United States General Accounting Office

GAO

Report to the Chairman
Subcommittee on Civil Service
Committee on Government Reform
House of Representatives

May 2000

FEDERAL EMPLOYEES' HEALTH PROGRAM

Reasons Why HMOs Withdrew in 1999 and 2000

GAO/GGD-00-100

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United States General Accounting Office
Washington, D.C. 20548

General Government Division

B-284492

May 2, 2000

The Honorable Joe Scarborough
Chairman, Subcommittee on Civil Service
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

This report responds to your request for information on the withdrawal of health maintenance organizations (HMO) from the Federal Employees' Health Benefits Program (FEHBP). Our specific objectives were to identify (1) changes in the number of HMOs participating in FEHBP from plan years 1994 to 2000, (2) reasons why HMOs withdrew from FEHBP in plan years 1999 and 2000, and (3) FEHBP enrollment experiences for HMOs that withdrew from the program in 2000.[1]

To identify changes in the number of HMOs entering or leaving FEHBP in recent years, we reviewed the Office of Personnel Management's (OPM) annual FEHBP open season guides and benefits administration letters.

To identify why HMOs withdrew from FEHBP in 1999, we relied on an OPM analysis of the survey responses it received from 40 of the 74 HMOs that left the program. For 36 of the 62 HMOs that left the program in 2000, we obtained information on their reasons for withdrawing. In most cases, these HMOs gave their reasons for leaving in letters to OPM; in other cases, we followed up with HMOs to clarify their reasons. We also (1) interviewed officials from OPM and organizations who were familiar with the national HMO environment and (2) reviewed recent articles and publications on changes in the national HMO setting. We did not attempt to identify additional documentation from HMOs to validate their reasons for withdrawing from FEHBP.

To identify recent enrollment experiences for plans withdrawing from FEHBP in 2000, we obtained and analyzed OPM enrollment data for these plans. (App. I contains a detailed description of our objectives, scope, and methodology.)

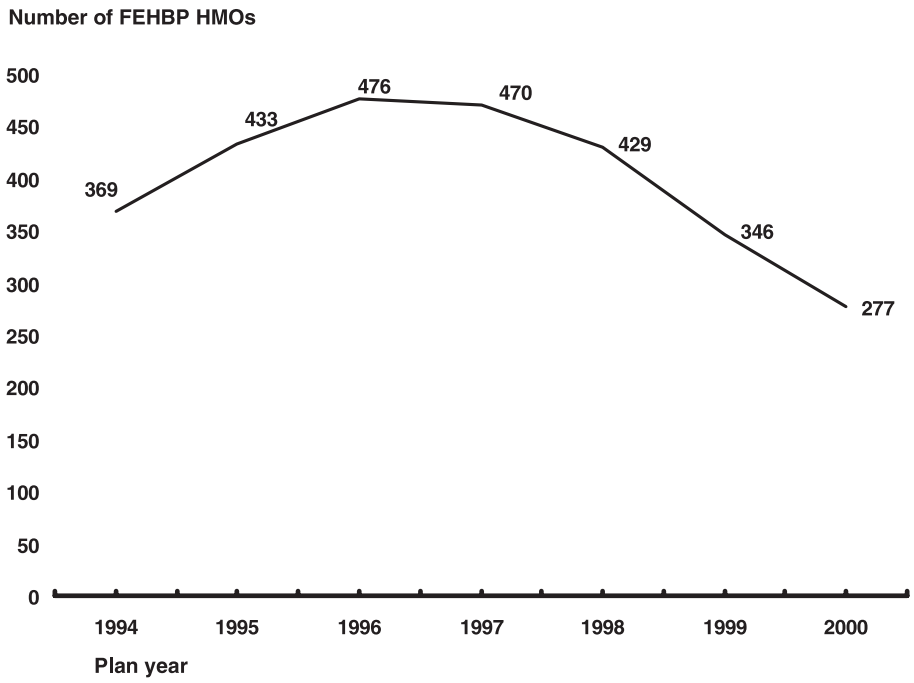
[1]Under FEHBP, a single HMO organization may offer different individual plans, in different geographical areas. In this report, our unit of analysis pertains to the individual plans. However, to simplify report presentation, we used the terms "plans" and "HMOs" interchangeably.

We requested written comments on a draft of this report from OPM. These comments are discussed at the end of this letter and reprinted in appendix II. We performed our work from August 1999 to March 2000 in accordance with generally accepted government auditing standards.

Results in Brief

For plan years 1999 and 2000, 136 HMOs withdrew from FEHBP—74 in 1999 and 62 in 2000. While a limited number of new plans entered FEHBP in 1999 and 2000, the withdrawals, combined with plans that either merged, consolidated service areas, or left service areas reduced the number of HMOs participating in FEHBP from 476 in 1996 to 277 HMOs in 2000. (See fig. 1.)

Figure 1: Number of HMOs Participating in FEHBP at the Beginning of the Plan Year



Source: GAO analysis of OPM data.

The growth or decline in the number of HMOs participating in FEHBP was not always the result of plans entering or withdrawing from the program. Some HMOs added new service areas, while others split their existing service areas. In other cases, HMOs merged, consolidated service areas, or left service areas. In any event, about 64,000 (or less than 2 percent) of the 4.1 million FEHBP enrollees were affected by HMOs' decisions to withdraw in 2000.

