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Federal Employees Health Benefits Program: Available Health Insurance Options

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Federal Employees Health Benefits Program: Available Health Insurance Options

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Summary

The Federal Employees Health Benefits Program (FEHBP) provides health insurance coverage to about 8 million people. FEHBP provides many health insurance plan options for enrollees, including several nationally available fee-for-service plans, locally available Health Maintenance Organizations (HMOs), and, since 2003, various high-deductible health insurance plan options combined with a tax-advantaged account. Beneficiaries can use their tax-advantaged accounts to cover qualified medical expenses. Also, since July 2003, FEHBP-eligible active employees can place their own pre-tax wages into a Health Care Flexible Spending Account (HCFSA) to cover qualified medical expenses. Since 2007, eligible individuals may also elect supplemental dental and vision plans. While enrollees have a range of choices, they must decide which options best match their needs, the amount of their wages to contribute to health insurance, and how risk-averse they are to potential out-of-pocket costs.

FEHBP Basics

The federal government is the largest employer in the United States, and the Federal Employees Health Benefits program (FEHBP) is the largest employer-sponsored health insurance program. FEHBP covers about 8 million current workers, Members of Congress, annuitants, and their families. FEHBP offers enrollees a choice of five fee-for-service plans available government-wide and another five plans available to employees of certain small federal agencies (such as the Foreign Service). In total, there are about 300 different plan choices, including all regionally available options, as well as choices offered by plans for standard option, high option, and high-deductible plans. As a practical matter, depending on where an enrollee resides, his or her choice of plans is limited to about five to 15 different plans. Plan details for all FEHBP plans are available on the website of the Office of Personnel Management (OPM)—http://www.opm.gov. Beginning in 2007, those eligible for FEHBP (whether or not they are actually enrolled) may also enroll in the Federal Employee Dental and Vision Insurance Program (FEDVIP), which provides supplemental dental and vision insurance.[1]

Participation in FEHBP is voluntary, and enrollees may change plans during designated annual "open season" periods. Special enrollment periods are also allowed for new employees and for those with a qualifying special circumstance, such as marriage. Enrollees are not subject to pre-existing condition exclusions. The government's share of premiums is set at 72% of the weighted average premium of all plans in the program, not to exceed 75% of any given plan's premium. The maximum annual government contribution for 2008 is $3,800 for self-only coverage and $8,600 for family coverage. The percentage of premiums paid by the government is calculated separately for individual and family coverage, but each uses the same formula. Annuitants and active employees pay the same premium amounts, although active employees have the option of paying premiums on a pre-tax basis. Premiums in 2008 will rise by an average of 2.1% over 2007 rates. While overall, the increases are small, some plans have large premium increases. However, premium increases ignore any changes in benefits or cost-sharing in a particular plan.

Although there is no core or standard benefit package required for FEHBP, all plans cover basic hospital, surgical, physician, and emergency care. Plans are required to cover certain special benefits including prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity of coverage for mental health and general medical care coverage; child immunizations; and limits on an enrollee's total out-of-pocket costs for a year, called the catastrophic limit. Generally, once an enrollee's covered out-of-pocket expenditures reach the catastrophic limit, the plan pays 100% of covered medical expenses for the remainder of the year. Plans must also include certain cost-containment provisions, such as offering preferred provider organization (PPO) networks in fee-for-service plans and hospital pre-admission certification.

FEHBP Plans

FEHBP statutes specify three types of participating plans:

- The **government-wide plan** is the fee-for-service plan that pays providers directly for services (this slot has always been filled by Blue Cross and Blue Shield).

[1] For more information on the FEDVIP program, see CRS Report RS22535, *Federal Employees Dental and Vision Insurance Program (FEDVIP)*, by Hinda Chaikind.

- **Employee organization plans** are fee-for-service plans, such as the American Postal Workers Union (APWU) plan. All persons eligible to enroll in FEHBP may choose an employee organization plan, subject to small annual membership dues.
- **Comprehensive medical plans** include the HMOs. Availability of these plans varies, depending on where the individual resides.

