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PURCHASING HEALTH CARE SERVICES IN A COMPETITIVE ENVIRONMENT

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PURCHASING HEALTH CARE SERVICES IN A COMPETITIVE ENVIRONMENT

THURSDAY, APRIL 3, 2003

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:18 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Thomas, Santorum, Baucus, Rockefeller, Breaux, Conrad, and Lincoln.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I thank all of you for being so prompt, because this is kind of an unusual starting time for a committee. Usually we would do this at 10:00. We accommodate more members by starting at 10:00 rather than 9:15, but today's early start is because, as I told some of the witnesses privately, later on I am going to have to go down the hall here and probably spend most of the time of this hearing in the Judiciary Committee, where there is a piece of legislation that I have worked hard on for about 5 years that is going to be up for consideration in that committee.

So I welcome not only the witnesses, but obviously I welcome everybody who has come to our hearing, and particularly for the time that it takes our witnesses to prepare for testimony and to help us in what might appear to be an inconsequential subject. But it is very basic to some of the legislation that this committee will be considering during the month of June that is very, very comprehensive.

Making health care in general, and Medicare in particular, more competitive has been a goal of many legislators over the years from both sides of the aisle.

And just to mention two members of this committee that have been involved in that. Senator Breaux, for one, and Senator Frist, the Majority Leader, for another, are just two examples of 100 Senators—well, I am not saying 100 Senators are interested in making Medicare more competitive, but at least a large number of people have been.

I believe that competition in Medicare, if done right, has the potential to change the lives of patients by improving benefits and increasing quality.

What this hearing is about, is gathering information so that that can be done in the right manner. Today, our witnesses, all of whom

have had experience purchasing health care services in a competitive environment, will tell us what it takes to do this job right.

Before I turn to their introduction, I would like to again acknowledge the bold commitment of President Bush in putting $400 billion on the table this year to strengthen and improve Medicare.

Besides putting $400 billion on the table, the President, at a meeting I had with him in roughly the December 10th time frame, also said that he was willing to expend political capital on bringing about bold changes in Medicare, along with a very prominent prescription drug program for that.

The President's principles include adding prescription drugs and—this is very important—making the program stronger and better for beneficiaries. That means improved benefits and higher quality care, more in synch with what is available in private insurance today, like we in the Federal employees' plan have. The President's principles look to the Federal employees' plan as a model for Medicare.

In the Federal employees' plan, all workers, even those in rural States, including even the postmaster in my hometown of 650 people called New Hartford, Iowa, all of these have a choice of health plans. Employees choose among competing plans for one that best suits their own needs.

Why should seniors living in the same town of New Hartford or any other rural community not have the same choice? Unfortunately, our attempts to bring those kinds of choices to seniors in Medicare have failed, especially in rural areas like mine, where insurance companies have given Iowans a firm no, even after we have given these companies bonuses and raised their base payments, which I think now, under Medicare, would be $490 per month, which is well above what fee-for-service pays within our State.

As a result, Iowa seniors then have few, if any, choices beyond fee-for-service Medicare. The environment is anything but competitive. So I will be especially interested in the views from our panelists who have made competition work for their beneficiaries, as I understand it, both urban as well as rural and how we can replicate some of those successes, and obviously we want to avoid failures in Medicare.

Our first witness, Abby Block, serves as Senior Advisor, Employee and Family Policy at the Office of Personnel Management. OPM administers the Federal Employees Health Benefit Plan, which requires plans to submit bids each year so that beneficiaries can measure a plan's value themselves.

Next, is Rear Admiral Thomas Carrato, who serves as Deputy Assistant Secretary of Defense for Health Administration, overseeing TRICARE, the system that serves our Nation's active and retired military, as well as their families. TRICARE is also based on a competitive model.

Third, Bruce Bradley, who serves as director of Health Plans Strategy and Public Policy, General Motors. This is one of the largest private purchasers of health benefits in the country and it provides competitive health plan choices to its 1.2 million employees.

Finally, we have Lois Quam, chief executive officer of Ovations, United Health Group Company, addressing her own company's ex-

perience with competition, providing us with a plan's perspective on what works and what does not, and particularly when it comes to competition in health care.

I am going to call on Senator Baucus for opening comments. Senator Baucus, I indicated to them, which I think you know, that I may be called out of here to handle a bill at Judiciary and I have been informed that you would be willing to chair the meeting.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I appreciate the to opportunity to explore these issues, particularly the issue of purchasing health care services in a competitive environment.

This is a little bit different from some of our other hearings. This is more of a "big think" hearing. this is more of a policy hearing. I hope that it enables us to kind of stand back a little bit in a little more perspective and try to figure out how to improve various systems, particularly as we try to enact a Medicare drug benefit, and perhaps reform Medicare as well.

We have the opportunity here to learn more about the competitive bidding structure that large purchases of health care currently use. I think this is very important, because the President recently has put forward a Medicare reform proposal, or at least the outline of a plan that emphasizes choice and competition among private health plans.

We are not here to pick at the administration's proposal. That is not the purpose. Rather, we are here to think about how a competitive model might or might not work for Medicare.

As I see it, there are many lessons here, both for the current Medicare+Choice program, as well as for traditional fee-for-service. In particular, some of the questions I hope our witnesses will help answer include, is it necessary to have losers in a bidding process like the TRICARE system, or is competition possible when essentially all bidders are accepted, like the FEHBP program?

How can quality be incorporated in a competitive purchasing system as GM has done? What are the challenges of bringing in PPOs to serve all parts of the country. Is a PPO model any less expensive or more efficient in a rural area than traditional Medicare?

My sense is that, with higher administrative costs, profits, and risk load, combined with an inability to contract with preferred providers in remote areas, that PPOs would actually be more expensive than traditional fee-for-service Medicare.

As I understand it, CBO happens to agree with this assessment. They also believe that getting regional PPOs to participate in Medicare will be very costly. At any rate, increased enrollment in PPOs certainly will not improve Medicare's solvency.

This leads to my last questions. Are these competitive systems truly transferrable to Medicare, and to what degree, to what degree not? Perhaps more importantly, are there lessons from these systems that we could apply to traditional Medicare, not just to private plans?

It is important to keep in mind that almost 90 percent of seniors are enrolled in traditional Medicare, and I do not see that ratio changing anytime soon. My State of Montana does not have any co-

ordinated care plans. We have a private fee-for-service plan in Medicare, but only 146 enrollees have signed up.

As we have tried to make improvements to Medicare, modernizations, reforms, or whatever you want to call them, we must think carefully about whether a competitive model truly can flourish in all areas of the country.

My colleagues on the committee know full well that I am skeptical that competition is the answer for seniors in my home State. That is why one of the biggest priorities is making sure that traditional fee-for-service Medicare remains a strong option for beneficiaries in Montana, as well as in other States.

These beneficiaries should have access to the same level of drug benefits as those who choose to enroll in private plans. We should spend just as much time, if not more, exploring ways to ensure that the fee-for-service program is operating efficiently, and think about other improvements we can make.

I am interested in hearing from our witnesses, learning more about how competition currently operates in other parts of the government and in the private sector, and how we might be able to apply these experiences to the Medicare program.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

Normally, just the two leaders speak. But since Senator Thomas represents a group called The Rural Health Caucus in the Senate, I would like to turn to him for a few comments, if he would like to make them, at this point.

Senator THOMAS. Thank you, Mr. Chairman. I did not come to make a statement. I am very pleased that you are having this hearing, however, because I am committed to the idea that we can better distribute health care through the private sector in a competitive way, and we have to find a way to do that.

I am also pleased that we are talking about it at this time in policy. That is where we ought to be in the first place, is deciding where we want to be and then get into the great details of how you get there.

So I think this is a great opportunity and appreciate each of you being here. I hope that you will give some thought as you give your comments as to how we might be able to provide these services through these kind of techniques.

So, thank you, Mr. Chairman.

The CHAIRMAN. I want to add to just what you say, though, and follow up on a strong point that Senator Baucus made that I think we all have to agree with. If we can do what Senator Thomas said, all three of us share the view that Senator Baucus made, that we want to make sure that it can be delivered in rural areas, and not find a way not to make it work, but to find a way that it would work. If we do it, we want to make sure it works.

Senator THOMAS. Well, we deliver services there now.

The CHAIRMAN. All right. Point well made. I do share Senator Baucus' comments, though, that we want to make sure that rural America is treated fair with urban America on this.

Now we will go to Ms. Block. Then we will hear from all four panelists, and then we will ask questions. Also, let me suggest that

all of your comments, if they are longer than the time allotted, will be included in the record, so we ask you to summarize.

Also, members who are here, and as well as for sure members who might not be able to come, might have questions for answer in writing. We would ask you to respond accordingly.

Would you start out, Ms. Block?

STATEMENT OF ABBY L. BLOCK, SENIOR ADVISOR FOR EMPLOYEES AND FAMILY POLICY, OFFICE OF PERSONNEL MANAGEMENT, WASHINGTON, DC

Ms. BLOCK. Thank you, Mr. Chairman and members of the committee. I did submit a longer statement which I hope will be included in the record.

The CHAIRMAN. Yes. Absolutely.

Ms. BLOCK. I am pleased to be here today to discuss the Federal Employees Health Benefit Program. During the more than 40 years that the FEHBP program has been in operation, the Office of Personnel Management has developed widely recognized expertise in the complexities of arranging health care coverage with more than 100 private health sector plans for a covered population of more than 8 million people. That includes 2.2 million employees, 1.9 million retirees, and members of their families. In 2002, the plan accounted for $24 billion in annual premium revenue.

The program relies heavily on market competition and consumer choice to provide our members with comprehensive, affordable health care. In 2003, 188 discrete options are being offered by 133 health plans.

An important and distinctive feature is nationwide availability. All members may choose from among a dozen options offered by nationwide fee-for-service preferred providing organization plans that are open to all.

Some members may elect one of the six nationwide plans limited to members of sponsoring organizations, and many may choose HMOs in their local geographic area. About 3 million Federal enrollees are in fee-for-service PPO plans, and 1 million are in HMOs.

There is an opportunity to enroll in the program, change plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November.

Although all participating plans offer a core set of benefits broadly outlined in the statute, benefits vary among plans because there is no standard benefit package. Even where coverage is nearly identical, cost sharing provisions may differ significantly.

While benefits and rates are negotiated annually, OPM does not issue a request for bids. Instead, we issue a call letter to participating carriers in the spring that provides them guidance for the upcoming negotiations.

Plans remain in the program from year to year unless they choose to terminate their contracts for business reasons, including failure to reach agreement with OPM on benefits and rates for the coming year.

Under current law, the window for new plans to enter the program is limited to HMOs. Unlike the 1980's when we were flooded with applications in the current market, we average about six new plans a year.

Rates are negotiated with the national plans based primarily on their claims experience. About 93 percent of premium, or 93 cents out of every dollar, reflects benefit costs. The remaining 7 percent covers the plans' administrative costs.

The community-rated plans rate negotiations are based on a per-member, per-month community rate. Adjustments may be negotiated to the base rate for a variety of reasons, including changes to their standard benefits package, the demographics of the Federal group, and the utilization of benefits by the Federal group.

Our oversight focuses on key areas of plan performance, including attention to quality, customer service, and financial accountability. Measures and expectations are built into our contracts.

Results are reported to our members in both print and electronic format. Members used the information, often in conjunction with decision support tools that we provide on our web site, to choose their health plans during the annual open season. All of our contracts include mechanisms through which profits can be adjusted based on performance.

In addition to oversight by the contracting office, all carriers are subject to audit by the independent OPM IG. As a result, we average yearly about $100 million in defective community rate findings, or unallowable administrative expense or benefit cost findings.

We administer the program in a way that mirrors other employer-based health insurance programs. While the program has a statutory and regulatory framework, key aspects of plan design such as coverage or exclusion of certain services and benefit levels are in neither law nor regulation.

Within broad parameters set by OPM, plans have the flexibility to determine both their benefits package and their delivery system. Because policy guidance is developed by OPM and provided to the plans annually prior to the start of negotiation, policy changes can be made very rapidly.

The CHAIRMAN. Let me make clear that we obviously do not people to go on forever and ever, but we do want to get information out. So is there maybe some way you can finish by summarizing, or at least finish your main points?

Ms. BLOCK. All right. Thank you.

We did, for example, this year accept a proposal from one of our plans for a new consumer-driven option that reflects developments in a fluid market. We do have special arrangements, and I think I would like to get to that point, for rural areas in particular. I think the best example I can give of that, is the Blue Cross/Blue Shield basic option which was introduced a couple of years ago.

Because that option has only an in-network benefit, it was necessary for them to demonstrate that they could, in fact, provide in-network services in every single place in the country, and they did manage to accomplish that. So, that is an example of how you can use networks in a universal, nationwide health plan. Other plans have other arrangements. We do have a statutory provision for medically under-served areas.

In final words, I would like to say that our experience has been very useful in terms of our partnership and cooperation with the private sector and other members of the public sector, including all the members on the panel here today that I have worked very

closely with, and we strongly believe that such a public/private partnership is very useful and can work well. Thank you for inviting me today.

The CHAIRMAN. My staff is way ahead of me, but let me suggest that where you talked about rural areas, we probably will get into depth on that more in this hearing. But if we do not, I would urge my staff, and hopefully even Democrat staff members, to sit down maybe in the same room with you to get some more details on that, because that is a very important part of our concern here.

Ms. BLOCK. We would be happy to provide that information.

[The prepared statement of Ms. Block appears in the appendix.]

The CHAIRMAN. Now, Mr. Carrato.

STATEMENT OF TOM CARRATO, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH PLAN ADMINISTRATION AND CHIEF OPERATING OFFICER FOR THE TRICARE MANAGEMENT ACTIVITY, WASHINGTON, DC

Admiral CARRATO. Mr. Chairman, distinguished committee members, thank you for inviting me to participate in today's very important hearing and to provide you with the Department of Defense's experience in delivering health care to a large worldwide population of military service members, their families, and military retirees and their families.

TRICARE provides health benefits to 8.7 million beneficiaries. We are a unique health care system, in that we both directly deliver health care services and also purchase a significant amount of health care from the private sector. Our total medical budget in DOD is over $27 billion, and we process almost 90 million claims per year.

Our health care system's primary mission is to provide a fit fighting force, and to be able to provide combat medical care and evacuation anywhere in the world, a mission, as you know, that is being carried out with great professionalism and success in Iraq today.

Because of our mission, our organizational structure, and our population, we are not a microcosm of the U.S. health care system. Yet, I believe that there are a number of elements of our system that can offer instruction on issues to consider in reshaping Medicare and on purchasing health care through a competitive process.

First, like Medicare, TRICARE provides one of the most comprehensive health care benefits in the world in a benefit design that is determined by Congress. Second, while active duty service members are our primary customers, we also serve more than 1.5 million Medicare-eligible military retirees and their families.

Finally, with the passage of the TRICARE for Life benefits in the National Defense Authorization Act of 2001, we significantly increased the benefits for this Medicare-eligible population and included a prescription drug benefit.

As we have developed partnerships with the private sector over the past 15 years, we have learned a great deal about how to structure this relationship in a manner that first provides our beneficiaries with high-quality, accessible health care, and also provides a means for the government to cost-effectively manage this care.

Among the many lessons learned from our experience, I would like to briefly share three relevant lessons with you. One, maintaining patient choice is essential. As we migrated to a managed care system, we have always maintained a fee-for-service benefit option that allowed patients to continue with their previous benefit, if that is what they wished to do.

The new benefits we introduced, TRICARE Prime and TRICARE Extra, offered inducements such as improved access to care, high-quality networks, reduced co-payments, or reduced paperwork to draw them into these latter options.

Two, partnerships with the private sector need to be collaborative rather than adversarial. We are about to enter into our third generation of contracts and we have learned a great deal since we began.

Perhaps most importantly, we have structured our newest contracts in a manner that ensures both the government and the private sector partner have shared goals that can only be achieved through a cooperative and helpful relationship. We share potential rewards and we share the risks.

Three, information systems need to be established and provide timely information to health care providers. When we introduced a TRICARE senior pharmacy benefit for Medicare-eligible persons in 2001, we were fortunate to have already implemented a worldwide pharmacy data transaction system that integrated pharmacy delivery from military facilities, retail pharmacies, and our mail-order pharmacy system.

This system has had dramatic improvements in patient quality and safety and avoided thousands of potential life-threatening drug interactions. It supports our medical surveillance programs that assist homeland security efforts, and it provides us with insight into high users of prescription drugs for whom we can develop programs to better manage their conditions.

Finally, I would like to add that our most recent efforts to procure health care services have been conducted in a very open process. We met frequently with our beneficiaries and their associations. We solicited frequent input from the health care industry. Comments and questions from potential offerers were incorporated into our contract documents and posted on an Internet site for public review.

Our program has seen ever-increasing levels of patient satisfaction, the quality of care has been sustained through this effort, and in some cases such as pharmacy, we have effectively used technology to improve.

Thank you very much.

Senator BAUCUS. Thank you, Mr. Carrato.

Mr. Bradley, please proceed.

STATEMENT OF BRUCE BRADLEY, DIRECTOR OF HEALTH PLANS STRATEGY AND PUBLIC POLICY, GENERAL MOTORS, WASHINGTON, DC

Mr. BRADLEY. Thank you, Mr. Chairman, Ranking Member Baucus, and distinguished members of the committee. I am Bruce Bradley, and it is a real pleasure to be here today to discuss pri-

vate sector approaches to purchasing the delivery of high-quality, efficient health care.

I believe our approach to health care value purchasing and quality improvement at General Motors not only benefits our employees, retirees, and our stockholders, but also makes a contribution to improving the overall health care system by encouraging health care delivery changes that benefit other patients, purchasers, and especially our communities.

We strongly believe that the quality- and performance-based strategies by other purchasers, such as Medicare as a purchaser, can, and will, improve the health care system for all consumers and payors of health care.

With this in mind, we support the Employers Coalition on Medicare and bipartisan efforts to modernize and improve the Medicare program. In fact, your efforts to reform the Medicare program will have a direct effect on the continuing interest of employers in providing voluntary retiree health benefits.

General Motors provides health care coverage for over 1.2 million employees, retirees, and their dependents, at an annual expense of over $4.5 billion. We are self-insured and provide numerous plan choices for our beneficiaries, including traditional indemnity plans, HMOs, and PPOs.

We believe there is significant clinical and administrative waste in our Nation's health care system today that contributes to not only excessive expenditures, but far more important, substandard or less than optimal health care.

Moreover, nearly 100,000 Americans a year die as a result of preventable medical errors just in hospitals alone. These figures translate into the preventable deaths of one to two General Motors beneficiaries every single day.

General Motors has made a company-wide commitment to improving the health care of our employees and retirees by focusing on value. To do this, we developed and implemented performance expectations, performance measures, and real incentives for change.

First, we chose four major expectations or goals for health care delivery: high quality health care, including positive medical outcomes; patient satisfaction; effective and responsive health plan and provider service; and value and cost effectiveness.

Second, we implemented performance measurements for our health care suppliers to determine if we were achieving our goals. For example, we require proven measures that have been clinically linked to better patient outcomes, such as frequent blood testing, eye exams, and foot exams for diabetics, use of computers for prescription drug orders in hospitals, and intensive care unit staffing. We also survey our members to determine satisfaction with their plan and providers. Finally, we evaluate plan and provide cost performance.

Third, and perhaps most important, we use our measures to drive accountability. The scores that our plans, and indirectly the providers they contract with, receive are used to provide incentives for beneficiaries to move to higher quality plans, as well as to drive quality improvement in the plans.

We do so through offering lower premium contributions for higher quality plans, coupled with quality report cards. Our members vote with their feet. The best plans significantly improve their market share.

For example, over the past 6 years, enrollment in our benchmark, our very best HMOs, has increased by well over 200 percent, while enrollment in our poorest performing HMOs has declined by 63 percent. The beneficiaries have moved through the organized delivery systems that improve their performance and produce higher quality health care.

This leads our HMOs, which largely provide very similar benefit packages, to compete on the basis of quality and cost, not on the basis of who can attract the healthiest beneficiary.

Mr. Chairman, I would like to share some of the techniques we use to manage our $1.5 billion prescription drug benefit. GM has a full-time doctorate level clinical pharmacist to lead the management of our drug benefits.

To ensure we are as effective as possible, we have performance-based financial arrangements with our PBM to assure appropriate utilization, the use of quality generic drug products, and customer service.

We use drug benefit designs with multi-tier co-payments to encourage the use of the most therapeutically and cost-effective medications. We have implemented prescription drug counseling and drug utilization review programs to help ensure enrollees avoid excessive and inappropriate use of medications, and we encourage plans to contract with hospitals that use computer-based prescribing tools to ensure safer medication use. Medicare can use these practices as well.

Mr. Chairman, there are a wide range of interventions we and our health plans use that are applicable for Medicare to purchase higher quality, more cost effective health care. Likewise, private purchasers would benefit if Medicare were empowered to be a more competitive and aggressive purchasing of health care.

Traditional Medicare fee-for-service and managed care plans participating in the Medicare program could be subject to greater accountability and be rewarded for their quality performance.

When Medicare and the Federal Employees Health Benefit Plan institute changes that make the delivery system more efficient, all purchasers, including us, benefit as well.

In conclusion, we believe that we benefit a great deal from each other. While private purchasers can generally implement innovations more rapidly, we rarely have the type of positive impact on overall health care delivery that public purchasers do when they implement and improve on our work.

We look forward to continuing our collaboration with you and others in the Federal Government to ensure that all health care consumers, purchasers, and taxpayers alike receive the value they deserve from the extraordinary financial investment in our Nation's health care system.

I would be happy to answer any questions that you may have.

Senator BAUCUS. Thank you, Mr. Bradley. That was very informative.

[The prepared statement of Mr. Bradley appears in the appendix.]

Senator BAUCUS. Ms. Quam?

STATEMENT OF LOIS QUAM, CEO, OVATIONS, UNITED HEALTH GROUP COMPANY, MINNETONKA, MN

Ms. QUAM. Good morning, Senator Baucus and members of the committee. It is a privilege to be here with you today.

I speak to you from the breadth of experience that United Health Group has providing health care services to 48 million people, with clients as diverse as half of the Fortune 100, to the British National Health Service.

The part of United I am responsible for provides services to Medicare beneficiaries. We provide services to 6 million Americans who benefit from the Medicare program, and our involvement is diverse.

We provide the Nation's largest fee-for-service offering in Medicare, the Medigap program we provide for AARP, which is offered in all 50 States and has substantial enrollment in the States represented by the members of the committee, to a specialized health plan for the frailest Medicare beneficiaries, called EverCare, to Medicare+Choice, HMO, and PPO offerings.

Finally, personally, I am a rural Minnesotan by birth. I came to my profession because of an interest in expanding health care in rural areas. As the committee knows, we have some work left to do there.

I would like to share three ideas for you, and I appreciate the committee's interest in this policy hearing today.

The first, is a better Medicare for consumers would, in fact, be a less costly Medicare. Not because it would cut benefits or it would cut payments to plans or payments to providers, but because it would significantly improve care for chronically ill Medicare beneficiaries.

Second, competition can contribute to this goal if it is well structured. Competition does not work automatically. The details here are important.

Third, Medicare deserves its own competitive model. It can benefit from learning from others, and we hope from all of us on the panel today, but its size and its importance requires a tailored competitive model.

So, if I may expand briefly on these points. My first, is that a better Medicare can be a less costly Medicare, not by cutting what Medicare is, but by responding to those beneficiaries who have the greatest needs.

Five percent of Medicare beneficiaries consume fully one-half of the whole Medicare budget. They are the frailest and sickest Medicare beneficiaries.

Congress has fostered demonstration projects that do a very good job of improving care to these beneficiaries, but those programs are small and they should be expanded much more rapidly.

Those programs invest in primary and preventive care and reorganize the delivery of services, working with existing practitioners and families. We operate one of the largest demonstration projects

in these areas, and I would be happy to answer your further questions.

Second, competition can truly contribute to this goal if it is well structured. As we, in preparation for this hearing, reviewed our experience with our contracts, we focused on three conditions where competition operates well.

The first, is it needs to focus on consumers. That means that consumers need to have the opportunity to choose rather than simply the agency. Second, it needs to be tailored to the needs of the program it serves. So in the case of Medicare, it needs to focus greatly on people with significant chronic conditions, with people towards the end of life, and with people living in the whole varied geography of the United States.

One organization we are very proud to work with who has done this well in many cases, and I would commend to you, is, in fact, the State of Arizona.

The second condition, is that service improvement needs to be a part of how competition works. It is important that competition is not designed such a way that it is so overly prescribed by the agency that there is not an opportunity to make improvements during the course of the work together.

Innovation can also be driven by setting aside resources and an avenue for innovation to occur. Public programs are so big that all of the focus of the agency can go to the existing program and what works within it.

It is very important that a fast track for innovation is established so that good ideas and improvements can be made. GM, who we are very privileged to work with, does this well. An example of a public system that we are just beginning to work with that has recently made massive changes to try to do this well, is our new work with the British National Health Service.

Finally, aligned incentives are an important condition to competition. The parties need to benefit from the same results, and performance standards, we find, do this well rather than overly prescribed standards.

Finally, Medicare deserves its own system. The average age of an employer program that we cover is 37. Employer programs have people with far fewer serious and chronic conditions, and many fewer people at the end of life. Organizations like TRICARE have the very important missions around the direct delivery system.

Having said that, Medicare can benefit much from the model of choice that FEHBP has provided, from the multi-year contracts that TRICARE has provided, and from the way that both of these offerings have the ability to exclude plans that do not participate effectively.

So in summation, members of the committee, there is a great opportunity here. Competition can work if well structured, but the details are important. There is a very significant opportunity in Medicare to improve services for those people who are chronically ill.

Thank you for the opportunity to speak with you today.

Senator BAUCUS. Thank you very much, Ms. Quam.

[The prepared statement of Ms. Quam appears in the appendix.]

Senator BAUCUS. Ms. Block, I would like to ask you a question about the degree to which preferred providers, under FEHBP actu-

ally do provide access to people in all parts of the country. You mentioned in your statement that under Blue Cross/Blue Shield, one of your plans, that every single place in the country is provided service.

My question really goes to, is that the same service? Does everyone have the same access to service in all parts of the country or not?

Ms. BLOCK. Well, everybody has the same access, given the availability of providers in a geographic area. So in an urban area, a person might have to drive less than a mile to get to a physician.

In some of the rural areas, it may be 50 miles or more. But that is not because we do not have a provider in the network, it is because that happens to be the closest provider in that geographic area.

Senator BAUCUS. But is it true that all providers are in that network, or, because it is a PPO, that all providers are not members of that network, so that it exacerbates the distances that somebody may have to travel.

For example, there might not be an orthopedic surgeon in the plan. There may not be an OBGYN in the plan. There might not be another kind of specialist in the plan. There may be some other doctors, but only a couple of doctors.

Ms. BLOCK. I think that we can demonstrate that there are not only primary care physicians, but specialists available. In preparation for this hearing, what I did was just go up on the web. All of our health plans have a web site, and on their web site they have an area where you can enter a zip code and get a list of network providers in that geographic area.

What I found, although there are certainly differences among the plans, and as I suggested earlier, Blue's basic is probably the best simply because of the structure of that plan. It was necessary for them to make special arrangements to have access absolutely everywhere.

Our other fee-for-service plans may not have as broad access, but they have reasonably good access, I must say. Where there is not a network provider for those other plans, there is an out-of-network benefit which does have slightly higher out-of-pocket costs, but access to a provider is definitely available.

Senator BAUCUS. Right. But I am just trying to establish, is it true or is it not true, when we see a fee for service under FEHBP and Blue Cross, we are actually talking about PPOs. We are not talking about fee for service as it is commonly understood in the country.

Ms. BLOCK. For Blue Cross/Blue Shield, and particularly in the basic option, we are talking about strictly PPO.

Senator BAUCUS. That is correct.

Ms. BLOCK. That is an in-network only plan.

Senator BAUCUS. We are talking about PPOs. We are not talking about fee for service.

Ms. BLOCK. That is right.

Senator BAUCUS. So it is really a PPO plan, not a fee-for-service plan.

Ms. BLOCK. That is right.

Senator BAUCUS. Now, again, I want to get the facts here. Because it is a PPO plan, preferred provider plan, that means that in some parts of the country—or in all parts of the country, probably—there are some doctors available, maybe next door, but who may not be a provider that is in the network, that is in the plan.

Ms. BLOCK. Well, the way that generally works, is in urban areas where there are more providers available, some may not be in the network. But typically in areas where there are fewer providers available, virtually every provider is in the network because that is the only way you can arrange in-network service in every geographic area.

Senator BAUCUS. I guess the question is the word "virtually." It is just finding out the degree to which that is actually the case. Even so, do people in rural areas, under the Federal plan, not have to pay more? It is more expensive.

Ms. BLOCK. No, it is not. Our premiums are the same everywhere in the country in the national plans.

Senator BAUCUS. What about co-payments and deductibles? Are they the same every place in the country, too?

Ms. BLOCK. They are absolutely the same everywhere in the country in the national plans. It is a national benefit package with a national premium.

Senator BAUCUS. But the problem really is availability. It is access, then.

Ms. BLOCK. Yes.

Senator BAUCUS. Again, it is a factual question we are going to have to find the answer to. It is 100 percent participation. If it is not 100 percent participation by providers, then to what degree is it not 100 percent? It is just a factual matter that we would have to find the answer to, because clearly those people who are not members are going to have to drive and go much greater distances.

That is, those people who are looking for doctors that are not in the plan are going to have to go a lot further to try to find that doctor. Is that not the case?

Ms. BLOCK. I do not believe that that is the case in the Blue's basic option because of the design of that plan and because of the standards that we have in place in terms of access. The closest providers would be part of the network. There would not be a site that I can think of where there was a doctor 10 miles away, and the network provider would be 50 miles away. That would not meet our access standards.

Senator BAUCUS. All right. Not to be critical, but you use words which make me believe there is a little, not intentional fudge, but there is something funny going on there, and I just have to find the answer to it.

Ms. BLOCK. We would be happy to work with you to find that information.

Senator BAUCUS. Again, I do not mean to be critical, but it sounds like it is not as cut and dried as some would like it to be. Thank you.

Senator Thomas?

Senator THOMAS. Thank you. I appreciate your comments. I come from probably the most rural State in the country, and I have to tell you that it works well. PPOs are organized a little differently.

They are not formal PPOs. But every provider, basically, in Wyoming operates as a PPO.

So we have some real problems with rural health care in terms of reimbursement and how they are paid, and all these things, hospitals, and so on. But I think, in terms of having these private services available, they are just as available in the rural areas as they are anywhere else.

Now, obviously you have a system in the State. Not every little town has an orthopedic surgeon. That is just the way it is. But, in any event, I appreciate what you are doing.

How do you manage to control the costs? What is your technique for controlling costs? Usually when you have a contract, why, you have a way because of the volume you have. I would like all of you, very briefly, to comment on that. How do you control the costs?

Ms. BLOCK. Well, there are several ways. Of course, one of the primary things that controls cost is the fact that competition in the FEHBP program is at the retail level. Every year, our members have the opportunity to elect a new health plan, and they are very, very cost conscious. We see a migration virtually every year.

In fact, in our calculation of rate increase our actuaries are now able to estimate that the potential rate increase in any given year, on average, is reduced by about 1 percent every year as a result of people moving to lower cost plans.

Senator THOMAS. Providers that you submit to your members or to your participants, they have choices. I can choose one that is less expensive.

Ms. BLOCK. Exactly.

Senator THOMAS. Admiral?

Admiral CARRATO. There are a variety of techniques to control cost through the contracting mechanism. In our current contracts, we have a shared risk mechanism, so our private sector partners, Humana, Sierra, TriWest, Health Net, they share the risk in any cost overruns, and they also share the reward with us if we beat our targets.

Senator THOMAS. I see. I see. So we have contractual mechanisms to do that, so the consumer does not make the choice as much as they do in the other one.

Admiral CARRATO. The consumer also has choice. We have three options. We have an enrolled HMO and then we have a PPO option, and a fee-for-service option. Each one of those is not enrolled.

We believe the best choice for our beneficiaries is the enrolled option. We provide financial incentives for the consumer to make that election. We also try and take advantage of our direct health care system, which is our system of military hospitals.

Senator THOMAS. Which is unique.

Admiral CARRATO. It is unique to our system. I guess the simple way of saying it is, we try and promote things that will keep our people healthy. We use disease management programs. If you can use effective preventive measures and make sure people stay healthy, that is also a way. Again, we have a unique advantage because our folks tend to——

Senator THOMAS. We tried that. For years, HMOs were doing that, and now they are not.

Mr. Bradley?

Mr. BRADLEY. I would like to address it using two different approaches. One, is for our HMOs, which are generally insured. Then the other is for our large, self-funded plan.

With respect to the HMOs, we use the traditional rate negotiation process just like OPM and others do, with a real focus during that process of understanding, what are the root causes of the increases in the cost? So when a health plan says it is claims costs, that is not a real acceptable answer. But we really try to get into that.

Senator THOMAS. I see.

Mr. BRADLEY. But the real work that we do with our health plans is through the quality mechanism. We are very, very rigorous using HEDIS measures, NCQA accreditation, and our own request for information, which really gets us to some of the root cause issues.

What we found, is that the health plans that have done the best on the quality measures is actually a statistically significant correlation, 0.512, between the performance on cost performance and on quality.

Senator THOMAS. I see.

Mr. BRADLEY. So, there is a real benefit there.

With respect to the indemnity plan, fee-for-service PPOs which are self-funded, we actually have a whole team using many of the traditional techniques. But perhaps the one that I would like to highlight the most is our community initiatives, where we have executives physically in the communities where we have our largest populations paired up with the UAW, working with the hospitals, the doctors, the providers, with data to try to understand the root causes of some of the inappropriate care or excess care. For example, we have reduced dramatically the number of inappropriate cardiac catheterizations in Flint, Michigan.

Senator THOMAS. Can we just take enough time to let Ms. Quam respond?

Senator BAUCUS. Certainly.

Ms. QUAM. Thank you, Senator Thomas. We work in three ways to try to lower the costs of medical care. First, we seek to negotiate mutually agreed lower rates with hospitals and doctors. The second, is we invest in technology and better ways of working so that our own costs are reduced over time. Third, we work to improve care and coordinating the delivery of care better, and using data, working with customers like GM.

Senator THOMAS. Thank you.

Thank you, sir.

Senator Baucus.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Ms. Block, these things have all been said, and they need to be said again, and again, and again. FEHBP. Your costs rise about 7 percent a year over the years; talking about Medicare+Choice plans, somewhere between 10 and 12 percent for administration of them. I do not mean a rise in cost, but the administration of them.

Medicare is about 2, sometimes 3 percent. It is between 2 or 3 percent. Medicare fee-for-service is much more efficient than what either of you are talking about. That is number one.

Number two, in my State, as in the Chairman's State, where there is no Medicare+Choice in his State, and I do not know about plans. In my State, there are no plans and there are two Medicare+Choice, which serve under 2 percent of the people.

Now, it is very interesting to me to sort of figure out why this is good for West Virginia. Why is that good for West Virginia that your places do not exist? Senator Thomas said Wyoming may be different, that they pretty much exist everywhere. Some of you have said that.

Sixty-two percent of Medicare beneficiaries are very satisfied with their care; 51 percent generally of the plans that you are talking about, 11 percent less are satisfied with their care. Medicare beneficiaries are much less likely to report negative feelings about an incident, much less likely that plans or Medicare+Choice, and that includes FEHBP.

In fact, the most important thing is, I do not recall ever getting a letter, an e-mail, a telephone call, or having a conversation with a West Virginian who wanted something different than Medicare. What they want, is prescription drug benefits. We can give that to them if we do not fritter so much money away on privatization.

Now, you get paid a lot more. You get paid more than fee-for-service, 104 percent of the cost. I just think at some point we need to consider that. It is 104 percent fee-for-service, on average, for Medicare+Choice.

The Secretary of HHS has said that the passage of the President's plan would "probably accelerate the date the Medicare trust fund becomes insolvent." I do not know what is good about that. I do not know what is good about that.

I just do not really know what your case is, other than that you like competition and because you can risk less and perhaps you can make money.

You indicated that we did not have enough things in Medicare about end of life, or the 5 percent that costs so much. We do have some things. We could have more, but there is not reason why we could not.

That does not argue for Medicare+Choice plans, it argues for having, within Medicare, which is more efficient, more popular, less complaints, and is less costly, for doing more of that and for putting on a prescription drug benefit.

Medicare+Choice and all of those things, and more privatization, are going to decrease substantially the chances of getting a prescription drug benefit. If you want a prescription drug benefit, you take the $400 billion in the President's plan and you take $397 billion of the President's tax cut which is put on towards the dividend exclusion, and you add those together and you get a prescription drug benefit which is better than anything anybody could ever want and you would have money left over. That is what people want.

That is the end of my statement. I just wondered if you have any comments. [Laughter.] Any of you have any comments? Ms. Block?

Ms. BLOCK. Well, my expertise is in the Federal Employees Health Benefit Program. I hope that I can answer any of your questions.

Senator ROCKEFELLER. No, no, no. I am asking if you had any comments on my comments.

Ms. BLOCK. No, I do not.

Senator ROCKEFELLER. You do not? That tells me something.

Do you?

Ms. QUAM. Yes, I would be happy to comment. Senator Rockefeller, we provide services on both the fee-for-service side and the health plan side of Medicare. We insure 49,000 people in West Virginia on the fee-for-service through the work we do with AARP.

Senator ROCKEFELLER. And how come you avoid us for the rest of what you do? Cannot make money?

Ms. QUAM. The Medicare choice, as you know, has not provided a structured, stable base for plan involvement over the last few years.

Senator ROCKEFELLER. What on earth do you mean by that? Do you mean, West Virginia has not provided a structured base? My time has run out.

Ms. QUAM. No, sir.

Senator ROCKEFELLER. Blanche Lincoln is about to shoot me.

Ms. QUAM. No, sir. Let me perhaps make two points.

Senator ROCKEFELLER. Yes.

Ms. QUAM. The first, is that competition can only work effectively if there is a structured, stable way for plans to participate over time.

Senator ROCKEFELLER. All right. Then that rules out West Virginia, because we do not have a structured, stable base.

Ms. QUAM. Second, I would like to make clear that my point about the chronically ill was, there are absolutely ways, both within Medicare fee-for-service and through Medicare health plans, to improve services for the chronically ill. I would urge you to look at ways to advance that immediately in addition to looking at that as a part of reform.

Senator ROCKEFELLER. All right. Mr. Chairman, I just wanted to make those points. They have been made. It does not mean I am not willing to look for alternatives and compromises, but please, let us keep our eye on some of the realities of the day. Thank you.

Senator BAUCUS. Thank you, Senator.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Senator Rockefeller, you make some excellent points there that are very applicable to Arkansas, and I want to kind of elaborate on some of those. I am glad we have such an extensive panel, because there are many questions that we have to answer. Ms. Quam, you bring a great point to this discussion. Medicare requires its own solution, there is no doubt. I guess most of my questions today—and Mr. Chairman, I would like unanimous consent to submit all of my questions for answers that would be in the record.

Senator BAUCUS. Without objection.

Senator LINCOLN. I would like to talk a little bit about the Federal Employees Health Benefit Program, because the President has pointed to it very often as a model for Medicare.

I have great concerns about it, because I look at my State's experience, much like Senator Rockefeller, with the Medicare+Choice

and the private plans that do not exist in our State. They just do not exist.

Ms. Quam, you make an excellent point, that when you talk about the group that you are trying to serve, you have to recognize the Federal Employees' plan basically serves a younger group of individuals.

Medicare is not going to have the same kind of concerns, challenges, and barriers as that group that is served by the FEHBP. I do not think anybody will argue that we do not need some reforms in Medicare, but we do need to make sure, again, as you mentioned in your statement, because we are dealing with a program and a group of individuals of such great size, magnitude, and of great importance, that it is going to require us to think outside the box and not use just an example that we already have, but to create something that is going to fit those individuals we are trying to serve.

I would like to ask Ms. Block. As Senator Baucus mentioned about the fee-for-service plans in FEHBP, they really are PPO networks. We find that pretty much in Arkansas and know we do not have a whole lot to choose from. Sixty-seven percent in Arkansas do use Blue Cross/Blue Shield because there are no other options. If you look in the back, Arkansas is not listed. We do not have any local options. We do not have any of that.

But I had a Federal employee in Arkansas, out in the rural parts of Arkansas, that told me that he had to go out of his PPO network in order to visit his local hospital. To stay in his network, he would have to drive many hours in order to stay within this PPO network that was designed for him.

So I think when you talk about a standard, across-the-Nation plan, it just definitely varies. I think Senator Baucus was trying to bring some of that out, because obviously, for him to go outside of his network to go to his local hospital, he is going to have to pay more out of pocket in order to be able to use those providers that are there locally to him, whether you have contracted with them or not. Apparently that is the problem. But, still, he is going to have to go outside of his network.

I just wonder if you have any numbers or if you can tell us any particulars about Federal employees that are in the plan. What percentage of them do have to go outside of their network?

Ms. BLOCK. Very few. Actually, about 80 to 90 percent of claims across the FEHBP program are in-network claims. I cannot tell you exactly why the other 10 percent may be out of network, whether it is the members' choice or the unavailability of a network provider.

Senator LINCOLN. But, clearly, we do not have that information. Maybe those 80 percent are going within the network. They are traveling the two hours to the only hospital that is in their network because they do not have the resources to pay the out-of-pocket.

Ms. BLOCK. Senator, I am not familiar with the particular situation you are talking about. We would be happy to look into it and give you an answer for the record.

Senator LINCOLN. Sure. Well, that might be helpful to us, I think, in making these decisions, is to better understand why people are going outside their network, whether they are forced to,

whether it is they do not have the services that are available. I think that is going to be very important as we look towards what we are doing.

I have got a little bit more time. In Arkansas, 78 companies have withdrawn from the Arkansas health insurance market since 1992, and 66 of these withdrawals have taken place within the last 5 years.

Additionally, in Arkansas and 10 other States, many of which are represented here in the committee, there are no HMO plans available to FEHBP beneficiaries. The claim by the President, is that remodeling Medicare based on FEHBP would increase choice for beneficiaries.

I guess our question is, how is that really the case? And if you also want to look at the comparative nature of cost, we are also finding in GAO studies that if those that had gone into some of these Medicare+Choice or private plans, if they had stayed in a fee-for-service, it would have actually cost the government less through regular fee-for-service than it would have in the HMO product or the private product.

So I guess to any of you all, but I guess particularly to Ms. Block, what kind of choice doe the Federal plan really offer in Arkansas and other States that offers only fee-for-service or really these PPO plans, and what would be the difference for Medicare beneficiaries in these States if they were moved into an FEHBP-like system, particularly elderly that are in these harder-to-serve areas?

Ms. BLOCK. Well, you are exactly right that Arkansas does not have a participating HMO in the FEHB program. But that is not because there are lots of HMOs in Arkansas and they just opted not to participate in our program.

Senator LINCOLN. Right. We have none. Medicare+Choice, none of them.

Ms. BLOCK. It is a function of what is available within the geographic area. However, all of our members have a choice of 12 different options in the nationwide plans. It is not just one single plan. All of those fee-for-service, PPO plans are open to people all over the country, including everywhere in Arkansas.

Senator LINCOLN. Well, Mr. Chairman, as mentioned here, I would also just reflect that Medicare also costs the same to patients all cross the country, and they still have a complete choice of providers and are not limited to just what is in that PPO in their area.

So, I think that is important. Thank you, Mr. Chairman.

Senator BAUCUS. Thank you.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Has there been a coup since I left? Are you Chairman? [Laughter.]

Senator BAUCUS. Temporary Chairman. It is three to two here.

I thank the panel members. We have had discussions with all of you on many occasions and we are delighted to have you back.

Let me just set the premise. The proposal the administration has submitted basically says, if you want to stay in existing fee-for-service, you can. We will provide a degree of prescription drugs in the existing fee-for-service, a discount card of 10 to 25 percent, and

catastrophic protection, out to which the government will pay 100 percent at no extra charge, no increase in the premium.

That is a heck of a deal. But if you would like a new system, you want to try something else, an integrated health care delivery system, you have that choice. If you want to go into it, you can go into it. It would be based on FEHBP.

The three objections people make against the FEHBP, Ms. Block, is, number one, it is not going to work in a rural area. Number two, that people are much older than you have in FEHBP. Number three, you would have to get into some type of an HMO that does not work in order to get your drugs.

First of all, what is the average age of the FEHBP people that you insure, including your retirees and your active duty workers?

Ms. BLOCK. The average age of our active duty workers is 47.

Senator BREAUX. No. Both combined. I will get to that.

Ms. BLOCK. The average age combined with retirees is 60.

Senator BREAUX. Sixty or sixty-one?

Ms. BLOCK. Sixty, sixty-one. Yes.

Senator BREAUX. So the average age of the people you serve in FEHBP with your retired segment and your active duty workers is about 60 to 61 years of age?

Ms. BLOCK. That is correct.

Senator BREAUX. All right. Now, on the rural question, which is very important to a significant number of members of this committee, and Senator Lincoln just expressed her concerns, I have tried to address those by saying, you pick the most rural county in America.

You probably have a Fish & Wildlife Service employee, or USDA employee, or a postal worker employee that has the FEHBP health care plan. How does that person get insurance coverage when there is no competition and that rural county has probably got one county hospital somewhere, maybe one doctor, maybe a couple of pharmacists, and that is it? How does the FEHBP guarantee that that person gets health care at an affordable price?

Ms. BLOCK. Well, there are a couple of ways. One thing, as I mentioned earlier, under the Blue Cross/Blue Shield basic option, that plan, because it is a nationwide, in-network only plan, has guaranteed access absolutely everywhere in the country to an in-network benefit.

