United States Government Accountability Office

GAO

Report to the Ranking Minority Member, Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Homeland Security and Governmental Affairs, U.S. Senate

December 2006

# FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

# Premium Growth Has Recently Slowed, and Varies among Participating Plans


GAO-07-141

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## Highlights

Highlights of GAO-07-141, a report to the Ranking Minority Member, Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Homeland Security and Governmental Affairs, U.S. Senate

## Why GAO Did This Study

Average health insurance premiums for plans participating in the Federal Employees Health Benefits Program (FEHBP) have risen each year since 1997. These growing premiums result in higher costs to the federal government and plan enrollees. The Office of Personnel Management (OPM) oversees FEHBP, negotiating benefits and premiums and administering reserve accounts that may be used to cover plans' unanticipated spending increases.

GAO was asked to evaluate the nature and extent of premium increases. To do this, GAO examined (1) FEHBP premium trends compared with those of other purchasers, (2) factors contributing to average premium growth across all FEHBP plans, and (3) factors contributing to differing trends among selected FEHBP plans. GAO reviewed data provided by OPM relating to FEHBP premiums and factors contributing to premium growth. For comparison purposes, GAO also examined premium data from the California Public Employees' Retirement System (CalPERS) and surveys of other public and private employers. GAO also interviewed officials from OPM and eight FEHBP plans with premium growth that was higher than average, and six FEHBP plans with premium growth that was lower than average to discuss premium growth trends and the variation in growth across plans.

www.gao.gov/cgi-bin/getrpt?GAO-07-141.

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.

## What GAO Found

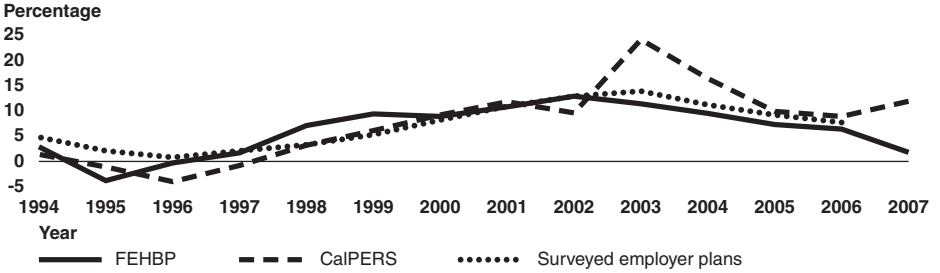
Growth in FEHBP premiums recently slowed, from a peak of 12.9 percent for 2002 to 1.8 percent for 2007. During this period FEHBP premium growth was generally slower than for other purchasers. Premium growth rates for the 10 largest FEHBP plans by enrollment ranged from 0 percent to 15.5 percent in 2007, while growth rates among smaller FEHBP plans varied more widely. The growth in average enrollee premium contributions—the share of total premiums paid by enrollees—was similar to the growth in total FEHBP premiums from 1994 through 2006, and was generally comparable with recent growth in enrollee premium contributions for surveyed employers.

Projected increases in the cost and utilization of health care services and in the cost of prescription drugs accounted for most of the average premium growth increases for 2000 through 2007. Other factors, including benefit changes resulting in less generous coverage and enrollee migration to lower cost plans, were projected to slightly offset premium increases. In 2006 and 2007, projected withdrawals from reserves significantly helped offset the effect of other factors on premium growth.

Officials from most of the plans with higher-than-average premium growth cited increases in the cost and utilization of services as well as a high share of elderly enrollees and early retirees. GAO's analysis of financial and enrollment data found that these plans generally experienced faster-than-average growth in the cost and utilization of services and faster-than-average growth in their share of elderly enrollees and retirees in recent years. Officials from most of the plans with lower-than-average premium growth cited adjustments for previously overestimated projections of cost growth. Officials also cited benefit changes that resulted in less generous coverage for prescription drugs. GAO's analysis of financial data provided by these plans found that that their increase in per enrollee expenditures for prescription drugs was significantly lower than average in recent years.

In commenting on a draft of this report, OPM said the draft confirms that growth in average FEHBP premiums has slowed and has been lower than that of other large employer purchasers for the last several years.

**Growth in Average Premiums for FEHBP and Other Purchasers**




Sources: OPM, CalPERS, and Kaiser Family Foundation/Health Research and Educational Trust.

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**Abbreviations**

| | |
|---|---|
| CalPERS | California Public Employees' Retirement System |
| CDHP | consumer-directed health plan |
| FEHBP | Federal Employees Health Benefits Program |
| FFS | fee-for-service |
| Kaiser/HRET | Kaiser Family Foundation/Health Research and Educational Trust |
| HMO | health maintenance organization |
| OPM | Office of Personnel Management |

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**United States Government Accountability Office**
**Washington, DC 20548**

December 22, 2006

The Honorable Daniel K. Akaka
Ranking Minority Member
Subcommittee on Oversight of Government Management,
the Federal Workforce, and the District of Columbia
Committee on Homeland Security and Governmental Affairs
United States Senate

Dear Senator Akaka:

Federal employees' health insurance premiums have steadily increased since the late 1990s, after a brief period of decreases.[1] About 8 million federal employees, retirees, and their dependents receive health coverage through plans participating in the Federal Employees Health Benefits Program (FEHBP), the largest employer-sponsored health insurance program in the country. The Office of Personnel Management (OPM) administers the program by contracting with multiple health insurance carriers to offer health plans through the program and negotiates benefits and premium rates with each carrier. OPM also administers reserve accounts for each plan that may be used to cover plans' unanticipated spending increases.[2]

Because higher FEHBP premiums pose higher costs to the federal government and plan enrollees, you asked us to evaluate the extent and nature of these increases. You also asked us to examine the potential effect on premium growth of the Medicare retiree drug subsidy had OPM applied for the subsidy and used it to offset premium growth.[3] To do this we examined

[1]GAO previously reported on federal employees' health insurance premium trends through 2003. See GAO, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits*, GAO-03-236 (Washington, D.C.: Dec. 31, 2002).

[2]Pursuant to 5 U.S.C. § 8909.

[3]As of January 1, 2006, employers offering prescription drug coverage to Medicare-eligible retirees enrolled in their plans could apply for a tax-exempt government subsidy. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2125 (2003). OPM has chosen not to apply for the subsidy.

1. recent FEHBP premium growth trends and compared them with those of plans offered by other purchasers,

2. the factors that contributed to average premium growth trends across all FEHBP plans as well as the effect the Medicare retiree drug subsidy would have had on premium growth, and

3. the factors that contributed to differing premium growth among selected FEHBP plans.

To identify growth trends in FEHBP premiums and enrollee premium contributions—the portion of the total premium paid by enrollees—we obtained premium trend data from 1994 through 2007 from OPM. We analyzed the data to identify trends in average premiums and average enrollee premium contributions for all plans.[4] To assess the variation in premium trends across all FEHBP plans by such characteristics as plan type,[5] plan option,[6] geographic area served, and share of retirees, we obtained plan-level premium and enrollment data from 2003 through 2006 from OPM.[7] To compare FEHBP premium trends with those of other purchasers, we obtained premium data from the California Public Employees' Retirement System (CalPERS)—the second largest public purchaser of employee health benefits—and surveys of employer-

[4]Throughout the report, the terms average premium and average enrollee premium contribution refer to the average premium and average enrollee contribution weighted by each plan's enrollment.