Deductibles, copayments, and coinsurance amounts vary across plans. Many plans offer two or more options with different premiums and levels of coverage. Even within individual plans, enrollees are offered a lower deductible and coinsurance amount if they choose to use services, such as a physician or hospital provider, in the plan's network. Examining the premiums, deductibles, copayment and coinsurance amounts for physician office visits in the Blue Cross and Blue Shield (BCBS) plans provides an example of this variation. For 2008, BCBS offers both a *Standard* plan (its more generous plan) and a *Basic* plan. Under the *Standard* BCBS plan, in 2008, monthly premiums will increase by more than 8% over 2007 rates to $134.66 for individual coverage and $314.47 for family coverage. The 2008 calendar year deductible is $300 per person with a maximum family deductible of $600 (an increase of $50 and $100, respectively). Enrollees receiving services from a "preferred" provider are responsible for a $15 copayment for a physician office visit with no requirement to first meet the deductible. For an office visit with a participating physician, enrollees are responsible for 25% of the plan's allowed amount, after meeting the deductible. For an office visit with a non-participating physician, enrollees are responsible for 25% of the allowed amount, after meeting the deductible, plus all of the difference between the allowed amount and the physician's actual charge.

Under the *Basic* plan, in 2008, enrollee's monthly premiums will increase about 3% over 2007 rates to $84.79 for individual coverage and $198.60 for family coverage. There is no calender-year deductible. Enrollees pay a $20 copayment for an office visit to a preferred primary care provider and a $30 copayment for an office visit to preferred specialist. The *Basic* plan operates similarly to an HMO, in that enrollees may use only preferred providers to receive benefits, except in special circumstances such as emergency care.

High-Deductible Plans Combined with Tax-Advantaged Accounts

In 2003, FEHBP began offering high-deductible plans coupled with tax-advantaged accounts that could be used to pay for qualified medical expenses. These plans are believed to help control costs by exposing enrollees to more risk for their health care expenditures. FEHBP first offered this arrangement by combining a consumer-driven health plan (CDHP) with a Health Reimbursement Arrangement (HRA). In 2005, FEHBP expanded this option to include a high-deductible health plan (HDHP) with either a Health Savings Account (HSA) or an HRA. Beginning in 2008, the Blue Cross/Blue Shield *Basic* plan will have a new basic plan sub-option called Basic Consumer option, which is a HDHP coupled with an HSA or HRA, available in limited areas. Additionally, both the employee organization plans and the comprehensive medical plans offer CDHPs and HDHPs. While CDHPs and HDHPs are both high-deductible plans, there are major differences between them, which are described below.

Consumer-Driven Health Plans

For 2008, those choosing APWU's CHDP plan are provided with an HRA (referred to as a Personal Care Account, or PCA, in the APWU plan), which the plan funds in the amount of

$1,200 for individuals and $2,400 for families. PCA funds are not taxable. Unused balances of a PCA may be carried over, with a limit of $5,000 for individuals and $10,000 for families, but balances are forfeited when an enrollee leaves the plan.

In APWU's CDHP, all eligible health care expenses (except in-network preventive care) are paid first from the PCA. Eligible expenses include basic medical, surgical hospital, prescription drug and other services covered under the high-deductible plan, as well as dental and vision services (with a limit of up to $400 per year for self and $800 for family). Once the enrollee has spent the amount contributed by the plan to the PCA (i.e., $1,200 or $2,400), enrollees must pay the "member responsibility." This member responsibility ($600 for individuals and $1,200 for families) is similar to a deductible, except that it is not for first-dollar coverage. Members who have built up the balances in their PCA over time may use any excess funds to meet their member responsibility.[2] Once the deductible has been satisfied, the high-deductible plan starts covering services, with copayments and coinsurance amounts similar to those found in traditional health plans. Enrollee monthly premiums in 2008 for APWU's CDHP are lower than 2007 rates by about 5% at $84.17 for individual and $189.37for family coverage. While enrollees may use either in- or out-of-network providers, the PCA funds will go further for in-network providers. For example, amounts over the plan allowance for out-of-network services do not count toward reducing the member responsibility.

