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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Premiums Continue to Rise, but Rate of Growth Has Recently Slowed

Statement of John E. Dicken
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May 18, 2007

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Highlights

Highlights of GAO-07-873T, a testimony before the 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 discuss its December 22, 2006 report, entitled *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies Among Participating Plans* (GAO-07-141). In this report, GAO reviewed (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 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.

www.gao.gov/cgi-bin/getrpt?GAO-07-873T.

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

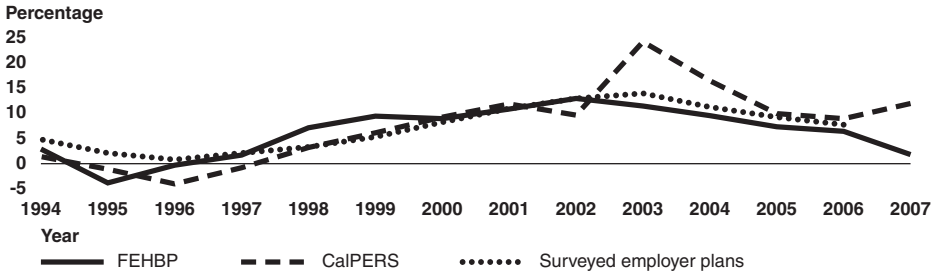
What GAO Found

Growth in FEHBP premiums recently slowed, from a peak of 12.9 percent for 2002 to 1.8 percent for 2007. Starting in 2003, FEHBP premium growth was generally slower than for other purchasers. 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.

Projected increases in the cost and utilization of health care services and in the cost of prescription drugs accounted for most of the average annual FEHBP premium growth for 2000 through 2007. Absent other factors, these increases would have raised 2007 average premiums by 9 percent. Other projected factors, including benefit changes resulting in less generous coverage and enrollee migration to lower-cost plans, slightly offset average premium growth. In 2006 and 2007, projected withdrawals from reserves helped offset average premium growth—by 2 percentage points for 2006 and 5 percentage points for 2007.

To explain the factors associated with premium growth, officials GAO interviewed from most of the FEHBP 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. Officials GAO interviewed from most plans with lower-than-average premium growth cited adjustments made for previously overestimated projections of cost growth, and some officials cited benefit changes that resulted in less generous coverage for prescription drugs. The plans with lower-than-average premium growth also experienced a decline of 0.5 years in the average age of their enrollees compared with an increase of 0.5 years in the average age of all FEHBP enrollees.

Growth in Average Premiums for FEHBP and Other Purchasers



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

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 testimony.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the findings from our December 2006 report entitled *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies among Participating Plans*.[1] For this report, we were asked to examine the nature and extent of premium increases in the Federal Employees Health Benefits Program (FEHBP) and 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.[2] Federal employees' health insurance premiums have increased each year since the late 1990s, and these increases pose higher costs for the federal government and plan enrollees.[3] About 8 million federal employees, retirees, and their dependents receive health coverage through plans participating in the 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.[4]

My remarks today will focus on (1) recent FEHBP premium growth trends compared to 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. These remarks are based on information contained in our December 2006 report.

In conducting our work, we analyzed historic and recent premium trend data from 1994 through 2007 from OPM for all FEHBP plans and compared

[1]GAO-07-141 (Washington, D.C.: Dec. 22, 2006).

[2]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.

[3]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).

[4]Pursuant to 5 U.S.C. § 8909.

them with premium data from the California Public Employees' Retirement System (CalPERS)—the second largest public purchaser of employee health benefits—and surveys of multiple employer-sponsored health plans from Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET).[5] 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.[6] We also examined aggregate data on the actual growth in per-enrollee expenditures from 2003 through 2005 for 5 large FEHBP plans.[7] We explored with officials from OPM and 14 selected FEHBP plans the potential effect on premium growth of the retiree drug subsidy if OPM had applied for the subsidy and used it to mitigate premium growth. The 14 plans were selected because of size (at least 5,000 enrollees) and length of participation in the FEHBP (at least 3 years). To examine the reasons for differing premium growth trends among FEHBP plans, we conducted interviews with officials from these 14 plans. Eight of the plans had higher-than-average premium growth, and six of the plans had lower-than-average premium growth for either (a) 2006 or (b) the 3-year period from 2004 through 2006. A detailed explanation of our scope and methodology is contained in appendix I of the December 2006 report. We conducted our work for that report from January 2006 through December 2006 in accordance with generally accepted government auditing standards.

