

January 2006

**FEDERAL
EMPLOYEES
HEALTH BENEFITS
PROGRAM**

**First-Year Experience
with High-Deductible
Health Plans and
Health Savings
Accounts**





Highlights of [GAO-06-271](#), a report to congressional requesters

Why GAO Did This Study

The Federal Employees Health Benefits Program (FEHBP) recently began offering high-deductible health plans (HDHP) coupled with tax-advantaged health savings accounts (HSA) that enrollees use to pay for health care. Unused HSA balances may accumulate for future use, providing enrollees an incentive to purchase health care prudently. The plans also provide decision support tools to help enrollees make purchase decisions, including health care quality and cost information. Concerns have been expressed that HDHPs coupled with HSAs may attract younger, healthier, or wealthier enrollees, leaving older, less healthy enrollees to drive up costs in traditional plans. Because the plans are new, there is also interest in the plan features and the decision support tools they provide to enrollees.

GAO was asked to evaluate the experience of the 14 HDHPs coupled with an HSA that were first offered under the FEHBP in January 2005. GAO compared the characteristics of enrollees in the 14 HDHPs to those of enrollees in another recently introduced (new) plan without a high deductible and to all FEHBP plans. GAO also compared characteristics of the three largest HDHPs to traditional FEHBP plans offered by the same insurance carriers, and summarized the information contained in the decision support tools made available to enrollees by these three plans.

www.gao.gov/cgi-bin/getrpt?GAO-06-271.

To view the full product, including the scope and methodology, click on the link above. For more information, contact John Dicken at (202) 512-7119 or dickenj@gao.gov.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

First-Year Experience with High-Deductible Health Plans and Health Savings Accounts

What GAO Found

FEHBP HDHP enrollees were younger and earned higher federal salaries than other FEHBP enrollees. The average age of HDHP enrollees (46) was similar to that of the other new plan (47) and younger than that of all FEHBP enrollees (59). These differences were largely due to a smaller share of retirees enrolling in the HDHPs and the other new plan. HDHP enrollees earned higher federal salaries compared to other enrollees. Forty-three percent of HDHP enrollees actively employed by the federal government earned federal salaries of \$75,000 or more, compared to 14 percent in the other new plan and 23 percent among all FEHBP plans. In addition, nonretired HDHP enrollees were more likely to be male and to select individual rather than family plans.

The three largest FEHBP HDHPs generally covered the same range of services—including preventive services—as their traditional plan counterparts; however, enrollees' financial responsibilities usually differed. Compared to the traditional plans, the HDHPs had higher deductibles. HDHP cost sharing was the same or lower for preventive services and prescription drugs, and all plans covered preventive services before the deductible. Prescription drugs in the HDHPs were subject to the deductible, while they were generally exempt from the deductible in the traditional plans. HDHP cost sharing varied with respect to nonpreventive physician office visits and inpatient hospital stays. Two of the three HDHPs had higher out-of-pocket spending limits, and HDHP premiums were lower on average than the traditional plans.

The extent to which the three largest FEHBP HDHPs made available provider quality and health care cost information was limited and varied. Two of the three plans provided several hospital-specific measures of quality on their Web sites, including the volumes of procedures provided by the hospitals and the outcomes of those procedures, and the other plan provided links to other Web sites containing such information. Regarding physician-specific quality data, one plan provided a single measure. One of the plans provided average hospital cost estimates and two provided average physician cost estimates for selected services, but none provided the actual rates an enrollee would pay that the plan had negotiated with providers. Regarding prescription drugs, two of the three plans provided the average retail pharmacy drug costs, but none provided the actual negotiated rates an individual would pay at a particular retail pharmacy.

In commenting on a draft of this report, the Office of Personnel Management (OPM) said that it would monitor enrollment trends over time to assess whether certain individuals—such as younger or healthier individuals—disproportionately enroll in HDHPs. OPM also said it would continue to encourage plans to expand the decision support information they provide to enrollees, including the pricing of health care services.

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Abbreviations

CDHP	consumer-directed health plan
FEHBP	Federal Employees Health Benefits Program
HDHP	high-deductible health plan
HMO	health maintenance organization
HRA	health reimbursement arrangement
HSA	health savings account
OPM	Office of Personnel Management
PPO	preferred provider organization

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United States Government Accountability Office
Washington, DC 20548

January 31, 2006

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The federal government provides health insurance coverage for over 8 million federal employees, retirees, and their family members through health plans participating in the Federal Employees Health Benefits Program (FEHBP), the largest employer-based health insurance program in the country. Similar to many large employers, the FEHBP has recently begun offering a type of “consumer-directed health plan” (CDHP) that combines a high-deductible health plan (HDHP) with a tax-advantaged health savings account (HSA) that enrollees use to pay for a portion of their health expenses.¹ (Throughout this report we refer to the FEHBP plans that are coupled with HSAs as HDHPs.) The higher deductibles typically result in lower premiums because the enrollee bears a greater share of the initial costs of care. The HDHPs provide decision support tools to help enrollees become more actively involved in making health care purchase decisions, such as information about the quality of health care providers and the cost of health care services.

¹Many health plans require enrollees to pay a portion of their health care costs up to a certain threshold, known as the deductible. Once the deductible has been met, the plan pays most of the costs. A CDHP is a health plan with a higher-than-average deductible that is coupled with a spending account to pay for health care, such as an HSA. HSA-related tax advantages were authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 for individuals covered by health plans that meet minimum deductibles and maximum out-of-pocket spending limits, including spending on deductibles and cost sharing for covered services. Pub. L. No. 108-173, §1201, 117 Stat. 2066, 2469. The minimum deductible in 2005 was \$1,000 for individual coverage and \$2,000 for family coverage. The maximum out-of-pocket spending in 2005 was \$5,100 for individual coverage and \$10,200 for family coverage.

