Order Code RS21974
November 17, 2004

Federal Employees Health Benefits Program: Available Health Insurance Options

Hinda Ripps Chaikind
Specialist in Social Legislation
Domestic Social Policy Division

Summary

The Federal Employees Health Benefits Program (FEHBP) provides health insurance coverage to over 8 million people. Until recently, eligible individuals could choose between several nationally available fee-for-service type plans or locally available Health Maintenance Organizations (HMOs). Continuing its commitment to provide choices and to constrain health insurance costs, FEHBP began offering a new type of plan in 2003; a health insurance plan that has a high deductible combined with a tax-advantaged account. Beneficiaries can use their account to cover certain qualified medical expenses. FEHBP now offers several variations of these plans and accounts. Since July 2003, FEHBP eligible active employees can also place their own pre-tax wages into a Health Care Flexible Spending Account (HCFSA) to cover qualified medical expenses. While enrollees have a range of health plan choices, they must decide which plan best matches their needs, how much of their wages to contribute to health insurance, and how risk adverse they are to potential out-of-pocket costs. This report will be updated for legislative activity.

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 8.2 million current workers, Members of Congress, annuitants, and their families. FEHBP offers enrollees a choice of six fee-for-service plans available government-wide, another five plans available to employees of certain small federal agencies (such as the Foreign Service), and almost 200 HMOs serving limited geographic areas. Because most of these plans are HMOs serving a limited locale, as a practical matter, an enrollee's choice is limited to between six and thirty options. Plan details for all FEHBP plans are available on the Office of Personnel Management's (OPM) website — [http://www.opm.gov].

Participation in FEHBP is voluntary, and enrollees may change from one plan to another 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. Since 1999, the government's share of premiums has been 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 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 there is no core or standard benefit package required for FEHBP plans, 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 (PPOs) networks in fee-for-service plans and hospital preadmission certification.

FEHBP Plans

FEHBP specifies three types of participating plans:

- **Government-wide plan** — This includes the fee-for-service plan that pays providers directly for services (this slot has always been filled by Blue Cross and Blue Shield);
- **Plans sponsored by employee organizations** — These are fee-for-service plans, such as the American Postal Workers Union (APWU) plan. All persons eligible to enroll in FEHBP may choose the APWU plan, subject to small annual membership dues;
- **Comprehensive medical plans** — These are the HMOs. Some eligible individuals have no access to FEHBP HMOs, while other may have several choices.

Deductibles, copayments, and coinsurance amounts vary across plans. Many plans offer two options with different premiums and levels of coverage. Even within individual plans, enrollees may be 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 2005, BCBS will offer both a *Standard* plan, which is its more generous plan and a *Basic* plan. Under the *Standard* BCBS plan, in 2005 enrollees will pay a monthly premium of $109.87 for individual coverage and $255.79 for family coverage. The 2005 calendar year deductible for this plan is $250 per person with maximum family deductible of $500. 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 2005, enrollees will pay a lower monthly premium of $82.32 for individual coverage and $192.82 for family coverage. There is no calender year deductible. Enrollees will pay a $20 copayment for an office visit with a preferred primary care provider and a $30 copayment for an office visit with a preferred specialist. The *Basic* plan operates similar to an HMO in that enrollees may only use preferred providers to receive benefits, except in special circumstances such as emergency care.

The Newest FEHBP Options: Combining a Plan with a High Deductible and a Tax-Advantaged Account

In 2003, FEHBP began offering a new option: a plan with a high deductible coupled with a tax-advantaged account that could be used to pay for qualified medical expenses. These plans have been offered in response to increasing health care costs and health insurance premiums. They are believed to help control these increases by exposing the enrollee to more of the decision-making process and the risk for expenditures for their health care services. In 2003, FEHBP first offered this arrangement by combining a consumer-driven health plan (CDHP) with a Health Reimbursement Arrangement (HRA). For 2005, FEHBP expanded this option by also offering a high-deductible health plan (HDHP) with either a Health Savings Account (HSA) or an HRA. While FEHBP's CDHPs and HDHPs both include a high-deductible plan, there are important differences between the two, described below. In FEHBP, HRAs can be combined with either a CDHP or HDHP, but HSAs are only available with an HDHP.

Consumer-Driven Health Plans. In 2003, FEHBP offered its first CDHP, available nationally, through the APWU. For 2005, those choosing this plan are provided with an HRA (referred to as a Personal Care Account [PCA] in the APWU plan), which the plan will fund in the amount of $1,200 for individuals and $2,400 for families. PCA funds are not taxable. Unused balances of the PCA may be carried over, with a limit of $5,000 for individuals and $10,000 for families, but balances are forfeited when the 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.[1] Once the deductible has been satisfied, the high-deductible plan will begin to cover

[1] For example, for individual coverage, if the PCA balance is $2,000, then the individual could use the first $1,200 from the fund to pay for services and then use 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.

services, with copayments and coinsurance amounts similar to coverage found in a traditional health plans. The 2005 monthly premium for APWU's CDHP is $88.60 for self and $206.34 for family coverage. While enrollees are free to use providers either in- or out-of-network, there are significant advantages to staying in the network. For example, amounts over the plan allowance for out-of-network services do not count toward reducing the "member responsibility." APWU advises enrollees that although they can use their PCA to pay to out-of network services, the PCA funds will go further if they chose in-network providers.

