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Bad Medicine for Federal Workers and Taxpayers: Killing FEHBP Competition

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President Barack Obama wants the Joint Committee on Deficit Reduction ("super committee") to kill market competition for prescription drug coverage chosen by workers and retirees in the Federal Employees Health Benefits Program (FEHBP).[1] In the President's sparsely worded proposal, the U.S. Office of Personnel Management (OPM), the agency that administers the FEHBP, would contract directly for pharmacy benefit management services on behalf of all federal workers, retirees, and their dependents.

The FEHBP currently offers decentralized consumer choice of a broad range of prescription drugs, but that would be replaced by a centralized government procurement program. Remarkably, the Administration dismisses private market negotiation between drug manufacturers and private health plans as a "fragmented purchasing strategy"; it claims government purchasing would "more efficiently leverage" the combined power of the program to "negotiate" a "better deal" for taxpayers and federal enrollees.[2] In fact, the President's policy guarantees the politicization of prescription drug coverage for federal workers, retirees, and their dependents—more than 8 million Americans.

Reducing Availability of Prescription Drugs. While short on details, this is not a new idea. The Administration and the Democratic congressional leadership have offered a broadly similar proposal to end private market negotiation in the provision of prescription drug coverage in Medicare Part D. They would have the government "negotiate" directly with a single pharmacy benefit manager, on the questionable assumption that it would get a better price for prescriptions than private market competition.[3] But the government does not "negotiate" drug prices; it fixes them.

When government is the price fixer, it is a "take it or leave it" proposition for suppliers of prescription drugs. If a company does not accept the government price, the company's drug offerings are excluded from a closed market, regardless of what individual patients in consultation with their physicians decide they want or need. If federal workers or Medicare beneficiaries imagine that this could work another way, they could be in for a very unpleasant surprise.

Of course, the government *can* pay less for drugs and secure larger "savings" than those produced by competitive market forces—but only if the government adopts a restrictive formulary (an approved drug list), reducing patient access to a broad range of drugs. In the case of Medicare Part D, the Congressional Budget Office concluded there would be no savings beyond those already achieved through

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private-sector negotiations without the power to impose such a formulary.[4]

Today, the Veterans Administration (VA) imposes such a restriction to lower drug spending. In 2008, the Lewin Group, a top econometrics firm based in Northern Virginia, conducted a comparative analysis of the range of drugs provided in the plans with the highest enrollment under Medicare, the FEHBP, and the VA. Of the top 281 drugs covered under Medicare Part D, 183 (65 percent) were available in the VA, while 273 (97 percent) were available in the FEHBP.[5] In analyzing 569 million prescriptions, or scripts, for drugs, Lewin found that 99 percent of all scripts and 100 percent of brand-name drug scripts were covered in the FEHBP, while the VA covered 72 percent of the total and just 41 percent of the brand-name scripts.[6] Not surprisingly, roughly two out of five Medicare-eligible VA enrollees, who have access to "free drugs" through the VA health plan, obtain their prescriptions through Medicare Part D instead. [7]

Even though the proposal lacks detail, it is pregnant with certainties. It would, for example, guarantee the politicization of prescription drugs. The very moment OPM imposes a restrictive formulary, setting payments for one drug or another, lobbyists for the drug industry or the unions will swing into furious action—replicating the frenzied lobbying and congressional micromanagement that characterizes Medicare benefit and provider payments, such as price fixing for durable medical equipment or the absurd Medicare physician payment formula. Federal workers and retirees would anxiously await the annual Capitol Hill dispensations on the prices and availability of their prescriptions.

Presumably, OPM would also set the drug deductible, the coinsurance or co-pays, and the out-of-pocket limit applicable to the carved-out benefit. But once OPM determines these details, the Office of Management and Budget (OMB) must decide if they comport with the Administration's "savings" targets. In any case, one could expect even more congressional micromanagement.

Deceptive "Savings." The FEHBP pays out $40 billion in claims annually. The Administration estimates that its FEHBP drug price-fixing scheme would save $1.6 billion over *10* years.[8] Based on the Administration's projections, drug payments