According to OPM officials and representatives from HMOs that left FEHBP, the factors most frequently cited for HMO withdrawals from the program in plan years 1999 and 2000 were insufficient enrollments, unpredictable plan utilization/excessive risk, and noncompetitive premium rates. In addition to citing these as the major factors influencing plans' decisions to withdraw, these officials and representatives noted that oftentimes it was a combination of these factors, rather than a single factor, that caused a plan's withdrawal. Other factors that plan representatives cited for withdrawing from FEHBP included mergers, federal mandates to provide selected benefits, OPM's administrative requirements, and saturated market areas. However, plan representatives and others with whom we spoke generally agreed that, in most cases, mandates and administrative requirements would not have been major factors contributing to a plan's decision to withdraw.

According to officials from the Health Insurance Association of America (HIAA) and the American Association of Health Plans (AAHP), an adequate enrollment base is perhaps one of the most important requirements necessary for plans to sustain their operations. An official from the Employee Benefit Research Institute (EBRI) told us that recent plan withdrawals from FEHBP, in all likelihood, represented a market correction in that plans with low FEHBP enrollments in areas dominated by large plans concluded that they could not compete effectively and therefore withdrew.

OPM plan enrollment information showed that 46 of the 62 HMOs that withdrew from FEHBP in 2000 actually increased enrollments between 1998 and 1999, 12 plans lost enrollment between 1998 and 1999, and 4 plans only had enrollment data for 1 year. From 1998 to 1999, of the 46 HMOs that increased enrollments, these increases numbered less than 100 enrollees for 26 of these HMOs. In addition, of the 62 plans that withdrew in 2000, 26 had fewer than 300 enrollees. An OPM official told us that they have the authority to terminate a plan's participation in FEHBP if it has less than 300 enrollees. However, OPM has seldom exercised this authority.

Background

FEHBP is the largest employer-sponsored health insurance program offering the widest selection of health plans in the United States. Over 4.1 million enrollees, covering about 9 million federal civil service employees, annuitants, and their dependents, participated in FEHBP in 1999. For fiscal year 2000, the cost of this program is estimated at $20 billion.

Under FEHBP, enrollees can choose three basic types of health plans: fee-for-service, HMOs, and point-of-service plans. Fee-for-service plans are traditional types of insurance in which the health plan will either reimburse the enrollee or pay the medical provider directly for each covered medical expense. Upon receiving medical treatment, enrollees usually pay a deductible and coinsurance or a copayment. Although few in number, fee-for-service plans cover about 70 percent of the FEHBP enrollees.

HMOs are health plans that provide care through a network of physicians and hospitals in particular geographic or service areas. HMOs provide a comprehensive set of services as long as enrollees use doctors and hospitals affiliated with the HMO. Enrollees pay specified copayments for primary care and specialist visits. Point-of-service plans are organizations in which enrollees may receive services either from providers who are affiliated with HMOs or from nonaffiliated providers. Enrollees may incur substantial additional costs in the form of deductibles or copayments when they use nonaffiliated providers.

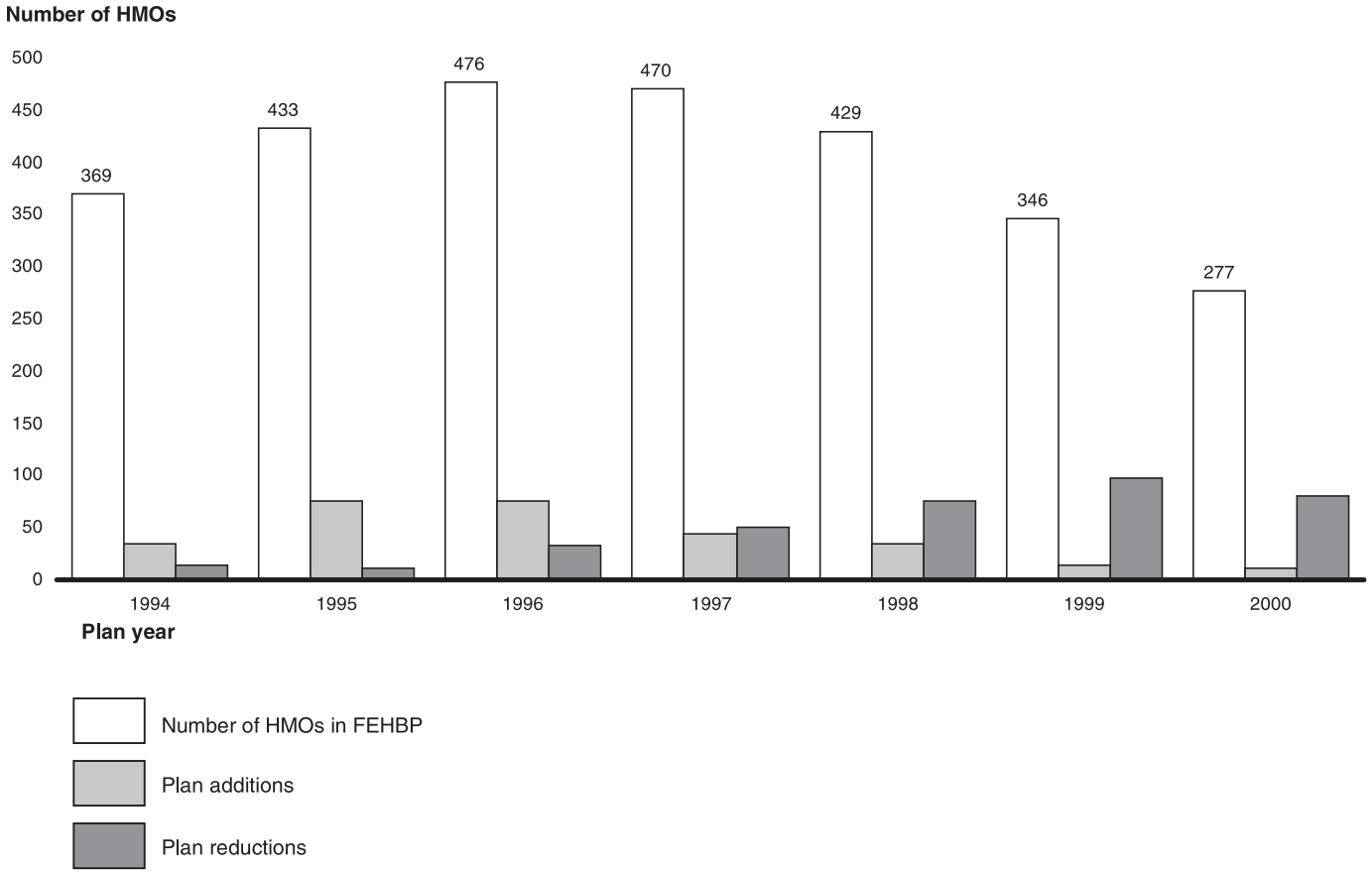
Number of HMOs Participating in FEHBP Declined Since 1997

