



Report to the Ranking Member,
Committee on Oversight and Government
Reform, House of Representatives

October 2017

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Enrollment Remains
Concentrated Despite
More Plan Offerings,
and Effects of Adding
Plan Types Are
Uncertain

Accessible Version

GAO Highlights

Highlights of [GAO-18-52](#), a report to the Ranking Member, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

FEHBP provides health care coverage to about 8 million federal employees, retirees, and their dependents through carriers that contract with OPM. The Federal Employees Health Benefits Act of 1959 limited the types of plans OPM could offer. OPM has reported that the program needs more competition between plans and more diverse health plan choices and has proposed that its contracting authority be expanded to allow a greater variety of types of health plans to participate in FEHBP than are currently allowed.

GAO was asked to examine FEHBP plan participation and the potential impact of OPM adding new plan types to the program. This report describes, among other things: (1) how the number of plans and market shares of carriers participating in FEHBP changed in recent years, and (2) what is known about the potential effects of allowing OPM to contract with a greater variety of types of health plans than are currently offered. GAO requested OPM plan availability and enrollment data by county for 2000 through 2015, but county-level availability data were only available for 2007 and 2009 through 2015.

Therefore, plan availability and market share analysis timeframes differ. GAO also interviewed OPM officials, 11 FEHBP stakeholders, such as carriers and federal employee and retiree organizations, and reviewed relevant documentation and research, such as cost estimates of the potential effects of expanding OPM's authority.

GAO provided a draft of this product to OPM for comment. The agency did not provide any comments.

View [GAO-18-52](#). For more information, contact John Dicken at (202) 512-7144 or dickenj@gao.gov.

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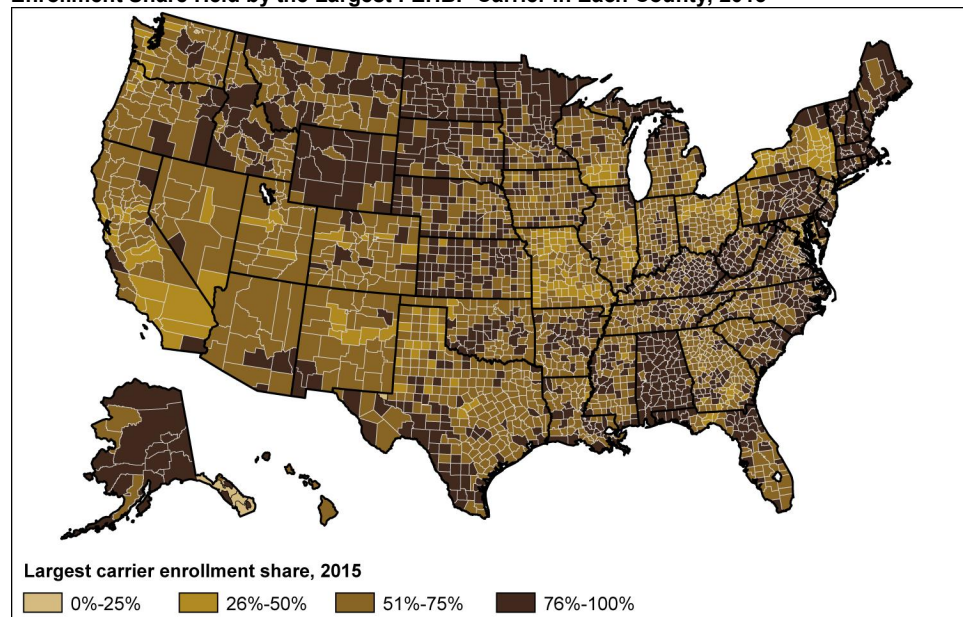
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Enrollment Remains Concentrated Despite More Plan Offerings, and Effects of Adding Plan Types Are Uncertain

What GAO Found

Federal Employees Health Benefits Program (FEHBP) enrollees can choose from a number of health plan offerings depending on where they live. From 2007 to 2015, the median number of plan offerings available in a county increased from 19 to 24. Of the 24 plan offerings in 2015, 19 were available nationwide and 5 were health maintenance organization plans offered in specific geographic areas. Yet despite more available plan offerings in recent years, enrollment has become more concentrated within the largest health insurance carrier in a county. Specifically, the median share of enrollment held by the largest carrier in a county increased from 58 percent in 2000 to 72 percent in 2015. Further, one carrier—the Blue Cross Blue Shield Association—was the largest carrier in 93 percent of counties in 2000 and 98 percent of counties in 2015.

Enrollment Share Held by the Largest FEHBP Carrier in Each County, 2015



Source: GAO analysis of Office of Personnel Management Federal Employees Health Benefits Program (FEHBP) data. | GAO-18-52

The stakeholders GAO interviewed and the cost estimates GAO reviewed about the potential effects of expanding the Office of Personnel Management's (OPM) authority to contract with more plan types than currently offered in FEHBP did not offer clear consensus about the effects. Most stakeholders supported expanding OPM's authority; those opposed were primarily concerned about OPM adding regional preferred provider organization plans, saying this could cause program instability and higher premiums. Estimates by OPM and others differed significantly on whether the expansion would increase or decrease costs. This is because they used differing assumptions about premiums, enrollment, and other factors, and it is unclear whether the assumptions used in these estimates will be realized.

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Abbreviations

BCBSA	Blue Cross Blue Shield Association
CAHPS	Consumer Assessment of Healthcare Providers and Systems

CDHP	consumer-driven health plan
CMS	Centers for Medicare & Medicaid Services
FEHBP	Federal Employees Health Benefits Program
FFS	fee-for-service
GEHA	Government Employees Health Association, Inc.
HDHP	high-deductible health plan
HEDIS	Healthcare Effectiveness Data and Information Set
HMO	health maintenance organization
OPM	Office of Personnel Management
PPO	preferred provider organization

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October 5, 2017

The Honorable Elijah E. Cummings
Ranking Member
Committee on Oversight and Government Reform
House of Representatives
Dear Mr. Cummings:

The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance program in the country, providing coverage to about 8.2 million federal employees, retirees, and their dependents in 2016.¹ The Office of Personnel Management (OPM) administers FEHBP in part by entering into contracts with qualified health insurance carriers, negotiating plan benefits and premiums as part of that process.² The statute that established FEHBP in 1959 authorized OPM to contract with four specific plan types, each of which must meet different requirements for their service areas and benefits, among other things.³ Today OPM generally groups these plan types into two main categories of plans—fee-for-service (FFS) plans and health maintenance organization (HMO) plans. FFS plans are offered nationwide to all participants, while HMO plans offer coverage in selected geographic areas.⁴ Despite having a number of plans to choose from, about two-thirds of FEHBP participants in 2015 were enrolled in one of the two

¹FEHBP was established by the Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708 (codified as amended at 5 U.S.C. §§ 8901-8914). The law became effective on July 1, 1960. Unless otherwise noted, our reference to the statute throughout this report refers to these sections of the U.S. Code.

²A carrier is generally defined as a voluntary association, corporation, partnership, or other nongovernmental organization engaged in providing, paying for, or reimbursing the cost of health services, in consideration of premiums or other periodic charges payable to the carrier. See 5 U.S.C. § 8901(7).

³Throughout this report, when we refer to the term “plan type” we are referring to those types of plans with which OPM is allowed to contract by statute. See 5 U.S.C. § 8903.

⁴There can be wide variation in the areas served by HMO plans, from as small as a few counties within a state to counties in every state across the country.

options offered as part of the Blue Cross Blue Shield Association's (BCBSA) nationwide FFS plan.⁵

OPM has reported that the health insurance marketplace has changed significantly since the statute establishing FEHBP in 1959 defined the plan types with which the agency could contract. According to OPM, this constrains it from responding to this changed marketplace. Specifically, a Director at OPM has testified that the program needs more competition between plans and more diverse health plan choices.⁶ To enhance program competition and modernize FEHBP, OPM and some stakeholders have proposed that OPM's contracting authority be expanded to allow a greater variety of health plan types to participate in FEHBP than are provided for under current law. For example, OPM has indicated that it does not have authority under current law to allow carriers to offer regional preferred provider organization (PPO) plans, which would be an additional kind of FFS plan.⁷ According to OPM, unlike the existing nationwide FFS plans, regional PPO plans would cover smaller regions and would not have nationwide premiums. However, some stakeholders have raised concerns with the proposal, noting, for example, that if

⁵A plan option is a level of benefits, e.g., a high or low benefit option. 5 C.F.R. § 890.101 (2016). BCBSA is a national association of 36 independent, community-based and locally operated BCBS companies. Within FEHBP, BCBSA also negotiates annually with OPM to determine the benefits and premiums for the two options offered as part of the nationwide service benefit plan, which is then administered by the local BCBS companies.

⁶Jonathan Foley, Director, Planning and Policy Analysis, OPM, *The Federal Employees Health Benefits Program*, testimony before the Subcommittee on Federal Workforce, U.S. Postal Service, and the Census, Committee on Oversight and Government Reform, United States House of Representatives, 113th Cong., 1st Sess. (Apr. 11, 2013).

⁷Regional PPOs have been used in other insurance markets, such as Medicare Advantage. For example, a 2016 Kaiser Family Foundation report on Medicare Advantage—a private health plan alternative to the original Medicare program—found that enrollment in regional PPO plans has increased from 1 percent of total Medicare Advantage enrollment in 2007 to about 7 percent total Medicare Advantage enrollment in 2016 (more than 500 percent). However, the report also found that average premiums for regional PPOs have increased 28 percent from 2010 to 2016, while premiums for other Medicare Advantage plans have decreased. See: Gretchen Jacobson, Giselle Casillas, Anthony Damico, Tricia Neuman, and Marsha Gold, *Medicare Advantage 2016 Spotlight: Enrollment Market Update*, (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation May 2016). While examining the experience of regional PPOs in the Medicare Advantage program may offer additional insight into the potential effects of adding these plan types to FEHBP, the applicability of this experience to FEHBP is limited given differences between Medicare Advantage and FEHBP—such as enrollee populations, total number of plans, and program designs.

regional PPO plans were added to the program they might have a competitive advantage over the nationwide plans.

With these issues in mind, you asked us to examine plan participation in FEHBP and the potential impact of OPM adding new plan types to the program. This report describes

1. how plans and market shares of carriers participating in FEHBP changed in recent years, and how FEHBP market shares compare to other selected markets; and
2. what is known about the potential effects of allowing OPM to contract with a greater variety of health plan types than are currently offered in FEHBP.

To describe how plans and market shares of insurers participating in FEHBP have changed in recent years, and how changes to FEHBP market shares compare to trends in other selected markets, we analyzed OPM data on zip code-level plan availability for 2007 and 2009 through 2015. (We requested data for 2000 through 2015, but OPM was not able to provide zip code-level plan availability data prior to 2007, or for year 2008.) Using a publicly available zip code conversion file, we converted these data from zip codes to counties. We then cross-referenced plan codes to other data provided by OPM to classify plans and determine, for each year, the number of plan offerings available in each county.⁸ To assess the reliability of the data, we reviewed relevant documentation, interviewed OPM officials involved in compiling the data, compared the data against FEHBP enrollment records and published plan brochures, and conducted data checks for reasonableness, outliers, and completeness.⁹ Based on our review of the data and discussions with OPM, we determined that our summaries and medians accurately reflected HMO plan availability across counties over time. Therefore, we determined that these data were sufficiently reliable for our purposes.

⁸A plan offering refers to FEHBP plans from which an enrollee may choose, including FFS and HMO plans, and also includes different levels of benefit options associated with some plans (e.g., a single plan may offer enrollees a choice between a high benefit option and a low benefit option).

⁹As we reviewed the data, we found and resolved, pursuant to conversations with OPM officials, several systematic discrepancies with the zip-code level data. OPM corroborated that our summaries of the corrected data were a generally reasonable representation of plan availability.

To determine FEHBP carrier market share, we analyzed OPM data on county-level enrollments for active employees and annuitants from 2000 to 2015.¹⁰ We used an OPM-provided crosswalk to identify a parent company, or carrier, for each plan, allowing us to calculate enrollment market shares for carriers at the county, state, and national levels.¹¹ We calculated county-level carrier market share in three ways: (1) the market share held by the largest, three largest, and five largest carriers in each county (regardless of which carriers held that position), (2) the market share held by certain specific carriers in each county (e.g., BCBSA and Kaiser Permanente), and (3) the combined market share held by plans categorized as HMO or FFS plans in each county. We assessed the reliability of the data by interviewing OPM officials who regularly use the data, testing for missing data, and reviewing the assignment of plans to insurance carriers. We determined these data were sufficiently reliable for our purposes.