[5]Several types of plans are offered to FEHBP enrollees, including fee-for-service (FFS), health maintenance organization (HMO), and consumer-directed health plans (CDHP). FFS plans are generally available to all enrollees nationwide. The plans offer a choice of preferred providers within the plans' networks at a lower cost to enrollees; providers outside the networks cost more. HMO plans are available to enrollees in particular geographic areas and generally have cost-containment mechanisms that require authorization from an enrollee's primary care physician before the enrollee can access services by specialist health providers. CDHPs are high-deductible plans that feature a savings account used to pay for health care and may be offered nationally or within particular geographic areas.

[6]Some FEHBP plans offer two levels of benefits, also known as high or low options. High-option plans offer more comprehensive coverage and richer benefits and have higher monthly premiums than do low-option plans.

[7]As 2007 premium data became available, we incorporated these data into our analyses as appropriate.

sponsored health plans from Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET).[8,9]

To identify factors contributing to average FEHBP premium growth trends across all FEHBP plans, we analyzed OPM summary reports assessing the effect of projected changes in various factors, including the cost and utilization of services, enrollee demographics, and use of reserves, on premium growth trends from 2000 through 2007.[10] We also examined aggregate data on the actual growth in per-enrollee expenditures by service category, including prescription drugs, hospital outpatient care, hospital inpatient care, and physician and other services, from 2003 through 2005 for 5 large FEHBP plans.[11] We explored with officials from OPM and 14 selected FEHBP plans the potential effect on premium growth of the retiree drug subsidy had OPM applied for the subsidy and used it to mitigate premium growth.

To examine the reasons for differing premium growth trends among FEHBP plans, we conducted interviews with officials from the 14 plans—selected because of size (at least 5,000 enrollees) and length of participation in FEHBP (at least 3 years)—with higher- or lower-than-average premium growth in 2006 or for the 3-year period from 2004 through 2006. Eight of the 14 selected plans had higher-than-average premium growth and 6 had lower-than-average premium growth. We analyzed aggregate data on the actual growth in per-enrollee expenditures by service category from 2003 through 2005 provided by officials from 6 of the 8 plans with higher-than-average premium growth and 2 of the 6 plans

[8]Kaiser/HRET has conducted surveys of employer-sponsored health benefits since 1999. These surveys capture data from employers ranging in size from 3 to 300,000 or more workers. KPMG Peat Marwick conducted the surveys before 1999.

[9]We analyzed premium growth trends for CalPERS from 1994 through 2007. We analyzed premium growth trends for Kaiser/HRET surveyed employers from 1994 through 2006, because the Kaiser/HRET survey data available when we prepared this report did not include growth rates for 2007.

[10]Premium rates for each year are prospectively set by individual FEHBP plans based on their projections of growth for various factors. OPM calculates the average premium growth across all FEHBP plans and estimates the composite projected growth in each of these factors across all FEHBP plans based on the plans' projections. Actual growth for each factor may differ from these projections.

[11]These five plans accounted for about 90 percent of FFS enrollment and about two-thirds of total FEHBP enrollment. OPM was not able to provide these data for all FEHBP plans for 2005.

with lower-than-average premium growth. We also analyzed demographic enrollment data provided by OPM for all 14 plans for 2001 through 2005.

We did not independently verify the data from OPM, the selected FEHBP plans, CalPERS, or the Kaiser/HRET surveys. We performed certain quality checks, such as determining consistency where similar data were provided by OPM and the plans. We collected and evaluated information from OPM regarding collection, storage, and maintenance of the data. We reviewed all data for reasonableness and consistency and determined that these data were sufficiently reliable for our purposes. Appendix I provides more detailed information on our methodology. We conducted our work from January 2006 through December 2006 in accordance with generally accepted government auditing standards.

## Results in Brief

Growth in average FEHBP premiums recently slowed and was lower than growth for other purchasers, while premium growth varied across FEHBP plans. Growth in average FEHBP premiums slowed from a peak of 12.9 percent for 2002 to 1.8 percent for 2007. The average annual growth in FEHBP premiums has been slower than for other purchasers beginning in 2003—7.3 percent for FEHBP, compared with 14.2 percent for CalPERS and 10.5 percent for surveyed employers. Premium growth rates for the 10 largest FEHBP plans by enrollment, accounting for about three-quarters of total enrollment, ranged from 0 percent to 15.5 percent for 2007. The growth in average enrollee premium contributions—the portion of the total premium paid by enrollees—was similar to the growth in total FEHBP premiums from 1994 through 2007 and was generally comparable with the recent growth in enrollee premium contributions for surveyed employers.

Premium growth was affected by projected increases and decreases in the costs associated with several factors. Projected increases in the cost and utilization of health care services and in the cost of prescription drugs accounted for most of the average premium growth across all plans for 2000 through 2007. Absent projected changes in the costs associated with other factors, projected increases in the cost and utilization of services alone would have accounted for a 6 percent increase in premiums for 2007, down from a peak of about 10 percent for 2002. Similarly, projected increases in the cost of prescription drugs alone would have accounted for about a 3 percent increase in premiums for 2007, down from a peak of about 5 percent in 2002. Projected decreases in the costs associated with other factors, including benefit changes that resulted in less generous coverage and enrollee migration to lower cost plans, generally helped

offset average premium increases from 2000 through 2007. From 2000 through 2005, projected additions to reserves contributed less than 1 percent to premium growth. However, projected withdrawals from reserves helped offset the effect of other factors on premium growth by about 2 percent for 2006 and 5 percent for 2007. Regarding the potential effect of the retiree drug subsidy, plan officials differed on whether the subsidy would have affected growth in FEHBP premiums in 2006 had OPM applied for the subsidy and used it to mitigate premium growth. Most plan officials we interviewed stated that the subsidy would have had a small effect on premium growth. Officials from two large plans with higher-than-average shares of retirees stated that the subsidy would have lowered their plans' premium growth—officials from one plan claimed by at least 3.5 to 4 percentage points for their plan. We estimated that the subsidy would have lowered the growth in premiums across all FEHBP plans for 2006 by more than 2 percentage points on average, from 6.4 percent to about 4 percent. OPM officials stated that OPM did not apply for the subsidy for FEHBP because the intent of the subsidy was to encourage employers to continue offering prescription drug coverage to Medicare-eligible enrollees, and FEHBP plans were already doing so.

Officials we interviewed from most of the plans with higher-than-average premium growth cited increases in the cost and utilization of services as well as a high share of elderly enrollees and early retirees. Our analysis of financial data provided by these plans and enrollment data provided by OPM found that these plans experienced faster-than-average growth in the cost and utilization of services and faster-than-average growth in their share of elderly enrollees and retirees in recent years. Officials we interviewed from most plans with lower-than-average premium growth cited adjustments made for previously overestimated projections of cost growth. Officials also cited benefit changes that resulted in less generous coverage for prescription drugs. Our analysis of financial data provided by these plans showed that the increase in their per-enrollee expenditures for prescription drugs was significantly lower than average in recent years. In addition, our analysis of enrollment data found that these plans experienced greater declines than average in their share of aging enrollees.