The number of HMOs participating in FEHBP increased from 369 in 1994 to 476 in 1996.[2] Since then, the number of HMOs participating in FEHBP has declined steadily to 277 in 2000.[3] Although 74 HMOs left the program in 1999 and 62 left in 2000, the number of HMOs participating in FEHBP in any particular year also depends on other factors, such as service area consolidations or mergers among plans (plan reductions) or 2 plans covering a service area previously covered by 1 plan (plan additions). Figure 2 shows the number of HMOs participating in FEHBP as well as the number of plan additions and reductions in each year from 1994 to 2000.

[2]For the purposes of this report, we considered point -of- service plans to be HMOs.

[3]Plans that withdrew from FEHBP included those that terminated their participation during the plan year as well as those that did not continue participating at the start of a new plan year.

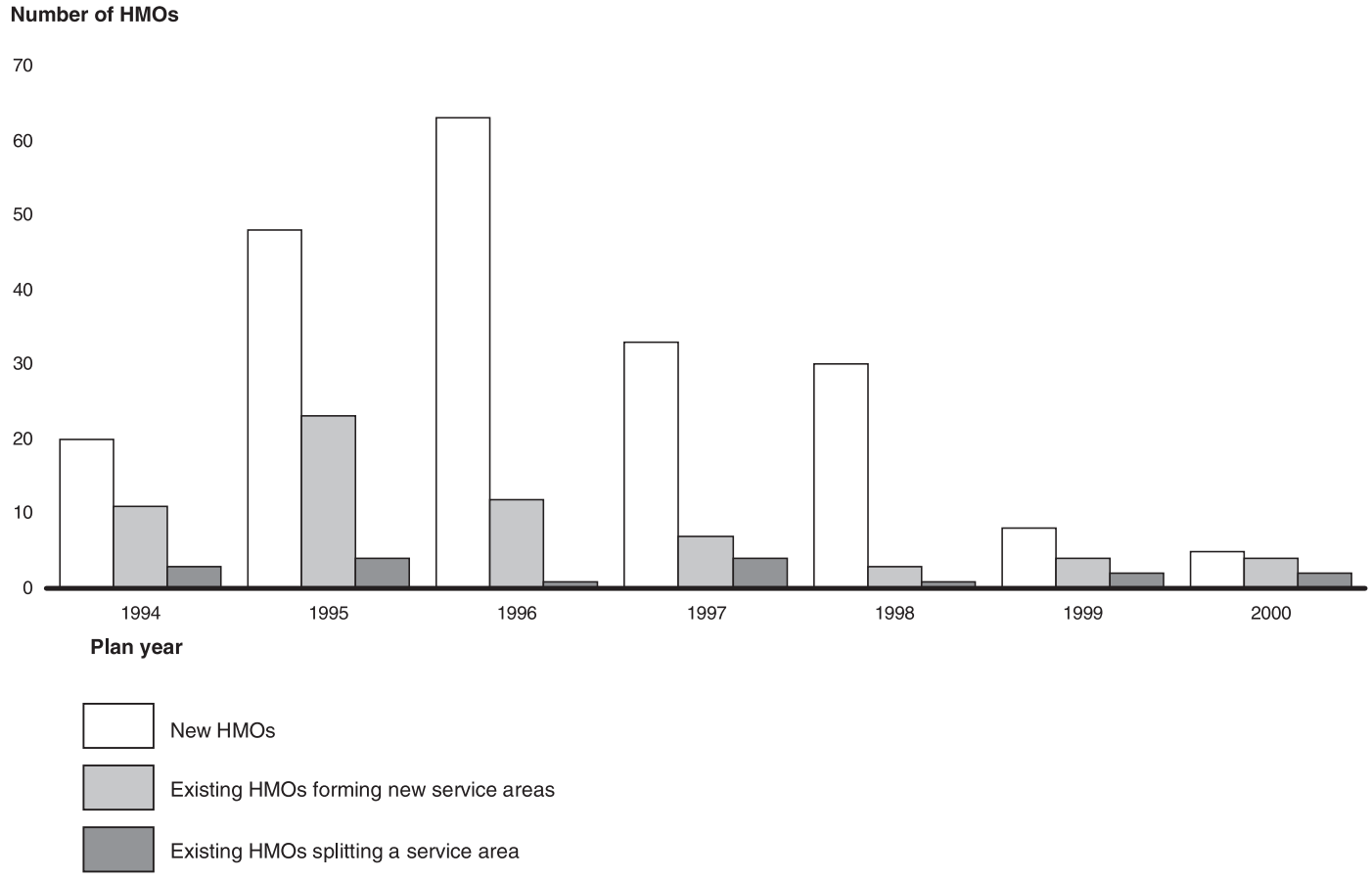
Figure 2: Number of HMOs Participating in FEHBP (1994-2000)