In 2008, in addition to APWU's nationally available CDHP, two other plans, AETNA and Humana, also offer a CDHP. Although widely available, neither of these plans is nationally available. While these three plans are similar in many ways, there are some significant differences, including (1) the amount the plans place in the HRA, (2) the carryover amount, (3) rules for when the plan begins to cover medical expenses, (4) the catastrophic limit amount, and (5) availability. For example, AETNA's Medical Fund (similar to the PCA) is funded by the plan in the amount of $1,250 for individuals and $2,500 for families with no limits on carryover amounts, provided you remain in the plan.

High-Deductible Plans with an HSA or HRA

Since 2005, FEHBP has offered several HDHP plans paired with either an HSA[3] or HRA, available both nationally and regionally for 2008. FEHBP's HRAs coupled with the HDHP are similar to HRAs offered with CDHPs, in that they (1) cannot exclude FEHBP-eligible individuals, (2) can only be used for medical expenses, (3) are not subject to tax, (4) are funded solely by the plan, (5) do not earn interest, and (6) are forfeited when an enrollee leaves the plan. However, FEHBP's HRAs connected with HDHPs have no limits on carryover amounts, unlike the HRAs connected with CDHPs.

The rules for FEHBP HSAs are very different. HSAs are only available to certain individuals: those who are not enrolled in Medicare, not covered by another health plan, not claimed as a dependent on someone else's federal tax return, and those who have not received Veterans Administration health benefits in the past three months. Enrollees may add additional funds to

[2] For example, for individual coverage, if the PCA balance is $2,000, the individual could use $1,200 from the fund to pay for services and another $600 from the fund to meet the member responsibility. The enrollee would then qualify for coverage under the high-deductible health care plan while still retaining a PCA balance of $200.

[3] For more information on HSAs, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2008*, by Bob Lyke.

their HSA, as long as the plan's and the enrollee's combined contributions do not exceed the federal limit (for 2008, the limit is $2,900 for self coverage and $5,800 for family coverage). Enrollees over age 55 can make a "catch-up" contribution, in the amount of $900 in 2008. The plan's contribution to the HSA is tax-free, an enrollee's contribution is tax-deductible (an above-the line deduction, not limited to those who itemize), and any interest earned is tax-free. All unused funds, as well any interest, may be carried over each year without limit. In addition to qualified medical expenses, HSA funds may also be used for non-medical expenses, subject to the income tax and an additional penalty for those under 65. Each month, the plan automatically deposits a portion of the FEHBP HDHP premiums into an HSA or HRA. Individuals enrolled in an HDHP who are not eligible for an HSA, as of the first day of the month, have their funds credited to an HRA. Plans place the same amount into an enrollee's HRA as they do into an HSA.

There are also similarities and differences between the CDHP's and HDHP's high- deductible plans. Both may cover preventive services without first meeting a deductible, both operate similar to traditional health care once the deductible has been met, both save beneficiaries money for using in-network services, and both require higher deductibles and catastrophic limits than other FEHBP plans. However, the CDHP's high-deductible plan only covers services after both the amount contributed by the plan for the year has been spent and the member responsibility/deductible has been met, while the HDHP begins to cover services once the deductible has been met. There are exceptions in both cases for preventive care. The minimum deductible for the HDHP is specified in law, as is the maximum catastrophic limit, while neither is specified for the CDHP.

Examining GEHA's HDHP provides an example of premiums, deductibles and HSA/HRAs for these types of plans. For individual coverage in 2008, the monthly premium is $95.20, the deductible is $1,500, the plan will place $60 per month in the HSA/HRA, and those in the HSA may contribute another $2,180 annually (the difference between the amount contributed by the plan and the federal self coverage limit). For family coverage in 2008, the monthly premium is $217.45; the deductible is $3,000; the plan places $120 per month into the HSA/HRA; and those with an HSA may contribute another $4,360 annually (the difference between the amount contributed by the plan and the federal family coverage limit). Enrollees over age 55 may also make "catch-up" contributions. While the premiums and deductible for GEHA's HDHP plan did not increase over the 2007 amounts, the amount contributed by the plan to the HSA/HRA decreased by $30 per month for individual and $60 per month for family coverage.