Senator BREAUX. All right. Suppose that hospital is the only hospital in the county.

Ms. BLOCK. Then that plan has made special arrangements to include that hospital in its network.

Senator BREAUX. That hospital, if it is the only hospital in the region, is included in their network under the FEHBP plan?

Ms. BLOCK. For that particular plan.

Senator BREAUX. All right.

Ms. BLOCK. Some of the other fee-for-service plans, because they offer an out-of-network benefit, have not done that. What they do, is provide an in-network benefit where it is feasible——

Senator BREAUX. To have at least one national plan that would make that that hospital, that doctor, if they are the only ones in that county, are included in the plan that is offered by the FEHBP provider?

Ms. BLOCK. That is correct.

Senator BREAUX. All right. And that is at the same premium rate, is it not?

Ms. BLOCK. Yes.

Senator BREAUX. That is a national premium rate.

Ms. BLOCK. It is a national premium, national benefit package.

Senator BREAUX. All right. The third objection, is I think that they say, well, you are going to force people into HMOs to get prescription drugs. I am in FEHBP. I would imagine all of us are in FEHBP. I have prescription drug access, as well as doctors and hospitals. I am not in an HMO. I am in a Blue Cross/Blue Shield high-option plan. So, I mean, how does it work?

They are not being forced, under FEHBP, into any type of HMO if that is their choice not to be. Is that not correct?

Ms. BLOCK. That is correct. In fact, three-quarters of our members are in the fee-for-service PPO plans, one-quarter are in HMOs, and they have that choice.

Senator BREAUX. All right. So just as a more general question—you have answered the question about the rural areas. Every hospital in a rural area would have to be included in at least one of the networks, because you would not let the companies participate in the program if they did not, and that they would be in that program at the same national premium for everybody.

Ms. BLOCK. That is correct.

Senator BREAUX. I know the rest of you. We have visited, we have talked. I just wanted to ask Ms. Block some questions. I thank you all for your participation. Thank you.

Senator BAUCUS. Senator Santorum?

Senator SANTORUM. Senator Breaux asked all of the questions I wanted to ask. You did a fine job. Thank you.

Senator BREAUX. Thank you.

Senator BAUCUS. Ms. Block, it is my understanding that Blue Cross threatened to pull out of FEHBP recently. They threatened to pull out because they did not want to comply with certain cost accounting standards.

Apparently—I do not know whether there was a resolution to all that—but one can surmise that maybe they stayed in because they did not have to comply with the standards, that OPM said, all right. Now, that raises lots of questions, clearly, to the degree to which my assumptions are correct. They may not be correct.

One question is, what standards are there that are enforceable with the plans that are participating? FEHBP is so different from, say, TRICARE. TRICARE has fairly specific requirements, whereas OPM, as I understand it, administering FEHBP, basically takes on all comers, there are no winners and no losers.

That is, if you are a plan and you meet certain standards, you participate, whereas, in a TRICARE, if you do not meet certain standards, you are out of luck. So you take all comers, and there are no losers in FEHBP.

But in my little fact situation here about Blue Cross threatening to pull out raises questions as to what standards are there, if there is any way you can participate. There are certain cost accounting standards, for one. There could be other standards.

The next question that comes up, clearly, is what happens if Blue Cross pulls out? Sometimes people make good on their threats. Then what happens to FEHBP?

Ms. BLOCK. Well, for one thing, I would like to assure you that there are very high standards. Just because the cost accounting standards do not apply does not mean at all that we have no standards.

In fact, the Federal Acquisition Regulation applies. We have our own implementing regulation to the Federal Acquisition Regulation which is called the FEBAR. We have a very close relationship with our independent IG, who audits all of our plans on a regular basis and our plans have to meet all of the Federal requirements and general accounting standard requirements. All of our plans have to submit annual accounting statements which are certified.

In addition to that, they have to submit an audit by an independent auditor. We have rigorous standards in terms of reviewing their financial status, their financial reports, to make sure that their charges are appropriate, and our IG goes out and verifies that on a regular basis.

Senator BAUCUS. What happens, though, if Blue Cross pulled out? Blue Cross is, what, 50 percent of FEHBP?

Ms. BLOCK. Yes. It is a little more than 50 percent at this point.

Senator BAUCUS. So if Blue Cross said, all right, we do not want to do this, what problems, if any, would that create for Federal employees and retirees?

Ms. BLOCK. I would have to say that that would probably create considerable problems. It would be foolish to imply that it would not. However, we have some other major underwriters in the program and other plans that would have to just pick it up and make the appropriate arrangements. Provided we had sufficient notice, which we actually did in the Blue Cross situation, others would just have to jump in and pick up the enrollments.

Senator BAUCUS. Mr. Bradley, I would like you to give us some ideas, applying some of GM's experience, on how we could transfer some of that to Medicare, that is, in terms of quality and incentives for quality and so forth.

Mr. BRADLEY. There are a broad range of things. But I would first want to say that Medicare has actually been quite active in the performance measurement arena with the National Quality Forum. They have been very good participants.

The National Quality Forum, which, as you may know, had its origins in the Congress to essentially establish a national basis for providing highly vetted, consistent standard, quality-based performance measures, not unlike the role of the Federal Accounting Standards Board. Medicare has been very active with that and they are about to implement, actually, a number of those.

The next step, I believe, is to start to tie a couple of things to participating in the Medicare business. One, is disclosure. It should be a condition of participating in the Medicare program. At certain levels when the data and the measures are out there, that providers, be they hospitals, health plans, doctors, nursing homes, disclose the performance that they have on quality. That would sort of be a baseline.

There are models, which we would be delighted to share with them, on actually how we score performance for our health plans on quality measures, and then how we can actually use those to be tied to a number of performance incentives.

One, is simply to enable beneficiaries, especially with health plans, to pay less for higher quality plans. But that has to be revenue neutral, meaning you pay more for less higher quality plans. So there is work being done right now as we speak trying to develop pay-for-performance mechanisms for providers that really, truly make sense.

That is being done under the auspices of some funded work from the Robert Wood Johnson Foundation, the Leapfrog Group, and so on, that we believe will start to set some models so that we can actually pay providers to do a better job. Right now, they get hurt for doing a good job.

The other thing that I think that Medicare can do, and a lot of my testimony is actually working with providers in communities with private purchasers as we try to drive quality improvement with actual direct interaction, sharing of best practices and so on.

Medicare is very, very powerful. They have got a great database. In fact, by just disclosing information and using it, I think we can make a huge difference.

Senator BAUCUS. I appreciate that. Just so, what percentage, or can you quantify the quality improvements that are available under Medicare if you were to apply some of GM's techniques? Is that possible?

Mr. BRADLEY. Yes, it is possible. We have measures—and let me focus on health plans for a moment.

Senator BAUCUS. Sure. Sure.

Mr. BRADLEY. That is the starting point.

Senator BAUCUS. Right.

Mr. BRADLEY. We are working on getting it down to the hospitals and providers, and that will deal with the rural areas, and so on.

Senator BAUCUS. Right.

Mr. BRADLEY. But we have actually seen, using the HEDIS measures, which is a set of quality measures, plan-specific improvement. For example, the use of a beta-blocker after heart attack, everyone knows, will reduce the probability of the second heart attack by about half.

We have actually seen—I do not have the numbers at the top of my head—in our health plans, and I use this as an example, 60 percent of their patients would have a beta blocker after heart attack to 90 or even higher.

Then you can do the math and figure out the number of lives that are saved, or the number of reduced costs that take place that result from that because you haven't hospitalized the person a second time.

Diabetes measures is another one. H6A1–C, which is a blood test. People that have those frequently, combined with eye exams and foot exams, have fewer amputations, less blindness, and less hospitalizations. NCQA has actually developed a calculator where you can actually do the math and show what the impact is. So, all that is available.

I think the real need is for Medicare to be empowered to use that information in its actual contracting and holding providers and health plans accountable.

Senator BAUCUS. Right. That is my next question. Are they now not empowered?

Mr. BRADLEY. I believe they are under demonstration projects. I think that what we need to do, is to keep encouraging the rapid implementation and broad-based dissemination of this so that the demonstrations can move quickly.

Senator BAUCUS. My gosh. If Medicare were to fully utilize all those techniques, it seems to me that health care costs would be brought down quite a bit.

Mr. BRADLEY. Yes, that is sort of the premise of my presentation. There is a book called Crossing the Quality Chasm, which was produced by the Institute of Medicine, which I think is one of the most important books every written on health care.

Senator BAUCUS. What is it?

Mr. BRADLEY. It is called Crossing the Quality Chasm.

Senator BAUCUS. I see all the panelists nodding their heads. They all know it well.

Mr. BRADLEY. I would commend it to you. The chasm is the difference between what we know today and what we can do in terms of improving care, and where we are, and how to get from A to B. You will hear the number, 30 percent of the health care dollar that we spend in this country is wasted.

Senator BAUCUS. Do you agree with that? Do you think that is about accurate?

Mr. BRADLEY. Yes. I absolutely do. We see it firsthand. Waste being defined as any service process, procedure, or things that are done or not done that should be done that does not benefit the patient at the end of the day.

So, not giving a beta blocker is waste because of the heart attack. There is a great deal of money out there, and that is a very, very important document to use as a baseline for some of our strategies.

I have got a number of things we could talk about offline or separately, if you would like.

Senator BAUCUS. Sure. I would appreciate that, Mr. Bradley.

Ms. Quam, what would it take for your company to come into a State like Montana? We have got lots of beautiful scenery.

Ms. QUAM. Yes.

Senator BAUCUS. There is great skiing, great rafting, fishing.

Ms. QUAM. Thank you, Senator.

Senator BAUCUS. Is that enough? [Laughter.]

Ms. QUAM. We, in fact, do provide services to 15,000 people in Montana through the fee-for-service offers that we are involved with.

Senator BAUCUS. Oh, you do? All right.

Ms. QUAM. So, we are pleased to do that.

We would be very interested in helping rural Medicare beneficiaries in Montana. I particularly believe that we could take the kinds of work that we have done in improving care to people who are chronically ill, and that those are very applicable in rural areas.

We, on behalf of the State of Arizona, provide a broad set of services in rural areas to Medicare and Medicaid dual eligibles. Arizona has better outcomes and lower costs than nearly all other States in that regard.

I would very much agree with what Mr. Bradley said in terms of improving quality of care. I think there is room for innovation through specialized plans that can particularly address the kinds of needs in rural areas, where plans are not going to benefit people by going in and negotiating lower rates with providers, because as you know well, there are not enough providers.

The role that plans can play in improving care is to better organize the way that care is delivered. The existing programs are not set up well to do that.

I think there is the opportunity for the Congress to take some of the demonstration programs that have worked well in this area and to look at what some States have done like Arizona and develop demonstration models that then can be put in place in States like Montana. We would be very happy to help with that.

Senator BAUCUS. I appreciate that. I apologize to my colleagues, I have been taking a lot of time here.

Senator BREAUX. I do not have anything. I would have to think of something else.

Senator BAUCUS. You have to think of something else? That is pretty easy for you to think of.

Well, I have some more questions. The service you provide in Montana is Medigap, right?

Ms. QUAM. Yes, that is correct.

Senator BAUCUS. What would it take to provide more than Medigap if you were to have a full managed care plan in Montana?

Ms. QUAM. I think one of the challenges, and I very much understand the role that the Congress has played to try to encourage plans to go to rural areas, and the frustration that has been expressed by several members of the committee at the failure for that to happen, I believe that central to the reason why that has not happened is because the Medicare Choice program has been relatively unstable year to year over the last many years.

That makes it difficult for companies to make decisions to move into new areas, particularly to move into rural areas. When I said that we seek to control costs in three ways, one of the ways we seek to control costs really is not available in rural areas, because there is a scarcity of providers rather than a surplus of providers.

So the opportunity to control costs and improve services in rural areas is focused on using technology to be able to fill gaps and provide services better, and then very heavily focused on improving care.

Senator BAUCUS. But could you negotiate better deals with providers in Montana than Medicare service?

Ms. QUAM. I think that in rural areas where there are too few providers, that it is not possible to negotiate lower rates on Medicare because providers are very important to the community and they do not have any reason to negotiate the lower rate in order to get more patients, because they have them.

I think the opportunity really is in organizing the delivery of care. The points that Mr. Bradley made would apply in rural areas

as well as in urban areas, so there is enormous opportunity to improve the delivery of care, and Medicare could do much more to do that.

Senator BAUCUS. What I do not understand, is how could Blue Cross come under FEHBP and provide care—it is not really fee-for-service, it is a PPO—and your company cannot in the same area.

Ms. QUAM. Well, what FEHBP does, as I understand, is it pools the enrollment nationally and then negotiates national rates, very similar to what the Medicare program has done in terms of setting rates. We absolutely can negotiate lower rates than Medicare and provide savings to the Medicare program, and more coverage in many areas. But in rural areas, I think it is difficult to do that, given the scarcity of providers.

Senator BAUCUS. Now, FEHBP. Is that nationwide or do you have 12 areas, and 4 areas? As I recall, there are various sections.

Ms. BLOCK. No. Ms. Quam is exactly right. The way that we can do it, is because our National plans have a national rate, there are clearly cross subsidies from one geographical area to another. That is how Blue Cross can do it.

Senator BAUCUS. How much more expensive would it be—you said the average is around 60—if you include all seniors? The average age would go up quite a bit.

Ms. BLOCK. Well, we cover our Medicare eligible——

Senator BAUCUS. I am talking about all Medicare patients, not just Federal retirees.

Senator BREAUX. She does not want to do that.

Senator BAUCUS. As I understand it, and correct me—these two guys are here to watch me. That is why they are here right now. [Laughter.] They admit it, too. But the administration's plan, in effect, would like to bring all of those Medicare folks over to FEHBP.

Ms. BLOCK. Well, actually, the FEHBP program is an employer-based health plan.

Senator BAUCUS. I am sorry?

Ms. BLOCK. The FEHBP program is an employer-based health program.

Senator BAUCUS. Right.

Ms. BLOCK. It is very similar to General Motors. In fact, that is why Bruce and I know each other quire well, because we have shared a lot of experience in the sense that we have very much the same population and a very similar structure.

So we consider our plan part of the recruitment and retention package that attracts the kind of workforce that the Federal Government needs to have. It is very much like General Motors, an employer-based health plan, even though the employees happen to be Federal employees.

Senator BAUCUS. But, still, it is true that seniors, on average, are older. [Laughter.]

Ms. BLOCK. I do not think anyone could argue with that.

Senator CONRAD. Boy, I am really glad I came to learn stuff here. [Laughter.]

Senator BAUCUS. We are going to start with the basics here. Therefore, it would be more costly than FEHBP. That is, the administration is talking about an FEHBP-type program, so therefore we are talking about seniors here who are older than the average

FEHBP enrollee. The average is 60 years of age. Their costs, therefore, would be higher, even with the cross subsidization.

Ms. BLOCK. I should point out, out of our 1.9 million covered retirees, 1.4 million of those are Medicare eligible. We are providing all of their drug coverage at this point in time, and that gets factored into the FEHBP program costs.

Senator BAUCUS. Go ahead.

Senator BREAUX. I thank the Chairman. I think his questions were helpful.

Explain, Ms. Block—and I have a question for Ms. Quam—the FEHBP plan on how it delivers prescription drugs to your members. I take it, and would like you to elaborate on it, that if you have a Blue Cross provider, as an example, that provides an integrated health plan which includes doctors, hospitals, and drugs, that that Blue Cross, just as an example, could utilize a PBM to deliver and set up the delivery system for the Federal workers.

But the risk of what they did provide drugs for is borne not by a PBM, but rather by the insured's company that has overall responsibility. Is that correct? Can you elaborate on how that works a little bit?

Ms. BLOCK. Yes. That is exactly correct, Senator. Virtually all of our plans at this point in time, even our HMOs, are using PPMs to deliver their prescription drug benefit. But that is a contractual arrangement between the health plan and the PBM, and it is subsumed into the total premium price that we pay, and the risk is borne entirely by the plan.

Senator BREAUX. So Office of PBM looks to the plan provider, the insurance company, Blue Cross, as an example, to make sure they do it right. You deal with them. You do not deal with the PBMs at all.

Ms. BLOCK. That is exactly right.

Senator BREAUX. And if there is any risk that they bid too low, I mean, that is their risk. They eat that loss.

Ms. BLOCK. That is correct.

Senator BREAUX. If they can do it for less, then that is to their benefit, too.

Ms. BLOCK. That is correct.

Senator BREAUX. All right. I would also say to the Chairman, I do not think anyone is proposing that we take the existing FEHBP system and just move 40 million Federal workers into your system.

Ms. BLOCK. We certainly hope not.

Senator BREAUX. I think she would not want that. But to take that model that is out there and create that model to be used for the Medicare beneficiaries if they want to go into that plan, at their choice, not being forced into it. But it is not to make 40 million Medicare beneficiaries all of a sudden become part of FEHBP.

Ms. Quam, let me ask you. I mean, you are knowledgeable in this area. Do you think, from your understanding of the system, that the type of model that we have with FEHBP could be adaptable to the Medicare beneficiaries and workable?

Ms. QUAM. I think that FEHBP does provide important things for Medicare to learn in the way that it improves choice offered to beneficiaries. I think that it has to be tailored to reflect the different needs of the Medicare population, the fact that it is older,

more chronically ill, larger, and obviously has much more extensive issues around the end of life to be confronted.

I think that it is very important that Medicare has its own model for doing this, because given the size and the uniqueness of the model. But I think it is possible to learn from these other offerings.

Senator BREAUX. Yes. I think that is what we are trying to say. I mean, obviously the criteria that Ms. Block uses for the 10 million Federal employees, and some of the things that you do with your negotiations, will be different from what you do with a Medicare population. It is a different population.

But the question is, can the structure of a system that provides competition and choice with a combination of the Federal Government and the private sector being combined to do best what each can do the best, is something that would seem to me to be workable. I think you would agree with that.

Ms. QUAM. Yes.

Senator BREAUX. Mr. Bradley, do you have any comments?

Mr. BRADLEY. Yes. I was going to perhaps say just what you said, that all of us here at the table work together and share our own best practices. I think that the real approach might be for the Medicare program, with its unique characteristics, everything from its diversity to its age structure and so on, can probably work with us and others and pull out of what we are doing those things that would work best for the program.

So the FEHBP model, as was said, of choice certainly works. I think some of the work that we are doing in creating the level playing field so that the beneficiaries pay for the value of whatever option it is, not pay more or less based on whether their compatriots that happen to be healthy or sick enroll in similar plans, and therefore affect the rates. We have got some models that are working that we could share with that.

The other thing that I think is important to understand, is that there has been a lot of discussion about the ability of Medicare to negotiate rates as well as anybody in the country just by virtue of their size. That is only part of the equation. They do. They are very, very good at that.

But I think the thing that will move the needle, to use auto terms, is to also focus on the actual use of care and the appropriate use of care, because that is where the real payoff, I believe, is sitting there. You can have very, very low rates, but if you do not manage the appropriate use of care and the appropriate use of services and so on, then we miss a huge, huge opportunity. I think all of us have got some experience there that we would be delighted to share with Medicare. In fact, we already are working with them on some of these.

Senator BREAUX. Thank you, Mr. Bradley.

My last point, Ms. Block, is the administration, I think, is proposing a creation of a number of regions. I think it is 10 regions—I do not have the map in front of me now—in which the Medicare beneficiaries would operate in as a program.

I take it that, under the FEHBP, the premiums in a rural area, you have a national premium for your constituents, and the same thing would be modeled for Medicare beneficiaries. Do you think that that same concept can be transferred to Medicare if we were

to try and create the same type of system? Explain to me how that works.

Ms. BLOCK. Well, as I indicated earlier, there are clearly cost subsidies in our National rates. That is, obviously, lower health care cost areas are subsidizing higher-cost areas in a national rate.

The same would work, as I understand it, to a degree in a regionalized program, provided that the regions were structured so that they included both urban and rural areas, with a balance of medical costs within each region. You would get the same kind of cross subsidy, although on a smaller scale.

Senator BREAUX. I take it that in a rural area, which has only one doctor, one hospital, one drug store——

Senator BAUCUS. Let me add this to the record here. In Montana, there are many counties where there are no hospitals, no doctor, and no health care whatsoever in a lot of counties. Just for your information.

Senator BREAUX. Well, what does a Medicare patient do?

Senator BAUCUS. He has got to travel, that is right.

Senator BREAUX. That is what I am saying. He has got to travel no matter what type of insurance plan. What we are talking about is not building more hospitals. We are trying to have insurance. So, even in that area——

Senator BAUCUS. As long as the total access is the same.

Senator BREAUX. Is the same.

Senator BAUCUS. But I am not sure that it is.

Senator BREAUX. That is the point I would like to make. If you are in a rural area that has no hospital, no matter what type of insurance plan you have, that person is going to have to go somewhere else to go to a hospital because there is no hospital in that county, whether you are a Medicare patient, whether you are Blue Cross/Blue Shield, or whatever.

But assuming you have a system under an FEHBP model where you have one doctor, one hospital. Essentially, that person that is in a Federal employee program in that county, it is essentially a fee-for-service type of system, you go to that hospital and you go to that doctor. Is that correct?

Ms. BLOCK. Yes, that is correct. Presumably, as Ms. Quam pointed out earlier, the plan would not be able to negotiate the discounts with that hospital or provider that it could in an area where there were many providers available.

So that cost might be higher, but it would be offset by lower costs in another part of the region where there were enough providers available that better discounts could be negotiated.

Senator BREAUX. But that one Federal employee in that county would not be deprived of utilizing that facility in that county under FEHBP.

Ms. BLOCK. In certain plans, yes.

Senator BREAUX. Like the national Blue Cross/Blue Shield. You make them cover that hospital.

Ms. BLOCK. That is correct. That is correct.

Senator BREAUX. You say, look, you want to play ball with FEHBP, you want to cover nine million employees, you have got to include every hospital in a rural area.

Ms. BLOCK. That is correct, in the basic option.

Senator BREAUX. If they do not do that, they have got problems with you.

Ms. BLOCK. Yes, that is exactly right. Because they proposed an in-network-only option nationwide, they have to provide coverage everyplace in the country.

Senator BREAUX. All right. Thank you.

Senator LINCOLN. Let me follow up on what Senator Breaux said. In Arkansas, 67 percent of our FEHBPs are in Blue Cross/Blue Shield. So when you talk about negotiating with them, they really have most of the negotiating power.

So if they choose not to contract with a health care facility in that area—as I mentioned, the Federal employee I had who had to go outside of his PPO network, and going outside of it to get to his local hospital, and staying within it was going to a hospital that was two hours away.

So I would just keep that in mind, that sometimes when you have States where the only player is a Blue Cross/Blue Shield like that, and the majority of your Federal employees are there, some of the negotiating power of the Federal plan is lost because they are the only ones that are serving the Federal plan.

Senator BREAUX. Would the Senator yield?

Senator LINCOLN. Sure.

Senator BREAUX. She is the negotiator nationwide, though. She can tell Blue Cross/Blue Shield in Arkansas in that one county, you have got to do that. Is that not correct, Ms. Block?

Senator LINCOLN. If she would.

Senator BREAUX. I mean, she does.

Ms. BLOCK. Again, I am not familiar with the particular situation. I do not know whether the person was in the standard option or the basic option. So, we would be happy to look at the particular situation. Once we understand it, we would be happy to give you an answer.

Senator LINCOLN. We would hope that that would be the case. But, unfortunately, if you have one that is too top heavy, there may be less of that negotiating power.

Senator SANTORUM. Mr. Chairman? Mr. Ranking Member? What am I saying? [Laughter.]

Senator BAUCUS. Anyway, whatever you want. Anything works here.

Senator SANTORUM. A couple of things. You were talking about how much more expensive it would be. But my understanding is that the average Medicare recipient's medical costs are about five times as much as people who are outside of Medicare.

So, obviously, it is going to be a more expensive plan than the plans that are offered here because you are talking about sicker people who use more health care services.

So I think the question is whether we are delivering the care efficiently as cost effectively as possible. So, the question is, what model are we going to put together to do so? So I think if we look at these experts in the field, we should try to derive from them what models are the best models to work.

Would any of you put together a model that is just a fee-for-service plan and a separate drug benefit that is not integrated into that plan, and believe that that would be the best way to either deliver

quality care or to do so efficiently? Would anyone suggest that is the best way to efficiently, cost effectively, and quality-wise deliver care to patients?

[No response.]

Senator SANTORUM. Nobody. I mean, unfortunately, that is one of the options that we have on the table here, which is to continue the fee-for-service Medicare program, and then have on top of that a separate drug benefit that is run separately from the program.

I would like comments from you as to the result and impact on the quality of the care delivered to patients when you are not having any kind of integrated health planning for delivering care to those patients when it comes to inpatient procedures and pharmaceutical care, if anybody would like to comment on that.

Mr. BRADLEY. I might want to comment. What I think you are talking about is a stand-alone model.

Senator SANTORUM. Right.

Mr. BRADLEY. I think that the importance here is, how well is that stand-alone model managed, meaning, is there good benefit design, good cost sharing? Are PBMs and carriers engaged to manage the benefit design?

The nature of integration. Maybe I did not fully understand your question earlier, but the nature of integration is that in any well-managed prescription drug model, the provider has got to be incorporated on education issues, whether they be formularies, or whatever it is. Benefit design, clearly, is part of a more integrated approach. It has got to make sense.

So I guess what I am suggesting, is just to kind of lay it on top there without a good management structure would not make sense. But you can have, I think, a well-managed prescription drug, whether it be on top of the existing program or as part and parcel to a carrier.

I think the trick is, how well is that program managed, and then how well can you link it into the other. And disease management is a great case in point of really tying some of these things together.

Senator SANTORUM. I guess that is the point I am making. If you really are going to have a better management of quality and of care, do you not really need to have that prescription drug benefit integrated into the rest of the care continuum?

Mr. BRADLEY. Yes. Ideally, you would want to integrate.

Senator SANTORUM. Ideally, you would want to do that. But should we not try to get the best system that we can for our Medicare recipients?

Mr. BRADLEY. Oh, absolutely. But I do think that it is important to recognize that it can be a stand-alone model with the existing program if it is well managed.

Senator SANTORUM. I understand that. But would you suggest that is the optimum way to do it?

Mr. BRADLEY. I think the optimal way, obviously—I grew up in an organized delivery system way of thinking. But, clearly, the more we can tie together all of the elements of managing health care for beneficiaries, that is not necessarily HMO, but it is organized systems of care where all the providers are working together. That is ideal.

Senator SANTORUM. Ideal in what respects? What are the benefits of doing that?

Mr. BRADLEY. You get the most value because you are coordinating care. You are not doing things inappropriately. You are using best practices. There is accountability on the part of the providers to the entity that they are part and parcel to.

It creates the mechanisms for disease management, and so on. There are just many, many advantages to doing that. But we have to start someplace. I think you can have a stand-alone design that is well managed.

Senator SANTORUM. I understand that, but that is a sub-optimal choice, is what you are saying, as a starting point. You would take that as a sub-optimal starting point. But my point is that if what we hopefully are here to do is try to provide the best system for our Medicare beneficiaries, then we should go about designing the best system, not something that is sub-optimal that can pass, because our Medicare beneficiaries deserve better than that.

They deserve, as you suggested, a program that is more efficient, that has better disease management, that results in higher quality output for less money, potentially. That is what we should be focused on.

I see, Ms. Block, you are nodding your head. I will let you nod with me, if you want to say it, so everybody else can hear you.

Ms. BLOCK. I would just like to say that we have seen a great deal of movement in the PPO world toward better care management, disease management, case management programs, and we strongly encourage those.

We think they are an absolute win-win for both the patient and for the plan, and ultimately for us as the payor, because, as people have said earlier, if you can work with a diabetic and make sure that that person knows about his or her disease, takes all the proper steps, gets all the proper care, is a well-educated consumer, ultimately that person stays healthier longer and we save money.

Senator SANTORUM. And would it be more difficult to do that if you had a system, as your system is structured, that the drug benefit was separate from all the other benefits that were provided? Would that be harder to do?

Ms. BLOCK. Well, optimally I think it is better to do it in an integrated program, and pharmaceutical data that is part of our plan information is clearly used in all of those programs.

Senator SANTORUM. So we would not be moving forward with what would be called "best practices" if we set up something separate like that. It would not be what the private sector would recommend.

Ms. BLOCK. It would be different.

Senator BAUCUS. Well, it sort of begs a deeper question, though. It assumes cost savings.

Senator SANTORUM. Mr. Chairman? Excuse me. I apologize for that, calling you Mr. Chairman, but I am sure you enjoy it. The point is, what it does assume, and I think what they are saying, is it assumes better quality and better disease management, and that should be one of our goals.

Senator BAUCUS. Let me finish, please.

Senator LINCOLN. Mr. Chairman?

Senator BAUCUS. Let me finish. I was trying to make a point here, first.

The point is, there is a little bit of difference between theory and practice. We are talking about theory, and there is also a little bit of practice here. The practice is, as Ms. Quam said, her company will not go into Montana. Why will it not go into Montana? Because it is too costly for what you get.

This means a lot of plans will not go into rural areas and provide for seniors, particularly, because it costs too much. It is just too costly. We are talking here about how we cut costs, but we are not quite yet at the point where plans feel they have got ways to cut costs enough to go into these areas.

In fact, CBO has said that to set up a model where plans are all competing and it is going to cost hundreds of billions of dollars extra from what we now pay.

Senator SANTORUM. If the Senator will yield. We have talked to CBO. The reason they say that, is because——

Senator BAUCUS. Senator, I was speaking. You interrupted me. You will have your chance to speak.

Senator SANTORUM. I thought we would have a nice dialogue so we could learn.

Senator BAUCUS. Well, not when we interrupt. Not when we interrupt. That is not a dialogue when you interrupt. You will get your chance. You will get your chance.

Senator SANTORUM. All right. You go ahead.

Senator BAUCUS. You will get your chance.

Senator SANTORUM. Wonderful. I will take it.

Senator BAUCUS. But I agree, we have to have quality. I very much appreciate all the things that you are doing that you cited in that book in looking for quality. But at the same time, it is true that plans will not go into certain areas of the country because it is just too expensive.

It is also true, as Senator Rockefeller pointed out, that these plans and PPOs, actually, the rate of increase of costs is higher than Medicare. It is quite a bit higher. On average, I think it is about 168, 167 percent. The highest is 40 percent higher, and in Montana 30 percent higher for the small managed care that we do have.

It is just more expensive, and therein lies the reason why CBO came up with their conclusions. If private plans were forced to compete in all these areas, in order to compete, in order for them to play, if you will, and for the same benefit, they would have to be paid more to cover their costs.

CBO says it comes out to a big chunk of change. It is a lot. It is a lot of money. So it just seems to me, as we work to try to get more competition, which we all want, and work to get better quality, too, we also cannot just blithely assume that the competition, per se, is going to provide universal, if you will, health care around the country. It just seems to me we have to, with eyes wide open, work in a way so that we can accommodate all of our goals together.

Mr. Bradley? You are raising your hand.

Mr. BRADLEY. Yes. Senator, I think that one way to address the rural issue, is managing the broader indemnity plan well, which

does not require sort of the specific delivery system, health plan, or whatever. That is something that we do with our basic plan and our PBM management is for the whole country, benefit designs for the whole country, and so on.

I think that there is a real opportunity here, as legislation is being developed, for employers like us and others that have those broad-based plans—we have people living in virtually every zip code in the country.

We have an ability to integrate—back to sort of the other question—our prescription drug program with our indemnity program. If the legislation is designed in such a way so that there is flexibility for different employees to incorporate into their plans the Medicare prescription drug program—and we have actually offered up some ideas on that—we can, I think, start to address some of those rural issues better than you might just by specific organized health plans where they do not do exist.

Senator BAUCUS. Ms. Quam, then the Senator.

Ms. QUAM. I think Mr. Bradley has made a very important point. As I mentioned, we provide insurance coverage through Medigap to millions of Medicare beneficiaries on fee-for-service. We also do it on the employer side and for State Medicaid programs.

Both State Medicaid programs and the employer side use more tools to improve the quality of care in fee-for-service, therefore benefitting rural areas where I think fee-for-service will always be very important, than Medicare does. I think there is a real opportunity in Medicare to be able to do that more effectively.

Senator BAUCUS. All right. Thank you.

Senator Lincoln?

Senator LINCOLN. Thank you. I would just like to touch on a couple of these issues. The Senator from Pennsylvania mentioned trying to separate the prescription or integrating those services. Ninety of the Senators voted last year on a separate prescription drug package, all of us included.

So, I think it is important to note that we recognize that there is an importance of having that program there, and certainly being able to make sure that it is administrable everywhere. I think that was one of the reasons.

You talk a lot about disease management, and that is an important point. But I think we also have to bring it back to the context of what we are talking about, and that is Medicare, Medicare beneficiaries who are traditionally older individuals who have multiple complications.

So if you only focus on disease management, which is usually one disease, 95 percent of the Medicare patients who are Alzheimer's victims have multiple complications, and these are multiple complications that are chronic, then we sometimes miss the opportunity to be as efficient as we can in providing the kind of quality of care that we want to provide.

So I think it is really important that we integrate that into our debate. Disease management is very important. But to recognize that those that we are dealing with or that we are looking to try and cover are those that are going to be dealing with multiple disease managements, and most of them chronic, soit is going to be more costly.

One of the things I have tried to do, and I would really like to hear from Mr. Bradley, Ms. Quam, and anybody else who wants to enter into that, but when we talk about the importance of what we are doing here and how we do it well, it is working to improve the coordination of care in many instances, particularly with the age group that we are talking about.

I have introduced and have been working on some ways that we do that in terms of coordination of care for the elderly, because I think that is critical. When you are managing multiple chronic conditions, if you are not coordinating the care they are getting, then unfortunately some of it can be adverse and certainly not productive.

At a time when we are going from 40 million seniors to 70 million seniors, if we do not prepare ourselves for providing that kind of care to this large group that we are trying to serve, we are not going to understand about any of thee models that we are trying to use if we do not recognize the individuality of the group we are trying to serve.

Out of 125 medical schools in this country, only three of them offer a residency program in geriatrics. We are having a declining number of geriatricians out there to serve an increasing population of elderly.

So I would just like to see any of your comments on coordinated care and preventive care as a mechanism in what we are trying to develop and how productive it can be.

Ms. QUAM. Well, Senator Lincoln, you are absolutely right, Medicare beneficiaries have many chronic illnesses. The work we do in Medicare is focused on those beneficiaries. Our EverCare program provides services to 60,000 Medicare beneficiaries, where the average age of the people we serve is 88. Most of them have some form of Alzheimer's or dementia, and they all have multiple chronic conditions. They are very frail.

It is very important to look at the whole person, because therein lies the opportunity to improve their care; not to look at different diseases, but to look at the whole person.

You can dramatically improve people's lives, the quality of life, even at the frailest point of life by doing that. It also, as I mentioned in my remarks, has a very important budgetary element because 5 percent of Medicare beneficiaries, this frailest group, consume about half the Medicare budget.

So I think that you are absolutely correct that this is a central area that we need to work on, both immediately in the Medicare system and in any reform efforts.

Ms. BLOCK. I would like to make you aware of a research project that we have under way that is exactly on point with what you are talking about. The Blue Cross/Blue Shield Association, in conjunction with OPM, CMS, and Johns Hopkins University has a project under way to look at multiple chronic disease individuals who are our enrollees, Medicare-covered, in the FEHBP program, in the Blue Cross/Blue Shield plan, and Blue Cross is sharing data with CMS and with Johns Hopkins researchers to look exactly at that population and what kinds of programs might be most effective for addressing their needs.

Senator LINCOLN. Coordination of care that they are trying to get now?

Ms. BLOCK. Well, I cannot tell you the conclusion of the study because it is exactly in the area that you are concerned about and that we are concerned about as well.

Senator LINCOLN. When do you anticipate the study being completed?

Ms. BLOCK. Probably in the next 6 months.

Senator LINCOLN. Great. Well, I just want to reaffirm how important it is, because I think it is a cost-effective measure of looking at how we are going to deal with this ever-increasing population.

Mr. BRADLEY. Also, another resource, is the Institute of Medicine, last fall produced a document called "Fostering Rapid Advances in Health Care." One of the issues gets right to the point that you are talking about. That is, chronic care or organized care for the elderly.

It was aimed at doing demonstrations which would be, I believe, under CMS or the Secretary. It gets right to the issue that you were talking about, because, again, it is all part of this whole integrating, which I really agree with.

Admiral CARRATO. Senator Lincoln, I just would like to talk a little bit about our Medicare experience. We have introduced a program for our over 65-year-old military retirees who are also Medicare-eligible, TRICARE for Life. It offers a comprehensive health benefit and prescription drug benefit.

To your point of coordination of care, for those folks in our military hospital catchment areas, we offer an enrollment option in our military treatment facilities, TRICARE Plus, and we try and bring in those folks with the most chronic conditions so we can coordinate their care using a military primary care provider. We found that to be very effective, and actually welcomed by our over-65 beneficiaries.

Senator LINCOLN. Can I ask you, how comprehensive is that? Do you also include nutrition? Do you include mental health, depression? I mean, is it pretty comprehensive in terms of the different areas of coordination that they need?

Admiral CARRATO. It is comprehensive. It depends upon, in some cases, the capability and the capacity of the institution and the provider. But we try, as all the panelists have talked about, to take advantage of disease management. Our system-wide approach is looking at reducing or eliminating practice variation. We find that also quite promising.

Senator LINCOLN. You can all just nod your heads one way or the other. Do you all find that that is a cost-effective tool?

[Nodding in the affirmative.]

Ms. QUAM. Absolutely.

Senator LINCOLN. Thank you.

Senator SANTORUM. Thank you. The Senator from Arkansas, I think you made the point that with this older population, sicker population, more costly population that has multiple disease, that coordination is essential.

The point I was trying to make earlier, is that what is the optimal way to coordinate these things is making sure that the benefit

that we add to prescription drugs is integrated into that coordination, and it should not be separate.

If anybody on the panel disagrees with that, that the most optimal way to do so is to have an integrated benefit so you can optimize the coordination of these multiple, and potentially chronic disease patients, is to have all of this coordinated under one system.

Would everybody agree with that?

[Nodding in the affirmative.]

Senator SANTORUM. All right.

One of the points I wanted to respond to of the Senator from Montana, is the fact that this PPO approach, according to CBO, is going to be scored hundreds of billions of dollars more expensive. I just want to review and set the record clear as to why CBO has deemed this to be the case.

I have a chart here that shows CBO projections for the cost of private sector private health insurance and the cost for the CBO baseline for Medicare. You can see, it starts right about here. This is 2002 here. They do not have last year's numbers, it is actually a projection.

But they show over the years that this number of per capita spending dramatically widens. This is the hundreds of billions of dollars that, if we went to a "private sector" model, we would have to have this number go up here to basically compete in a private sector model. Thus, CBO suggested that if we go to a "private sector" model, this number would be up here and it would cost us a lot more.

The problem I have with that, is if you look back this way, there is no evidence that Congress would allow it, and in fact, just the opposite. Most of the years prior to this, for the 20-plus years prior to this, Medicare paid more than the private sector.

The reason is, if this number gets too far below the private sector, guess what? Doctors do not participate in the Medicare program and hospitals do not participate in the Medicare program.

So what CBO is making as the assumption, is that people will still participate in the Medicare program when they are getting 20 percent, more or less, in reimbursements per capita than under the private sector.

There is just no basis of fact in that. So the idea that somehow this is going to cost a lot more to do what we anticipate, which is these lines tracking pretty closely together, and if anything Congress having this line slightly above to make sure of maximum participation by providers, is folly.

So, I would just suggest that I understand the Senator from Montana. He is reporting accurately what CBO says, and I do not question him or the veracity of his statement. I certainly question the sanity of the people at CBO who would suggest that that is the case. You would have no Medicare program if these lines looked like this any time soon.

To suggest that we are going to be held to that standard just simply biases the decision of the Congress based on phony economic projections. I am confident that people who will think a little deeper about these things in the Congressional Budget Office will come to that same conclusion, or at least make the statement that if we did continue with the current projections for these two sys-

tems, that the Medicare system would be a great system without anybody providing care because they would not do so at this price.

That has nothing to do with any of you and the questions to be asked, but I wanted to clarify the record to make sure that we understood that. I would be happy to recognize the Senator from North Dakota.

Senator CONRAD. I thank the Senator from Pennsylvania. Let me put up that chart that shows what the private sector has been, the second one there. Interestingly enough, if we look in the rear view mirror instead of trying to look forward, here is what we see on this very question.

Private insurers' costs have been higher than Medicare's. This is the cumulative growth in per enrollee payments for comparable services, comparing Medicare and private insurers. We have seen that private insurers, since 1988, have been substantially higher than Medicare. I think you will find private insurers are not in a position to go lower.

Medicare has had really a quite strong record of controlling costs. In fact, maybe Ms. Quam, you might tell me, what is the overhead cost on Medicare? Do you know what the percentage cost of the program is to administer Medicare?

Ms. QUAM. Senator Conrad, it is a very low administrative cost in Medicare. I do not have the number in front of me.

Senator CONRAD. Yes. I think it is between 1 and 2 percent, which is remarkably low. I mean, you are not going to get that kind of administrative cost in the private sector because they have got to make a profit.

Let me just go to the first chart, if I could, and while we are doing that, indicate that in my own State, I have 103,000 people in North Dakota who are enrolled in fee-for-service, and 635 are not in fee-for-service. So when we talk about designing a system, it has got to be a national system and it has got to meet the needs that are out there.

I can tell you, in rural areas like mine where we have almost nothing in the way of Medicare+Choice—I think we have just gotten Medicare+Choice. Do we not have one provider now? One provider. I do not know how many they are covering. It is next to nothing.

I think we have got to be very conscious of what the results are. The fact is, Medicare is overwhelmingly popular. People are satisfied with what they are getting. Does that mean it should not be reformed? Absolutely not. It has got to be modernized. One part of modernization is prescription drug benefits.

But I do not think seniors in traditional Medicare should be penalized for remaining in fee-for-service. This notion that we are going to have differential treatment, that if you are in a private sector plan you get prescription drug treatment, but if you are in traditional Medicare you do not, other than a catastrophic plan, that is not an acceptable outcome, at least to this Senator.

The first question I have, is whether embarking on Federal Employees Health Benefit Plan-like reforms would save Medicare money. Would it make it more efficient? We know that, in general, Medicare has done a better job than FEHB at holding down costs.

This shows the comparison. The red bars here are Federal Employees Health Benefit Plans, the increases they have experienced from 1999 through 2003. The yellow, is Medicare cost increases. You can see in every single year, Medicare has done a better job of controlling costs than has Federal Employees Health Benefit Plans.

I put up the previous chart that shows Medicare compared to private insurers; the same thing over a very extended period of time.

In addition, the head of CBO was recently quoted—I think this is what Senator Baucus was talking about earlier—as saying that the President's Medicare plan could add hundreds of billions of dollars in costs.

So against this backdrop, I wonder if we achieve any savings by moving toward a private sector model. Will these efforts make the program more solvent or less solvent? I would ask that to the panel. I would start with you, Ms. Quam.

Ms. QUAM. Senator Conrad, Medicare has done a very effective job at controlling costs through its ability to set the rates by which costs are paid for services, and your charts reflect that.

The opportunity for Medicare is to do a better job of conserving resources and improving quality of care by improving care to those people with significant chronic illnesses. Five percent of beneficiaries consume about half of the Medicare budget. Therein lies a great opportunity to improve the care for them because they are the frailest users of service, and to conserve resources for the program.

Senator CONRAD. Can I just stop you there and get you to repeat that?

Ms. QUAM. Yes.

Senator CONRAD. Because I have heard this statistic in varying forms, but maybe you could just repeat it. As I heard you say it, 5 percent of those eligible for Medicare are consuming half of the resources.

Ms. QUAM. That is correct. I am relying on the testimony of the former CBO director to the Congress, I believe it was, last year, that 5 percent use half of the Medicare resources. They are the frailest Medicare beneficiaries. They are people with multiple conditions. They are people who no longer can care for themselves. They are people at the end of life.

There is a very substantial opportunity to improve the care delivered for them in a way that also costs less. That opportunity should be seized by the Congress for the Medicare program.

Senator CONRAD. And what is the opportunity, if I can ask?

Ms. QUAM. The opportunity is to better organize a way that care is delivered to those patients, improving the primary and preventive care, so improving care to them so they are less likely to get pneumonia and end up with a long hospitalization. So, it really is investing more in primary prevention.

It is doing a better job, as Mr. Bradley has testified, in closing this gap between what the best research says about what works in medical care and what is actually provided.

It is coordinating all of the points of service more effectively. These Medicare beneficiaries see many, many doctors and many, many care providers and it often is not very well coordinated.

The Congress has fostered some very good programs that are effective in this area through the Medicare demonstration projects. We operate one of them. But they are very small. I think that there is an opportunity for them to be very large.

That opportunity can be played across both the fee-for-service Medicare program, of which we participate significantly, and a health plan Medicare program of which we also participate in significantly. I think that is where the greatest opportunity lies now for the Medicare program.

Senator CONRAD. Mr. Bradley?

Mr. BRADLEY. Yes. I think Ms. Quam said pretty much everything that I would say. I think that the real issue here, is how can we take advantage of the best that Medicare has to offer with respect to their price negotiations and so on, and the best that the various other programs have to offer with respect to managing care, and bring them together as an opportunity to really make an impact.

Senator CONRAD. Let me just say, while I am concerned on the cost front, because when I look at the data it tells me that the private sector approach would be more costly rather than less costly. I am also very concerned about what would be available to seniors.

I understand, under Federal Employees Health Benefit plans there is no standardization of benefits, so there is no guarantee that beneficiaries will have access to their local doctors, pharmacies, or other providers, particularly in rural areas. I think you have to ask the question, is this the model that we want to force seniors to choose? I am simply not convinced.