Source: GAO analysis of OPM data.

Additions to the number of HMOs participating in FEHBP resulted from new HMOs deciding to participate and from existing HMOs either splitting a service area or designating an additional service area with a different premium rate structure. As shown in figure 3, the number of new plans entering FEHBP has declined each year since 1996, with substantially fewer, 13, added during the last 2 years.

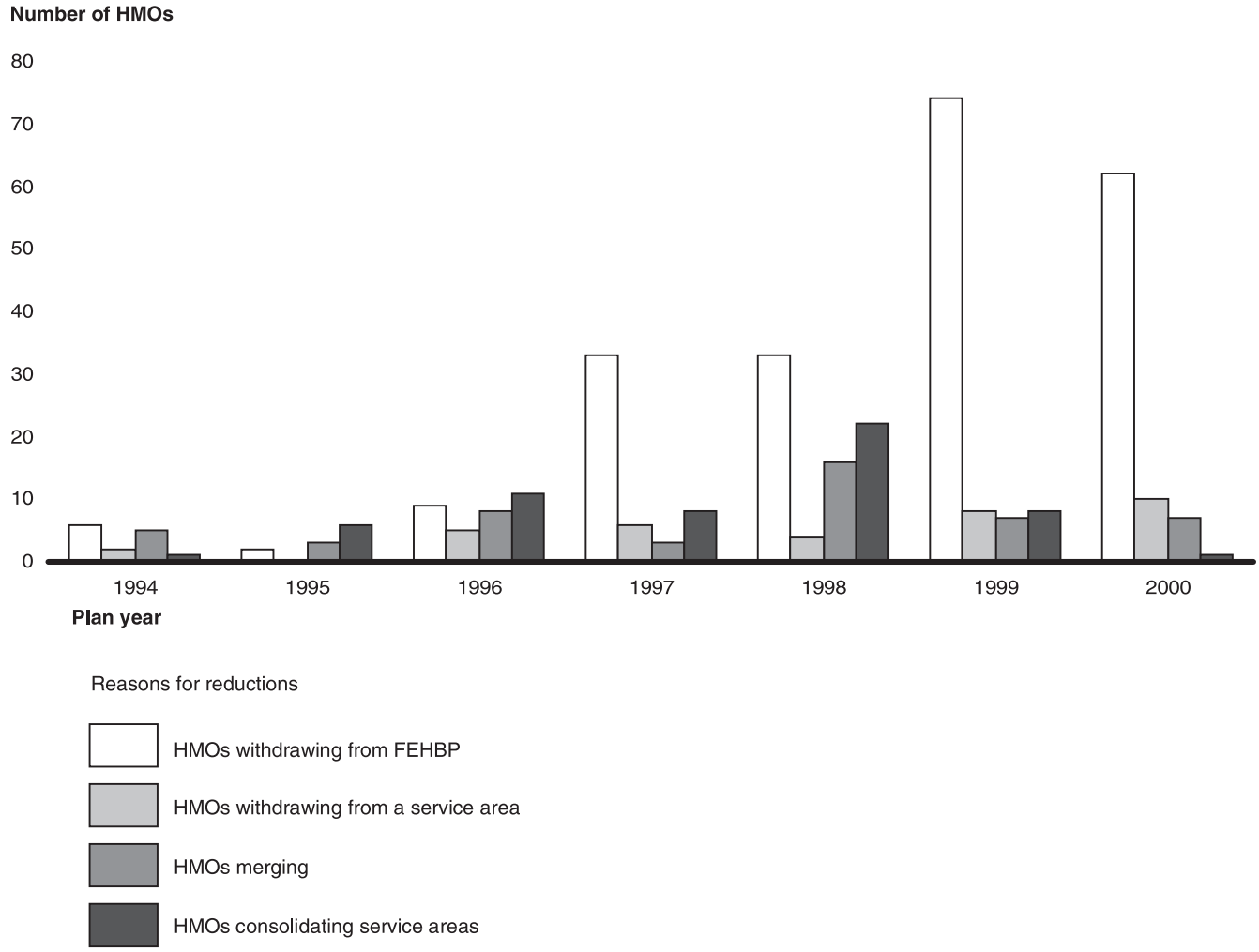
Figure 3: FEHBP Plan Additions (1994-2000)



Source: GAO analysis of OPM data.

