United States Government Accountability Office

GAO

Report to the Ranking Minority Member, Committee on Finance, U.S. Senate

November 2005

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Early Experience with a Consumer-Directed Health Plan



GAO-06-143

November 2005

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Early Experience with a Consumer-Directed Health Plan

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-06-143, a report to the Ranking Minority Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

Since 2003, the Federal Employees Health Benefits Program (FEHBP) has offered "consumer-directed" health plans (CDHP) to federal employees. A CDHP is a high-deductible health plan coupled with a savings account enrollees use to pay for health care. Unused balances may accumulate for future use, providing enrollees the incentive to purchase health care prudently. However, some have expressed concern that CDHPs may attract younger and healthier enrollees, leaving older, less healthy enrollees to drive up costs in traditional plans. They also question whether enrollees are satisfied with the plans, and have sufficient access to health care providers and discounts on health care services.

GAO was asked to study the first FEHBP CDHP, offered by the American Postal Workers Union (APWU). GAO compared the number, characteristics, and satisfaction of APWU enrollees to those of FEHBP enrollees in other recently introduced (new) non-CDHP plans, and national preferred provider organization (PPO) plans. GAO also compared the APWU CDHP provider networks and discounts to those of other FEHBP plans.

www.gao.gov/cgi-bin/getrpt?GAO-06-143.

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 dickenj@gao.gov.

What GAO Found

The APWU CDHP is a small but growing FEHBP health plan whose enrollees were younger than PPO plan enrollees, and healthier and better educated than other new plan and PPO enrollees. The average age of APWU CDHP and other new plan enrollees was the same (47 years), but younger than that of PPO plan enrollees (62 years), largely because fewer retirees and elderly people selected the new plans. Excluding retirees and the elderly, the average age of enrollees was more similar across the plans. A larger share of nonelderly enrollees in the APWU CDHP reported being in "excellent" or "very good" health status compared to the other new plan and PPO plan enrollees—73 percent versus 64 and 58 percent, respectively. Similarly, a larger share of nonelderly enrollees in the APWU CDHP reported having a 4-year or higher college degree compared to enrollees in the other new plans and PPO plans—49 percent versus 42 and 36 percent, respectively.

Enrollee satisfaction with the APWU CDHP was mixed compared to enrollee satisfaction with the other FEHBP plans. For overall plan performance, APWU enrollees were more satisfied than other new plan enrollees, but less satisfied than PPO plan enrollees. For four of five specific quality measures—access to health care, timeliness of health care, provider communication, and claims processing—APWU enrollees were as satisfied as other enrollees. On the fifth measure, customer service, APWU enrollees were more satisfied than other new plan enrollees, but less satisfied than PPO plan enrollees. In particular, a lower share of APWU enrollees were satisfied with their ability to find or understand written or online plan information, the help provided by customer service, and the amount of paperwork required by the plan.

The APWU CDHP provider networks and discounts were comparable to other FEHBP PPO plans. In 21 states, the APWU CDHP used the same networks used by other national PPO plans. In the remaining states, the APWU CDHP networks were among the most commonly used networks nationwide, or were large, nationally accredited, or comparable in size to networks used by other FEHBP plans. Across all states the average hospital inpatient and physician discounts obtained by the APWU CDHP were within 2 percentage points of the discounts obtained by another large national FEHBP PPO plan.

GAO received comments on a draft of this report from the Office of Personnel Management (OPM) and APWU. Both generally concurred with our findings. Regarding the potential for CDHPs to disproportionately attract healthier enrollees, OPM said it would continue to monitor the enrollment trends and take appropriate action to eliminate or minimize any adverse effects.

Contents

Letter 1

Results in Brief 4
Background 6
APWU CDHP Enrollees Were Generally Younger, Healthier, Better Educated, and More Likely to Select an Individual Plan Than Other FEHBP Enrollees 10
APWU CDHP Enrollee Satisfaction Was Mixed Compared to Other FEHBP Plan Enrollees 14
APWU CDHP Enrollee Access to Provider Networks and Discounts Was Generally Comparable to Other FEHBP Plans 19
Agency Comments and Comments from APWU 20

Appendix I **Comments from the Office of Personnel Management** 22

Tables

Table 1: Average FEHBP Enrollee Age 13
Table 2: Self-Reported Health Status and Education of FEHBP Enrollees 13
Table 3: Characteristics of APWU CDHP Provider Networks 19

Figures

Figure 1: Age of APWU CDHP and Other FEHBP Enrollees 12
Figure 2: FEHBP Enrollee Satisfaction with Overall Plan Performance 15
Figure 3: FEHBP Enrollee Satisfaction with Five Specific Performance Measures 16
Figure 4: FEHBP Enrollee Satisfaction with Components of Customer Service Quality 17

Abbreviations

APWU	American Postal Workers Union
CDHP	consumer-directed health plan
FEHBP	Federal Employees Health Benefits Program
HMO	health maintenance organization
HRA	health reimbursement arrangement
HSA	health savings account
NCQA	National Committee for Quality Assurance
OPM	Office of Personnel Management
PPO	preferred provider organization

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 21, 2005

The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Baucus:

The federal government provides health insurance coverage for over 8 million federal employees, retirees, and their family members through health plans participating in the Federal Employees Health Benefits Program (FEHBP), the largest employer-based health insurance program in the country. Similar to many large employers, the FEHBP has recently begun offering "consumer-directed" health plans (CDHPs). A CDHP is a high-deductible health plan coupled with a savings or reimbursement account that enrollees use to pay for a portion of their health care expenses.[1] The high deductibles typically result in lower premiums than for a traditional plan with similar benefits, because the enrollee bears a greater share of the initial costs of care. CDHPs may also provide enrollees decision-support tools to help them become more actively involved in making health care purchase decisions—such as information about the cost of health care services and the quality of health care providers, and online access to the savings account to enable them to track their expenses and progress toward meeting their deductibles.