In summary, we found that growth in average FEHBP premiums recently slowed from a peak of 12.9 percent for 2002 to 1.8 percent for 2007. This

[5]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. 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 our December 2006 report did not include growth rates for 2007.

[6]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.

[7]OPM was not able to provide these data for all FEHBP plans for 2005. These 5 plans accounted for about 90 percent of fee-for-service enrollment and about 67 percent of total FEHBP enrollment.

was lower than growth for other purchasers from 2003 through 2007. Premium growth rates for the 10 largest FEHBP plans by enrollment, accounting for about three-quarters of total enrollment, ranged from 0 to 15.5 percent for 2007, but varied more widely across the smaller FEHBP plans.

Projected increases in the cost and utilization of health care services and in the cost of prescription drugs accounted for most of the average annual premium growth across all FEHBP plans for 2000 through 2007. Absent projected decreases in the costs of other factors, these increases would have raised 2007 average premiums by about 9 percent, rather than the 1.8 percent actual increase for that year. During this same period, projected decreases in the costs associated with certain other factors, including benefit changes that resulted in less generous coverage and enrollee migration to lower-cost plans, generally helped offset premium growth to a small extent. In 2006 and 2007, projected withdrawals from reserves particularly helped offset average premium growth by about 2 percentage points for 2006 and about 5 percentage points for 2007. Regarding the potential effect of the retiree drug subsidy, most plan officials we interviewed stated that the subsidy would have had a small effect on premium growth for 2006 had OPM applied for the subsidy and used it to mitigate premium growth. Officials from two large plans with higher-than-average shares of retirees, however, stated that the subsidy would have lowered their plans' premium growth—officials from one plan said by at least 3.5 to 4 percentage points for their plan. We estimated that the subsidy would have lowered premium growth across all FEHBP plans for 2006 by more than 2 percentage points on average, from the 6.4 percent average growth rate for 2006 to about 4 percent. OPM officials said that OPM did not apply for the subsidy 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.

To explain the factors associated with premium growth, 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. Officials we interviewed from most plans with lower-than-average premium growth cited adjustments made for previously overestimated projections of cost growth, and some officials cited benefit changes that resulted in less generous coverage for prescription drugs. The plans with lower-than-average premium growth also experienced a decline of 0.5 years in the average age of their enrollees compared with an increase of 0.5 years in the average age of all FEHBP enrollees.

Background

The 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 employees 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. 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.[8] 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.

By statute, OPM can negotiate contracts with health plans without regard to competitive bidding requirements.[9] Plans meeting the minimum requirements specified in the statute and regulations may participate in the

[8]The Balanced Budget Act of 1997 established the government's current share of the premiums beginning in the 1999 contract year. 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.

[9]5 U.S.C. §8902.

program, and plan contracts may be renewed automatically each year. OPM may terminate contracts if the minimum standards are not met.[10]

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.[11] 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.

On January 1, 2006, Medicare began offering prescription drug coverage (also known as Part D) to Medicare-eligible beneficiaries.[12] 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.[13] 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 to average about $670 per beneficiary per year. OPM opted not to apply for the retiree drug subsidy.

[10]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.

[11]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.