Reductions in the number of participating HMOs are shown in figure 4. These reductions resulted from HMO withdrawals from FEHBP, mergers, service area consolidations, and HMOs deciding to terminate a plan in one area while continuing to operate another plan in an adjoining area. In the latter case, each plan—the one leaving and the one staying—had its own premium rate structure.

Figure 4: FEHBP Plan Reductions (1994-2000)



Source: GAO analysis of OPM data.

Most of the HMOs that withdrew from FEHBP communicated their intentions to leave the program at about the same time that their applications for participation in the next contract year were due. Some plans, however, did not notify OPM of their decisions to withdraw from the program until after OPM had published its annual program guide.

While figures 3 and 4 show the number of additions and reductions in the number of HMOs since 1994, several HMOs either expanded or reduced their service area coverage without affecting the total number of HMOs participating in FEHBP. Table 1 shows the numbers of HMOs that either

expanded or reduced their service areas from 1994 to 2000. Enrollees living in affected areas would have either greater or fewer choices among HMOs, depending on whether areas of coverage were expanding or contracting.

Table 1: HMOs Reducing and Expanding Service Areas (1994-2000)

	Service area	
Plan year	Reductions	Expansions
1994	4	35
1995	8	35
1996	4	48
1997	6	67
1998	12	45
1999	34	9
2000	23	11

Source: GAO analysis of OPM information.

Regarding the recent decline in the number of HMOs participating in FEHBP, an official from EBRI told us that factors contributing to the turnover in FEHBP were, in all likelihood, indicative of the managed care market in general. This official indicated that some smaller plans may not be getting a sufficient mix of healthy and less than healthy enrollees, and that the number of HMOs participating in FEHBP is declining because of a natural weeding out of those that cannot compete in the marketplace. OPM, in its survey findings for plans that withdrew in 1999, stated that the HMO industry as a whole had probably expanded beyond a point at which it could sustain itself and an inevitable retrenchment was occurring.

Factors Influencing Plan Withdrawals in Plan Years 1999 and 2000

In 1999, 74 HMOs withdrew from FEHBP; in 2000, 62 withdrew. Our analysis of information that (1) OPM obtained from 40 HMOs that withdrew in 1999 and (2) we and OPM obtained on 36 HMOs that withdrew in 2000 showed that insufficient enrollment, unpredictable utilization/excessive risk, and noncompetitive premiums were the reasons most often cited for HMOs' withdrawal from FEHBP. Table 2 shows our categorizations and the frequency of the reasons HMOs gave for their withdrawal. Some plans provided multiple reasons for leaving the program.

Table 2: Factors Contributing to HMOs' Withdrawal Decisions for Plan Years 1999 and 2000

Reasons for withdrawal (plans could provide multiple reasons)	Plan years 1999	2000
Insufficient enrollment	16	18
Unpredictable utilization/Excessive risk	15	18
Noncompetitive premiums	17	12
HMO mergers	9	8
Administrative requirements	13	7
FEHBP benefit requirements	5	6
Market area saturation	2	2

Note: OPM obtained information on reasons for withdrawal from 40 plans in 1999. For 2000, we obtained withdrawal information from 36 plans, either from information these plans provided to OPM or by contacting plan representatives.

Source: GAO analysis of information provided by HMOs.

OPM and plan officials told us that the above reasons for withdrawal, oftentimes in combination, either had affected or were expected to adversely affect a plan's "loss ratio" and therefore a plan's ability to continue to provide healthcare benefits. Loss ratios are relationships between premiums collected and plan expenses. According to national organizations that study HMO issues, the profitability of HMOs has steadily declined since 1994 to the point that many HMOs were showing losses. According to AAHP officials, HMOs are no longer willing to take chances or to be aggressive in their marketing plans unless plan executives are very confident that their plans will succeed.

Insufficient Enrollments

Eighteen of the 36 HMOs on which we obtained information about their decision to withdraw from FEHBP in 2000 cited insufficient enrollment as a reason. Of the 40 HMOs that responded to OPM's survey of plans withdrawing in 1999, 16 cited insufficient enrollment as a reason for withdrawal. OPM's analysis also indicated that many of the HMOs that had joined FEHBP in recent years were the ones that cited low enrollments as a reason for withdrawal.

According to OPM officials, OPM has the authority to terminate a plan's participation in FEHBP if it has less than 300 enrollees, although this authority has seldom been exercised. Of the 62 HMOs that withdrew in 2000, 26 plans had fewer than 300 enrollees, and 17 of the 26 plans had participated in FEHBP for 3 years or less. Plan representatives told us that plan enrollment is one of the most critical components of a plan's overall profitability.

HIAA and AAHP officials told us that insufficient enrollments are of a particular concern, especially for the typical small plan. They added that for whatever reasons, some of the smaller HMOs in FEHBP apparently

have been unable either to increase their enrollment base or to sustain a meaningful enrollment. When less than expected enrollment increases or declining enrollments fail to keep pace with utilization, these officials said that the only prudent decision for a plan is to withdraw from FEHBP. These officials believed that over the years, FEHBP has suffered from a "small case syndrome" with a large number of smaller plans moving in and out of the program.