Proponents believe that HDHPs coupled with HSAs can help restrain health care spending. They believe enrollees have an incentive to seek lower-cost health care services, and to only obtain care when necessary because account funds can accrue from year to year. Enrollees may use these funds to pay for health care in subsequent years or for other purposes, such as retirement. However, some believe that these plans will attract a disproportionate share of wealthier enrollees who seek to use the HSA as a tax-advantaged savings vehicle. Some also express concern that HDHPs may disproportionately attract younger and healthier enrollees. If this occurred to a large extent, premiums for traditional plans could rise due to a disproportionate share of older and less healthy enrollees with higher health care expenses remaining in the traditional plans. Because HDHPs coupled with HSAs are a relatively new concept in health care benefits plan design, there is also interest in how the plans' features compare to traditional plans and the extent to which the plans provide decision support tools, such as provider quality and cost data, to help enrollees make informed and prudent health care purchase decisions.

You asked us to evaluate the experience of the HDHPs coupled with HSAs that were offered under the FEHBP beginning in January 2005.² Because there is limited experience to date with these plans, we limited our review to the demographic characteristics of the enrollees and key features of the HDHPs.³ In particular, we examined (1) characteristics of HDHP enrollees compared to all FEHBP plan enrollees, (2) features of the HDHPs compared to traditional FEHBP health plans, and (3) the extent to which FEHBP HDHPs provide information to enrollees to assist them in making health care purchase decisions.

To identify the demographic characteristics of HDHP enrollees, we analyzed FEHBP enrollment data provided by the Office of Personnel Management (OPM), the federal agency responsible for administering the

²We recently reported on the early experience with another type of CDHP first offered under the FEHBP in 2003. See GAO, *Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan*, [GAO-06-143](#) (Washington, D.C.: Nov. 21, 2005).

³Data to examine the first year of health care utilization and spending under the plans for 2005 will not be available before August of 2006. Health policy analysts believe that 2 or more years of such data are necessary to assess the cost savings potential of these plans.

FEHBP.⁴ We obtained data for each of the 14 HDHPs coupled with HSAs that was introduced in 2005. To determine how the enrollees in these plans compared to other FEHBP enrollees, we compared their demographic characteristics to two groups. First, we compared them to the characteristics of all FEHBP plan enrollees.⁵ Second, because characteristics of the HDHP enrollees may differ from the typical FEHBP enrollee primarily because these plans are new, we also compared HDHP enrollee characteristics to the characteristics of first-year enrollees of another FEHBP national preferred provider organization (PPO) plan that was recently introduced.⁶ For each group we examined enrollee age, income, gender, and whether the plan was for an individual or a family. Because our preliminary analysis found that retirees were much less likely to enroll in the FEHBP HDHPs and the other new plan, we excluded retirees from most comparisons to help ensure that differences were related to the plan design and not to the absence of retirees among the new plans. Our assessment of the demographic characteristics of HDHP enrollees reflects only the first year of plan enrollment and thus may not reflect future enrollment trends. We did not independently verify the data provided by OPM; however, we performed certain quality checks, such as determining consistency among the various data sets provided. We also evaluated information from OPM concerning how data are collected, stored, and maintained. We determined that the data were adequate for this report.

To evaluate the features of the HDHPs, we reviewed plan brochures for the three HDHPs that operated in most or all states and comprised about 96 percent of all FEHBP HDHP enrollment in 2005. Throughout this report

⁴In administering the FEHBP, OPM contracts with and regulates health insurance carriers and negotiates benefits and premium rates. OPM also receives and deposits health insurance premium withholdings and contributions from federal employees, and pays premiums to carriers.

⁵Because comprehensive demographic data for all FEHBP enrollees in 2005 were not yet available, we reviewed enrollment data from 2004.

⁶FEHBP offers national plans to all enrollees who may work anywhere in the country and local plans that are offered in certain local markets. National plans are typically PPO plans that allow enrollees to choose their own health care providers, and reimburse either the provider or the enrollee for the cost of covered services. Enrollees' costs are generally lower if they obtain care from the plan's network of preferred providers rather than from providers not in the plan's network, referred to as "out-of-network" providers. Local plans are typically health maintenance organization plans that provide or arrange for comprehensive health care services on a prepaid basis, and require that care be coordinated through a primary care physician.

we refer to these plans as multistate HDHPs. We compared key features of these plans to the features of other plans offered by the same insurance carrier, which we refer to as the HDHPs' traditional plan counterparts. We compared two of the HDHPs to two national PPO plans offered by the same carriers, and we compared the third HDHP to 22 regional health maintenance organization (HMO) plans offered by the same carrier. The features we examined included covered services, coverage of out-of-network providers, deductibles, cost-sharing arrangements, out-of-pocket spending limits, and premiums.⁷

To evaluate the decision support tools that plans make available to enrollees, we reviewed the literature and interviewed experts to identify the information that experts believe is most helpful to consumers in assessing the quality of health care providers and the costs of health care services. We then reviewed the decision support tools that the three multistate HDHPs made available to enrollees on the plan Web sites to determine whether the information was present, but did not independently verify the accuracy of the information.

We conducted our work according to generally accepted government auditing standards from July 2005 through January 2006.

Results in Brief

FEHBP HDHP enrollees were generally younger, earned higher federal salaries, and were more likely to select individual rather than family plans than other FEHBP enrollees. The average age of HDHP enrollees was 46, compared to 47 for the other new plan enrollees and 59 for all FEHBP enrollees. The age difference was largely due to a smaller share of retirees enrolling in the HDHPs compared to the other plans. Excluding retirees, the range in average ages narrowed to 44 for both the HDHPs and the other new plan and 47 for all FEHBP plans. HDHP enrollees also earned higher federal salaries compared to other FEHBP enrollees. Forty-three percent of actively employed HDHP enrollees earned federal salaries of \$75,000 or more compared to 14 percent of the other new plan enrollees and 23 percent of all FEHBP plan enrollees. Finally, HDHP enrollees were

⁷Cost-sharing arrangements refer to the enrollee's share of payments for covered services, such as co-payments—a fixed charge—and coinsurance—a percentage of the charges. We define out-of-pocket spending limits as the maximum amount enrollees may pay out of pocket under the plan, including the deductibles and cost sharing. Our analyses of deductibles, cost sharing, and out-of-pocket spending limits were limited to in-network care.

more likely to be male and were more likely to select individual rather than family plans. Sixty-nine percent of HDHP enrollees were male, compared to 59 percent of enrollees in both the other new plan and all FEHBP plans. Forty-seven percent of HDHP enrollees had individual coverage, compared to 35 and 37 percent of enrollees in the other new plan and all FEHBP plans, respectively.