I would be curious to hear from Ms. Block how often enrollees have to go out of network and pay higher costs to receive care, particularly in rural communities. Do you have that information?

Ms. BLOCK. Well, depending on what plan they are in. In the Blue Cross/Blue Shield basic option, which is an in-network-only plan, they never have to go out of network. That plan has guaranteed that in-network coverage will be available everywhere in the country. In other plans, people occasionally do have to go out of network depending on their choice of plans.

Senator CONRAD. And do you have data on that?

Ms. BLOCK. Yes, we have data on the percentage of claims overall that are out-of-network claims. We certainly have very clear data on Blues Basic, because the requirement in order for us to accept that plan was that in-network coverage would be available.

Senator CONRAD. Would be provided in that plan.

Ms. BLOCK. In that plan.

Senator CONRAD. But there are other plans where that is not the case.

Ms. BLOCK. There are other plans where that is not the case because they have an out-of-network benefit available.

Senator CONRAD. And could you share with the committee what the percentage is that are out of network, and what the costs are for out of network?

Ms. BLOCK. It would vary, of course, for each plan. We would have to look at each plan individually.

Senator CONRAD. I would be very interested in what that data would be.

Senator SANTORUM. The Senator's time has expired. I will take a few minutes. Then I would be happy to let you, if you have some more questions, come back.

Senator CONRAD. Very good. All right.

Senator SANTORUM. I want to ask a question on that. Actually, it is a chart from you, Senator from North Dakota. The question I have on that, is number one, are you comparing comparable benefits?

Because, as you know, the FEHBP program has a prescription drug component in it. It has mental health parity, it has a variety of other benefits which have gone up dramatically in cost that Medicare does not have. See, we are not really comparing apples to apples here.

Are you comparing comparable benefit versus increased costs and comparable benefit? If you do not know the answer, that is fine. But I think it is important that, as we have seen and many have commented here, the escalating costs of prescription drugs has driven health care costs at a higher rate. When you do not have that included in your primary benefit, then you are going to have lower increases in cost.

As you also know, we had the BBA of 1997, which had a dramatic impact on the rate of increase in Medicare spending, which is probably reflected in there, too. As a result of that, we have a lot of doctors who are not seeing Medicare patients right now because some have suggested we squeeze Medicare down too much.

So I guess my point is, yes, that chart shows things. The increases may not be equivalent because of the benefits that are covered under one plan versus the other.

Second, even with that alteration, there still may be a difference, but that difference has resulted in a lot of providers not seeing Medicare patients because we are not reimbursing enough.

So I think there are good reasons why we see the chart the way it is and they have real dramatic impact on providers, as well as patients, and the quality of care in which they receive.

With respect to that chart, I do not know where that number comes from. You know, it is the battle of the charts here. The chart I have is from the Congressional Budget Office using CMS numbers and numbers that CBO has gathered from the private sector, and that chart does not look like this chart. So I do not know where that chart came from. I know where this chart came from.

Senator CONRAD. I would just answer the Senator. this is from the Urban Institute. They did an analysis of national health expenditures for the Centers for Medicare and Medicaid services. This is an apples-to-apples comparison. Drugs has been taken out. So with respect to this, this is an apples-to-apples comparison.

Senator SANTORUM. All right.

Senator CONRAD. With respect to this chart, it is not apples to apples in the sense that the Senator is correct. You have fundamentally different plans under Federal employee health benefits. Obviously, it depends on which plan a person is enrolled in precisely what benefits they have, unlike Medicare.

Even in Medicare, obviously, you have got some differences because you have some people here in Medicare+Choice, you have got others who are small. You have got others who are in traditional

Medicare. But this does show the difference in cost increases between those plans. That is not as comparable, obviously, as the other one that compares private to Medicare.

Senator SANTORUM. I appreciate the Senator from North Dakota responding. Just at some point maybe we can bring these two different charts that we have, because our numbers show that, in fact, from—I think your chart showed in 1987, that line split. Is that right?

Senator CONRAD. Yes. Well, it looks to me like——

Senator SANTORUM. I cannot see your numbers.

Senator CONRAD. That is since 1988.

Senator SANTORUM. All right. 1988.

Senator CONRAD. 1987, 1988.

Senator SANTORUM. Yes. Our chart shows, in fact, just the opposite, that Medicare spending roughly at that point started to go up above the private sector. So that is why these numbers do not seem to match. But it is important. I mean, we need to come to some resolution as to what is going on.

But I would say that, in any event, the fact that one of the reasons that Medicare is in trouble right now, is the fact that a lot of the providers are not seeing Medicare patients.

So, your chart may be in fact more accurate than mine because it may reflect the fact that Medicare recipients are having trouble getting access to health care as a result of lower rates of reimbursement, in part driven by the BBA of 1997.

I would be happy to let the Senator from North Dakota continue for a few more minutes.

Senator CONRAD. I just have a few more.

Senator SANTORUM. Yes. The staff is sort of saying, if we could wrap up, that would be great.

Senator CONRAD. Wrap up. I would be happy to do that. I would just say this. There was one other chart I wanted to put up, and that is the question of stability. We have got a question of cost, we have got a question of what is provided, and we have also an important question of stability.

Medicare+Choice. Here is what has happened to Medicare+Choice. In 1998, we had 17 percent enrolled. In 2002, you are down to 12 percent. In 2013, the estimates are, according to the Congressional Budget Office and the Kaiser Family Foundation, we are going to be down to 8 percent.

We have seen well-publicized pull-outs of Medicare+Choice programs all across the country leaving people high and dry, leaving the people that were signed up in a circumstance in which those who have been providing coverage are long gone.

So I wonder if the witnesses would be willing to comment on ways that we could adopt some private sector practices, such as rewarding providers for quality into the traditional Medicare program, and other ideas that you might have.

What are things that could be done that would improve access, that would improve quality of care? What are the best ideas that you have heard for improving the Medicare program? I would start with you, Ms. Quam.

Ms. QUAM. Thank you, Senator Conrad. The best ideas that I have seen for improving the Medicare program are all around car-

ing for this group of frailest Medicare beneficiaries. I think the advances in the hospice benefit represent an opportunity to do that.

The programs that we have developed under the auspices of a Medicare demonstration project to have geriatric-trained nurse practitioners and reorganize the delivery of care, working with the family physician that the elderly beneficiary has, has been very effective. I will just give you an example there. As a part of that offering, we often worked with beneficiaries who have drug coverage either through their State Medicaid programs or purchase drug coverage, or we provide some drug coverage through the offering.

What our nurse practitioner does, is he or she analyzes all the drugs that a patient is on. These patients are very frail, so they are often on over 15 individual drugs. They analyze all the drugs and understands what the purpose for each drug is, and looks at all the relationships between the drugs, because many of the drugs are treated the side effects of other drugs or they clash with each other.

Then our nurse practitioner sits down with the physician and they walk through a strategy to set up a better drug regime for the patient.

Senator CONRAD. Can I just stop you on that point?

Ms. QUAM. Yes.

Senator CONRAD. I would say, this is an area I think has got enormous opportunity.

Ms. QUAM. Yes.

Senator CONRAD. My father-in-law was in his final illness a couple of years ago and he was on 12, 13, 14 different medications. The elderly have a very hard time keeping it straight. Frankly, we had a hard time keeping it straight.

Ms. QUAM. Yes.

Senator CONRAD. I often wonder, does anybody really know all the medications this man is on, and what is the interactive effect of all of these medications? How often are mistakes being made? Because I can tell you, we found repeatedly that he was making errors in taking those medications. He was not taking them as they were prescribed.

So this is a pilot that you have done?

Ms. QUAM. We started a demonstration project with the Federal Government many years ago. We are now in over 10 States. We cover about 60,000 people. We would very much like to expand it. If the program was shaped in some different ways, it could work in rural areas.

What we do, is you are exactly right. What you saw with your father-in-law is very typical. What we found is, in general, no one does know what all the drugs are that a person is on, because these drugs have accumulated over years, have accumulated from different practitioners.

In addition to all the problems you highlighted, the older people's metabolism slows, so that the average dosage of a drug is really set more for people in midlife. Oftentimes, the dosages are too high.

So we do a full analysis of this, work with their family doctor, and come to agreement as to what the new drug regimen should be. On average, that saves about 20 percent of costs because people generally are on too many drugs and not always on the right drugs,

and re-sets that. We often see with that an improvement in day-to-day quality of life. They become more aware.

A second example, just very briefly, is we work very, very hard to diagnose pneumonia early. We have determined that if one of our nurse practitioners can diagnose pneumonia about 12 hours earlier than would be diagnosed because of a high fever, which is how it is usually diagnosed, we are very likely to prevent a hospitalization.

These hospitalizations are, on average, 10 to 14 days long. It is very expensive, very disruptive to the quality of life of the older person, very hard on their families.

How do we do that? We know the patients well enough that we look for small signs and changes. One sign, is if there is a beneficiary who usually eats breakfast and does not eat breakfast, we ask the nursing home or the assisted living facility to call us so we can come over because that can be a sign.

The earliest signs are lethargy and not engaging. But these are very elderly patients, so we have to pay attention to those signs. If we can come over and start antibiotics earlier, we can prevent very, very costly, very adverse circumstances.

I have many examples like this. I think that these are programs that could be expanded more rapidly. It is hard to expand them within the current setting in the fee-for-service Medicare, but there could be things that could do it well.

Senator SANTORUM. I unfortunately have to wrap this up. If anybody on the committee has any more questions, we would be happy to have them submitted in writing and ask you to answer them.

I want to thank the indulgence of the panel, and thank the Senator from North Dakota.

Senator CONRAD. If I could just say, I would like to submit for the other members the last question I was on, good ideas you would have for improving Medicare. What are the best ideas you have heard? I would like to submit that, if I could get answers.

Senator SANTORUM. Without objection.

We are adjourned.

[Whereupon, at 11:42 p.m. the hearing was concluded.]

APPENDIX

PREPARED STATEMENT OF HON. MAX BAUCUS

I appreciate the opportunity to explore the issue of purchasing health care services in a competitive environment. This is a "big-think" kind of hearing. We have the opportunity to consider what sort of competitive bidding structures large purchasers of health care currently use. And this is important, because the President has recently put forth a Medicare reform proposal—or at least the outline of a plan—that emphasizes choice and competition among private health plans.

We aren't here to pick at the administration's proposal. Rather, we're here to think about how a competitive model might—or might not—work for Medicare. As I see it, there are many lessons here—both for the current Medicare+Choice program as well as for traditional fee-for-service Medicare.

In particular, some of the questions I hope our witnesses will help answer include:

- Is it necessary to have losers in a bidding process, like the TRICARE system? Or is competition possible when essentially all bidders are accepted, like the FEHB program?
- How can quality be incorporated in a competitive purchasing system, as GM has done?
- What are the challenges of bringing in PPOs to serve ALL parts of the country?
- Is a PPO model any less expensive or more efficient in a rural area than traditional Medicare?

My sense is that with higher administrative costs, profits, and risk load, combined with an inability to contract with preferred providers in remote areas, PPOs would actually be more expensive than traditional fee-for-service Medicare. And as I understand it, CBO happens to agree with this assessment. They also believe that getting regional PPOs to participate in Medicare will be very costly. At any rate, they certainly won't improve Medicare solvency.

Which leads me to my last questions.

- Are these competitive systems truly transferable to Medicare?
- And, perhaps more importantly, are there lessons from these systems that we can apply to traditional Medicare—not just to private plans?

It's important to keep in mind that almost 90 percent of seniors are enrolled in traditional Medicare, and I don't see that ratio changing any time soon. Montana doesn't have any coordinated care plans. We have a private fee-for-service plan in Medicare, but only 146 enrollees have signed up. And that is not an exaggeration.

As we try to make improvement to the system—modernizations, reforms, or whatever you want to call these changes—we must think carefully about whether a competitive model truly can flourish in all areas of the country.

My colleagues on the Committee know full well that I am skeptical that competition is the answer for seniors in my home state. That is why one of my biggest priorities is making sure that traditional fee-for-service Medicare remains a strong option for beneficiaries in Montana and other places in the country.

These beneficiaries should have access to the same level of drug benefits as those enrolled in private plans. And we should spend just as much time—if not more—exploring ways to ensure that the fee-for-service program is operating efficiently, and what improvements we can make there.

I'm interested in hearing from our witnesses and learning more about how competition currently operates in other parts of the government and in the private sector, and also how we might be able to apply these experiences to the Medicare program.

PREPARED STATEMENT OF ABBY L. BLOCK

Mr. Chairman and Members of the committee:

I am pleased to be here today to discuss the Federal Employees Health Benefits (FEHB) Program.

Our health benefits program has been in operation for more than forty years. It is an employer-based program and forms an important part of the compensation package offered by the Government, enabling it to recruit and retain individuals who carry out the vital work of government. The Office of Personnel Management (OPM) has developed widely-recognized expertise in the complexities of arranging health care coverage with more than one hundred private sector health plans with a covered population of about eight and a half million people including 2.2 million employees, 1.9 million retirees, and members of their families. In 2002, the program accounted for $24 billion in annual premium revenue.

Federal Employee Program Structure

The program relies heavily on market competition and consumer choice to provide our members with comprehensive, affordable health care. In 2003, 188 discrete options are being offered by 133 health plans.

An important and distinctive feature is nationwide availability. No matter where one lives, all members may choose from among a dozen options offered by nationwide fee-for-service/preferred provider organization (PPO) plans open to all. Some members may elect one of the six nationwide plans limited to members of sponsoring organizations, and many may choose a Health Maintenance Organization (HMO) in their geographic area. About 3 million Federal enrollees are in fee-for-service/PPO plans and 1 million in HMO's. There is an opportunity to enroll in the program, change health plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November.

The design of the FEHB program permits OPM to focus on three key elements: policy design, contract negotiations, and contract administration including financial oversight.

While all participating plans offer a core set of benefits broadly outlined in statute, benefits vary among plans because there is no standard benefits package. Even where coverage is nearly identical, cost-sharing provisions may differ significantly among plans.

Benefit and Rate Negotiations

While benefits and rates are negotiated annually, OPM does not issue a request for bids. Instead we issue a call letter to participating carriers in the spring that provides them guidance for the upcoming negotiations. Plans remain in the program from year to year unless they choose to terminate their contracts for business reasons, including failure to reach agreement with OPM on benefits and rates for the coming year. Under current law, the window for new plans to enter the program is limited to HMO's. Unlike the 1980s when we were flooded with HMO applications, in the current market, we average about 6 new plans a year.

Rates are negotiated with the national plans based primarily on their claims experience. About 93 percent of premium, or 93 cents out of every dollar, reflects benefit costs. The remaining 7 percent covers the plan's administrative costs.

For the community-rated plans, rate negotiations are based on a per member per month community rate. Adjustments may be negotiated to the base rate for a variety of reasons, including changes to their standard benefits package, the demographics of the Federal group, and the utilization of benefits by the Federal group.

Contract Administration and Financial Oversight

Our oversight focuses on key areas of plan performance, including attention to quality, customer service, and financial accountability. Measures and expectations regarding quality assurance, patient safety, prevention of fraud and abuse, and compliance with accounting standards are built into our contracts. Some measures, such as the results of the industry standard consumer satisfaction survey conducted annually, and the accreditation of health plans and providers by independent accrediting organizations, are reported to our members in both print and electronic format. Members use the information, often in conjunction with decision support tools that we provide on our web site, to choose their health plan during the annual open season.

We began recently to centralize plan performance data in a data repository that facilitates analysis by contracting staff. All of our contracts include mechanisms through which profits can be adjusted based on performance.

In addition to oversight by the contracting office, all carriers are subject to audit by the independent OPM Inspector General (IG). As a result of the close collabo-

rative relationship between the contracting office and the IG, the program recovers on average more than one hundred million dollars a year based on defective community rate findings and unallowable administrative expense or benefit cost findings.

Policy Design

We administer the FEHB Program in a way that mirrors other employer-based health insurance programs. We also are in compliance with all applicable, Federal laws and meet all the standard Federal accountability requirements.

While the program has a statutory and regulatory framework, key aspects of plan design, such as coverage or exclusion of certain services and benefit levels are in neither law nor regulation.

Within broad parameters set by OPM, plans have the flexibility to determine both their benefits package and their delivery system. Because policy guidance is developed by OPM and provided to the plans annually prior to the start of negotiations, policy changes can be made quickly in response to market factors. For example, this past year we accepted a proposal from one of our plans for a consumer-driven option that reflects the development of new products in a fluid market.

Because our policy is to encourage innovation and private sector initiatives, plans use business-based processes to achieve desired results. For example, when Blue Cross and Blue Shield introduced its basic option a couple of years ago, they had to make adjustments to their provider arrangements to ensure members access to a nationwide provider network since the plan does not cover out-of-network services. Other plans take a different approach and guarantee out-of-network benefits only in parts of the country where they cannot develop a strong provider network, such as rural areas.

While plans have considerable flexibility to deal with specific issues such as access to services, the FEHB Program, by statute, has a provision for "Medically Underserved Areas" that ensures that Members have access to health care providers. Our fee-for-service plans must pay for covered services provided by any licensed provider practicing within the scope of his or her license, even if that provider is not considered a covered plan provider.

Conclusion

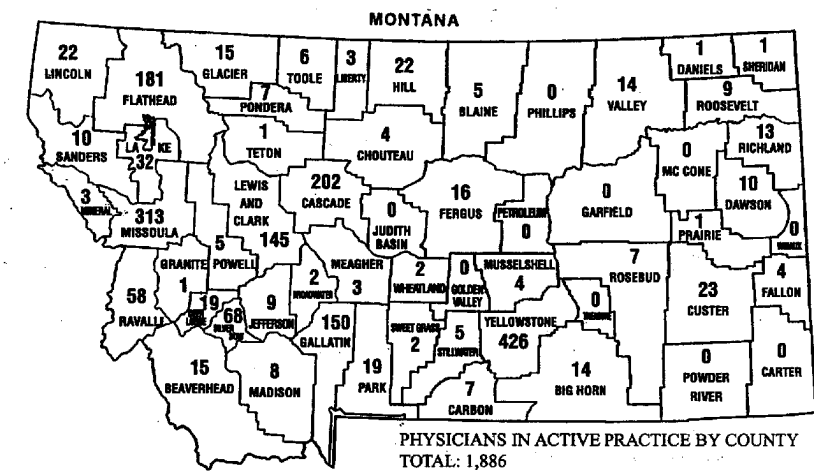
The FEHB Program uses a hybrid approach that shares practices with both public sector and private employer health insurance programs. While we believe the program has been very successful over its long history in offering Federal employees, retirees, and their families quality coverage for a reasonable price, we are always looking for ways to ensure that it continues to reflect the current health care environment, meet the needs of its members, and serve the Government in its recruitment and retention efforts.

We have benefited from close collaboration with the participating health plans and with other purchasers, including those on the panel with me today. We also work closely with the Center for Medicare and Medicaid Services (CMS), particularly on issues affecting the population we serve jointly, our Medicare-covered retirees.

We think that the FEHB Program is an excellent example of effective public-private partnerships.

Thank you for inviting me to be here today. I will be pleased to answer your questions.

RESPONSES TO QUESTIONS FROM SENATOR BAUCUS



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Question 1: We often hear that the Federal Employees Health Benefit program (FEHB) boasts 7 national fee-for-service programs with 12 national plan options. We hear that federal employees all over the country can choose a plan that best meets their need, no matter where they live, and even if they live in the most remote part of the country.

During your testimony to the Finance Committee, I asked you if all federal employees really have the same access to services in all areas of the country. You responded:

> Everybody has the same access given the availability of providers in the geographic area. So, in an urban area, a person might have to drive less than a mile to get a physician. In some of the rural areas, it may be 50 miles or more. But that's not because we don't have a provider in the network; it's because that happens to be the closest provider in that geographic area.

A recent analysis by Senate Finance Committee minority staff found that, for federal employees in Montana, the only plan for which that statement holds true is the Blue Cross Blue Shield plan. The GEHA and Mail Handlers plan options do not contract with many—if any—physicians in many counties of the state (see table below). Together, Blue Cross Blue Shield, GEHA and Mail Handlers are the three plans that represent 65 percent of total FEHB enrollment.

Based on this analysis, would you agree with my conclusion that Blue Cross Blue Shield plan is really the only viable option for federal employees in Montana who want convenient access to providers in their area?

Access to Physicians Under FEHBP Plans in Selected Montana Counties

Montana County	Total # of physicians in county	Medicare participating physicians	FEHB BCBS in-network physicians	FEHB GEHA in-network physicians	FEHB Mail Handlers in-network physicians
Beaverhead	15	12	10	4	0
Dawson	11	10	7	1	1
Fergus	18	14	13	1	0
Liberty	3	3	1	0	0
Lincoln	22	18	18	6	6
Prairie	1	0	0	0	0
Richland	13	10	10	0	1

Source: Senate Finance Committee staff analysis of Medicare physician participation data, www.fepblue.org, www.geha.com, and www.firsthealth.com.

Answer: Since the fee-for-service plans introduced preferred provider networks into the Federal Employees Health Benefits (FEHB) Program in the 1980s, we have always made clear in our informational materials that the preferred provider benefit is an enhancement over the standard non-network benefit offered by the plans. In a typical network arrangement, the provider agrees to accept a rate of payment lower than billed charges in exchange for advantages such as more potential patients, expedited reimbursement, and other services offered by the plan. Often plans monitor the services provided in-network to ensure that their providers are well informed about current practice patterns and new developments in health care delivery. The plan, in turn, can pass on the benefits it derives from provider participation in the network to members in the form of lower out-of-pocket costs when they use a preferred provider. Those lower costs are offered as an incentive to members to choose in-network services when they are available. We have never guaranteed in-network coverage except in the Blue Cross Blue Shield (BCBS) Basic Option. Since Basic is an Option in a nationwide plan and it provides no coverage for out-of-network services, we negotiated special provisions to ensure that coverage would be available everywhere in the country. While the other nationwide plans, such as GEHA and Mail Handlers, make a concerted effort to keep expanding their networks, they do not guarantee in-network coverage everywhere in the country. However, GEHA and Mail Handlers members have access to all of the providers available in the community. But for those providers that have not agreed to accept a discounted payment rate, the member does not get the advantage of reduced out-of-pocket costs. Information on provider availability is available during the annual open season, and members make their plan election based on that information as well as other factors that help them determine which plans best suits their needs and the needs of their family.

Question 2: During your testimony to the Finance Committee, I asked you whether enrollees in FEHBP have access to specialists located in rural areas. You responded:

> I think that we can demonstrate that there are not only primary care physicians but specialists available. . . . Although there are certain differences among the plans and as I suggested earlier, Blues basic is probably the best, simply because of the structure of that plan it was necessary for them to make special arrangements to have access absolutely everywhere our other fee-for-service plans may not have broad access, but they have reasonably good access, I must say.

Later, you added:

> In urban areas, where there are more providers available, some may not be in the network. But typically in areas where there are fewer providers available, virtually every provider is in the network, because that's the only way you can arrange in-network service in every geographic area.

However, a recent analysis by Senate Finance Committee minority staff found that even the Blue Cross Blue Shield Standard Option does not include many spe-

cialists in its network, and as a result, many rural Montanans must travel significant distances to receive care from an in-network specialist or else face higher deductibles or cost-sharing amounts.

Montana Access to Selected Specialists Under Medicare and FEHBP Blue Cross Plan

Montana Town	Specialty	Medicare Participating Physician?	Included in Blue-Cross Network?	Nearest In-Network Specialist
Augusta	Obstetrics & Gynecology	Yes	No	63 miles (Great Falls)
Bozeman	Neurology	Yes	No	98 miles (Helena)
Butte	Neurology	Yes	No	53 miles (Helena)
Columbia Falls	Psychiatry	Yes	No	32 miles (Trenton, ND)
Dillon	Orthopedic Surgery	Yes	No	55 miles (Butte)
Dillon	Diagnostic Radiology	Yes	No	55 miles (Butte)
Glasgow	Diagnostic Radiology	Yes	No	158 miles (Havre)
Glasgow	Urology	Yes	No	270 miles (Great Falls)
Glendive	Psychiatry	Yes	No	219 miles (Billings)
Glendive	Diagnostic Radiology	Yes	No	219 miles (Billings)
Hamilton	Diagnostic Radiology	Yes	No	42 miles (Missoula)
Kalispell	Nephrology	Yes	No	121 miles (Missoula)
Livingston	Orthopedic Surgery	Yes	No	25 miles (Bozeman)
Miles City	Diagnostic Radiology	Yes	No	144 miles (Billings)
Sidney	Radiology	Yes	No	42 miles (Williston, ND)

Source: Senate Finance Committee staff analysis of Medicare physician participation data, www.fepblue.org, and www.bluecrossmontana.com.

Based upon this analysis, do you still believe that Blue Cross enrollees have reasonable access to in- network health care providers in rural Montana?

Answer: For the record, the BCBS rural access standard for key specialties, including cardiology, gastroenterology, general surgery, ophthalmology, orthopedic surgery, otolaryngology, and urology, is that 90 percent of members will have access within 75 miles of their home.

In rural areas, there may be isolated instances where highly specialized care is not available at the Preferred benefit level within a 75 mile travel distance. In most instances this is due to the fact that there is no provider in the area. The Montana BCBS plan requires that all of its providers be credentialed. The credentialing process protects consumers because it ensures that the providers who treat them meet generally accepted quality standards. Some providers decide that they do not want to complete the paperwork required. A few do not meet the credentialing requirement. Some of those who refuse to be crentialed, although they may not be Preferred, are Participating with BCBSMT. Many OB–GYN providers and Orthopedic Surgeons in the Bozeman area fall into that category. Participating providers, because they have a contractual relationship with the Montana Plan, cannot balance bill members for charges in excess of the Plan allowance under the BCBS Standard Option.

In the specific instance you cite of a urologist practicing in Glasgow but not participating in the BCBS network, I have verified that the sole practitioner in that specialty has now retired. However, in all instances, primary care providers are available and routinely provide similar service to BCBS members. In addition, there are network specialists that visit rural hospitals to see patients on a weekly or monthly basis although they do not have offices in the area. While they do evalua-

tions, minor testing, surgeries and follow-up care, major diagnostic testing and/or surgery typically is done at an urban or suburban hospital.

Finally, Basic Option members may use their "exception" process negotiated by OPM and noted in the BSBS plan brochure. The brochure directs members in special provider access situations to contact their Local Plan for more information. The "exception" process allows for case by case exceptions if a Preferred Provider is not available. However, since the providers whose services may be covered on an exception basis are not network providers, they are not listed in the plan directories. Members who contact the Local Plan prior to receiving services will be granted an exception if no Preferred Provider is available within the distances specified in the access standards. If a member receives services without contacting the Local Plan, the claim may be denied initially, but will be paid if reconsideration is requested in accordance with the provisions of the contract.

Question 3: During your testimony to the Finance Committee, you discussed access to services from remote rural hospitals with Senator Breaux:

BREAUX: You pick the most rural county in America, you probably have a Fish and Wildlife Service employee or a USDA employee or a postal worker that has the FEHBP health care plan. How does that person get insurance coverage when there is no competition . . . how does FEHBP guarantee that that person gets health care at an affordable price?

BLOCK: Well there are a couple of ways. For one thing, as I mentioned earlier, under the Blue Cross-Blue Shield basic option, that plan, because it's a nation-wide in-network-only plan, has guaranteed access. Absolutely everywhere in the country has access to an in-network benefit.

BREAUX: OK, suppose that hospital is the only hospital in the county?

BLOCK: Then that plan has made special arrangements to include that hospital in its network. . . .

BREAUX: But you have at least one national plan that would make sure that that hospital, that doctor, if they're the only ones in that county, are included in the plan that's offered by the FEHB provider?

BLOCK: That's correct.

Research by the Senate Finance Committee minority staff indicates that in Montana at least three rural hospitals are not included in the Blue Cross-Blue Shield network: Fallon Medical Complex in Baker, Big Sandy Medical Center in Big Sandy, and Dahl Memorial Hospital in Ekalaka. All of these hospitals participate under Medicare. But federal employees in these communities who are seeking in-network hospital care must drive thirty to sixty miles to obtain it sometimes across state lines.

Based on this research, do you still believe that every facility that is the only hospital in a rural county is included in the Blue Cross-Blue Shield network?

Answer: All BCBS members have access to the 3 rural hospitals cited in emergency situations. However, 2 of the 3 are not full service hospitals and could not provide the full range of services. Nevertheless, the Montana BCBS plan has asked all of those hospitals to accept a 10 percent discount if they participate in the network. These facilities have made the business decision to not accept the discount or participate in the network. BCBS of Montana will continue to seek their participation in the network.

Question 4: Relatively few FEHBP enrollees switch plans each year, even in light of rapid increases in premiums. Some argue tat the fact that OPM does not require standardized benefits and cost-sharing makes it very difficult for enrollees to adequately evaluate their plan options. As a result, few enrollees switch plans during the open enrollment period. Would enrollees have an easier time selecting a health plan, if all of the benefit packages were standardized?

Answer: OPM and the FEHB participating health plans provide extensive informational materials during the annual open season. In addition to printed information, the OPM web site offers retirees as well as employees data in user friendly format including decision support tools to facilitate plan comparison. Standardized benefits would dilute the strength of the FEHB Program which is consumer choice. Members would no longer be able to select the plan that best meets their needs if all plans were, in fact, identical. We believe that relatively few enrollees switch plans each year because the vast majority is very satisfied with the plan they are in. There is a one percent decrease in premiums due to enrollees switching plans, presumably because they have determined that the benefits by those plans meet their needs.

Question 5: Please provide a breakdown of the number of FEHBP plan options and the percent of eligible FEHBP members enrolled in each plan for all 50 states.

Answer:

FOR ALABAMA (AL)
(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S	BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN S	78.96%	66810	1,261	5,014	7,752	17,011	19,568	16,204	28,581	38,229
45H	MAIL HANDLERS BENEFIT PLAN	9.32%	7887	102	405	826	2,302	1,833	2,419	2,761	5,126
31H	GEHA BENEFIT PLAN	2.04%	1728	12	50	111	228	624	703	747	981
45S	MAIL HANDLERS BENEFIT PLAN	1.93%	1630	41	72	233	353	446	485	720	910
DF	THE OATH (HEALTH PARTNERS OF ALABAMA)	1.84%	1561	131	249	360	331	293	197	784	777
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.53%	1298	65	198	229	445	128	233	422	876
32	NALC HEALTH BENEFIT PLAN	1.39%	1172	18	76	14	21	519	524	551	621
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.08%	916	20	132	0	0	379	385	399	517
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.82%	697	24	53	10	9	364	237	398	299
AA	PRIMEHEALTH OF ALABAMA (MOBILE HEALTH PLAN)	0.45%	378	5	30	62	112	79	90	146	232
31S	GEHA BENEFIT PLAN	0.22%	183	6	7	20	31	48	71	74	109
44	SAMBA HEALTH BENEFIT PLAN	0.13%	106	0	0	0	4	46	56	46	60
36S	POSTMASTERS BENEFIT PLAN	0.11%	95	2	1	2	8	57	25	61	34
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.07%	62	0	0	0	1	31	30	31	31
42	ASSOCIATION BENEFIT PLAN	0.06%	47	0	0	0	0	16	31	16	31
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.05%	45	0	2	0	3	30	10	30	15
Total			**84615**	**1,687**	**6,289**	**9,619**	**20,859**	**24,461**	**21,700**	**35,767**	**48,848**

HBDF PLAN TOTALS (2002)

FOR ALASKA (AK)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	68.90%	10262	257	740	2360	4117	1504	1284	4121	6141
31H	GEHA BENEFIT PLAN	14.49%	2158	39	131	408	800	359	421	806	1,352
45H	MAIL HANDLERS BENEFIT PLAN	5.41%	805	14	85	181	348	77	100	272	533
45S	MAIL HANDLERS BENEFIT PLAN	3.22%	479	9	23	145	191	55	56	209	270
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.01%	299	32	121	27	36	48	35	107	192
31S	GEHA BENEFIT PLAN	1.75%	260	4	16	79	80	31	50	114	146
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.62%	242	9	26	79	104	14	10	102	140
32	NALC HEALTH BENEFIT PLAN	1.21%	180	23	53	16	30	26	32	65	115
36S	POSTMASTERS BENEFIT PLAN	0.59%	88	12	21	9	8	22	16	43	45
36H	POSTMASTERS BENEFIT PLAN	0.21%	32	4	3	6	2	14	3	24	8
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.19%	29	1	0	7	2	17	2	25	4
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.17%	25	0	0	0	2	8	15	8	17
44	SAMBA HEALTH BENEFIT PLAN	0.15%	23	0	0	4	7	5	7	9	14
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.07%	11	1	8	0	0	1	1	2	9
Total		100.00%	**14893**	**405**	**1,227**	**3,321**	**5,727**	**2,181**	**2,032**	**5,907**	**8,986**

HBDF PLAN TOTALS (2002)

FOR ARKANSAS (AR)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S	BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN S	65.33%	22535	575	2,540	2,241	5,161	6,456	5,562	9,272	13,263
45H	MAIL HANDLERS BENEFIT PLAN	10.98%	3787	104	508	401	1,007	686	1,081	1,191	2,596
31H	GEHA BENEFIT PLAN	9.34%	3221	80	315	165	391	1,018	1,252	1,263	1,958
45S	MAIL HANDLERS BENEFIT PLAN	3.18%	1096	30	98	132	300	224	312	386	710
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.88%	994	30	261	0	0	317	386	347	647
32	NALC HEALTH BENEFIT PLAN	2.30%	795	15	102	9	30	309	330	333	462
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.19%	755	42	133	124	292	53	111	219	536
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.02%	696	38	96	10	13	305	234	353	343
31S	GEHA BENEFIT PLAN	1.09%	377	14	35	55	89	71	113	140	237
36S	POSTMASTERS BENEFIT PLAN	0.42%	144	7	13	3	9	75	37	85	59
44	SAMBA HEALTH BENEFIT PLAN	0.27%	92	0	0	0	1	35	56	35	57
Total		100.00%	34492	**935**	**4,101**	**3,140**	**7,293**	**9,549**	**9,474**	**13,624**	**20,868**

HBDF PLAN TOTALS (2002)

FOR ARIZONA (AZ)
(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S	BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN S	44.16%	30825	834	1648	3925	5886	10913	7619	15672	15153
A7	HEALTHNET OF ARIZONA, INC. (INTERGROUP OF ARIZONA	11.02%	7696	372	1,183	1,291	2,414	1,198	1,238	2,861	4,835
A3	PACIFICARE OF ARIZONA - METRO	10.04%	7012	890	1,491	1,305	1,520	1,055	751	3,250	3,762
WQ	AETNA US HEALTHCARE, INC. - ARIZONA	8.65%	6037	426	1,357	1,142	2,091	461	560	2,029	4,008
45H	MAIL HANDLERS BENEFIT PLAN	6.69%	4673	152	356	639	1,268	1,035	1,223	1,826	2,847
31H	GEHA BENEFIT PLAN	6.61%	4617	95	219	353	659	1,530	1,761	1,978	2,639
45S	MAIL HANDLERS BENEFIT PLAN	2.97%	2075	42	75	368	593	455	542	865	1,210
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.63%	1839	159	355	294	572	193	266	646	1,193
32	NALC HEALTH BENEFIT PLAN	2.44%	1703	90	235	36	67	662	613	788	915
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.87%	1306	86	170	14	24	618	394	718	588
31S	GEHA BENEFIT PLAN	1.13%	789	16	33	142	183	189	226	347	442
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.45%	317	16	41	0	0	137	123	153	164
44	SAMBA HEALTH BENEFIT PLAN	0.38%	264	0	0	7	16	106	135	113	151
42	ASSOCIATION BENEFIT PLAN	0.25%	175	0	0	0	0	68	107	68	107
36S	POSTMASTERS BENEFIT PLAN	0.24%	168	1	12	7	6	91	51	99	69
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.17%	121	0	0	5	3	39	74	44	77
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.13%	89	2	1	11	10	53	12	66	23
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.09%	60	0	0	1	4	27	28	28	32
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.06%	42	0	0	3	0	21	18	24	18
Total		100.00%	69808	**3,181**	**7,176**	**9,543**	**15,316**	**18,851**	**15,741**	**31,575**	**38,233**

HBDF PLAN TOTALS (2002)

FOR CALIFORNIA (CA)
(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S	BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN S	26.74%	96237	3,340	7,443	13,311	16,985	35,773	19,385	52,424	43,813
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	19.92%	71708	4,013	11,282	7,614	9,829	21,788	17,182	33,415	38,293
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	16.31%	58720	4,698	12,209	7,825	11,047	13,531	9,410	26,054	32,666
LB	HEALTH NET	7.30%	26261	2,114	6,405	4,272	6,656	3,693	3,121	10,079	16,182
CY	PACIFICARE OF CALIFORNIA (FHP-CA)	6.68%	24043	2,067	5,475	5,329	6,729	2,583	1,860	9,979	14,064
31H	GEHA BENEFIT PLAN	5.88%	21154	586	1,408	2,336	4,404	6,088	6,332	9,010	12,144
M5	BLUE CROSS CALIFORNIACARE	3.55%	12790	881	2,736	2,731	3,953	1,217	1,272	4,829	7,961
45H	MAIL HANDLERS BENEFIT PLAN	2.20%	7902	333	890	1,296	2,044	1,663	1,676	3,292	4,610
32	NALC HEALTH BENEFIT PLAN	2.08%	7472	679	1,436	159	202	2,857	2,139	3,695	3,777
SJ	BLUE SHIELD OF CALIFORNIA ACCESS + HMO	1.80%	6483	554	1,592	1,403	1,765	643	526	2,600	3,883
2X	AETNA US HEALTHCARE, INC. - SOUTHERN CALIFORNIA/S/	1.53%	5519	335	1,130	1,419	2,156	237	242	1,991	3,528
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.32%	4755	424	743	83	116	2,217	1,172	2,724	2,031
45S	MAIL HANDLERS BENEFIT PLAN	0.90%	3227	92	215	768	755	703	694	1,563	1,664
9T	CIGNA HEALTHCARE OF CALIFORNIA	0.88%	3153	322	863	499	811	380	278	1,201	1,952
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	0.83%	3005	225	615	652	860	328	325	1,205	1,800
31S	GEHA BENEFIT PLAN	0.61%	2179	75	156	392	459	516	581	983	1,196
44	SAMBA HEALTH BENEFIT PLAN	0.29%	1047	0	0	69	61	406	511	475	572
42	ASSOCIATION BENEFIT PLAN	0.26%	927	0	0	0	504	246	177	246	681
36S	POSTMASTERS BENEFIT PLAN	0.17%	629	16	45	38	47	294	189	348	281
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.16%	573	39	113	0	0	232	189	271	302
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.12%	439	0	0	11	18	247	163	258	181
6Q	UNIVERSAL CARE, INC. OF CALIFORNIA	0.12%	425	31	80	125	110	44	35	200	225
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.11%	411	12	12	38	30	245	74	295	116
C4	UNITED HEALTH PLAN (CALIFORNIA)	0.07%	237	23	37	63	62	25	27	111	126
36H	POSTMASTERS BENEFIT PLAN	0.05%	165	16	10	25	13	78	23	119	46
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	161	0	0	48	50	18	45	66	95
5Z	WESTERN HEALTH ADVANTAGE	0.03%	96	6	10	27	31	14	8	47	49
43	PANAMA CANAL AREA BENEFIT PLAN	0.02%	83	0	0	0	0	54	29	54	29
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.02%	78	1	4	7	10	37	19	45	33
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.01%	39	0	1	21	6	7	4	28	11
Total		100.00%	359918	**20,882**	**54,910**	**50,561**	**69,713**	**96,164**	**67,688**	**167,607**	**######**

HBDF PLAN TOTALS (2002)

FOR COLORADO (CO)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	32.30%	24183	524	1343	2859	4935	8698	5824	12081	12102
65	KAISER FOUNDATION HP - COLORADO	18.76%	14043	775	2,138	2,562	3,708	2,588	2,272	5,925	8,118
D6H	PACIFICARE - COLORADO (FHP-CO)	17.28%	12934	1,333	2,390	2,967	2,766	2,051	1,427	6,351	6,583
45H	MAIL HANDLERS BENEFIT PLAN	7.86%	5885	213	674	646	1,425	1,195	1,732	2,054	3,831
D6S	PACIFICARE - COLORADO (FHP-CO)	6.65%	4981	83	974	711	2,384	188	641	982	3,999
31H	GEHA BENEFIT PLAN	4.90%	3668	80	194	387	795	950	1,262	1,417	2,251
XJH	ROCKY MOUNTAIN HMO (WAS CODE 88/COMM. TO EXP.)	2.28%	1705	100	239	236	359	401	370	737	968
45S	MAIL HANDLERS BENEFIT PLAN	2.13%	1597	34	96	282	369	349	467	665	932
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.88%	1405	68	167	251	644	108	167	427	978
32	NALC HEALTH BENEFIT PLAN	1.75%	1310	66	194	30	72	470	478	566	744
31S	GEHA BENEFIT PLAN	1.14%	855	21	58	181	251	147	197	349	506
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.11%	830	68	148	20	39	324	231	412	418
XJS	ROCKY MOUNTAIN HMO (WAS CODE 88/COMM. TO EXP.)	0.53%	399	35	90	55	90	43	86	133	266
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.46%	346	22	71	30	0	111	112	163	183
44	SAMBA HEALTH BENEFIT PLAN	0.23%	169	0	0	5	9	59	96	64	105
36S	POSTMASTERS BENEFIT PLAN	0.21%	159	12	13	9	6	77	42	98	61
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.17%	127	0	0	2	4	76	45	78	49
42	ASSOCIATION BENEFIT PLAN	0.13%	94	0	0	0	0	40	54	40	54
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	76	3	5	11	19	33	5	47	29
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.05%	36	0	0	1	5	0	30	1	35
36H	POSTMASTERS BENEFIT PLAN	0.03%	22	1	3	3	2	12	1	16	6
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.02%	15	0	0	2	1	5	7	7	8
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.02%	14	0	0	2	3	7	2	9	5
Q1	LOVELACE HEALTH PLAN	0.02%	12	1	1	2	1	5	2	8	4
Total		100.00%	**74865**	**3,439**	**8,798**	**11,254**	**17,887**	**17,937**	**15,550**	**32,630**	**42,235**

HBDF PLAN TOTALS (2002)

FOR CONNECTICUT (CT)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	**Plan**		**Total Contracts**	**Self**	**Family**	**Self**	**Family**	**Self**	**Family**	**Self**	**Family**
10S+	BCBS Standard plus plans with 10 or fewer enrollees	48.30%	13184	1350	2846	1291	2087	3434	2176	6075	7109
TE	CONNECTICARE	23.27%	6352	1,405	2,715	708	858	357	309	2,470	3,882
45H	MAIL HANDLERS BENEFIT PLAN	5.89%	1607	107	222	111	172	535	460	753	854
DP	HEALTH NET, INC. (PHYSICIANS HEALTH SERVICES OF CO	4.61%	1257	350	145	218	71	366	107	934	323
32	NALC HEALTH BENEFIT PLAN	4.59%	1252	70	78	7	6	618	473	695	557
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	3.55%	969	63	72	3	4	539	288	605	364
31H	GEHA BENEFIT PLAN	2.76%	753	41	96	37	74	246	259	324	429
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.50%	682	125	208	109	131	64	45	298	384
45S	MAIL HANDLERS BENEFIT PLAN	1.86%	507	33	39	76	44	158	157	267	240
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.82%	224	21	44	0	0	84	75	105	119
44	SAMBA HEALTH BENEFIT PLAN	0.38%	104	0	0	0	2	42	60	42	62
36S	POSTMASTERS BENEFIT PLAN	0.29%	78	1	4	1	2	47	23	49	29
31S	GEHA BENEFIT PLAN	0.28%	76	4	6	12	7	17	30	33	43
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.21%	58	8	28	7	14	0	1	15	43
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.15%	40	3	4	3	0	26	4	32	8
DA	BLUCHIP COORDINATED HEALTH PLANS (COORDINATED H	0.12%	32	2	0	12	18	0	0	14	18
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.08%	23	0	0	0	0	23	0	23	0
80	GHI HEALTH PLAN	0.08%	23	4	8	3	2	5	1	12	11
JV	FALLON COMMUNITY HEALTH PLAN	0.08%	23	1	8	2	9	0	3	3	20
42	ASSOCIATION BENEFIT PLAN	0.06%	16	0	0	0	0	16	0	16	0
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.04%	12	0	4	6	0	1	1	7	5
MX	MVP HEALTH PLAN - MID HUDSON DIVISION	0.04%	11	0	1	3	7	0	0	3	8
Y7H	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	11	0	0	4	4	3	0	7	4
Total		100.00%	**27294**	**3,588**	**6,528**	**2,613**	**3,512**	**6,581**	**4,472**	**12,782**	**14,512**

HBDF PLAN TOTALS (2002)

