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Federal Employees Health Benefits Program

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The Federal Employees' Health Benefits Program (FEHBP) is a health insurance program for federal employees, annuitants, and their dependents. In 1997, about 9 million people participate in 374 FEHBP plans nationwide. On average, the federal government pays 71% of the cost of FEHBP premiums; participants pay the remaining 29%. The formula determining the government's share of health insurance premiums and the enrollees' share was to expire at the end of 1998, which, many believe, would have resulted in an average increase of about 23% in enrollee premiums and a concomitant reduction in the government share. However, the Balanced Budget Act of 1997 (P.L. 105-33) established a new formula that permanently sets the government's share of premiums at 72% of the average total premium cost of all plans in the FEHBP, weighted by the number of participants in each plan. The government share cannot exceed 75% of the premium of any particular plan.

Background. FEHBP, authorized by the Federal Employees Health Benefits Act of 1959 (P.L. 86-382), began operations on July 1, 1960. The total cost of the program is estimated to be $16.3 billion in FY1997, of which $12.1 billion is the government's share and $4.2 billion is paid by enrollees. The basic structure of FEHBP has undergone relatively few changes since the program began operation. Since 1991, the U.S. Office of Personnel Management (OPM) has required participant plans to implement cost containment procedures and policies such as hospital precertification, case management, and development of preferred provider networks. These efforts helped FEHBP join the recent trend toward slower growth in health insurance premiums. From 1989 to 1997, FEHBP premiums increased at an average annual rate of 3.7%. The premiums for 1998 will increase by an average of 8.5%. Among the reasons for the larger increase are the general trend toward higher health care costs and a reduction in the use of reserve funds in the health benefits trust fund. New benefits for 1998 include longer hospital stays for childbirth and for mastectomy patients and the elimination of maximum dollar limits on covered mental health care.

Eligibility and Participation. Participation in FEHBP is voluntary, and enrollees may change from one plan to another during annual "open season" periods. Active and retired Members of Congress may participate under the same rules as other federal employees. At the time of retirement, enrollees must make a one-time election to continue to participate in FEHBP as retirees, provided they have been enrolled for at least 5 years continuously up to the retirement date and are eligible for an immediate annuity. Participating retirees pay the same premiums as active employees. In 1996, about 9

million individuals were covered: 2.3 million active employees, 1.8 million annuitants, and 5 million dependents. Approximately 86% of all eligible federal employees and annuitants are enrolled in their own names, and another 4% are covered as dependents.

Plans and Options. FEHBP offers a choice among many plans with varying levels of benefits and premiums. Several FEHBP plans offer more than one benefit package: a high option and a "standard" option. Once again new plans have joined the program for 1998, and there will be a total of more than 350 plans available. As a practical matter, enrollees' choices are limited to between 10 and 30 options, depending on where they live. Two basic types of plans are offered under FEHBP:

- **Fee-for-Service Plans**, which pay the participant or health care provider for covered services, include the Service Benefit Plan administered by the National Blue Cross and Blue Shield Association and several employee organization plans. These are sponsored by employee organizations or unions and most of them are open to employees or annuitants who are, or who become, members of the sponsoring organization.

- **Health Maintenance Organizations (HMOs)**, which provide or arrange for health care by designated plan physicians, hospitals, and other providers in particular geographic locations. For 1998, there are more than 300 participating HMOs.

Some plans offer a Point of Service (POS) product, which is a hybrid of the two above forms. Enrollees choose between "out of network" and "in network" providers for each visit to a health care provider. Participants pay lower copayments and deductibles by using the "in network" providers. The FEHBP plans cover a range of benefits, including hospital, surgical, physician, mental health, prescription drug, and emergency care benefits. However, there are variations in the amount they pay for each benefit (as reflected in coinsurance provisions and deductibles), the availability of other benefits (such as dental care), and the extent to which they limit enrollees' out-of-pocket costs for medical bills in case of "catastrophic" illness or injury.

Financing. The federal government and enrollees jointly pay for the cost, or premiums, of the FEHBP plans, according to a statutory formula. Through 1998, the government's share of plan premiums is a fixed dollar amount equal to 60% of the average of the high option premiums (known as the "maximum contribution") for what have been commonly known as the "Big Six" plans. The government pays the lesser of this maximum contribution or 75% of the specific plan's premium. In 1998, the government will pay up to $1,715 annually for each self-only enrollment and $3,699 for each family enrollment.

When Aetna, one of the "Big Six" plans, withdrew from the FEHBP at the end of 1989, a temporary method for computing the government's premium share was put into effect by use of a "proxy" premium. In every year since 1990, substitute premiums for Aetna have been constructed by increasing Aetna's 1989 premiums by the average premium increase for the remaining five plans. The new formula based on the weighted average of the premiums for all plans will take effect in January 1999.