To compare FEHBP market shares to those in other selected markets, we analyzed 2010 through 2014 data for the large group market and Medicare Advantage. We selected the years of comparison based on data available for the large group market from prior GAO reports issued in 2014 and 2016.¹² We selected the large group market (coverage offered by large employers) as a comparison market because it includes other large public and private employers offering coverage from private carriers

¹⁰We limited our enrollment-based calculations to the 50 states and the District of Columbia, excluding, for example foreign enrollees and those from Puerto Rico and Guam. OPM provided family size adjustment files that approximate the number of covered dependents associated with each carrier's policyholders.

OPM was able to provide enrollment data for all years requested, allowing us to summarize market share trends across a broader time period than the plan availability data.

¹¹The carriers that we refer to in our report may offer as few as one plan in a single state or offer a number of plans within multiple states. For example, as a parent company, Kaiser Permanente manages a variety of plans in multiple states.

¹²See GAO, *Private Health Insurance: In Most States and New Exchanges, Enrollees Continued to be Concentrated among Few Issuers in 2014*, [GAO-16-724](#), (Washington, D.C.: Sept. 6, 2016) and GAO, *Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013*, [GAO-15-101R](#) (Washington, D.C.: Dec. 1, 2014). Also, a list of related GAO products appears at the end of this report.

and plans.¹³ In prior GAO reports, we analyzed data reported annually by carriers and identified the market share held by the largest and three largest carriers in each state.¹⁴ We relied on reliability testing conducted for those prior reports and determined that they were sufficiently reliable for our purposes. We selected the Medicare Advantage program—a private health plan alternative to the original Medicare program—as a comparison market because it is another federal program with nationwide enrollees who can choose a plan from a number of options.¹⁵ To determine Medicare Advantage carrier market shares, we obtained enrollment data from the Centers for Medicare & Medicaid Services (CMS) for each year from 2010 through 2014 that provides enrollment by plan for each state, as of April. Using additional CMS data, we identified the parent carrier for each plan and calculated the market share held by the largest and the three largest Medicare Advantage carriers in each state for each year. We conducted reliability testing of the Medicare Advantage state level enrollment data, including tests for missing data and comparisons to previously published information related to market share, and determined that it was sufficiently reliable for our purposes. While we present data from these markets as points of comparison with FEHBP, the markets have substantive differences and do not offer perfect comparisons. For example, in the large group market data, federal agencies participating in FEHBP were considered large group employers and FEHBP’s approximately 8 million enrollments were included in the

¹³Federal law defines a large employer as having an average of at least 51 employees during the preceding calendar year; however, states have the option to use a definition with a higher threshold, up to a threshold of at least 101 employees. See 42 U.S.C. §§ 300gg-91(e), 18024(b). The large group market is comprised of private employers, public employers—including federal agencies that participate in FEHBP—and groups offering private insurance.

¹⁴For these prior reports, for 2010 large group market data, we used data reported by carriers to the National Association of Insurance Commissioners. For 2011 to 2014 data, we used data that all carriers reported to CMS that include enrollment data that can be used to calculate the market share of covered life-years for fully insured health plans. These data are publicly available on the CMS website, <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

¹⁵Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare’s managed care program—also known as Part C.

data carriers reported for the large group market.¹⁶ In addition, employers participating in the large group market are providing coverage options for many fewer employees than FEHBP, while often offering fewer plan options. Medicare Advantage provides coverage for a larger population of enrollees (17.6 million) compared to FEHBP. Medicare Advantage enrollees are typically older and more likely to be on a fixed income than federal employees and their dependents. Additionally, the 17.6 million Medicare Advantage enrollees in 2016 represents about one-third of all Medicare enrollees; the remaining two-thirds are enrolled in traditional Medicare.

To describe the potential effects of allowing OPM to contract with a greater variety of health plan types than are currently offered in FEHBP, we interviewed OPM officials and reviewed relevant federal laws, FEHBP policies, and other documents related to the potential effects of expanding OPM's contracting authority. We also interviewed 11 FEHBP stakeholders and experts (stakeholders)—the Association of Federal Health Organizations, two federal employee and retiree organizations, six FEHBP carriers, and two FEHBP subject matter experts—and reviewed supplementary documents the stakeholders provided.¹⁷ For additional context on the effects of adding new plans to a health care market, we interviewed members of the American Academy of Actuaries and officials from the California Public Employees' Retirement System. In addition to

¹⁶FEHBP enrollment data could not be separated from the overall large group market data used to calculate state-level market share in prior GAO reports. We estimated that, in 2014, FEHBP enrollment accounted for about 20 percent of the 44 million total enrollment in the large group market nationally; however, this percentage varies across states. In states where FEHBP comprised a larger percentage of total large group market enrollment, it may thus have had a disproportionate impact on large group market trends. To determine whether the overlap between FEHBP and large group enrollment in a state could significantly impact our results, we compared the market share patterns for states with high relative FEHBP enrollment to states with low relative FEHBP enrollment. We found market share patterns were not markedly different between the two groups and therefore concluded that the inclusion of FEHBP enrollments did not significantly affect the national trends we observed in our comparisons.

¹⁷We interviewed the following FEHBP stakeholders: the Association of Federal Health Organizations; two organizations representing federal employees and retirees—the American Federation of Government Employees and the National Active and Retired Federal Employees Association; representatives from six FEHBP carriers—Aetna, BCBSA, EmblemHealth, the Government Employees Health Association, Inc., Kaiser Permanente, and UnitedHealth Group; and, two additional stakeholders with expertise in FEHBP. We selected FEHBP carriers to interview that represented a range of FEHBP market shares. Other stakeholders were selected based on factors such as published work on FEHBP or prior testimony on this topic.

the information obtained from OPM and FEHBP stakeholders, we also reviewed available estimates of the financial effects of expanding OPM's contracting authority, including two studies we identified from Avalere Health and the Center for Health and Economy on the potential effects if OPM were to use such authority to add regional PPO plans to FEHBP.¹⁸ We also reviewed relevant research related to consumer choice and decision-making in health care.

We conducted this performance audit from April 2016 to October 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

FEHBP was established primarily to help the government compete with private-sector employers in attracting and retaining talented and qualified workers. As indicated by the legislative history of the original FEHBP statute, lawmakers wanted enrollees to exercise choice among various plan types and, by using their own judgment, select health plans that best meet their specific needs.¹⁹ While participation in FEHBP is voluntary, in 2015, 85 percent of federal workers and 90 percent of federal retirees were enrolled in the program.

Each FEHBP carrier offers one or more plans, and these plans can have up to three options, or levels of benefits, depending on which type of plan is being offered.²⁰ Although they may differ in the specific benefits they provide, all FEHBP plans cover basic hospital, surgical, physician, emergency, and mental health care, as well as childhood immunizations

¹⁸See Center for Health and Economy, *Expanding FEHBP Plan Options* (September 2014). Avalere Health provided a study to BCBSA at their request in December 2013 titled, *Federal Costs Associated with Allowing Regional PPOs Into FEHBP*. Avalere Health is a research and consulting firm with expertise in healthcare-related issues while the Center for Health and Economy is a nonpartisan research organization that provides analysis on the outlook of the U.S. healthcare system.

¹⁹See Committee on Post Office and Civil Service, H.R. Rep. No. 86-957, at 3-4 (1959).

²⁰5 C.F.R. § 890.201(b) (2016).

and certain prescription drugs. However, FEHBP plans offer different levels of benefits, with many plans offering a choice between a more expensive plan option, which offers a higher level of coverage, and a less expensive plan option, which offers a lower level of coverage. FEHBP enrollees can purchase individual or family coverage. Beginning in 2016, enrollees could also purchase coverage for themselves and one eligible family member, referred to as “self plus one” coverage. FEHBP enrollees can change health care plans during an annual open enrollment period or at other times if they experience a qualifying life event, such as a change in family status. OPM data indicates that between 2005 and 2015, the annual percentage of FEHBP enrollees who changed their plan enrollment by choice—rather than because of mergers or plan terminations—ranged from 5 to 7 percent.²¹

The FEHBP statute limits the program to four specific plan types: (1) one service benefit plan—a government-wide plan with two levels of benefits; (2) one government-wide indemnity benefit plan; (3) employee organization plans; and (4) and comprehensive medical plans—also known as HMO plans.²² OPM generally refers to these plan types as either FFS plans (the service benefit plan and the employee organization plans), or HMO plans (comprehensive medical plans). Within the categories of FFS and HMO plans, there can be significant variation in the plan designs and enrollee cost sharing. Most FFS plans have PPO arrangements, which usually have lower out-of-pocket expenses (i.e., a smaller copayment and/or a reduced or waived deductible) when

²¹OPM reports that data regarding the percentage of enrollment change from 2010 to 2011 were omitted from this analysis due to a change in record keeping in 2011. Additionally, enrollees who were not enrolled in a health plan in both years or who changed retirement status between the two years were excluded from these data.

²²Although four plan types are authorized under 5 U.S.C. § 8903, the offerings are more limited in practice. For example, the indemnity plan type, which is a FFS plan that reimburses the beneficiary for actual expenses incurred, is no longer offered. 5 U.S.C. § 8903(2). The only indemnity plan that participated in FEHBP withdrew from the program in 1990 and has not been replaced.

OPM also reports that the employee organizations authorized to carry FEHBP plans were grandfathered into FEHBP at inception or shortly thereafter and no new employee organizations have been permitted to join. See 5 U.S.C. §§ 8903(3), 8903a, 8901(8) (limiting eligible employee organizations to those approved during certain times prior to 1986). Some employee organization plans allow all active and retired federal employees to enroll, while other employee organization plans limit enrollment to their members or employees of certain federal agencies. For example, in 2015, four of the nine employee organizations—such as the National Rural Letter Carriers’ Association and the American Foreign Service Protective Association—only allowed eligible members to enroll.

enrollees use providers within the plan's preferred network. Compared with HMOs, PPOs typically offer their enrollees a greater choice of providers and have less plan management of the care that enrollees receive. HMOs provide or arrange for comprehensive health care services on a prepaid basis through designated plan physicians, hospitals, and other providers in particular locations. Each HMO sets a geographic area for which health care services will be available. Some HMOs offer a point of service product that offers FEHBP enrollees the choice of using a designated network of providers or using non-network providers at an additional cost.

Additionally, in 2003 and 2005 respectively, FEHBP also began offering consumer-driven health plan (CDHP) and high-deductible health plan (HDHP) designs that are coupled with a tax-advantaged account to help enrollees pay for qualified medical expenses. Any of the FEHBP plan types may be offered with a CDHP or HDHP design, and therefore CDHPs and HDHPs can be either FFS or HMO plans.²³ Enrollees in typical CDHPs have responsibility for certain up-front medical costs, an employer-funded account that enrollees may use to pay these up-front costs, and catastrophic coverage with a high deductible. CDHP enrollees receive full coverage of in-network preventive care. HDHPs offer low premiums but higher deductibles and annual out-of-pockets limits combined with a tax-advantaged account. HDHPs can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers.

OPM is responsible for negotiating health benefits and premiums with FFS and HMO plans. Each year, OPM sends a letter to all approved and participating FFS and HMO plans—its annual “call letter”—to solicit proposed benefit and premium changes for the next calendar year, which are due by the end of May.²⁴ The descriptions of both covered and

²³Although CDHPs and HDHPs fall within one of the statutory plan types and are also either FFS or HMO plans, we report their numbers separately in this report because they have clear definitions and are tracked separately from other FFS and HMO plans in OPM's FEHBP data.

²⁴OPM is authorized to negotiate with FFS and HMO plans without regard to competitive bidding requirements that typically apply to federal government contracting. See 5 U.S.C. § 8902. Each year, HMOs can submit applications to participate in FEHBP without having to respond to a specific request for proposals. The statute limits the participation of FFS plans in FEHBP to one service benefit plan, one indemnity plan, and certain employee organization plans and thereby limits entry of new FFS plans.

excluded benefits are incorporated into the final contracts. Each plan subsequently prints brochures describing the benefits and costs according to a standard format, as specified by OPM. The brochures are binding statements of benefits and exclusions that plans must follow as parties to FEHBP contracts. Those plans meeting the minimum requirements specified in the statute and regulations may participate in the program and their contracts may be automatically renewed each year.