In commenting on a draft of this report, OPM said the draft confirms that growth in average FEHBP premiums has slowed and has been lower than that of other large employer purchasers for the last several years. Regarding our discussion of benefit changes that resulted in less generous coverage for prescription drugs, OPM said that some plans have modified their prescription drug benefit to create incentives to use generic medications, and that this does not result in a less generous benefit. While

we agree that plans can change benefits to encourage generic drug utilization without resulting in less generous coverage, officials from three of the six plans we interviewed with lower–than-average premium growth said that they made benefit changes that resulted in less generous coverage.

## Background

FEHBP is the largest employer-sponsored health insurance program in the country, providing health insurance coverage for about 8 million federal employees, retirees, and their dependents through contracts with private insurance plans. All currently employed and retired federal workers and their dependents are eligible to enroll in FEHBP plans, and about 85 percent of eligible workers and retirees are enrolled in the program. For 2007, FEHBP offered 284 plans, with 14 fee-for-service (FFS) plans, 209 health maintenance organization (HMO) plans, and 61 consumer-directed health plans (CDHP). About 75 percent of total FEHBP enrollment was concentrated in FFS plans, about 25 percent in HMO plans, and less than 1 percent in CDHPs.

Total FEHBP health insurance premiums paid by the government and enrollees were about $31 billion in fiscal year 2005. The government pays a portion of each enrollee's total health insurance premium. As set by statute, the government pays 72 percent of the average premium across all FEHBP plans but no more than 75 percent of any particular plan's premium.[12] The premiums are intended to cover enrollees' health care costs, plans' administrative expenses, reserve accounts specified by law, and OPM's administrative costs. Unlike some other large purchasers, FEHBP offers the same plan choices to currently employed enrollees and retirees, including Medicare-eligible retirees who opt to receive coverage through FEHBP plans rather than through the Medicare program. The plans include benefits for medical services and prescription drugs.

[12]The Balanced Budget Act of 1997 established the government's current share of the premiums beginning in 1999. Pub. L. No. 105-33, §7002, 111 Stat. 251, 662 (amending 5 U.S.C. §8906). OPM determines separate averages for individual plans and for family plans. Although the average enrollee premium contribution is 28 percent of the average premium for all plans, enrollee premium contributions can be higher than 28 percent for plans with premiums significantly higher than the average FEHBP plan. For example, the 2006 monthly premium for a particular FEHBP plan was $642, compared with the average premium of $415. Because the government's share is $299 (72 percent of $415), the enrollee premium contribution for this particular plan was $343 ($642 minus $299), or about 53 percent of the plan's premium.

By statute, OPM can negotiate contracts with health plans without regard to competitive bidding requirements.[13] Plans meeting the minimum requirements specified in the statute and regulations may participate in the program, and plan contracts may be renewed automatically each year. OPM may terminate contracts if the minimum standards are not met.[14]

OPM administers a reserve account within the U.S. Treasury for each FEHBP plan, pursuant to federal regulations. Reserves are funded by a surcharge of up to 3 percent of a plan's premium.[15] Funds in the reserves above certain minimum balances may be used, under OPM's guidance, to defray future premium increases, enhance plan benefits, reduce government and enrollee premium contributions, or cover unexpected shortfalls from higher-than-anticipated claims.

As of January 1, 2006, Medicare began offering prescription drug coverage (also known as Part D) to Medicare-eligible beneficiaries. Employers offering prescription drug coverage to Medicare-eligible retirees enrolled in their plans could, among other options, offer their retirees drug coverage that was actuarially equivalent to standard coverage under Part D and receive a tax-exempt government subsidy to encourage them to retain and enhance their prescription drug coverage.[16] The subsidy provides payments equal to 28 percent of each qualified beneficiary's prescription drug costs that fall within a certain threshold and is estimated

[13]5 U.S.C. §8902.

[14]OPM can terminate a plan's contract at the end of the contract term if fewer than 300 federal employees and retirees were enrolled during the two preceding contract terms. In addition, if a plan fails to meet minimum standards, OPM can withdraw its approval after giving the plan notice and providing an opportunity for a hearing.

[15]5 U.S.C.§8909. Reserves may also be credited with any unused portions of funds set aside for OPM's administrative expenses and income from investment of the reserves. In the case of FFS plans, reserves may also be credited with portions of excess premiums that may remain after claims and the plan's administrative costs and other financial obligations have been met. These excess premiums may not be transferred into reserve accounts for most HMO plans.

[16]In general, according to the Centers for Medicare & Medicaid Services, actuarial equivalence measures whether the expected amount of paid claims under the employer's prescription drug coverage is at least equal to the expected amount of paid claims under the standard prescription drug coverage under Medicare Part D. The conference committee report for the legislation authorizing this subsidy indicated a belief by the committee that the subsidy would help employers retain and enhance their prescription drug coverage in the face of increasing pressure to drop or scale back such coverage. H.R. Conf. Rep. No. 108-391, at 484 (2003).

to average about $670 per beneficiary per year. OPM opted not to apply for the retiree drug subsidy.

## Growth in Average FEHBP Premiums Has Recently Slowed and Was Lower Than That of Other Purchasers

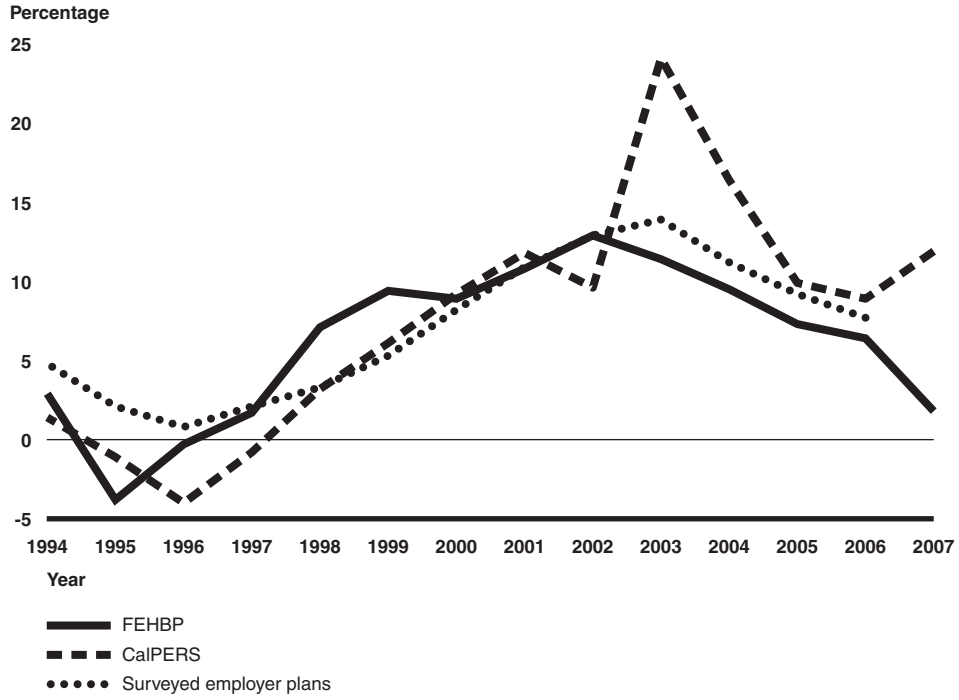
The average annual growth in FEHBP premiums slowed from 2002 through 2007 and was generally lower than the growth for other purchasers since 2003. Premium growth rates of the 10 largest FEHBP plans by enrollment varied to a lesser extent than did growth rates of smaller plans from 2005 through 2007. The growth in the average FEHBP enrollee premium contribution generally tracked average premium growth and was generally similar to recent growth in enrollee premium contributions for surveyed employers.