Views are mixed about the potential benefits and risks associated with CDHPs. Proponents believe the plans can help restrain health care spending. Enrollees have an incentive to seek lower-cost health care services, and only obtain services when necessary because unspent account funds can accrue from year to year within defined limits. They also suggest that the lower premiums make the health plans more

[1]Most health plans require enrollees to pay a portion of their health care costs up to a certain threshold, known as the deductible. Once the deductible has been met, the plan pays most of the costs. CDHP deductibles are about $1,900 on average for an individual plan, compared to about $320 on average for a traditional plan. Henry J. Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2005 Summary of Findings* (Menlo Park, Calif.: 2005), http://www.kff.org/insurance/7315/ (October 2005).

affordable. Others, however, express concern that CDHPs may disproportionately attract younger, healthier, or wealthier enrollees who are less likely to use health care or who can better afford to pay the higher deductibles. If this occurred to a large extent, premiums for traditional plans could rise due to a disproportionate share of older and less-healthy enrollees with higher health care expenses remaining in the traditional plans. Because CDHPs are a relatively new concept in health plan design, there is also interest in determining whether enrollees are satisfied with the quality of services provided and whether the plans provide enrollees with the same access to health care providers and negotiated discounts on provider charges as do traditional plans.

In light of the recent introduction of CDHPs as a health coverage option, you asked us to evaluate the early experience of the first CDHP offered under the FEHBP by the American Postal Workers Union (APWU) in 2003. We examined: (1) the number and characteristics of enrollees in the APWU CDHP compared to other FEHBP plans, (2) enrollee satisfaction with the APWU CDHP compared to other FEHBP plans, and (3) provider networks and discounts under the APWU CDHP compared to other FEHBP plans.

To identify characteristics of APWU CDHP enrollees, we analyzed data provided by APWU CDHP and the Office of Personnel Management (OPM), the federal agency responsible for administering the FEHBP.[2] To determine age, gender, and family status, we analyzed enrollment data for the plan years 2003 through 2005. To determine health status and education, we analyzed enrollee survey data that were available for plan years 2003 and 2004.[3] To determine how the identified characteristics of enrollees in the APWU CDHP compared to enrollees in other FEHBP plans, we compared the characteristics to those of two groups of

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

[3]FEHBP plans are required to conduct annual enrollee surveys to assess consumer satisfaction with the plans (new plans and those with fewer than 500 enrollees are exempt from this requirement). The surveys also collect information about enrollee demographics, such as age, gender, health status, and education. The National Committee for Quality Assurance (NCQA) uses the survey data in its accreditation of health plans, and requires health plans to follow established guidelines for collecting and submitting the data. These guidelines, including the specification of a randomly drawn sample, and minimum sample size, help ensure that respondents are representative of the overall plan enrollment.

enrollees. First, we compared the characteristics to those of enrollees in all national PPO plans combined.[4] These 19 plans include approximately 75 percent of all federal employees covered through the FEHBP. Second, because characteristics of APWU CDHP enrollees may differ from the typical FEHBP enrollee primarily because the plan was recently introduced, we compared the APWU CDHP enrollee characteristics to those of two FEHBP plans that had similarly been introduced within the past 5 years.[5] To control for the effects of a disproportionately small share of retirees and the elderly in the APWU CDHP plan, we excluded from the analysis retirees and those aged 65 or older, or both, when comparing other enrollee demographic characteristics between the plans.

To assess enrollee satisfaction, we reviewed enrollee survey data obtained from APWU and OPM for the APWU CDHP and the other FEHBP plans for the plan years 2003 and 2004. These surveys use a standardized instrument to measure enrollee satisfaction along several plan quality measures, such as access to health care, claims processing, customer service, and overall plan performance. We also examined the volume and nature of appeals regarding claim disputes filed with OPM by APWU CDHP enrollees and other plan enrollees for plan years 2003 and 2004.[6]

To determine how the APWU CDHP provider networks compare to those used by other FEHBP plans, we examined aspects of the APWU CDHP networks used in each state and the District of Columbia (hereafter referred to as a state), and compared them to the networks used by other national FEHBP plans. We identified the states in which the networks were the same, and for the remaining states, identified other characteristics of the networks used, such as their size and accreditation

[4]FEHBP offers national plans to all enrollees who may work anywhere in the country, while local plans are offered only in certain local markets. National plans are generally preferred provider organization plans (PPO) that allow enrollees to choose their own health care providers, and reimburse either the provider or the enrollee for the cost of covered services. Enrollees generally pay a lower share of the cost if they obtain care from the plan's network of preferred providers. Local plans are typically health maintenance organization (HMO) plans that provide or arrange for comprehensive health care services on a prepaid basis, and require that all care be coordinated through a primary care physician. The APWU CDHP is a national PPO plan, offered to all FEHBP enrollees.

[5]The two plans were a national PPO plan and a regional HMO plan.

[6]OPM independently reviews disputes filed by enrollees against FEHBP plans regarding denied claims that cannot be resolved by the plan to the enrollees' satisfaction.

status.[7] We also compared the average hospital and physician discounts in each state between the APWU CDHP and another large, national PPO plan.[8] We had several discussions with APWU CDHP, its plan administrator, Definity Health Plan, and OPM to clarify our understanding of the data and materials.

We did not independently verify the data provided by APWU CDHP and OPM; however, we performed certain quality checks, such as determining consistency where similar data were provided by both sources. We also evaluated information from APWU CDHP and OPM concerning how the data are collected, stored, and maintained, and determined that the data were adequate for this report. We conducted our work according to generally accepted government auditing procedures from November 2004 to November 2005.