The federal government and FEHBP enrollees generally each bear a portion of the cost of FEHBP plan premiums.²⁵ By statute, the government generally pays 72 percent of the weighted average premium of all health benefit plans participating in FEHBP, but no more than 75 percent of any particular plan's premium, while enrollees pay the balance.²⁶ Premium prices vary across plans and within plans and depend on whether an enrollee is enrolled in self-only, family, or self plus one coverage. The premiums are intended to cover enrollees' health care costs, plans' expenses, reserves, and OPM's administrative costs.

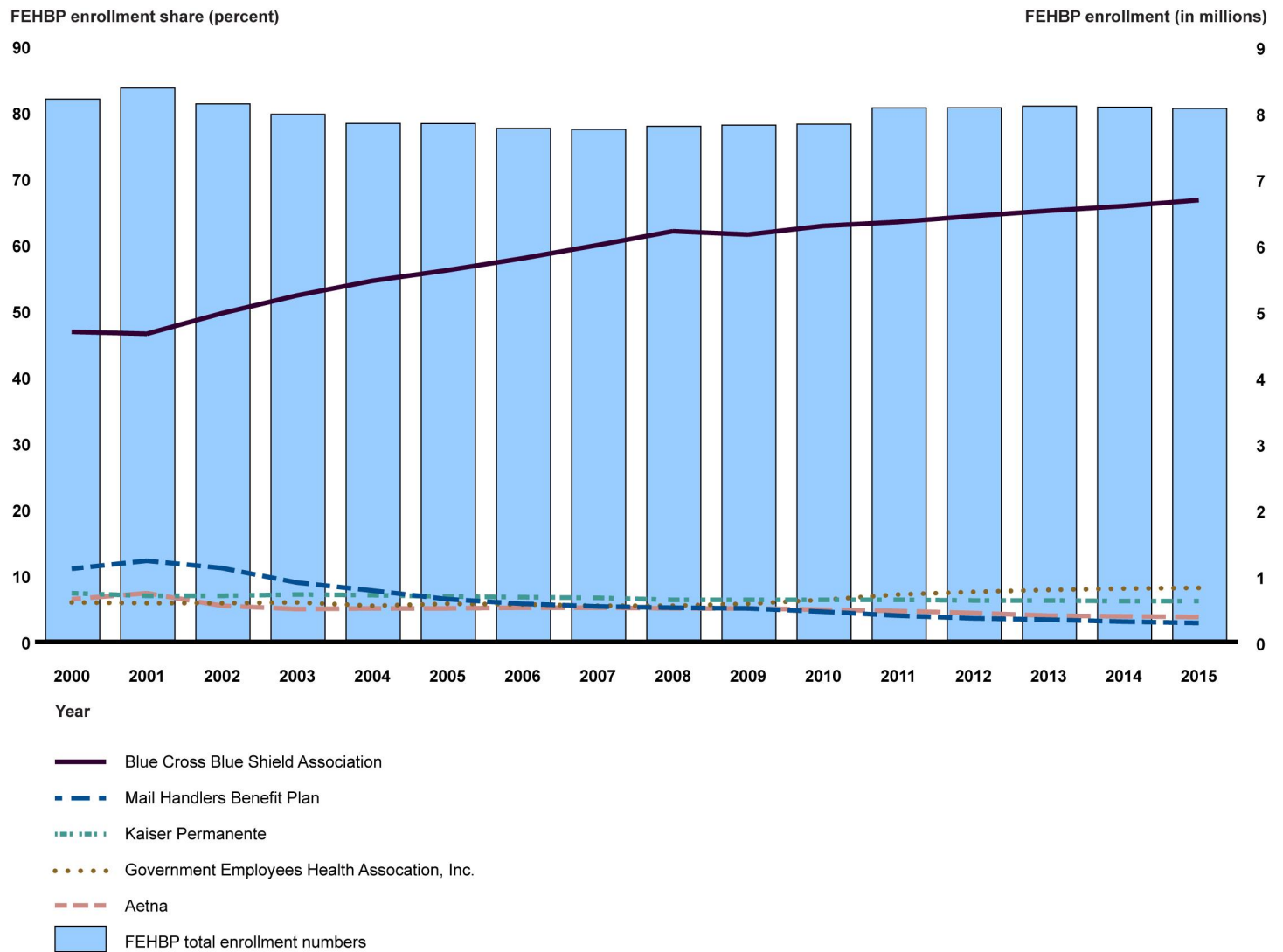
Although there has been some minor fluctuation in the number of FEHBP enrollees over time, total program enrollment has remained around 8 million enrollees since 2000. As the Congressional Research Service has reported previously, FEHBP enrollment is concentrated among a small number of carriers and BCBSA has the largest share of total program enrollment by far.²⁷ See figure 1 for the total FEHBP enrollment and enrollment market share of the top five carriers in the program from 2000 through 2015.

²⁵See 5 U.S.C. §§ 8906(b)–(d).

²⁶See 5 U.S.C. § 8906(b).

²⁷See, Congressional Research Service, *Federal Employees Health Benefits (FEHB) Program: An Overview* (Washington, D.C.: Feb. 3, 2016), 7.

Figure 1: Total Federal Employees Health Benefits Program (FEHBP) Enrollment, and Top Five Carriers Enrollment Share, 2000 through 2015



Source: GAO analysis of Office of Personnel Management data. | GAO-18-52

The Number of Available FEHBP Plan Offerings Increased Since 2007 and Enrollment Was Increasingly Concentrated

Available FEHBP Plan Offerings Generally Increased in Recent Years, although Variation Existed among Counties

The number of plan offerings available to FEHBP enrollees generally increased from 2007 through 2015. In 99 percent of counties nationwide, enrollees had more plan offerings in 2015 than they had in 2007. The median number of plan offerings available in a county increased from 19 in 2007 to 24 in 2015. Most of these offerings were the nationwide FFS plans that are available in all counties.²⁸ There were 17 such plan offerings in 2007 and 19 in 2015. The remaining plan offerings were HMOs that were available in more limited areas. While the total number of HMO plans that participated in FEHBP decreased from 2007 through 2015, the median number of HMO plan offerings in a county increased. This suggests that those HMO plans in FEHBP in 2015 generally participated in more counties than was the case in 2007. (See table 1 for a comparison of plan offerings in 2007 and 2015.)

²⁸From 2007 to 2015, between four and six of the available nationwide FFS plan offerings were only offered to select groups of enrollees (e.g., Foreign Service Benefit Plan and Rural Carrier Benefit Plan).

Table 1: Available FEHBP Plan Offerings by Plan Design, 2007 and 2015

n/a	FEHBP-wide				County median			
Plan design	2007 plan year	2007 plan year (all)	2015 plan year	2015 plan year (all)	2007 plan year	2007 plan year (all)	2015 plan year	2015 plan year (all)
All Nationwide FFS ^a	n/a	17	n/a	19	n/a	17	n/a	19
FFS CDHP	1	n/a	2	n/a	1	n/a	2	n/a
FFS HDHP	2	n/a	2	n/a	2	n/a	2	n/a
Other FFS	14	n/a	15	n/a	14	n/a	15	n/a
All HMO	n/a	268	n/a	238	n/a	2 ^b	n/a	5
HMO CDHP	31	n/a	17	n/a	1	n/a	2	n/a
HMO HDHP	27	n/a	13	n/a	1	n/a	1	n/a
Other HMO	210	n/a	208	n/a	1	n/a	2	n/a
Total	n/a	285	n/a	257	n/a	19^b	n/a	24^b

Legend: FEHBP = Federal Employees Health Benefits Program, FFS = fee-for-service, HMO = health maintenance organization, CDHP = consumer-driven health plan, HDHP = high-deductible health plan

Source: GAO analysis of FEHBP plan availability data from the Office of Personnel Management. | GAO-18-52

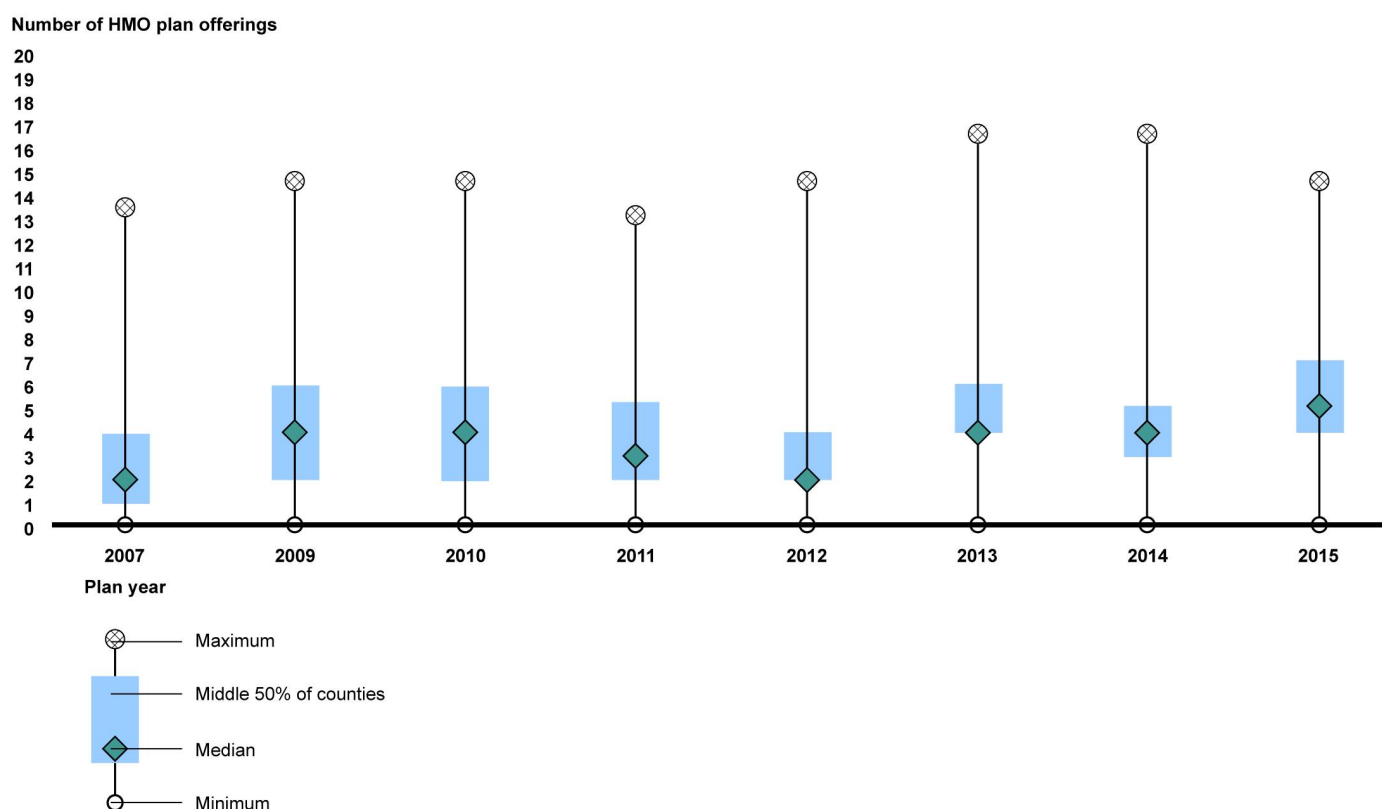
Notes: CDHP and HDHP designs are subsets of FFS and HMO plan categories.

^aNationwide FFS plan offerings are available in all counties. However, six of the offerings in 2007 (and four in 2015) were only available to select groups of enrollees, such as members of the Foreign Service or rural letter carriers.

^bCounts represent the median number of plan offerings for each category across all counties and therefore do not add up to total.

Despite increases in the availability of the median number of HMO plan offerings in a county, there was wide variation in the number of HMO offerings available to enrollees in a given county. For example, while FFS plan offerings were available nationwide, in some counties enrollees had no HMO plan offerings. Since 2007, however, the number of counties without any HMO plan offerings available declined from 18 percent to less than 2 percent in 2015.²⁹ Most counties had a couple of HMO plan offerings, and some counties had at least 10 HMO offerings. For example, in 2015, enrollees in one county in New York had 15 HMO plan offerings, giving enrollees a total of 34 offerings from which to select coverage. (See fig. 2 for the range of available HMO plan offerings among counties across all years.)

²⁹The less than 2 percent of counties without any HMO plans in 2015 were spread among 14 different states located across the country. Mississippi, Missouri, and Oregon contained the most counties without any HMO plan offerings.