Each of the three multistate HDHPs generally covered the same range of health care services—including preventive care services—as its traditional plan counterparts; however, enrollees’ financial responsibilities usually differed. Each of the HDHPs had higher annual deductibles for in-network care, ranging from \$1,100 to \$2,500 for individual plans and from \$2,200 to \$5,000 for family plans. This compared to deductibles among the traditional PPO counterparts of from \$450 to \$950 and from \$900 to \$1,900 for individual and family plans, respectively. Regarding cost sharing for preventive care services, HDHP enrollees paid the same or less than the traditional plan enrollees and always covered certain preventive care services before the deductible was met, whereas these same services were not always covered before the deductible by their traditional plan counterparts. For prescription drugs, all three HDHPs required that the deductible be met before prescription drug coverage began, whereas two of the traditional plans covered all prescription drugs before the deductible and the third covered generic drugs before the deductible. After the deductible, all three HDHPs had comparable or lower cost sharing for prescription drugs than their traditional plans. Cost sharing for physician office visits and hospital stays for the three HDHPs was mixed relative to the traditional plan counterparts—HDHP enrollees paid more in some instances, the same or less in others. Two of the HDHPs had higher out-of-pocket spending limits for in-network providers compared to their traditional plans: for individual coverage \$4,000 and \$5,000 compared to \$1,500 and \$4,450; for family coverage \$8,000 and \$10,000 compared to \$3,000 and \$5,400. Finally, the HDHPs typically had lower monthly premiums—the average employee premium was \$91 for individual coverage and \$208 for family coverage, compared to \$99 and \$243, respectively, for the traditional plans.

Each of the three multistate HDHPs provided online access to account management tools and health education information, but the extent to which they made available provider quality and health care cost information was limited and varied. Regarding quality data, two of the three plans provided several measures on their Web sites to assess hospital quality, including the volume of procedures provided by the hospitals and the outcomes of those procedures, and the other plan

provided links to other Web sites containing such information. None of the three plans provided similar measures to assess individual physician quality, although one plan provided information on physicians' medical board certifications. Experts we interviewed believed that physician-specific quality data were not yet widely available for most health insurance carriers to provide to their enrollees.⁸ Regarding cost data, one of the three HDHPs provided average hospital cost estimates and two provided average physician cost estimates for selected services, but none provided the actual negotiated payment rates enrollees would be charged by a specific provider.⁹ All three plans provided actual prescription drug prices available through their mail-order pharmacies, and two of the plans provided average retail pharmacy drug costs, but none provided the actual negotiated rates an individual would pay at a particular pharmacy.

In commenting on a draft of this report, OPM said that it would monitor enrollment trends over time to assess whether certain individuals—such as younger or healthier individuals—disproportionately enroll in HDHPs. OPM also said it would continue to encourage plans to expand the decision support information they provide to enrollees, including the pricing of health care services.

Background

CDHPs are relatively new health care benefits plan designs that are offered in various forms, including that of an HDHP coupled with an HSA. The FEHBP began to offer CDHPs in 2003 and first offered HDHPs coupled with HSAs in January 2005.

The Consumer-Directed Health Plan Concept

While insurers and employers offer several variants of CDHPs, these plans generally include three basic precepts—an insurance plan with a high deductible, a savings account to pay for services under the deductible, and enrollee decision support tools.

- **An insurance plan with a high deductible.** CDHP deductibles are about \$1,900 on average nationwide for individual coverage and about \$3,900 for

⁸Two plans were in the process of developing physician-specific patient satisfaction ratings.

⁹One plan has begun a pilot project to publish physician-specific negotiated rates for certain services in one market.

family coverage, compared to about \$320 and \$680, respectively, on average, for a traditional PPO plan.¹⁰

- **A savings account to pay for services under the deductible.** These savings accounts encompass different models, the most prominent being health reimbursement arrangements (HRA) and HSAs. Both HRAs and HSAs are tax advantaged, and funds from these accounts may be spent on qualified medical expenses—such as the plan deductible and payments for covered and noncovered services.¹¹ Funds that are used for qualified medical expenses that are not covered by the health plan do not count toward meeting the plan’s deductible or out-of-pocket spending limits.

Important distinctions exist between HRAs and HSAs. HRAs are funded solely by the employer and are generally not portable once the employee leaves. These funds may accumulate up to any employer-specified maximums and may only be spent on qualified medical expenses. Although HRAs are generally coupled with health plans that include a high deductible, this is not a requirement for favorable tax treatment.

An HSA is a new type of tax-advantaged savings account that, unlike HRAs, must be coupled with an HDHP that meets statutorily defined minimum deductibles and limits on out-of-pocket expenditures for enrollees. Contributions to an HSA may be made by both the employer and employee. The HSA account holder essentially owns the account and can transfer funds from one HSA account to another. Funds in these accounts may earn interest, are allowed to roll over from year to year, and may accumulate subject only to annual limits on contributions. HSA funds may also be withdrawn for purposes other than qualified medical expenses subject to regular taxes and an additional tax penalty, and may be used as retirement income subject to regular taxes.¹² Certain individuals are not

¹⁰The Henry J. Kaiser Family foundation and Health Research and Education Trust, *Employer Health Benefits: 2005 Summary Findings* (Menlo Park, Calif.: 2005). This publication reports the results of a national survey of both public and private employers.

¹¹Both HRAs and HSAs were offered as tax-advantaged ways for employees to pay for unreimbursed medical expenses. The Department of the Treasury affirmed in 2002 the exclusion from taxable gross income of employer contributions to employee HRAs (I.R.S. Rev. Rul. 02-41; I.R.S. Notice 02-45 (June 26, 2002)). Itemized tax deductions for individual contributions to HSAs were authorized beginning in tax year 2004 by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §1201, 117 Stat. 2066, 2469.

¹²Use of these funds as retirement income is restricted to account holders who are eligible for Medicare.

eligible for HSAs, including those eligible for Medicare or covered by another health plan in addition to the HDHP.

