forces driving health insurance costs in general.