Figure 2: Available FEHBP HMO Plan Offerings within U.S. Counties (2007, 2009-2015)

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) plan availability data from the Office of Personnel Management. | GAO-18-52

Note: The approximately 3,000 counties were divided into four groups and ranked by number of available health maintenance organization (HMO) plan offerings in each county. The Office of Personnel Management was not able to provide county-level plan availability data prior to 2007, or for year 2008.

Regarding reasons for the variation in available FFS and HMO plan offerings, OPM officials told us that plans participating in FEHBP enter and withdraw based on internal business decisions and often in response to changing economic conditions. For example, according to OPM officials, some plans may enter the program with the expectation of gaining a target market share. OPM officials also noted that decreases in plan participation in the past may have been a response to premium increases that impacted plans' ability to effectively compete.³⁰ In addition,

³⁰For more information on why HMOs may exit FEHBP, see GAO, *Federal Employees' Health Program: Reasons Why HMOs Withdrew in 1999 and 2000*, [GAO/GGD-00-100](#), (Washington, D.C.: May 2, 2000).

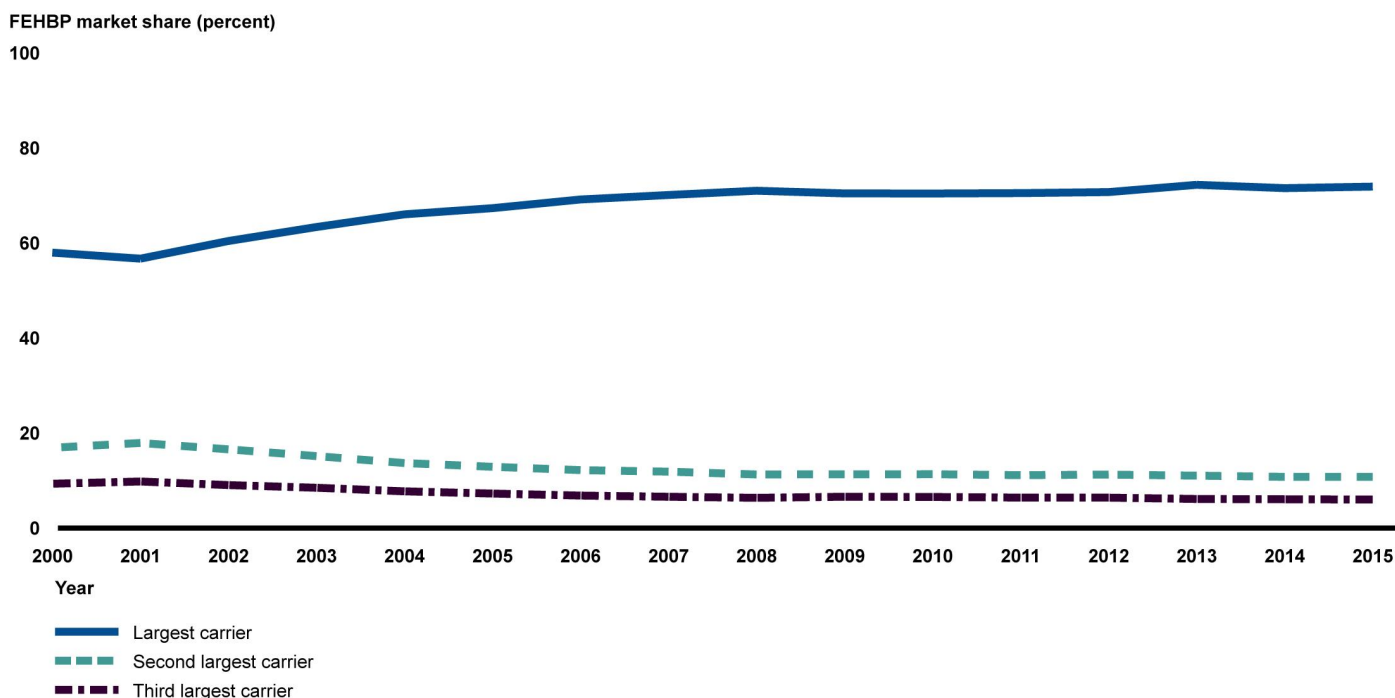
a 2012 OPM report noted that many prominent HMO plan carriers have reduced the number of states in which they participated since 1985.³¹

Market Share Held by the Largest FEHBP Carrier in Each County, Generally BCBSA, Increased from 2000 through 2015

FEHBP enrollment within counties generally became more concentrated from 2000 through 2015, although most of that growth occurred prior to 2007. The share of the market held by the largest carrier increased from a county median of 58 percent in 2000 to 70 percent in 2007, to 72 percent in 2015. Similarly, the combined median county market share of the three largest carriers increased from 86 to 90 percent over the same time period. However, we observed that the median market share held by the second and third largest carrier generally decreased over time. This suggests that the increases in combined market share held by the three largest carriers were generally due to increases observed in the single largest carrier. Although there was little change in the median county market share of the top five carriers, these carriers accounted for nearly all enrollments in a county in each of the years we examined. (See fig. 3 for a comparison of the market share held by the three largest carriers over time.)

³¹Office of Personnel Management, *Health Plan Competition in the FEHB Program* (Washington, D.C.: 2012). This report references a decreasing participation over time by several carriers, including Aetna, Cigna, Coventry, Humana, and United Healthcare.

Figure 3: FEHBP Market Share Held by the Three Largest Carriers in a Median County, 2000-2015

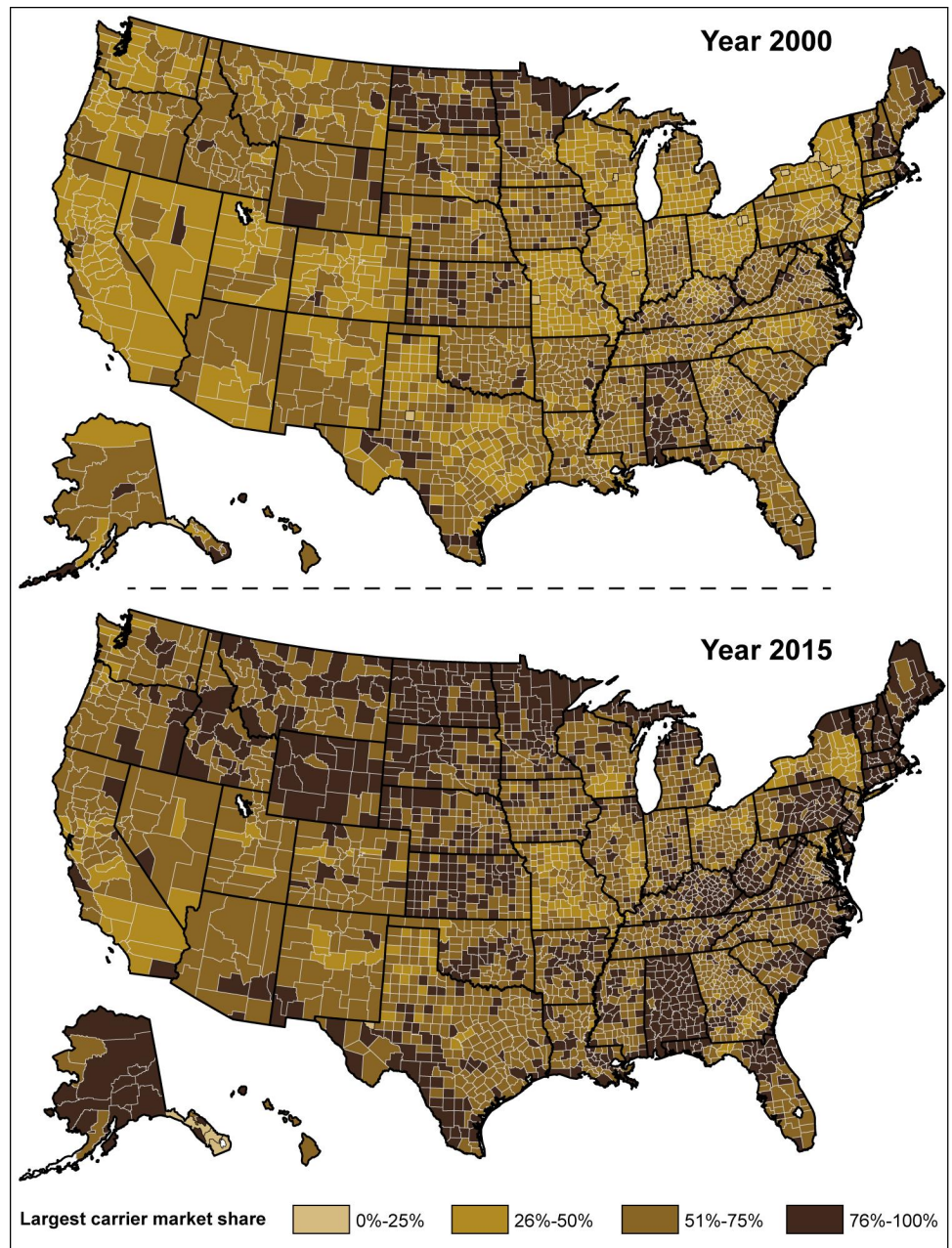


Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment data from the Office of Personnel Management. | GAO-18-52

We found that these increases in concentration were widespread. Overall, from 2000 through 2015, almost 90 percent of counties experienced an increase in the market share held by the largest carrier. Over this period, the percentage of counties in which the largest carrier held at least half of the market also increased—from 70 percent in 2000 to 93 percent in 2015. Additionally, the proportion of counties where at least 80 percent of the market share was held by the top three carriers increased from about 76 percent of counties in 2000 to 94 percent of counties in 2015.³² (See fig. 4 for maps showing the market share of the largest carrier in each county in 2000 and 2015.)

³²We tested the statistical relationship between county enrollment counts, number of plan offerings, and market share. We found that, across all the data, the number of enrollees in a county did not reflect a strong relationship to the concentration of market share held by the single largest or three largest carriers. We also found that although there was consistently a statistically significant negative relationship between number of available plan options in a county and the market share held by the largest carrier, the correlation was low.

Figure 4: FEHBP Market Share Held by the Largest Carrier, by County, 2000 and 2015



Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment data from the Office of Personnel Management. | GAO-18-52

Similar to the combined median county market share of the top five carriers, nationwide FFS plans' combined median county market share accounted for almost all FEHBP enrollment and showed a slight increase from 97 percent in 2000 to 99 percent in 2015, although variation existed in some counties. Comparatively, the combined median county market share held by HMO plans decreased from 6 percent to 2 percent.³³ In addition, in each year since 2000, 16 to 30 percent of counties had all of their FEHBP enrollment in FFS plans, and, in years for which we had HMO plan availability data, almost all of these counties offered at least one HMO plan offering.³⁴ At the same time, we observed a small number of counties each year where HMO plans' combined market share was at least 50 percent.

BCBSA was the largest carrier in almost all counties nationwide and the share of these markets held by its two nationwide FFS plan options increased from 2000 through 2015. While BCBSA was already the largest carrier in 93 percent of counties in 2000, by 2015 it was the largest in 98 percent of counties. Over this same time period, the median county market share held by BCBSA also increased—from 58 percent in 2000 to 72 percent in 2015. Most of BCBSA's 14 percent market share increase occurred between 2000 and 2008.

Other carriers had significantly smaller median county market shares, but they had the highest share in a certain limited number of counties.

- The Government Employees Health Association, Inc. (GEHA), another carrier offering nationwide FFS plans, had the second highest program-wide market share in 2015, and an 8 percent median county market share. GEHA held the second or third largest market share in 77 percent of counties in 2015, reaching as high as 65 percent of the county market share, for example, in a county in Texas, but was the largest carrier in less than 1 percent of counties.

³³Calculations for HMO plan market share excluded counties without any HMO plan enrollments. Therefore, combined FFS and HMO plan market shares do not add to 100.

³⁴Because OPM only provided plan offering availability for 2007 and 2009-2015, these were the only years we could assess which counties with 100 percent FFS market share also had HMO plan offerings available to enrollees. Each of these years, except for 2007, showed at least one HMO offering available in over 90 percent of these counties. In 2007, 67 percent of counties where FFS plans combined for 100 percent of market share had HMO offerings available to enrollees. We also found that median enrollments for counties where FFS plans held 100 percent of market share were lower than median enrollments in all counties.