Results in Brief

The APWU CDHP is a small but fast-growing FEHBP health plan whose enrollees were on average younger than national PPO plan enrollees, and healthier, better educated, and more likely to select individual rather than family plans than enrollees in other new plans and the national PPO plans. Enrollment in the APWU CDHP more than doubled, from 4,500 at its introduction in 2003, to over 9,500 in 2005. Including dependents, total covered lives increased from an estimated 10,000 to 21,000 during the same period. Over half of these enrollees migrated from existing national PPO plans, and about a quarter from existing HMO plans participating in the FEHBP. The average age of APWU CDHP enrollees was the same as enrollees in other new plans—47 years—but younger than national PPO plan enrollees by about 15 years. This age difference was largely due to a smaller share of retirees and elderly people enrolled in the APWU CDHP and other new plans—less than 20 percent—compared to the national PPO plans—over 50 percent. Excluding retirees and the elderly, the average age of enrollees was more similar across the APWU CDHP, the other new plans, and the national PPO plans—45, 43, and 47,

[7]Accreditation is the approval of a health plan by a nationally recognized, independent organization, such as the NCQA. The organization reviews the health plan provider networks, policies, and procedures to determine that they meet minimum quality standards.

[8]Provider discount information, which is proprietary, was not available from OPM. We obtained such discount information directly from one large FEHBP PPO for comparison purposes. This plan is offered in all states, covers over 100,000 members, and has been operating for decades.

respectively—although other notable differences in enrollee characteristics existed. A larger share of nonelderly enrollees reported being in "excellent" or "very good" health status in the APWU CDHP compared to enrollees in the other new plans and the national PPO plans—73 percent versus 64 and 58 percent, respectively. Similarly, a larger share of nonelderly enrollees in the APWU CDHP reported having a 4-year or higher college degree compared to enrollees in other new plans and the national PPO plans—49 percent versus 42 and 36 percent, respectively. Finally, excluding retirees and the elderly, fewer APWU CDHP enrollees selected family plans as compared to enrollees in other new plans and the national PPO plans—55 percent, versus 66 and 65 percent, respectively.

Enrollee satisfaction with the APWU CDHP was mixed compared to enrollee satisfaction with other FEHBP plans. For the measure of overall plan performance, APWU CDHP enrollees were more satisfied than other new plan enrollees, but less satisfied than national PPO plan enrollees. For four of five specific plan performance measures—access to health care, timeliness of health care, provider communication, and claims processing—APWU CDHP enrollees were generally as satisfied as other enrollees. With regard to the fifth measure—customer service—APWU CDHP enrollees were more satisfied than other new plan enrollees, but less satisfied than national PPO plan enrollees. Relating to customer service, a smaller proportion of APWU CDHP enrollees reported being satisfied with their ability to find or understand written or online plan information, with the help provided by customer service, and with the amount of paperwork required by the plan, compared to national PPO plan enrollees. Further evidence of enrollee difficulty finding or understanding plan information was revealed by the appeals filed with OPM against the APWU CDHP in 2003 and 2004. Over half of the appeals related to enrollees' understanding of the plan features, such as their ability to track their account expenditures or their progress toward meeting their deductibles, in contrast to appeals filed against other FEHBP plans, which tended to be distributed among a wider variety of issues. OPM officials said a higher rate of enrollee dissatisfaction and confusion are traits typically observed among new plans, reflecting transitional issues as enrollees learn the features of new plans.

APWU CDHP enrollees generally had access to comparable provider networks and discounts as enrollees in large national PPO plans participating in the FEHBP. In 21 states, the APWU CDHP used the same provider networks as used by other national PPO plans. In 13 of the remaining states, the APWU CDHP used networks that were listed among

the 25 most commonly used PPO networks nationwide. In 8 states, the APWU CDHP used large networks that had been in existence for over 10 years. In the remaining 9 states, the APWU CDHP used networks that were either nationally accredited, or were comparable in size to networks used by other FEHBP plans based on counts of hospitals or physicians included in the network. Across all states, the average hospital inpatient and physician discounts differed by no more than 2 percentage points between the APWU CDHP and one other national PPO plan.

In commenting on a draft of this report, both OPM and APWU generally concurred with its findings. Regarding the potential for CDHPs to disproportionately attract healthier enrollees, OPM said it would continue to monitor enrollment trends in the FEHBP and take appropriate action to eliminate or minimize any adverse effects. OPM and APWU also provided technical comments, which we incorporated as appropriate.

Background

Federal employees have a choice of multiple health plans offered by private health insurance carriers participating in the FEHBP. Mirroring private sector trends, several participating carriers have begun to offer CDHPs. In 2003, the APWU plan became the first CDHP offered to federal employees.

FEHBP

OPM administers the FEHBP by contracting with private health insurance carriers to provide health benefits to over 8 million federal employees, retirees, and their dependents. Federal employees enrolled in the FEHBP can select from a number of private insurance plans. In 2005, 19 national plans and more than 200 local plans were offered through the FEHBP.[9] Plans vary in terms of benefit design and premiums. In 2004, nearly 75 percent of those covered under the FEHBP were enrolled in national PPOs; the remainder were in regional or local HMOs.

The CDHP Concept

CDHPs are a relatively new health care plan design. While many variants exist on CDHP models, such plans generally include three basic precepts:

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

- **An insurance plan with a high deductible**. Deductibles are about $1,900 on average for an individual plan and about $3,900 for a family plan, compared to about $320 and $680, respectively, on average for a traditional PPO plan.[10]

- **A savings account to pay for services under the deductible**. The savings account may encompass different models, the two most prominent being health reimbursement arrangements (HRAs) and health savings accounts (HSAs).[11] Important distinctions exist between HRAs and HSAs. HRAs are funded solely by the employer, are generally not portable once the employee leaves, and may accumulate up to a specified maximum.[12] In contrast, HSAs may include contributions from both the employer and the employee, are portable, and may accumulate without limit.

  Unused savings account balances from prior years may roll over and accumulate, along with the annual contributions from year to year. If the savings account is exhausted, the enrollee pays out of pocket for services until the deductible is met, after which point, the plan pays for services much like a traditional health plan. To avoid the likelihood of enrollees curtailing preventive care services—such as cancer screening tests or immunizations—to preserve their account balances, most of the cost of these services is typically paid for by the plan, regardless of whether or not the enrollee has met the deductible.