### Growth in Average FEHBP Premiums Slowed and Was Lower Than That of Other Purchasers in Recent Years

After a period of decreases in 1995 and 1996, FEHBP premiums began to increase in 1997, to a peak increase of 12.9 percent in 2002. The growth in average FEHBP premiums began slowing in 2003 and reached a low of 1.8 percent for 2007. The average annual growth in FEHBP premiums was faster than that of CalPERS and surveyed employers from 1997 through 2002—8.5 percent compared with 6.5 percent and 7.1 percent, respectively. However, beginning in 2003, the average annual growth rate in FEHBP premiums was slower than that of CalPERS and surveyed employers—7.3 percent compared with 14.2 percent and 10.5 percent, respectively.[17] (See fig. 1.).

[17]In 2006, average monthly FEHBP premiums were $415 for individual plans and $942 for family plans. Average monthly premiums for private employer plans were $354 for individual plans and $957 for family plans.

**Figure 1: Growth in Average Premiums for FEHBP and Other Purchasers, 1994 through 2007**




Sources: OPM, CalPERS, and Kaiser/HRET.

Note: The 2007 average premium growth rate for employer plans in the Kaiser/HRET surveys was not available at the time we completed our work for this report.

## FEHBP Premium Growth Varied Less for Large Plans Than for Smaller Plans from 2005 through 2007

The premium growth rates for the 10 largest FEHBP plans by enrollment—accounting for about three-quarters of total FEHBP enrollment—ranged from 0 percent to 15.5 percent in 2007. The average annual premium growth for these plans fell within a similar range for 2005 through 2007. (See table 1.)

**Table 1: Growth in Premiums for 10 Largest FEHBP Plans, 2005 through 2007**

| Plan | Premium growth, 2007 | Average premium growth, 2005-2007 |
|---|---|---|
| Kaiser Foundation Health Plan of California | 15.5% | 10.2% |
| Kaiser Foundation Health Plan Mid-Atlantic States | 9.7% | 10.3% |
| M.D. Individual Practice Association | 7.3% | 8.7% |
| Mail Handlers Benefit Plan – (standard option) | 3.0% | 15.4% |
| National Association of Letter Carriers | 2.0% | 6.1% |
| American Postal Workers Union Health Plan – (high option) | 1.7% | 3.4% |
| Government Employees Hospital Association Benefit Plan - (high option) | 1.3% | 6.3% |
| Blue Cross Blue Shield – (standard option) | 1.0% | 5.4% |
| Government Employees Hospital Association Benefit Plan - (standard option) | 0.0% | 3.3% |
| Blue Cross Blue Shield – (basic option) | 0.0% | 0.0% |
| **Average of 10 largest plans** | **1.7%** | **6.3%** |
| **Average of all FEHBP plans** | **1.8%** | **5.2%** |

Source: GAO analysis of FEHBP premium data from OPM.

Premium growth rates across the smaller FEHBP plans in 2007 varied more widely, from a decrease of 43 percent to an increase of 27.1 percent.

The average premium growth in 2006 also varied by such characteristics as plan type, plan option, geography, and share of retirees.

- Premium growth for FFS plans (6.0 percent) was lower than for HMO plans (8.5 percent).
- Premium growth for low-option plans (2.6 percent) was lower than that for high-option plans (7.3 percent).
- Premium growth was higher for regional HMO plans in the southern United States (9.2 percent) than for regional HMO plans elsewhere (from 7.2 percent to 8.7 percent).[18]

[18]National FFS plans charge the same premium in all geographic areas.

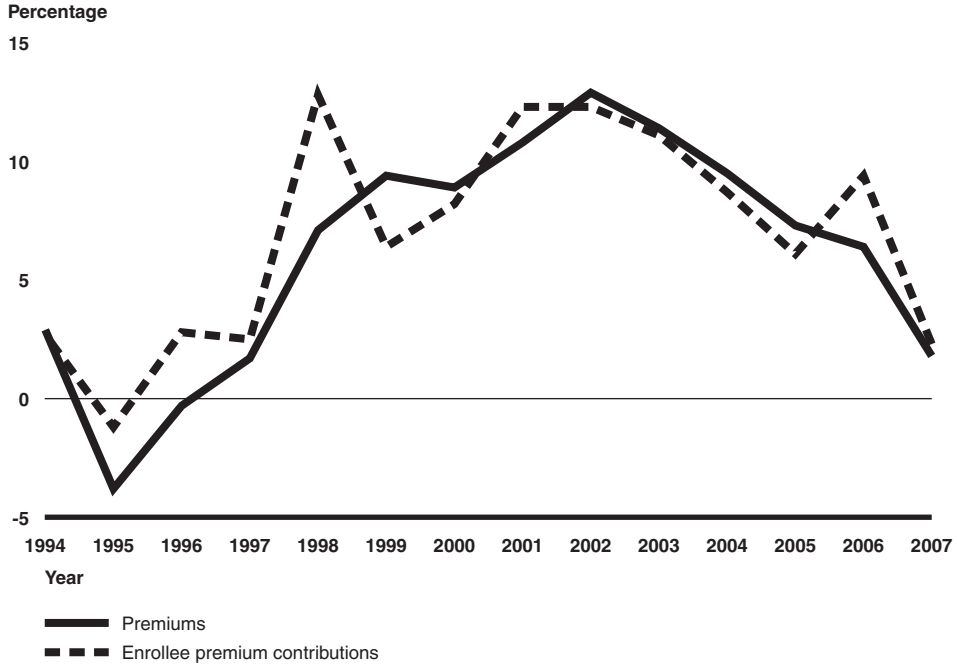
- Premium growth for plans with 20 percent or fewer retirees (4.5 percent) was lower than for plans with greater than 20 percent retirees (7 percent).

## Growth in Average FEHBP Enrollee Premium Contributions Tracked Average Premium Growth and Was Comparable with That of Surveyed Employer Plans

Growth in average FEHBP enrollee premium contributions generally paralleled premium growth from 1994 through 2007. The average annual growth in enrollee premium contributions during this period was 6.9 percent, while premium growth was 6.1 percent. After decreasing in 1995, average enrollee premium contributions began to increase, rising to a peak of 12.8 percent in 1998. Paralleling premium growth trends, the average annual growth in enrollee premium contributions has slowed since 2002, except for an upward spike in 2006.[19] (See fig. 2.)

