Federal Employees Dental and Vision Insurance Program (FEDVIP)

Hinda Chaikind
Specialist in Health Care Financing

November 26, 2007

Congressional Research Service
7-5700
www.crs.gov
RS22535

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 was enacted on December 23, 2004 (P.L. 108-496), directing the Office of Personnel Management (OPM) to establish a supplemental dental and vision benefits program. OPM created the Federal Employees Dental and Vision Insurance Program (FEDVIP), with coverage first available on December 31, 2006. Enrollees are responsible for 100% of premiums and may choose a self-only, self + 1, or family plan. Coverage for dental and/or vision services provided through Federal Employees Health Benefits (FEHB) plans is the primary source of coverage, and the supplemental dental and vision plan is secondary. Employees may still contribute to a Flexible Spending Account (FSA) to cover any qualified unmet medical expenses.

FEDVIP Basics

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 was enacted on December 23, 2004, requiring the Office of Personnel Management (OPM) to establish arrangements under which supplemental dental and vision benefits are available to federal employees, Members of Congress, annuitants, and dependents. OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP), with coverage first available on December 31, 2006. Enrollees are responsible for 100% of the premiums, and OPM does not review disputed claims. Employees who are eligible to enroll in the Federal Employees Health Benefits (FEHB) program, whether or not they are actually enrolled, may enroll in FEDVIP. Annuitants, survivor annuitants, and compensationers (someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation program) may also enroll in FEDVIP.[1] Eligible family members include a spouse, unmarried dependent children under age 22, and continued coverage for qualified disabled children 22 years or older. Former spouses receiving an apportionment of an annuity, deferred annuitants,[2] and those in FEHB temporary continuation of coverage are not eligible to enroll in FEDVIP.

There are four nationwide dental plans, and three additional dental plans that are only available regionally. The nationwide plans also provide coverage overseas. There are three vision plans, which all provide both nationwide and overseas coverage. Eligible individuals may enroll in a FEDVIP plan during the standard open season for FEHB plans (for 2008 coverage, open season is from November 12 through December 10, 2007). Individuals may change plans during open season each year, or following a qualifying life event. As with FEHB, new employees have 60 days to enroll. FEDVIP enrollment can be done through the Internet at http://www.BENEFEDS.com, or, for those without Internet access, by calling 1-877-888-FEDS.

Individuals may choose a self-only, self +1, or a family plan. This set of options differs from the FEHB plans, which only allow for two choices: a self-only or a family plan. Individuals who choose to enroll in FEDVIP are not required to enroll in both a dental and a vision plan; they may choose only one type of coverage or both. Individuals are not required to enroll in the dental plan offered by their FEHB plan; for example, an individual whose health insurance is provided by GEHA may enroll in MetLife's dental plan and in Blue Cross Blue Shield's vision plan. However, any coverage for dental and/or vision services provided under the individual's FEHB plan is the primary source of coverage, and the FEDVIP supplemental dental and vision plans pay secondary. Additionally, active workers (not annuitants) may still contribute to a Flexible Spending Account (FSA) to cover any qualified unmet medical expenses, such as dental copayments or deductibles.[3]

[1] Annuitants must have retired with an immediate annuity; those who have a deferred annuity may not be eligible to enroll in FEDVIP. However, unlike FEHB plans, one does not have to be enrolled in FEDVIP five years before retirement to continue enrollment into retirement.

[2] These are individuals who separate from federal service before they could retire and receive a deferred annuity at age 62. Individuals who retire with at least the minimum retirement age + 10 years of service and postpone receipt of an annuity can enroll in FEDVIP (as well as FEHB), when they begin to receive their annuity.

[3] For more information on FEHB and FSAs, see CRS Report RS21974, *Federal Employees Health Benefits Program: Available Health Insurance Options*, by (name redacted), and CRS Report RL32656, *Health Care Flexible Spending Accounts*, by (name redacted).

Premiums vary by plan, by whether the enrollment includes other family members, and by residency (for dental plans only). Unlike nationwide FEHB plans, individuals enrolled in a FEDVIP dental plan pay different premiums depending on where they live in the country or overseas. Active employees pay FEDVIP premiums on a pre-tax basis (called premium conversion). However, unlike FEHB plans, employees may not opt out of premium conversion. Pre-tax premiums are not available to annuitants, survivor annuitants, or compensationers.