1. The Office of Management and Budget, *Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction*, September 2011, p. 43, at *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf* (October 28, 2011).
2. *Ibid.*
3. Recent research disputes greater cost control from "carving out" pharmacy benefits. In integrated health plans, where drug benefits are "carved in," researchers found that, over a four-year period, clients with integrated plan coverage had annual medical expenses that were 6.2 percent lower on average than those with a "carved out" drug benefit, and those enrolled in an integrated health plan "experienced an annual average of 15.8 percent less in outpatient expenses and 7.7 percent less in ER expenses for their employees." Eric J. Culley, Laura C. Williams, and Lisa Thomas, "Pharmacy Benefit Carve-In: The Right Prescription for Cost Savings," *Benefits and Compensation Digest* (February 2010), p. 24.
4. See the Congressional Budget Office, letter to the Honorable Ron Wyden, "Re: Issues Regarding Price Negotiation in Medicare," April 10, 2007. The Congressional Budget Office reached roughly the same conclusions with similar legislative proposals concerning Medicare Part D.
5. The Lewin Group, "Comparison of VA National Formulary and Formularies of the Highest Enrollment Plans in Medicare Part D and the Federal Employee Health Benefit Program," prepared for the Pharmaceutical Research and Manufacturers of America, December 10, 2008, p. 1, at *http://www.lewin.com/content/publications/3987.pdf* (November 2, 2011).
6. *Ibid.*, p. 2.
7. See Greg D'Angelo, "The VA Drug Pricing Model: What Senators Should Know," Heritage Foundation *WebMemo* No. 1420, April 11, 2007, at *http://www.heritage.org/research/reports/2007/04/the-va-drug-pricing-model-what-senators-should-know.*
8. OMB, *Living Within Our Means*, p. 43.

account for 30 percent of all claims in the FEHBP, or roughly $12 billion annually.[9] While predicting future health spending is difficult given sharp variations in the utilization of medical goods and services or breakthroughs in medical research, FEHBP drug expenditures will easily be in excess of $120 billion over the next 10 years. Thus, the projected savings generated by this wrenching change would be miniscule, amounting to much less than 2 percent of drug expenditures.

But government drug purchasing is no guarantee of cost control or *any* savings at all. Government officials—for political reasons—may simply decide to pay *more* for drugs, regardless of market prices. In TRICARE, the health program for military dependents, between 2000 and 2008, per capita pharmacy costs grew twice as fast as costs in the FEHBP over roughly the same period. [10]

New Taxpayer Liabilities. The FEHBP is well designed, not only to secure high-quality care at competitive prices, but also to limit taxpayers' exposure to its financial liabilities. This is done in two ways.

First, the FEHBP is a premium-support program, a variant of defined contribution for health coverage. The government (as employer) pays up to 75 percent of premium costs for the private plans chosen by federal workers and retirees, with an annual cap on the dollar amount. If enrollees choose a health plan with more expensive benefits—drugs or otherwise—they are free to do so, but they pay the amount over and above the government contribution. The Administration proposal is silent on whether or not the existing FEHBP payment formula would be retained for drug coverage. The current premium-support arrangement not only promotes cost-controlling competition but also limits taxpayers' exposure.

Second, FEHBP plans—not taxpayers—assume all of the risks and liabilities in offering health benefits. Unlike large private companies, the federal government does not self-insure. Presumably, under the new proposal, the government (i.e., taxpayers) as purchaser would take on the risks of offering drug benefits that were previously the exclusive responsibility of private health plans. It is hard to imagine how such an annual assumption of billions of dollars of risk for the provision of pharmaceuticals is a sound prescription for avoiding future deficits.

If You Like Your Coverage… The Administration's FEHBP proposal is integral to its ambitious agenda for centralized government control over the health care system. Instead of consumer choice and competition and robust market prices for drugs, the prescription drug formulary and cost sharing would be set by federal officials. Those officials would determine which drugs would be available, at what prices, and under what conditions.

Today, FEHBP plans offer solid drug coverage. Private negotiations between plans and pharmaceutical benefit managers have secured serious price discounts and a broad range of drugs and therapies at competitive prices. The Administration's proposal would wreck this productive arrangement and replace it with a highly politicized system of drug pricing and delivery. This would either restrict consumer choice or saddle taxpayers with new liabilities.

For the FEHBP and private insurance alike, the Administration's policy has a common theme: massive and costly disruptions of the existing coverage of millions of Americans, whether they like it or not.

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9. This 30 percent claim share should not be surprising. Most employer-sponsored insurance no longer covers retirees. However, FEHBP does cover retirees, who use FEHBP plans as Medicare "wraparound" coverage for drugs. Older workers and retirees rely on prescriptions much more heavily than younger, active workers. But appropriate drug therapy can also reduce other medical spending.
10. Walton Francis, "Where's The Beef in Claims that Employee Health Plans Overspend on Drugs?" *Roll Call*, March 2, 2010, at *http://www.rollcall.com/news/-43716-1.html* (October 28, 2011).