- Kaiser Permanente—which offers HMO plans—was the third largest carrier program-wide in 2015 and held the largest market share among HMOs (6 percent), though its market share decreased slightly over time. In counties where a Kaiser Permanente plan was available in 2015 (fewer than 200 out of more than 3,000 counties nationwide), those plans had a median county market share of 8 percent; however, in some counties Kaiser Permanente plans held a larger market share, for example, reaching as high as 64 percent in one county in California. In counties where Kaiser Permanente plans were available in 2015, it was the largest carrier 8 percent of the time and the second or third largest carrier in a majority of cases.

(See table 2 for a description of market share and position for the three carriers with the largest program-wide market share within FEHBP.)

Table 2: Comparison of the Top Three FEHBP Carriers' Median County Market Share and Market Share Rank within Counties, 2000, 2007, and 2015

n/a		Percent of counties where carrier was ranked as the...										
Year	Median county market share (percent)			Largest carrier (percent)			Second largest carrier (percent)			Third largest carrier (percent)		
	BCBSA	GEHA	Kaiser	BCBSA	GEHA	Kaiser	BCBSA	GEHA	Kaiser	BCBSA	GEHA	Kaiser
2000	58	8	n/a	93	1	n/a	6	23	n/a	1	31	n/a
2007	70	6	13	97	less than 1	19	3	34	45	1	28	14
2015	72	8	8	98	1	8	2	55	39	less than 1	22	20

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management (OPM). | GAO-18-52

Note: OPM data describing health maintenance organization plan availability, which is necessary to calculate market share for carriers with geographically specific plan service areas was only available for 2007 and 2009-2015. Therefore, we were unable to present market shares for Kaiser Permanente (Kaiser) plans in intervening years. The median county market share and carrier ranking percentages for Kaiser only considers counties in which a Kaiser plan was available, whereas the percentages for Blue Cross Blue Shield Association (BCBSA) and Government Employees Health Association, Inc. (GEHA) are based on nationwide availability.

BCBSA's increased FEHBP market share may be due to a number of factors. For example, officials from several FEHBP carriers told us that BCBSA's market share performance was tied to several factors, including brand recognition, comparably favorable plan premiums, and enrollee population characteristics. According to an OPM report, another factor contributing to BCBSA's increased market share was the introduction of the Basic option to the Service Benefit Plan in 2002. Compared to its Standard option, this nationwide FFS plan option restricts enrollees to a more narrowly defined provider network (with some limited exceptions) and offers lower premiums, thereby broadening BCBSA's ability to

compete with other lower cost plans.³⁵ As shown in table 3, while program-wide enrollments in BCBSA's nationwide FFS plan options have increased by 32 percent following the introduction of the Basic option, enrollments in the Standard option decreased, suggesting that enrollees are shifting to the Basic option or plans offered by other carriers.

Table 3: FEHBP Enrollments Captured by BCBSA Service Benefit Plan Standard and Basic Options, 2002 and 2015

Year	Standard option enrollments	Basic option enrollments	Total BCBSA enrollments
2002	3,747,444	205,728	3,953,172
2015	3,056,186	2,170,160	5,226,346
Percent change over time	-18%	955%	32%

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment data for Blue Cross Blue Shield Association (BCBSA) plans provided by the Office of Personnel Management. | GAO-18-52

In addition, a study published in 2012 noted that BCBSA market concentration was the possible outcome of the carrier's established provider network and lower relative administrative costs.³⁶ For examples of BCBSA's and other carriers' premiums, plan offerings, and market shares in 2015, in select counties, see appendix I.

FEHBP Market Share Concentration among the Largest Carriers Was Generally Similar to the Large Group Market and More Concentrated than Medicare Advantage

The combined market share for the three largest FEHBP carriers in a state was generally similar to the large group market and higher than Medicare Advantage. As shown in figure 5, in 2014, the median state market share for FEHBP was 89 percent compared to 90 percent in the large group market and 74 percent for Medicare Advantage.³⁷ And, the range of state market shares held by the three largest carriers in Medicare Advantage and the large group market (69 and 62 percentage points, respectively) was wider than in FEHBP (23 percentage points).

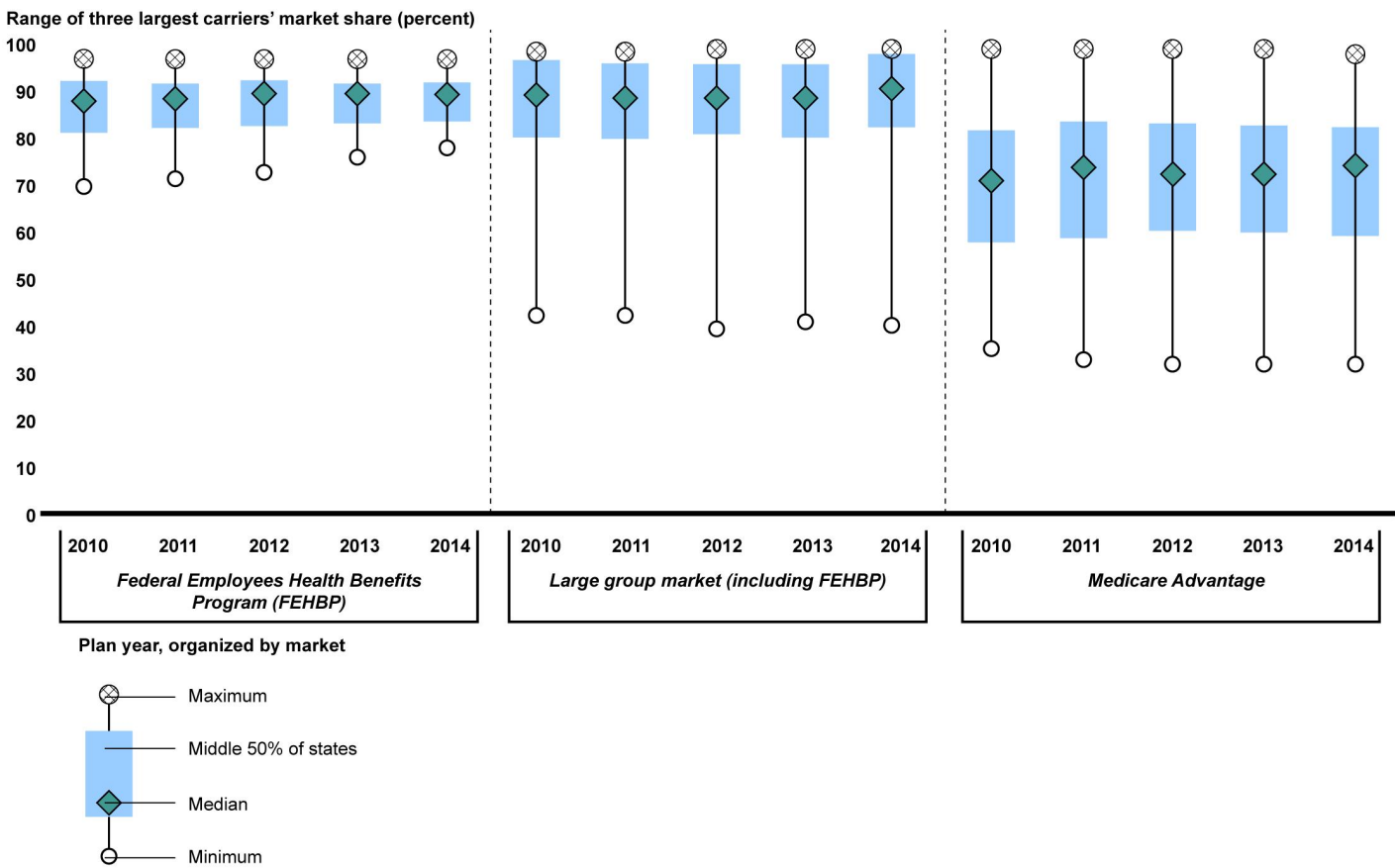
³⁵Office of Personnel Management, *Health Plan Competition in the FEHB Program* (Washington, D.C.: 2012).

³⁶T. D. McBride, A. R. Barker, L. M. Pollack, L. M. Kemper and K. J. Mueller, "Federal Employees Health Program Experiences Lack Of Competition In Some Areas, Raising Cost Concerns For Exchange Plans," *Health Affairs*, vol. 31, no.6 (2012).

³⁷Since county-level enrollment data were not available for the large group market, we used state-level market share measures to compare these selected markets to FEHBP.

However, programmatic differences between the three selected markets, such as varying enrollee demographics, market sizes, and program designs, make it difficult to draw conclusions about these contrasting market trends.

Figure 5: Distribution of Market Share for the Combined Three Largest Carriers in Each State for FEHBP, Medicare Advantage, and Large Group Market (2010-2014)



Source: GAO analysis of data from the Office of Personnel Management, the Centers for Medicare and Medicaid Services, and the National Association of Insurance Commissioners. | GAO-18-52

Notes: The Centers for Medicare & Medicaid Services published Medicare Advantage enrollment data and Medical Loss Ratio data—describing the percentage of premium a carrier spends on its customers' medical claims and activities that improve the quality of care—for private insurance markets, including the large group market.

For each market and each year, the 50 states and the District of Columbia were ranked from highest to lowest market share for the combined three largest carriers in each state and then divided into four groups based on those rankings.

FEHBP enrollment data could not be separated from the overall large group market data used to calculate state-level market share in prior GAO reports. In 2014, we estimated that FEHBP plans accounted for about 20 percent of the 44 million total enrollments in the large group market nationally.

Compared to Medicare Advantage and the large group market, the state market shares held by the largest carrier in FEHBP generally held a larger share of the market. For example, in 2014, the median market share held by the largest carrier in a state was higher in FEHBP (75 percent) than both Medicare Advantage (35 percent) and the large group market (59 percent).

Stakeholder Opinions and Cost Estimates Do Not Offer Clear Consensus about the Potential Effects of Expanding OPM's Contracting Authority

Stakeholders Generally Supported Expanding OPM's Authority, but Said Using That Authority to Add Regional PPO Plans Could Have Negative Effects

Seven of the 10 stakeholders we interviewed, and who commented on OPM's contracting authority, generally supported expanding OPM's contracting authority to allow it to contract with a greater variety of health plan types than are currently offered in FEHBP.³⁸ Stakeholders we interviewed that offer HMO plans generally supported this expansion. However, the 2 stakeholders that offer nationwide FFS plans and 1 stakeholder that represents federal employees opposed it. Most of the concerns expressed by these 3 stakeholders were related specifically to the potential effects of OPM adding regional PPO plans to FEHBP.

Five of the seven stakeholders we interviewed who supported expanding OPM's contracting authority said that adding additional plan types could result in both positive and negative effects. In terms of positive effects,

³⁸We interviewed 11 stakeholders. However, the Association of Federal Health Organizations did not comment on the potential effects of allowing OPM to contract with a greater variety of health plan types than are currently offered in FEHBP.

one stakeholder said the authority could potentially allow OPM to offer different types of plans—such as value-based plan designs and accountable care organizations—that could lead to improved benefit options and health outcomes for enrollees.³⁹ One stakeholder also told us that OPM’s expanded authority would enable the agency to improve transparency by allowing plans to contract with OPM as the type of plan they actually are, rather than fitting into outdated statutorily established categories, which the stakeholder characterized as an “antiquated labeling system.” Another stakeholder said that participation by new plans in FEHBP would foster competition and help keep health plan costs down. One stakeholder also noted that if plan expansion would only be undertaken when it is in the best interests of FEHBP and its enrollees—as OPM has indicated would be the case—there was little or no downside to such expanded authority. Additionally, in April 2013, three FEHBP carriers that offer HMO plans sent a letter to Congress in favor of expanding OPM’s authority, citing that it would “ensure OPM has the tools it needs to lower costs and provide federal workers access to innovation, choice, and value” and would allow more competition in the program.

Some stakeholders we interviewed, however, suggested that any positive effects of expanding OPM’s authority and adding new plan types could be limited due to other aspects of FEHBP that affect competition and discourage participation by carriers. In particular, these stakeholders cited concerns related to costs associated with FEHBP enrollees who are Medicare-eligible but who do not enroll in Medicare, and the formula that determines the government’s contributions to enrollee premiums. According to these stakeholders, this creates unfair competitive advantages for the nationwide plans and BCBSA in particular. They also cited FEHBP’s system for assessing the performance of participating carriers, which they said discourages competition and participation by carriers in FEHBP, particularly for certain HMO plans. OPM reported that it was open to considering some program changes related to these concerns; however, some proposed changes could require changes to the FEHBP statute. For more information about stakeholder comments regarding these other aspects of FEHBP, see appendix II.