Unpredictable Utilization/Excessive Risk

For plan year 2000, 18 of the 36 HMOs providing reasons for withdrawal cited utilization or risk factors as reasons for their withdrawals. Over half (10 of 18) of the HMOs that cited insufficient enrollments as a reason for withdrawing from FEHBP also cited unpredictable utilization/excessive risk as a reason. For 1999, 15 of the 40 plans that withdrew cited unpredictable utilization/excessive risk as a reason for withdrawal.

On the basis of personal characteristics (age, gender, and number of dependents) of a plan's enrollment population, plans expect to incur medical and administrative expenses in amounts that will be covered by premiums collected. If medical expenses are greater than expected, either because medical services are used more frequently than expected, innovative medical techniques come to market, or medical costs increase, plan revenues will be insufficient to cover increased costs associated with unexpected utilization.

AAHP officials provided us with an example of unpredictable utilization involving the premature birth of triplets to an enrollee who belonged to a smaller FEHBP plan. In this example, each baby had required extensive amounts of high-cost intensive care that had not been expected. Therefore, it was difficult to absorb the unanticipated cost of this care within the plan's rate structure. An OPM official told us that on the basis of characteristics of a plan's enrollment population and past experiences, plans are willing to accept only a certain amount of financial risk. If plans are operating on thin profit margins with declining enrollment bases or in geographic areas where they cannot raise premiums because they are competing with other plans, it is likely that they would have to withdraw from the program because of their inability to remain profitable.

AAHP officials told us that plans develop their premium rates on the basis of an expected enrollment base and predicted plan utilization while maintaining compliance with OPM requirements. Each group of enrollees covered by an HMO is expected to be self-supporting in that a covered group that uses less services would not be expected to support other

covered groups that have experienced higher-than-expected utilization rates.

OPM pays HMOs a fixed payment for each federal enrollee and generally bases its payment on the rates the plan charges for enrollees in the two largest nonfederal employer-sponsored groups in that community or service area. OPM refers to this procedure under FEHBP as "community rating."

Noncompetitive Premiums

For HMOs withdrawing from FEHBP in 2000, 12 of the 36 cited noncompetitive premiums as a reason for withdrawal. For HMOs' leaving in 1999, 17 of the 40 plans responding to OPM's survey also mentioned noncompetitive premiums as a reason.

According to an OPM official, for plans to be competitive in the marketplace, they must offer their members benefit packages at premium rates that their members view as a fair value. However, setting rates at levels that will accomplish plan goals and objectives, yet at the same time maintain competitiveness with other plans, including fee-for-service plans, is difficult. Falling short of its enrollment goals or experiencing utilization rates that are greater than predicted would require a plan to raise its premiums to cover anticipated expenses. Such increases could make the plan less attractive to its members if competitors' premiums do not rise or do not rise as much.

On a somewhat unrelated premium rate issue, HIAA officials told us that several of their members had concerns about OPM requiring plans to prepare rates for the next plan year about 4 months before they would normally establish their premium rates for other clients. Some plans set subsequent year rates with their non-OPM clients in the October or November time frame, whereas OPM requires signed benefit and rate proposals by June 1, for a plan year starting in January. According to HIAA officials, in some cases, claims experience information from the previous year may not be available in time to prepare FEHBP rates and OPM's rate submission deadlines might cause some plans to withdraw from FEHBP. However, of the 36 plans from which we obtained information on their withdrawal in 2000, none raised this as an issue. Also, an official in OPM's Office of Inspector General (OIG) told us that it was not unusual for HMOs, when dealing with larger plans, to prepare rate proposals well in advance of a new plan year.

HMO Mergers

Eight of the 36 plans withdrawing in 2000 cited mergers as a reason for leaving FEHBP, 1 less than the 9 plans that cited this reason in 1999. According to industry studies, recent years have seen a large number of mergers among HMO plans; 18 of the largest for-profit HMOs and managed care companies were reduced to 6. HIAA officials told us that as the managed care marketplace matures, even further mergers among HMOs are likely. A study by the University of Minnesota School of Public Health[4] concluded that smaller and younger HMOs were more likely to merge and exit the market or fail. Older, larger, and more profitable HMOs were more likely to merge and survive.

According to HIAA officials, mergers may make it easier for HMOs to penetrate new areas, increase the size of their enrollment group, improve efficiency, and decrease operational and administrative expenses. Conversely, a 1999 magazine article[5] evaluating the effect of national mergers on local market concentration suggests that too many mergers may adversely affect the number of HMOs competing for enrollees.

Plan Administration Requirements

In 2000, about half as many—7 versus 13—HMOs mentioned OPM administrative requirements as a reason for withdrawing from FEHBP as compared to 1999. Although mentioned, OPM requirements were viewed as relatively minor reasons for plans' withdrawing, according to most plan representatives to whom we talked and officials from OPM, HIAA, and AAHP.

OPM's Annual Call Letter to plans that are expected to participate in FEHBP describes both administrative and benefit requirements with which plans would need to comply. Examples of administrative requirements discussed in the call letter for plan year 2000 included such items as patients' bill of rights, patients' access to medical records, the conduct of customer service surveys, the use of electronic communications to send to and receive information from OPM, and responsibility for preparing plan brochures that comply with OPM guidelines.