FOR DELAWARE (DE)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	71.76%	6982	495	973	731	1038	2089	1656	3315	3667
42	ASSOCIATION BENEFIT PLAN	5.66%	551	0	0	0	504	16	31	16	535
45H	MAIL HANDLERS BENEFIT PLAN	5.34%	520	19	37	56	101	150	157	225	295
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	4.00%	389	63	85	75	65	74	27	212	177
31H	GEHA BENEFIT PLAN	2.47%	240	2	9	16	26	75	112	93	147
32	NALC HEALTH BENEFIT PLAN	2.21%	215	8	17	2	1	91	96	101	114
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.83%	178	14	11	0	1	93	59	107	71
45S	MAIL HANDLERS BENEFIT PLAN	1.77%	172	15	4	25	20	47	61	87	85
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	1.41%	137	36	30	29	18	19	5	84	53
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	0.83%	81	7	12	18	23	12	9	37	44
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.59%	57	8	10	0	0	18	21	26	31
31S	GEHA BENEFIT PLAN	0.56%	54	6	9	9	4	14	12	29	25
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	0.53%	52	2	7	8	13	8	14	18	34
44	SAMBA HEALTH BENEFIT PLAN	0.32%	31	0	0	1	1	14	15	15	16
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.28%	27	5	13	2	6	1	0	8	19
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.17%	17	3	0	0	0	11	3	14	3
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.15%	15	0	0	0	0	0	15	0	15
FK	AMERIHEALTH HMO (KEYSTONE/DELAWARE VALLEY)	0.11%	11	3	2	3	3	0	0	6	5
Total		100.00%	**9729**	**686**	**1,219**	**975**	**1,824**	**2,732**	**2,293**	**4,393**	**5,336**

HBDF PLAN TOTALS (2002)

FOR DISTRICT OF COLUMBIA (DC)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	45.08%	81393	695	1238	29212	32420	13966	3862	43873	37520
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	17.74%	32023	411	1,010	11,198	14,189	3,899	1,316	15,508	16,515
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	9.75%	17609	175	439	7,075	9,525	283	112	7,533	10,076
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	8.22%	14835	199	471	5,658	7,569	639	299	6,496	8,339
31H	GEHA BENEFIT PLAN	3.95%	7132	57	115	2,309	3,745	546	360	2,912	4,220
JNS	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	3.26%	5886	14	45	2,642	3,026	111	48	2,767	3,119
45H	MAIL HANDLERS BENEFIT PLAN	2.61%	4712	119	201	1,591	1,840	655	306	2,365	2,347
2G	CAPITALCARE	1.83%	3310	35	59	1,449	1,595	129	43	1,613	1,697
42	ASSOCIATION BENEFIT PLAN	1.80%	3242	0	0	1,644	1,009	428	161	2,072	1,170
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.18%	2136	18	40	1,049	899	92	38	1,159	977
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.93%	1682	0	0	535	618	248	281	783	899
45S	MAIL HANDLERS BENEFIT PLAN	0.84%	1523	10	23	669	533	207	81	886	637
44	SAMBA HEALTH BENEFIT PLAN	0.66%	1196	0	0	670	458	52	16	722	474
31S	GEHA BENEFIT PLAN	0.62%	1127	6	10	483	509	88	31	577	550
32	NALC HEALTH BENEFIT PLAN	0.44%	786	36	98	226	210	131	85	393	393
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.42%	763	0	0	369	373	6	15	375	388
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.28%	510	60	69	86	122	126	47	272	238
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.15%	262	8	12	98	88	47	9	153	109
36S	POSTMASTERS BENEFIT PLAN	0.09%	157	4	4	63	31	44	11	111	46
36H	POSTMASTERS BENEFIT PLAN	0.05%	93	1	19	33	22	18	0	52	41
X8	HEALTHKEEPERS, INC. (HMO VIRGINIA - RICHMOND)	0.02%	44	0	0	21	23	0	0	21	23
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.02%	40	1	4	22	12	1	0	24	16
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.01%	24	0	0	16	8	0	0	16	8
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	0.01%	21	0	2	8	11	0	0	8	13
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.01%	15	2	0	7	5	1	0	10	5
9R	OPTIMA HEALTH PLAN	0.01%	15	0	1	10	4	0	0	10	5
2U	AETNA US HEALTHCARE, INC. - GEORGIA (ATLANTA/MACOI	0.01%	13	0	0	4	9	0	0	4	9
26	HEALTHAMERICA OF PENNSYLVANIA (WESTERN PENNSYL	0.01%	11	0	0	5	6	0	0	5	6
Total		100.00%	**180560**	**1,851**	**3,860**	**67,152**	**78,859**	**21,717**	**7,121**	**90,720**	**89,840**

HBDF PLAN TOTALS (2002)

FOR FLORIDA (FL)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	64.03%	139340	5778	16843	13048	24529	44769	34373	63595	75745
45H	MAIL HANDLERS BENEFIT PLAN	7.62%	16574	623	2,064	1,694	3,673	3,681	4,839	5,998	10,576
31H	GEHA BENEFIT PLAN	5.30%	11542	323	812	566	1,192	4,180	4,469	5,069	6,473
EM	AV-MED HEALTH PLAN - MIAMI (SOUTH FLORIDA)	3.99%	8688	1,202	1,519	2,135	1,623	1,432	777	4,769	3,919
32	NALC HEALTH BENEFIT PLAN	3.96%	8611	351	963	92	149	3,608	3,448	4,051	4,560
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.84%	6171	480	1,492	870	1,759	589	981	1,939	4,232
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.79%	6080	310	600	30	76	3,079	1,985	3,419	2,661
45S	MAIL HANDLERS BENEFIT PLAN	2.75%	5985	188	401	791	1,184	1,501	1,920	2,480	3,505
EE	HUMANA MEDICAL PLAN - SOUTH FLORIDA	1.60%	3476	270	1,233	469	1,034	238	232	977	2,499
31S	GEHA BENEFIT PLAN	0.80%	1732	43	153	182	282	479	593	704	1,028
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.68%	1473	88	241	0	0	561	583	649	824
5E	FOUNDATION HLTH A FL HP-DADE/BROWARD (SOUTHERN)	0.57%	1238	91	357	243	402	85	60	419	819
EA	CAPITAL HEALTH PLAN	0.53%	1159	90	313	175	313	107	161	372	787
42	ASSOCIATION BENEFIT PLAN	0.50%	1078	0	0	0	0	595	483	595	483
44	SAMBA HEALTH BENEFIT PLAN	0.49%	1074	0	0	51	51	423	549	474	600
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.42%	923	0	0	27	17	495	384	522	401
3N	HIP HEALTH PLAN OF FLORIDA - SOUTH FLORIDA	0.27%	591	74	159	117	97	102	42	293	298
43	PANAMA CANAL AREA BENEFIT PLAN	0.20%	445	0	0	2	2	198	243	200	245
36S	POSTMASTERS BENEFIT PLAN	0.20%	437	10	5	13	17	276	116	299	138
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.14%	307	10	14	18	10	210	45	238	69
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.08%	172	0	0	10	26	30	106	40	132
80	GHI HEALTH PLAN	0.05%	103	2	2	6	3	69	21	77	26
36H	POSTMASTERS BENEFIT PLAN	0.05%	101	3	5	10	10	61	12	74	27
89	TRIPLE - S	0.04%	77	1	3	1	12	24	36	26	51
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.02%	49	0	0	6	4	19	20	25	24
4A	TOTAL HEALTH CHOICE	0.01%	30	3	5	7	8	4	3	14	16
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.01%	30	0	0	2	0	19	9	21	9
YM	NYLCARE HEALTH PLANS OF THE GULF COAST/AUSTIN/CC	0.01%	30	0	0	12	18	0	0	12	18
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.01%	21	0	0	2	1	14	4	16	5
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.01%	21	0	0	2	0	15	4	17	4
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.01%	20	1	3	2	1	6	7	9	11
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.01%	16	0	0	3	2	7	4	10	6
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.01%	14	0	0	0	2	7	5	7	7
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.01%	14	0	0	1	1	7	5	8	6
Total		100.00%	**217622**	**9,941**	**27,187**	**20,587**	**36,498**	**66,890**	**56,519**	**97,418**	**######**

HBDF PLAN TOTALS (2002)

FOR FOREIGN (FR)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	42.07%	27030	13	60	9147	15493	1352	965	10512	16518
43	PANAMA CANAL AREA BENEFIT PLAN	14.72%	9457	0	0	3	13	4,115	5,326	4,118	5,339
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	8.34%	5355	0	0	2,280	2,184	448	443	2,728	2,627
45H	MAIL HANDLERS BENEFIT PLAN	7.32%	4701	0	6	1,593	2,608	242	252	1,835	2,866
JKH	PACIFICARE HEALTH INSURANCE COMPANY MICRONESIA	4.59%	2950	20	101	265	824	644	1,096	929	2,021
45S	MAIL HANDLERS BENEFIT PLAN	3.32%	2130	0	1	697	1,142	150	140	847	1,283
44	SAMBA HEALTH BENEFIT PLAN	3.03%	1945	0	0	996	919	14	16	1,010	935
31H	GEHA BENEFIT PLAN	2.94%	1888	9	46	538	973	182	140	729	1,159
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.67%	1073	1	2	331	687	26	26	358	715
42	ASSOCIATION BENEFIT PLAN	0.96%	618	0	0	0	504	52	62	52	566
JKS	PACIFICARE HEALTH INSURANCE COMPANY MICRONESIA	0.78%	502	1	0	37	97	121	246	159	343
31S	GEHA BENEFIT PLAN	0.57%	364	1	1	111	208	18	25	130	234
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.51%	327	9	89	49	84	52	44	110	217
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.46%	296	0	0	141	137	11	7	152	144
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.40%	260	0	0	146	113	0	1	146	114
89	TRIPLE - S	0.40%	255	0	2	70	178	5	0	75	180
80	GHI HEALTH PLAN	0.39%	251	1	0	153	86	9	2	163	88
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.37%	240	0	0	135	101	3	1	138	102
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.36%	232	0	0	94	96	22	20	116	116
U4	THE HEALTH PLAN OF THE UPPER OHIO VALLEY	0.34%	218	0	0	100	118	0	0	100	118
CY	PACIFICARE OF CALIFORNIA (FHP-CA)	0.33%	213	0	0	96	113	2	2	98	115
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.33%	212	0	2	57	119	18	16	75	137
32	NALC HEALTH BENEFIT PLAN	0.33%	210	7	24	39	89	26	25	72	138
LB	HEALTH NET	0.30%	193	0	0	84	104	2	3	86	107
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.18%	118	0	0	56	51	6	5	62	56
M5	BLUE CROSS CALIFORNIACARE	0.18%	116	0	0	54	61	1	0	55	61
YM	NYLCARE HEALTH PLANS OF THE GULF COAST/AUSTIN/CC	0.17%	111	0	0	29	81	0	1	29	82
2X	AETNA US HEALTHCARE, INC. - SOUTHERN CALIFORNIA/S/	0.16%	105	0	0	50	55	0	0	50	55
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	0.16%	102	0	0	46	56	0	0	46	56
QA	INDEPENDENT HEALTH ASSOCIATION - WESTERN NEW YC	0.13%	84	0	0	35	48	1	0	36	48
SJ	BLUE SHIELD OF CALIFORNIA ACCESS + HMO	0.13%	83	0	0	35	47	1	0	36	47
R5	HEALTH MAINTENANCE PLAN (HMP)	0.13%	82	0	0	22	60	0	0	22	60
TE	CONNECTICARE	0.12%	80	0	0	33	47	0	0	33	47
54	GROUP HEALTH COOPERATIVE OF PUGET SOUND/WESTEI	0.12%	78	0	0	27	47	1	3	28	50
RD	AETNA US HEALTHCARE, INC. - OHIO (GREATER CINCINNA	0.12%	78	0	0	53	25	0	0	53	25

GF	PACIFICARE OF TEXAS (SAN ANTONIO)	0.12%	75	0	0	25	50	0	0	25	50
9K	ALTIUS HEALTH PLANS, INC. (PACIFICARE OF UTAH)	0.11%	72	0	0	12	60	0	0	12	60
2U	AETNA US HEALTHCARE, INC. - GEORGIA (ATLANTA/MACOI	0.11%	69	0	0	19	49	0	1	19	50
EE	HUMANA MEDICAL PLAN - SOUTH FLORIDA	0.11%	69	0	0	19	49	0	1	19	50
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	64	0	1	26	21	14	2	40	24
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	0.10%	64	0	0	17	44	2	1	19	45
8W	UPMC HEALTH PLAN	0.09%	61	0	0	20	41	0	0	20	41
52	HEALTH ALLIANCE PLAN	0.09%	57	0	0	23	30	1	3	24	33
F8	KAISER FOUNDATION HP - GEORGIA	0.09%	57	0	0	26	31	0	0	26	31
YX	NYLCARE HEALTH PLANS OF THE SOUTHWEST (DALLAS) ('	0.09%	57	0	0	23	34	0	0	23	34
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.09%	55	1	1	31	19	3	0	35	20
9G	BLUECHOICE OF MISSOURI (WAS CODE M4)	0.08%	54	0	0	16	38	0	0	16	38
WQ	AETNA US HEALTHCARE, INC. - ARIZONA	0.08%	53	0	0	23	28	1	1	24	29
75	HUMANA HEALTH PLAN - CHICAGO	0.08%	51	0	0	16	35	0	0	16	35
EM	AV-MED HEALTH PLAN - MIAMI (SOUTH FLORIDA)	0.08%	51	0	0	32	19	0	0	32	19
57H	KAISER FOUNDATION HP - NORTHWEST	0.08%	50	0	0	20	26	2	2	22	28
63H	KAISER FOUNDATION HP - HAWAII	0.08%	50	0	0	11	26	8	5	19	31
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.08%	50	0	0	21	28	0	1	21	29
LX	BLUE CARE NETWORK - SOUTHEAST MICHIGAN	0.08%	50	0	0	22	27	1	0	23	27
SG	CAPITAL DISTRICT PHYSICIANS' HP - CAPITAL REGION	0.07%	48	0	0	20	28	0	0	20	28
17	UNICARE HEALTH PLANS OF THE MIDWEST (RUSH PRUDEI	0.07%	46	0	0	21	25	0	0	21	25
3U	UNITED HEALTHCARE OF WESTERN OHIO - DAYTON	0.07%	46	0	0	12	33	0	1	12	34
A3	PACIFICARE OF ARIZONA - METRO	0.07%	46	0	0	14	31	0	1	14	32
D6H	PACIFICARE - COLORADO (FHP-CO)	0.07%	45	0	0	20	25	0	0	20	25
36S	POSTMASTERS BENEFIT PLAN	0.07%	44	0	1	16	18	8	1	24	20
Q1	LOVELACE HEALTH PLAN	0.07%	42	0	0	15	27	0	0	15	27
2V	AMCARE HEALTH PLANS OF TEXAS (HOUSTON, EL PASO A	0.06%	37	0	0	16	21	0	0	16	21
5E	FOUNDATION HLTH A FL HP-DADE/BROWARD (SOUTHERN)	0.06%	36	0	0	12	24	0	0	12	24
Q8	UNIVERA HEATHCARE - WNY (HEALTHCAREPLAN)	0.06%	36	0	0	13	23	0	0	13	23
2N	PACIFICARE OF OKLAHOMA - OKLAHOMA CITY	0.05%	35	0	0	9	25	0	1	9	26
9T	CIGNA HEALTHCARE OF CALIFORNIA	0.05%	33	0	0	9	23	1	0	10	23
A7	HEALTHNET OF ARIZONA, INC. (INTERGROUP OF ARIZONA	0.05%	33	0	0	9	24	0	0	9	24
JNS	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.05%	32	0	0	16	16	0	0	16	16
26	HEALTHAMERICA OF PENNSYLVANIA (WESTERN PENNSYL	0.05%	31	0	0	12	18	1	0	13	18
HA	COVENTRY HEALTHCARE OF KANSAS CITY (KAISER FOUNI	0.05%	31	0	0	10	21	0	0	10	21
EG	M-CARE	0.05%	30	0	0	4	26	0	0	4	26
FK	AMERIHEALTH HMO (KEYSTONE/DELAWARE VALLEY)	0.05%	30	0	0	8	22	0	0	8	22
64	KAISER FOUNDATION HP - OHIO (CLEVELAND)	0.04%	28	0	0	9	18	0	1	9	19
65	KAISER FOUNDATION HP - COLORADO	0.04%	27	0	0	10	15	1	1	11	16
7D	AETNA US HEALTHCARE, INC. - OHIO (CLEVELAND/TOLEDC	0.04%	27	0	0	14	13	0	0	14	13
PX	CIMARRON HEALTH PLAN, INC. (QUALMED PLANS FOR HEA	0.04%	25	0	0	7	17	1	0	8	17
9R	OPTIMA HEALTH PLAN	0.04%	24	0	0	10	14	0	0	10	14

UR	HUMANA HEALTH PLAN - TEXAS (SAN ANTONIO)	0.04%	24	0	0	6	17	1	0	7	17
D6S	PACIFICARE - COLORADO (FHP-CO)	0.04%	23	0	0	4	19	0	0	4	19
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.03%	22	0	0	7	12	3	0	10	12
8J	AETNA US HEALTHCARE, INC. - WASHINGTON	0.03%	21	0	0	14	7	0	0	14	7
P2	PRESBYTERIAN HEALTH PLAN (FHP-NEW MEXICO)	0.03%	21	0	0	4	17	0	0	4	17
2G	CAPITALCARE	0.03%	19	0	0	8	10	1	0	9	10
FX	HEALTH ALLIANCE HMO (CARLECARE)	0.03%	19	0	0	6	13	0	0	6	13
K9	PACIFICARE OF NEVADA (FHP - NEVADA)	0.03%	18	0	0	5	13	0	0	5	13
36H	POSTMASTERS BENEFIT PLAN	0.03%	17	0	0	9	2	5	1	14	3
VRH	GROUP HEALTH COOPERATIVE OF PUGET SOUND/EASTEF	0.03%	17	0	0	4	13	0	0	4	13
MM	GROUP HEALTH PLAN	0.02%	16	0	0	5	10	0	1	5	11
D2	HUMANA HEALTH PLAN - LOUISVILLE, LEXINGTON & NO KY	0.02%	15	0	0	8	7	0	0	8	7
MK	BLUE CHOICE OF NEW YORK	0.02%	15	0	0	5	9	1	0	6	9
NM	HEALTH PLAN OF NEVADA	0.02%	15	0	0	5	10	0	0	5	10
X8	HEALTHKEEPERS, INC. (HMO VIRGINIA - RICHMOND)	0.02%	15	0	0	6	9	0	0	6	9
8L	AETNA US HEALTHCARE, INC. - NEVADA	0.02%	14	0	0	6	8	0	0	6	8
DF	THE OATH (HEALTH PARTNERS OF ALABAMA)	0.02%	14	0	0	11	3	0	0	11	3
WB	PACIFICARE OF WASHINGTON	0.02%	14	0	0	7	7	0	0	7	7
53H	HEALTHPARTNERS SELECT (GROUP HEALTH PLAN)	0.02%	12	0	0	6	6	0	0	6	6
7L	AETNA US HEALTHCARE, INC. - KENTUCKY (LEXINGTON)/(	0.02%	12	0	0	1	11	0	0	1	11
IN	THE M*PLAN	0.02%	11	0	0	2	9	0	0	2	9
L4	HMO HEALTH OHIO - NORTHEAST OHIO/CLEVELAND	0.02%	11	0	0	5	6	0	0	5	6
Total		100.00%	**64243**	**63**	**337**	**18,424**	**28,948**	**7,579**	**8,892**	**26,066**	**38,177**

HBDF PLAN TOTALS (2002)

FOR GEORGIA (GA)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	54.37%	71563	1451	5188	9945	18818	21319	14842	32715	38848
45H	MAIL HANDLERS BENEFIT PLAN	12.81%	16864	429	1,577	2,395	5,846	2,937	3,680	5,761	11,103
F8	KAISER FOUNDATION HP - GEORGIA	8.21%	10802	747	2,258	2,526	3,716	836	719	4,109	6,693
2U	AETNA US HEALTHCARE, INC. - GEORGIA (ATLANTA/MACOI	6.67%	8779	568	2,064	2,177	2,932	568	470	3,313	5,466
31H	GEHA BENEFIT PLAN	5.43%	7150	148	518	667	1,569	1,923	2,325	2,738	4,412
45S	MAIL HANDLERS BENEFIT PLAN	3.31%	4350	100	212	793	1,343	908	994	1,801	2,549
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.50%	3290	154	593	750	1,361	183	249	1,087	2,203
32	NALC HEALTH BENEFIT PLAN	2.03%	2678	74	358	77	138	995	1,036	1,146	1,532
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.54%	2028	145	389	49	71	797	577	991	1,037
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.42%	1864	98	536	0	0	569	661	667	1,197
31S	GEHA BENEFIT PLAN	0.67%	883	16	41	155	253	192	226	363	520
36S	POSTMASTERS BENEFIT PLAN	0.27%	355	12	8	21	27	196	91	229	126
44	SAMBA HEALTH BENEFIT PLAN	0.23%	304	0	0	17	13	118	156	135	169
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.12%	153	2	8	8	12	99	24	109	44
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.07%	86	0	0	8	18	15	45	23	63
42	ASSOCIATION BENEFIT PLAN	0.06%	83	0	0	0	0	52	31	52	31
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.06%	82	0	0	7	6	39	30	46	36
EM	AV-MED HEALTH PLAN - MIAMI (SOUTH FLORIDA)	0.06%	82	1	0	31	46	3	1	35	47
36H	POSTMASTERS BENEFIT PLAN	0.05%	63	4	7	9	4	33	6	46	17
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.03%	40	0	1	9	11	8	11	17	23
43	PANAMA CANAL AREA BENEFIT PLAN	0.03%	35	0	0	0	0	21	14	21	14
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.02%	27	0	0	3	5	14	5	17	10
80	GHI HEALTH PLAN	0.01%	17	2	0	1	0	9	5	12	5
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.01%	15	1	0	3	2	8	1	12	3
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.01%	12	2	0	5	3	1	1	8	4
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.01%	11	0	2	3	2	4	0	7	4
Total		100.00%	**131616**	**3,954**	**13,760**	**19,659**	**36,196**	**31,847**	**26,200**	**55,460**	**76,156**

HBDF PLAN TOTALS (2002)

FOR HAWAII (HI)
(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	71.73%	27069	526	1,395	4,477	7,361	7,202	6,108	12,205	14,864
63H	KAISER FOUNDATION HP - HAWAII	20.35%	7678	109	241	1,239	2,060	2,374	1,655	3,722	3,956
10S+	BCBS Standard plus plans with 10 or fewer enrollees	3.90%	1470	10	29	261	405	501	264	772	698
63S	KAISER FOUNDATION HP - HAWAII	2.24%	844	16	14	299	146	235	134	550	294
45H	MAIL HANDLERS BENEFIT PLAN	0.58%	219	4	11	38	75	48	43	90	129
31H	GEHA BENEFIT PLAN	0.48%	180	1	3	25	31	58	62	84	96
32	NALC HEALTH BENEFIT PLAN	0.21%	79	7	8	0	7	29	28	36	43
45S	MAIL HANDLERS BENEFIT PLAN	0.14%	51	0	0	13	14	16	8	29	22
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.09%	33	1	6	0	0	16	10	17	16
44	SAMBA HEALTH BENEFIT PLAN	0.08%	29	0	0	0	1	11	17	11	18
31S	GEHA BENEFIT PLAN	0.06%	21	0	1	3	4	7	6	10	11
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.05%	18	0	3	2	2	7	4	9	9
42	ASSOCIATION BENEFIT PLAN	0.04%	16	0	0	0	0	8	8	8	8
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.04%	16	0	0	2	9	5	0	7	9
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	0.03%	12	0	0	2	3	5	2	7	5
Total		100.00%	**37735**	**674**	**1,711**	**6,361**	**10,118**	**10,522**	**8,349**	**17,557**	**20,178**

HBDF PLAN TOTALS (2002)

FOR IOWA (IA)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	59.82%	18145	907	3404	1435	2963	5053	4383	7395	10750
45H	MAIL HANDLERS BENEFIT PLAN	7.18%	2178	152	457	183	385	430	571	765	1,413
SV	COVENTRY HEALTH CARE OF IOWA, INC. (PRINCIPAL HEAL	7.11%	2157	319	707	337	493	161	140	817	1,340
31H	GEHA BENEFIT PLAN	6.05%	1834	45	219	65	151	642	712	752	1,082
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	5.19%	1574	57	372	0	0	501	644	558	1,016
47H	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	3.66%	1109	85	165	3	3	518	335	606	503
32	NALC HEALTH BENEFIT PLAN	3.55%	1077	53	102	5	5	479	433	537	540
45S	MAIL HANDLERS BENEFIT PLAN	2.30%	698	48	63	107	121	166	193	321	377
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.67%	507	64	150	51	129	38	75	153	354
YHH	JOHN DEERE HEALTH PLAN (HERITAGE NATIONAL HP)(WA	0.91%	277	38	65	50	39	43	42	131	146
31S	GEHA BENEFIT PLAN	0.80%	243	17	28	10	37	52	99	79	164
3Q	SECURECARE OF IOWA (EASTERN)	0.76%	232	7	59	34	105	8	19	49	183
36S	POSTMASTERS BENEFIT PLAN	0.47%	144	7	2	2	0	94	39	103	41
FX	HEALTH ALLIANCE HMO (CARLECARE)	0.24%	72	3	12	23	27	4	3	30	42
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.12%	35	2	2	2	1	27	1	31	4
44	SAMBA HEALTH BENEFIT PLAN	0.12%	35	0	0	2	1	17	15	19	16
36H	POSTMASTERS BENEFIT PLAN	0.05%	16	0	0	1	0	15	0	16	0
Total		100.00%	**30333**	**1,804**	**5,807**	**2,310**	**4,460**	**8,248**	**7,704**	**12,362**	**17,971**

HBDF PLAN TOTALS (2002)

FOR IDAHO (ID)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	61.40%	11644	298	1017	1735	3270	2644	2680	4677	6967
45H	MAIL HANDLERS BENEFIT PLAN	11.14%	2113	55	259	254	606	327	612	636	1,477
31H	GEHA BENEFIT PLAN	9.67%	1833	28	92	117	302	532	762	677	1,156
45S	MAIL HANDLERS BENEFIT PLAN	4.37%	829	25	48	155	221	146	234	326	503
VRH	GROUP HEALTH COOPERATIVE OF PUGET SOUND/EASTEF	3.01%	570	42	66	93	109	117	143	252	318
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.85%	540	13	71	109	236	42	69	164	376
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.89%	359	11	47	3	3	157	138	171	188
32	NALC HEALTH BENEFIT PLAN	1.72%	326	12	37	10	13	107	147	129	197
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.57%	298	16	92	0	0	79	111	95	203
31S	GEHA BENEFIT PLAN	1.20%	228	3	10	35	37	42	101	80	148
36S	POSTMASTERS BENEFIT PLAN	0.41%	78	2	3	2	2	49	20	53	25
44	SAMBA HEALTH BENEFIT PLAN	0.25%	47	0	0	0	1	14	32	14	33
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.16%	30	0	0	0	0	15	15	15	15
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.15%	28	1	0	0	0	23	4	24	4
42	ASSOCIATION BENEFIT PLAN	0.08%	16	0	0	0	0	16	0	16	0
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.07%	13	0	0	0	0	8	5	8	5
54	GROUP HEALTH COOPERATIVE OF PUGET SOUND/WESTEI	0.06%	12	0	0	2	2	5	3	7	5
Total		100.00%	**18964**	**506**	**1,742**	**2,515**	**4,802**	**4,323**	**5,076**	**7,344**	**11,620**

HBDF PLAN TOTALS (2002)

FOR ILLINOIS (IL)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	53.97%	68009	5439	12387	8284	12812	18467	10620	32190	35819
75	HUMANA HEALTH PLAN - CHICAGO	10.08%	12698	1,566	4,327	1,769	2,280	1,849	907	5,184	7,514
45H	MAIL HANDLERS BENEFIT PLAN	6.12%	7716	531	1,326	1,087	1,854	1,519	1,399	3,137	4,579
17	UNICARE HEALTH PLANS OF THE MIDWEST (RUSH PRUDEI	5.59%	7040	870	2,576	1,130	1,498	617	349	2,617	4,423
31H	GEHA BENEFIT PLAN	4.42%	5573	240	767	475	888	1,597	1,606	2,312	3,261
32	NALC HEALTH BENEFIT PLAN	3.86%	4861	386	792	39	71	1,967	1,606	2,392	2,469
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.41%	3040	308	558	20	45	1,364	745	1,692	1,348
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.06%	2595	302	762	478	709	168	176	948	1,647
FX	HEALTH ALLIANCE HMO (CARLECARE)	1.97%	2482	208	481	308	555	478	452	994	1,488
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.73%	2182	146	562	0	0	693	781	839	1,343
45S	MAIL HANDLERS BENEFIT PLAN	1.66%	2094	108	195	375	542	450	424	933	1,161
GE	PERSONALCARE'S HMO	1.34%	1692	151	399	248	421	242	231	641	1,051
9F	OSF HEALTH PLANS	1.11%	1398	207	570	119	340	73	89	399	999
MMH	GROUP HEALTH PLAN	0.96%	1206	31	176	187	397	229	186	447	759
YH	JOHN DEERE HEALTH PLAN (HERITAGE NATIONAL HP)(WA	0.57%	713	59	61	269	242	52	30	380	333
31S	GEHA BENEFIT PLAN	0.55%	695	38	90	123	166	131	147	292	403
9G	BLUECHOICE OF MISSOURI (WAS CODE M4)	0.36%	448	11	66	83	197	41	50	135	313
7M	MERCY HEALTH PLANS OF MISSOURI	0.29%	360	21	35	82	132	52	38	155	205
76	UNION HEALTH SERVICE	0.25%	313	44	91	40	50	60	28	144	169
44	SAMBA HEALTH BENEFIT PLAN	0.24%	303	0	0	23	23	106	151	129	174
36S	POSTMASTERS BENEFIT PLAN	0.22%	283	11	17	2	14	152	87	165	118
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.09%	113	5	6	12	9	66	15	83	30
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.06%	71	0	0	6	3	62	0	68	3
42	ASSOCIATION BENEFIT PLAN	0.04%	48	0	0	0	0	40	8	40	8
36H	POSTMASTERS BENEFIT PLAN	0.03%	42	4	5	5	3	22	3	31	11
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.03%	34	0	0	10	12	12	0	22	12
43	PANAMA CANAL AREA BENEFIT PLAN	0.01%	12	0	0	0	0	9	3	9	3
Total		100.00%	**126021**	**10,686**	**26,249**	**15,174**	**23,263**	**30,518**	**20,131**	**56,378**	**69,643**

HBDF PLAN TOTALS (2002)

FOR INDIANA (IN)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	57.91%	33166	1675	5408	3246	6744	9155	6938	14076	19090
45H	MAIL HANDLERS BENEFIT PLAN	10.11%	5792	295	890	587	1,534	1,127	1,359	2,009	3,783
IN	THE M*PLAN	8.72%	4997	364	1,167	961	1,292	724	489	2,049	2,948
31H	GEHA BENEFIT PLAN	3.70%	2121	69	247	124	283	672	726	865	1,256
32	NALC HEALTH BENEFIT PLAN	3.70%	2120	106	299	15	27	866	807	987	1,133
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.67%	1527	119	239	8	18	702	441	829	698
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.59%	1481	82	350	0	0	496	553	578	903
45S	MAIL HANDLERS BENEFIT PLAN	2.50%	1431	67	164	221	317	322	340	610	821
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.32%	757	70	226	107	195	65	94	242	515
D2	HUMANA HEALTH PLAN - LOUISVILLE, LEXINGTON & NO KY	1.29%	737	12	37	262	209	118	99	392	345
6Y	ADVANTAGE HEALTH PLAN, INC. (SAGAMORE ADVANTAGE	1.07%	610	46	142	104	198	70	50	220	390
DQ	PHYSICIANS HEALTH PLAN OF NORTHERN INDIANA	0.99%	566	63	207	65	159	29	43	157	409
31S	GEHA BENEFIT PLAN	0.70%	401	18	54	64	114	60	91	142	259
H3	WELBORN HMO - INDIANA	0.65%	370	64	94	51	47	61	53	176	194
G2	ARNETT HMO HEALTH PLAN	0.48%	274	60	73	31	28	50	32	141	133
75	HUMANA HEALTH PLAN - CHICAGO	0.35%	198	37	72	10	22	38	19	85	113
36S	POSTMASTERS BENEFIT PLAN	0.32%	185	7	8	1	4	115	50	123	62
7L	AETNA US HEALTHCARE, INC. - KENTUCKY (LEXINGTON)/(	0.29%	164	5	10	51	77	12	9	68	96
44	SAMBA HEALTH BENEFIT PLAN	0.18%	105	0	0	3	6	40	56	43	62
17	UNICARE HEALTH PLANS OF THE MIDWEST (RUSH PRUDEI	0.18%	104	18	37	6	14	18	11	42	62
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.09%	53	1	2	2	2	40	6	43	10
42	ASSOCIATION BENEFIT PLAN	0.06%	35	0	0	0	0	20	15	20	15
36H	POSTMASTERS BENEFIT PLAN	0.05%	27	1	0	1	0	17	8	19	8
RD	AETNA US HEALTHCARE, INC. - OHIO (GREATER CINCINNA	0.03%	20	2	6	0	0	8	4	10	10
FX	HEALTH ALLIANCE HMO (CARLECARE)	0.03%	17	0	0	0	3	12	2	12	5
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.03%	15	0	0	0	0	15	0	15	0
Total		100.00%	**57273**	**3,181**	**9,732**	**5,920**	**11,293**	**14,852**	**12,295**	**23,953**	**33,320**

HBDF PLAN TOTALS (2002)

FOR KANSAS (KS)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	**Plan**		**Total Contracts**	**Self**	**Family**	**Self**	**Family**	**Self**	**Family**	**Self**	**Family**
10S+	BCBS Standard plus plans with 10 or fewer enrollees	59.38%	23274	741	2910	2407	5256	6638	5322	9786	13488
31H	GEHA BENEFIT PLAN	8.25%	3232	92	338	225	406	1,073	1,098	1,390	1,842
45H	MAIL HANDLERS BENEFIT PLAN	7.91%	3101	128	410	376	931	523	733	1,027	2,074
HA	COVENTRY HEALTHCARE OF KANSAS CITY (KAISER FOUNI	5.70%	2236	110	435	498	894	138	161	746	1,490
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	3.64%	1425	108	343	245	551	55	123	408	1,017
MSH	HUMANA KANSAS CITY - KANSAS CITY	2.98%	1167	73	215	281	380	136	82	490	677
32	NALC HEALTH BENEFIT PLAN	2.52%	987	38	111	11	24	402	401	451	536
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.47%	970	34	233	0	0	314	389	348	622
45S	MAIL HANDLERS BENEFIT PLAN	1.85%	727	32	57	131	217	131	159	294	433
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.74%	681	43	97	4	10	298	229	345	336
7W	COVENTRY HEALTH CARE OF KANSAS (PRINCIPAL HEATH(	1.48%	582	53	154	86	189	46	54	185	397
31S	GEHA BENEFIT PLAN	0.94%	370	13	36	59	80	75	107	147	223
VA	PREFERRED PLUS OF KANSAS	0.33%	131	15	16	53	20	16	11	84	47
MSS	HUMANA KANSAS CITY - KANSAS CITY	0.32%	126	8	16	24	62	6	10	38	88
36S	POSTMASTERS BENEFIT PLAN	0.22%	85	3	6	2	0	42	32	47	38
44	SAMBA HEALTH BENEFIT PLAN	0.15%	57	0	0	1	3	19	34	20	37
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.07%	27	0	2	3	3	17	2	20	7
42	ASSOCIATION BENEFIT PLAN	0.05%	19	0	0	0	0	4	15	4	15
Total		100.00%	**39197**	**1,491**	**5,379**	**4,406**	**9,026**	**9,933**	**8,962**	**15,830**	**23,367**

HBDF PLAN TOTALS (2002)

FOR KENTUCKY (KY)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	59.54%	28973	997	3253	3050	6040	9114	6519	13161	15812
45H	MAIL HANDLERS BENEFIT PLAN	9.85%	4795	104	469	553	1,236	1,043	1,390	1,700	3,095
D2	HUMANA HEALTH PLAN - LOUISVILLE, LEXINGTON & NO KY	5.72%	2781	232	473	433	530	615	498	1,280	1,501
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	4.51%	2194	171	428	382	717	251	245	804	1,390
31H	GEHA BENEFIT PLAN	3.60%	1750	45	188	87	209	602	619	734	1,016
45S	MAIL HANDLERS BENEFIT PLAN	2.71%	1320	33	76	205	336	311	359	549	771
RD	AETNA US HEALTHCARE, INC. - OHIO (GREATER CINCINNA	2.49%	1214	43	56	562	345	136	72	741	473
32	NALC HEALTH BENEFIT PLAN	2.47%	1202	55	139	6	28	495	479	556	646
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.26%	1101	53	287	0	0	361	400	414	687
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.81%	880	42	96	4	9	433	296	479	401
7L	AETNA US HEALTHCARE, INC. - KENTUCKY (LEXINGTON)/(	1.63%	792	55	176	180	286	45	50	280	512
3U	UNITED HEALTHCARE OF WESTERN OHIO - DAYTON	1.05%	511	14	70	159	196	29	43	202	309
R5	HEALTH MAINTENANCE PLAN (HMP)	0.88%	429	4	16	173	232	2	2	179	250
31S	GEHA BENEFIT PLAN	0.61%	297	15	23	48	90	55	66	118	179
36S	POSTMASTERS BENEFIT PLAN	0.42%	206	6	9	1	0	130	60	137	69
44	SAMBA HEALTH BENEFIT PLAN	0.20%	99	0	0	3	1	54	41	57	42
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.08%	37	0	0	1	3	27	6	28	9
42	ASSOCIATION BENEFIT PLAN	0.07%	35	0	0	0	0	20	15	20	15
36H	POSTMASTERS BENEFIT PLAN	0.06%	27	4	1	0	0	20	2	24	3
Y7H	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	18	0	0	4	8	6	0	10	8
Total		100.00%	**48661**	**1,873**	**5,760**	**5,851**	**10,266**	**13,749**	**11,162**	**21,473**	**27,188**

HBDF PLAN TOTALS (2002)

FOR LOUSIANNA (LA)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	57.19%	27036	799	3415	3239	7879	6789	4915	10827	16209
45H	MAIL HANDLERS BENEFIT PLAN	10.23%	4835	186	827	580	1,464	820	958	1,586	3,249
31H	GEHA BENEFIT PLAN	8.17%	3863	101	489	268	759	1,087	1,159	1,456	2,407
ZH	AMCARE HEALTH PLANS OF LOUISIANA (NEW ORLEANS AF	3.75%	1771	110	361	415	732	78	75	603	1,168
32	NALC HEALTH BENEFIT PLAN	3.46%	1638	66	342	18	48	527	637	611	1,027
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	3.16%	1494	98	298	12	35	569	482	679	815
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	3.10%	1467	112	433	246	512	70	94	428	1,039
45S	MAIL HANDLERS BENEFIT PLAN	2.60%	1229	33	76	205	452	219	244	457	772
BJ	COVENTRY HEALTHCARE OF LOUISIANA - NEW ORLEANS	2.46%	1165	56	251	227	486	61	84	344	821
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.73%	817	50	291	0	0	205	271	255	562
ZQ	AMCARE HEALTH PLANS (BATON ROUGE, ALEXANDRIA, SH	1.24%	585	58	219	94	143	31	40	183	402
JA	COVENTRY HEALTHCARE OF LOUISIANA - BATON ROUGE (	1.08%	510	25	132	55	153	86	59	166	344
31S	GEHA BENEFIT PLAN	0.81%	383	14	33	56	134	73	73	143	240
36S	POSTMASTERS BENEFIT PLAN	0.28%	131	2	4	3	5	78	39	83	48
44	SAMBA HEALTH BENEFIT PLAN	0.26%	123	0	0	12	14	34	63	46	77
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.22%	106	0	3	8	3	75	17	83	23
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.09%	41	0	0	6	5	15	15	21	20
42	ASSOCIATION BENEFIT PLAN	0.06%	28	0	0	0	0	20	8	20	8
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.03%	15	0	0	0	0	15	0	15	0
36H	POSTMASTERS BENEFIT PLAN	0.03%	13	0	0	1	1	11	0	12	1
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.03%	12	0	0	1	0	7	4	8	4
43	PANAMA CANAL AREA BENEFIT PLAN	0.02%	11	0	0	0	0	5	6	5	6
Total		100.00%	**47273**	**1,710**	**7,174**	**5,446**	**12,825**	**10,875**	**9,243**	**18,031**	**29,242**

HBDF PLAN TOTALS (2002)

FOR MASSACHUSETTS (MA)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	74.26%	57466	4887	8841	7190	8530	17808	10210	29885	27581
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	7.70%	5960	1,237	1,885	1,123	1,118	318	279	2,678	3,282
JV	FALLON COMMUNITY HEALTH PLAN	7.28%	5634	795	1,709	946	1,164	507	513	2,248	3,386
45H	MAIL HANDLERS BENEFIT PLAN	3.56%	2751	156	288	297	352	920	738	1,373	1,378
32	NALC HEALTH BENEFIT PLAN	2.46%	1900	97	153	13	19	956	662	1,066	834
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.26%	973	68	70	5	5	552	273	625	348
45S	MAIL HANDLERS BENEFIT PLAN	1.08%	839	38	17	243	109	232	200	513	326
31H	GEHA BENEFIT PLAN	0.77%	596	14	22	49	82	233	196	296	300
DA	BLUCHIP COORDINATED HEALTH PLANS (COORDINATED H	0.49%	377	66	96	68	63	45	39	179	198
44	SAMBA HEALTH BENEFIT PLAN	0.29%	222	0	0	6	3	115	98	121	101
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.16%	123	5	12	0	0	55	51	60	63
31S	GEHA BENEFIT PLAN	0.14%	105	8	2	23	18	22	32	53	52
42	ASSOCIATION BENEFIT PLAN	0.13%	102	0	0	0	0	56	46	56	46
TE	CONNECTICARE	0.13%	99	21	39	14	21	2	2	37	62
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.08%	63	0	0	0	1	62	0	62	1
36S	POSTMASTERS BENEFIT PLAN	0.07%	53	1	1	1	1	34	15	36	17
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.04%	28	0	1	0	1	25	1	25	3
Q8	UNIVERA HEATHCARE - WNY (HEALTHCAREPLAN)	0.02%	16	4	11	1	0	0	0	5	11
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.02%	14	0	0	4	4	6	0	10	4
43	PANAMA CANAL AREA BENEFIT PLAN	0.02%	13	0	0	0	0	11	2	11	2
QA	INDEPENDENT HEALTH ASSOCIATION - WESTERN NEW YC	0.02%	13	3	10	0	0	0	0	3	10
36H	POSTMASTERS BENEFIT PLAN	0.02%	12	0	1	1	0	8	2	9	3
SG	CAPITAL DISTRICT PHYSICIANS' HP - CAPITAL REGION	0.02%	12	2	4	3	3	0	0	5	7
DJ	HEALTH NEW ENGLAND	0.01%	11	0	0	3	2	5	1	8	3
Total		100.00%	**77382**	**7,402**	**13,162**	**9,990**	**11,496**	**21,972**	**13,360**	**39,364**	**38,018**

HBDF PLAN TOTALS (2002)

FOR MARYLAND (MD)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	56.02%	127705	1742	4007	20787	26104	45892	29173	68421	59284
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	10.41%	23722	681	2,082	6,708	10,121	2,151	1,979	9,540	14,182
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	9.06%	20662	405	1,223	4,653	5,765	5,369	3,247	10,427	10,235
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	6.57%	14973	452	1,371	4,109	5,371	2,092	1,578	6,653	8,320
31H	GEHA BENEFIT PLAN	4.13%	9410	45	128	1,234	2,073	2,734	3,196	4,013	5,397
45H	MAIL HANDLERS BENEFIT PLAN	3.33%	7582	203	560	1,213	1,617	2,136	1,853	3,552	4,030
JNS	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	2.29%	5210	59	148	1,816	2,440	365	382	2,240	2,970
2G	CAPITALCARE	2.11%	4817	123	293	1,330	1,589	874	608	2,327	2,490
42	ASSOCIATION BENEFIT PLAN	1.15%	2632	0	0	822	0	881	929	1,703	929
45S	MAIL HANDLERS BENEFIT PLAN	1.04%	2380	36	51	487	448	756	602	1,279	1,101
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	0.97%	2221	64	147	608	691	402	309	1,074	1,147
32	NALC HEALTH BENEFIT PLAN	0.81%	1847	74	166	105	107	786	609	965	882
31S	GEHA BENEFIT PLAN	0.57%	1310	7	17	264	269	369	384	640	670
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.47%	1079	104	137	49	73	454	262	607	472
44	SAMBA HEALTH BENEFIT PLAN	0.28%	642	0	0	11	9	337	285	348	294
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.23%	522	0	0	8	6	271	237	279	243
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.13%	288	0	0	10	41	25	212	35	253
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.11%	240	15	50	0	0	80	95	95	145
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.09%	200	2	8	44	50	64	32	110	90
36S	POSTMASTERS BENEFIT PLAN	0.08%	192	4	6	18	14	116	34	138	54
SW	HEALTHAMERICA OF PENNSYLVANIA (EASTERN PENNSYL\	0.03%	75	4	11	18	42	0	0	22	53
36H	POSTMASTERS BENEFIT PLAN	0.03%	70	5	2	18	6	31	8	54	16
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.03%	65	2	0	33	26	3	1	38	27
NQ	HEALTHGUARD OF LANCASTER	0.02%	37	1	4	8	24	0	0	9	28
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	0.01%	34	0	1	11	19	1	2	12	22
S4	KEYSTONE HEALTH PLAN CENTRAL - HARRISBURG	0.01%	26	2	3	5	16	0	0	7	19
43	PANAMA CANAL AREA BENEFIT PLAN	0.01%	13	0	0	0	1	8	4	8	5
80	GHI HEALTH PLAN	0.01%	13	1	2	2	1	7	0	10	3
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.01%	12	1	2	3	5	1	0	5	7
Total		100.00%	**227979**	**4,032**	**10,419**	**44,374**	**56,928**	**66,205**	**46,021**	**114,611**	**######**

HBDF PLAN TOTALS (2002)

FOR MAINE (ME)

(April 11, 2003)