[19]The simultaneous slowing in average premium growth and acceleration in average enrollee premium contributions in 2006 are related in part to the statutory level of federal contribution to premiums. Because the federal government share of plan premiums is 72 percent of the average premium across all FEHBP plans, enrollees in plans with higher-than-average premiums or rates of growth will pay a higher share of the premium than other enrollees. Thus, because the premium for the largest FEHBP plan increased at a higher rate than the average of all FEHBP plans—8.5 percent compared with 6.4 percent, respectively—enrollees in this plan saw their premium contributions rise faster in 2006.

**Figure 2: Growth in Average FEHBP Premium and Enrollee Premium Contribution, 1994 through 2007**

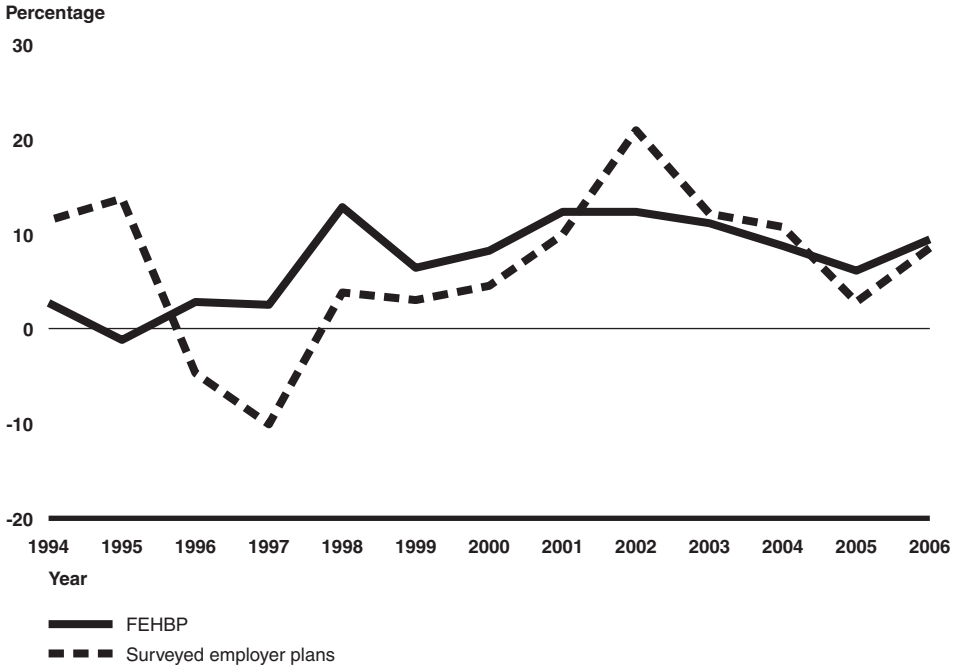



Source: OPM.

The growth in average FEHBP enrollee premium contributions was generally similar to that of surveyed employer plans. (See fig. 3.) From 1994 through 2006, the average annual growth in FEHBP enrollee premium contributions ranged from a decrease of 1.2 percent to an increase of 12.8 percent, compared with a decrease of 10.1 percent to an increase of 20.9 percent for surveyed employer plans. From 2003 through 2006, the average annual increase in FEHBP enrollee premium contributions—8.8 percent—was comparable with that of surveyed employer plans.[20]

[20]In 2006, average monthly FEHBP enrollee premium contributions were $123 for individual plans and $278 for family plans. Average monthly enrollee premium contributions for surveyed employer plans were $52 for individual plans and $248 for family plans.

**Figure 3: Growth in Average Enrollee Premium Contributions for FEHBP and Surveyed Employer Plans, 1994 through 2006**




Sources: OPM and Kaiser/HRET.

Note: Data on the growth in enrollee premium contributions for CalPERS were not available.

The growth in enrollee premium contributions for the 10 largest FEHBP plans by enrollment ranged from negative 1.1 percent to 51.5 percent in 2007. The growth in enrollee premium contributions for smaller FEHBP plans varied more widely, from negative 62.6 percent to 86.8 percent.

## Projected Growth in Several Factors Contributed to Average FEHBP Premium Growth

Projected increases in the cost and utilization of services and in the cost of prescription drugs accounted for most of the average premium growth across FEHBP plans. However, projected withdrawals from reserves offset much of this growth from 2006 through 2007. Officials we interviewed from most of the FEHBP plans said that the retiree drug subsidy would have had a small effect on premium growth had OPM applied for the subsidy and used it to offset premiums. Our interviews with officials from two large plans and our analysis of the potential effect of the subsidy showed that it would have lowered the growth in premiums and enrollee premium contributions for 2006. OPM officials stated that the subsidy was not necessary because its intent was to encourage employers to continue

offering prescription drug coverage to Medicare-eligible enrollees, and FEHBP plans were already doing so. The potential effect of the subsidy on premium growth would also have been uncertain because the statute did not require employers to use the subsidy to mitigate premium growth.

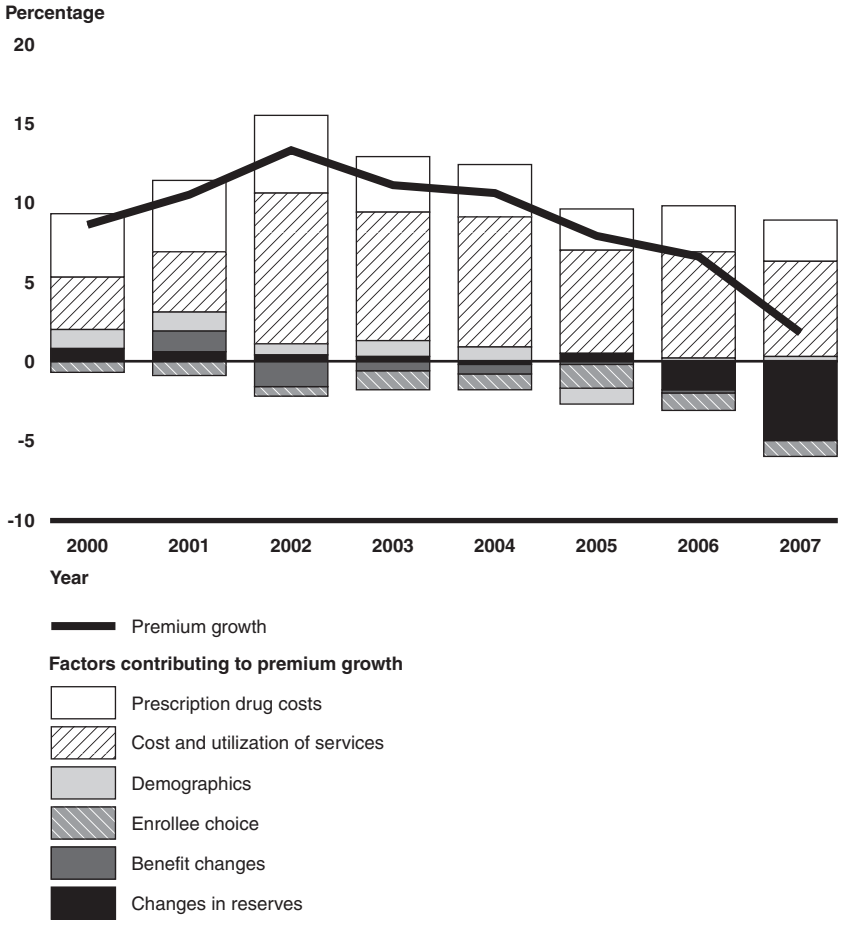
## Projected Increases in the Cost and Utilization of Health Care Services Accounted for Most of the Premium Growth but Were Mitigated by Use of Reserves in Recent Years