In addition to meeting FEHBP administrative and benefit requirements, the records of an HMO participating in FEHBP could be audited by OPM's OIG. Neither OPM nor plan representatives cited audit requirements as a specific reason for withdrawal from FEHBP. According to HIAA officials, some of its members did mention that the possibility of an OIG audit might

[4] HMO Mergers: Analysis of Trends and Public Policy Issues, University of Minnesota School of Public Health, May 1996.

[5] "HMO Consolidations: How National Mergers Affect Local Markets," Health Affairs, July/August 1999.

discourage them from merging with a FEHBP plan. Plans believed that if they merged, OPM's OIG might later identify audit findings for which they could be held responsible.

FEHBP Benefit Requirements

Six HMOs cited benefit requirements as a reason for withdrawing from FEHBP in 2000 compared to five HMOs that cited benefit requirements in 1999. Like FEHBP administrative requirements, OPM officials believed that even when mentioned, federal mandates to provide specific benefits were rarely the primary reason for a plan's withdrawal from FEHBP.

OPM requires FEHBP plans to provide benefits such as (1) allowing obstetrician-gynecology physicians to act as primary care providers or allowing their members to have direct access to these physicians for routine gynecological examinations, (2) allowing consumers with complex or serious medical problems to have direct access to a qualified plan specialist for an adequate number of visits, and (3) limiting drug benefit deductibles that customers are required to pay. An OPM official opined that the number of benefits mandated under FEHBP pales in comparison to the number mandated by states.

Market Area Saturation

Two HMOs in plan years 1999 and 2000 mentioned market area saturation as a reason for withdrawing from FEHBP. Market area saturation can relate either to the number of HMOs providing service in a particular area or to the low percentage of individuals in an area who select HMOs versus fee-for-service plans.

According to OPM, saturation rates relate primarily to the number of HMOs in an area. For example, smaller HMOs might have difficulty entering areas, such as Baltimore-Washington, Minnesota-Michigan, or California, in which many HMOs are already doing business. One plan official told us that even a state such as Alabama, in which a large fee-for-service plan has more than 70 percent of the market, could have too much HMO competition.

Enrollment Increases and Decreases for HMOs Leaving FEHBP in 2000

Although HMOs leaving FEHBP often said that they left due to insufficient enrollment, departing plans typically were not losing enrollees. Rather, in most cases, plan enrollments increased, but these increases were small. Even with these increases, 1999 enrollments for the 62 plans that withdrew from FEHBP in 2000 were about 64,000, or less than 2 percent of FEHBP's 4.1 million enrollees. Table 3 shows increases and decreases in plan enrollments for 58 HMOs that terminated their participation in 2000 but which participated in FEHBP in both 1998 and 1999; 4 plans had enrollment data for 1999 only.

Table 3: Changes in Enrollment From 1998 to 1999 for Plans Terminating FEHBP Participation

	Changes in 58 terminating plans' enrollment from 1998 to 1999	
Plan enrollees	**Increases**	**Decreases**
Under 100	26	7
100 to 499	12	3
Over 499	8	2
Total	**46**	**12**

Source: GAO analysis of OPM enrollment information for March 1998 and 1999.

As shown in table 3, in many cases, the enrollment increases were relatively small, most often under 100 new enrollees.

Of the 62 plans that terminated their participation in 2000, 35 had participated in FEHBP from 1996 to 1999. Of these 35 plans, 4 had fewer enrollees in each subsequent year.

According to HIAA and AAHP officials, competing plans vary widely in their ability to retain members. A plan's poor marketing practices, less generous benefits, higher beneficiary out-of-pocket costs, or inferior service could cause enrollment decreases. In addition, disenrollment rates could be higher in areas where competition among plans was strong or where many beneficiaries were unaccustomed to managed care.

Agency Comments and Our Evaluation

In commenting on a draft of this report, OPM said that it was in agreement with the report's findings. OPM said that our report confirmed its observations and conclusions as to why plans left FEHBP in 1999. OPM also noted that, along with the plans, it has processes in place to ensure that enrollees are fully and timely notified when a plan withdraws from FEHBP. OPM's written comments are contained in appendix II.

As we arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 10 days after its date. At that time, we will send copies of this report to Representative Elijah E. Cummings, Ranking Minority Member, Subcommittee on Civil Service, House Government Reform Committee; Representative Dan Burton, Chairman, and Representative Henry Waxman, Ranking Minority Member, House Government Reform Committee; the Honorable Janice R. Lachance, Director, OPM; and the Honorable Jacob J. Lew, Director, OMB. Copies will also be made available to others upon request.

Key contributors to this report are listed in appendix III. If you have any questions, please call me or Larry Endy, Assistant Director, at (202) 512-8676.