- **Decision support tools.** CDHPs may provide decision support tools for consumers to help them become actively engaged in making health care purchase decisions. These tools may provide enrollees online access to their savings accounts to help them manage their spending. They may also provide enrollees with information to assess the quality of health care providers and the prices for health care services.

While health insurance carriers may provide decision support tools to all enrollees, these tools may be more important to CDHP enrollees who have a greater financial incentive to take a more active role in their health care purchase decisions. To help enrollees choose a doctor or a hospital, experts suggest they need data to assess the quality of those providers. Such data may include the volume of procedures provided; the outcomes of those procedures, such as mortality and complication rates; as well as certain process indicators, such as the percentage of cases in which a provider followed established clinical practice guidelines for a particular procedure. To help enrollees manage their HSA account funds and evaluate the price competitiveness of various providers, some experts believe enrollees need information about the expected costs of services—such as an average or expected range of costs for a procedure, or the actual price a provider will charge based on the payment rates negotiated between the provider and the health insurance carrier.

Insurance carriers have faced challenges in obtaining or presenting quality and cost data. For example, experts believe that it may be difficult for carriers to provide hospital- or physician-specific quality measures because such measures are not always readily available, particularly for physicians. They also believe that certain measures can be difficult for consumers to interpret, such as outcomes measures, and may not appropriately account for the poorer patient outcomes that may occur among providers who tend to treat sicker patients.¹³ Experts also believe that insurers have been reluctant to make negotiated provider payment rates available to consumers due to concerns over future provider contract negotiations. Therefore, the cost information insurers are willing

¹³Outcomes measures are routinely adjusted for the risks associated with each case. However, both providers and researchers have expressed concern over the adequacy of risk-adjustment processes currently in use.

to provide is more likely to reflect average rates or a range of costs within a geographic region rather than the actual negotiated rates.

FEHBP and Consumer-Directed Health Plans

Federal employees have a choice of multiple health plans offered by private health insurance carriers participating in the FEHBP, with 19 national plans and more than 200 local plans offered in 2005.¹⁴ Plans vary in terms of benefit design and premiums.¹⁵ In 2004, nearly 75 percent of those covered under the FEHBP were enrolled in national plans, with the remainder in regional or local HMOs. Mirroring the private sector, FEHBP carriers began offering CDHP options in 2003.

The FEHBP offers two types of CDHPs—high-deductible plans coupled with an HRA or an HSA. The American Postal Workers Union offered the first HRA-based option under the FEHBP in 2003.¹⁶ This was followed by HRA-based plans offered by Aetna and Humana in 2004. In 2005, 14 HDHPs coupled with HSAs were first offered.¹⁷ As of March 2005, 3,900 individuals were enrolled in these 14 HDHPs. Including retirees and family members, about 7,500 individuals were covered by the plans, with nearly all—about 96 percent—in the three multistate plans.

All HDHPs offered by the FEHBP must include certain features. OPM requires that the plans cover preventive health services before the deductible has been met.¹⁸ In addition, because OPM is prohibited from contracting with plans that deny enrollment based on age, all must be offered with an HRA alternative of equivalent value for those who are ineligible for an HSA, such as Medicare enrollees. All HSAs and HRAs must be managed either by the insurance carrier or a trustee—such as a bank—which has received high ratings from a major financial rating service. OPM requires all HDHP carriers to offer health care decision

¹⁴Six of the 19 national plans were available only to certain groups of federal employees, such as Federal Bureau of Investigation employees.

¹⁵All premiums include both employer and employee shares. Across the FEHBP, the employee's share of the monthly premium averages about 28 percent of the total monthly premium paid to carriers.

¹⁶See [GAO-06-143](#).

¹⁷OPM has announced that all 14 of these HDHPs will continue to be offered in 2006 along with 7 additional HDHPs.

¹⁸OPM does not specify the preventive health services to be covered.

support tools to enrollees.¹⁹ Finally, all HDHPs offered in the FEHBP must deposit a monthly contribution to the enrollee's HSA, which is a portion of the enrollee's premium payment, called the premium pass through. The premium pass through can be thought of as a required contribution to an employee's HSA, with the remainder of the premium going to the insurance carrier to pay for the insurance coverage.

FEHBP HDHP Enrollees Were Generally Younger and Earned Higher Federal Salaries Than Other FEHBP Enrollees

HDHP enrollees were younger, earned higher federal incomes, were more likely to be male, and were more likely to have individual coverage than other FEHBP enrollees. The average age of HDHP enrollees was similar to that of another new plan, but was 13 years younger than that of all FEHBP enrollees. The share of actively employed enrollees earning federal incomes of \$75,000 or more was 43 percent for HDHPs, compared to 14 percent for the other new plan, and 23 percent for all FEHBP plans. About 69 percent of HDHP enrollees were male, compared to 59 percent in both the other new plan and all FEHBP plans, and about 47 percent of HDHP enrollees had individual coverage, compared to 35 and 37 percent for the other new plan and all FEHBP enrollees, respectively.

HDHP Enrollees Were Younger and Included Fewer Retirees Than Enrollees in All FEHBP Plans

The average age of HDHP enrollees was younger than all FEHBP plan enrollees, but was similar to that of enrollees in another new FEHBP plan. The average age of HDHP enrollees was 46, compared to 47 for the other new plan, and 59 for all FEHBP plans. Differences were largely due to fewer retirees selecting the HDHPs. Eleven and 18 percent of the HDHP and other new plan enrollees were retirees, respectively, compared to 45 percent for all FEHBP plan enrollees. Excluding the retirees, the average age narrowed to 44 for both the HDHP and other new plan enrollees, and 47 for all FEHBP plan enrollees. (See table 1.)

¹⁹OPM did not specify the type of information that should be provided in the decision support tools.