- **Decision-support tools**. CDHPs may provide enrollees information to help them become actively engaged in making health care purchase decisions, such as the typical fees charged for specific health procedures at participating hospitals, and quality measures for participating health

[10]Henry J. Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2005 Summary of Findings.*

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

[12]The average annual employer contribution to an HRA in 2005 was about $800 for an individual plan and $1,550 for a family plan, while the average annual employer contribution to an HSA in 2005 was about $550 for an individual plan and $1,200 for a family plan. Henry J. Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2005 Summary of Findings.*

care providers. In addition, plans may provide enrollees online access to their savings account to help them manage their spending.

Proponents of CDHPs assert that the savings account and higher deductibles encourage consumers to become more price conscious, and use only necessary health care services to maintain and accumulate balances in their savings accounts. The availability of information on provider fees and quality is also expected to enable consumers to select providers on the basis of price and quality. In addition, the higher deductibles typically result in lower premiums than for a PPO plan with similar benefits, because the enrollee bears a greater share of the initial costs of care.

Opponents, however, question the underlying premise of CDHPs—that health care spending is discretionary and will be constrained to any significant extent by the financial incentives offered through a health savings or reimbursement account. They cite, for example, research that indicates that 10 percent of the population accounts for the majority—about 70 percent—of health care spending.[13] For such high-cost users, a savings or reimbursement account would likely be quickly exhausted and provide little incentive for enrollees to change health care utilization and purchasing behavior. Some analysts have also reported that decision-support tools such as comparative cost and quality information about providers—important to enable effective consumer participation in health care purchase decisions—are lacking or not widely used.[14]

Given the relatively recent introduction of CDHPs, conclusive assessments of their effectiveness at restraining health care utilization and spending have not been made. Analysts believe that enrollment in CDHPs should reach sufficient levels for a sustained period of time before definitive conclusions about the cost and utilization of services can be drawn.

[13]K. Davis, "Consumer-Directed Health Care: Will It Improve Health System Performance?", *Health Services Research* vol. 39, no. 4, part II (August 2004): 1219-1233.

[14]M. Rosenthal and A. Milstein, "Awakening Consumer Stewardship of Health Benefits: Prevalence and Differentiation of New Health Plan Models," *Health Services Research*, vol. 39, no. 4, part II (August 2004): 1055-1070; J. Christianson et al, "Consumer Experiences in a Consumer-Driven Health Plan," *Health Services Research*, vol. 39, no. 4, part II (August 2004): 1123-1139; and J.B. Fowles et al, "Early Experience with Employee Choice of Consumer-Directed Health Plans and Satisfaction with Enrollment," *Health Services Research*, vol. 39, no. 4, part II (August 2004): 1141-1158.

CDHPs Are a Small but Growing Segment of the Employer-Sponsored Health Insurance Market

Employers are increasingly offering CDHPs to their employees. According to a 2005 annual survey, the share of employers offering such plans coupled with either an HRA or HSA was 4 percent, compared to the 1 percent reported in a separate 2004 annual survey.[15] Many health insurance carriers now offer CDHPs, including Aetna, Anthem/Wellpoint, Blue Cross and Blue Shield plans, CIGNA, Humana, and United HealthCare.

The FEHBP has recently begun to offer CDHPs to federal employees. The American Postal Worker's Union (APWU CDHP) was the first to offer a CDHP in 2003, followed by Aetna and Humana in 2004. In January 2005, several carriers began offering health plans designed to be coupled with the newly authorized HSAs, increasing the number of CDHPs in the FEHBP to 3 national and 13 local plans. OPM expects that additional CDHPs will be offered in 2006. Nevertheless, as of January 2005, these plans collectively insured fewer than 38,000 covered lives, a small share of the more than 8 million employees, retirees, and dependents covered under the FEHBP.

The APWU CDHP

Administered by Definity Health Plan, the APWU CDHP is a high-deductible PPO plan coupled with an HRA. The deductibles are currently $1,800 for an individual plan and $3,600 for a family plan. For an individual plan, the first $1,200 of the deductible is paid for from the HRA—which is funded every year by the enrollee's employing federal agency. The remaining $600 of the deductible is considered the member's responsibility. Unused balances may accumulate and roll over from year to year up to a maximum of $5,000 for an individual plan and $10,000 for a family plan. The member responsibility is paid by the employee, either out of pocket or from accumulated balances in the HRA from prior years.[16]

[15]The 2005 survey includes employers ranging in size from three to hundreds of thousands of employees. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Summary of Findings*. The 2004 survey includes a wide range of small to large employers. Mercer Human Resource Consulting, *The National Survey of Employer-Sponsored Health Plans 2004*. Both surveys reported that large employers with 5,000 or more employees were more likely than smaller firms to offer high-deductible plans.

[16]For example, if the enrollee had an HRA balance from a prior year of $300, the HRA balance in the current year would be $1,500 ($1200 + $300). After paying the first $1,200 of the deductible from the HRA, the enrollee is still liable for the $600 member responsibility, $300 of which would be paid from the remaining HRA balance, and the remaining $300 would be paid out of pocket.

Once the deductible has been met and the HRA is exhausted, the plan generally pays 85 percent of the cost of covered services.[17]

The HRA may be used to pay for two types of services: basic expenses, such as doctor visits and hospital charges, and "extra" expenses, such as certain preventive care services that are not covered by the plan.[18] The HRA coverage of extra expenses does not count toward the deductible. For example, if an enrollee exhausts the HRA by spending $1,200 on basic physician office visit expenses, and then spends another $600 out of pocket for extra preventive care services, the enrollee would need to spend another $600 out of pocket on basic expenses before the $1,800 deductible is met and the plan begins paying 85 percent of expenses.

APWU CDHP Enrollees Were Generally Younger, Healthier, Better Educated, and More Likely to Select an Individual Plan Than Other FEHBP Enrollees

The APWU CDHP is a small but fast-growing health plan whose enrollees on average were younger than enrollees in national PPO plans. In addition, the APWU CDHP enrollees were healthier, better educated, and more likely to enroll in an individual plan than enrollees in other new plans and the national PPO plans.