While there are no preexisting condition exclusions for this coverage, there are waiting periods for orthodontia. Individuals must be in the same plan for the entire waiting period, and switching to a new plan may require beginning the waiting period over again. There are no waiting periods for vision services. While the statutes allow for more stringent waiting periods for individuals who do not enroll at their first enrollment opportunity, the brochures for 2008 do not indicate that plans have imposed additional restrictions. Enrollees will pay less out-of-pocket costs if they use in-network services.

Dental Plans

For 2008, the four nationwide dental plans are Aetna, GEHA, MetLife, and United Concordia. Both GEHA and MetLife have two options—a high and a standard option. There are also three regional plans: Triple-S (covering Puerto Rico), GHI (covering New York and parts of Pennsylvania, Connecticut, and New Jersey), and CompBenefits (covering 19 states,[4] Washington, D.C., and parts of Maryland). Only the nationwide plans also provide coverage overseas. The benefits provided by these plans include, but are not limited to, the following: (1) Class A (Basic) services—oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays; (2) Class B (Intermediate) services—restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments; (3) Class C (Major) services—endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, and bridges, and prosthodontic services such as complete dentures; and (4) Class D (Orthodontic) service.

Premiums for these plans vary by geographic area. For example, an Aetna enrollee in Washington, D.C., will pay a monthly premium of $28.97 for self-only coverage. Monthly premiums for Aetna's plan range from $26.35 to $36.83, depending on where the enrollee resides. For all dental plans, self + 1 premiums are approximately twice the plan's self-only premium, and family premiums are about three times the plan's self-only premium. Thus, comparing plan premiums is slightly more complex than comparing nationwide FEHB plan premiums, for which everyone in the same self-only plan pays the same premium, regardless of where they live, and for which there is no self + 1 option. Similar to the FEHB program, premiums also vary by high or standard options.

Table 1, below, compares the national dental plans, including the monthly premiums for the Washington, D.C., area.[5] Monthly self-only premiums range from $22.71 for MetLife's standard plan to $37.90 for GEHA's high option plan. Only Aetna had no premium increase over last year, with other plans increasing self-only premiums from about $1 per month (GEHA high option,

[4] The covered states are Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Missouri, Mississippi, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

[5] The premiums for all areas are available at OPM's website http://www.OPM.gov, and in each of the plan brochures.

with about a 2% increase) to $4.50 per month (United Concordia, with about a 15% increase) per month. The percentage of services covered by a plan varies by class of service, with only GEHA's standard plan requiring a copayment for preventive services. Enrollees who choose out-of-network services pay their coinsurance plus any amount over the plan's payment. The United Concordia plan pays only for emergency out-of-network services. All of the plans cover underserved areas, as well as those overseas. The plans also impose an annual benefit limit for total Class A through C services of $1,200 for all plans, except MetLife's high option plan with a $3,000 limit. There is a lifetime orthodontia limit, which is $1,500 for all plans, except MetLife's high option plan, which has a $3,000 limit.

Table 1. Comparison of National Dental Plans

	Aetna	GEHA (high)	GEHA (standard)	Metlife (high)	Metlife (standard)	United Concordia
Washington, DC monthly self-only premium[a]	$28.97	$37.90	$27.13	$37.09	$22.71	$34.91
Preventive % covered (Class A)	100%	100%	100% (after $10 copay)	100%	100%	100%
Intermediate % covered (Class B)	60%	80%	55%	70%	55%	80%
Major % covered (Class C)	40%	50%	35%	50%	35%	50%
Orthodontic % covered (Class D)	30%	30%	30%	50%	50%	50%
Per-person deductible (Class B)	$0	$0	$0	$0	$0	Combined deductible, $75 for self and $150 for family
Per-person deductible (Class C)	$0	$0	$0	$0	$0	
Annual per-person Limit	$1,200	$1,200	$1,200	$3,000	$1,200	$1,200
Orthodontic Lifetime Limit (up to age 19)	$1,500	$1,500	$1,500	$3,000	$1,500	$1,500
Out-of-Network	Same % per class, based on Usual and Customary	Same % per class, based on plan allowance	Same % per class, based on plan allowance	Lesser % per class, based on Usual and Customary	Lesser % per class, based on Usual and Customary	Emergency only

Source: OPM.

a. Premiums vary by residence, so it is important to check the plan.