Table 1: Average Age of HDHP and Other FEHBP Enrollees

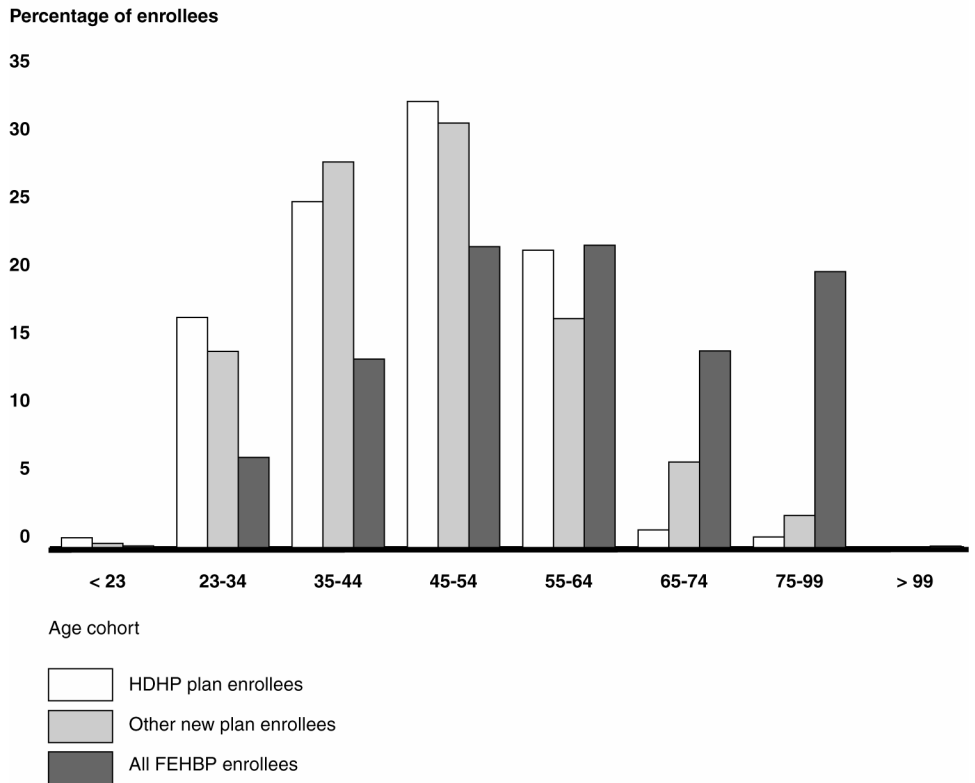
	HDHP plans	Other new plan	All FEHBP plans
All enrollees	46	47	59
Excluding retirees	44	44	47

Source: GAO analysis of OPM data.

Notes: The average ages are based on 2005 enrollees in the HDHPs, and are estimated for the first-year (2002) enrollees of the other new plan and 2004 enrollees of all FEHBP plans. Dependents are not included.

The distribution of enrollees by age group similarly illustrates the relatively younger ages of HDHP enrollees and enrollees of the other new plan. Relative to all FEHBP enrollees, the HDHP and other new plan enrollees comprise a larger share of enrollees in each age group under 55 years and a smaller share of enrollees in each age group over 64. (See fig. 1.)

Figure 1: Age Distribution of HDHP and Other FEHBP Enrollees



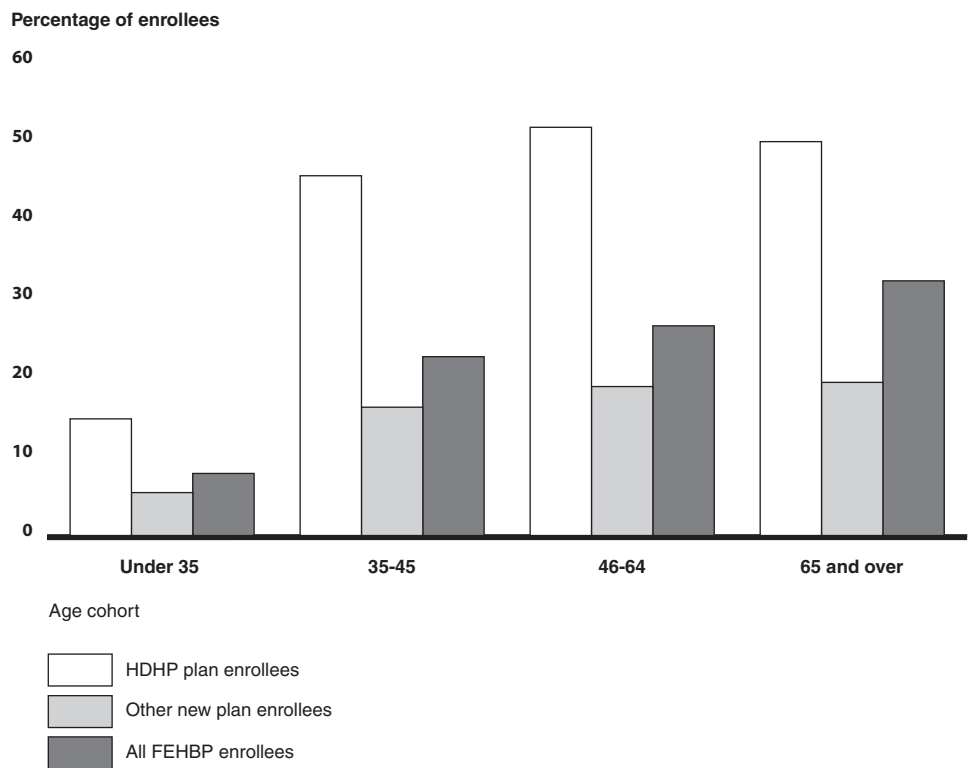
Source: GAO analysis of OPM data.

Notes: The age distributions are based on 2005 enrollees in the HDHPs, the first-year (2002) enrollees of the other new plan, and 2004 enrollees of all FEHBP plans. Retirees are included, dependents are not.

HDHP Enrollees Had Higher Federal Salaries and Were More Likely to Select Individual Plans Than Other FEHBP Enrollees

HDHP enrollees who were actively employed by the federal government earned higher federal salaries than other active federal employees in the FEHBP. The share of enrollees earning federal incomes of \$75,000 or more in 2005 was 43 percent for HDHPs, compared to 14 percent for the other new plan and 23 percent for all FEHBP plans. These differences existed across all age groups. (See fig. 2.)

Figure 2: Actively Employed FEHBP Enrollees Earning Annual Federal Salaries of \$75,000 or More, 2005



Source: GAO analysis of OPM data.