In 2005, in addition to APWU's nationally available CDHP, two other plans, AETNA and Humana, will also begin to offer a CDHP. Although widely available, neither of these plans is available nationally. 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 high-deductible plan begins to cover medical expenses, (4) the catastrophic limit amount, and (5) availability. For example, under the AETNA plan, the Medical Fund (similar to the PCA) will be funded by the plan in the amount of $1,000 for individuals and $2,000 for families with a carry-over limit of $4,000 for self and $8,000 for families.

High-Deductible Plans with an HSA or HRA. Beginning in 2005, FEHBP will offer several HDHP plans paired with either an HSA or HRA. 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 the 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 their HSA, as long as the plan's and the enrollee's combined contributions do not exceed the lesser of the deductible or a federal limit (for 2005, the lesser amount will be the deductible for most, if not all, FEHBP HSAs). Enrollees over age 55 can make a "catch-up" contribution, in the amount of $600 in 2005. 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 to for non-medical expenses, subject to the income tax and an additional penalty for those under 65.

Each month, the plan will automatically credit a portion of the FEHBP HDHP premium into an HSA or an HRA. Individuals enrolled in an HDHP who are not eligible for an HSA, as of the first day of the month, will have their funds credited to an HRA. Plans will place the same amount into an enrollee's HRA as they do into an HSA. Individuals who retire and remain in the same health plan can still use and accumulate funds in their HRA.

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 will save beneficiaries money for using in-network services, and both require higher deductibles and catastrophic limits than other FEHBP health plans. However, the CDHP's high-deductible plan only covers services once the amount contributed by the plan for the year and the "deductible" have both been met, while the HDHP begins to cover services once the deductible has been meet. 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.

As an example, the GEHA will offer an HDHP nationally. For self-coverage in 2005, the monthly premium is $96.80, the deductible is $1,100, the plan will put $60 per month in the HSA/HRA, and those in the HSA may contribute another $380 (the difference between the amount contributed by the plan and the individual deductible for 2005). For family coverage in 2005, the monthly premium is $223.62, the deductible is $2,200, the plan will put $120 into the HSA/HRA, and those with an HSA may contribute another $760 (difference between the amount contributed by the plan and the family deductible for 2005). Enrollees over 55 in self or family plans may also make "catch-up" contributions.

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.[2] 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 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 $4,000 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 cannot be carried over from one year to the next so that unused funds are forfeited at the end of the year. During the annual FEHBP open season, employees may voluntarily make a new election for an FSA amount to be set aside in the upcoming year. Federal employees eligible for FEHBP (even those not currently enrolled) are able to elect a FSA. Under the rules of the Internal Revenue Code, only current employees and not annuitants are eligible to participate in an FSA.

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. While the Internal Revenue Service allows individuals to have both an HCFSA and an HSA, OPM has determined that under the FEHBP, individuals must chose between the two (although they may still

---

[2] For a detailed description of the FSA program, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Chris Peterson and Bob Lyke.

have a Dependent Care FSA). Therefore, individuals have to weigh the benefits and limitations of the HCFSA and the HSA, choosing the one that best fits their needs, especially if they have a big expense, such as a hearing aid. HSAs are the more flexible of the two, because they can be carried over each year. Additionally, some of the funding in the HSA comes from the plan. The FSA limit is $4,000 per year, which is higher than the HSA limit for individual coverage, but may be lower than the HSA limit for family coverage.

Medicare and FEHBP

Finally, most federal employers or annuitants reaching age 65 will qualify for Medicare coverage. Federal workers and their employer each pay 1.45% of earnings and individuals must have at least 40 quarters of Medicare-covered employment to be eligible for Medicare Part A, Hospital Insurance (HI). The other parts of Medicare, Part B Supplementary Medicare Insurance (SMI), and Medicare Part D, prescription drug coverage (available in 2006), are voluntary, and qualified individuals choosing to enroll are required to pay a monthly premium. Generally, individuals are required to enroll in Part B, and in 2006, Part D, during their initial eligibility period, and those who wait to enroll at a later date are subject to a penalty. However, if individuals are covered by employer-sponsored health insurance either though their own active employment (not annuitant coverage) or their spouse's active employment, they may wait until either they or their spouse retires to enroll in Part B and, beginning in 2006, Part D, without incurring a delayed enrollment penalty. Upon retirement, individuals must enroll in Parts B or D, or be subject to a late enrollment penalty. The same rules also apply in the private sector.

Conclusion

FEHBP's wide range of plans gives eligible individuals a greater say in how they want to spend their health insurance dollars. Members can use their decision-making authority to hold down their own health insurance costs, and because premiums are based on an average of all plan costs, individual decisions ultimately affect all members. Each eligible individual or family must weigh personal factors such as how much of their wages they are willing to contribute to health insurance and how risk adverse they are to potentially incurring out-of-pocket costs. In the end, however, because FEHBP eligibles may re-visit their decision every year during the annual open season, these decisions can be changed each year. Individuals who find themselves with too much or too little risk, under- or over-coverage, and those whose health status changes during the year or those who experience life changes such as having a child, may leave any plan at the end of the year. They may try another option and continue to do so every 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 FEHB plans tend to remain in their plan from year to year. Perhaps this will change now that the options have been expanded, and as people face increasing premiums, they may be more willing to try new options.