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# FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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

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Highlights

Highlights of GAO-06-271, a report to congressional requesters

## Why GAO Did This Study

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

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

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

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

## What GAO Found

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

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

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

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