³⁹Value-based plan designs are health plans that focus on reducing consumer cost sharing in health insurance for preventive tests and medications for chronic diseases. Accountable care organizations are organizations of health care providers and suppliers that come together voluntarily to provide coordinated care to a defined group of patients with the goal of reducing spending while improving quality.

Some of the 10 stakeholders we interviewed and who commented on OPM's contracting authority also identified other potential negative effects that could occur with expanding OPM's contracting authority. For example, 1 stakeholder said that an increase in plan types offered could lead to a subsequent increase in OPM's administrative costs. In addition, several of these stakeholders said that adding more plans to FEHBP would exacerbate an existing problem of choice overload for enrollees. One of the stakeholders said that FEHBP enrollees are already confused by the number of available plan offerings, and that the current information provided to enrollees does not allow for easy comparison of their choices. They noted that additional expansion of offerings will only complicate enrollees' plan analysis.

Consistent with these concerns, studies that we reviewed related to consumer choice and decision-making processes in health insurance markets suggest that adding additional plans may not always yield positive effects or improve competition. For example, a 2016 report by the RAND Corporation found that health insurance consumers are unlikely to change plans, even as better choices become available.⁴⁰ Additionally, a 2009 study examining the Swiss health insurance market similarly found that as the number of choices offered to individuals grows their willingness to switch plans declines.⁴¹ The study found persistently low rates of plan switching despite high variation in premiums between plans, and found that more choice inhibited plan switching. It concluded that having a large number of plans to choose from likely reduces the effectiveness of consumer decision making, and that simplifying health plan decision making by reducing the number of choices might result in more price competition among insurers, and benefit consumers.

⁴⁰See E.A. Taylor, et al., for the RAND Corporation, *Consumer Decisionmaking in the Health Care Marketplace* (Santa Monica, CA: 2016). The study reviewed the literature on how consumers make choices in the context of health insurance enrollment to determine what plan characteristics matter most, what types of errors in decision making are common, and what (if any) best practices exist for helping consumers make optimal (or at least improved) decisions. They found that consumers are prone to stick with their initial choices even if prices change or if new, potentially better choices become available. The study identified several potential reasons for this, including the complexity of the information needed to make these decisions and consumers' limited health insurance literacy.

⁴¹See Frank, Richard G. and Lamiraud, Karine, "Choice, Price Competition and Complexity in the Markets for Health Insurance", *Journal of Economic Behavior & Organization*, vol. 71, no. 2 (2009). Similar to FEHBP, consumers in Switzerland have a large number of health plans to choose from, and their number of choices has grown over time—in 2004 the mean level of health plans a consumer had to choose from was 56.

Additionally, 6 of the 10 stakeholders we interviewed and who commented on OPM's contracting authority said that there would potentially be negative effects if OPM were to use the expanded authority to add regional PPO plans to FEHBP. For example, 5 of these 6 stakeholders said there could be instability and higher premiums in FEHBP if new regional PPO plans were able to "cherry pick" low cost areas in which to participate. This was of particular concern to 1 of the 2 stakeholders we spoke to who offer nationwide plans. Because they offer the same premiums nationally, they said the lower-cost areas of the country help subsidize the premiums of the higher-cost areas. If these nationwide plans lost customers in lower-cost areas to regional PPO plans, then their premiums would likely rise. These 2 stakeholders and a third said, therefore, that adding regional PPO plans could result in nationwide carriers discontinuing their coverage due to their inability to compete with regional plans. According to 1 stakeholder that offers a nationwide FFS plan, if the nationwide carriers dropped out of the program, plan offerings would be significantly reduced in certain areas of the country and some areas could potentially be left with no offerings at all.⁴² Additionally, in 2014 and 2015, six nationwide FEHBP carriers, including the two we interviewed, sent letters to Congress expressing their opposition to legislation that would add new plan types in FEHBP. In the letters, they cited negative effects such as program destabilization, increased premiums, and fewer consumer choices—all of which were specifically tied to the proposal to add regional PPO plans to FEHBP.

Two of the 10 stakeholders we interviewed and who commented on OPM's contracting authority, however, said that adding regional PPO plans to FEHBP would have positive effects. For example, 1 of these stakeholders that offers HMO plans and referred to FEHBP's plan type labels as antiquated noted that this would enable them to promote their existing FEHBP products—currently categorized as HMO plans—more appropriately as regional PPO plans. This stakeholder said the current categorization causes enrollees to erroneously believe their plans are more restrictive than the plans listed as nationwide FFS plans.

When we shared these stakeholder concerns about expanding OPM's contracting authority with OPM officials, they told us that the agency has existing strategies and is working towards implementing additional ones,

⁴²As noted previously, in 2015, FEHBP enrollees in less than 2 percent of counties had no HMO offerings and had access only to the nationwide FFS plans.

which officials said should allow it to address many of these concerns. For example, OPM officials said in January 2017 that the agency was in the process of building models that would allow it to simulate the impact that adding new plan types would have on FEHBP, but that the agency is still years away from being able to make such assessments. The officials said that the agency would only seek to introduce new plan types that it determines to be in the best interests of FEHBP enrollees and the federal government. With regards to enrollee confusion over the number of plan choices, the OPM officials said that the agency is improving the tools enrollees can use to learn about the available plans. For open season in 2016, the agency released what it considers to be a new and improved Plan Comparison Tool on its website that enables enrollees to gain more knowledge about their health plan options before making a selection. According to the officials, some of the improved functions of the tool include more details about the plan benefits and services, clearer definitions of the health insurance terms, and easier ability to compare the plans. Officials also told us that they expect to make more improvements to the tool in future years based on feedback from the FEHBP enrollees who use it. OPM officials said the agency would continue existing plan negotiation strategies that, among other things, would prevent plans from “cherry picking”—that is, offering products in only the most profitable service areas—by ensuring that new carriers provide services in contiguous regions that include both low- and high-cost areas. Additionally, related to the concern that nationwide plans might withdraw from the program if regional PPO plans were introduced, OPM officials noted that if, for example, BCBSA were to cancel its nationwide plan options, another carrier might step up to gain the service benefit plan designation and provide nationwide service.

Estimates of the Financial Effects of Expanding OPM’s Contracting Authority Differed on Whether Costs Will Increase or Decrease

We identified three significantly differing estimates of the financial effects on the federal budget that expanding OPM’s FEHBP contracting authority would have. However, these estimates are based on different assumptions about a variety of factors such as premium changes, administrative costs, and enrollment, and only limited information was available about the methodologies used for each set of estimates. It is also important to note that the assumptions used in developing these estimates are subject to professional judgment and have inherent

uncertainty regarding whether the assumed scenarios will be realized. The three estimates include:

- The President's Budget for fiscal year 2017 estimated that expanding FEHBP to a greater variety of plan types would save \$88 million from 2017 through 2026.⁴³ According to information provided by OPM, the estimate considered the effect of a broad expansion of OPM's authority to add new plan types, and OPM did not indicate whether the agency specifically considered the effect of adding regional PPOs to FEHBP when developing this estimate. OPM officials told us that these savings were based on a number of assumptions, including an estimate of the number of enrollees that will migrate to new plan types based on previous FEHBP experience and projecting a medical loss ratio of 90 percent for the new plan types added to FEHBP.⁴⁴ However, in follow-up with the agency, OPM officials were not able to provide us with more detailed information about how these savings were calculated. The Congressional Budget Office, in its analysis of the budget proposal, estimated a range from \$50 million in savings to \$50 million in costs over the 10-year period.⁴⁵
- A 2014 study from the Center for Health and Economy that examined the effects of introducing regional PPOs to FEHBP across three scenarios estimated cost savings ranging from \$1.2 to \$2.1 billion over 7 years (2015 to 2021). The study provided limited information about the data, assumptions, and methodology the center used to develop its estimates.⁴⁶ The study did explain that the center modeled

⁴³Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2017*, Feb. 9, 2016.

⁴⁴A medical loss ratio is the is percentage of premiums an insurer spends on its customers' medical claims and activities that improve the quality of care, versus what they spend on overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. For example, an insurer that uses 90 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care has a medical loss ratio of 90 percent. The higher the medical loss ratio, the more value per premium dollar a plan is thought to provide.

⁴⁵Congressional Budget Office, *Proposals for Health Care Programs—CBO's Estimate of the President's Fiscal Year 2017 Budget*, Mar. 29, 2016.

⁴⁶The Center for Health and Economy reported that it used the Department of Health and Human Services' Medical Expenditure Panel Survey data to estimate premiums for various PPO plan designs and OPM contract data for its analysis of enrollee plan choices. Medical Expenditure Panel Survey data do not reflect FEHBP-specific claim experience. The study did not note what medical loss ratio was assumed for the new plan types added to FEHBP.

the projected impact on enrollment, average premiums, and the federal budget of adding regional PPOs to FEHBP using three different sets of assumptions about how expensive the newly introduced regional PPO plans would be. Under each scenario, the center estimated shifts over time in enrollment from existing FEHBP plan designs (FFS, HMO, CDHP, and HDHP) to the new PPO plans—and assumed that these new plans would achieve 10 percent of the market share throughout the analysis period. The study also projected decreases in average FEHBP premiums and a corresponding reduction in total government contributions in each scenario.

A December 2013 study conducted by Avalere Health at BCBSA's request specifically examined the effect of adding regional PPOs into FEHBP and estimated an increase in spending of \$7.8 billion over 10 years (2014 to 2023). In developing its estimates, the study noted that it assumed that the BCBSA national plans dissolve and would break into regional plans in response to new regional plan competition. The study stated that the \$7.8 billion in increased costs was based on an assumption that both regional PPOs and BCBSA regional plans would have higher administrative costs as compared to BCBSA's national plans. The study estimated that these costs would be offset slightly by an initial anticipated decrease in premiums resulting from new plans introducing competition into these regions.⁴⁷

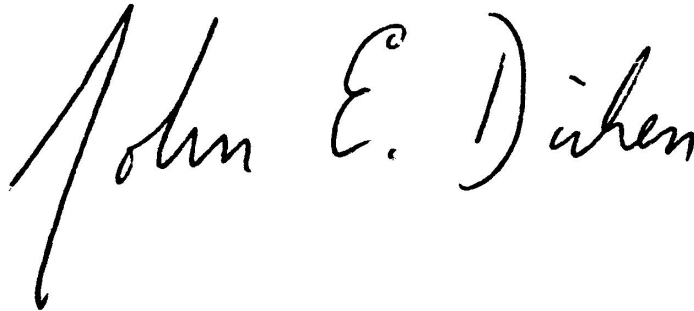
Agency Comments

We provided a draft of this product to OPM for comment. The agency did not provide any comments.

⁴⁷Avalere Health reported that to develop its estimate it used 2012 BCBSA-provided OPM data on plan-level enrollment and premium costs and CMS's 2011 National Health Expenditures data on spending growth projections, among other sources. The study noted that Avalere Health assumed a medical loss ratio of 85 percent for both the new BCBSA regional plans and the regional PPOs.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to OPM and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>. If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large, sweeping initial "J".

John E. Dicken
Director, Health Care

Appendix I: Federal Employees Health Benefits Program (FEHBP) Plan Attributes for Selected Counties in 2015

In table 4, we present information about a selection of counties that reflect a range of FEHBP attributes, but which are not intended to be a representative sample of all counties. We chose counties with a range of total enrollments, market shares held by different plan offerings (with different enrollee premiums), and number of health maintenance organization (HMO) plan offerings.

Table 4a: FEHBP Enrollment, Plan Offering Availability, and Premium Attributes for Selected Counties in 2015

n/a	Washington, D.C.	Honolulu County, Hawaii	Madison County, Alabama
Total FEHBP county enrollment	344,221	70,780	50,903
Total FEHBP county plan options	32 (13 HMO offerings)	26 (7 HMO offerings)	23 (4 HMO offerings)

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management. | GAO-18-52

Note: ^a These values reflect the self-only coverage premium.