Code	Plan		Total Contracts	Postal Self	Postal Family	Non-Postal Self	Non-Postal Family	Annuitant Self	Annuitant Family	Total Self	Total Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	73.51%	16245	675	1909	1991	4401	3875	3394	6541	9704
45H	MAIL HANDLERS BENEFIT PLAN	12.29%	2715	82	271	285	707	600	770	967	1,748
45S	MAIL HANDLERS BENEFIT PLAN	3.56%	787	32	47	123	151	196	238	351	436
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.74%	606	65	150	128	178	24	61	217	389
31H	GEHA BENEFIT PLAN	1.88%	415	15	34	16	32	141	177	172	243
32	NALC HEALTH BENEFIT PLAN	1.86%	410	12	22	4	3	206	163	222	188
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.66%	366	13	16	1	6	202	128	216	150
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.46%	322	25	54	0	0	132	111	157	165
31S	GEHA BENEFIT PLAN	0.24%	53	4	4	11	9	9	16	24	29
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.24%	53	0	0	0	0	8	45	8	45
36S	POSTMASTERS BENEFIT PLAN	0.24%	52	0	2	2	0	33	15	35	17
44	SAMBA HEALTH BENEFIT PLAN	0.16%	36	0	0	0	2	9	25	9	27
42	ASSOCIATION BENEFIT PLAN	0.12%	27	0	0	0	0	4	23	4	23
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.05%	12	0	0	0	0	10	2	10	2
Total		100.00%	**22099**	**923**	**2,509**	**2,561**	**5,489**	**5,449**	**5,168**	**8,933**	**13,166**

HBDF PLAN TOTALS (2002)

FOR MICHIGAN (MI)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	**Plan**		**Total Contracts**	**Self**	**Family**	**Self**	**Family**	**Self**	**Family**	**Self**	**Family**
10S+	BCBS Standard plus plans with 10 or fewer enrollees	43.75%	31144	2559	5381	3232	4931	9244	5797	15035	16109
52	HEALTH ALLIANCE PLAN	15.11%	10757	1,803	3,557	1,482	1,638	1,424	853	4,709	6,048
45H	MAIL HANDLERS BENEFIT PLAN	5.99%	4262	248	717	470	865	924	1,038	1,642	2,620
LX	BLUE CARE NETWORK - SOUTHEAST MICHIGAN	5.00%	3558	494	1,138	714	721	310	181	1,518	2,040
EG	M-CARE	4.47%	3179	384	1,084	474	946	147	144	1,005	2,174
32	NALC HEALTH BENEFIT PLAN	3.75%	2672	147	250	17	22	1,267	969	1,431	1,241
31H	GEHA BENEFIT PLAN	2.39%	1702	82	249	91	214	524	542	697	1,005
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.38%	1697	117	214	5	10	843	508	965	732
KR	BLUE CARE NETWORK GREAT LAKES - WEST MICHIGAN	2.06%	1463	409	406	212	136	164	136	785	678
KA	OMNICARE HEALTH PLAN	1.95%	1387	206	580	146	244	144	67	496	891
KF	BLUE CARE NETWORK GREAT LAKES - SOUTHWEST MI.	1.93%	1373	209	169	437	228	242	88	888	485
45S	MAIL HANDLERS BENEFIT PLAN	1.78%	1270	59	123	233	285	292	278	584	686
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.77%	1263	77	293	0	0	429	464	506	757
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.64%	1164	165	419	180	251	74	75	419	745
LN	BLUE CARE NETWORK - MID MICHIGAN (HEALTH CENTRAL	1.08%	772	203	185	91	107	106	80	400	372
X5	HEALTHPLUS OF MICHIGAN	0.91%	648	97	335	55	110	26	25	178	470
RL	GRAND VALLEY HEALTH PLAN	0.80%	568	101	287	28	100	22	30	151	417
K5	BLUE CARE NETWORK - EAST MICHIGAN/SAGINAW	0.63%	446	77	120	55	32	91	71	223	223
K3	THE WELLNESS PLAN (COMPREHENSIVE HEALTH SERVICE	0.59%	418	50	138	66	82	48	34	164	254
31S	GEHA BENEFIT PLAN	0.50%	359	23	93	51	84	47	61	121	238
KN	BLUE CARE NETWORK - EAST MICHIGAN/FLINT	0.31%	219	75	49	23	9	50	13	148	71
36S	POSTMASTERS BENEFIT PLAN	0.27%	194	4	8	6	5	119	52	129	65
N2	TOTAL HEALTH CARE	0.24%	170	23	76	16	41	8	6	47	123
44	SAMBA HEALTH BENEFIT PLAN	0.16%	113	0	0	8	6	38	61	46	67
U2	PARAMOUNT HEALTH CARE	0.14%	101	5	12	34	36	5	9	44	57
G7	BLUE CARE NETWORK GREAT LAKES - NORTH MICHIGAN	0.12%	87	12	12	4	5	40	14	56	31
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.09%	63	0	0	1	1	31	30	32	31
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.08%	57	2	5	6	4	36	4	44	13
36H	POSTMASTERS BENEFIT PLAN	0.06%	45	7	2	3	1	30	2	40	5
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.02%	15	0	0	8	7	0	0	8	7
R5	HEALTH MAINTENANCE PLAN (HMP)	0.02%	14	0	0	0	12	1	1	1	13
Total		100.00%	71180	**7,638**	**15,902**	**8,148**	**11,133**	**16,726**	**11,633**	**32,512**	**38,668**

HBDF PLAN TOTALS (2002)

FOR MINNESOTA (MN)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	50.63%	23923	1683	4504	2263	4270	6091	5112	10037	13886
53H	HEALTHPARTNERS SELECT (GROUP HEALTH PLAN)	17.35%	8197	1,343	1,991	1,044	1,423	1,258	1,138	3,645	4,552
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	8.59%	4059	480	1,214	589	1,371	129	276	1,198	2,861
HQ	HEALTH PARTNERS PRIMARY CLINIC (HEALTHPARTNERS H	3.90%	1843	371	546	263	238	244	181	878	965
31H	GEHA BENEFIT PLAN	3.10%	1463	58	123	55	98	540	589	653	810
53S	HEALTHPARTNERS SELECT (GROUP HEALTH PLAN)	3.03%	1433	116	179	217	161	386	374	719	714
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.94%	1388	95	112	20	40	715	406	830	558
45H	MAIL HANDLERS BENEFIT PLAN	2.89%	1365	90	186	130	203	351	405	571	794
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.78%	1313	43	229	0	0	497	544	540	773
32	NALC HEALTH BENEFIT PLAN	2.59%	1222	63	66	1	5	614	473	678	544
45S	MAIL HANDLERS BENEFIT PLAN	1.06%	501	30	29	105	90	108	139	243	258
31S	GEHA BENEFIT PLAN	0.47%	220	19	16	28	24	52	81	99	121
36S	POSTMASTERS BENEFIT PLAN	0.28%	132	6	3	2	0	84	37	92	40
44	SAMBA HEALTH BENEFIT PLAN	0.16%	74	0	0	1	1	40	32	41	33
42	ASSOCIATION BENEFIT PLAN	0.09%	44	0	0	0	0	36	8	36	8
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.04%	21	2	1	1	2	11	4	14	7
36H	POSTMASTERS BENEFIT PLAN	0.04%	19	0	1	1	1	15	1	16	3
Y7H	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	18	0	0	8	7	3	0	11	7
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.03%	15	0	0	0	0	15	0	15	0
Total		100.00%	**47250**	**4,399**	**9,200**	**4,728**	**7,934**	**11,189**	**9,800**	**20,316**	**26,934**

HBDF PLAN TOTALS (2002)

FOR MISSOURI (MO)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	42.00%	36420	1330	3687	3967	6617	12351	8468	17648	18772
31H	GEHA BENEFIT PLAN	9.93%	8613	228	922	677	1,375	2,537	2,874	3,442	5,171
45H	MAIL HANDLERS BENEFIT PLAN	9.27%	8039	382	1,148	909	2,060	1,646	1,894	2,937	5,102
9G	BLUECHOICE OF MISSOURI (WAS CODE M4)	9.13%	7916	586	2,070	1,412	2,489	637	722	2,635	5,281
MM	GROUP HEALTH PLAN	4.83%	4185	309	987	695	930	737	527	1,741	2,444
HA	COVENTRY HEALTHCARE OF KANSAS CITY (KAISER FOUNI	4.77%	4132	223	804	950	1,639	273	243	1,446	2,686
7M	MERCY HEALTH PLANS OF MISSOURI	3.25%	2814	204	620	570	943	160	317	934	1,880
32	NALC HEALTH BENEFIT PLAN	3.01%	2613	117	329	21	53	1,076	1,017	1,214	1,399
MSH	HUMANA KANSAS CITY - KANSAS CITY	2.94%	2551	205	450	648	667	373	208	1,226	1,325
45S	MAIL HANDLERS BENEFIT PLAN	2.60%	2252	87	174	396	579	463	553	946	1,306
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.28%	1973	82	526	0	0	620	745	702	1,271
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.21%	1912	140	352	25	30	783	582	948	964
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.43%	1237	96	274	252	374	114	127	462	775
31S	GEHA BENEFIT PLAN	1.25%	1084	22	95	157	281	221	308	400	684
MSS	HUMANA KANSAS CITY - KANSAS CITY	0.36%	312	9	43	87	140	24	9	120	192
36S	POSTMASTERS BENEFIT PLAN	0.24%	207	9	14	3	4	112	65	124	83
44	SAMBA HEALTH BENEFIT PLAN	0.18%	154	0	0	5	3	60	86	65	89
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.12%	108	3	10	8	4	66	17	77	31
42	ASSOCIATION BENEFIT PLAN	0.08%	70	0	0	0	0	32	38	32	38
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.06%	49	0	0	6	4	9	30	15	34
36H	POSTMASTERS BENEFIT PLAN	0.04%	32	3	4	7	0	17	1	27	5
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.03%	24	0	0	1	0	23	0	24	0
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.01%	11	0	0	0	0	10	1	10	1
Total		100.00%	**86708**	**4,035**	**12,509**	**10,796**	**18,192**	**22,344**	**18,832**	**37,175**	**49,533**

HBDF PLAN TOTALS (2002)

FOR MISSISSIPPI (MS)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	66.92%	25843	556	2530	3081	7870	6397	5409	10034	15809
45H	MAIL HANDLERS BENEFIT PLAN	13.21%	5100	55	335	593	1,875	952	1,290	1,600	3,500
31H	GEHA BENEFIT PLAN	6.99%	2700	25	161	212	526	757	1,019	994	1,706
45S	MAIL HANDLERS BENEFIT PLAN	3.18%	1227	9	48	206	394	249	321	464	763
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.94%	1134	49	288	0	0	377	420	426	708
32	NALC HEALTH BENEFIT PLAN	2.22%	857	16	80	10	35	333	383	359	498
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.78%	689	21	82	13	11	311	251	345	344
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.39%	537	18	64	107	216	53	79	178	359
31S	GEHA BENEFIT PLAN	0.63%	243	4	11	30	55	46	97	80	163
44	SAMBA HEALTH BENEFIT PLAN	0.21%	82	0	0	0	2	30	50	30	52
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.18%	70	0	6	5	2	49	8	54	16
36S	POSTMASTERS BENEFIT PLAN	0.18%	69	1	3	3	3	40	19	44	25
UB	PRUDENTIAL HEALTHCARE HMO - MEMPHIS	0.07%	27	0	1	5	1	15	5	20	7
36H	POSTMASTERS BENEFIT PLAN	0.04%	14	0	1	4	1	8	0	12	2
AA	PRIMEHEALTH OF ALABAMA (MOBILE HEALTH PLAN)	0.03%	13	0	0	1	12	0	0	1	12
42	ASSOCIATION BENEFIT PLAN	0.03%	12	0	0	0	0	12	0	12	0
Total		100.00%	**38617**	**754**	**3,610**	**4,270**	**11,003**	**9,629**	**9,351**	**14,653**	**23,964**

HBDF PLAN TOTALS (2002)

FOR MOUNTANA (MT)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	59.01%	10964	264	1020	1536	3434	2317	2393	4117	6847
31H	GEHA BENEFIT PLAN	14.18%	2634	35	143	155	454	811	1,036	1,001	1,633
45H	MAIL HANDLERS BENEFIT PLAN	11.43%	2124	53	256	253	664	337	561	643	1,481
45S	MAIL HANDLERS BENEFIT PLAN	5.17%	961	20	50	183	341	133	234	336	625
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.42%	450	26	42	109	190	27	56	162	288
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.00%	371	21	68	1	13	130	138	152	219
32	NALC HEALTH BENEFIT PLAN	1.77%	328	12	38	5	11	120	142	137	191
31S	GEHA BENEFIT PLAN	1.70%	315	4	11	53	71	57	119	114	201
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.15%	214	24	47	0	0	70	73	94	120
36S	POSTMASTERS BENEFIT PLAN	0.58%	108	2	17	1	1	60	27	63	45
44	SAMBA HEALTH BENEFIT PLAN	0.24%	45	0	0	0	0	21	24	21	24
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.17%	32	0	0	0	1	16	15	16	16
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	19	0	1	3	0	11	4	14	5
36H	POSTMASTERS BENEFIT PLAN	0.08%	15	0	1	1	0	13	0	14	1
Total		100.00%	**18580**	**461**	**1,694**	**2,300**	**5,180**	**4,123**	**4,822**	**6,884**	**11,696**

HBDF PLAN TOTALS (2002)

FOR NORTH CAROLINA (NC)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	55.70%	49684	2123	6307	5462	10480	14588	10724	22173	27511
45H	MAIL HANDLERS BENEFIT PLAN	17.07%	15227	449	1,860	1,605	4,228	3,154	3,931	5,208	10,019
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	7.90%	7044	845	2,301	1,059	1,830	441	568	2,345	4,699
31H	GEHA BENEFIT PLAN	5.84%	5213	142	373	242	563	1,884	2,009	2,268	2,945
45S	MAIL HANDLERS BENEFIT PLAN	3.73%	3328	101	232	473	867	755	900	1,329	1,999
32	NALC HEALTH BENEFIT PLAN	2.68%	2388	84	290	33	63	966	952	1,083	1,305
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.33%	2077	115	268	13	24	997	660	1,125	952
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.32%	2073	104	500	0	0	675	794	779	1,294
31S	GEHA BENEFIT PLAN	0.73%	651	23	40	114	108	165	201	302	349
44	SAMBA HEALTH BENEFIT PLAN	0.35%	314	0	0	5	6	124	179	129	185
42	ASSOCIATION BENEFIT PLAN	0.34%	305	0	0	0	0	167	138	167	138
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.29%	263	0	0	8	5	131	119	139	124
36S	POSTMASTERS BENEFIT PLAN	0.20%	181	4	6	6	1	106	58	116	65
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.16%	139	3	10	4	11	93	18	100	39
9R	OPTIMA HEALTH PLAN	0.08%	73	1	0	5	20	14	33	20	53
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.08%	73	0	0	2	8	18	45	20	53
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.05%	43	0	1	5	1	21	15	26	17
36H	POSTMASTERS BENEFIT PLAN	0.03%	28	1	1	2	1	22	1	25	3
43	PANAMA CANAL AREA BENEFIT PLAN	0.03%	27	0	0	0	2	19	6	19	8
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	0.03%	25	5	4	1	3	7	5	13	12
80	GHI HEALTH PLAN	0.02%	17	0	0	0	0	13	4	13	4
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.01%	12	0	0	0	0	8	4	8	4
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.01%	11	0	0	0	0	8	3	8	3
Total		100.00%	**89196**	**4,000**	**12,193**	**9,039**	**18,221**	**24,376**	**21,367**	**37,415**	**51,781**

HBDF PLAN TOTALS (2002)

FOR NORTH DAKOTA (ND)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	71.96%	7747	258	1,013	886	2,225	1,633	1,732	2,777	4,970
45H	MAIL HANDLERS BENEFIT PLAN	8.66%	932	12	90	123	368	132	207	267	665
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	4.76%	512	28	71	134	217	23	39	185	327
45S	MAIL HANDLERS BENEFIT PLAN	3.86%	416	8	10	94	176	59	69	161	255
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	3.59%	387	10	62	0	0	147	168	157	230
31H	GEHA BENEFIT PLAN	3.01%	324	2	11	13	60	119	119	134	190
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.63%	176	8	17	1	2	87	61	96	80
32	NALC HEALTH BENEFIT PLAN	1.13%	122	6	16	1	1	45	53	52	70
31S	GEHA BENEFIT PLAN	0.46%	50	1	3	4	15	9	18	14	36
36S	POSTMASTERS BENEFIT PLAN	0.41%	44	3	1	0	0	24	16	27	17
RU	HEART OF AMERICA HMO	0.28%	30	0	2	6	10	7	5	13	17
36H	POSTMASTERS BENEFIT PLAN	0.12%	13	0	0	0	0	13	0	13	0
42	ASSOCIATION BENEFIT PLAN	0.11%	12	0	0	0	0	4	8	4	8
Total		100.00%	**10765**	**336**	**1,296**	**1,262**	**3,074**	**2,302**	**2,495**	**3,900**	**6,865**

HBDF PLAN TOTALS (2002)

FOR NEBRASKA (NE)

(April 11, 2003)

Code	Plan		Total Contracts	Postal Self	Postal Family	Non-Postal Self	Non-Postal Family	Annuitant Self	Annuitant Family	Total Self	Total Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	66.38%	14816	658	2424	1668	3586	3538	2942	5864	8952
45H	MAIL HANDLERS BENEFIT PLAN	10.25%	2287	136	456	241	596	379	479	756	1,531
31H	GEHA BENEFIT PLAN	7.05%	1574	38	171	90	246	489	540	617	957
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	3.92%	874	28	222	0	0	284	340	312	562
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.85%	636	43	91	4	8	291	199	338	298
45S	MAIL HANDLERS BENEFIT PLAN	2.78%	620	26	61	126	148	104	155	256	364
32	NALC HEALTH BENEFIT PLAN	2.75%	614	17	47	9	8	237	296	263	351
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.30%	514	43	139	102	179	20	31	165	349
31S	GEHA BENEFIT PLAN	0.78%	174	7	21	25	42	26	53	58	116
36S	POSTMASTERS BENEFIT PLAN	0.69%	154	8	15	1	0	72	58	81	73
44	SAMBA HEALTH BENEFIT PLAN	0.16%	36	0	0	0	0	16	20	16	20
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.09%	20	1	0	4	1	12	2	17	3
Total		100.00%	**22319**	**1,005**	**3,647**	**2,270**	**4,814**	**5,468**	**5,115**	**8,743**	**13,576**

HBDF PLAN TOTALS (2002)

FOR NEW HAMPSHIRE (NH)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	75.95%	11553	729	1936	810	1665	3526	2887	5065	6488
45H	MAIL HANDLERS BENEFIT PLAN	8.80%	1338	52	157	54	105	435	535	541	797
45S	MAIL HANDLERS BENEFIT PLAN	3.08%	468	20	24	46	63	132	183	198	270
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.98%	453	94	121	55	73	51	59	200	253
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.41%	367	14	24	0	1	194	134	208	159
31H	GEHA BENEFIT PLAN	1.96%	298	5	12	11	18	141	111	157	141
32	NALC HEALTH BENEFIT PLAN	1.89%	288	5	13	2	2	139	127	146	142
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.99%	151	15	20	0	0	46	70	61	90
42	ASSOCIATION BENEFIT PLAN	0.49%	74	0	0	0	0	20	54	20	54
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.35%	53	0	0	0	0	8	45	8	45
44	SAMBA HEALTH BENEFIT PLAN	0.30%	46	0	0	1	0	14	31	15	31
36S	POSTMASTERS BENEFIT PLAN	0.28%	42	0	0	0	1	26	15	26	16
31S	GEHA BENEFIT PLAN	0.25%	38	2	2	4	4	10	16	16	22
JV	FALLON COMMUNITY HEALTH PLAN	0.20%	30	4	9	1	8	5	3	10	20
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.09%	13	0	1	2	1	8	1	10	3
Total		100.00%	**15212**	**940**	**2,319**	**986**	**1,941**	**4,755**	**4,271**	**6,681**	**8,531**

HBDF PLAN TOTALS (2002)

FOR NEW JERSEY (NJ)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	52.19%	49446	3750	9711	4851	7756	14336	9042	22937	26509
P3H	#N/A	13.72%	13002	2,657	2,091	2,503	1,626	2,748	1,377	7,908	5,094
45H	MAIL HANDLERS BENEFIT PLAN	5.70%	5399	554	1,177	476	657	1,357	1,178	2,387	3,012
32	NALC HEALTH BENEFIT PLAN	4.53%	4292	359	557	44	64	1,782	1,486	2,185	2,107
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	4.30%	4071	239	425	37	55	2,175	1,140	2,451	1,620
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	4.29%	4060	571	1,680	467	893	185	264	1,223	2,837
31H	GEHA BENEFIT PLAN	3.94%	3735	155	343	315	599	1,177	1,146	1,647	2,088
80	GHI HEALTH PLAN	3.44%	3256	544	812	496	344	769	291	1,809	1,447
FK	AMERIHEALTH HMO (KEYSTONE/DELAWARE VALLEY)	3.19%	3023	384	1,119	288	622	261	349	933	2,090
45S	MAIL HANDLERS BENEFIT PLAN	1.71%	1616	88	113	245	238	461	471	794	822
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	0.54%	507	39	77	120	183	35	53	194	313
31S	GEHA BENEFIT PLAN	0.51%	487	23	52	81	75	114	142	218	269
44	SAMBA HEALTH BENEFIT PLAN	0.41%	391	0	0	6	12	164	209	170	221
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.30%	280	40	71	72	83	10	4	122	158
36S	POSTMASTERS BENEFIT PLAN	0.27%	260	1	8	13	13	150	75	164	96
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.20%	192	22	44	0	0	73	53	95	97
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.17%	164	3	4	18	4	114	21	135	29
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.13%	122	20	27	19	21	23	12	62	60
36H	POSTMASTERS BENEFIT PLAN	0.10%	96	2	7	20	9	48	10	70	26
27	HEALTH NET (QUALMED PLANS FOR HEALTH-GREATER AT	0.09%	86	5	9	12	21	17	22	34	52
89	TRIPLE - S	0.06%	57	12	36	0	4	2	3	14	43
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.05%	46	0	0	0	1	30	15	30	16
42	ASSOCIATION BENEFIT PLAN	0.04%	40	0	0	0	0	32	8	32	8
S4	KEYSTONE HEALTH PLAN CENTRAL - HARRISBURG	0.04%	40	3	12	7	18	0	0	10	30
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	34	0	2	9	5	18	0	27	7
43	PANAMA CANAL AREA BENEFIT PLAN	0.02%	20	0	0	0	0	16	4	16	4
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.01%	13	0	1	5	2	3	2	8	5
Total		100.00%	**94735**	**9,471**	**18,378**	**10,104**	**13,305**	**26,100**	**17,377**	**45,675**	**49,060**

HBDF PLAN TOTALS (2002)

FOR NEW MEXICO (NM)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	39.96%	15522	147	573	1856	3696	5038	4212	7041	8481
Q1	LOVELACE HEALTH PLAN	21.17%	8222	261	777	1,428	2,206	1,759	1,791	3,448	4,774
P2	PRESBYTERIAN HEALTH PLAN (FHP-NEW MEXICO)	10.78%	4189	170	644	788	1,578	441	568	1,399	2,790
PX	CIMARRON HEALTH PLAN, INC. (QUALMED PLANS FOR HEA	9.04%	3513	85	373	766	1,606	284	399	1,135	2,378
31H	GEHA BENEFIT PLAN	6.54%	2540	16	61	207	566	744	946	967	1,573
45H	MAIL HANDLERS BENEFIT PLAN	5.42%	2106	23	99	356	791	355	482	734	1,372
45S	MAIL HANDLERS BENEFIT PLAN	2.03%	787	5	15	165	247	162	193	332	455
32	NALC HEALTH BENEFIT PLAN	1.27%	494	10	62	6	13	206	197	222	272
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.08%	421	17	50	8	22	164	160	189	232
31S	GEHA BENEFIT PLAN	0.76%	296	1	6	50	66	68	105	119	177
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	0.69%	267	2	30	65	86	24	60	91	176
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.27%	103	5	18	0	0	34	46	39	64
44	SAMBA HEALTH BENEFIT PLAN	0.27%	103	0	0	3	2	39	59	42	61
36S	POSTMASTERS BENEFIT PLAN	0.25%	99	4	6	7	0	52	30	63	36
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.22%	87	0	0	2	1	39	45	41	46
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.10%	37	0	0	1	3	3	30	4	33
42	ASSOCIATION BENEFIT PLAN	0.06%	24	0	0	0	0	16	8	16	8
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.06%	22	0	0	3	0	18	1	21	1
36H	POSTMASTERS BENEFIT PLAN	0.03%	11	1	0	0	1	8	1	9	2
Total		100.00%	**38843**	**747**	**2,714**	**5,711**	**10,884**	**9,454**	**9,333**	**15,912**	**22,931**

HBDF PLAN TOTALS (2002)

FOR NEVADA (NV)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	40.69%	10319	341	730	1124	1578	3945	2601	5410	4909
31H	GEHA BENEFIT PLAN	12.75%	3234	122	221	243	541	1,063	1,044	1,428	1,806
NM	HEALTH PLAN OF NEVADA	10.29%	2610	176	488	384	569	536	457	1,096	1,514
45H	MAIL HANDLERS BENEFIT PLAN	8.21%	2082	102	265	254	454	484	523	840	1,242
K9	PACIFICARE OF NEVADA (FHP - NEVADA)	6.40%	1623	119	268	207	297	385	347	711	912
8L	AETNA US HEALTHCARE, INC. - NEVADA	4.50%	1140	101	285	173	278	159	144	433	707
32	NALC HEALTH BENEFIT PLAN	3.85%	977	90	254	14	31	303	285	407	570
45S	MAIL HANDLERS BENEFIT PLAN	3.34%	848	35	67	147	161	202	236	384	464
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.87%	729	83	161	5	11	299	170	387	342
31S	GEHA BENEFIT PLAN	2.11%	536	14	28	83	126	118	167	215	321
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.96%	498	38	94	88	128	61	89	187	311
44	SAMBA HEALTH BENEFIT PLAN	0.69%	174	0	0	6	7	65	96	71	103
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.56%	143	0	2	3	7	72	59	75	68
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.35%	90	1	3	3	5	41	37	45	45
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.31%	79	0	0	1	2	46	30	47	32
36S	POSTMASTERS BENEFIT PLAN	0.30%	75	3	6	0	3	41	22	44	31
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.23%	58	0	0	0	0	30	28	30	28
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.16%	40	3	13	0	0	13	11	16	24
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.14%	36	0	0	2	3	24	7	26	10
42	ASSOCIATION BENEFIT PLAN	0.11%	28	0	0	0	0	12	16	12	16
CYH	PACIFICARE OF CALIFORNIA (FHP-CA)	0.06%	15	1	1	5	2	5	1	11	4
36H	POSTMASTERS BENEFIT PLAN	0.05%	13	2	1	1	0	8	1	11	2
M5	BLUE CROSS CALIFORNIACARE	0.04%	11	0	1	4	2	0	4	4	7
Total		100.00%	**25358**	**1,231**	**2,888**	**2,747**	**4,205**	**7,912**	**6,375**	**11,890**	**13,468**

HBDF PLAN TOTALS (2002)

FOR NEW YORK (NY)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	27.38%	49481	2693	6086	6835	8662	17034	8171	26562	22919
80	GHI HEALTH PLAN	18.43%	33295	6,071	7,267	5,088	3,474	7,877	3,518	19,036	14,259
JC	AETNA US HEALTHCARE, INC. - NEW YORK	9.69%	17501	2,863	6,173	3,186	3,613	912	754	6,961	10,540
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	7.29%	13180	1,979	3,522	1,557	1,304	3,386	1,432	6,922	6,258
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	4.17%	7526	499	616	39	60	4,540	1,772	5,078	2,448
32	NALC HEALTH BENEFIT PLAN	3.91%	7058	427	724	86	73	3,447	2,301	3,960	3,098
QA	INDEPENDENT HEALTH ASSOCIATION - WESTERN NEW YC	3.75%	6784	495	1,526	1,184	1,810	735	1,034	2,414	4,370
45H	MAIL HANDLERS BENEFIT PLAN	3.43%	6199	646	1,088	524	694	1,836	1,411	3,006	3,193
SG	CAPITAL DISTRICT PHYSICIANS' HP - CAPITAL REGION	3.02%	5465	628	1,106	912	1,191	854	774	2,394	3,071
Q8	UNIVERA HEATHCARE - WNY (HEALTHCAREPLAN)	1.98%	3570	362	942	561	737	481	487	1,404	2,166
31H	GEHA BENEFIT PLAN	1.89%	3415	133	289	350	574	1,144	925	1,627	1,788
M9	MVP HEALTH PLAN - CENTRAL/NORTH	1.74%	3152	230	1,092	281	754	302	493	813	2,339
MK	BLUE CHOICE OF NEW YORK	1.59%	2867	470	836	328	476	394	363	1,192	1,675
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.29%	2334	252	856	379	567	128	152	759	1,575
GV	PREFERRED CARE (ROCHESTER)	1.25%	2257	308	868	171	302	294	314	773	1,484
GA	MVP HEALTH PLAN - EASTERN DIVISION	1.14%	2066	229	703	146	425	220	343	595	1,471
MX	MVP HEALTH PLAN - MID HUDSON DIVISION	0.99%	1793	327	460	350	363	171	122	848	945
45S	MAIL HANDLERS BENEFIT PLAN	0.96%	1740	73	108	283	267	538	471	894	846
J6	VYTRA HEALTH PLANS	0.82%	1488	363	287	421	245	113	59	897	591
AH	HMO BLUE (BC/BS OF UTICA-WATERTOWN)	0.70%	1263	105	222	239	450	129	118	473	790
EB	EXCELLUS HEALTH PLAN, INC. (HMO-CNY CENTRAL)	0.61%	1101	219	223	180	163	194	122	593	508
QE	UNIVERA HEALTHCARE-CNY (PREPAID HP - SYRACUSE)	0.53%	966	180	184	194	148	147	113	521	445
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.48%	861	47	102	0	0	347	365	394	467
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.36%	650	68	129	267	176	9	1	344	306
PW	CAPITAL DISTRICT PHYSICIANS' HP - NORTH/CENTRAL (K	0.33%	589	38	67	87	75	194	128	319	270
PD	HEALTH NET, INC. (PHYSICIANS HEALTH SERVICES OF NY	0.27%	479	90	82	168	65	59	15	317	162
44	SAMBA HEALTH BENEFIT PLAN	0.24%	438	0	0	28	26	207	177	235	203
31S	GEHA BENEFIT PLAN	0.21%	377	15	22	53	51	124	112	192	185
QB	CAPTIAL DISTRICT PHYSICIANS' HP - EASTERN HUDSON V	0.21%	374	42	75	95	88	45	29	182	192
X4	GHI HMO SELECT (WELLCARE OF NEW YORK /HUDSON VA	0.18%	330	29	72	46	99	32	52	107	223
36S	POSTMASTERS BENEFIT PLAN	0.18%	319	7	15	15	10	186	86	208	111
6V	GHI HMO SELECT (WELLCARE OF NEW YORK /NEW YORK (	0.14%	253	54	92	38	21	33	15	125	128
43	PANAMA CANAL AREA BENEFIT PLAN	0.13%	227	0	0	0	0	132	95	132	95
TG	AETNA US HEALTHCARE, INC. - NEW YORK (SYRACUSE)	0.12%	219	14	53	69	59	11	13	94	125
SH	UNIVERA HEALTHCARE-CNY (PHP/MOHAWK VALLEY REGIC	0.11%	206	14	28	25	25	64	50	103	103

1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	182	14	10	16	7	112	23	142	40
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.08%	146	0	0	28	13	61	44	89	57
42	ASSOCIATION BENEFIT PLAN	0.08%	137	0	0	0	0	68	69	68	69
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.06%	109	0	0	52	27	15	15	67	42
FK	AMERIHEALTH HMO (KEYSTONE/DELAWARE VALLEY)	0.05%	99	7	43	21	28	0	0	28	71
36H	POSTMASTERS BENEFIT PLAN	0.04%	66	6	2	12	2	40	4	58	8
TE	CONNECTICARE	0.03%	50	8	14	6	22	0	0	14	36
89	TRIPLE - S	0.02%	36	1	12	0	1	13	9	14	22
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.01%	15	0	0	0	1	11	3	11	4
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	0.01%	14	0	3	4	7	0	0	4	10
DP	HEALTH NET, INC. (PHYSICIANS HEALTH SERVICES OF CO	0.01%	13	4	0	3	6	0	0	7	6
Total		100.00%	**180690**	**20,010**	**35,999**	**24,327**	**27,161**	**46,639**	**26,554**	**90,976**	**89,714**

HBDF PLAN TOTALS (2002)

FOR OHIO (OH)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	40.87%	49312	1971	5325	4934	8118	17988	10976	24893	24419
R5	HEALTH MAINTENANCE PLAN (HMP)	14.74%	17784	1,354	4,393	3,369	5,776	1,426	1,466	6,149	11,635
45H	MAIL HANDLERS BENEFIT PLAN	8.86%	10694	583	1,766	1,135	1,896	2,594	2,720	4,312	6,382
3U	UNITED HEALTHCARE OF WESTERN OHIO - DAYTON	4.69%	5654	311	808	1,134	1,761	909	731	2,354	3,300
32	NALC HEALTH BENEFIT PLAN	4.60%	5545	318	614	45	81	2,460	2,027	2,823	2,722
31H	GEHA BENEFIT PLAN	4.23%	5100	158	480	407	814	1,540	1,701	2,105	2,995
64	KAISER FOUNDATION HP - OHIO (CLEVELAND)	3.62%	4372	361	1,132	588	863	848	580	1,797	2,575
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.76%	3335	247	449	33	52	1,589	965	1,869	1,466
45S	MAIL HANDLERS BENEFIT PLAN	2.54%	3070	126	241	544	593	783	783	1,453	1,617
7D	AETNA US HEALTHCARE, INC. - OHIO (CLEVELAND/TOLEDC	1.80%	2172	449	667	401	389	143	123	993	1,179
5W	SUMMACARE HEALTH PLAN	1.56%	1877	229	731	244	492	75	106	548	1,329
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.52%	1833	133	489	0	0	592	619	725	1,108
L4	HMO HEALTH OHIO - NORTHEAST OHIO/CLEVELAND	1.49%	1795	255	495	286	333	243	183	784	1,011
RD	AETNA US HEALTHCARE, INC. - OHIO (GREATER CINCINNA	1.40%	1689	237	339	488	368	161	96	886	803
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.36%	1642	135	411	268	463	185	180	588	1,054
3A	AULTCARE HMO	1.00%	1208	202	621	63	170	52	100	317	891
31S	GEHA BENEFIT PLAN	0.74%	898	36	75	186	194	158	249	380	518
U2	PARAMOUNT HEALTH CARE	0.66%	796	221	288	87	55	95	50	403	393
5M	SUPERMED HMO (OHIO)	0.43%	522	91	98	153	107	44	29	288	234
36S	POSTMASTERS BENEFIT PLAN	0.32%	386	14	17	16	9	222	108	252	134
U4	THE HEALTH PLAN OF THE UPPER OHIO VALLEY	0.28%	339	51	142	11	46	42	47	104	235
44	SAMBA HEALTH BENEFIT PLAN	0.15%	186	0	0	3	12	74	97	77	109
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.12%	146	13	11	13	4	91	14	117	29
42	ASSOCIATION BENEFIT PLAN	0.09%	106	0	0	0	0	44	62	44	62
36H	POSTMASTERS BENEFIT PLAN	0.05%	64	7	1	8	3	35	10	50	14
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.03%	40	0	0	1	0	24	15	25	15
8W	UPMC HEALTH PLAN	0.03%	31	0	2	6	22	1	0	7	24
26	HEALTHAMERICA OF PENNSYLVANIA (WESTERN PENNSYL	0.02%	28	1	0	3	20	2	2	6	22
Y7H	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.02%	27	0	0	8	7	12	0	20	7
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.01%	13	0	0	0	3	4	6	4	9
Total		100.00%	**120664**	**7,503**	**19,595**	**14,434**	**22,651**	**32,436**	**24,045**	**54,373**	**66,291**

HBDF PLAN TOTALS (2002)

FOR OKLAHOMA (OK)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	59.72%	45329	718	2666	5337	11062	14141	11405	20196	25133
2N	PACIFICARE OF OKLAHOMA - OKLAHOMA CITY	11.29%	8572	319	1,135	1,682	3,692	809	935	2,810	5,762
31H	GEHA BENEFIT PLAN	9.20%	6983	114	494	413	935	2,357	2,670	2,884	4,099
45H	MAIL HANDLERS BENEFIT PLAN	6.62%	5026	59	334	654	1,757	901	1,321	1,614	3,412
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.73%	2075	61	211	450	906	208	239	719	1,356
ZXH	AMCARE HEALTH PLANS OF OKLAHOMA	2.28%	1727	23	144	359	805	181	215	563	1,164
45S	MAIL HANDLERS BENEFIT PLAN	2.08%	1578	29	75	246	511	309	408	584	994
32	NALC HEALTH BENEFIT PLAN	1.92%	1461	39	168	30	68	557	599	626	835
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.26%	953	42	221	0	0	313	377	355	598
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.18%	898	33	116	15	28	396	310	444	454
31S	GEHA BENEFIT PLAN	1.04%	791	28	56	96	224	183	204	307	484
36S	POSTMASTERS BENEFIT PLAN	0.16%	120	3	2	4	4	62	45	69	51
44	SAMBA HEALTH BENEFIT PLAN	0.16%	118	0	0	2	4	43	69	45	73
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	75	0	2	6	8	51	8	57	18
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.06%	46	0	0	0	1	15	30	15	31
42	ASSOCIATION BENEFIT PLAN	0.06%	43	0	0	0	0	28	15	28	15
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	29	0	0	1	7	6	15	7	22
UR	HUMANA HEALTH PLAN - TEXAS (SAN ANTONIO)	0.03%	24	0	0	3	19	2	0	5	19
36H	POSTMASTERS BENEFIT PLAN	0.03%	20	0	2	5	1	12	0	17	3
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.02%	17	0	0	1	2	9	5	10	7
GF	PACIFICARE OF TEXAS (SAN ANTONIO)	0.02%	16	0	0	1	14	1	0	2	14
Total		100.00%	**75901**	**1,468**	**5,626**	**9,305**	**20,048**	**20,584**	**18,870**	**31,357**	**44,544**

HBDF PLAN TOTALS (2002)

FOR OREGON (OR)

(April 11, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	42.01%	19927	585	1560	2510	4154	6083	5035	9178	10749
57H	KAISER FOUNDATION HP - NORTHWEST	21.94%	10406	823	1,738	1,594	2,289	2,183	1,779	4,600	5,806
31H	GEHA BENEFIT PLAN	7.89%	3743	63	214	316	590	1,158	1,402	1,537	2,206
45H	MAIL HANDLERS BENEFIT PLAN	7.42%	3520	144	487	431	906	613	939	1,188	2,332
7Z	PACIFICARE OF OREGON (WAS CODE SS)	5.14%	2439	171	450	393	646	363	416	927	1,512
45S	MAIL HANDLERS BENEFIT PLAN	3.16%	1498	31	75	382	381	275	354	688	810
57S	KAISER FOUNDATION HP - NORTHWEST	2.80%	1330	52	82	197	204	374	421	623	707
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.47%	1171	102	244	231	348	95	151	428	743
32	NALC HEALTH BENEFIT PLAN	2.01%	955	38	103	12	38	402	362	452	503
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.55%	733	45	80	8	20	361	219	414	319
31S	GEHA BENEFIT PLAN	1.51%	718	16	35	136	202	115	214	267	451
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.77%	367	15	68	0	0	133	151	148	219
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.26%	125	2	0	2	2	65	54	69	56
36S	POSTMASTERS BENEFIT PLAN	0.22%	102	2	6	5	1	64	24	71	31
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.21%	99	0	0	0	0	54	45	54	45
44	SAMBA HEALTH BENEFIT PLAN	0.18%	87	0	0	1	6	31	49	32	55
42	ASSOCIATION BENEFIT PLAN	0.16%	78	0	0	0	0	16	62	16	62
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	47	0	1	1	5	36	4	37	10
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.05%	26	0	0	0	0	17	9	17	9
54	GROUP HEALTH COOPERATIVE OF PUGET SOUND/WESTEI	0.04%	18	1	0	3	6	4	4	8	10
VR	GROUP HEALTH COOPERATIVE OF PUGET SOUND/EASTEF	0.03%	16	0	0	4	10	2	0	6	10
36H	POSTMASTERS BENEFIT PLAN	0.03%	15	1	0	3	0	10	1	14	1
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.03%	13	0	0	0	0	8	5	8	5
Total		100.00%	**47433**	**2,091**	**5,143**	**6,229**	**9,808**	**12,462**	**11,700**	**20,782**	**26,651**

HBDF PLAN TOTALS (2002)

FOR PENNSYLVANIA (PA)

(April 11, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	44.23%	76490	2793	6504	7585	10710	30407	18491	40785	35705
ED	KEYSTONE HEALTH PLAN EAST - PENNSYLVANIA	13.68%	23659	2,520	5,645	5,524	5,692	2,366	1,912	10,410	13,249
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	6.90%	11936	1,163	1,431	2,805	1,835	3,023	1,679	6,991	4,945
SW	HEALTHAMERICA OF PENNSYLVANIA (EASTERN PENNSYL\	6.15%	10640	705	1,712	2,482	3,523	1,101	1,117	4,288	6,352
45H	MAIL HANDLERS BENEFIT PLAN	5.29%	9149	340	839	990	1,777	2,578	2,625	3,908	5,241
26	HEALTHAMERICA OF PENNSYLVANIA (WESTERN PENNSYL	4.32%	7468	863	2,223	965	1,349	1,038	1,030	2,866	4,602
8W	UPMC HEALTH PLAN	3.65%	6310	700	1,841	1,092	1,848	332	497	2,124	4,186
32	NALC HEALTH BENEFIT PLAN	2.74%	4745	151	240	31	35	2,367	1,921	2,549	2,196
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.47%	4263	159	200	21	32	2,635	1,216	2,815	1,448
31H	GEHA BENEFIT PLAN	1.43%	2477	49	132	143	266	911	976	1,103	1,374
45S	MAIL HANDLERS BENEFIT PLAN	1.42%	2462	68	94	445	331	739	785	1,252	1,210
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.33%	2292	175	436	406	684	248	343	829	1,463
2K	HEALTH NET (QUALMED PLANS FOR HEALTH-LACKAWANN	1.12%	1930	87	243	517	725	169	189	773	1,157
NQ	HEALTHGUARD OF LANCASTER	0.93%	1603	128	564	156	395	122	238	406	1,197
S4	KEYSTONE HEALTH PLAN CENTRAL - HARRISBURG	0.85%	1470	195	329	266	322	177	181	638	832
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.85%	1469	81	228	0	0	531	629	612	857
EF	KEYSTONE HEALTH PLAN WEST - PITTSBURGH	0.79%	1367	327	127	448	103	293	69	1,068	299
27	HEALTH NET (QUALMED PLANS FOR HEALTH-GREATER AT	0.35%	613	46	73	106	103	222	63	374	239
FK	AMERIHEALTH HMO (KEYSTONE/DELAWARE VALLEY)	0.30%	526	15	51	127	332	1	0	143	383
31S	GEHA BENEFIT PLAN	0.23%	395	17	17	66	74	92	129	175	220
36S	POSTMASTERS BENEFIT PLAN	0.17%	299	6	14	5	10	177	87	188	111
44	SAMBA HEALTH BENEFIT PLAN	0.17%	287	0	0	11	5	145	126	156	131
42	ASSOCIATION BENEFIT PLAN	0.14%	247	0	0	0	0	131	116	131	116
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.09%	152	0	0	4	2	101	45	105	47
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.08%	143	6	7	8	4	99	19	113	30
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	0.05%	86	1	8	12	38	10	17	23	63
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.04%	70	0	0	6	7	12	45	18	52
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.03%	59	4	6	11	10	21	7	36	23
U4	THE HEALTH PLAN OF THE UPPER OHIO VALLEY	0.03%	55	5	14	11	24	1	0	17	38
QA	INDEPENDENT HEALTH ASSOCIATION - WESTERN NEW YC	0.03%	46	0	1	7	36	0	2	7	39
36H	POSTMASTERS BENEFIT PLAN	0.03%	45	3	4	7	1	25	5	35	10
80	GHI HEALTH PLAN	0.02%	36	2	0	7	6	16	5	25	11
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.02%	34	0	1	4	6	11	12	15	19
R5	HEALTH MAINTENANCE PLAN (HMP)	0.02%	29	4	18	1	5	1	0	6	23
JNS	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.01%	23	0	2	12	6	2	1	14	9

2G	CAPITALCARE	0.01%	13	0	6	4	1	1	1	5	8
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.01%	13	0	0	0	0	10	3	10	3
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.01%	13	1	2	2	3	5	0	8	5
64	KAISER FOUNDATION HP - OHIO (CLEVELAND)	0.01%	11	1	9	0	0	0	1	1	10
EB	EXCELLUS HEALTH PLAN, INC. (HMO-CNY CENTRAL)	0.01%	11	1	3	0	1	3	3	4	7
Total		100.00%	**172936**	**10,616**	**23,024**	**24,287**	**30,301**	**50,123**	**34,585**	**85,026**	**87,910**

HBDF PLAN TOTALS (2002)