APWU CDHP Enrollment Is Small but Growing

Enrollment in the APWU CDHP grew from 4,500 in 2003, its first year of operation, to approximately 7,600 in 2004, an increase of almost 70 percent. In 2005, enrollment grew an additional 25 percent, to approximately 9,500. Including dependents, total covered lives were estimated to be approximately 10,000, 16,800, and 21,000 in each of the 3 years, respectively. Most APWU CDHP enrollees in 2003 and 2004 migrated

[17]The remaining 15 percent is paid by the enrollee out of pocket. The enrollee pays a higher share (generally 40 percent plus any difference between the provider's charges and the plan's negotiated fees) for services from nonnetwork providers. Once the enrollee's out-of-pocket expenses reach $4,500 for either an individual or family plan, the plan pays 100 percent of the enrollee's eligible health care expenses.

[18]Routine preventive care services, such as immunizations and cancer screening tests, are paid 100 percent by the APWU CDHP.

from FEHBP national PPO plans—57 percent—and HMO plans—26 percent, while 17 percent were not previously covered by an FEHBP plan.[19]

APWU CDHP Enrollees Included Few Retirees and Elderly and Were Younger than Other FEHBP Enrollees

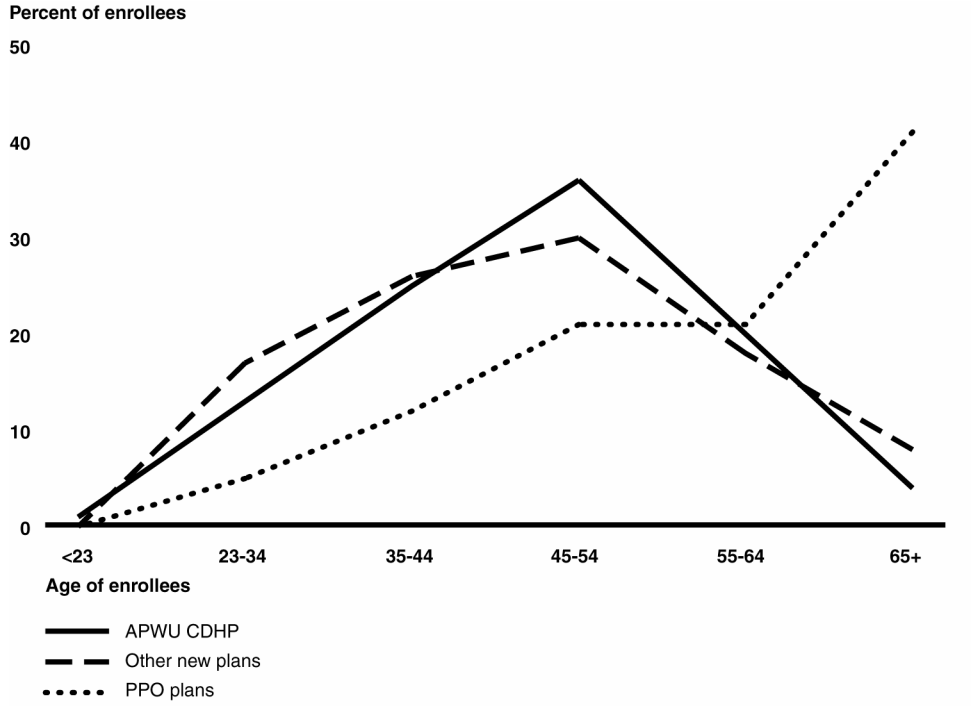
Fewer retirees and elderly people selected the APWU CDHP compared to the national PPO plans, a phenomenon also found among the other new plans. Among the APWU CDHP and other new plans, 11 and 19 percent of enrollees, respectively, were retirees or aged 65 or over, compared to 53 percent for the national PPO enrollees.[20] The distribution of enrollees by age groups was similar for the APWU CDHP and other new plans, while national PPO plans had a smaller share of enrollees in all age groups under 55 and a significantly higher share of enrollees in the over-65 age group. Figure 1 illustrates the share of enrollees in the APWU CDHP, the other new plans, and the national PPO plans within each age group.[21]

[19]Enrollees with no prior FEHBP coverage were either new federal employees, previously uninsured, or previously covered under a spouse's health plan.

[20]Most retirees (77 percent) are aged 65 and over.

[21]Enrollment data do not include dependents.

Figure 1: Age of APWU CDHP and Other FEHBP Enrollees



Source: GAO analysis of 2003-2005 FEHBP enrollment data.

Note: The APWU CDHP distributions are based on a 3-year average of enrollment for 2003 through 2005. The new plan and PPO distributions are based on a 2-year average of enrollment for 2003 and 2004 because data for 2005 were not yet available. Data on the age of dependents were not available from OPM.

The average age of APWU CDHP enrollees was comparable to that of enrollees in other new plans, but lower than enrollees in the national PPO plans by about 15 years—47 each in both the APWU CDHP and the other new plans compared to 62 for the PPO plans. Excluding the elderly and retirees, the average ages of enrollees in the APWU CDHP, the other new plans, and the national PPO plans were more similar—45, 43, and 47, respectively. (See table 1.)

Table 1: Average FEHBP Enrollee Age

	APWU CDHP	Other new plans	PPO plans
All enrollees	47	47	62
Excluding retirees and elderly enrollees	45	43	47

Source: GAO analysis of FEHBP enrollment data.

Note: The APWU CDHP enrollee ages are based on a 3-year average of enrollment between 2003 and 2005. The other new plan and PPO enrollee ages are based on a 2-year average of enrollment between 2003 and 2004 because data for 2005 were not yet available.

APWU CDHP Enrollees Were Healthier, Better Educated, and More Likely to Enroll in Individual Plans

Excluding enrollees over age 65, the proportion of APWU CDHP enrollees who reported on annual satisfaction surveys being in "excellent" or "very good" health status was higher than among the other new plan and PPO plan enrollees.[22] APWU CDHP enrollees also appeared to be better educated than enrollees in other new plans and the PPO plans. The proportion of APWU CDHP enrollees under the age of 65 who reported having a 4-year or higher college degree was higher than among the other new plan and the PPO plan enrollees. (See table 2.)