Projected increases in the cost and utilization of health care services and the cost of prescription drugs accounted for most of the average FEHBP premium growth from 2000 through 2007. Absent projected changes associated with other factors, projected increases in the cost and utilization of services alone would have accounted for a 6 percent increase in premiums for 2007, down from a peak of about 10 percent for 2002. Projected increases in the cost of prescription drugs alone would have accounted for about a 3 percent increase in premiums for 2007, down from a peak of about 5 percent for 2002. Enrollee demographics—particularly the aging of the enrollee population—were projected to have less of an effect on premium growth. Projected decreases in the costs associated with other factors, including benefit changes that resulted in less generous coverage and enrollee choice of plans—typically the migration to lower cost plans—generally helped offset average premium increases for 2000 through 2007.

Officials we interviewed from most of the plans stated that OPM monitored their plans' reserve levels and worked closely with them to build up or draw down reserve funds gradually to avoid wide fluctuations in premium growth from year to year. Projected additions to reserves nominally increased premium growth—by less than 1 percent—from 2000 through 2005. However, projected withdrawals from reserves helped offset the effect of increases by about 2 percent for 2006 and 5 percent for 2007.[21] (See fig. 4.) According to OPM, increases in the actual cost and utilization of services in 2006 were lower than projected for that year, and therefore the projected withdrawals from reserves were not made in 2006. Because of the resulting higher reserve balances, plans and OPM projected even larger reserve withdrawals for 2007.

[21]OPM said that reserves had a larger effect in mitigating average premium growth for 2007 for FFS plans compared with HMO plans because FFS plans had larger accumulated reserves upon which they could draw.

**Figure 4: Projected Changes in Various Factors Affecting FEHBP Premium Growth, 2000 through 2007**




Source: OPM.

Detailed data on total claims expenditures and expenditures by service category actually incurred were available for five large FEHBP plans. These data showed that total expenditures per enrollee increased an average of 25 percent from 2003 to 2005. Most of this increase in total expenditures per enrollee was explained by expenditures on prescription drugs and on hospital outpatient services. (See table 2.)

**Table 2: Actual Cost Drivers for Five Large FEHBP Plans, 2003 through 2005**

| Service category | Contribution to increase in total expenditures per enrollee |
|---|---|
| Prescription drugs | 34% |
| Hospital outpatient | 26% |
| Hospital inpatient | 14% |
| Physician services | 14% |
| All other | 13% |

Source: GAO analysis of data provided by FEHBP plans.

Notes: These five plans represent about 90 percent of total FFS enrollees and about two-thirds of total FEHBP enrollees.

Numbers do not total 100 percent due to rounding.

## Plan Officials Differed on Whether OPM's Decision Not to Accept the Retiree Drug Subsidy Would Have Affected FEHBP Premium Growth

Officials we interviewed from several plans stated that the retiree drug subsidy would have had a small effect on premium growth because of two factors. First, drug costs for Medicare beneficiaries enrolled in these plans accounted for a small proportion of total expenses for all enrollees, and the subsidy would have helped offset less than one-third of these expenses. Second, because the same plans offered to currently employed enrollees were offered to retirees, the effect of the subsidy would have been diluted when spread across all enrollees. However, officials we interviewed from two large plans with high shares of elderly enrollees stated that the subsidy would have lowered premium growth for their plans. Officials from one of these plans estimated that 2006 premium growth could have been 3.5 to 4 percentage points lower.

Our analysis of the potential effect of the retiree drug subsidy on all plans in FEHBP showed that had OPM applied for the subsidy and used it to offset premium growth, the subsidy would have lowered the 2006 premium

growth by 2.6 percentage points from 6.4 percent to about 4 percent.[22,23] The reduction in premium growth would have been a onetime reduction for 2006.[24] Absent the drug subsidy, FEHBP premiums in the future would likely be more sensitive to drug cost increases than would be premiums of other large plans that received the retiree drug subsidy for Medicare beneficiaries.

Officials from OPM explained that there was no need to apply for the subsidy because its intent was to encourage employers to continue offering prescription drug coverage to enrolled Medicare beneficiaries, which all FEHBP plans were already doing. As such, the government would be subsidizing itself to provide coverage for prescription drugs to Medicare-eligible federal employees and retirees. The potential effect of the subsidy on premium growth would also have been uncertain because the statute did not require employers to use the subsidy to mitigate premium growth.

## Changes in the Cost and Utilization of Services and Enrollee Demographics Accounted for Differing Premium Growth among FEHBP Plans

Officials we interviewed from most of the plans with higher-than-average premium growth stated that increases in the cost and utilization of services as well as a high share of elderly enrollees and early retirees were key drivers of premium growth. Our analysis of these plans' financial and enrollee demographic data showed that these plans experienced faster-than-average growth in the cost and utilization of services and faster-than-average growth in their share of elderly enrollees and retirees in recent years. Officials we interviewed from most of the plans with lower-than-average premium growth cited adjustments made for previously overestimated projections of cost growth. Officials also cited benefit changes that resulted in less generous coverage for prescription drugs. Our analysis of financial data provided by two of these plans showed that

[22]We used the nationwide average subsidy estimated by the Centers for Medicare & Medicaid Services to be about $670 per Medicare-eligible retiree. The actual subsidy for Medicare-eligible retirees in FEHBP may have varied from this average.

[23]Officials from CalPERS stated that the subsidy, which they had applied for but not yet decided how to use, amounted to 13 percent to 17 percent of the total premium for Medicare-eligible enrollees in 2006. They stated that the subsidy would have a greater effect on premiums for CalPERS enrollees because, unlike FEHBP, CalPERS offers separate plans for employed enrollees and retirees (including Medicare beneficiaries), and the subsidy would thus be applied exclusively to premiums for retirees.

[24]Continued use of the subsidy in subsequent years would affect actual FEHBP premiums but not their rate of increase.

the increase in their per-enrollee expenditures for prescription drugs was significantly lower than average in recent years. In addition, our analysis of enrollment data found that these plans experienced greater declines than average in their share of aging enrollees.