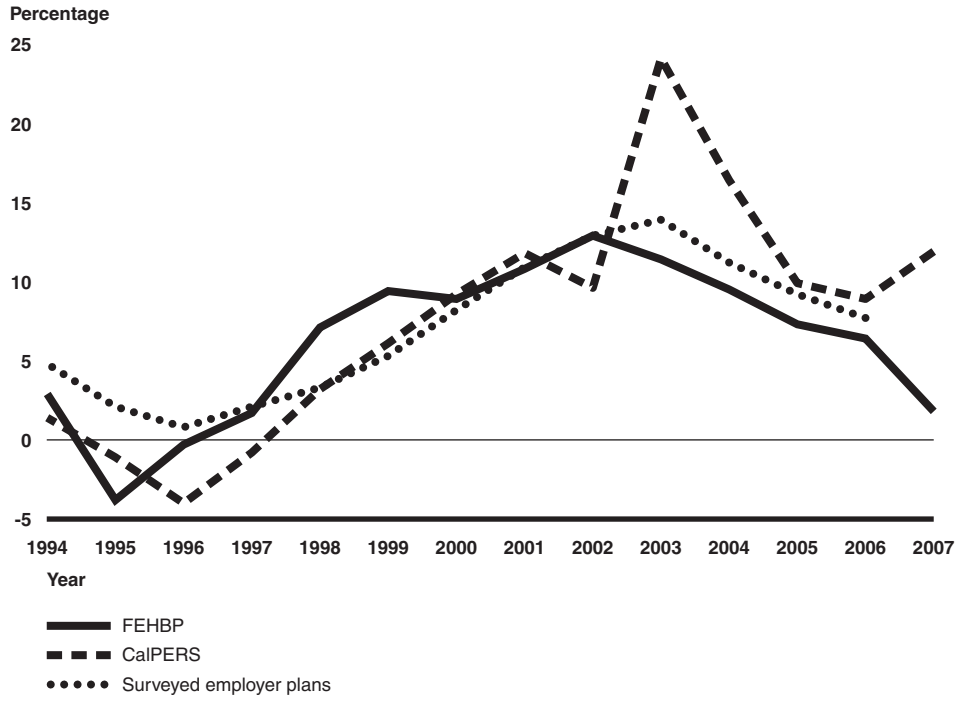
[12]For more information on Medicare Part D, see GAO, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits under the Medicare Modernization Act*, GAO-05-205 (Washington, D.C.: Feb. 14, 2005).

[13]In general, according to the Centers for Medicare & Medicaid Services, actuarial equivalence measures whether the expected amount of paid claims under the employers' 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).

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

The average annual growth in FEHBP premiums has slowed since 2002—declining each year from 2003 through 2007—and was generally lower than the growth for other purchasers since 2003. After a period of decreases in 1995 and 1996, FEHBP premiums began to increase for 1997, to a peak increase of 12.9 percent for 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. (See fig. 1).

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 testimony.

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 for 2007. Premium growth rates across the smaller FEHBP plans varied more widely.

Regarding enrollee premiums—the share of total premiums paid by enrollees—the growth in average enrollee premiums generally paralleled total premium growth from 1994 through 2007. In 2006, average monthly FEHBP premiums were $415 for individual plans and $942 for family plans in total. The enrollee premium contributions were $123 for individual plans and $278 for family plans.