Note: Dependents and retirees are excluded.

Excluding retirees, HDHP enrollees were more likely to be male and to select individual rather than family plans than were enrollees in other plans. Sixty-nine percent of HDHP enrollees were male, compared to 59 percent of enrollees in both the other new plan and all FEHBP plans. Forty-seven percent of HDHP enrollees selected individual plans, compared to 35 and 37 percent of enrollees in the other new plan and all FEHBP plans, respectively. (See table 2.)

Table 2: Gender and Plan Selection for HDHP and Other FEHBP Enrollees

	HDHP plans	Other new plan	All FEHBP plans
Percentage male	69	59	59
Percentage enrolled in individual plans	47	35	37

Source: GAO analysis of OPM data.

Notes: The table is based on 2005 enrollees in the HDHPs, the first-year (2002) enrollees in the other new plan, and 2004 enrollees in all FEHBP plans. Dependents and retirees are not included.

FEHBP HDHPs Generally Covered the Same Services as Traditional Plans, but Enrollees' Financial Responsibilities Usually Differed

HDHPs generally covered the same services as those covered by their traditional plan counterparts; however, enrollees' financial responsibilities usually differed. The FEHBP HDHPs had higher deductibles than their traditional plan counterparts. In addition, relative to traditional plans, HDHP cost sharing after the deductible was comparable or lower for preventive services and prescription drugs. Cost sharing was mixed for physician office visits and hospital stays—higher than the carriers' traditional plans in some instances and the same or lower in others. Two of the HDHPs had higher out-of-pocket spending limits than their traditional plan counterparts, and in most cases the HDHPs had lower premiums.

FEHBP HDHPs Generally Covered the Same Services as Traditional Plans

All three multistate HDHPs generally covered the same services as those covered by their traditional plan counterparts. These plans covered the same broad categories of services, such as preventive, diagnostic, maternity, surgical, outpatient, and emergency care, and all plans typically covered the same services within these categories. While each HDHP defined preventive services slightly differently, each plan covered certain core services:

- routine physical exam,
- routine immunizations,
- cholesterol screening,
- colorectal cancer screening,
- routine pap test,
- annual prostate-specific antigen test,
- routine mammogram, and
- well-child care.

These same services were also covered by the traditional plans. The few instances where covered services differed typically involved vision, dental, or chiropractic care benefits. For example, one HDHP did not include

glasses or contact lenses in its vision care coverage, while its counterpart plan did.

While the same services were typically covered by the three multistate HDHPs and their traditional plan counterparts, the plans sometimes imposed different restrictions and stipulations on the coverage of these services. For example, one HDHP allowed more frequent vision exams, but covered fewer days in skilled nursing facilities relative to the traditional plan. Another HDHP had no time restrictions for receiving emergency services following an accidental injury, while the traditional plan did. In addition, the HDHP for which the traditional plan counterparts were HMOs offered coverage for out-of-network providers for nonemergency care, while the HMOs did not. The other two HDHPs had similar restrictions as the traditional plans on obtaining coverage from out-of-network providers.

Enrollees' Financial Responsibilities Usually Differed between FEHBP HDHPs and Traditional Plans

The three multistate HDHPs often differed from their traditional plan counterparts in terms of enrollees' financial responsibilities. All three HDHPs had higher deductibles, ranging from \$1,100 to \$2,500 for individual coverage and from \$2,200 to \$5,000 for family coverage, compared to \$450 to \$950 and \$900 to \$1,900 in their traditional PPO counterparts, respectively.²⁰ Cost sharing also differed between HDHPs and the traditional plan counterparts. All HDHPs offered preventive care cost sharing for in-network providers that was the same or lower than the traditional plans. In addition, while all HDHPs covered preventive services before the deductible, those services were not always covered before the deductible by the traditional PPO plans. All HDHPs required that the deductible be met before prescription drug coverage began, whereas two of the traditional plans covered all prescription drugs before the deductible was met, and the third covered only generic drugs before the deductible was met.²¹ After the deductible was met, all HDHPs had comparable or lower cost sharing than the traditional plans for prescription drugs. Cost sharing for physician office visits for nonpreventive care and for hospital stays was mixed across plans—higher for the traditional plan counterparts in some instances, but the same or lower in others. Finally, two of the HDHPs had higher out-of-pocket

²⁰For the HDHP for which the traditional plan counterparts were HMOs, there was no deductible for comparison purposes.

²¹One traditional plan had a separate deductible for prescription drugs.

spending limits for in-network providers of \$4,000 and \$5,000 for individual coverage and \$8,000 and \$10,000 for family coverage, compared to \$1,500 and \$4,450 and \$3,000 and \$5,400 for their traditional counterparts, respectively.

HDHPs more often had lower monthly premiums than their traditional plan counterparts. One HDHP had lower premiums than both of its traditional plan counterparts, another plan had lower premiums than one of its two counterparts, and the third HDHP had lower premiums than a majority of its 22 traditional plan counterparts. On average, enrollees' monthly premiums for the three HDHPs were \$91 for individual coverage and \$208 for family coverage, compared to \$99 and \$243 for their traditional plan counterparts, respectively. (See table 3.)

Table 3: Key Plan Features of the Multistate HDHPs in the FEHBP Compared to Their Traditional Plan Counterparts, 2005

Compared to its traditional plans, the HDHP's	HDHP 1	HDHP 2	HDHP 3
Preventive care cost sharing (in-network) was the same or lower	●	●	●
Generic drugs cost sharing was comparable or lower after meeting the deductible ^a	●	●	●
Brand-name drugs cost sharing was comparable or lower after meeting the deductible ^b	●	●	●
Primary care physician office visit cost sharing (in-network) was the same or lower ^c	●	◐	●
Specialist office visit cost sharing (in-network) was the same or lower ^d	●	◐	●
Hospital stay cost sharing (in-network) was the same or lower ^e	○	◐	●
Out-of-pocket spending limits for in-network providers were the same or lower ^f	○	○	●
Enrollee premiums were lower	◐	◐	●

Source: GAO analysis of FEHBP plan brochures.