Table 2: Self-Reported Health Status and Education of FEHBP Enrollees

	APWU CDHP	Other new plans	PPO plans
Percent of respondents under age 65 reporting "excellent" or "very good" health status	73	64	58
Percent of respondents under age 65 with 4-year or higher college degree	49	42	36

Source: GAO analysis of 2003-2004 FEHBP consumer satisfaction survey data.

Excluding retirees and the elderly, a lower share of APWU CDHP enrollees selected family plans compared to other enrollees. About 55 percent of APWU CDHP enrollees selected family plans, compared to 66 percent and 65 percent of enrollees in other new plans and PPO plans, respectively.

[22]The survey data did not identify retirees; therefore, we were unable to exclude them from the analysis.

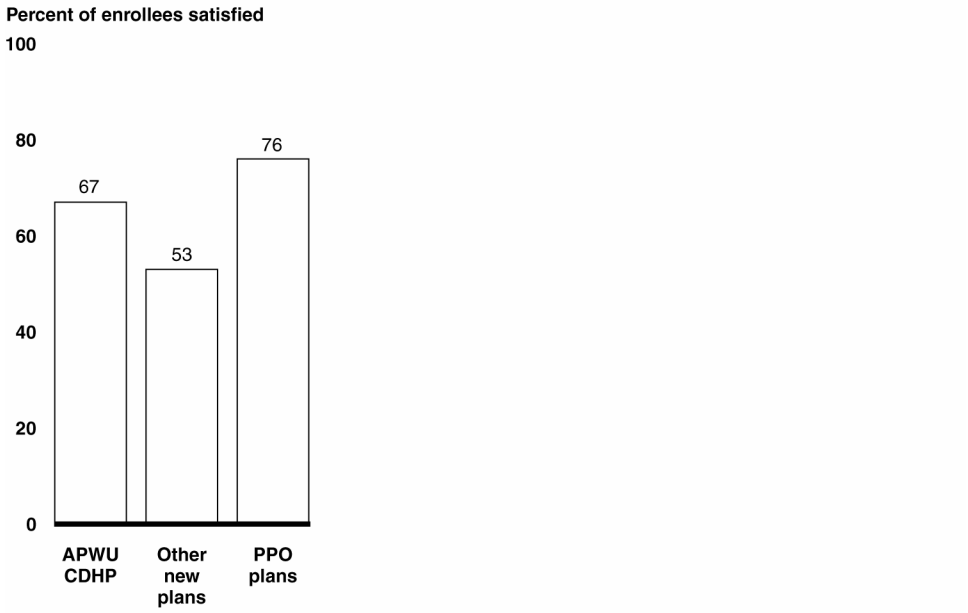
APWU CDHP Enrollee Satisfaction Was Mixed Compared to Other FEHBP Plan Enrollees

APWU CDHP enrollee satisfaction with overall plan performance was higher than that of other new plan enrollees, but lower than that of national PPO plan enrollees. APWU CDHP enrollee satisfaction was generally comparable to that of other new plan and national PPO plan enrollees on four of five specific plan performance measures—access to health care, timeliness of health care, provider communications, and claims processing. APWU CDHP enrollee satisfaction was higher than other new plan enrollees but lower than national PPO plan enrollees for the remaining specific measure relating to customer service. In addition, some APWU CDHP enrollees may have more difficulty tracking their health care spending under the APWU CDHP compared to other FEHBP enrollees.

APWU CDHP Enrollee Satisfaction with Overall Plan Performance Was Mixed Compared to Other Plans

On the overall plan performance measure included in annual consumer satisfaction surveys, APWU CDHP enrollees were more satisfied than other new plan enrollees, but less satisfied than national PPO plan enrollees—67 percent versus 53 and 76 percent, respectively. This performance measure is not comprised of component scores, nor is it directly related to the scores for the other performance measures. Rather, according to OPM, overall plan performance is a measure of enrollees' broad assessment of the plan. (See fig. 2.)

Figure 2: FEHBP Enrollee Satisfaction with Overall Plan Performance



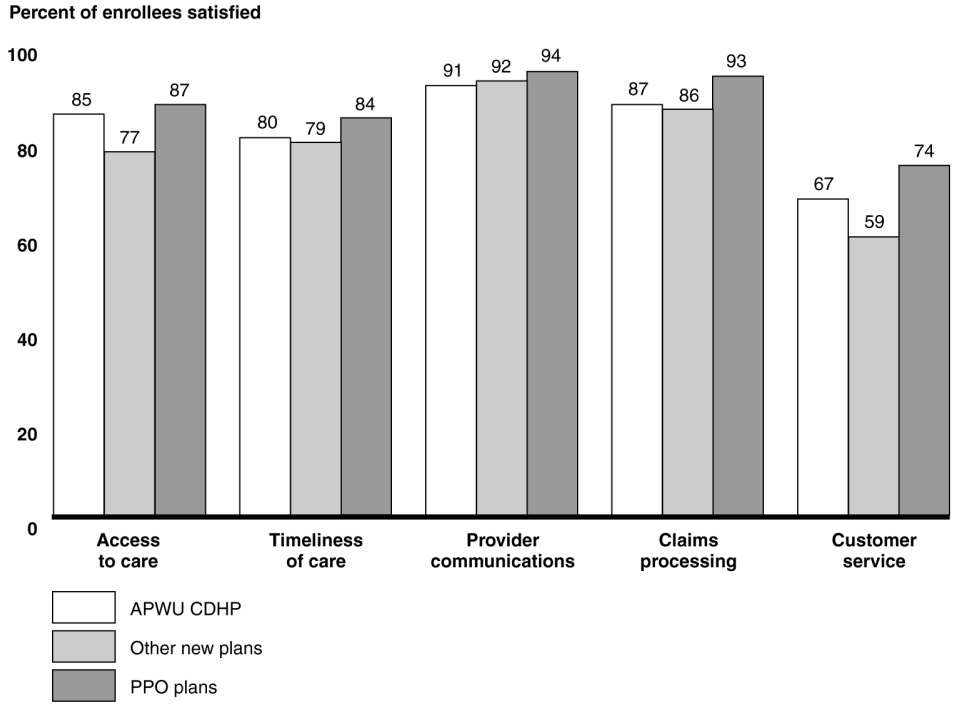
Source: GAO analysis of 2003-2004 FEHBP consumer satisfaction survey data.