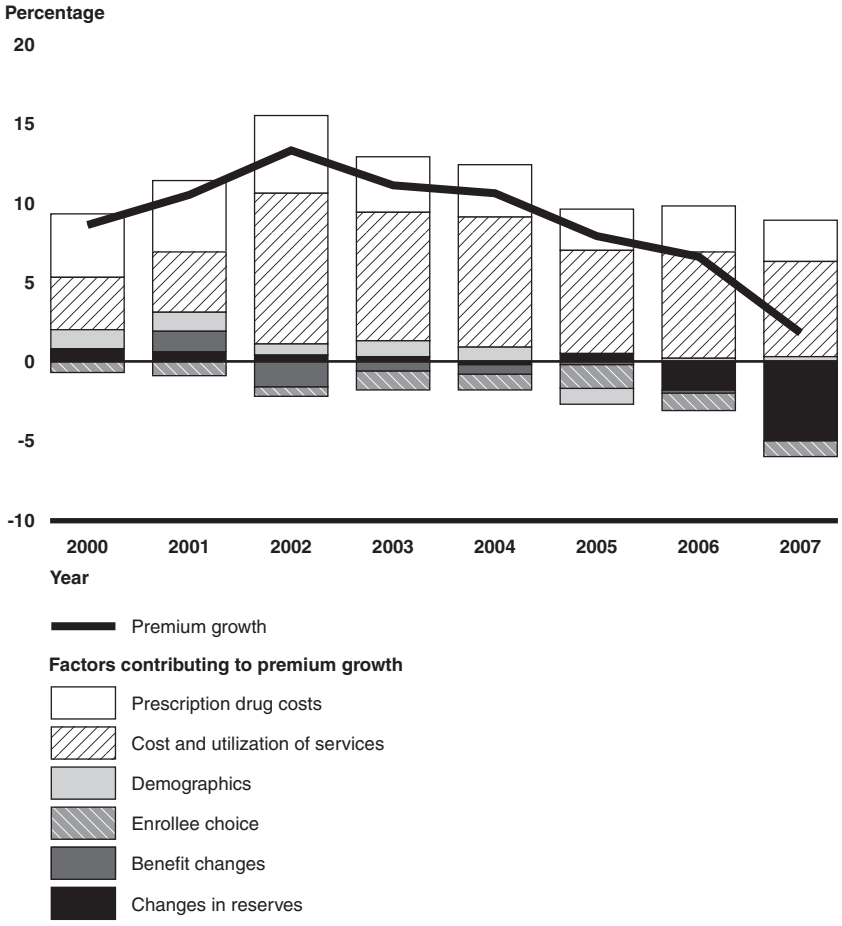
Projected Growth in Several Factors Contributed to Average FEHBP Premium Growth

Projected increases in the cost and utilization of services and in the cost of prescription drugs accounted for most of the average annual premium growth across FEHBP plans for the period from 2000 through 2007, although projected withdrawals from reserves offset much of this growth for 2006 and 2007. Absent projected changes associated with other factors, projected increases in the cost and utilization of services and the cost of prescription drugs would have accounted for a 9 percent increase in average premiums for 2007. Projected increases in the cost of and utilization of services alone would have accounted for about a 6 percent increase 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 certain 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 growth for 2000 through 2007 to a small extent.

Projected withdrawals from reserves offset average premium growth for 2006 and 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 contributed to average premium growth—by less than 1 percentage point—for 2000 through 2005. However, projected withdrawals from reserves offset average premium growth by about 2 percentage points for 2006 and 5 percentage points for 2007.[14] (See fig. 2.)

[14]OPM officials 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. According to OPM officials, 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.

Figure 2: Projected Changes in Various Factors Affecting FEHBP Premium Growth, 2000 through 2007



Source: OPM.

We also reviewed detailed data available for five large FEHBP plans on claims actually incurred from 2003 through 2005. These data showed that most of the increase in total expenditures per enrollee was explained by expenditures on prescription drugs (34 percent) and on hospital outpatient services (26 percent).

Officials we interviewed from several FEHBP plans stated 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. 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.[15] The reduction in premium growth would have been a onetime reduction for 2006.[16] 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.

OPM officials explained that there was no need to apply for the subsidy 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. 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.

[15]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. Officials from CalPERS stated that the subsidy, which they had received but had not decided how to use as of August 2006, amounted to 13 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.

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

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 FEHBP plans with higher-than-average premium growth in 2006 cited increases in the actual cost and utilization of services and high shares of elderly enrollees and early retirees as key 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 five large FEHBP plans that represented about two-thirds of total FEHBP enrollment. From 2001 through 2005, the average age of enrollees across all eight plans with higher-than-average premium growth increased by 2.7 years—compared with an average increase of 0.5 years across all FEHBP plans.

Officials we interviewed from most of the FEHBP plans with lower-than-average premium growth in 2006 cited adjustments for previously overestimated projections of cost growth and benefit changes that resulted in less generous coverage for prescription drugs as factors that limited premium growth. Our analysis of financial data provided by two 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. Also, from 2001 through 2005, the average age of enrollees across all six of these plans decreased by 0.5 years—compared with an average increase of 0.5 years across all FEHBP plans.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members of the subcommittee may have.

Contacts and Acknowledgements

For future contacts regarding this testimony, please contact John E. Dicken 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 testimony. Randy Dirosa, Assistant Director; Iola D'Souza; and Timothy Walker made key contributions to this testimony.

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