Key: ● = Yes

○ = No

◐ = Mixed

^aBased on GAO analysis of the average retail, in-network pharmacy prices published by two of the HDHP drug pricing tools for 20 generic drugs commonly prescribed to non-Medicare FEHBP enrollees in 2004.

^bBased on GAO analysis of the average retail, in-network pharmacy prices published by two of the HDHP drug pricing tools for 20 brand-name drugs commonly prescribed to non-Medicare FEHBP enrollees in 2004.

^cBased on GAO analysis of the average charges of 10 nonspecialist office visit services published by one of the HDHP pricing tools.

^dBased on GAO analysis of the average charges of five specialist office visit services published by one of the HDHP pricing tools.

^eBased on the median costs and length of stay for hospital patients covered by commercial insurers in 2003, published by the Healthcare Cost & Utilization Project.

^fOut-of-pocket spending limit for in-network providers includes plan deductible and cost sharing for covered services.

Another difference between the HDHPs and their traditional plan counterparts was the monthly contribution HDHPs made to the enrollee's HSA—the premium pass through—which was not a feature of the traditional plans. The average monthly pass through of the three multistate HDHPs was \$82 for individual coverage and \$165 for family coverage, representing 93 percent and 81 percent of the employee's share of the monthly premium on average, respectively. The annual sum of the monthly contributions represented an average of 53 percent of the annual deductible across the three plans.

FEHBP HDHPs Provided Online Access to Decision Support Tools, but Did Not Always Include Health Care Quality and Cost Information

Each HDHP provided online account management tools and access to health education information on the plan's Web site. However, the extent to which they also included provider quality and health care cost data was more limited and varied across the plans. Moreover, the quality and cost information provided on the HDHP Web sites was available to both HDHP enrollees as well as to traditional plan enrollees.

FEHBP HDHPs Provided Access to Online Account Management Tools and Health Education Information

Each of the three multistate FEHBP HDHP Web sites provided online access to account management tools and health education information. The plans allowed enrollees to view their progress toward meeting their deductibles and track their HSA balances online. They also provided online access to certain health education information, including information on general preventive care, common medical procedures and conditions, various treatment options for certain conditions, information concerning prescription drug alternatives, and a disease management

program.²² Two plans also provided a health risk assessment tool, and one offered access to a health advice line.²³

The Extent to Which FEHBP HDHPs Provided Online Access to Provider-Specific Quality and Cost Information Varied

The HDHPs provided varying degrees of provider quality data. Two of the three plans provided data on their Web sites for several measures to assess hospital quality, including outcomes data, procedure volumes, and patient safety ratings, and the other plan provided links to Web sites that contained this type of information. None of the plans provided similar process or outcome measures to assess individual physician quality, although one plan provided information on physicians' medical board certifications. Each of the plans provided certain general information about the physicians in the plan networks, such as their hospital affiliations, languages spoken, and gender.²⁴

Cost information provided by the three multistate plans was limited. One of the plans provided average hospital cost estimates and two provided average physician cost estimates for a limited number of services. For example, one plan provided average cost estimates within certain geographic regions based on its own claims data for certain physician services, such as diagnostic tests and surgical procedures. It also provided estimated total annual costs to treat certain conditions, such as diabetes and heart disease. None of the plans provided the actual payment rates that would be charged to enrollees that the plan had negotiated with specific hospitals or physicians.²⁵ Two of the three plans provided access to average retail prescription drug prices and estimates of out-of-pocket

²²A disease management program is a voluntary program offered by health plans for those with certain high-risk conditions, such as diabetes, asthma, congestive heart failure, and coronary artery disease. Patients generally have access to a case manager who coordinates physician care and educational materials to help them learn how to effectively manage their disease and improve their quality of life.

²³A health risk assessment generally includes a questionnaire about health-related behaviors and risk factors that generates a report that provides guidelines on ways to reduce the risk of disease. A health advice line is an on-call clinician who can answer health-related questions and provide medical advice.

²⁴Experts we interviewed believed that physician-specific quality information, such as process and outcomes data or patient satisfaction ratings, were generally not available to health plans. Physician-specific patient satisfaction ratings were being developed for the online tools provided by two of the three plans.

²⁵One plan had begun a pilot project to publish physician-specific negotiated rates for certain services in one market.

costs for drugs, and all three plans provided actual prices for drugs purchased through the mail-order pharmacy services offered by the plans. None of the plans provided the actual payment rate the plan had negotiated with particular retail pharmacies. (See table 4.)

Table 4: Information Available through Online Decision Support Tools of the Three Multistate HDHPs, 2005

	HDHP 1	HDHP 2	HDHP 3
Member account access			
Progress toward deductible	●	●	●
HSA account balance	●	●	●
Health education information			
General preventive care	●	●	●
Common medical procedures and conditions	●	●	●
Treatment options for certain conditions	●	●	●
Disease management program ^a	●	●	●
Health risk assessment tool ^b	●	○	●
Health advice line ^c	●	○	○
Hospital-specific quality data			
Process indicators ^d	●	○	●
Outcomes data ^e	●	○	●
Procedure volumes	●	○	●
Patient safety ratings ^f	●	○	●
Patient satisfaction ratings	○	○	○
Links to other Web sites that contain hospital quality data	○	●	○
Physician-specific quality data			
Board certifications	●	○	○
Process indicators ^d	○	○	○
Outcomes data ^e	○	○	○
Patient volumes	○	○	○
Patient satisfaction ratings	○	○	○
Links to other Web sites that contain physician quality data	○	○ ^g	○
General physician-specific information			
Medical education information (e.g., school, year of graduation)	●	○	○
Hospital affiliations	●	●	●
Personal characteristics (e.g., language, gender)	●	○	●

	HDHP 1	HDHP 2	HDHP 3
Provider cost information on plan Web site			
Actual negotiated, hospital-specific payment rates	○	○	○
Average hospital payment rates ^h	●	○	○
Actual negotiated, physician-specific payment rates ⁱ	○	○	○
Average physician payment rates ^h	●	○	●
Actual pharmacy-specific prescription drug prices	○	○	○
Average retail prescription drug prices	●	●	○
Actual mail-order pharmacy prices	●	●	●
Estimated out-of-pocket prescription drug costs ⁱ	●	●	^k

Source: GAO analysis of HDHP decision support tools.