Table 4b: FEHBP Enrollment, Plan Offering Availability, and Premium Attributes for Selected Counties in 2015

n/a	Washington, D.C.		Honolulu County, Hawaii		Madison County, Alabama	
Top three plan offerings with largest enrollment and percent of county enrollment	Plan name	Enrollment share (percent)	Plan name	Enrollment share (percent)	Plan name	Enrollment share (percent)
Largest	Blue Cross and Blue Shield Service Benefit Plan (Standard)	34	Hawaii Medical Service Association Plan (High)	75	Blue Cross and Blue Shield Service Benefit Plan (Standard)	68

**Appendix I: Federal Employees Health Benefits
Program (FEHBP) Plan Attributes for Selected
Counties in 2015**

n/a		Washington, D.C.		Honolulu County, Hawaii		Madison County, Alabama	
Top three plan offerings with largest enrollment and percent of county enrollment		Plan name	Enrollment share (percent)	Plan name	Enrollment share (percent)	Plan name	Enrollment share (percent)
Second largest		Blue Cross and Blue Shield Service Benefit Plan (Basic)	19	Kaiser Foundation Health Plan, Inc.—Hawaii Region (High)	15	Blue Cross and Blue Shield Service Benefit Plan (Basic)	26
Third largest		Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (High)	9	Blue Cross and Blue Shield Service Benefit Plan (Standard)	3	Government Employees Health Association, Inc. Benefit Plan (Standard)	2

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management. | GAO-18-52

Note: ^a These values reflect the self-only coverage premium.

Table 4c: FEHBP Enrollment, Plan Offering Availability, and Premium Attributes for Selected Counties in 2015

n/a		Washington, D.C.		Honolulu County, Hawaii		Madison County, Alabama	
Total bi-weekly premium and enrollee's premium share for the county's top three plan offerings (by market share) ^a		Total bi-weekly premium (dollar)	Employee share (dollar)	Total premium (dollar)	Employee share (dollar)	Total premium (dollar)	Employee share (dollar)
Largest		293.04	91.03	230.00	57.50	293.04	91.03
Second largest		253.62	63.40	243.84	60.96	253.62	63.40
Third largest		279.94	77.93	293.04	91.03	196.18	49.04

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management. | GAO-18-52

Note: ^a These values reflect the self-only coverage premium.

Table 4d: FEHBP Enrollment, Plan Offering Availability, and Premium Attributes for Selected Counties in 2015

n/a		Solano County, California		Vernon County, Louisiana	
Total FEHBP county enrollment		11,429		3,544	
Total FEHBP county plan offerings		28 (9 HMO offerings)		19 (0 HMO offerings)	

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management. | GAO-18-52

Note: ^a These values reflect the self-only coverage premium.

Appendix I: Federal Employees Health Benefits
Program (FEHBP) Plan Attributes for Selected
Counties in 2015

Table 4e: FEHBP Enrollment, Plan Offering Availability, and Premium Attributes for Selected Counties in 2015

n/a	Solano County, California		Vernon County, Louisiana	
Top three plan offerings with largest enrollment and percent of county enrollment	Plan name	Enrollment share (percent)	Plan name	Enrollment share (percent)
Largest	Kaiser Foundation Health Plan, Inc.—Northern California Region (High)	40	Blue Cross and Blue Shield Service Benefit Plan (Standard)	61
Second largest	Kaiser Foundation Health Plan, Inc.—Northern California Region (Standard)	22	Blue Cross and Blue Shield Service Benefit Plan (Basic)	21
Third largest	Blue Cross and Blue Shield Service Benefit Plan (Standard)	14	Mail Handlers Benefit Plan (Standard)	6

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management. | GAO-18-52

Note: ^a These values reflect the self-only coverage premium.

Table 4f: FEHBP Enrollment, Plan Offering Availability, and Premium Attributes for Selected Counties in 2015

n/a	Solano County, California		Vernon County, Louisiana	
Total bi-weekly premium and enrollee's premium share of premiums for the county's top three plan offerings (by market share) ^a	Total bi-weekly premium (dollar)	Employee share (dollar)	Total premium (dollar)	Employee share (dollar)
Largest	359.81	157.80	293.04	91.03
Second largest	301.78	99.77	253.62	63.40
Third largest	293.04	91.03	294.66	92.65

Source: GAO analysis of Federal Employees Health Benefits Program (FEHBP) enrollment and plan availability data provided by the Office of Personnel Management. | GAO-18-52

Note: ^a These values reflect the self-only coverage premium.

Appendix II: Stakeholder Opinions about Other Federal Employees Health Benefits Program Aspects That Affect Competition

Some of the stakeholders we interviewed suggested that any positive effects of expanding the Office of Personnel Management's (OPM) contracting authority and adding additional plan types to the Federal Employees Health Benefits Program (FEHBP) could be limited because of other aspects of the program that affect competition and discourage carrier participation.¹ In particular, stakeholders cited concerns related to: Medicare-eligible enrollees, the government contribution formula for FEHBP premiums, and FEHBP's plan performance assessment system.²

Medicare-eligible enrollees. Six of the 11 stakeholders we interviewed suggested that problems associated with Medicare-eligible enrollees negatively affect FEHBP premiums, and 5 of the 6 noted these problems create an unfair competitive advantage for the nationwide FEHBP plans. These stakeholders suggested that because certain older, Medicare-eligible FEHBP enrollees tend to incur higher health care costs, they drive up premiums. Some stakeholders noted that plans—in particular, health maintenance organizations (HMOs) that offer service in areas with higher concentrations of older enrollees—experience challenges keeping

¹We interviewed 11 FEHBP stakeholders—health insurance carriers, federal employee and retiree organizations, and subject matter experts—and reviewed supplementary documents they provided. One stakeholder that offered comments on these other aspects of FEHBP that affect competition did not wish to comment about the potential effects of allowing OPM to contract with a greater variety of health plan types than are currently offered in FEHBP.

²Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Parts A and B are known as Medicare fee-for-service. Medicare Part A covers hospital and other inpatient stays. Medicare Part B covers hospital outpatient, physician, and other services.

premium rates competitive with the nationwide plans like those offered by the Blue Cross Blue Shield Association (BCBSA). Additionally, 3 stakeholders we interviewed that offer HMO plans pointed specifically to costly retirees who opt not to enroll in Medicare coverage of outpatient services, known as Part B, making it difficult for them to compete. FEHBP retirees eligible to enroll in Medicare are not required to do so, and some maintain only their FEHBP coverage instead.³ While there is no penalty for choosing not to enroll in Medicare, retirees who later decide to enroll in Part B must pay a penalty.⁴ For retirees in FEHBP who choose not to enroll in Medicare, their FEHBP plan remains the primary payer and they continue to receive the same level of coverage through that plan as they did prior to becoming eligible for Medicare.⁵ Two stakeholders said that charging the same rates to the retiree population without Part B and the active employee population—a scenario that occurs in FEHBP—is not typical of the private, commercial insurance market.

In a recent publication, one of the stakeholders we interviewed reported that these types of issues have been a problem for FEHBP since its inception, and that it is therefore in the interest of every enrollee to join plans with the lowest proportion of high-cost retirees.⁶ The stakeholder noted that this distorts plan selection and alters results, noting that while the Kaiser plans on the West Coast do an outstanding job of keeping costs low for enrollees, they have a disproportionate number of retirees who correctly understand that they do not need to enroll in Medicare. According to the stakeholder, this puts Kaiser at a disadvantage since it has to cover the age-related costs of these enrollees.

³According to OPM, in 2015, about 21 percent of Medicare-eligible retirees with self-only coverage and 24 percent with family coverage were not enrolled in Medicare coverage of outpatient services (Part B). Additionally, about 5 percent of Medicare-eligible retirees with self-only coverage and 2 percent with family coverage percent were not enrolled in Medicare coverage for hospital services (Part A).

⁴Medicare beneficiaries generally would be billed an extra 10 percent of their monthly premium for each full 12-month period that they were eligible for Part B coverage but did not sign up for it.

⁵In general, for those FEHBP retirees eligible-for and enrolled in Medicare and FEHBP, Medicare is the primary insurer, and the FEHBP plans typically cover any expenses that Medicare does not cover.

⁶W. Francis, "Postal Service Health Benefits and the FEHBP: The Urgent Case for Getting Reform Right," *The Heritage Foundation BACKGROUNDER*, no. 3155 (2016).

Stakeholders we interviewed offered a number of potential solutions for OPM to address these challenges. For example, two stakeholders suggested that OPM could introduce some form of risk adjustment into FEHBP to assist plans that have a disproportionate number of Medicare-eligible enrollees. Risk adjustment provides a way to correct for imbalances that occur when some carriers attract a larger share of enrollees at low risk for expensive claims and other carriers attract a larger share of enrollees at high risk for expensive claims. One of the two stakeholders suggested that FEHBP could introduce a budget-neutral risk adjustment program that adjusts the amount of a plan's premium that is paid by the government based on a plan's ratio of age-65 retirees with Medicare (Parts A, B, or both) to those without. The stakeholder said that this would greatly improve plan competition over time.

OPM officials agreed with stakeholders that providing nationwide service is an advantage for carriers like BCBSA in high cost areas, but noted that it is a disadvantage in low cost areas, and said that, similarly, a lack of risk adjustment in the program works both in favor of and against BCBSA and HMOs. OPM officials said, for example, that the BCBSA Standard option would likely benefit from risk adjustment, while the BCBSA Basic option would likely be negatively impacted.⁷ OPM officials also said that risk adjustment could be a way for the agency to compensate plans that have enrollees with higher than average risk and to improve competition by discouraging plans from avoiding those higher risk enrollees. However, officials noted that risk adjustment would require the agency to have reliable claims-level data from each of the plans, which the agency does not have. In January 2017, OPM officials said that the agency is in the process of collecting claims data from FEHBP carriers and expects to have a sufficiently reliable data set by July 2018. OPM officials also noted that before implementing any form of risk adjustment in FEHBP they would have to use that data to determine the effects on the program, and they would also need to determine whether doing so would require any legislative changes.

Some stakeholders we interviewed also suggested retirees could be incentivized to enroll in Medicare Part B (for example, by waiving the Medicare Part B late enrollment fee for FEHBP retirees, or by having

⁷The BCBSA Standard option has a higher proportion of retirees than the BCBSA Basic option. For example, in 2015, 59 percent of the Standard option's 1,618,701 policyholders were retirees, while only 21 percent of the Basic option's 888,199 policyholders were retirees.

FEHBP plans subsidize Part B premiums), and two stakeholders went as far as suggesting that Medicare enrollment should be required for those eligible.⁸ OPM officials said that they already encourage enrollment in Medicare Part B; in particular, they noted that in their annual call letters they have encouraged carriers to offer benefits in their plans that incentivize Medicare enrollment for eligible FEHBP enrollees. However, OPM officials said that they are open to pursuing additional approaches that would encourage FEHBP retirees to fully participate in Medicare coverage.⁹

The government contribution formula for FEHBP premiums. Five of the 11 stakeholders we interviewed suggested that the government contribution formula for FEHBP premiums negatively impacts program competition. The FEHBP statute establishes the amount the government contributes towards the costs of FEHBP plan premiums. By statute, the government pays an amount equal to 72 percent of the weighted average premium across all FEHBP plans, but no more than 75 percent of any particular plan's premium.¹⁰ Enrollees generally pay the remaining premium. As such, enrollee contributions will generally be 25 percent for lower-premium plans and can be higher than 28 percent if their plan's premiums are significantly higher than the weighted average FEHBP plan.

Some stakeholders we interviewed noted that BCBSA has an advantage under the contribution formula, and that the existing formula does not incentivize enrollees to choose low cost plans. Two stakeholders noted

⁸We have previously reported on a proposal to increase U.S. Postal Service retirees' use of Medicare, which would decrease the Postal Service's costs but increase Medicare costs. Because we have also previously reported that Medicare is on a fiscally unsustainable path over the long term, we noted that any additional costs resulting from such a proposal would also have to be weighed alongside the fiscal pressure already faced by Medicare. See GAO, *U.S. Postal Service: Proposed Health Plan Could Improve Financial Condition, but Impact on Medicare and Other Issues Should Be Weighed before Approval*, [GAO-13-658](#) (Washington, D.C.: July 18, 2013).

⁹For example, in OPM's 2015 FEHBP call letter to carriers, the agency noted that it was focusing on encouraging participation in Medicare Part B, and that plans should propose benefit changes that allow members to maximize their benefits under FEHBP and Medicare, such as reduced cost sharing under hospital, medical or pharmacy benefits for members with Part B.

¹⁰See 5 U.S.C. § 8906(b). Some agencies, such as the U.S Postal Service and the Federal Deposit Insurance Corporation, provide higher premium contributions for FEHBP enrollees.

that BCBSA's large program market share—66 percent of total program enrollment in 2015—allows it significant influence over the government contribution amount. Therefore, several stakeholders suggested that BCBSA's enrollees end up paying closer to the minimum of 25 to 28 percent of their premium's costs. Conversely, other plans—particularly HMOs operating in high cost areas—may have premiums that are higher than BCBSA's and the weighted program average, resulting in their enrollees having to pay considerably more than 28 percent of their total premium's costs. Two stakeholders said that, as a result, carriers may exit the program once their premiums exceed the weighted program average. Additionally, two stakeholders we interviewed suggested that the formula does not incentivize enrollees to choose lower cost plans because the maximum government contribution amount is 75 percent—regardless of whether the plan's premiums are less than the weighted FEHBP average. See table 5 for examples of how the government contribution formula affects the share of premiums that enrollees pay.