## Plans with High Premium Growth Had Higher-Than-Average Increases in the Cost and Utilization of Services and Faster Rising Shares of Elderly Enrollees

Officials we interviewed from most of the plans with higher-than-average premium growth cited large increases in the actual cost and utilization of services as one of the key cost drivers of premium growth. Our analysis of financial data provided by six of these plans showed that the average increase in total expenditures per enrollee from 2003 through 2005 was about 40 percent, compared with the average of 25 percent for the five large FEHBP plans.

Although enrollee demographics were projected to have a small effect on premium growth in the average FEHBP plan for 2006, change in enrollee demographics was cited as a key cost factor for most plans with higher-than-average premium growth. Officials we interviewed from five of these plans stated that an aging population and higher shares of early retirees were factors driving premium growth for their plans. For example, officials from two plans cited a high concentration of elderly enrollees in their respective service areas of southern New Jersey and Pennsylvania, while officials from another plan cited an aging population in its service area of San Antonio, Texas.

Our comparison of the demographic characteristics of the eight plans with higher-than-average premium growth with those of all FEHBP plans from 2001 through 2005 supports the officials' statements that unique demographic profiles contributed to higher premium increases. (See table 3.)

**Table 3: Eight FEHBP Plans with Higher-Than-Average Premium Growth: Enrollee Demographic Changes, 2001 through 2005**

| Demographic characteristics | Plans with higher-than-average premium growth | All plans |
|---|---|---|
| Change in average age (years) | 2.7 | 0.5 |
| Percentage change in share of enrollees aged 65+ | 3.7 | -1.0 |
| Percentage change in share of early retirees | 1.8 | 1.0 |

Source: GAO analysis of OPM enrollment data.

## Plans with Lower-Than-Average Premium Growth Cited Adjustments for Previously Overestimated Cost Growth and Benefit Changes and Had Greater Declines in the Shares of Elderly Enrollees

Officials we interviewed from most of the plans with lower-than-average premium growth for their plans in 2006 cited adjustments for previously overestimated projections of cost growth. Officials from two of these plans stated that projections for a new low-option plan they had recently introduced were pegged high because of concerns about potential migration of high-cost enrollees from their high-option plan. The actual cost increases of enrollees in the low-option plan in 2004 (the basis for 2006 rates) turned out to be lower than projected. Officials from two other plans said that the projected cost growth of 14 percent to 20 percent in 2004 (the basis for 2006 rates) for those plans was much higher than the actual cost growth in 2006 of about 5 percent to 8 percent.

Officials we interviewed from three plans with lower-than-average growth cited lower-than-anticipated rates of increase in prescription drug costs caused by benefit changes that resulted in less generous coverage to explain low rates of premium growth for their plans. Our analysis of financial data provided by two of these plans showed that per-enrollee expenditures for prescription drugs increased by 3 percent for one plan and 13 percent for the other from 2003 through 2005, compared with 30 percent for the average of the five large FEHBP plans. The six plans with lower-than-average premium growth also had greater declines in their share of elderly enrollees compared with all plans from 2001 through 2005. (See table 4.)

**Table 4: Six FEHBP Plans with Lower-Than-Average Premium Growth: Enrollee Demographic Changes, 2001 through 2005**

| Demographic characteristics | Plans with lower-than-average premium growth | All plans |
|---|---|---|
| Change in average age (years) | -0.5 | 0.5 |
| Percentage change in share of enrollees aged 65+ | -2.9 | -1.0 |
| Percentage change in share of early retirees | 0.9 | 1.0 |

Source: GAO analysis of OPM enrollment data.

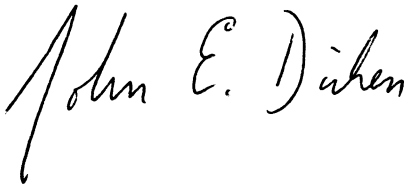
## Agency Comments and Our Evaluation

We received comments on a draft of this report from OPM (see app. II). OPM said the draft report confirms that growth in average FEHBP premiums has slowed and has been lower than that of other large employer purchasers for the last several years. Regarding the projected withdrawals of reserves for 2007, OPM said that the actual drawdown could be lower if the actual increase in the cost and utilization of services in 2007 is less than projected. We agree this could occur, and as we noted in the draft report and as OPM said in its comments, the projected withdrawals of reserves for 2006 were ultimately not made because of lower than expected increases in the cost and utilization of services in that year. Regarding the manner in which premiums are set, OPM said that rate negotiations between OPM and the plans are guided by projections of future costs that are based on a retrospective analysis of actual costs, and that adjustments to the reserve accounts of most plans are made when actual costs differ from the projections. OPM said that, as a result, these reserve adjustments help stabilize premium growth over time and ensure that premiums ultimately reflect actual cost increases. We agree with this characterization of the effect of reserve adjustments. Regarding our discussion of benefit changes that resulted in less generous coverage for prescription drugs, OPM said that some plans modified their prescription drug benefit to create incentives to use generic medications, and that this does not result in a less generous benefit. While we agree that plans can change benefits to encourage generic drug utilization without resulting in less generous coverage, officials from three of the six plans we interviewed with lower-than-average premium growth said that they made benefit changes that resulted in less generous coverage. OPM provided other comments describing aspects of FEHBP and provided technical comments that we incorporated as appropriate.

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

If you or your staff have any questions about this report, please contact me at (202) 512-7119 or 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; Iola D'Souza; Menq-Tsong P. Juang; and Timothy Walker made key contributions to this report.

Sincerely yours,



John E. Dicken
Director, Health Care

# Appendix I: Scope and Methodology

To identify growth trends in the average Federal Employees Health Benefits Program (FEHBP) premiums and enrollee premium contributions, we analyzed trend data for 1994 through 2007 from the Office of Personnel Management (OPM). To identify the variation in premium trends across plans by plan characteristics, we analyzed detailed plan-level premium data and enrollment data for 2003 through 2006 from OPM.[1] We examined the variation in premiums based on plan type—fee-for-service (FFS), health maintenance organization (HMO), and consumer-directed health plan (CDHP)—plan option (high option, low option); geography (West, Midwest, South, Northeast); and share of retirees.[2]

To compare FEHBP premium trends with those of other purchasers, we obtained premium trend data for 1994 through 2007 from the California Public Employees' Retirement System (CalPERS)—the second largest public purchaser of employee health benefits after FEHBP—and from surveys of employer-sponsored health benefits conducted by KPMG Peat Marwick from 1993 through 1998 and by Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) from 1999 through 2006.[3]

To identify factors contributing to average FEHBP premium growth trends for all plans, we obtained and analyzed OPM summary reports on the projected effects of various factors on premium growth for all FEHBP plans from 2000 through 2007.[4] We analyzed more detailed data obtained individually from five large FFS plans on actual growth in per-enrollee expenditures by service category, including prescription drugs, hospital

[1]Plan-level premium data for 2007 were not available at the time we conducted our analysis of premium growth by plan characteristics.

[2]Geographical analyses of the plans were based on the U.S. Census Bureau's regional designation for the states in which the plans operated.

[3]These surveys capture data from employers ranging in size from 3 workers to 300,000 or more workers. The survey for 2007 had not been conducted at the time we prepared our report.