FOR PUERTO RICO (PR)
(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
89	TRIPLE - S	97.06%	19755	356	2,872	2,273	6,534	3,097	4,623	5,726	14,029
10S+	BCBS Standard plus plans with 10 or fewer enrollees	2.23%	453	4	12	66	134	142	95	212	241
45H	MAIL HANDLERS BENEFIT PLAN	0.19%	38	2	3	4	14	6	9	12	26
32H	NALC HEALTH BENEFIT PLAN	0.15%	31	1	4	0	1	16	9	17	14
31H	GEHA BENEFIT PLAN	0.14%	29	0	0	5	6	11	7	16	13
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.12%	25	0	1	0	1	14	9	14	11
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.06%	12	0	0	1	3	8	0	9	3
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	0.05%	11	0	0	3	4	1	3	4	7
Total		100.00%	**20354**	**363**	**2,892**	**2,352**	**6,697**	**3,295**	**4,755**	**6,010**	**14,344**

HBDF PLAN TOTALS (2002)

FOR RHODE ISLAND (RI)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	61.58%	9616	387	726	1097	1848	3388	2170	4872	4744
DA	BLUCHIP COORDINATED HEALTH PLANS (COORDINATED H	25.69%	4011	666	985	759	852	434	315	1,859	2,152
45H	MAIL HANDLERS BENEFIT PLAN	3.11%	486	18	33	60	75	144	156	222	264
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.76%	431	35	109	67	158	28	34	130	301
32	NALC HEALTH BENEFIT PLAN	1.70%	265	12	17	3	1	139	93	154	111
45S	MAIL HANDLERS BENEFIT PLAN	1.52%	237	9	8	69	32	59	60	137	100
31H	GEHA BENEFIT PLAN	1.10%	171	2	2	23	59	48	37	73	98
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.07%	167	8	7	0	1	110	41	118	49
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.30%	47	0	0	1	0	31	15	32	15
31S	GEHA BENEFIT PLAN	0.29%	45	5	1	17	8	9	5	31	14
JV	FALLON COMMUNITY HEALTH PLAN	0.28%	44	4	14	8	17	1	0	13	31
DP	HEALTH NET, INC. (PHYSICIANS HEALTH SERVICES OF CO	0.15%	24	0	0	16	8	0	0	16	8
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.13%	21	0	4	0	0	11	6	11	10
44	SAMBA HEALTH BENEFIT PLAN	0.13%	20	0	0	1	2	7	10	8	12
TE	CONNECTICARE	0.13%	20	1	0	6	13	0	0	7	13
36S	POSTMASTERS BENEFIT PLAN	0.07%	11	0	0	1	0	9	1	10	1
Total		100.00%	**15616**	**1,147**	**1,906**	**2,128**	**3,074**	**4,418**	**2,943**	**7,693**	**7,923**

HBDF PLAN TOTALS (2002)

FOR SOUTH CAROLINA (SC)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	63.53%	32435	871	3118	3386	6536	10554	7970	14811	17624
45H	MAIL HANDLERS BENEFIT PLAN	18.78%	9586	225	931	808	1,979	2,290	3,353	3,323	6,263
31H	GEHA BENEFIT PLAN	4.19%	2141	50	144	96	228	765	858	911	1,230
45S	MAIL HANDLERS BENEFIT PLAN	4.09%	2088	65	131	277	423	511	681	853	1,235
32	NALC HEALTH BENEFIT PLAN	2.38%	1215	34	117	13	34	517	500	564	651
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.02%	1031	59	289	0	0	342	341	401	630
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.65%	844	31	117	5	10	399	282	435	409
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.52%	774	45	134	135	224	103	133	283	491
31S	GEHA BENEFIT PLAN	0.56%	286	3	18	38	77	64	86	105	181
44	SAMBA HEALTH BENEFIT PLAN	0.36%	183	0	0	1	5	78	99	79	104
36S	POSTMASTERS BENEFIT PLAN	0.28%	143	1	5	1	4	95	37	97	46
42	ASSOCIATION BENEFIT PLAN	0.26%	133	0	0	0	0	64	69	64	69
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.12%	61	3	3	2	3	41	9	46	15
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.09%	47	0	0	3	6	23	15	26	21
36H	POSTMASTERS BENEFIT PLAN	0.05%	23	2	0	1	0	19	1	22	1
43	PANAMA CANAL AREA BENEFIT PLAN	0.04%	20	0	0	0	1	13	6	13	7
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.04%	19	0	0	0	0	14	5	14	5
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.03%	13	0	0	0	0	6	7	6	7
80	GHI HEALTH PLAN	0.03%	13	0	0	0	0	12	1	12	1
Total		100.00%	**51055**	**1,389**	**5,007**	**4,766**	**9,530**	**15,910**	**14,453**	**22,065**	**28,990**

HBDF PLAN TOTALS (2002)

FOR SOUTH DAKOTA (SD)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	65.33%	9646	208	994	1183	3119	2138	2004	3529	6117
45H	MAIL HANDLERS BENEFIT PLAN	12.70%	1875	34	137	253	596	393	462	680	1,195
31H	GEHA BENEFIT PLAN	5.74%	848	16	70	39	122	261	340	316	532
45S	MAIL HANDLERS BENEFIT PLAN	5.01%	740	14	26	147	259	116	178	277	463
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	3.93%	581	12	152	0	0	191	226	203	378
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	1.91%	282	9	33	0	6	118	116	127	155
32	NALC HEALTH BENEFIT PLAN	1.69%	250	8	30	1	8	111	92	120	130
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.65%	243	11	32	56	94	20	30	87	156
31S	GEHA BENEFIT PLAN	0.74%	109	3	12	15	24	20	35	38	71
36S	POSTMASTERS BENEFIT PLAN	0.45%	66	4	9	1	0	38	14	43	23
AU	SIOUX VALLEY HEALTH PLAN	0.42%	62	1	6	7	39	1	8	9	53
AVH	AVERA HEALTH PLAN	0.27%	40	2	3	12	20	3	0	17	23
44	SAMBA HEALTH BENEFIT PLAN	0.16%	24	0	0	1	0	8	15	9	15
Total		100.00%	**14766**	**322**	**1,504**	**1,715**	**4,287**	**3,418**	**3,520**	**5,455**	**9,311**

HBDF PLAN TOTALS (2002)

FOR TENNESSEE (TN)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	57.21%	37154	1379	4995	4027	7801	10651	8301	16057	21097
45H	MAIL HANDLERS BENEFIT PLAN	15.47%	10048	472	1,941	1,147	2,498	1,660	2,330	3,279	6,769
31H	GEHA BENEFIT PLAN	5.04%	3275	86	274	204	482	979	1,250	1,269	2,006
UB	PRUDENTIAL HEALTHCARE HMO - MEMPHIS	4.50%	2924	189	530	795	940	291	179	1,275	1,649
45S	MAIL HANDLERS BENEFIT PLAN	4.00%	2598	94	242	418	831	452	561	964	1,634
32	NALC HEALTH BENEFIT PLAN	2.74%	1777	64	199	36	62	730	686	830	947
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.51%	1633	61	394	0	0	526	652	587	1,046
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.30%	1492	102	281	10	26	614	459	726	766
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.24%	1453	108	319	231	577	84	134	423	1,030
6J	AETNA US HEALTHCARE, INC. - TENNESSEE	1.32%	854	106	177	236	193	82	60	424	430
6K	HEALTHNET HMO	1.05%	685	65	148	184	204	39	45	288	397
31S	GEHA BENEFIT PLAN	0.58%	375	10	25	56	113	74	97	140	235
44	SAMBA HEALTH BENEFIT PLAN	0.35%	225	0	0	4	6	89	126	93	132
36S	POSTMASTERS BENEFIT PLAN	0.24%	155	6	7	1	7	86	48	93	62
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.14%	89	3	8	3	5	55	15	61	28
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.09%	61	0	0	0	0	31	30	31	30
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.07%	48	0	0	2	4	12	30	14	34
42	ASSOCIATION BENEFIT PLAN	0.06%	40	0	0	0	0	32	8	32	8
36H	POSTMASTERS BENEFIT PLAN	0.05%	33	2	4	5	2	19	1	26	7
43	PANAMA CANAL AREA BENEFIT PLAN	0.03%	19	0	0	0	0	10	9	10	9
Total		100.00%	**64938**	**2,747**	**9,544**	**7,359**	**13,751**	**16,516**	**15,021**	**26,622**	**38,316**

HBDF PLAN TOTALS (2002)

FOR TEXAS (TX)

(April 14, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	48.00%	119448	3424	11329	13432	27281	37266	26716	54122	65326
31H	GEHA BENEFIT PLAN	9.67%	24058	762	2,738	1,838	4,383	6,519	7,818	9,119	14,939
45H	MAIL HANDLERS BENEFIT PLAN	8.34%	20765	638	2,657	2,507	6,031	3,862	5,070	7,007	13,758
YM	NYLCARE HEALTH PLANS OF THE GULF COAST/AUSTIN/CC	6.62%	16486	1,370	4,195	3,145	5,262	1,244	1,270	5,759	10,727
YX	NYLCARE HEALTH PLANS OF THE SOUTHWEST (DALLAS) ('	4.83%	12014	1,453	4,107	1,931	2,971	801	751	4,185	7,829
GF	PACIFICARE OF TEXAS (SAN ANTONIO)	4.22%	10514	504	1,881	1,902	3,793	1,112	1,322	3,518	6,996
UR	HUMANA HEALTH PLAN - TEXAS (SAN ANTONIO)	3.43%	8541	131	743	1,158	2,532	1,656	2,321	2,945	5,596
32	NALC HEALTH BENEFIT PLAN	3.23%	8050	439	1,650	141	353	2,531	2,936	3,111	4,939
45S	MAIL HANDLERS BENEFIT PLAN	2.56%	6366	176	356	1,093	1,691	1,429	1,621	2,698	3,668
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.21%	5502	449	1,313	126	246	1,840	1,528	2,415	3,087
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.63%	4045	239	731	800	1,390	390	495	1,429	2,616
31S	GEHA BENEFIT PLAN	1.14%	2833	97	253	436	716	589	742	1,122	1,711
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.95%	2372	143	606	0	0	836	787	979	1,393
2V	AMCARE HEALTH PLANS OF TEXAS (HOUSTON, EL PASO A	0.88%	2188	188	675	371	571	189	194	748	1,440
6U	FIRSTCARE (WACO REGION)	0.72%	1790	65	322	372	728	128	175	565	1,225
44	SAMBA HEALTH BENEFIT PLAN	0.32%	792	0	0	95	90	224	383	319	473
CK	FIRSTCARE (ABILENE, AMARILLO & LUBBOCK REGIONS)	0.28%	689	50	173	86	217	63	100	199	490
36S	POSTMASTERS BENEFIT PLAN	0.25%	622	24	35	34	36	332	161	390	232
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.13%	315	0	0	20	7	169	119	189	126
ZG	AMCARE HEALTH PLANS OF TEXAS	0.12%	292	11	17	98	91	37	38	146	146
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.10%	259	9	9	24	18	157	42	190	69
42	ASSOCIATION BENEFIT PLAN	0.07%	186	0	0	0	0	87	99	87	99
HM	MERCY HEALTH PLANS OF TEXAS	0.06%	142	6	19	39	73	1	4	46	96
36H	POSTMASTERS BENEFIT PLAN	0.05%	134	18	10	10	8	76	12	104	30
43	PANAMA CANAL AREA BENEFIT PLAN	0.05%	117	0	0	2	0	54	61	56	61
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.03%	82	0	0	3	2	39	38	42	40
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.02%	61	0	0	9	25	12	15	21	40
PX	CIMARRON HEALTH PLAN, INC. (QUALMED PLANS FOR HEA	0.02%	40	0	0	9	30	0	1	9	31
Q1	LOVELACE HEALTH PLAN	0.01%	33	0	0	4	24	5	0	9	24
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.01%	32	0	2	1	1	18	10	19	13
P2	PRESBYTERIAN HEALTH PLAN (FHP-NEW MEXICO)	0.01%	23	0	0	4	16	3	0	7	16
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.01%	15	0	0	3	1	6	5	9	6
2N	PACIFICARE OF OKLAHOMA - OKLAHOMA CITY	0.01%	14	1	4	0	6	1	2	2	12
65	KAISER FOUNDATION HP - COLORADO	0.01%	13	0	0	0	1	5	7	5	8
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.01%	13	1	0	2	2	3	5	6	7
ZH	AMCARE HEALTH PLANS OF LOUISIANA (NEW ORLEANS AF	0.01%	13	1	11	0	1	0	0	1	12
Total		100.00%	**248859**	**10,199**	**33,836**	**29,695**	**58,597**	**61,684**	**54,848**	**101,578**	**147,281**

HBDF PLAN TOTALS (2002)

FOR UTAH (UT)
(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	42.90%	22700	204	787	2582	5246	8054	5827	10840	11860
45H	MAIL HANDLERS BENEFIT PLAN	32.11%	16991	298	1,454	1,868	5,528	2,934	4,909	5,100	11,891
9K	ALTIUS HEALTH PLANS, INC. (PACIFICARE OF UTAH)	13.01%	6884	127	679	1,352	3,116	736	874	2,215	4,669
45S	MAIL HANDLERS BENEFIT PLAN	5.00%	2647	37	96	563	739	527	685	1,127	1,520
31H	GEHA BENEFIT PLAN	2.02%	1069	9	21	98	268	283	390	390	679
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.31%	693	22	41	178	298	65	89	265	428
42	ASSOCIATION BENEFIT PLAN	0.98%	516	0	0	0	504	12	0	12	504
32	NALC HEALTH BENEFIT PLAN	0.96%	508	8	37	19	26	205	213	232	276
31S	GEHA BENEFIT PLAN	0.52%	277	2	10	79	110	35	41	116	161
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.47%	250	11	15	4	15	124	81	139	111
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.16%	87	1	23	0	0	35	28	36	51
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.14%	76	1	1	2	4	56	12	59	17
44	SAMBA HEALTH BENEFIT PLAN	0.14%	73	0	0	2	1	28	42	30	43
36S	POSTMASTERS BENEFIT PLAN	0.12%	62	1	0	7	2	37	15	45	17
Y7H	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.07%	35	0	0	2	3	0	30	2	33
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.04%	23	0	0	3	12	4	4	7	16
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.03%	18	0	0	1	1	16	0	17	1
Total		100.00%	**52909**	**721**	**3,164**	**6,760**	**15,873**	**13,151**	**13,240**	**20,632**	**32,277**

HBDF PLAN TOTALS (2002)

FOR VIRGINIA (VA)

(April 14, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	55.30%	131542	1937	5516	19189	30113	43390	31397	64516	
45H	MAIL HANDLERS BENEFIT PLAN	7.87%	18731	427	1,482	3,011	5,821	3,611	4,379	7,049	11,682
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	6.92%	16451	378	1,154	4,566	6,009	2,313	2,031	7,257	9,194
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	6.33%	15048	530	1,713	4,022	7,347	644	792	5,196	9,852
31H	GEHA BENEFIT PLAN	4.18%	9950	95	289	1,141	2,231	2,805	3,389	4,041	5,909
9R	OPTIMA HEALTH PLAN	3.44%	8189	174	437	2,101	2,879	1,405	1,193	3,680	4,509
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	2.99%	7111	280	687	2,253	2,957	519	415	3,052	4,059
45S	MAIL HANDLERS BENEFIT PLAN	1.99%	4743	90	209	934	1,298	1,035	1,177	2,059	2,684
X8	HEALTHKEEPERS, INC. (HMO VIRGINIA - RICHMOND)	1.91%	4533	172	537	1,091	2,029	383	321	1,646	2,887
42	ASSOCIATION BENEFIT PLAN	1.63%	3873	0	0	0	0	1,894	1,979	1,894	1,979
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.23%	2922	83	213	786	1,097	351	392	1,220	1,702
32	NALC HEALTH BENEFIT PLAN	1.22%	2890	141	324	120	164	1,114	1,027	1,375	1,515
JNS	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	1.08%	2566	28	112	946	1,258	110	112	1,084	1,482
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.79%	1874	111	265	58	96	824	520	993	881
44	SAMBA HEALTH BENEFIT PLAN	0.60%	1419	0	0	123	102	472	722	595	824
2G	CAPITALCARE	0.53%	1249	37	79	418	525	100	90	555	694
31S	GEHA BENEFIT PLAN	0.52%	1247	13	33	207	264	305	425	525	722
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.43%	1025	52	234	0	0	349	390	401	624
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.41%	981	1	0	21	24	534	401	556	425
36S	POSTMASTERS BENEFIT PLAN	0.15%	353	12	9	45	28	176	83	233	120
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.09%	217	8	12	45	41	83	28	136	81
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.09%	215	0	0	1	1	42	171	43	172
2C	PIEDMONT COMMUNITY HEALTHCARE (VIRGINIA)	0.05%	120	18	34	10	27	8	23	36	84
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.04%	93	1	4	24	58	5	1	30	63
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.04%	92	1	1	17	67	3	3	21	71
36H	POSTMASTERS BENEFIT PLAN	0.03%	78	1	7	14	5	42	9	57	21
JKH	PACIFICARE HEALTH INSURANCE COMPANY MICRONESIA	0.03%	77	0	0	15	62	0	0	15	62
43	PANAMA CANAL AREA BENEFIT PLAN	0.02%	57	0	0	0	0	29	28	29	28
P3	AETNA US HEALTHCARE, INC. - NEW JERSEY	0.01%	31	1	3	9	14	4	0	14	17
80	GHI HEALTH PLAN	0.01%	28	0	0	4	15	8	1	12	16
89	TRIPLE - S	0.01%	23	0	3	4	15	1	0	5	18
JKS	PACIFICARE HEALTH INSURANCE COMPANY MICRONESIA	0.01%	22	0	0	4	18	0	0	4	18
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.01%	19	0	0	3	14	2	0	5	14
F8	KAISER FOUNDATION HP - GEORGIA	0.01%	18	2	3	7	3	2	1	11	7
JC	AETNA US HEALTHCARE, INC. - NEW YORK	0.01%	17	1	3	3	7	3	0	7	10

M5	BLUE CROSS CALIFORNIACARE	0.01%	17	0	0	6	11	0	0	6	11
51	HEALTH INSURANCE PLAN OF GREATER N.Y. (HIP/HMO)	0.01%	14	0	1	2	3	6	2	8	6
LB	HEALTH NET	0.01%	13	1	1	3	7	1	0	5	8
CY	PACIFICARE OF CALIFORNIA (FHP-CA)	0.00%	11	0	0	2	8	1	0	3	8
Total		100.00%	**237859**	**4,595**	**13,365**	**41,205**	**64,618**	**62,574**	**51,502**	**108,374**	**129,485**

HBDF PLAN TOTALS (2002)

FOR VERMONT (VT)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	64.57%	4692	321	777	754	1147	926	767	2001	2691
45H	MAIL HANDLERS BENEFIT PLAN	9.21%	669	47	122	45	69	149	237	241	428
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	8.24%	599	58	96	180	201	21	43	259	340
VW	MVP HEALTH PLAN - VERMONT	3.52%	256	36	16	93	40	48	23	177	79
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	3.29%	239	11	17	1	1	138	71	150	89
45S	MAIL HANDLERS BENEFIT PLAN	3.03%	220	10	13	34	29	60	74	104	116
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	2.59%	188	9	33	0	0	66	80	75	113
31H	GEHA BENEFIT PLAN	2.05%	149	7	7	7	20	54	54	68	81
32H	NALC HEALTH BENEFIT PLAN	1.75%	127	2	7	2	2	51	63	55	72
36S	POSTMASTERS BENEFIT PLAN	0.59%	43	1	3	1	0	25	13	27	16
31S	GEHA BENEFIT PLAN	0.41%	30	0	2	3	6	6	13	9	21
44	SAMBA HEALTH BENEFIT PLAN	0.23%	17	0	0	0	1	8	8	8	9
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.21%	15	0	0	0	0	15	0	15	0
42	ASSOCIATION BENEFIT PLAN	0.17%	12	0	0	0	0	4	8	4	8
GA	MVP HEALTH PLAN - EASTERN DIVISION	0.15%	11	0	10	0	1	0	0	0	11
Total		100.00%	**7267**	**502**	**1,103**	**1,120**	**1,517**	**1,571**	**1,454**	**3,193**	**4,074**

HBDF PLAN TOTALS (2002)

FOR WASHINGTON (WA)

(April 14, 2003)

				Postal		Non-Postal		Annuitant		Total	
Code	Plan		Total Contracts	Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	38.60%	37178	1093	2782	4959	7399	12192	8753	18244	
54	GROUP HEALTH COOPERATIVE OF PUGET SOUND/WESTEI	25.58%	24636	1,175	2,757	4,653	7,280	4,579	4,192	10,407	14,229
31H	GEHA BENEFIT PLAN	6.62%	6374	60	185	495	1,135	2,020	2,479	2,575	3,799
VTS	KITSAP PHYSICIANS SERVICE	4.41%	4252	13	47	557	1,373	1,148	1,114	1,718	2,534
VR	GROUP HEALTH COOPERATIVE OF PUGET SOUND/EASTEF	4.28%	4120	339	718	867	1,108	510	578	1,716	2,404
45H	MAIL HANDLERS BENEFIT PLAN	3.83%	3692	146	426	481	1,040	714	885	1,341	2,351
57H	KAISER FOUNDATION HP - NORTHWEST	3.19%	3077	87	295	418	670	825	782	1,330	1,747
WB	PACIFICARE OF WASHINGTON	2.40%	2309	165	309	764	593	287	191	1,216	1,093
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	2.21%	2124	137	348	472	709	169	289	778	1,346
8J	AETNA US HEALTHCARE, INC. - WASHINGTON	1.75%	1685	110	299	525	553	88	110	723	962
45S	MAIL HANDLERS BENEFIT PLAN	1.60%	1542	39	97	318	369	299	420	656	886
32	NALC HEALTH BENEFIT PLAN	1.19%	1144	86	121	13	35	473	416	572	572
47H	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	0.98%	940	52	109	14	18	509	238	575	365
31S	GEHA BENEFIT PLAN	0.88%	849	15	26	166	190	186	266	367	482
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.48%	458	28	96	0	0	174	160	202	256
57S	KAISER FOUNDATION HP - NORTHWEST	0.41%	395	3	10	42	55	144	141	189	206
VTH	KITSAP PHYSICIANS SERVICE	0.37%	361	0	3	54	62	185	57	239	122
7Z	PACIFICARE OF OREGON (WAS CODE SS)	0.34%	329	9	34	70	111	47	58	126	203
44	SAMBA HEALTH BENEFIT PLAN	0.21%	203	0	0	12	15	70	106	82	121
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.16%	156	0	0	5	5	86	60	91	65
36S	POSTMASTERS BENEFIT PLAN	0.16%	154	5	8	10	5	89	37	104	50
42	ASSOCIATION BENEFIT PLAN	0.10%	94	0	0	0	0	40	54	40	54
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.08%	80	6	4	12	7	45	6	63	17
59	KAISER FOUNDATION HP - NORTHERN CALIFORNIA	0.06%	56	0	0	4	10	25	17	29	27
62	KAISER FOUNDATION HP - SOUTHERN CALIFORNIA	0.03%	31	0	1	5	2	16	7	21	10
36H	POSTMASTERS BENEFIT PLAN	0.03%	26	3	3	2	0	17	1	22	4
87	HAWAII MEDICAL SERVICE ASSOCIATION PLAN	0.02%	24	0	0	3	1	9	11	12	12
43	PANAMA CANAL AREA BENEFIT PLAN	0.02%	23	0	0	0	0	13	10	13	10
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.01%	11	0	0	3	2	6	0	9	2
Total		100.00%	**96323**	**3,571**	**8,678**	**14,924**	**22,747**	**24,965**	**21,438**	**43,460**	**52,863**

HBDF PLAN TOTALS (2002)

FOR WISCONSIN (WI)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	49.55%	20190	1777	3960	2072	3105	5491	3785	9340	
WD	DEAN HEALTH PLAN	9.01%	3671	476	972	426	630	504	663	1,406	2,265
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	6.49%	2644	552	780	453	450	211	198	1,216	1,428
45H	MAIL HANDLERS BENEFIT PLAN	6.08%	2476	110	471	231	469	543	652	884	1,592
32	NALC HEALTH BENEFIT PLAN	5.04%	2055	105	247	29	45	849	780	983	1,072
31H	GEHA BENEFIT PLAN	4.38%	1786	59	190	137	196	581	623	777	1,009
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	3.80%	1547	121	196	14	22	670	524	805	742
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	3.73%	1520	82	367	0	0	453	618	535	985
WJ	GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WI.	3.32%	1352	144	238	296	388	136	150	576	776
45S	MAIL HANDLERS BENEFIT PLAN	2.91%	1185	92	136	257	187	229	284	578	607
W4	UNITY HEALTH PLANS (HMO OF WISCONSIN)	2.89%	1178	96	166	262	292	197	165	555	623
31S	GEHA BENEFIT PLAN	1.07%	436	34	46	64	97	82	113	180	256
WT	GROUP HEALTH COOPERATIVE OF EAU CLAIRE	0.40%	165	22	33	21	17	50	22	93	72
36S	POSTMASTERS BENEFIT PLAN	0.32%	129	7	7	3	3	69	40	79	50
53H	HEALTHPARTNERS SELECT (GROUP HEALTH PLAN)	0.29%	118	14	38	5	6	29	26	48	70
44	SAMBA HEALTH BENEFIT PLAN	0.16%	65	0	0	1	2	32	30	33	32
HQ	HEALTH PARTNERS PRIMARY CLINIC (HEALTHPARTNERS H	0.15%	61	9	18	1	1	14	18	24	37
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.13%	52	2	4	4	3	35	4	41	11
42	ASSOCIATION BENEFIT PLAN	0.09%	36	0	0	0	0	28	8	28	8
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.08%	31	0	0	0	0	31	0	31	0
53S	HEALTHPARTNERS SELECT (GROUP HEALTH PLAN)	0.05%	22	1	12	0	1	3	5	4	18
36H	POSTMASTERS BENEFIT PLAN	0.03%	13	1	1	0	0	9	2	10	3
Y7	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.03%	11	0	0	3	2	6	0	9	2
Total		100.00%	**40743**	**3,704**	**7,882**	**4,279**	**5,916**	**10,252**	**8,710**	**18,235**	**22,508**

HBDF PLAN TOTALS (2002)

FOR WEST VIRGINIA (WV)

(April 14, 2003)

Code	Plan		Total Contracts	Postal Self	Postal Family	Non-Postal Self	Non-Postal Family	Annuitant Self	Annuitant Family	Total Self	Total Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	69.66%	18842	516	2021	2923	6101	4056	3225	7495	
45H	MAIL HANDLERS BENEFIT PLAN	8.80%	2379	69	235	284	630	553	608	906	1,473
31H	GEHA BENEFIT PLAN	5.22%	1411	35	128	123	247	384	494	542	869
47	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.55%	689	33	108	8	19	302	219	343	346
45S	MAIL HANDLERS BENEFIT PLAN	2.51%	678	9	26	118	188	139	198	266	412
U4	THE HEALTH PLAN OF THE UPPER OHIO VALLEY	2.34%	632	63	127	116	202	49	75	228	404
32	NALC HEALTH BENEFIT PLAN	2.33%	630	27	62	5	4	295	237	327	303
11	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.83%	496	30	68	117	189	32	60	179	317
38	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1.47%	398	25	101	0	0	140	132	165	233
36S	POSTMASTERS BENEFIT PLAN	0.84%	227	13	12	4	1	116	81	133	94
31S	GEHA BENEFIT PLAN	0.55%	148	4	8	22	33	39	42	65	83
JP	M.D. IPA: THE QUALITY CARE HEALTH PLAN	0.47%	128	0	9	28	51	17	23	45	83
42	ASSOCIATION BENEFIT PLAN	0.30%	82	0	0	0	0	36	46	36	46
44	SAMBA HEALTH BENEFIT PLAN	0.22%	60	0	0	0	3	25	32	25	35
E3	KAISER FOUNDATION HP - MID-ATLANTIC STATES (DC)	0.18%	50	0	0	8	12	10	20	18	32
8W	UPMC HEALTH PLAN	0.15%	40	2	8	9	21	0	0	11	29
JNH	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.14%	37	1	0	13	15	6	2	20	17
26	HEALTHAMERICA OF PENNSYLVANIA (WESTERN PENNSYL	0.10%	26	2	7	5	11	0	1	7	19
40	AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION	0.09%	23	0	0	0	0	8	15	8	15
1R	ALLIANCE HEALTH BENEFIT PLAN (WAS CODE YQ/YK/YA)	0.08%	22	0	1	1	0	18	2	19	3
Y7H	SECRET SERVICE EMPLOYEES HEALTH ASSOCIATION	0.07%	19	0	0	3	1	15	0	18	1
36H	POSTMASTERS BENEFIT PLAN	0.06%	16	0	0	0	0	11	5	11	5
JNS	AETNA US HEALTHCARE, INC. - MID-ATLANTIC (NYLCARE	0.05%	14	0	0	4	10	0	0	4	10
Total		100.00%	**27047**	**829**	**2,921**	**3,791**	**7,738**	**6,251**	**5,517**	**10,871**	**16,176**

HBDF PLAN TOTALS (2002)

FOR WYOMING (WY)

(April 14, 2003)

Code	Plan		Total Contracts	Postal		Non-Postal		Annuitant		Total	
				Self	Family	Self	Family	Self	Family	Self	Family
10S+	BCBS Standard plus plans with 10 or fewer enrollees	67.11%	5950	156	641	821	1867	1312	1153	2289	3661
45H	MAIL HANDLERS BENEFIT PLAN	11.45%	1015	14	102	101	338	198	262	313	702
31H	GEHA BENEFIT PLAN	9.14%	810	12	42	75	170	213	298	300	510
45S	MAIL HANDLERS BENEFIT PLAN	3.98%	353	4	13	66	120	54	96	124	229
47H	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	2.28%	202	15	28	6	8	78	67	99	103
32H	NALC HEALTH BENEFIT PLAN	1.59%	141	5	17	1	7	61	50	67	74
11H	BLUE CROSS AND BLUE SHIELD SERVICE BASIC	1.48%	131	5	18	34	43	8	23	47	84
PVH	WINHEALTH PARTNERS	1.14%	101	1	7	36	44	9	4	46	55
31S	GEHA BENEFIT PLAN	1.11%	98	0	1	16	27	20	34	36	62
38H	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	0.43%	38	0	12	0	0	10	16	10	28
36S	POSTMASTERS BENEFIT PLAN	0.30%	27	0	10	1	1	9	6	10	17
Total		100.00%	**8866**	**212**	**891**	**1,157**	**2,625**	**1,972**	**2,009**	**3,341**	**5,525**

RESPONSES TO QUESTIONS FROM SENATOR LINCOLN

Question 1: It is my understanding that all FEHBP fee-for-service plans are actually preferred provider organization (PPO) networks that charge higher cost-sharing for "out-of-network" health care services. A federal employee residing in rural Arkansas recently told me that he would have to go out of his PPO network in order to visit his local hospital, and to stay in network, he would have to drive many hours. I understand that PPOs don't contract with providers in all areas. Is this a particular problem in rural areas? Do rural beneficiaries typically have to go "out

of network" to receive care from their local providers (and thus pay higher copays and deductibles?) How does this compare to traditional Medicare?

Answer: Since the fee-for-service plans introduced preferred provider networks into the Federal Employees Health Benefits (FEHB) Program in the 1980s, we have always made clear in our informational materials that the preferred provider benefit is an enhancement over the standard non-network benefit offered by the plans. In a typical network arrangement, the provider agrees to accept a rate of payment lower than billed charges in exchange for advantages such as more potential patients, expedited reimbursement, and other services offered by the plan. Often plans monitor the services provided in-network to ensure that their providers are well informed about current practice patterns and new developments in health care delivery. The plan, in turn, can pass on the benefits it derives from provider participation in the network to members in the form of lower out-of-pocket costs when they use a preferred provider. Those lower costs are offered as an incentive to members to choose in-network services when they are available. We have never guaranteed in-network coverage except in the Blue Cross Blue Shield (BCBS) Basic Option. Since Basic is an Option in a nationwide plan and it provides no coverage for out-of-network services, we negotiated special provisions to ensure that coverage would be available everywhere in the country. While the other nationwide plans, such as GEHA and Mail Handlers, make a concerted effort to keep expanding their networks, they do not guarantee in-network coverage everywhere in the country. However, GEHA and Mail Handlers members have access to all of the providers available in the community. But for those providers that have not agreed to accept a discounted payment rate, the member does not get the advantage of reduced out-of-pocket costs. Information on provider availability is available during the annual open season, and members make their plan election based on that information as well as other factors that help them determine which plan best suits their needs and the needs of their family.

For BCBS nationwide, 97 percent of inpatient claims, 93 percent of outpatient claims, and 93 percent of professional claims are for in-network services. For GEHA, the percentages are 80 percent, 80 percent, and 74 percent. For the Mail Handlers Benefit Plan, the overall percentage is 69. We do not have a breakdown by type of service. While access to network providers may be a reason members go out-of-network for services, the biggest reason is that they have an established relationship with an out-of-network doctor. The BCBS outside network access standard for a preferred provider is 75 miles in rural areas. BCBS data for Arkansas indicates that the standard of 30 miles for both primary care physicians, including internal medicine, general practice, pediatrics, family practice, and obstetrics and gynecology and for hospitals is met, as well as the standard for key specialties, including cardiology, gastroenterology, orthopedic surgery, otolaryngology, and urology. There are situations where no provider is available within the standards. If only a non-network provider is available, in special provider access situations, members in Basic Option may use the case by case exemption process available to them by contacting their Local Plan.

Question 2: I've looked at the health plan offerings in my home state of Arkansas. Nearly everyone is enrolled in Blue Cross/Blue Shield because there are no local options or HMOs for federal employees in Arkansas. The last HMO to be offered to Arkansas FEHBP members pulled out of the program in 2000. Similarly, the last Medicare HMO (in the Medicare+Choice program) pulled out in 20001. I see a trend here. In recent years, how many enrollees have been forced to change insurance plans because they withdrew from the program? Are local options (HMOs) hard to come by?

Answer: BCBS is the most popular plan in the FEHB Program nationally, as well as in Arkansas. It is the most popular health insurer in Arkansas not only for Federal members, but for all lines of business. Nevertheless, more than one-third of Federal employees and annuitants in Arkansas have chosen to enroll in one of the other ten options available to them. Although the number of HMOs available nationally has declined in recent years as a result of mergers and consolidations in the industry, they are still widely available in some areas of the country. However, in some areas, including rural areas, health plans have less economic leverage because there are few competing providers. Over all, although the FEHB Program has lost 178 HMOs in the past 5 years, the number of enrollees affected has been relatively small. In 2002, 27,000 enrollees were affected. In 2003, the total was 27,461. These numbers represent well under one percent of the total FEHB enrollment.

Question 3: In Arkansas, 78 companies have withdrawn from the Arkansas health insurance market since 1992. 66 of these withdrawals have taken place within the last five years! Additionally, in Arkansas and ten other states, there are no HMO plans available to FEHBP beneficiaries. The claim by the President is that remod-

eling Medicare based on FEHBP would increase choice for beneficiaries. But, what kind of choice does FEHBP really offer in Arkansas and the other states that offer only fee-for-service (really PPO) plans? What would be different for Medicare beneficiaries in these states if they were moved into an FEHBP—like system? It seems that the only difference is that they would be giving up Medicare's choice of doctor at a guaranteed price for a PPO program in which they would face unknown out-of-pocket costs for seeing the doctor or hospital of their choice.

Answer: Most people in Arkansas are enrolled in plans offered by a few large carriers. While this is generally true in other states as well as in the FEHB Program, many enrollees can and do take advantage of choice. Overall, about 27 percent of FEHB members are enrolled in HMOs. The percentage of active employees is higher at 36 percent. The disparity in our Program, in part, is the result of coordination mechanisms unique to the FEHB Program that would not be true in an expanded choice system such as the President proposes. For FEHB enrollees, the out-of-pocket costs associated with seeing a non-network provider are fully disclosed in every plan brochure so that our members are not facing unknown costs.

The current economic and regulatory environment in Arkansas has had the result you cite. We understand that the situation is so dire that Governor Huckabee recently signed a law allowing small employers access to the Medicaid system via a waiver. Despite this upheaval in the Arkansas insurance market, Federal employees continue to enjoy a broad range of coverage options through the FEHB Program. No national open enrollment plan has withdrawn from the Program since 1996. Federal employees enrolled in these plans can choose their own doctors and also pay less out of their own pockets for medical care than do Medicare beneficiaries when they receive care from network providers. As I understand it, the President's proposal would make similar plans available to Medicare beneficiaries.

Question 4: Blue Cross/Blue Shield covers over 50% of FEHBP enrollees nationwide, and about 67% of FEHBP enrollees in Arkansas. What if Blue Cross/Blue Shield pulled out of the FEHBP program? I understand that this was a real possibility in 2002, when Blue Cross threatened to withdraw from FEHBP. What did OPM do to keep the in the program? Since this plan covers most FEHBP enrollees, doesn't it—and not the OPM—have the upper hand in negotiations? How does this affect your ability to negotiate benefits and premiums and run an efficient program?

Answer: While BCBS does have over 50 percent of the enrollment in the FEHB Program, that has not limited our ability to negotiate benefits and premiums and run an efficient Program. Several factors contribute. First, the national FEHB enrollment in BCBS makes us their largest customer. We pay them about $10 billion in premiums each year, no small change even to the largest insurer in the country. About 97 percent of that amount covers the cost of claims. Administrative expenses are carefully monitored by both the contracting office and the independent OPM Inspector General. The service charge or profit available is negotiated annually based on a regulated formula and is well under 1 percent of premium. The plan has every incentive to keep its rates as low as possible since the FEHB Program is a competitive market. Second, OPM staff carefully monitors the performance of all the plans in the Program, including the BCBS plan. Since the inception of the Program, the Association has established a special office to administer our account. We deal with that office daily to ensure that customer service levels meet our requirements.

In regard to the threatened pull-out at the end of 2002, the issue involved application of the Cost Accounting Standards. FEHB Plans have been exempted from the standards by statute for the past 4 years. However, as we were closing negotiations and gearing up for the annual open season, continuation of the statutory exemption was not certain. Therefore, the Director of OPM, Kay Coles James, used her statutory authority to waive coverage for all affected FEHB contracts. She made that determination with the certainty that adequate oversight provisions were in place to monitor the financial operations of the plans.

Question 5: I understand that active federal workers, who are typically younger, are more likely to choose an HMO than retirees. Also, a recent article in *Health Affairs* shows that most Medicare beneficiaries aren't interested in joining a Medicare HMO. Do you think federal retirees are more likely to choose less restrictive fee-for-service/PPO plans because they have the ability to better choose their own providers?

Answer: Federal retirees are more likely to choose fee-for-service plans because of unique features of FEHB and Medicare that allow them to use those plans as a Medicare supplement, resulting in broad coverage with very low levels of cost sharing. Typically, retirees who used an HMO delivery system extensively before they retired remain in those plans. For that reason, the California Kaiser plan has an unusually large FEHB retiree enrollment. Others who used the fee-for-service/PPO system prior to their retirement tend to remain in those plans.

For active workers, the PPO option has long been an attractive alternative. This mirrors the trend in private insurance markets away from tightly managed care and toward more open provider networks. As I understand the President's proposal, he would make these same sorts of networks broadly available to Medicare beneficiaries. The *Health Affairs* article you cited lists several reasons for the recent decline in Medicare+Choice enrollment, including a slowdown in Federal payments to plans. Supplemental coverage is another reason mentioned in the article. Because Medicare offers coverage that is less generous than that typically offered by private plans, the vast majority of Medicare beneficiaries need supplemental coverage. Some qualify for public programs like Medicaid and veterans benefits. About on-third have coverage through their former employers. Others purchase their own supplemental private insurance policies, which tend to be fairly expensive. Because Medicare+Choice plans generally require lower copayments than Medicare and usually cover more services, the plans are very popular among beneficiaries who do not have supplemental coverage. The article reports that 39 percent of beneficiaries who live in a county with a Medicare+Choice plan and who do not get supplemental coverage through a former employer or Medicaid are enrolled in a Medicare+Choice plan.

Question 6: Public programs like Medicare and Medicaid are a significant source of revenue for health care providers in Arkansas. Some hospitals in my state have expressed reservations about the President's plans to privatize Medicare because, in their experience, Medicare HMOs paid a lot less than Medicare. Can you comment on the experience of health care providers in the FEHBP program? What would happen to these providers if we were to privatize Medicare? If they are shut out of PPO networks, won't they financially suffer?

Answer: I do not interpret the President's proposal as an attempt to privatize Medicare. His proposal clearly stipulates that beneficiaries will retain the option to enroll in traditional Medicare fee-for-service, but adds a new option that would give Medicare beneficiaries the same sorts of choices among private plans that Federal workers have now.

It is hard to understand why providers believe that a private option for Medicare beneficiaries would change their revenue stream. While the rates paid by private health plans are negotiated, and providers can refuse to contract if the offered rate is not satisfactory, Medicare reimbursement is set by regulation and Medicare is so large that few hospitals can choose not to participate. In our experience, Medicare DRGs are not generally higher than negotiated network rates. Thus, hospitals should not suffer diminished revenues from contracting with private insurers.

Question 7: A January 2002 report by the *Congressional Research Service* on the FEHBP program explains that in general all FEHBP plans limit enrollees' choice of providers. In PPO plans, CRS found that enrollees do not know what the coinsurance rate will be for seeing an out-of-network provider and face great difficulties in determining what those costs will be. Do you know what the average out-of-pocket coinsurance rate is in FEHBP plans, and what that amount is in Arkansas?

Answer: The FEHB fee-for-service/PPO plans do not limit the choice of providers. Except for the Blue Cross Blue and Shield Basic Option, members have a complete choice of providers, since all the other national plans offer an out-of-network benefit. Of course, the basic concept of PPO networks is to give members an incentive to use network providers by reducing their out-of-pocket costs if they do so. PPO networks have saved the FEHB Program and therefore both the taxpayers and the members millions and millions of dollars since their inception in the late 1980s and early 1990s. We disagree that members do not know the coinsurance rate for seeing an out-of-network provider since the out-of-network benefits are spelled out explicitly in the plan brochures. We know precisely the coinsurance rates for out-of-network services for every plan in the Program since we negotiate those benefits with every plan annually. The rates are the same in Arkansas as anywhere else in the country. The out-of-pocket dollar costs for out-of-network services will depend upon the billed charges and plan allowance for a particular service.

Question 8: I've noticed that the number of HMOs participating in FEHBP nationwide has fluctuated from 470 in 1996 to less than 200 today. In Arkansas, we have no HMOs participating in FEHBP. The commercial HMOs in Arkansas that used to participate in FEHBP pulled out because they say they suffered huge losses. Is this a nationwide trend that you think will continue?

Answer: It is true that many HMOs changed marketing strategies and left some markets. In some cases it was because of financial losses. In others it was an estimate that the risk was too great. In some cases, it was related to business problems that led to corporate bankruptcies or restructuring. The HMOs seem to have reversed the loss problems that many faced during the last few years. However, there are areas of the country where cost pressures are making it increasing difficult for

HMOs to negotiate the provider rates they need to offer their types and ranges of benefits.

PREPARED STATEMENT OF BRUCE E. BRADLEY

Mr. Chairman, Ranking Democratic Member Baucus, and distinguished Members of the Finance Committee, my name is Bruce Bradley. I am director of Health Plan Strategy and Public Policy for General Motors and it is a pleasure to be before you today to discuss private sector approaches to purchasing the delivery of high quality, efficient health care. This is an issue that has been a focus of my professional career including nearly two decades of managing health plans and community-based health maintenance organizations, as well as my responsibility for developing and implementing value-based health care purchasing over the past twelve years at GTE and General Motors.

I am particularly proud of General Motor's commitment to improve health care by focusing on value oriented purchasing with an emphasis on accountability for high quality care and positive medical outcomes. We believe our work not only benefits our employees, retirees and our stockholders, but also makes a contribution to improving the overall health care system by encouraging health care delivery changes that benefit other patients, purchasers and communities as well.

Not surprisingly, we strongly believe that quality and performance based strategies by other purchasers, such as the Medicare program, can and will improve the health care system for all consumers and payers of health care. With this in mind, we support the Employer's Coalition on Medicare and bipartisan efforts to modernize and improve health care delivery within the Medicare program, including—but not limited to—the eventual enactment of a meaningful and universal Medicare prescription drug benefit within the broader context of reform. We therefore greatly appreciate the opportunity to share GM's experience driving quality improvement and health care delivery reforms that could potentially be applied to Medicare on behalf of the program's beneficiaries and the taxpayers who support it.

GM Experience

At General Motors, we provide health care coverage for over 1.2 million employees, retirees and their dependents at an annual expense of over $4.5 billion. We are self-insured and provide numerous plan choices for our beneficiaries. We offer traditional indemnity plans and contract with over 160 HMOs and PPOs. GM spends over $1.5 billion a year on prescription drugs alone. We manage this drug benefit quite aggressively and I will detail some of these efforts in short order. However, we are also very committed to competitively oriented management of all our health care plans and all the services they provide.

We believe that there is significant clinical and administrative waste in our nation's health care delivery system that contributes to not only excessive expenditures, but far more important, substandard care. One cannot come to any other conclusion when studies find that billions of dollars are wasted in unnecessary and inappropriate health care diagnostics and interventions, that hundreds of thousands of lives are put at risk and countless unnecessary and expensive hospitalizations ensue as a result of medication errors, and that nearly 100,000 Americans a year die as a result of preventable medical errors just in hospitals. These figures really strike home when you recognize that they could translate to the deaths of one to two GM beneficiaries a day. This is unacceptable to us and should be intolerable for all public and private plans.