Key: ● = information provided

○ = information not provided

^aA disease management program is a voluntary program offered by health plans for those with certain high-risk conditions, such as diabetes, asthma, and congestive heart failure. Patients generally have access to a case manager who coordinates physician care and educational materials to help them learn how to effectively manage their disease and improve their quality of life.

^bA health risk assessment generally includes a questionnaire about health-related behaviors and risk factors that generates a report that provides guidelines on ways to reduce the risk of disease.

^cThe plan offers on-call clinicians to answer health-related questions and provide medical advice.

^dProcess data indicate whether providers follow certain guidelines for care, such as the share of patients for whom recommended treatment guidelines were followed.

^eOutcomes data are collected by hospitals and physicians to track patient outcomes following a treatment or procedure, such as mortality rates, complication rates, and average length of hospital stay.

^fPatient safety ratings include data on compliance with safety practices such as meeting certain staff-to-patient ratios.

^gThe plan Web site did not specify a link to physician-specific quality data, although it did provide a link to the American Medical Association Web site, through which a physician's board certifications may be identified.

^hAverage payment rates were available for a limited list of services.

ⁱOne carrier had initiated a pilot project to provide physician-specific actual negotiated rates for physicians in one regional market for a limited list of procedures.

^jEstimates included enrollees' costs after the deductible was met.

^kNo out-of-pocket estimates were provided for retail drugs. Mail-order drug pricing information was restricted to members, so specific information provided could not be assessed.

The quality and cost information provided on each plan's Web site was made available to the enrollees of both HDHP and traditional plans. In some instances, information was tailored to the specific plan in which an individual was enrolled. For example, one plan's out-of-pocket cost

estimates for prescription drugs took into account plan-specific coverage and cost-sharing features.

Concluding Observations

Like many large employers, the FEHBP has expanded enrollee health plan choices by offering HDHPs combined with HSAs. While first-year enrollment is modest, the number of carriers offering these products in 2005 and expected to offer them in 2006 indicates that OPM and health insurance carriers anticipate continued interest in these new plans.

Although the first-year enrollment in FEHBP HDHPs may not predict future trends, it does raise the possibility that individuals with certain demographic characteristics may be disproportionately attracted to these plans. For example, first-year HDHP enrollees had consistently higher incomes across all age groups than enrollees of another new plan and all FEHBP enrollees. This may suggest that aspects of HDHPs—such as the greater financial exposure coupled with the potential for tax-advantaged savings—uniquely attract higher-income individuals with the means to pay higher deductibles and the desire to accrue tax-free savings. First-year enrollees were also younger on average than all FEHBP enrollees; however, they were not younger than enrollees in another new plan. Thus it is not clear whether younger individuals were uniquely attracted to HDHPs, or if younger enrollees are typical of recently introduced health plans in general. Additional years of enrollment data will be necessary to determine whether characteristics of first-year enrollees are predictive of future trends; to identify other important characteristics of HDHP enrollees, such as their health status; and to assess the implications of these enrollment trends for the FEHBP.

HDHPs, like other CDHPs, are premised on the notion that enrollees will become more actively involved in making health care purchase decisions than enrollees of traditional health plans. To do so, enrollees need information to help them assess the cost and quality trade-offs between different health care treatments and providers. However, the extent to which FEHBP HDHPs made such information available to enrollees was varied and limited, and HDHP enrollees were not provided any more or different information than was provided to traditional plan enrollees. Most notably lacking was specific information to assess the quality of health care provided by particular physicians and the actual prices plans had negotiated with particular providers. Some of this information may become available in the future. Two of the three largest HDHPs were developing physician-specific patient satisfaction ratings to help enrollees assess physician quality, and one had initiated a pilot project to provide enrollees with the actual, negotiated prices they would pay for certain

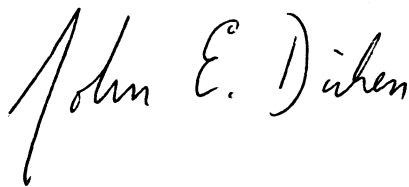
services performed by a particular provider. Until such provider-specific quality and cost data become more widely available, the CDHP goal of having enrollees make health care purchase decisions based on an informed assessment of the quality/cost trade-offs may not be fully realized.

Agency Comments

We received comments on a draft of this report from OPM (see app. I). OPM expressed interest in our findings on the differences in characteristics of first-year HDHP enrollees compared to traditional FEHBP plan enrollees, and said that it would monitor enrollment trends over time to assess whether certain individuals—such as younger or healthier individuals—disproportionately enroll in HDHPs. OPM also said that it would continue to encourage plans to expand the decision support information they provide to enrollees, including the pricing of health care services.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issue date. At that time, we will send copies to the Director of OPM and other interested parties. We will also make copies available to others upon request. This report is also available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7119 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Randy DiRosa, Assistant Director; Gerardine Brennan; and Laura Brogan made major contributions to this report.



John E. Dicken
Director, Health Care

Appendix I: Comments from the Office of Personnel Management



OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-1000

JAN 13 2006

Mr. John Dicken
Director, Health Care
United States Government
Accountability Office
Washington, DC 20548

Dear Mr. Dicken:

Thank you for the opportunity to review your proposed report entitled *FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: First Year Experience with High Deductible Health Plans and Health Savings Accounts (GAO-06-271)*.

We read with interest the report which indicated the average age of High Deductible Health Plan (HDHP) enrollees was 47 years compared to 59 years for the average age of FEHB enrollees. The report also indicated that 43 percent of HDHP enrollees actively employed by the Federal government earned salaries of over \$75,000 per year as compared to only 23 percent in the FEHB overall. Your report also pointed out the possibility of risk selection occurring over time by enticing the young and healthy into HDHP plans at the expense of our traditional insurance plans. We will have to monitor this over time.

As the report correctly points out, we recognize the need to provide consumer support tools to allow enrollees to maximize the benefits of high deductible health plans with Health Savings Accounts. We will continue to encourage these plans to expand support tools, including pricing data.

Thank you for the opportunity to provide comments.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Springer", with a long, sweeping flourish extending to the right.

Linda M. Springer
Director

CON 151-64-4
September 2001

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