Table 5: Hypothetical Illustration of the Government Contribution and Enrollee Share of Premiums in the Federal Employees Health Benefits Program (FEHBP)

n/a	Plan A – Premium is the weighted FEHBP average	Plan B – Premium is below the weighted FEHBP average	Plan C – Premium exceeds the weighted FEHBP average
Total bi-weekly premium	\$100.00	\$75.00	\$125.00
Government contribution	\$72.00	\$56.25	\$72.00
Enrollee share	\$28.00	\$18.75	\$53.00
Enrollee share, as percentage of total premium	28%	25%	42%

Source: GAO. | GAO-18-52

Note: The federal government and FEHBP enrollees bear a portion of the cost of FEHBP plan premiums. By statute, the government pays 72 percent of the weighted average premium of all health benefit plans participating in FEHBP, but no more than 75 percent of any particular plan's premium, while enrollees pay the balance. See 5 U.S.C. § 8906(b). In this hypothetical illustration it is assumed that the weighted average premium of all health benefit plans participating in FEHBP is \$100.00.

Some stakeholders we interviewed proposed solutions to the concerns they identified with the government contribution formula. For example, two stakeholders suggested that the formula be changed so that plans that cost less than 72 percent of the weighted average would be covered either in full or to a greater extent by the government. They noted that this would incentivize enrollees to choose lower cost plan options and would strengthen the competitiveness of lower-cost plans—particularly as compared to the BCBSA options. One stakeholder also suggested that the government contribution formula could be varied by metropolitan regions (i.e., vary government and enrollee premium contributions based on regional health care costs), which they suggested would lead to more

carriers introducing more plan offerings overall. While the government contribution formula is set in statute, OPM officials said that they are open to pursuing changes that would encourage FEHBP enrollees to select the health plans that meet their current and expected health care needs at affordable costs.

FEHBP plan performance assessment system. Five of the 11 stakeholders we interviewed cited concerns with OPM's system for assessing FEHBP plan performance, with 2 noting that it discourages competition and participation in FEHBP. OPM announced a new methodology for assessing plan performance in a letter to carriers in 2015, noting that the agency would use a discrete set of quantifiable measures to examine aspects of contract performance and link this performance assessment to the profit plans receive.¹¹ OPM reported in the letter that it implemented performance assessment to move away from paying for procedures or services and towards paying for value and prevention of disease. It also noted that the system was intended to create a more objective performance standard and provide more transparency for enrollees. Stakeholders we interviewed, however, were particularly critical of the way in which community-rated plans are assessed in this new system, noting that plans are penalized rather than rewarded.¹² Regulations specify a process by which OPM may withhold a portion of payments to a community-rated carrier based on plan performance thereby reducing the carrier's profits.¹³ Two of these stakeholders said that the only way for a plan to not receive a financial penalty is to get a perfect score on the assessment and said that it is

¹¹OPM, *FEHB Program Carrier Letter No. 2015-10* (Washington, D.C.: May 12, 2015).

¹²OPM negotiates plan premiums with carriers and establishes premiums in one of two ways: experience rating or community rating. Experience-rated carriers set their premiums based on their experience; that is, their actual costs of providing health care services and the costs of administrative services. Most community-rated carriers set their FEHBP premiums based on a medical loss ratio formula comparing non-claim costs to overall expenditures, except for plans required by state law to use traditional community rating. All of the nationwide, fee-for-service FEHBP plans are experience-rated while HMOs can be either experience-rated or community-rated. See 48 C.F.R. § 1615.402 (2016).

¹³Under the 2015 final rule, OPM uses a standardized methodology to assess plan performance that is applied differently to community-rated and experience-rated carriers. See 80 Fed. Reg. 37180 (June 30, 2015). For community-rated carriers, OPM withholds a performance adjustment from net-to-carrier payments. In contrast, for experience-rated carriers, OPM uses a performance based percentage in negotiating the projected total profit or service charge for a contract. See 48 C.F.R. §§ 1615.404-4, 1615.404-70 and 1632.170 (2016).

impossible to receive such a score. Therefore, one stakeholder noted that the system is extremely discouraging to carriers, particularly to new carriers considering joining FEHBP. Additionally, two stakeholders said that the measures used in the assessment—Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures—favor certain types of HMOs. For example, one stakeholder noted that some carriers can have problems meeting the HEDIS measure for breast cancer screening rates, because they have to get patients to go to a separate mammography center while carriers that are part of more integrated health systems can offer mammograms in-house.

With regard to how the plan performance assessment system could be improved, stakeholders we interviewed suggested that OPM should switch to a reward or incentive-based system for community-rated carriers. Several stakeholders suggested that OPM could implement a system similar to the Medicare Advantage star ratings system.¹⁴ In December 2016, OPM officials told us that they were listening to community-rated plans' concerns regarding the performance assessment penalty and would consider adjustments to address these concerns. Then in March 2017, in response to some of these concerns, OPM issued a letter to FEHBP carriers proposing an update to the assessment of community-rated plans that would allow carriers with high-performing plans to avoid any financial penalties.¹⁵ Regarding the concern about the use of HEDIS and CAHPS measures, OPM officials said that these measures are well-established and commonly required by other commercial and government payers, such as Medicare Advantage. Nonetheless, OPM officials said that the plan performance system will continuously be improved through the introduction of new measures and the retirement of measures on which all FEHBP plans have achieved satisfactory performance.

¹⁴The Medicare Advantage program, an alternative to the original Medicare fee-for-service program, provides health care coverage to Medicare beneficiaries through private health plans offered by organizations under contract with the Centers for Medicare & Medicaid Services. To help Medicare beneficiaries select a Medicare Advantage plan in their area, the Centers for Medicare & Medicaid Services rates Medicare Advantage contractors on a 5-star scale, with 5 stars indicating the highest quality. As an incentive for plans to achieve high star ratings, plans receive bonus payments based on these ratings.

¹⁵OPM, *FEHB Program Carrier Letter No. 2017-02* (Washington, D.C.: Mar. 16, 2017).

Appendix III: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, William Hadley (Assistant Director), Kristi Peterson (Assistant Director), Christina Ritchie (Analyst in Charge), Leonard Brown, William Garrard, Daniel Ries, and Said Sariolghalam made key contributions to this report. Also contributing were Sandra George, Emei Li, Yesook Merrill, Laurie Pachter, Vikki Porter, Jennifer Rudisill, Frank Todisco, and Merrile Sing.

Appendix IV: Accessible Data

Data Tables

Accessible Data for Figure 1: Total Federal Employees Health Benefits Program (FEHBP) Enrollment, and Top Five Carriers Enrollment Share, 2000 through 2015

Parent Company	Year 2000 percent age enrollment share	Year 2001 percent age enrollment share	Year 2002 percent age enrollment share	Year 2003 percent age enrollment share	Year 2004 percent age enrollment share	Year 2005 percent age enrollment share	Year 2006 percent age enrollment share	Year 2007 percent age enrollment share
Blue Cross Blue Shield Association	46.0%	46.0%	49.0%	52.0%	54.0%	56.0%	58.0%	60.0%
Mail Handlers Benefit Plan	11.0%	12.0%	11.0%	8.6%	7.3%	6.0%	5.0%	4.9%
Kaiser Permanente	6.9%	6.5%	6.5%	6.7%	6.6%	6.4%	6.3%	6.1%
Government Employees Health Association, Inc.	5.5%	5.3%	5.4%	5.4%	5.1%	5.3%	5.2%	5.0%
Aetna	5.3%	5.9%	3.8%	3.8%	4.1%	4.1%	4.3%	4.4%
<i>Total Enrollment, all FEHBP carriers</i>	<i>8,174,804</i>	<i>8,342,249</i>	<i>8,102,335</i>	<i>7,946,458</i>	<i>7,806,460</i>	<i>7,803,938</i>	<i>7,731,865</i>	<i>7,715,680</i>

Parent Company	Year 2008 percent age enrollment share	Year 2009 percent age enrollment share	Year 2010 percent age enrollment share	Year 2011 percent age enrollment share	Year 2012 percent age enrollment share	Year 2013 percent age enrollment share	Year 2014 percent age enrollment share	Year 2015 percent age enrollment share
Blue Cross Blue Shield Association	62.0%	61.0%	62.0%	63.0%	64.0%	65.0%	65.0%	66.0%
Mail Handlers Benefit Plan	4.7%	4.6%	4.1%	3.5%	3.1%	2.9%	2.8%	2.9%
Kaiser Permanente	5.9%	5.9%	5.9%	5.9%	5.8%	5.8%	5.7%	5.7%
Government Employees Health Association, Inc.	5.0%	5.2%	5.9%	6.7%	7.1%	7.4%	7.6%	7.7%
Aetna	4.5%	4.5%	4.3%	4.1%	3.8%	3.5%	3.4%	3.2%
<i>Total Enrollments, all FEHBP carriers</i>	<i>7,764,643</i>	<i>7,779,821</i>	<i>7,796,858</i>	<i>8,042,951</i>	<i>8,044,362</i>	<i>8,066,940</i>	<i>8,052,897</i>	<i>8,032,922</i>

Accessible Data for Figure 2: Available FEHBP HMO Plan Offerings within U.S. Counties (2007, 2009-2015)

Year	Minimum	Lower Quartile	Median	Upper Quartile	Maximum
2007	0.0	1.0	2.0	4.0	14.0
2009	0.0	2.0	4.0	6.0	15.0
2010	0.0	2.0	4.0	6.0	15.0
2011	0.0	2.0	3.0	5.0	13.0
2012	0.0	2.0	2.0	4.0	15.0
2013	0.0	4.0	4.0	6.0	17.0
2014	0.0	3.0	4.0	5.0	17.0

Year	Minimum	Lower Quartile	Median	Upper Quartile	Maximum
2015	0.0	4.0	5.0	7.0	15.0

Accessible Data for Figure 3: FEHBP Market Share Held by the Three Largest Carriers in a Median County, 2000-2015

Year	Largest Carrier	Second Largest Carrier	Third Largest Carrier
2000	57.991	16.923	9.348
2001	56.724	17.926	9.817
2002	60.441	16.589	9.062
2003	63.381	15.161	8.502
2004	66.052	13.7	7.746
2005	67.353	12.912	7.279
2006	69.18	12.213	6.856
2007	70.123	11.892	6.605
2008	71.02	11.3	6.381
2009	70.459	11.333	6.61
2010	70.436	11.349	6.562
2011	70.521	11.151	6.427
2012	70.735	11.269	6.419
2013	72.265	11.047	6.137
2014	71.566	10.794	6.08
2015	71.888	10.79	6.017

Accessible Data for Figure 5: Distribution of Market Share for the Combined Three Largest Carriers in Each State for FEHBP, Medicare Advantage, and Large Group Market (2010-2014)

FEHBP	Minimum	25th Percentile	Median	75th Percentile	Maximum
2010	69.2%	81.0%	88.1%	91.9%	98.5%
2011	70.9%	81.7%	88.1%	91.3%	98.4%
2012	71.6%	82.4%	88.9%	91.5%	98.3%
2013	74.0%	83.2%	89.1%	91.3%	98.3%
2014	75.5%	83.5%	89.1%	91.4%	98.3%

Medicare Advantage	Minimum	25th Percentile	Median	75th Percentile	Maximum
2010	33.8%	58.4%	70.6%	81.4%	100.0%

Medicare Advantage	Minimum	25th Percentile	Median	75th Percentile	Maximum
2011	31.6%	58.4%	73.8%	83.2%	100.0%
2012	29.9%	60.0%	72.6%	82.8%	100.0%
2013	30.4%	59.8%	72.4%	82.4%	100.0%
2014	30.3%	59.0%	74.0%	82.2%	99.3%

Large Group Market	Minimum	25th Percentile	Median	75th Percentile	Maximum
2010	40.7%	80.0%	89.7%	96.2%	99.9%
2011	40.8%	79.8%	88.3%	95.5%	99.9%
2012	37.5%	80.9%	88.7%	95.4%	100.0%
2013	39.5%	80.0%	89.3%	95.4%	100.0%
2014	38.2%	82.2%	90.0%	97.5%	100.0%

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