GM's Value-Based Purchasing Approach. Recognizing the quality and cost problems within the health care system and how they negatively affect us, GM has made a company-wide commitment to improving health care and utilizing the best of value-oriented principles of health care delivery to improve the care our employees and retirees receive. To effectively do this it is necessary to develop and implement performance expectations, measures of success and failure, and real incentives for change. At GM, we have done all three.

First, we chose four major expectations or goals for health care delivery: (1) high quality care, including positive medical outcomes, (2) patient satisfaction, (3) effective and responsive health plan and provider service delivery, and (4) value and cost effectiveness. All four goals are critically important, as we believe they contribute to a healthier and productive workforce and health care at a more affordable cost. At a time when health care costs per employee in this nation far more than double that of our worldwide competitors, we have no choice. More importantly, though, it is the prudent management course of action to take.

Second, we have developed scorekeeping methods that help us measure the performance of our health care suppliers to determine if we are achieving our goals. For example, we require the use and reporting of structural and process measures, which determine if plans and providers have instituted proven methods that result in better patient outcomes. Examples include frequent blood testing, eye exams and foot exams for diabetics, use of computers to enter prescription drug orders in the hospital, and Intensive Care Unit staffing. We also survey our members to determine satisfaction rates with their encounters with their plan and providers. Finally, of course, we evaluate the costs to determine the plans and providers that most consistently produce value for our multibillion dollar investment on behalf our employees, retirees and their families.

Third, and perhaps most important, we use our measures in a very competitive fashion. The scores that our plans, and indirectly the providers they contract with, receive are used as an explicit tool to improve care OR lose business. More specifically, we provide incentives for beneficiaries to move to higher quality plans as well as to drive quality improvement in the plans. We do so through offering lower premium contributions for higher quality health plans, coupled with a report card providing information about each plan.

Our members vote with their feet and the best plans and providers significantly improve their market share. For example, over the past six years, enrollment in our "benchmark" or best HMOs have increased by 217 percent while enrollment in our poorest performing HMOs have declined by 63 percent. This is the result of beneficiaries moving to those organized health delivery systems that improved their performance and produced higher quality health care. Also we have dropped a number of poor performing plans. The CEOs of several of our newly designated benchmark HMOs have told us that their improvement was directly influenced by GM's benchmarking strategy. In fact, from 1998 through 2002, our plans have produced a 40 percent increase in their quality assessment scores.

As a consequence of our health care management techniques, our GM employees, retirees and families are receiving better, more cost-effective care. Our plans, which largely provide very similar benefit packages, are actually competing on the basis of quality and cost—not on the basis of who can attract the healthiest beneficiary. Good plans are rewarded and plans performing less well are given incentives to improve. While we have used our purchasing leverage to drop poor performing plans, our actual goal is to use our techniques to improve the quality of all plans and providers.

Mr. Chairman, I am pleased to report that a number of our plans and providers have made dramatic improvements. For example, our largest organized health delivery plan, designated a "benchmark" this year, has made dramatic improvements in its diabetes care performance measures resulting in reduced probability of hospitalization, blindness and foot amputation of its diabetic members. Notably, after reviewing our statistics on the performance of all of our plans for all the health care they provide, we have found an explicit and positive statistically significant correlation between plan performance and cost-effectiveness.

GM's Management of Prescription Drug Costs. Mr. Chairman, I would be remiss if I did not share with the Committee some of the benefit design, administrative and competitive techniques we use to manage our $1.5 billion prescription drug benefit. GM has a full time doctorate level clinical pharmacist on its health care initiatives management team. Her role is to lead the management of our drug benefits, focusing on quality and appropriate use, through both GM programs and a Pharmacy Benefit Manager or PBM. To ensure we benefit as much as possible from the drug managing techniques the PBM utilizes, we provide performance awards that provide incentives for successes at assuring appropriate utilization, increasing the use of quality generic drug products, and reducing cost growth.

In our efforts to improve the appropriate use of pharmaceuticals, we have drug benefit designs with multi-tier co-payments to encourage the use of the most therapeutically and cost-effective medications. We utilize prescription drug counseling/drug utilization review (DUR) programs to help ensure our enrollees avoid excessive and inappropriate use of medications that can lead to drug interactions that can have severe health and cost consequences. We also use physician-based therapeutic interchange programs that encourage physicians to prescribe medications that are both therapeutically and cost effective. And, as I have mentioned, we continue to encourage plans to contract with hospitals that utilize computer-based prescribing tools to ensure proper medication use.

The GM Quality Purchasing Experience and Implications for Federal Purchasers

Mr. Chairman, there are a wide range of interventions we and our health plans use that we believe could improve Medicare's ability to purchase higher quality,

more cost-effective health care. Likewise, I believe that private purchasers would generally benefit if Medicare were empowered to be a more competitive purchaser of health care. We have noted that when Medicare and FEHBP do institute positive changes that make the delivery system more efficient, all purchasers—including us—indirectly benefit as well. We are aware of many excellent Medicare demonstration projects and encourage continued and widespread implementation of those that add value by improving quality and efficiency for its beneficiaries.

The quality orientation approach GM now uses is something that we believe could be applied to Medicare fee-for-service and managed care contracts as well. In recent years, CMS, and formerly HCFA, has started to effectively push for and implement quality measures. We have found our joint collaborations to be extremely fruitful. For example, Medicare is actively participating in a number of public and private sector performance measurement initiatives, most notably the National Quality Forum. They have begun to use a series of hospital quality performance measures, which combined with private sector use will have a real impact on quality improvement. Medicare has also participated in several of GM's community initiatives to improve quality.

Applications of GM lessons learned for Medicare. There is no question, however, that Medicare could use its purchasing leverage even more aggressively to produce more value out of the health system. There is no reason that managed care plans participating in the Medicare program could not be subject to greater accountability for their quality performance similar to what I have previously described. Likewise, contracts with private carriers and intermediaries administering the traditional Medicare fee-for-service program could also be required to be held similarly accountable. And CMS should certainly be given even more authority to drop contracts from those plans, whether they are insurers administering the fee-for-service program or managed care plans bearing insurance risk, that are not performing.

Having said this, few people know more than us that unassailable quality and cost-effectiveness measuring tools have yet to be fully developed. Moreover, the risk-adjustor to fairly evaluate differential patient mix by different plans and providers will—for the foreseeable future—be subject to some level of dispute. As such, in the more politically sensitive world of Medicare, it might well be more difficult and controversial for Medicare to implement these approaches than it has been for us. It would be our hope, however, that the Congress and the Administration could cite the ever improving valued-based purchasing techniques that GM and other innovative large private purchasers are using and developing as the very rationale for moving ahead in this arena.

Just as we believe that a modernized Medicare program should be empowered to promote a much greater emphasis on quality and value, we share the Congress' belief that it is long past time for the program to be updated and include a well-managed and meaningful outpatient prescription drug benefit. We believe that the management and benefit design tools we use to ensure appropriate prescription drug utilization can and should be utilized by Medicare and we would be happy to provide any assistance we can in this regard.

Conclusion

As I am confident you and most Members of this Committee in both parties well recognize, we simply cannot allow less than perfect quality improvement measures and sometimes politically difficult to implement purchasing improvements to be an excuse for not taking steps now to improve Medicare and all health care in this nation. If GM and our competitors took that course of action in the 1980s, American car manufacturers would not have benefited from the quality improvements we now have in our marketplace today. While many of the steps we took were similarly extremely difficult at the beginning, we simply would not be as competitive as we are today.

Mr. Chairman, at GM we strongly believe the quality of care our employees, retirees and their families are receiving has improved substantially and costs are perhaps lower than they would otherwise be. However, the one indisputable fact we have learned in our experience in managing health care is that no purchaser—private or public—has a monopoly on wisdom. We all could do a better job at assuring quality, affordable health care for our enrollees.

We benefit from learning from each other's successes and failures. While private purchasers can generally implement innovations more rapidly, we rarely have the type of positive impact on overall health care delivery that public purchasers do when they implement and improve on what we have done. We look forward to continuing our collaboration with you and others in the Federal government to ensure that all health care consumers and purchasers and taxpayers alike receive the value they deserve from their extraordinary financial investment in our nation's health

system. I hope my comments prove helpful in your ongoing efforts to modernize and strengthen the Medicare program. I would be happy to answer any questions you may have.

RESPONSES TO QUESTIONS FROM SENATOR LINCOLN

Question 1: In your opinion, what are the best ways Medicare could adopt a competitive bidding model that encourages plans to compete on quality and price and not by simply cherry-picking the healthiest beneficiaries? How can Congress ensure that beneficiaries choose a plan based on both quality and price? For example, would you agree that having a standardized benefit is important for beneficiaries to make informed choices?

Answer: To best answer this question, I think it is important that we describe GM's approach to ensuring that the health plans we contract out with compete on quality and price. First, where possible, our contracts are oriented towards performance rewards rather than inadvertently providing incentives for plans to avoid sick populations. Plans should not be compensated for their ability to segment healthy from sick populations.

To work towards this end, we review in depth financial, cost and patient population data to determine if rates are appropriate to the population served. If we determine they are not, we negotiate and adjust subsequent contracts accordingly. In addition, we—rather than our contract plans—determine the design of our benefit packages. In practice, this means that our indemnity plans, our HMO plats, and our PPO offerings each provide the same benefit design within their insurance category. Finally, we review, manage and authorize the marketing information that is provided to each of our members to ensure that it is understandable, comparable and objective. In combination, we believe these practices work to minimize the ability plans to compete on the basis of risk selection.

Risk-adjustment payment mechanisms to compensate plans that are treating disproportionately sicker patients can and should be utilized. While the state-of-the-art techniques are far from perfect, we are encouraged by the work CMS is undertaking to apply these techniques in their reimbursement process. Without doubt, risk-adjustment mechanisms must be continually refined aid improved. In order to do this, however, CMS must be given more explicit authority, timetables, and resources, to achieve the most effective approach.

Question 2: Some prescription drug proposals would not count employer contributions toward out-of-pocket limits. In your opinion, what would the effect of such a proposal be on employers to maintain prescription drug coverage to their retirees under a Medicare prescription drug benefit?

We believe that not counting employer contribution towards out-of-pocket limits within Medicare prescription drug benefit designs would lead to an acceleration of employers dropping retiree health coverage all together. This would not only reduce benefits for vulnerable populations, but would also eliminate the opportunity for Medicare to learn and financially benefit from drug management techniques used by employer-provided plans.

All parties believe it is in the best interest of the Medicare program for employers to retain their commitment to retiree health plans. Purchasers, whether they are consumers or employers, should have access to the same Medicare benefit. We strongly object to the concept that employers voluntarily providing coverage should in effect be assigned a differential benefit and a disincentive to retain current coverage. Some of the current proposals would in effect treat Medicare beneficiaries who happen to have retiree health coverage differently by reducing the value of the Medicare benefit that is available to them (and by extension their employers) even though the premium they pay for the benefit remains the same.

Not surprisingly, we strongly believe that employers providing supplemental benefits to the Medicare standard package should not be subject to the so-called "true out-of-pocket" cost provision. Moreover, we believe that retirees receiving employer-based supplemental coverage should have access to a Medicare benefit package that is designed to be more easily supplemented by an employer provided "wrap around" package. These approaches would help encourage employers to continue to provide retiree health benefits.

Question 3: You self-insure for the cost of your employees' health care because as a big employer you can save money that way. Yet there are members of Congress who want to see Medicare, which is one of the largest payers for health care in the country contact out to insurance companies for the cost of prescription drugs. What are you thoughts about this? As a large purchaser wouldn't it make sense for Medicare to self-insure for prescription drugs rather that contract to private insurers?

It all depends on how well the program is managed. We believe that well managed, risk-adjusted integrated health care plans could be an extremely desirable option for Medicare and the beneficiaries it serves. If done well, such a plan, based on evidence-based care with a commitment to quality outcomes, could contribute not only to improvements in care and affordability for beneficiaries and Medicare but also for other patients as well, since Medicare influences so many health care practices.

Regarding stand-alone plans, your question suggests there may be problems associated with relying on insurers or PBMs to manage stand-alone, risk-bearing drug benefits. Such a model could be susceptible to risk avoidance techniques that could increase costs and inappropriately segment patient populations. We believe an integrated health plan would avoid such problems as it would be much more difficult for plans to select risk if they have to provide the full range of services. And, as I mentioned previously, however, we believe that CMS should be given the authority it needs to most effectively risk adjust its payments to plans to avoid problems in this area.

Rear Admiral THOMAS F. CARRATO, USPHS
Deputy Assistant Secretary of Defense for Health Plan Administration

RADM Carrato was appointed as the Deputy Assistant Secretary of Defense (Health Plan Administration) within the Office of the Assistant Secretary of Defense (Health Affairs), and as the Chief Operating Officer of the TRICARE Management Activity (TMA) on July 19, 2002. RADM Carrato serves as the principal advisor to the Assistant Secretary of Defense (Health Affairs) on DoD health plan policy and oversight of the health plan performance. As Chief Operating Officer, RADM Carrato is responsible for the operations and performance of the TRICARE health plan, medical and dental programs.

Prior to this position, RADM Carrato served as the Executive Director, TMA, overseeing the Department of Defense's TRICARE managed health care program for members of the uniformed services, their families, retirees, and other eligible persons. RADM Carrato previously served as the Department of Health and Human Service's Regional Health Administrator for Region IV, which includes the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. He was the principal representative in the Region, providing advice and participated in policy development and implementation of key health care initiatives in the Southeastern United States. He managed regionally based programs of the Office of Public Health and Science including the Offices of Emergency Preparedness, Minority Health, Women's Health, and Population Affairs.

From 1998 to 2000, RADM Carrato served as the Chief Operating Officer of the TRICARE Management Activity, Office of the Assistant Secretary of Defense (Health Affairs). Preceding this he spent 10 years involved in all facets of health policy, program development, and operations within the Military Health System.

RADM Carrato began his Public Health Service Career in 1978 at the U.S. Public Health Service Hospital on Staten Island, New York. His subsequent assignments included tours at the Public Health Service Hospital in New Orleans, Louisiana; the Alcohol, Drug Abuse and Mental Health Administration; the Health Resources and

Services Administration; the Office of Health Maintenance Organizations; and the Health Care Financing Administration. During the Mariel Boatlift, RADM Carrato was assigned as the PHS Administrator at the Fort Indiantown Gap Refugee Camp where he was responsible for the relocation of thousands of Haitian and Cuban refugees. RADM Carrato was appointed as an Assistant Surgeon General of the United States on August 1, 1997.

RADM Carrato holds a Master of Science in Accounting from Georgetown University and is a licensed Certified Public Accountant. In addition, he holds a Master of Social Work from the University of South Carolina and is a licensed Clinical Social Worker.

RADM Carrato's decorations include the Defense Distinguished Service Medal and the Public Health Service Distinguished Service Medal.

RESPONSE TO A QUESTION FROM SENATOR BAUCUS

Question: An estimated $27 billion per year is devoted to the U.S. military health system, funding care for 8.7 million TRICARE beneficiaries. As I understand it, TRICARE contractors are not fully at risk for beneficiary spending, since most of this population's health care services are provided at the military's own 75 hospitals and 500 clinics. Can you please provide an estimate of the percentage of TRICARE health spending for which TRICARE contractors are at risk?

Answer: The Department's Unified Medical Budget (UMB) request for Fiscal Year (FY) 2004 totals $28.143 billion. The requested budget is broken out as follows:

	FY04 President's Budget	% of Total
Private Sector Care	12.232B	43%
Other UMB	15.911B	57%
Total	28.143B	100%

Of the $12.2 billion budgeted for private sector care in FY 2004, $5.5 billion (19% of the UMB) is programmed for application to the at-risk portion of TRICARE's Managed Care Support (MCS) contracts. Each MCS contractor faces risk that changes in prices, beneficiary population totals, health care service utilization, and other factors may result in contract costs exceeding the contractor's initial bid price. If this occurs, the contractor must pay for a portion of the overrun (i.e., the contractor is "at risk" for a portion of the increased costs).

Defense Health Program workload data (see next page) for Fiscal Years 2000–2002 show that the majority of outpatient visits were to military treatment facilities, while a majority of inpatient admissions were to private sector facilities.

Direct Care and Purchased Care Workload <65 (FY 2000-2002)

Inpatient

FY	Direct Care Dispositions	% Change	% of total admissions	DC Bed Days	% Change	% of total bed days	Network Admissions	% Change	% of total admissions	Network Bed Days	% Change	% of total bed days
2000	248,323		49%	774,959		39%	256,027		51%	1,230,811		61%
2001	239,695	-3.47%	47%	747,850	-3.50%	37%	268,442	4.85%	53%	1,269,226	3.12%	63%
2002	238,180	-0.63%	44%	732,013	-2.12%	34%	300,808	12.06%	56%	1,410,093	11.10%	66%

Outpatient

FY	Direct Care Visits	% change	% of total visits	Network Visits	% Change	% of total visits
2000	28,077,210		61%	18,183,640		39%
2001	28,263,575	0.66%	60%	19,152,373	5.33%	40%
2002	28,042,456	-0.78%	56%	22,002,822	14.88%	44%

PREPARED STATEMENT OF HON. BILL FRIST

Mr. Chairman, thank you for holding this hearing. I appreciate your commitment to strengthening and improving the Medicare program.

As a doctor, I've treated thousands of Medicare patients. I've seen first-hand the good the program has done for the health of America's seniors over the past four decades. And I've seen the good it still does every day in doctors' offices and hospitals across the nation.

When Lyndon Johnson signed the bill creating Medicare in 1965, he said, "No longer will older Americans be denied the healing miracle of modern medicine." But

today, older Americans are being denied exactly that. Medicare is falling short of its noble mission.

The program was designed at that time when sickness was defined by acute, episodic illnesses that generally required hospitalization. But since that time, health care delivery, science, medicine, molecular biology, and genetics have been changing dramatically and we have a system that has not adapted. The Medicare program has not fully incorporated preventive care or chronic disease management. This is a serious shortcoming. Approximately 80 percent of Medicare beneficiaries have at least one chronic disease, and the 20 percent of beneficiaries with five or more chronic diseases account for nearly two thirds of Medicare spending[1]. Beneficiaries are not protected from unlimited out-of-pocket expenses. And we are all well aware that Medicare does not cover outpatient prescription drugs.

America's seniors deserve a Medicare program that responds to their health care needs, adapts to medical advances, and prevents and manages disease rather than merely treating individual episodes. They deserve choice—the choice of plan, choice of provider, and choice of treatment. The framework for Medicare reform outlined by President Bush earlier this year would be a good starting point. It would introduce innovation and choice into the Medicare program through private plans competition, similar to the programs enjoyed by most federal workers and many private employees.

But as we shape final legislation here in the Senate Committee on Finance, we need to look very closely at the experience of other public and private sector purchasers. I would like to welcome our witnesses and thank them in advance for agreeing to share some of the lessons they have learned in purchasing and providing health care for millions of Americans.

We must take action this year to strengthen and improve the Medicare system. The demographic tidal wave will not subside. It will not be easy and we appreciate the experience and advice of those who know and understand the challenges in the health care system and the Medicare population. I look forward to their testimony and responses to our questions.

PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

Today I'm pleased to welcome four witnesses who will help us explore how competition works in health care. Making health care in general—and Medicare in particular—more competitive has been a goal of many legislators over the years from both sides of the aisle. I believe that competition in Medicare, if done right, has the potential to change the lives of patients by lowering costs, improving benefits and increasing quality. Today our witnesses—all of whom have experience purchasing health care services in a competitive environment—will tell us what it takes to do it right. Before I turn to their introductions, I want to again acknowledge the bold commitment of President Bush in putting $400 billion on the table this year to strengthen and improve Medicare. The President's principles include adding a prescription drugs and making the program stronger and better for beneficiaries. That means improved benefits and higher quality care more in sync with what's available in private insurance today, like we in the federal employees' plan have.

The President's principles look to the federal employees' plan as a model for Medicare. In the federal employees' plan, all workers—even those in rural states, including the postmaster in my home town of New Hartford, Iowa—have a choice of health plans. Employees choose among competing plans for one that best suits their own needs. Why shouldn't seniors living in the same town have that same choice? Unfortunately, our attempts to bring those kinds of choices to seniors in Medicare have failed, especially in rural states like mine, where insurance companies have given Iowans a "firm no"—even after we gave them bonuses and raised their base payments. As a result, Iowa seniors have few choices but fee-for-service Medicare. The environment is anything but competitive. So I will be especially interested in the views of those here today who have made competition work for their beneficiaries, urban and rural, and how we can replicate some of those success—and avoid some of those failures—in Medicare.

Our first witness is Abby Block, who serves as Senior Advisor for Employee and Family Policy at the Office of Personnel Management, or OPM. The OPM administers the Federal Employees' Health Benefit Plan, which requires plans to submit bids each year so that beneficiaries can measure a plan's value themselves. Next is Rear Admiral Thomas Carrato, who serves as Deputy Assistant Secretary of Defense for Health Administration. He oversees health plan policy and performance for

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[1] Berenson and Hovarth, *Health Affairs*, January 22, 2003

TRICARE, the health plan that serves our nation's active and retired military and their families. TRICARE also utilizes a competitive structure for making its health care purchasing decisions. Third is Bruce Bradley, who serves as Director of Health Plan Strategy and Public Policy for General Motors, which, as one of the largest private purchasers in the country, provides competitive health plan choices to its 1.2 million employees. Finally, Lois E. Quam, Chief Executive Officer of Ovations, a UnitedHealth Group Company, will address her own company's experience with competition, providing us with a plan's perspective on what works, and what doesn't, when it comes to competitive bidding.

PREPARED STATEMENT OF LOIS E. QUAM

INTRODUCTION

Thank you Chairman Grassley, Senator Baucus and other distinguished members of the Committee for the opportunity to testify before you today. I am Lois Quam, the Chief Executive Officer of Ovations, UnitedHealth Group's business that focuses on meeting the health care needs of the over-50 population. I am pleased to speak on our experiences with providing health care services in a competitive market.

Ovations, and the other companies of UnitedHealth Group, have extensive experience providing health care services to the federal government, state governments and private payers in many types of competitive environments. As the largest health and well-being company in the United States, UnitedHealth Group's operating businesses provide a diverse and comprehensive array of services to over 48 million Americans. We provide services to approximately 300 large employers, over half of the nation's 100 largest companies, and serve over one million beneficiaries of Medicaid and other government-sponsored health care programs in 14 states.

UnitedHealth Group has a long-standing commitment to serving senior Americans. Our participation in the Medicare program is fundamental to our core mission—to support individuals, families, and communities to improve their health and well-being at all stages of life. We aim to facilitate broad and direct access to affordable, high quality health care.

My business, Ovations, is the largest provider of health care services to seniors in America. We offer a unique perspective on Medicare because we are a major provider of services through the traditional fee for service program, health plans, and demonstrations for the frailest Medicare beneficiaries. Our commitment is therefore to Medicare and its beneficiaries—rather than a specific Medicare product offering.

Ovations is dedicated to helping Americans in the second half of life address needs for preventive and acute health care services, deal with chronic conditions and respond to unique senior issues relating to overall well-being. On behalf of AARP, we operate the only national Medigap offering today. We deliver supplemental health insurance products and services to 3.7 million AARP members living in all 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. Through this program, we provide prescription drug coverage to the majority of all Medicare beneficiaries who receive drug coverage through Medigap plans. The prescription drug card we offer, also working with AARP, is the nation's largest, providing beneficiaries who remain in traditional Medicare with some of the best drug discounts available. Over two million working aged and retirees receive Medigap health coverage through our employer-sponsored programs. Through Evercare, our business that serves the unique needs of frail elderly and chronically ill patients, we provide specialized care services to nearly 25,000 frail elderly individuals and 36,000 elderly and disabled Medicaid beneficiaries on behalf of the federal government and the states of Texas, Minnesota, Arizona, and Florida. Additionally, more than 200,000 Medicare beneficiaries are enrolled in one of our Medicare+Choice plans and nearly 4,000 are enrolled in one of our Preferred Provider Organization (PPO) demonstration plans.

In 2003, we have reaffirmed our commitment to Medicare through continued expansion of Evercare, participation in the PPO demonstration, continued enhancement of AARP offerings in all 50 states, and by making every effort to remain in counties that are not marked by high reimbursement. In fact, we just received approval from CMS to introduce a PPO product in Council Bluffs, Iowa, and Omaha, Nebraska. We support Medicare offerings in metropolitan, urban and rural areas and have developed culturally sensitive programs such as multi-lingual customer service and programs focused on social well-being.

DESIGNING A BETTER MEDICARE

We believe a better Medicare would be a less expensive Medicare. It would be less expensive because it would deliver services in a more cost effective way, allowing for an expansion of benefits, not because it would cut payment levels or reduce benefits. It would be more cost effective because it would vastly improve care to people with chronic conditions and would provide greater emphasis on keeping healthy beneficiaries healthy longer.

Addressing the needs of chronically-ill beneficiaries is imperative to the success of Medicare modernization. The opportunity to improve the lives of chronically-ill beneficiaries and conserve Medicare resources is enormous. Research has widely documented the costs, lack of coordination, and poor health outcomes associated with chronic illness.

- Medicare spends two out of every three dollars on people with five or more chronic illnesses.
- A beneficiary with five chronic conditions has Medicare costs of about $13,700 per year, compared to $980 for a beneficiary with one chronic condition.
- Medicare beneficiaries with multiple chronic conditions experience unnecessary or avoidable hospitalizations for illnesses that could have received effective outpatient treatment.
- Per 1,000 beneficiaries, these hospitalizations increase from seven for people with one chronic condition to 95 for beneficiaries with five chronic conditions, and to 261 for people with 10 or more chronic conditions.
- There is clear evidence of adverse outcomes from hospitalizations exposing seniors to risk factors for which they do not need to be exposed. In 1999, the Institute of Medicine released a report that contends that two million medical errors occur in hospitals every year.

Research also has documented the effectiveness of various clinical and social interventions designed to treat the highest users of Medicare services. One study showed that nurse-directed education programs and follow-up interventions for patients hospitalized with congestive heart failure have reduced subsequent hospitalizations by over one-half and overall health care costs by nearly $500 per patient. In addition, the evaluation of the PACE program for frail elderly beneficiaries eligible for both Medicare and Medicaid shows that PACE program participants have fewer hospitalizations and nursing home days, short-run improvements in quality of life, satisfaction with care and functional status. A study of our own Evercare program, which provides coordinated medical care through primary care teams for institutionalized Medicare beneficiaries, shows a 50 percent decrease in hospitalizations and improved family satisfaction. These types of results could be achieved across the Medicare program. However, the government has not made major changes to Medicare to address these issues.

HOW CAN COMPETITION LEAD TO A BETTER MEDICARE?

Many have contended that competition would reduce Medicare costs and improve care. Competition does not automatically achieve desired goals. Our experience has shown us that three principles are vital to competition that works:

1. The competitive process focuses on results for consumers
2. It promotes improvements in services
3. It aligns the interests of the parties

Results for Consumers

Competition will only succeed if it is focused on delivering results to consumers. To do this, two conditions must be met. First, the unique needs of the different groups of Medicare beneficiaries need to be understood and reflected in the Medicare program. Second, consumers should have the opportunity to choose based on their own preferences rather than having the choice be made at the agency level.

The first condition is imperative to achieving a better, less expensive Medicare program. In many ways, Medicare has operated in a uniform way, a one size fits all approach. Competition can help Medicare provide options that are linked to the diverse needs of beneficiaries—in particular those who have chronic illnesses.

The first condition is especially important when designing competitive offerings for Medicare, because competitive designs have normally been modeled on the employer market. Medicare beneficiaries are very different from the employees of large companies. They represent vastly different age groups and therefore very different clinical needs. The average age of enrollees in employer-sponsored health plans is 37—half the median age of Medicare beneficiaries. Moreover, Medicare beneficiaries have multiple chronic illnesses and comorbidities that are not addressed by the single-focus disease management programs used by employers. Unlike the employer

population, many Medicare beneficiaries cannot manage their own care due to dementia or other functional limitations.

Currently, 50 percent of Medicare resources are consumed by five percent of Medicare beneficiaries. Reducing the impact of chronic illness requires a different approach than those currently provided through the Medicare program. Changing the way the chronically ill and frail elderly are served by the Medicare system not only will result in better quality of care for these beneficiaries, it also provides the best opportunity for controlling costs associated with this special population. For example, Evercare efforts have resulted in a 50 percent reduction in hospitalizations, a 97 percent satisfaction rating among families and a 20 percent reduction in the number of medications consumed by enrollees.

Creating specialized approaches for treating the chronically ill also will provide a more stable environment for general health plan competition. It will allow for competition over cost and quality, not over risk selection. Without addressing the issue of the highest users of Medicare services first, no amount of competition will be effective in producing significant savings or improving outcomes in the Medicare system.

Providing flexibility to establish programs that meet the varying needs of the various Medicare populations would provide dramatic results in improving the competitive environment. A consumer-results focused approach would increase choices and allow beneficiaries to select the plan that best meets their needs. It should include programs that effectively deal with the health care needs of the highest users of Medicare services, plans that focus on keeping healthy beneficiaries healthy, and strategies designed to meet the unique aspects of our diverse culture.

Allowing consumers, rather than the contracting agency, to select from competing options is vital to successful competition. The agency should establish a framework and then allow for a variety of Medicare options to be offered within that framework. This model most effectively responds to the diverse needs of beneficiaries, beneficiary expectations, and offers the opportunity to develop best practices.

Our experience has shown us that competition that focuses on "competitive bidding" tends to be process oriented, rather than results focused. Often, it serves to reduce competition and limit consumer choice. It tends to reflect the preferences of the contracting organization, which often are not aligned with those of consumers. Competition that places great emphasis on low cost most likely would result in a more restrictive health care option, not unlike a staff-model HMO with limited networks, rigid medical management practices (denial of care) and fewer beneficiary options. In our estimation, competitive bidding that relies on low bids or a "winner takes all" approach provides high risk for both beneficiaries and the government.

Consumers look to Medicare for a degree of security and stability. This model does not provide it. A consumer driven model that provides various options from which beneficiaries may choose is more like the model used by large employers and even the federal government. We think Medicare beneficiaries and their families are in the best position to decide which plan is best for them.

Improvements in services

In addition to focusing on results for consumers, effective models of competition are designed in a manner that fosters improvements in services. A better Medicare encourages improvements in services. Historically, innovations in Medicare too often have faced barriers because they are different from the status quo.

An effective competition model is one that encourages new and innovative ideas and includes streamlined, efficient review processes that allow the government and beneficiaries to quickly benefit from innovation and advances in technology. A structure that strives for a fair and reasonable balance between the need for regulatory oversight and the promotion of quality health care, rather than a monolithic one, would facilitate innovation and broader participation. Finally, an effective model of competition would foster the development of population-specific approaches.

We participate in many effective competitive programs. Those that work best have built in ways to improve services during the contract term. As a result, they have mechanisms to allow dialogue, which can lead to a modification of terms and required conditions during the contract term. These competitive models assiduously avoid contractor micro-management or over specification of process. Instead, they rely on clearly articulated objectives and performance standards that are related to those objectives.

Aligned Interests

Through our experiences, we have learned that the most effective contract relationships are those in which our incentives are closely aligned with the goals of our customer. The best contracts include clearly articulated performance standards and

appropriate incentives for results tied directly to functions over which the contractor exerts control. We're proud to say that we have a good track record of meeting or exceeding performance standards.

Effective contracts also include reimbursement levels that are reasonable and provide plans the opportunity to gain if they meet or exceed expected results for beneficiaries. Additionally, contracts based on aligned interests seek ways of linking the financing structure and the delivery system. They seek to achieve a true partnership between both entities in order to provide the most effective services possible.

TRICARE AS A MODEL FOR MEDICARE

UnitedHealth Group spent considerable time and resources preparing a bid in response to the recent Department of Defense solicitation for the next generation of TRICARE contracts. We want to emphasize that we appreciate the leadership at the Department of Defense and support its efforts to improve the TRICARE program. However, after much consideration, we decided not to submit a bid. At the Committee's request, we are providing our reasons for not participating.

There were many things we liked about the TRICARE solicitation, and we think it should provide significant improvements in the program. However, from our point of view, the solicitation was not structured in a manner that supported our three principles of effective competition.

The TRICARE contracts are competitively bid under a "winner takes all" approach in each of the three TRICARE regions. This approach has led to a TRICARE format that is strongly rooted in the existing contractor practices and the historic practices of the TRICARE contract management staff. Therefore, while the Request for Proposals (RFP), and the DOD leadership, has been articulate about the desire to achieve results for beneficiaries, the actual RFP favored these historic, institutional practices.

For example, one of the objectives of the TRICARE solicitation was the achievement of the highest levels of beneficiary satisfaction. However, rather than looking to commercial contractors to offer best business practices, the solicitation established complex reporting requirements, burdensome referral processes, and other costly administrative items. The RFP requirements appeared to be historical and process oriented rather than focused on producing the best results for TRICARE beneficiaries. They did not seem to support the Department's clearly articulated objectives and evaluation criteria.

Achieving "best value" health care is a principal objective of the DOD solicitation. However, the solicitation requirements limit contractors' ability to achieve this objective. For example, contractors are at risk for target health care costs, yet they have no control over many key decisions and factors that could impact TRICARE costs. These factors include benefit changes, implementation of best practices across the direct care system, major policy changes and structural changes to the MHS. Under this arrangement, the contractors assume tremendous risk while DOD maintains control of circumstances necessary for cost control and penalty avoidance. This approach creates a gross misalignment of interests and negative practices, such as change orders. As a result, the costs of the TRICARE program have been high and less stable.

In the end, we decided that the structure of the solicitation limited our ability to deliver results to beneficiaries and improve services. Moreover, from our point of view, the contract specifications and requirements did not align with the achievement of the Department's objectives. We concluded that the TRICARE solicitation contained barriers to entry for new competitors, and that only incumbent companies would be likely to participate given highly specified process requirements in the RFP and the ambiguity about provider financial risks.

Why TRICARE is an Ineffective Model for Medicare

Based on our experience with TRICARE, we do not believe it a good model for Medicare. The Military Health System is very different than Medicare. As a result of its dual mission and direct care system, it requires a tailored approach designed to optimize its unique structure. Under TRICARE, the military's direct care system delivers the bulk of services to DOD beneficiaries. TRICARE has been effective in producing savings for DOD largely through improving the efficiencies of its direct care system and steering more care into military treatment facilities. Medicare has no direct care system. Therefore, while a TRICARE-like model may be effective for the Department of Defense and the unique mission of the Military Health System, it probably would not produce comparable savings for Medicare.

Also, the TRICARE population is very different from the Medicare population. TRICARE covers active-duty military members (average age is about 25 years), their families, retirees and their families. While over-65 retirees are covered by

TRICARE, they actually are covered under a separate program—TRICARE for Life—that serves as a comprehensive Medicare supplemental program. In fact, under the new TRICARE contracts, TRICARE for Life is being addressed under a separate contract, not under the managed care contracts that provide comprehensive health care services on a regional basis.

Finally, while DOD believes that a "winner takes all" approach works the TRICARE program, it probably would be more challenging to manage under Medicare. The TRICARE program serves just over six million beneficiaries; Medicare serves 40 million today and that number is expected to climb dramatically in the coming years. Even if the country were divided into several regions like the TRICARE program, it's hard to imagine how a healthy mix of health care organizations would be able to compete to serve so many beneficiaries under a TRICARE "winner takes all" model.

CONCLUSION

In closing, Medicare would experience better results at lower costs under a model which embraced these principles—a competitive process that focuses on results for consumers, promotes innovation and aligns the interest of the parties. Congress can advance this model by establishing a consumer-driven competitive process that creates programs tailored to meet the varying needs of Medicare beneficiaries, particularly the five percent that consumes 50 percent of Medicare resources; promoting innovation; and ensuring that Medicare contractor interests are aligned with the government's objectives for Medicare. Simply introducing competition to the program will not affect meaningful change.

Results for Consumers

If Congress decides to establish a more competitive environment for Medicare, we strongly recommend that it be based on consumer-driven competition rather than process-driven competition. More importantly, it should focus on delivering results for consumers by providing programs tailored to meet the varying needs of the diverse Medicare population. Specifically, Medicare needs to change the way it delivers health care services to beneficiaries with chronic illnesses and should include preventive coverage to keep healthy beneficiaries healthy longer. Introducing competition will not produce meaningful savings without addressing this issue first.

Including special programs for the chronically ill and frail elderly population would benefit Medicare beneficiaries by providing better quality and outcomes, as well as increased patient satisfaction. The government would benefit from lowered hospitalizations and other health care costs, as well as demonstrated effectiveness. These tailored approaches should be provided through both Medicare fee-for-service and Medicare health plans, building upon the traditional Medicare program and while expanding health plan options for the chronically ill.

Efforts to modernize and improve Medicare should include specialized health plan options for the chronically-ill. The government would contract with organizations that met specific clinical, financial, and quality requirements. Organizations would guarantee the government savings relative to the current costs of treating beneficiaries with chronic illness. Organizations would also be required to achieve agreed upon clinical outcomes that measure health and functional status. Enrollment in these plan options would be voluntary, and beneficiaries who choose to enroll would keep their current primary care physicians.

Modernization efforts also should include a new fee-for-service chronic illness coordination benefit for Medicare beneficiaries with four or five chronic conditions. The program could be modeled on the Medicaid primary care management benefit. Medicare would reimburse certain qualified providers for complex clinical care management and coordination. A physician or other practitioner would be responsible for coordinating the care by all practitioners, and facilitate non-Medicare covered supportive services in exchange for an additional fee. Care coordinators would monitor all aspects of a beneficiary's care and maintain a comprehensive medical record. Medicare would establish fees for these services and would set requirements for improvements in outcomes, including the frequency of avoidable hospitalizations, and other accepted measures of quality.

In addition, Medicare improvements should include options to allow care management organizations to provide care coordination services for fee-for-service beneficiaries. Beneficiaries would voluntarily enroll in the program and receive care coordination services including a nurse line, a comprehensive health assessment, and ongoing education and communication. Care management organizations would receive a fee from the government for providing these services, and in exchange guarantee a level of medical cost savings relative to fee-for-service Medicare. The fees

would be contingent on an organization's ability to meet cost savings and other quality targets.

Many have suggested that Medicare would benefit from a PPO option that would improve beneficiary access to care, even in rural parts of the country, and help to provide efficiencies in the system. In reality, traditional Medicare is a lot like a PPO already—there are "network" (Medicare) providers who agree to accept Medicare rates in return for prompt payment of properly submitted claims. The primary PPO element missing today is care management. Adding care management services to traditional Medicare would in effect, create the desired PPO structure.

Innovation

Critical to the success of consumer-focused competition is the flexibility to innovate and design options tailored to meet the varying needs of the diverse Medicare population. In order to ensure an environment that is conducive to robust competition, the competitive model selected needs to minimize administrative and regulatory requirements to streamline the process for introducing innovation and emerging technologies. Additionally, the competitive environment should create a level-playing field for all competitors to ensure the best services and outcomes for both beneficiaries and the government.

Aligned Interests

Finally, we recommend that efforts to improve Medicare be focused on alignment of the interests of the federal government, companies and beneficiaries to produce stable and innovative options for Medicare. Congress and the Administration should decide the desired outcomes of any changes to the current system and provide effective rewards and incentives for performance in whatever structure is created to achieve those goals. In designing a competitive approach to Medicare, Congress and the Administration should focus on specific objectives—operating more efficiently, refining the system to meet today's health care needs, effectively incorporate emerging technologies, providing better outcomes for beneficiaries, promoting healthy aging, and increasing access to care. Then, design a competitive structure that supports achieving those outcomes.

CLOSING

At UnitedHealth Group, we have extensive experience in the competitive environment and compete in a number of ways and based on a number of factors. Therefore, we cannot provide you with a single "best approach" for competition; each situation is somewhat unique. However, based on our experience, we do think that a consumer-driven approach unencumbered by regulation, such as a modified Federal Employees Health Benefits Program, offers the best competitive solution for Medicare.

In closing, we believe a better Medicare would include a prescription drug benefit and deliver most cost-effective health care services. We see opportunities for improving the current Medicare system to provide better results for both beneficiaries and the federal government. We think efforts to do so will be most effective if they build upon the choices currently available to beneficiaries and draw upon the strengths of both the public sector and the private sector. Creating a structure designed to meet emerging health care needs by changing the way care is delivered to the highest users of Medicare services, coupled with contracts that focus on results for beneficiaries and allow for innovation, will provide enormous benefits to the Medicare program. Not only would these structural changes improve outcomes and increase efficiencies, they also will increase beneficiary satisfaction and provide them with greater choice.

We have heard numerous references in discussions on modernizing Medicare that emphasize the concept "do no harm." We agree that it is very important to do no harm, but believe that simply focusing on that concept is not enough. Efforts to modernize Medicare should result in a better Medicare—for beneficiaries, taxpayers and the federal government. Competition alone will not provide that. A better Medicare, we believe, is a more efficient Medicare that uses prevention to keep the healthy fit and specialized programs to improve the quality of life and effectiveness of health care services provided to the chronically ill. Medicare improvements could change Medicare from a uniform system, where one size fits all, to a responsive program with options tailored to distinct groups of beneficiaries.

We appreciate the committee's leadership on this important matter and thank you for the opportunity to share our thoughts. I would be happy to answer any questions you might have for me.

PREPARED STATEMENT OF DR. WILLIAM WINKENWERDER, JR.

Introduction

Mr. Chairman, Distinguished Committee Members, it is a pleasure to have this opportunity to address you, and to describe the delivery of health care to Uniformed Services beneficiaries in the Military Health System, and in particular the purchase of health care services through TRICARE regional contracts. We have made some significant strides in recent years in our purchase of health care services and both opportunities and challenges lie ahead.

In 2003, the Department's senior military medical leadership—the Surgeons General of the Army, Navy and Air Force, and the Joint Staff Surgeon—have been deeply involved in and expertly executing the operational missions for which we exist, in particular medical readiness activities. Their leadership has been instrumental in our successful management of deployment health issues, dramatic decreases in non-battle injuries and illnesses, and expert casualty care management. Along with their operational focus, the Surgeons General have not wavered from their efforts to make TRICARE work better for all of our beneficiaries.

Supporting Our Families

TRICARE provides a peacetime health care benefit to 8.7 million beneficiaries—active duty Service members and their families, as well as retirees and their families and survivors. Nearly half are enrolled in TRICARE Prime, our HMO-type option, and the others are in TRICARE Standard, our fee-for-service option. We operate 75 hospitals and almost 500 clinics, with over 130,000 personnel, both uniformed and civilian. To supplement the care available in military hospitals and clinics, we purchase additional health care services on a large scale, delivering a managed care and fee-for-service program and processing about 90 million claims per year currently through seven regional contracts. Overall, the budget of the military health system was over $27 billion in FY 2003.

In order to sustain our medical readiness posture, as well as to attract and retain the best qualified Americans for military service, we operate a quality, world-wide health care system. Wherever we maintain medical capability and capacity, whether through military hospitals and clinics or contracted civilian services, our goal is a world-class health benefit that serves the health care needs of our active duty Service members, retirees, the family members of both active and retired Service members, and survivors. Through the operation of a clinically challenging medical practice, we ensure our health care providers and other medical experts are best prepared for their operational mission.

TRICARE

With the essential support of Congress, TRICARE is one of the most comprehensive health care benefits in the world. Recent enhancements have done even more to bring TRICARE to the forefront:

- Two years ago, we eliminated cost sharing requirements for families of active duty Service members enrolled in TRICARE Prime, our HMO option;
- Also at that time, we implemented a prescription drug benefit for senior beneficiaries;
- Eighteen months ago we implemented a TRICARE benefit for military beneficiaries who are also eligible for Medicare.
- Last summer, we released requests for proposals for the next generation of TRICARE contracts, to support our efforts to build a performance-based health care system with an emphatic focus on customer service.
- Most recently we have focused on improving access to care for the families of reservists, including the many serving their country at home and abroad today.

Yet, there is more to do. For example, in the coming year, we are introducing new programs to improve patient safety and quality health care.

We recently restructured our Patient Safety Program. Our objectives for the Patient Safety Program involve improving coordination of patient safety activities across the three Services, with the Armed Forces Institute of Pathology (AFIP), the Uniformed Services University of the Health Sciences (USUHS), and the TRICARE Management Activity providing essential integrating and leadership functions. We will align our patient safety data with national standards; to increase our reporting of near misses from Military Treatment Facilities; and to create a culture of disclosure and reporting to improve systems within healthcare. Surrounding these objectives, we intend to increase patient awareness and involvement in our patient safety initiatives.

One of the most significant advancements we have made in the area of patient safety was achieved through the deployment of the Pharmacy Data Transaction

Service (PDTS). The PDTS provides real-time integration of individual beneficiary prescription drug profiles from MTF, mail order and retail pharmacy points of service. In the brief time since its implementation, PDTS has already alerted TRICARE providers and patients to more than 69,000 potentially life-threatening drug interactions. It was recognized recently by President Bush as one of the most outstanding innovations in all of the federal government.

Shaping Our Future

TRICARE continues to set standards as one of the premier health plans in the world. While we are proud of our accomplishments in TRICARE, we also recognize that improvements can be made in the administration of this program. This year is an important transition year for TRICARE and we have begun the transition process already.

New TRICARE Contracts

In August 2002, we issued a Request for Proposal for a new generation of TRICARE contracts—simpler, more customer-focused, easier to administer, and with greater local accountability for performance. We reduced the number of TRICARE regional contracts from seven to three, and we reduced the number of TRICARE regions from eleven to three.

We continue to purchase managed care and administrative services from a single entity for a geographic area, offering beneficiary choice by offering managed care and fee-for-service options through the single entity. This is for two reasons. First, TRICARE delivers a defined benefit mandated in law, rather than setting a payment level and seeking health care plans to design coverage options for that price. Second, it is in the Government's best interest for our beneficiaries to receive their care in the MTF, and it is much simpler for the government and for beneficiaries to have a single health care entity coordinating referrals of care into military facilities.