Sincerely yours,

Michael Brostek
Associate Director, Federal
Management and Workforce Issues

Contents

Abbreviations

AAHP	American Association of Health Plans
EBRI	Employee Benefit Research Institute
FEHBP	Federal Employees' Health Benefits Program
HIAA	Health Insurance Association of America
HMO	health maintenance organization
OIG	Office of the Inspector General
OPM	Office of Personnel Management

Objectives, Scope, and Methodology

Objectives

The Chairman, Subcommittee on Civil Service, House Committee on Government Reform, asked us, among other things, to provide information on the withdrawal of health maintenance organizations (HMO) from the Federal Employees' Health Benefits Program (FEHBP) in plan years 1999 and 2000. Our primary objectives were to identify

- changes in the number of HMOs participating in FEHBP since 1994,
- reasons why HMOs withdrew from FEHBP in plan years 1999 and 2000, and
- FEHBP enrollment experiences for HMOs that withdrew from the program in 2000.

Scope and Methodology

To identify changes in the number of plans participating in FEHBP since 1994, we reviewed the Office of Personnel Management's (OPM) annual FEHBP open season guides and benefits administration letters. We counted individual plans of an HMO separately when the benefits and premiums applied to enrollees in specifically defined geographical areas. However, we did not count as separate plans, those that offered both a high and standard option. This method differs from OPM's method of counting, which is based on its number of HMO contracts irrespective of whether a contract applies to more than one plan in more than one service area. Our method of counting plans was designed to capture changes in plan availability by service area that would not necessarily be discerned when changes in the number of HMOs participating in FEHBP occur and when these changes do not affect the number of contracts between OPM and participating HMOs.

To identify reasons why HMOs withdrew from FEHBP in plan years 1999 and 2000, we relied primarily on information that OPM had obtained from HMOs. For 1999, we used OPM's analysis of 40 plans' responses to its survey asking them why they had withdrawn from the program. For 2000, we reviewed correspondence that 40 plans sent to OPM advising it of their intentions to withdraw from the program. As necessary, we followed up with plans when their correspondence did not state reasons for their withdrawal. Although 40 HMOs sent letters to OPM, we could only discern, from the letters or our follow-ups, the reasons that 36 HMOs withdrew from FEHBP in 2000. Because of time and resource constraints, we did not attempt to identify the reasons for withdrawal for those plans that notified OPM of their decision to withdraw from the program after August 1999.

To obtain additional insight on why HMOs might be withdrawing from FEHBP, we discussed the reasons for their withdrawal with OPM officials as well as officials from organizations such as the Health Insurance

Association of America (HIAA), the American Association of Health Plans (AAHP), and the Employee Benefit Research Institute (EBRI). HIAA officials describe HIAA as a nonprofit research, education, and lobby association dedicated to preserving the private free-enterprise healthcare system. It has over 260 members that represent companies that finance and deliver healthcare and that provide other health insurance products and services. AAHP officials said that AAHP represents more than 1,000 HMOs, preferred provider organizations, and other network-based healthcare plans. It represents HMOs that cover federal enrollees; provides technical support and legal expertise on state legislative and regulatory issues; and offers education and training programs, research, and publications to its members. EBRI officials describe EBRI as a nonprofit organization that conducts independent public policy research and provides education on economic security and employee benefits.

We also reviewed information obtained from the Internet and other relevant health publications on various HMO issues, such as HMO mergers or expansion trends at the national level, mandated benefit laws, healthcare cost escalation, and HMOs' profitability. We accepted the reasons that plan representatives and others gave us as reasons for withdrawing from FEHBP. We did not visit plans or attempt to identify or obtain other documents to validate their reasons for withdrawing.

To determine FEHBP enrollment experiences for HMOs that withdrew from the program in 2000, we analyzed 1996 to 1999 enrollment head-count information prepared by OPM's Office of the Actuary. OPM reports head counts for all plans participating in FEHBP semiannually in March and September of each year. We used March data because September 1999 data were not available when we did our analysis. Head counts represent the total number of FEHBP enrollees by line of coverage--individual or family. Each enrollee represents a premium payer.

We did our review in Washington, D.C., from August 1999 to March 2000 in accordance with generally accepted government auditing standards.

We requested comments on a draft of this report from the Director of OPM, and these comments are discussed in the letter and reprinted in appendix II.

Comments From the Office of Personnel Management

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

APR 24 2000

Mr. Michael Brostek
Associate Director
Federal Management
and Workforce Issues
General Accounting Office
Washington, D.C. 20548

Dear Mr. Brostek:

Thank you for the opportunity to review your draft report, FEDERAL EMPLOYEES HEALTH PROGRAM: Reasons Health Maintenance Organizations Withdrew in 1999 and 2000.

Based upon the number of termination notices we received from health plans in 1998, we conducted our own review of why plans were exiting the Federal Employees Health Benefits Program for 1999. Our observations and conclusions are seconded by health plan trade groups and research organizations in this GAO report.

We are acutely aware of the disruption to our enrollees when a health plan ceases to participate. We and our plans have processes in place to ensure that our enrollees are fully and timely notified when a plan leaves, and the protections afforded by the Patients' Bill of Rights and Responsibilities, specifically the transitional care benefit, are most helpful in lessening the burden of choosing a new plan.

We are in agreement with the theme and conclusion of the report. The effort behind this was an excellent example of joint collaboration between OPM and GAO staff.

Sincerely,

Janice R. Lachance
Director

CON 131-64-4
September 1993

GAO Contacts and Staff Acknowledgments

GAO Contacts

Michael Brostek or Larry H. Endy (202) 512-8676

Acknowledgments

In addition to the individuals named above, Edward R. Tasca and Michael G. Valle made key contributions to this report.

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