APWU CDHP Enrollees Were Generally as Satisfied as Other Plan Enrollees on Four of Five Specific Performance Measures

For four of five specific plan performance measures—access to health care, timeliness of health care, provider communications, and claims processing—APWU CDHP enrollee satisfaction was generally comparable to that of other enrollees.[23] APWU CDHP enrollee satisfaction with customer service, though higher than that of other new plan enrollees, was lower than that of the PPO plan enrollees by 7 percentage points—67 percent versus 59 and 74 percent respectively. (See fig. 3.)

[23]Each performance measure is based on the scores of at least two component measures. For example, the claims processing measure score is based on the scores for the components of satisfaction with the timely payment of claims and accurate payment of claims.

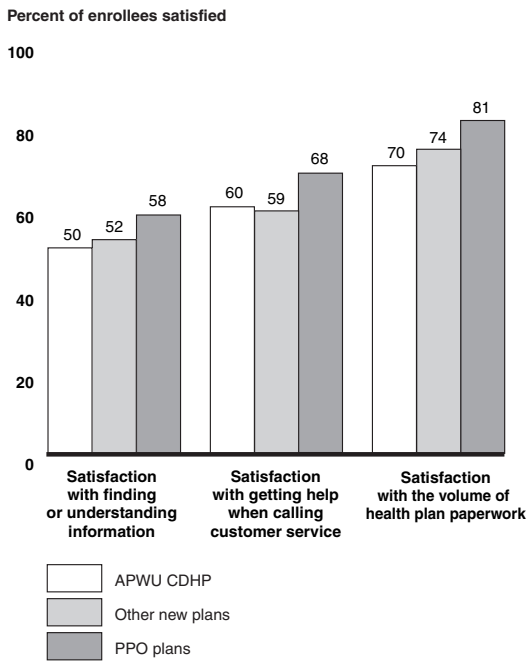
Figure 3: FEHBP Enrollee Satisfaction with Five Specific Performance Measures



Source: GAO analysis of 2003-2004 FEHBP consumer satisfaction survey data.

Moreover, for three of the components that constitute the customer service performance measure, APWU CDHP enrollees were less satisfied than national PPO plan enrollees. The components are satisfaction with finding or understanding information, satisfaction with getting help when calling customer service, and satisfaction with the health plan paperwork. (See fig. 4.)

Figure 4: FEHBP Enrollee Satisfaction with Components of Customer Service Quality



Source: GAO analysis of 2003-2004 FEHBP consumer satisfaction survey data.

Note: APWU CDHP scores were higher than the other new plan and national PPO plan scores for a fourth component of customer service, no problems reported with plan paperwork.

Some APWU CDHP Enrollees Face Difficulty Tracking Their Spending

Our analysis of appeals regarding claim disputes filed with OPM for the APWU CDHP and PPO plans in 2003 and 2004 indicate a higher rate of confusion about certain APWU CDHP features, such as enrollees' ability to track their account expenditures and their progress toward meeting their deductibles. The average annual rate of appeals per 1000 enrollees filed with OPM against the APWU CDHP was almost twice as high as the rate for national PPO plans—1.98 and 1.11 respectively.[24] Some health policy researchers have noted that this may be expected as CDHP enrollees gain familiarity with a relatively new plan concept. However, whereas appeals for the PPO plans were distributed among a wider variety of issues, a disproportionate share of the APWU CDHP appeals—over half—related to tracking account expenditures or deductible balances.

[24]Appeals data for the other new plans were not readily available.

Possibly contributing to enrollee inability to track their progress toward meeting their deductible, the APWU CDHP brochure contains potentially confusing language about whether expenses for dental and vision services count toward the deductible. APWU CDHP officials told us that in 2005, the HRA may be used to pay for dental and vision services, and that these services would also count toward the member's deductible. However, while one page of the plan brochure explicitly states that these expenses count toward the deductible, another page appears to indicate that such expenses do not count toward the deductible.[25]

Instances of Lower Satisfaction and Difficulty Tracking Health Care Spending May Relate to the APWU CDHP's Recent Introduction

The lower enrollee satisfaction related to overall plan performance and customer service, and enrollee confusion in tracking their account spending, may relate to the recent introduction of the APWU CDHP. OPM officials said that a higher rate of dissatisfaction and confusion about plan features are traits typically observed among new plans, as enrollees gain familiarity with their benefits and features. According to one health policy analyst, CDHP enrollees are more likely to report problems understanding the plan because CDHPs are a relatively new concept, and plan paperwork and management of the HRA account are new experiences for enrollees.[26]

[25]The APWU CDHP brochure identifies dental and vision services as "extra" expenses. Page 55 of the brochure states: "If you decide to use your . . . PCA . . . [HRA] for extra . . . expenses for *other than covered dental and/or vision services* (emphasis added) you may increase your member responsibility [deductible]." However, page 53 of the brochure states that "extra . . . expenses do not count toward reducing your member responsibility [deductible]" and does not specify that dental and vision expenses are an exception. In commenting on a draft of this report, OPM and APWU officials said that the 2006 brochure has been revised to explain this coverage with greater clarity. They also stated that in spite of this potential lack of clarity in 2005, the health plan credited enrollees' dental and vision expenses incurred during that year towards the enrollees' deductible.

[26]J. Christianson et al, "Consumer Experiences in a Consumer-Driven Health Plan".