Key features of this new TRICARE acquisition include:

- There is a single request for proposals; offerors may bid on all regions, but may only win one region.
- The procurement was developed in an open process, with input from industry and beneficiaries. Comments and questions from potential offerors were incorporated into evolving draft documents posted on an Internet site for public review.
- The procurement is performance-based, with a "Statement of Objectives" replacing the customary "Scope of Work." Whenever appropriate, we have set performance objectives rather than specifying the technical approach to be used. Key areas that require continuation of specifications are interface with Government systems and achievement of superior customer service.
- Offerors make oral presentations of their technical approach rather than submitting multi-volume proposals on paper.
- The Government and the regional contractors will share in the risk for health care costs; contractors will be paid fixed prices per claim or per beneficiary for administrative services
- The contracts include incentives for contractors to utilize local military medical facilities and to increase patient satisfaction. We are aligning our incentive structure so that Service medical departments and local military medical facility commanders are similarly rewarded for cost-effective decisions to optimize use of their medical facilities.

In January 2003, the acquisition process reached a milestone when bids were received for the three TRICARE regions. We have already accomplished a major objective by ensuring market competition for each of the three regional contracts.

We have also simplified our TRICARE contracts through selective identification of functions and services that can be more easily administered through single, nationwide contracts, or through more focused, local solutions. For example, local MTF commanders sought, and we provided more direct control of contracting for local support functions such as appointing and resource sharing with civilian providers for support to military hospitals and clinics.

We have competed and awarded a national mail order pharmacy contract that began March 1, 2003. This will be followed by a single national retail pharmacy contract; the request for proposals was released in March of this year. The establishment of national pharmacy services will enhance our management of this high-cost service, and enhance customer service for patients traveling in different regions who require short-notice prescriptions.

In addition, we are partnering with the VA very successfully on many different levels. To name a few of our efforts: The VA/DoD Health Executive Committee has

been established and is co-chaired by the Deputy Secretary, Veterans Affairs, and the Under Secretary of Defense for Personnel and Readiness. We have successfully launched a one-year DoD/VA Consolidated Mail Outpatient Pharmacy (CMOP) pilot program at three DoD medical treatment facility (MTF) sites. Our joint ventures and facility sharing efforts are progressing extremely well, and our sharing agreements now cover 163 VA medical facilities, most DoD MTFs and 280 Reserve units. Approximately 622 sharing agreements are now in operation, covering 6,017 health services with the military.

TRICARE GOVERNANCE

The most important element of our TRICARE transition, however, is our effort to ensure a seamless transition for our patients. The establishment of a new governance model for TRICARE that focuses on local health care needs will best support this transition.

Over the next several years, our Lead Agent offices around the country will have a critical role in this transition. For 2003, we have fully operational TRICARE contracts that continue to require the full efforts of our Lead Agents staffs in coordinating and overseeing contractor performance. In 2004, these contracts will still be operational for several months. The transition issues between contractors will require intensive oversight and coordination that will largely be conducted by Lead Agent staff. As the contract transition passes, there will be a migration of Lead Agent staff responsibilities from regional matters to local health care market management. Our Lead Agent/Market Manager offices are all located in areas of significant military medical capability as well as sizable beneficiary population. The Lead Agent/Market Manager duties may differ in some respects but the need for experienced health care executive staff with knowledge of local market circumstances will remain.

To further our ability to best deliver services in local health care markets, the Department is studying health care delivery in those markets served by more than one military medical treatment facility. Our objective is to identify business practices that allow us to sustain high quality health care programs, to include graduate medical education programs, and ensure patient satisfaction with access to these services.

Metrics

The DoD medical leadership has established a long-term strategic plan, using the Balanced Scorecard model. As part of this strategic plan, we have established a series of metrics and performance targets for our health system. Although there are a number of important measures, we have selected three indicators that will receive great visibility throughout our system. These indicators are:

- An Individual Medical Readiness metric to determine individual Service member's medical preparedness to deploy. This is a new, joint Service metric that promises to provide valuable information to both line and medical leadership.
- Patient Satisfaction with Making an Appointment by Phone. While we will measure a number of patient satisfaction indicators with access to health care, we are providing heightened attention to the specific indicator of phone access, which we have found to be a significant determinant of overall satisfaction with access. We will also measure ourselves against civilian benchmarks on this item.
- Patient Satisfaction with the Health Plan. This comprehensive review of patient satisfaction with their health plan provides a perspective on our overall performance on behalf of our patients. Similar to the previous metric, we will again compare ourselves to civilian benchmark standards.

Conclusion

Mr. Chairman, our responsibility to provide a world-class health system for our Service members, our broader military family, and to the American people has always been recognized by the Congress, and I am very grateful.

Thank you for the opportunity to testify before the Committee on this important issue.

COMMUNICATIONS

March 26, 2003

The Honorable Charles Grassley, Chairman
The Honorable Max Baucus, Ranking Member
Finance Committee
United States Senate
Washington, D.C. 20510

Dear Chairman Grassley and Ranking Member Baucus:

Thank you for the opportunity to submit testimony about the reauthorization of the Temporary Assistance for Needy Families (TANF) program. Legal Action Center is a nonprofit law and policy organization specializing in alcohol, drug, HIV/AIDS and criminal justice issues and represents the views of drug and alcohol treatment providers and consumers of those services nationwide.

TANF recipients with alcohol and drug problems and criminal justice histories need treatment and other supportive services to make the expected transition to self-sufficiency. Numerous studies have demonstrated that treatment helps low-income mothers achieve recovery, decrease their use of welfare, and increase their earnings. We urge the Senate Finance Committee

to facilitate access to drug and alcohol treatment services by including the following provisions in its TANF reauthorization legislation:

For funding of TANF benefits and services:

- **Increase funding for the TANF program to provide both supportive services and cash benefits.**
- **Add alcohol and drug treatment to the list of defined work activities that count toward an individual's work requirement and toward a State's participation rate.**
- **Repeal Medicaid's ban on reimbursement for residential alcohol and drug treatment services.**
- **Exempt alcohol and drug treatment from the definition of "medical services" to allow States to improve their use of TANF funds for treatment.**

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- **Create a "promote treatment" initiative that provides financial incentives for States to expand assessment, referral to treatment, and treatment services for TANF recipients and custodial and non-custodial parents of TANF-eligible children.**

- **Create a "promote prevention" initiative to provide alcohol and drug prevention services for parents, particularly teen parents, and children in TANF families who are at risk.**

For TANF eligibility:

- **End the ban on TANF assistance and food stamps for individuals with drug felony convictions, or narrow the ban so it does not apply to those in treatment or recovery.**

- **Add exceptions to the TANF and Medicaid sanction provisions for recipients who are in treatment or willing to enter treatment.**

- **Exempt individuals in alcohol and drug treatment – or on a waiting list to receive treatment – from the Federal time limit.**

- **Codify current Medicaid procedures for ensuring enrollment for eligible individuals who are leaving prison and jail.**

Addiction Among Welfare Families

Most national studies have indicated that 10 to 20 percent of adult welfare recipients have alcohol and drug problems. (As a comparison, 4.5 percent of American women reported past month drug use and 2.1 percent reported heavy alcohol use in 1995.[1]) These studies were conducted before the implementation of TANF, however, and it is not clear whether they are generalizable to the current caseload.

More recent studies have also found an elevated prevalence of addiction in TANF caseloads. In February 2001, Multnomah County, Oregon, found that 13 percent of TANF applicants screened positive for having an alcohol or drug problem.[2] An Alameda County, California, study estimated

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[1] Substance Abuse and Mental Health Services Administration. *Substance Use Among Women in the United States*. Rockville, Maryland: SAMHSA, 1997, p. 2-18.

[2] "Six-Month Report of A&D Activity Within AFS, Multnomah County," unpublished data, February 2001.

that 10 to 22 percent of TANF recipients in 1998 had an alcohol or drug problem.[3]

Cost-Effectiveness of Alcohol and Drug Treatment for Welfare Families

Studies have shown that alcohol and drug treatment programs provide effective and cost-effective services, despite limitations in funding. Specifically, current treatment capacity can meet only about half of the demand – even less for low-income women.

Programs serving women with children, including women on welfare, have demonstrated many positive outcomes, including increased employment and earnings and decreased use of public assistance. Key findings include:

- The benefits of treating welfare recipients in California exceeded costs by more than two and one-half times.[4] The authors of the study considered this ratio an underestimate because post-treatment employment and earnings data were deflated by a recession in the State at the time of the study.

- An Oregon study found that treatment completers received 65 percent higher wages than those who didn't complete treatment, with the difference due to improved earning power and an increase in the number of weeks worked. Increases were recorded in all treatment modalities, but highest in methadone maintenance.[5]

- A Washington State study found that indigent clients who completed treatment worked more and earned more than those who did not. Treatment completers earned an average of $403 per month, compared to non-completers, who earned an average of $265.

- A Minnesota study reported that among clients treated with public funds, 41.2 percent were employed full time after treatment, compared to 23.1 percent before.[6]

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[3] R. S. Green, L. Fujiwara, J. Norris, S. Kappagoda, A. Driscoll, and R. Speiglman, "Alameda County CalWORKs Needs Assessment: Barriers to Working and Summaries of Baseline Status." Berkeley, California: Public Health Institute, February 2000, p. 8.

[4] D. R. Gerstein, R.A. Johnson, and C.L. Larson, "Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits." Washington, DC: Department of Health and Human Services, 1997, p. 39.

[5] M. Finigan. "Societal Outcomes & Cost Savings of Drug & Alcohol Treatment in the State of Oregon." Salem: Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources, 1996, p. 16.

[6] C. Turnure, "Implications of the State of Minnesota's Consolidated Chemical Dependency Treatment Fund for Substance Abuse Coverage under Health Care Reform." Testimony to the Senate Labor & Human Resources Committee, March 8, 1994, p. 5.

Criminal Records Among TANF Recipients

Many women involved in the criminal justice system have alcohol and drug problems and will need treatment and other services to make the transition to employment. However, few studies have examined whether individuals involved in the criminal justice system are receiving welfare assistance (either before their incarceration or while on parole or probation) or whether those receiving welfare assistance are or have been involved in the criminal justice system.

A 1997 study found that many mothers in State and Federal prisons received welfare benefits before being incarcerated. A total of 41 percent of mothers in State prison and 33 percent of mothers in Federal prison reported receiving welfare before being incarcerated.[7]

A study in Alameda County, California, found that 20 percent of adult TANF recipients had been convicted of a crime, about 10 percent had been convicted of two or more crimes, and 10 percent had been convicted of a felony since the age of 18.[8] The study did not report on the nature of the convictions.

Effectiveness of Employment Programs for Ex-Offenders

Findings from evaluations over the last 20 years indicate that employment programs for ex-offenders have increased their employment and earnings and reduced their recidivism. Key findings include:

- A study of New York City's Wildcat program, "Supported Work," which provided jobs and job training to chronically unemployed former heroin addicts and criminal offenders, demonstrated increased employment and pay for recovered addicts and lower arrest rates among those employed in both the experimental and control groups.[9]

- A 1988 study of the effectiveness of Illinois prison programs found that those who obtained vocational training and education had higher employment and fewer arrests.[10]

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[7] Christopher J. Mumola, "Incarcerated Parents and Their Children." Washington, DC: Bureau of Justice Statistics, August 2000, p. 10.

[8] R. S. Green, *et. al., op. cit.*, p. 37.

[9] L. N. Friedman, *The Wildcat Evaluation: An Early Test of Supported Work in Drug Use Rehabilitation.* Rockville, Md.: National Institute on Drug Abuse, 1978. The project had financial support from the US Department of Labor, National Institute on Drug Abuse, Ford Foundation, Law Enforcement Assistance Administration, and New York City Department of Employment.

[10] D.B. Anderson, *et. al.*, "Correctional Education A Way to Stay Out: Recommendations for Illinois and a Report of the Anderson Study." Illinois Council on Vocational Education, 1988.

- An evaluation of the Texas Project Re-Integration of Offenders (RIO) program, which helps parolees find jobs, reported that 69 percent of participants found employment, compared with 36 percent of a matched control group. During the year after release, 23 percent of RIO participants returned to prison, compared to 38 percent in the control group, which saved the State $15 million in 1990.[11]

Recommendations for TANF Reauthorization

TANF recipients with alcohol and drug problems and/or criminal justice histories need supportive services, including treatment and vocational training, to make the expected transition to work. If they do not receive these services, they may not be able to meet their TANF work requirements and may be more likely to have their benefits reduced or cut off or reach their time limit without being able to work and take care of their family. Faced with a loss of benefits and a lack of employment, these families could experience greater poverty and deprivation – even dissolution.

Without continued success in moving TANF recipients to work, States could face penalties for not meeting their work participation requirements or for having too many families on assistance for more than 60 months. States could also face supporting these individuals and their families in State-only welfare programs[12] or in other, more expensive systems supported by State dollars, such as criminal justice and foster care.

Together, these negative effects – on TANF recipients and State and local governments – could erode the success of welfare reform, as well as other Federal and State poverty reduction initiatives.

Recommendations on Benefits and Services

- ***Increase funding for the TANF program to provide both cash benefits (assistance) and supportive services (non-assistance).***

Increasing the TANF program's funding will allow States to continue to provide assistance to those who need it during the current economic downturn. It will also give States a secure source of funding to begin and expand initiatives to provide services ("non-assistance") to help TANF recipients address barriers to self-sufficiency.

Several States, for example, are using TANF funds to identify low-income adults with alcohol and

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[11] P. Finn, "Job Placement for Ex-Offenders: A Promising Approach to Reducing Recidivism and Correctional Costs," *NIJ Journal*, July 1999.

[12] A study in one California county found that addiction was a stronger predictor of repeat use of general assistance than of Federal welfare assistance. L. Schmidt, C. Weisner, and J. Wiley, "Substance Abuse and the Course of Welfare Dependency," *American Journal of Public Health*, Vol. 88 (1998), pp. 1616-1622.

drug problems and refer them to treatment, including Illinois, Kansas, Kentucky Maryland, Minnesota, New York, New Jersey, North Carolina, Oregon, Tennessee, and Utah. At least one other State, New York, has begun to allocate TANF funds to programs to help divert appropriate individuals from prison into treatment and welfare-to-work services.

- ***Adding alcohol and drug treatment to the list of defined work activities that count toward an individual's work requirement and toward a State's participation rate.***

Presently, the Federal law lists 12 activities that can satisfy an individual's work requirement and count toward the State's minimum work participation rate.[13] Alcohol and drug treatment is not on the list.

Including treatment in the definition of work that can count toward a State's participation rate will help States both to engage TANF recipients in a broader range of work preparation activities and move addicted recipients to sobriety and work while and still meeting their Federal participation rates. The change will also help TANF recipients better coordinate their treatment and work requirements – since they will be able to perform them in the same program.

Presently, the Administration's and House of Representative's TANF reauthorization proposals would count drug and alcohol treatment as work for up to three months. We support counting drug and alcohol treatment as a work activity. However, we recommend that drug and alcohol treatment be permitted to count as work for as long as necessary and appropriate in order for individuals to achieve recovery and the ability to go to work, education, or training.

- ***Repeal Medicaid's ban on reimbursement for residential alcohol and drug treatment.***

A key barrier to alcohol and drug treatment for TANF recipients is the Medicaid program's "Institutions for Mental Diseases" (IMD) exclusion. IMDs are inpatient treatment facilities (including non-hospital residential programs) with more than 16 treatment beds for individuals with "mental diseases," with addiction being included in the definition of "mental disease."

The exclusion prohibits reimbursement for any service provided in an IMD or for any service provided to an IMD patient in a non-IMD setting for individuals between the ages of 22 and 64. For example, Medicaid will not cover prenatal care – either inside or outside the facility – for woman in a residential alcohol or drug treatment program with 16 or more treatment beds.[14] For facilities under 16 beds, treatment can be covered by Medicaid, but not room and board.

Excluding addiction from the definition of "mental disease" would significantly increase access to

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[13] §407(d).

[14] Beds for children in women's residential treatment programs do not count toward the 16-bed limit. Memo from Acting Medicaid Bureau Director Rozann Abato to HCFA regional administrators, June 23, 1993.

residential treatment for women with children, who are the majority of TANF recipients, increasing their likelihood of achieving recovery and moving from welfare to work.

- ***Exempt alcohol and drug treatment from the definition of "medical services" to allow States to improve their use of TANF funds for core treatment services.***

States are not currently allowed to use TANF funds for "medical services,"[15] with the TANF final rule leaving it up to States to define the term.[16] While this gives States flexibility, the lack of a clear definition has left some State welfare directors reluctant to invest TANF in core alcohol and drug treatment services, such as counseling (covered in some State Medicaid plans) for fear of being penalized for misuse of funds.[17] This is problematic for States that are doing active outreach and screening because they will find more people needing treatment but will not be able to increase core treatment slots.

Left as is, the ban acts as an unnecessary barrier to TANF investment in alcohol and drug treatment. Change would enhance State flexibility, as well as help close the treatment gap for women with children.

- ***Create a "promote treatment" initiative that gives States a financial incentive to expand assessment, referral to treatment, and treatment services for TANF recipients and non-custodial parents of TANF-eligible children.***

The law currently gives States financial incentives to reduce non-marital births, meet work participation requirements (through a reduction in the "maintenance of effort" requirement), achieve high levels of performance on TANF goals, and other outcomes deemed nationally desirable. Financial incentives should also be used to encourage States to implement initiatives that focus programmatic energy on improving work-related outcomes for TANF recipients with alcohol and drug problems and/or criminal justice histories. States would not be required to participate (so this would not be an unfunded mandate) but could be eligible for supplemental funding or matching funding if they did.

- ***Create a "promote prevention" initiative to provide alcohol and drug prevention for parents, particularly teen parents, and children in TANF families who are at risk.***

For adolescents, alcohol and drug use is associated with a range of negative health and social outcomes, including risky sexual behaviors that can lead to unplanned pregnancy, HIV/AIDS, and long-term welfare participation for the entire family. Risks can be even higher for adolescents

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[15] §408(a)(6).

[16] Preamble language, 64 *Federal Register* 17840 (April 12, 1999).

[17] Personal communication from welfare officials in several States and localities.

whose parents have alcohol and drug problems, because they are statistically more likely to develop alcohol and drug problems themselves.

Both children and young parents in TANF families should have access to prevention and early intervention services designed specifically for them. These services can help young parents reduce their alcohol and drug use so they can finish school, work, and take care of their children. These services can also help children avoid alcohol and drugs and the related health and social problems that can lead to reliance on welfare. In turn, this will decrease welfare and child welfare caseloads and costs, as well as build healthier individuals, families, and communities.

The law currently funds abstinence education, which is required to include a component that teaches adolescents how "alcohol and drugs can increase their vulnerability to sexual advances."[18] But more is needed, including family-based services, which are identified as key for child and adolescent prevention programming.[19]

Funding should be directed to the Center for Substance Abuse Prevention (CSAP) (part of the Substance Abuse and Mental Health Services Administration, or SAMHSA), the lead Federal agency on prevention, for this purpose. The program should require evaluation (including identification of model practices) and be coordinated with other prevention activities for these families administered by ACF, other agencies in the Department of Health and Human Services, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Department of Education.

Recommendations on Eligibility

- ***End the ban on eligibility for TANF assistance and food stamps for individuals with drug felony convictions, or narrow the ban so that it does not apply to those in drug and alcohol treatment or recovery.***

Under the law, individuals with drug felony convictions are not eligible for TANF assistance and food stamps, unless the State they live in enacts legislation to opt out of or narrow the ban.[20] The ban applies to convictions where the conduct and the conviction occurred after August 22, 1996, and lasts for the person's lifetime.

If a State does not "opt out," no one is exempt from the ban, not even pregnant women or individuals participating in treatment. The ban is permanent and continues regardless of an

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[18] §912(b)(2)(G).

[19] National Institute on Drug Abuse. Preventing Drug Use Among Adolescents: A Research-Based Guide. Rockville, Maryland: NIDA, 1997.

[20] §115, as amended by §5516 of the Balanced Budget Act of 1997 (P.L. 105-33).

individual's successful job history, participation in drug treatment, or abstinence from drug use.

Federal action to end the ban or narrow it would replicate action taken by a majority of States. A total of eight States (and the District of Columbia) have opted out completely – Connecticut, Michigan, New Hampshire, New York, Ohio, Oklahoma, Oregon, and Vermont. Another 19 States – including Florida, Illinois, Iowa, Maryland, Washington, and Wisconsin[21] – have narrowed the ban's scope, most commonly by exempting individuals in treatment (or who are on a waiting list for treatment or have finished treatment or achieved recovery).

Left unmodified at the Federal level, the ban reduces access to alcohol and drug treatment in 24 States. In fact, a study (of eight women's residential programs in California) found that providers reported that their loss in monthly revenue ranged from none to 25 to 30 percent.[22] (Treatment programs, particularly residential programs, have traditionally relied on a family's welfare and food stamps to help fund room and board.)

Unmodified, the ban also acts as an impediment to recovery for individual women because it denies them support as they are leaving treatment and re-entering the community. Repealing it gives them the means, as well as the incentive, to stay in treatment.

- ***Add exceptions to the TANF and Medicaid sanctions for recipients who are in treatment or willing to enter treatment.***

Some TANF recipients with alcohol and drug problems who are trying to become self-sufficient through treatment may have difficulty complying with their work requirements, either because their addiction interferes with their ability to work or because their treatment schedule conflicts with their work or training schedule. Ending their eligibility for TANF and Medicaid virtually ensures that they will not be able to make the transition to recovery and self-sufficiency.

Those who are in treatment – or on a waiting list to receive treatment – should be able to retain their TANF and Medicaid so they can continue to afford treatment. Without it, they may not be able to learn the recovery and vocational skills they need to achieve self-sufficiency.

- ***Exempt individuals in alcohol and drug treatment – or on a waiting list to receive treatment – from the Federal time limit.***

Without treatment, few welfare recipients with alcohol and drug problems will be ready to work when they reach their time limit on Federal assistance. Unfortunately, in many communities,

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[21] Legal Action Center, *Getting to Work: How TANF Can Support Ex-Offender Parents in the Transition to Self-Sufficiency*. Washington, DC: LAC, 2001. Kentucky has since enacted legislation to narrow the ban.

[22] A. Noble and E. Zahnd, "The Gramm Amendment to Welfare Reform: Problems for Women's Residential Treatment Providers and Their Clients." Davis: University of California, January 2000.

individuals needing treatment and willing to enter it cannot – because it is not available.

Providing incentives for welfare recipients with alcohol and drug problems to enter and stay in treatment will help them become ready to work. Exempting TANF recipients in alcohol and drug treatment from the Federal time limit gives them incentive to enter treatment and to stay in treatment. It also gives States more flexibility to engage TANF recipients in treatment as a work-promoting activity for as long as necessary, regardless of whether the State has reached its 20 percent hardship exemption maximum.

- ***Codify current Medicaid procedures for ensuring enrollment for eligible individuals who are leaving prison and jail.***

Current HHS policy[23] states that incarcerated individuals must be returned to Medicaid enrollment immediately upon their release unless the State determines they are no longer eligible. Few States, however, seem aware of this requirement. A 2001 study found 46 States and two territories have policies that require termination of Medicaid supports for people in jail, meaning that these individuals must complete the Medicaid application process again when released and wait for a decision and benefits.[24]

Many women leaving prison and jail reunite with children (whom they left with relatives) and would likely continue to be eligible for Medicaid. Many also having pressing medical conditions – such as mental illness, HIV, and alcohol and drug problems – that if left untreated would decrease their chances of working and achieving self-sufficiency.

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Thank you for considering these recommendations for TANF reauthorization. Please feel free to contact me at (202) 544-5478, x13 if you have any questions. Legal Action Center looks forward to working with you on these important issues.

Sincerely,

Jennifer Collier
Director of National Policy and State Strategy

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[23] Letter from Secretary of Health and Human Services Tommy G. Thompson to Representative Charles L. Rangel, October 1, 2001.

[24] C. Brown, "Jailing the Mentally Ill," *State Government News*, April 2001, p. 28.

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

April 4, 2003

Paul B. Ginsburg, Ph.D.
President
Center for Studying Health System Change
600 Maryland Avenue, SW, #500
Washington, DC 20024

Dear Dr. Ginsburg:

The Senate Finance Committee held a hearing yesterday entitled, "Purchasing Health Care Services in a Competitive Environment." The hearing raised important questions regarding the cost-implications of adopting a competitive bidding model for Medicare. More specifically, the Committee focused on competitive bidding models employed by large health care purchasers such as the Office of Personnel Management, the Department of Defense, and General Motors.

My judgment is that the cost or savings associated with this approach would depend, in part, on the ability of private plans to negotiate lower payment rates than providers are currently paid under the traditional fee-for-service Medicare program. If private plans could negotiate lower rates than fee-for-service Medicare, there is a potential for savings. Conversely, if these plans could not negotiate lower payment rates, spending by the federal government for beneficiary care would be higher than under current law.

Any cost or savings associated with a competitive bidding approach would also be influenced by the ability of private health plans, such as preferred provider organizations (PPOs), to reduce excessive health care utilization. Many argue that the cost-containment tools employed by health plans today have the potential to reduce the excessive utilization associated with fee-for-service Medicare.

Quantitative data on these questions are difficult to obtain. I understand that the best data available to answer these questions may be the survey results that the Center for Studying Health System Change has collected from its series of community reports over the past several years.

Based on your research and these reports, I am writing for your assistance in answering the following questions:

1) What is the available evidence of private health plans' ability to negotiate lower provider payment rates than fee-for-service Medicare currently pays? Is there any evidence of excess capacity in the health care system that would enable private health plans to negotiate lower rates than Medicare fee-for-service?

2) How do private plans' ability to negotiate lower rates vary across the country?

3) What is the current trend of preferred provider organizations' (PPOs') ability to control and reduce their enrollees' health care utilization of hospital and physician services?

In the interest of including your answers to these questions as part of the Finance Committee hearing record, I am hopeful that you can provide a response by 5:00 pm, Thursday, April 10, 2003, the deadline for submitted comments.

Thank you for your attention to this request. I am certain that your research into these matters will inform the Committee's discussion on this very important topic.

Sincerely,

Max Baucus

Max Baucus

Paul B. Ginsburg, Ph.D.
President

CENTER for STUDYING HEALTH SYSTEM CHANGE

TELEPHONE: 202-484-4699
www.hschange.org

Providing Insights that Contribute to Better Health Policy

April 10, 2003

The Honorable Max Baucus
Committee on Finance
United States Senate
Washington, DC 20510-6200

Dear Senator:

I am pleased to answer the questions that you posed to me in your letter of April 4 concerning the potential for private plans in the Medicare program to realize lower costs.

The Center for Studying Health System Change has been monitoring and analyzing health care markets since 1995. We visit a representative sample of 12 communities every two years for in-depth interviews with leaders of the major elements of local health systems. These site visits complement our surveys of households and physicians. The period in which we have studied these markets encompassed both the expansion of managed care and its subsequent transformation in response to a backlash by consumers and physicians.

1) What is the available evidence of private health plans' ability to negotiate lower provider payment rates than fee-for-service Medicare currently pays? Is there any evidence of excess capacity in the health care system that would enable private health plans to negotiate lower rates than Medicare fee-for-service?

In most areas of the country, payment rates for hospitals and physicians that are negotiated by private plans are higher than those paid by the Medicare fee-for-service (FFS) program. In our site visits, we routinely ask managed care plans how much they pay physicians. Since virtually all of them use the Medicare fee schedule as a benchmark, they usually answer the question in terms of a percentage of Medicare rates. In our 2000-2001 site visits, we found that private plans in 8 communities paid higher rates than Medicare while plans in 4 communities paid less. During our current round of site visits, which is mostly complete, 2 communities changed from private plans paying less than Medicare to more while none moved in the opposite direction. We have witnessed this trend of rates paid by private plans increasing relative to Medicare payment rates over a number of rounds of site visits.

Quantitative data analyzed by the Medicare Payment Advisory Commission (MedPAC) show higher payment rates in private health insurance (virtually all of which is managed care) for both physicians and hospitals. An analysis of claims data by Hogan conducted for MedPAC estimates that private insurers paid 25 percent higher rates than Medicare to physicians in 2001. MedPAC staff analysis of the American Hospital Association's Annual Survey shows that private insurers paid 14 percent higher rates for hospital care than Medicare in 2001 (*Report to Congress* March 2003).

An important factor behind this trend of payment rates by private insurers increasing in relation to Medicare rates is a trend of tightening capacity. Our 2000-2001 round of site visits found much greater pressures on hospital capacity. Many hospital executives indicated that lack of excess capacity had given them the leverage to decline managed care contracts with unattractive payment rates (see *Health Plan-Provider Showdowns on the Rise,* HSC Issue Brief No. 40, June 2001). HSC's physician survey has shown a strong trend of increasingly tight physician capacity. Waiting times for appointments are increasing and fewer physicians are accepting all new patients. These trends are similar for Medicare and privately insured patients (see *Growing Physician Access Problems Complicate Medicare Payment Debate,* HSC Issue Brief No. 55, September 2002).

2) How do private plans' ability to negotiate lower rates vary across the country?

For physician payment, we see large variation in payment rates for private plans relative to Medicare FFS across the 12 communities we track. In our 2000-2001 site visits, we found that in Miami, northern New Jersey and Orange County, California, private insurers' physician payment rates relative to Medicare are relatively low compared with other communities. For example, in Miami, private payments range from 80 to 108 percent of Medicare physician payments. In northern New Jersey, private rates ranged from 95 to 105 percent of Medicare payments. In contrast, Boston, Cleveland, Greenville, Little Rock and Seattle have private rates that are much higher than Medicare. For example, private payments in Little Rock range from 120 to 180 percent of Medicare physician payments and from 100 to 150 percent in Boston. This pattern of relative differences across markets has remained stable over time. Those markets that are typically more generous than Medicare have maintained these higher rates over the last 8 years of our study. Similarly, the communities with the lowest rates have consistently paid lower rates than other communities.

This pattern of variation in the ratio of private payments to Medicare payments is seen in hospitals as well. Interviews with insurers in the California market indicated that the Sacramento area has payment rates that are much higher than in San Francisco, which in turn are much higher than those in Los Angeles.

The ratio of private insurance payment rates to Medicare FFS payment rates is likely to be particularly unfavorable in rural areas. Although HSC does not collect this type of data for rural areas, managed care industry sources have reported that lack of competition among providers in rural areas results in little ability of private insurers to obtain discounts from charges.

This variation in payment ratios across communities suggests that there are likely to be some areas in which private plans can negotiate rates that are lower than Medicare FFS, but in most areas the opposite is true. But the trends are towards fewer areas in which the private plans have lower rates than Medicare FFS. Consequently, the presence in a few communities of PPOs that appear to have potential for lower costs than Medicare FFS is not an indication that this could happen in most areas.

3) What is the current trend of preferred provider organizations' (PPOs') ability to control and reduce their enrollees' health care utilization of hospital and physician services?

Our site visits show a broad decline in recent years in efforts by all managed care plans to reduce their enrollees' health care utilization. This is a reflection of the backlash against the restrictions of managed care. Indeed, this has been augmented by enrollment changes away from HMOs towards PPOs, as consumers seek broader choice of provider as well as fewer administrative controls. PPOs are the choice for those who are willing to spend more for health care in order to have less interference in their choice of provider and use of care.

Today, PPOs are engaged in few activities to manage care. Their main cost containment focus is on obtaining discounted rates. Their broader provider networks and their enrollees' ability to go out of network for some of their care makes it much more difficult for them than for HMOs to attempt to manage the utilization. For example, they cannot make physicians accountable for a patient's care when there is no requirement that patients see a single primary care provider as their initial point of contact in the health care system. An implication of this is that Medicare PPOs will inevitably be less successful in managing utilization of services than Medicare HMOs. Indeed, in employment-based insurance today, the PPO is often looked to by employers as a preferred platform to pursue a "consumer driven" approach to health care involving substantial patient cost sharing.

I would be pleased to be of further assistance to you and the Committee on these and related issues around reform of the Medicare program.

Sincerely Yours,

Paul B. Ginsburg

Paul B. Ginsburg

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement on

Purchasing Health Care Services in a Competitive Environment

United States Senate
Committee on Finance

April 3, 2003

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Mr. Chairman and Members of the Committee. The National Association of Chain Drug Stores (NACDS) is pleased to submit this statement for this hearing on "Purchasing Health Care Services in a Competitive Environment." Part of this hearing will likely focus on how to assure that a quality Medicare pharmacy benefit is delivered in the most cost-effective manner.

NACDS represents over 200 pharmacy companies that operate nearly 35,000 community-based retail pharmacies. NACDS members employ nearly 100,000 pharmacists and provide about 70 percent of all outpatient prescriptions. The majority of our prescriptions are paid for by insurance companies and pharmacy benefit managers – over 85 percent – so we have a significant amount of experience in operating in the current pharmacy benefit marketplace. We believe that we can provide a unique perspective on what we feel will work best for Medicare program, seniors, and the taxpayers.

FEHBP and DOD Use Different Approaches to Prescription Drug Benefit Design

Two of the models being discussed today are the Federal Employees Health Benefits Program, (FEHBP) and the Department of Defense (DOD) Tricare program. Frankly, we believe that examining the prescription drug benefit programs in FEHBP and DOD will give policymakers ample evidence to re-evaluate some of the major models being proposed that would rely primarily on pharmacy benefit managers (PBMs) to provide a prescription drug benefit.

Anyone who is following the health policy, business, and financial news would find that important public health and public policy questions are being raised about the current practices of PBMs, and whether they are holding down drug costs, or responsible, in part, for their significant increases.

The experience of the government's own FEHBP should be instructive to Members of Congress as they consider the true effectiveness and competitiveness of this approach to providing a prescription drug benefit for seniors. Our analysis indicates that escalating prescription drug spending in the FEHBP program – which is administered by the same PBMs that would be used for Medicare – has contributed significantly in recent years to the sharp premium increases seen in the program.

For example, the Office of Personnel Management's (OPM) own data indicate that drug cost increases were responsible for 40 percent of the 10.5% premium increase in 2001, 37 percent of the 13.3% premium increase in 2002, and 30 percent of the 11.1% premium increase in 2003.

Keep in mind that the average age of the FEHBP population is about 47 years of age, while that of traditional older Medicare population is about 70. Medicare beneficiaries have more chronic conditions, requiring greater drug use, which results in higher per capita expenditures than the much-younger, healthier FEHBP population. If the PBMs have not been able to manage prescription drug spending in the FEHBP program's younger, healthier population, why should we believe that they would be any more effective in the higher-cost Medicare population?

PBMs' Anti-Competitive Practices Not Aligned with Goals of Payors or Medicare

Many public and private payors are rethinking their PBM strategies because they recognize that PBMs have overpromised and underdelivered. The goal of payors to reduce prescription drug costs is not necessarily aligned with that of the PBMs, which is to drive manufacturers rebates to gain higher operating profits for the PBM. These rebates are generated by promoting the use of higher-cost brand name drugs. What follows is an excellent example of how rebates create perverse incentives and anti-competitive practices in the marketplace:

Most PBM-administered prescription drug benefit plans have both a community retail pharmacy network and a mail order pharmacy component (i.e. Medco, Express, Advance PCS, Caremark). In most cases, these mail order pharmacies are owned by the PBM, and the PBM uses the patient-identifiable information that they obtain from processing a retail pharmacy claim, to switch patients to their own mail-order facilities.

The PBMs have financial incentive to do this because they receive significant rebates from brand name manufacturers for moving (or increasing) a particular manufacturer's market share, so the more product that is dispensed through mail, the more rebates the PBM receives. This is not always cost-effective for the payor or the patient, since it increases copays for the patient and overall costs for the payor. Moreover, the retail pharmacy doesn't receive rebates and has no incentive to provide higher-cost brand name drugs.

In fact, retail pharmacies use more lower-cost generics than mail, so the net cost to the payor and the patient is actually lower for drugs dispensed through retail. (Latest data found that mail order uses 37% generics, while retail uses generics in 49% of the cases)

But, to force patients to obtain their brand name drugs through mail, these PBMs artificially limit the quantity of brand name drugs that a retail pharmacy can dispense. That is, while PBMs may incorrectly contend that state pharmacy practice laws prohibit retail pharmacies from dispensing a 90-day supply of medications, this is not the case. Some states do have limits on the amount of controlled substances that can be provided, but these restrictions would occur for any pharmacy outlet that dispenses these drugs. PBMs, however, will not allow pharmacies to provide any more than a 30-day supply because they want to run those prescriptions through their mail order facility so they can collect the manufacturer rebates.

Mail order operations are direct competitors to community pharmacies. PBMs should not be allowed to use information obtained through a retail prescription claims transaction to switch patients to mail order for their own financial gain. To avoid this anti-competitive practice, PBMs should not be allowed to be both the community pharmacy network contractor and mail order contractor within the same region, since this creates a competitive conflict with community retail pharmacies. In addition, pharmacies should be allowed to continue to provide maintenance medications to patients (i.e. fill a 90-day supply of maintenance medication). PBMs should not contractually prohibit pharmacies from providing these medications. PBMs should not use any coverage or cost sharing incentive that would create incentives for seniors to use one method of pharmacy distribution over another.

Some of these anti-competitive issues can be addressed by including strong "transparency" provisions in the Medicare pharmacy benefit. Pricing transparency is necessary for the efficient operation of markets, and also allows consumers and others to make the best purchasing choices. Right now, the PBM industry is operating without this necessary transparency.

The Medicare program and seniors should benefit directly from any and all price concessions given to plan administrators and PBMs. These price concessions take many forms – rebates, discounts, formulary placement fees, market share movement fees, data collection and analysis fees, and others.

If made transparent, and passed along, these incentives will ultimately reduce the cost of the benefit to Medicare and to seniors. It will also reduce the incentives that PBMs have to erect these anti-competitive barriers that increase cost and can negatively impact quality of care. The PBM industry argues against transparency because they know it will more fully expose that their business model centers almost exclusively on deriving and retaining rebates from drug manufacturers that are not passed along to plan sponsors. We urge policymakers to make sure that transparency is a hallmark of any Medicare pharmacy benefit.

Department of Defense (DOD) Recognizes PBM Influences

In contrast to the FEHBP program, which relies on private sector PBMs, the DOD's Tricare program has developed prescription drug models that are more cognizant of the negative influences of PBM rebates. Their approach uses a pharmacy benefits administrator (PBA) type model.

The PBA model relies on a benefits administrator to adjudicate and pay claims, determine eligibility, create networks, and perform other operational functions to run the program. The PBA doesn't become involved with direct rebate negotiations with manufacturers, and is therefore not in a position to retain these rebates or develop policies that would encourage the dispensing of drugs for which they are receiving rebates.

For example, the Tricare National Mail Order Program (NMOP) program passes along to DOD all the rebates that the DOD negotiates with pharmaceutical companies. This program is administered by Express Scripts, so even the traditional PBMs are able to participate in models that use PBA-type approaches. Building on the success of the NMOP program, DOD recently announced that its Tricare national retail pharmacy contract would operate in a similar manner. The DOD has recognized that PBMs retain a significant portion of manufacturer rebates and want these rebates to accrue to the DOD and the military eligibles and retirees. Thus, there are two major Federal government health care programs using different approaches – with very different outcomes – to provide pharmacy benefits to two important populations.

NACDS and community pharmacy support approaches to delivering a Medicare pharmacy benefit that take the perverse rebate incentives out of the system, since it results in nothing more than limiting seniors' access to needed medications and the pharmacy of their choice.

Medicare, seniors, and taxpayers would all benefit from a system where any manufacturer or pharmacy price concessions are passed along to the senior, and anti-competitive incentives to dispense larger quantities of brand name medications or restrict the use of generics are eliminated.

Marketplace Has Responded with Discounts for Low-Income Seniors

We believe that the market has changed significantly since the Department of Health and Human Services (HHS) announced its original Medicare-endorsed PBM-based discount card program in July 2001. For example, manufacturers now offer prescription drug assistance through participating retail pharmacies. These programs include "Lilly Answers," "Pfizer's Living Share Program" and the "Together Rx Program" all of which assure that truly needy low-income seniors are able to obtain meaningful savings on brand name prescription medications at their participating local pharmacy.

These private-sector approaches obviate the need for government-mandated programs on the private sector. Over 150 brand name prescription drugs are available at discounts of up to 40 percent. In fact, the best competition occurs in the market when manufacturers and pharmacies compete without the interference of a middleman PBM that has the government's sanction to create artificial barriers to competition in the marketplace.

By HHS' own estimate, their Medicare-endorsed PBM-based discount card program, such as those envisioned by CMS, would only generate savings of 10 to 13 percent for seniors on the cost of their prescriptions. Almost all of these savings would come from reduction in the prices that pharmacies charge, not a reduction in the price that the manufacturer charges the pharmacy for the drug. Moreover, these discount card programs – which already exist in the market – overuse higher-cost brand name drugs, rather than lower-cost generics. That is because PBMs earn rebates from drug manufacturers by promoting the use of their brand name drugs. These practices lead to higher prescription drug bills for seniors, not lower ones.

Under a Medicare-endorsed discount card program, seniors' access to needed prescription medications and their choice of pharmacy would be restricted. Under these other newer programs, however, seniors do not have to make choices between various discount programs, switch their medication from a drug they may be taking to another drug just to get a discount, and don't have to give up using their local pharmacy. In our opinion, this is better health care for seniors.

We would ask that you reconsider your approach to legislating a Medicare-endorsed discount card program that would be of little benefit to seniors and would significantly harm community pharmacies. Instead, we ask that you work with us to assure that private-sector approaches continue to be developed, which will help seniors obtain their prescription medications in the short term, while we work on a model for longer term Medicare reform that incorporates these important private-sector approaches.

Conclusion

NACDS believes that the Senate Finance Committee is asking the right questions regarding the competitive models that are best able to assure that seniors have access to a quality, cost effective pharmacy benefit. We believe that any pharmacy benefit should rely on the competitive market forces that already exist among pharmaceutical manufacturers and retail pharmacies, and that artificial barriers should not be erected to impede this competition.

The Committee should also take note of the market shift that appears to be occurring – both in private and public sector programs – away from PBM models and toward PBA or in-house administration models. These approaches help assure that the plan sponsors reap the benefits of their purchasing power, rather than having it diluted by a middleman.

In order to provide the most competitive pharmacy benefit possible, policymakers should assure that the following components are incorporated into the program: 1) transparency and pass through of all PBM-derived rebates, concessions, and discounts; 2) assurances that PBMs do not erect artificial barriers to seniors' access to the pharmacy of their choice, such as through restrictive networks, limitations on the quantity of medication that retail pharmacies can provide, or differential cost sharing to provide seniors with incentives to use mail order over retail pharmacies;

3) limits on the activities performed by PBMs so that they function more as PBAs, and do not become involved in patient care functions, which is the purview of the health professionals; and, 4) restrictions on the ability of the PBM to serve both as the retail network administrator and the mail order provider in the same region, which is an inherent conflict of interest since PBMs are direct competitors of retail pharmacies.

NACDS and its member companies look forward to working with the Finance Committee on developing this Medicare pharmacy benefit. Thank you for an opportunity to submit this statement.

March 27, 2003

VIA E-MAIL TO: editorial@finance-rep.senate.gov

SUBJECT: TANF REAUTHORIZATION – A Local County Perspective

Ramsey County, home to the Minnesota State Capitol and the county with the second largest responsibility for TANF programs in the state, urges the Senate Finance Committee to support policies in the reauthorization of TANF that will allow the most successful elements of welfare reform to continue:

- Adequate funding;
- Continued flexibility; and
- Protection for legal immigrants.

Some background information about Ramsey County

- More than 8,000 Ramsey County families are currently on the Minnesota Family Investment Program (MFIP), the State's TANF program. About 7,000 families are subject to the work requirements and time clock under welfare reform. This is a reduction from our peak caseload in 1994, when more than 11,400 families were on AFDC in this county.
- More than two-thirds of the Ramsey County families on MFIP since the state program was introduced in January, 1998, have either left welfare or are still on welfare but are working. This measure – about what happens in the end – is much more important than the measure of how many people are in what activity at any random point in time.
- Only 12% of the families on welfare when the clock started ticking in Ramsey County have actually reached the time limits. Of those that did, almost 90% have been found to have low IQ's, chronic and impairing illnesses, serious mental illness combined with high degrees of homelessness, domestic violence, or ill and disabled children.
  - More than one-third of the long-term families on welfare in Ramsey County have two such barriers to employment; and
  - More than one-quarter have three or more such barriers to employment.
- Current funding levels support job counselors with average caseloads of 100 participants each and financial workers with average caseloads of 150 families each.

Adequate Funding

Keep not only the funding for TANF at least at the 1996 levels, but increase funding for child care assistance. More than 1,300 families in our community are already on waiting lists for child care assistance. We cannot make welfare reform work if working families cannot meet their families' basic needs.

Continued Flexibility

Extend the waiver that allows Minnesota to develop the unique features that have made MFIP the most successful of the state programs in moving families out of poverty as they move off welfare.
The flexibility allowed in work activities pays off in the high number of people who leave MFIP for competitive work. But if we cannot ready people for that competitive work by addressing mental illness, homelessness, domestic violence, or the disabling conditions of many of the children, those families will be stuck in make-work jobs.

Treat legal immigrants fairly

The original federal bill, the Personal Responsibility and Work Reconciliation Act of August, 1996, unfairly targeted legal immigrants who need support. Ramsey County is increasingly a home to immigrants who have revitalized what had been disappearing business districts and distressed neighborhoods. Our communities suffer when residents cannot access the support services they need to work, raise children, and fully participate in our community.

Cordially,

Susan M. Haigh, Chair
Human Services/Workforce Solutions Committee of
The Ramsey County Board of Commissioners

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