

Chairman Danny K. Davis Responds to Enrollee Outrage Over BCBS 2009 Changes

Chairman Danny K. Davis Responds to Enrollee Outrage Over BCBS 2009 Changes

Rep.

Davis' (D-IL) and Members of the Subcommittee requested that the Office of Personnel Management extend the Federal Employees Health Benefits Program Open Season for millions of federal employees

Chairman Danny K. Davis Responds to Enrollee Outrage Over BCBS 2009 Changes

Rep.

Davis' (D-IL) and Members of the Subcommittee requested that the Office of Personnel Management extend the Federal Employees Health Benefits Program Open Season for millions of federal employees

Washington D.C. - On Wednesday, December 3, 2008 the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia held a hearing to examine the changes to the 2009 Blue Cross Blue Shield Service (BCBS) Standard Option Benefit Plan.

The most controversial change to the BCBS 2009 Benefit Plan is the fact that beneficiaries will be responsible for paying up to \$7,500 for surgery performed by a non-participating physician, except in the case of medical emergencies and accidents. Previously, beneficiaries have been responsible for paying 25 percent of the plan's allowance, plus 100 percent of any billed amount above the plan allowance.

The changes were spurred by OPM's concern that patients could not predict their out-of-pocket costs when using non-participating providers until the health care expenses had been incurred. BCBS subscribers filed disputed claims because the balance owed was a large amount, due to the difference between the allowed amount and the billed amount (balanced billing).

However, hearing witnesses Walton Francis, Author of the Checkbook's Guide to Health Plan for Federal Employees, and Dr. Peter Petrucci, President of the Medical Staff for Sibley Hospital, testified that the 2009 benefit changes were not adequately publicized and that there are solutions to the "balanced billing" problem raised by OPM that do not include a hefty \$7,500 penalty.

Subcommittee Chairman Danny K. Davis stated during the hearing:

The Office of Personnel Management should delay the December 8th open season deadline. This will allow BCBS and OPM to reach a better solution to the "balanced billing" problem and give BCBS subscribers more time to determine whether or not to opt out of the health plan.

Delegate Eleanor Holmes Norton noted:

OPM was unable to articulate a good reason for opposing extension of the deadline. An extension is the least subscribers are entitled to, particularly considering OPM's involvement in the lack of transparency concerning the change.

Representative Elijah Cummings declared:

We cannot sit idly by while Blue Cross and Blue Shield tries to pull the wool over the eyes of federal employees and retirees. People need to know about the drastic changes that are being made to their health plans-and they need an opportunity to switch plans should they decide to do so. We cannot expect people to be informed consumers when we have not informed them of the reality of the situation.

For further information on the hearing and the testimonies visit: <http://federalworkforce.oversight.house.gov/>

Background Information

The Blue Cross Blue Shield Service Benefit Plan (the Blues) standard option has the largest enrollment of any of the Federal Employees Benefit Plans (FEHB). Changes in the Blues' 2009 plan include; a premium increase, changes in payment for services provided by non-participating providers (except in cases of medical emergency or accident), catastrophic limits, copayments and coinsurance for covered services, and increases and decreases in coverage.

While the media has highlighted the Blues changes to the payment structure for services provided by non-participating providers, beneficiaries can avoid the increased costs by choosing preferred or participating providers where possible. There are other changes that will result in increased beneficiary spending that will be more challenging to avoid.

Non-emergency surgical benefit by non-participating physicians. What has emerged as the most controversial change to the Blues 2009 benefit plan is that beneficiaries will be responsible for paying up to \$7,500 for surgery performed by a non-participating physician, except in the case of medical emergencies and accidents. Currently, beneficiaries have been responsible for paying 25 percent of the plan's allowance, plus 100 percent of any billed amount above the plan allowance. However, the 25 percent counted toward the maximum out-of-pocket limit of \$6,500. Therefore, regardless of the number of surgeries performed by non-participating providers, the enrollee would never pay more than \$6,500 plus the amount above the plan allowance for the year.

The change will result in increased out-of-pocket costs for some beneficiaries and a decrease for others. For example, consider a case in which a non-participating surgeon billed \$10,000 for a surgery and the plan allowance is \$4,000. Under the current plan, the beneficiary would pay 25 percent of the \$4,000 (\$1,000), plus 100 percent of the difference between the \$10,000 and the \$4,000 (\$6,000), for a total out-of-pocket of \$7,000. Under the 2009 benefit plan, the beneficiary would pay the first \$7,500. In this case, the beneficiary's out-of-pocket cost is higher.