APWU CDHP Enrollee Access to Provider Networks and Discounts Was Generally Comparable to Other FEHBP Plans

Provider networks appeared to provide APWU CDHP enrollees with similar access to health care providers compared to networks of other FEHBP plans. In 21 states, the APWU CDHP used the same provider networks as other large, national PPO plans participating in the FEHBP—each with over 70,000 enrollees. These 21 states account for approximately 40 percent of the total APWU CDHP enrollment. In 13 of the remaining states, accounting for approximately 22 percent of total plan enrollment, the APWU CDHP used networks that were listed among the 25 most commonly used PPO networks nationwide. In 8 states, accounting for another 22 percent of total plan enrollment, the APWU CDHP used generally large networks that had been in existence for over 10 years. For example, the APWU CDHP network included over 70 percent of the hospitals in one state, and over 90 percent of the hospitals in another state. In the remaining 9 states, accounting for approximately 16 percent of total plan enrollment, the APWU CDHP used networks that were either nationally accredited, or were comparable in size to networks used by other FEHBP plans based on counts of hospitals or physicians included in the network. (See table 3).

Table 3: Characteristics of APWU CDHP Provider Networks

Characteristics of APWU CDHP networks	States	Percent of total enrollment
The same networks used by other national FEHBP plans	21	40
Among top 25 most commonly used PPO networks nationwide	13	22
Large networks in existence for over 10 years	8	22
Networks nationally accredited or comparable in size to networks used by other large FEHBP plans	9	16

Source: GAO analysis of FEHBP plan network information obtained from plan brochures and Web sites.

Provider networks appeared to provide APWU CDHP enrollees with negotiated provider discounts that were comparable to those of another large national FEHBP plan. Across all states, the average hospital inpatient and physician discounts for the APWU CDHP and another national PPO plan differed by no more than 2 percentage points. The actual level of the hospital and physician discounts in the APWU CDHP and the national PPO

plan were comparable to industry standard discounts negotiated by large PPO plans, according to an industry expert we interviewed.[27]

Agency Comments and Comments from APWU

We received comments on a draft of this report from OPM (see app. I) and APWU. Both generally concurred with our findings. OPM said that consumer-directed health plans have the potential to lower health insurance costs by allowing health plan members greater choice over their health care spending. Regarding the potential for CDHPs to disproportionately attract healthier enrollees, OPM said that while enrollment in the APWU CDHP is growing, the plan accounted for a small fraction of total FEHBP enrollment and that OPM did not anticipate any harm accruing to other FEHBP enrollees as a result of its enrollment trends. Nevertheless, OPM said it would continue to monitor enrollment trends and take appropriate action to eliminate or minimize any adverse effects. OPM also provided technical comments, which we incorporated in the report as appropriate.

APWU acknowledged that the language concerning dental and vision coverage in its plan brochure could have contained greater clarity, and said that in consultation with OPM it has revised the language for the 2006 plan brochure. APWU also stated that in spite of the potentially confusing language, the plan credited enrollees' dental and vision services incurred in 2005 toward the enrollees' deductible. We made reference to their comment in our report. APWU also requested that we disclose the source of the appeals data we cited in the report because it did not believe its rate of appeals was significantly higher than other national PPO plans. We notified APWU officials that we obtained the appeals data from OPM.

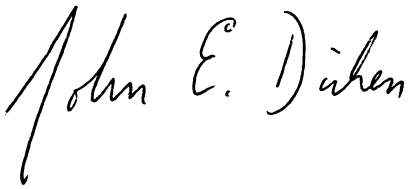
As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issue date. At that time, we will send copies of this report to OPM and other interested parties. We will also make copies available to others upon

[27]A recent independent survey of insurers offering CDHPs with collectively over 800,000 enrollees found that 95 percent of CDHP enrollees had access to national or local/regional networks used by existing, established plans along with the same negotiated rate structures. Reden & Anders, Ltd., *Consumer Directed Insurance Products: Survey Results* (Minneapolis, Minn.: April 2005), http://www.aha.org/aha/press_room-info/content/5 (April 2005).

request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff has any questions about this report, please contact me at (202) 512-7119 or at dickenj@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. Randy DiRosa, Assistant Director, and Iola D'Souza also made key contributions to this report.

Sincerely yours,



John E. Dicken
Director, Health Care

Appendix I: Comments from the Office of Personnel Management

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

OFFICE OF THE DIRECTOR

November 3, 2005

Mr. John E. Dicken
Director, Health Care
United States Government Accountability Office
441 G Street, NW., Room 5A23
Washington, DC 20548

Dear Mr. Dicken:

Thank you for the opportunity to provide comments from the United States Office of Personnel Management (OPM) concerning the Draft Report by the United States Government Accountability Office (GAO) entitled *FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: Early Experience with a Consumer-Directed Health Plan (GAO-06-143).*

OPM is pleased to offer the APWU Consumer Driven Option Health Plan as one of 279 health plan choices offered to Federal employees, retirees and their dependents. Consumer choice is one of the hallmarks of the Federal Employees Health Benefits (FEHB) Program. We believe that consumer directed health plans have the potential to lower health care, and health insurance, costs by allowing health plan members the ability to exercise greater control over their health care spending. The GAO report points out, however, that some are concerned that this kind of health plan may attract only the healthiest enrollees, thus leading to increased premiums for enrollees who remain in traditional health plans. We believe, therefore, that it is important to point out that the APWU Consumer Driven Option Health Plan is only three years old and while enrollment has increased each year, it still covers less than one-half of one percent (0.5 percent) of the FEHB Program enrollment population. FEHB Program enrollees have many different kinds of health plans to choose from, and we do not anticipate any enrollee harm accruing to individual enrollees as a result. Nonetheless, OPM will continue, as always, to monitor enrollment shift and take appropriate action to eliminate or minimize any adverse effects.

In our review of the Draft Report, we also identified several technical issues that we addressing in an attachment to this letter.

Thank you for the opportunity to review and comment on the Draft Report.

Sincerely,

Linda M. Springer
Director

Attachment

CON 131-64-4
September 2001

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548

PRINTED ON RECYCLED PAPER