[4]Premium rates for each year are prospectively set by individual FEHBP plans based on their projections of growth trends for various factors, such as the cost and utilization of services, changes in benefits, and enrollee demographics. OPM calculates the average premium growth across all FEHBP plans and estimates the composite projected growth in each factor across all FEHBP plans based on individual plan projections. Actual growth for each factor may differ from the projections.

outpatient care, hospital inpatient care, and physician and other services, from 2003 through 2005.[5]

To examine the reasons for differing premium growth trends among FEHBP plans, we conducted interviews with officials from 14 plans with higher- or lower-than-average premium growth in either 2006 or the 3-year period from 2004 through 2006, and analyzed financial data provided by some of these plans. We limited our study sample to plans participating in FEHBP for at least 3 years and with at least 5,000 enrollees in 2005.[6,7] Among these plans, we identified those with premium growth for 2006 or the average annual growth for the 3-year period from 2004 through 2006 of above or below one standard deviation of the mean. Of the 23 plans meeting these criteria, we selected 14 plans.[8] (See table 5.)

[5]Because OPM was not able to provide these data for all FEHBP plans for 2005, we used data provided by the five large plans. These plans were representative of the average FEHBP plan because they accounted for about 90 percent of FFS enrollment and about two-thirds of total FEHBP enrollment.

[6]Enrollment data for 2006 were unavailable when we selected the plans.

[7]We excluded plans with significantly higher- or lower-than-average premium growth. These plans tended to be smaller plans with fewer than 500 enrollees.

[8]The 14 plans included 5 nationwide FFS plans, 1 nationwide CDHP, and 8 HMO plans from eight states.

**Table 5: Plans with Higher- or Lower-Than-Average Premium Growth Selected by GAO**

| Plan | Premium growth, 2006 | Average annual premium growth, 2004-2006 |
|---|---|---|
| **Plans with higher-than-average growth** | | |
| Aetna Open Access (Southern New Jersey and Southeastern Pennsylvania) | 21.8% | 15.1% |
| Blue Cross HMO (California) | 20.3% | 12.0% |
| CDPHP Universal Benefits, Inc. (New York) | 17.2% | 12.1% |
| HealthAmerica Pennsylvania (Central, high option) | 13.0% | 17.4% |
| Humana Health Plan of Texas (San Antonio, high option) | 13.0% | 20.5% |
| Kaiser Foundation Health Plan of Colorado (high option) | 16.8% | 10.2% |
| Mail Handlers Benefit Plan (high option) | 5.0% | 20.0% |
| Mail Handlers Benefit Plan (standard option) | 6.7% | 19.4% |
| **Plans with lower-than-average growth** | | |
| American Postal Workers Union Health Plan (CDHP) | -1.9% | 3.6% |
| American Postal Workers Union Health Plan (high option) | 0.3% | 5.9% |
| Blue Cross Blue Shield Service Benefit Plan (basic option) | 0.0% | 2.9% |
| Government Employees Hospital Association, Inc., Benefit Plan (standard option) | 0.0% | 6.7% |
| Health Alliance Plan | 2.6% | 5.4% |
| Kaiser Foundation Health Plan, Inc., Hawaii Region (high option) | 2.1% | 6.9% |
| **Average of all FEHBP plans** | **6.4%** | **7.7%** |

Source: GAO analysis of OPM data.

We analyzed aggregate data on the actual growth in per-enrollee expenditures by service category from 2003 through 2005 provided by officials from some of these plans and demographic enrollment data from 2001 through 2005 from OPM.

We also explored with officials from OPM and the selected plans the potential effect of the retiree drug subsidy on premium growth had OPM applied for the subsidy and used it to offset premiums. To estimate the effect the subsidy would have had on average premium growth, we first calculated the total annual amount of the subsidy that would have been available for all Medicare-eligible beneficiaries in FEHBP using 2006 enrollment data and an estimate by the Centers for Medicare & Medicaid Services of the average annual subsidy per Medicare beneficiary in 2006 (about $670). We then divided this amount by total annual premiums for all FEHBP enrollees in 2005.

We did not independently verify the data from OPM, the selected FEHBP plans, CalPERS, or the Kaiser/HRET surveys. We performed certain quality checks, such as determining consistency where similar data were provided by OPM and the plans. We collected and evaluated information from OPM regarding collection, storage, and maintenance of the data. We reviewed all data for reasonableness and consistency and determined that these data were sufficiently reliable for our purposes. We conducted our work from January 2006 through December 2006 in accordance with generally accepted government auditing standards.

# Appendix II: Comments from the Office of Personnel Management

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

The Director

December 1, 2006

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

Dear Mr. Dicken:

Thank you for the opportunity to comment on the draft report: *FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: Premium Growth Has Recently Slowed and Varies Among Participating Plans* (GAO-07-141).

One of the Office of Personnel Management's goals is to promote affordable Federal Employees Health Benefits Program (FEHBP) options from which enrollees may select a health plan to meet their individual needs. The draft report confirms that growth in average FEHBP premiums has slowed and has been lower than that of other large employer purchasers for the last several years.

We have the following comments on the draft report:

- The report states that projected increases in the cost and utilization of health care services and prescription drugs accounted for most of the average premium growth increases for 2000 to 2007, and that for 2006 and 2007 projected withdrawals from reserves significantly helped offset the effect of other factors on premium growth. The projected reserve drawdown for 2007 (about five percent) is very dependent upon the assumed trend for 2006 and 2007. If the actual increase in cost and utilization is less than estimated, the drawdown will be less than five percent. For example, the projected two percent increase in cost and utilization estimated for 2006 was not realized and, in fact, reserves have increased during 2006.
- FEHBP premium negotiations are based on projections which, in turn, are generally based on retrospective analysis of actual costs. Going forward, if actual costs do not meet projections, adjustments are made to the reserve amounts held for the experience rated plans. Over a seven year period, premium stability is maintained through reserve adjustments. Thus, to a large degree, actual costs, not simply cost projections, are reflected in FEHBP premium levels.

- The report states that benefit changes, which resulted in "less generous" coverage for prescription drugs, helped to offset premium growth. Some plans have modified their prescription drug benefit structures to create incentives to use generic medications or the lowest-cost therapeutically appropriate medication. This type of benefit structure provides the same medical benefit, and not a less generous benefit, at a lower cost.
- The FEHBP multi-choice environment relies on competitive market forces to hold down average premium increases. Enrollees are able to make informed decisions and move to lower cost plans often with no reduction in benefits.
- The FEHBP is unique in that both active employees and annuitants are covered in the same risk pool. While cost and utilization generally increase with age, the cost for annuitants with Medicare coverage is offset because FEHBP coverage is secondary to Medicare. As a result, annuitant contracts where Medicare is primary cost less than the average. Plans that report higher cost due to an older membership mix are generally referring to pre-Medicare annuitants.

Enclosed are additional technical comments and clarifications which I would appreciate being considered in the final report.

Thank you for providing the opportunity for comment.

Sincerely,

Linda M. Springer
Director

Enclosure

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