Flexible Spending Accounts and Their Role in FEHBP

Active federal employees (not annuitants) may participate in the federal Flexible Spending Accounts (FSA) program, consisting of a Health Care FSA and a Dependent Care FSA.[4] Contributions to an FSA are voluntary, with accounts funded solely by an employee from his or her pre-taxed salary, thereby reducing taxable income. The government does not make any contribution to the FSA. Funds in a Health Care FSA (HCFSA) can be used to pay for qualified medical expenses that are not reimbursed or covered by any other source. Qualified medical expenses include coinsurance amounts, copayments, deductibles, dental care, glasses, hearing aids, as well as certain over-the-counter medical supplies that are not cosmetic in nature. The FSA

[4] For more information on FSAs, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Bob Lyke.

program provides a complete list of covered and non-covered medical expenses: http://www.fsafeds.com.

Employees choosing to participate in an HCFSA must contribute at least $250 and no more than $5,000 per year to an account, and the total pledged contribution for the year is available at the start of the year. One significant limitation of the HCFSA is that funds can only be carried over for 2½ months after the end of the plan year (for example, 2008 contributions to the HCFSA may be used to reimburse expenses incurred during calendar year 2008 continuing through March 15, 2009). Unused funds are forfeited. During the annual FEHBP open season, employees may voluntarily make an election for an HCFSA amount to be set aside in the upcoming year. Employees eligible for FEHBP (even those not currently enrolled) may elect an HCFSA. Under Internal Revenue Code rules, only current employees and not annuitants are eligible to contribute to an HCFSA.

Individuals who are enrolled in either a CDHP or HDHP coupled with an HRA may also enroll in the HCFSA, as long as they are not annuitants. Individuals enrolled in an HSA may also enroll in a limited expense HCFSA (LEX HCFSA) that can be used to cover qualified dental and vision care. Individuals have to weigh the pros and cons of the LEX HCFSA coupled with an HSA against a standard HCFSA, choosing the one that best fits their needs, especially if they have a large expense that can only be covered by the standard HCFSA, such as a hearing aid. On the other hand, HSAs funds can be carried over from year to year, and some of the funding in the HSA comes from the plan.

Medicare and FEHBP

Finally, most federal employees or annuitants reaching age 65 qualify for Medicare. Federal workers and their employer each pay 1.45% of earnings. Individuals must have the required number of quarters of Medicare-covered employment to be eligible for Medicare Part A, Hospital Insurance (HI). Medicare Part B Supplementary Medicare Insurance (SMI) and Part D prescription drug coverage are voluntary, and qualified individuals choosing to enroll must pay a monthly premium. Generally, individuals who do not enroll in Parts B or D during their initial eligibility period are subject to a penalty. However, for Part B, individuals covered by an FEHBP plan either through their own or a spouse's active employment (not annuitant coverage), may wait until either they or their spouse retires to enroll without incurring a delayed enrollment penalty. Upon retirement, individuals must enroll in Part B or be subject to a late enrollment penalty. For Part D, the prescription drug coverage included in FEHBP plans is determined to be at least actuarially equivalent to Part D, on average. Therefore, if an individual maintains FEHBP coverage and at a later date decides to enroll in Part D, there is no late enrollment penalty. The same rules for late enrollment penalties also apply in the private sector. Annuitants or former spouses may suspend FEHBP enrollment to enroll in a Medicare Advantage plan (basically, a Medicare HMO or regional PPO), with the option to re-enroll in FEHBP during open season, or sooner, if they involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Conclusion

FEHBP's wide range of options allows enrollees to use their own authority to hold down their health insurance costs, and because premiums are based on an average of all plan costs, individual decisions ultimately affect all enrollees. Eligible enrollees must weigh personal factors,

such as how much of their wages they are willing to contribute to health insurance and how risk-averse they are to potential out-of-pocket costs. However, FEHBP-eligible individuals may revisit their decision every year during the annual open season. Individuals who find themselves with too much or too little risk, under- or over-coverage, and those whose health status changes, may change plans each year. In the past, however, there has been very little movement from one plan to another each year. More than one-half of all FEHBP eligibles are enrolled in a Blue Cross and Blue Shield plan, and even those enrolled in other FEHBP plans tend to remain in their plan from year to year.

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