Vision Plans

For 2008, the three vision plans are FEP BlueVision (Blue Cross and Blue Shield), Spectera, and Vision Service Plans (VSP). Each of these plans has both a high and a standard option, and also provides both nationwide and overseas coverage. Annual premiums for the three plans are similar; annual self-only coverage is $71.76 for Spectera, $99.36 for VSP, and $103.20 for FEP BlueVision's plan. The high-option plans cost about $20 to $40 more per year. Premiums for self + 1 plans are about double the costs of self-only plans, and premiums for family plans are about triple the costs. For 2008, Spectera had a very small premium increase (for self-only standard coverage, premiums increased by $0.20 per month, and high plan premiums increased by $0.39 per month, each about a 5% increase). The other vision plans' premiums remained the same.

The more significant differences are found in benefits and network limitations. For example, under the FEP BlueVision plan, enrollees must stay in-network for covered services, with two exceptions: those who living in a limited access area or those who receive services overseas. Enrollees are responsible for any difference between the amount billed by the provider and the actual plan payment. Spectera and VSP both allow for reimbursement for visits to out-of-network providers.

Generally, covered services are limited to eye exams, a choice between lenses for glasses or contacts, and extra discounts and savings on non-covered services, such as progressive lenses and additional glasses. The services are provided according to a schedule, such as eye exams every 12 months and new frames every 24 months. Additionally, plans cover low vision coverage on a limited basis.

As shown in **Table 2**, an individual enrolled in either of Spectera's plans could have an exam and new lenses and frames once during the course of a year. The copayment would be $10 for the exam and $10 for the lenses, or $25 for both lenses and frames, if new frames were purchased. Spectera's standard option includes scratch-resistant coating and polycarbonate lenses, and the high option also covers basic progressive lenses, tinted lenses, and UV coating. Plan brochures provide more detail on the differences between the standard and high options. The choice of covered frames is also limited. For those using services outside the network, the plans provide a schedule of payments. Enrollees may opt for contact lenses in lieu of glasses, subject to each plan's limits (i.e., generally a limit on disposable contacts, supplying only enough for part of the year).

Table 2. Comparison of Vision Plans

	BlueVision (standard)	BlueVision (high)	Spectera (standard)	Spectera (high)	VSP (standard)	VSP (high)
Monthly self-only premium	$8.60	$10.86	$5.98	$7.78	$8.28	$11.70
Examination (months between covered services)	12	12	12	12	12	12
Lenses (months between covered services)	12	12	12	12	12	12

Frames (months between covered services)	24	12	12	12	12	12
Exam Copay	$0	$0	$10	$10	$10	$10
Lens Copay	$0	$0	$25	$10	$20	
Frame Allowance	$130	$130	$130	$130	$120	$150
Contact Lens[a]	In lieu of glasses	In lieu of glasses	In lieu of glasses	In lieu of glasses	In lieu of glasses	In lieu of glasses
Out-of Network	Not Available	Not Available	Fee Schedule	Fee Schedule	Fee Schedule	Fee Schedule

Source: OPM.

a. See plan details for contact lens examination and contacts coverage limits.

Deciding Whether or Not To Enroll in FEDVIP

Several factors should be considered in deciding whether or not to enroll in FEDVIP, including (1) coverage of these services in a FEHB plan—more likely for those enrolled in a Health Maintenance Organization (HMO), (2) likelihood of using services covered by the plans, and (3) placing the same dollar amount that would be used toward dental and/or vision benefits premiums in an FSA (available to employees and not annuitants). Each prospective enrollee must weigh these considerations and others against his or her own level of risk aversion, as well as the fact that the individual pays 100% of the premium.

Current coverage in a FEHB plan

Under the FEDVIP program, any coverage provided by an individual's FEHB health plan is primary, and the FEDVIP plans are the secondary payers. However, generally, the nationally available FEHB plans, have limited dental and vision coverage. This year, GEHA added limited vision coverage under its plans, offering an annual eye exam with a $25 copayment. GEHA, similar to some of the other national plans, has an arrangement with certain providers for discounted eyewear, but the enrollee would still be responsible for 100% of the discounted cost. In contrast, some of the FEHB HMO-type plans offer more comprehensive dental and vision benefits. Some high-deductible plans also provide some coverage. It is important to compare FEHB coverage to determine if also enrolling in FEDVIP is beneficial.

Likelihood of Using Dental/Vision Services

While some enrollees know that they will use services, such an individual who wears glasses or a dependent who will need orthodontics, some services cannot be as easily predicted, such as an individual needing a root canal. Individuals must weigh their expected benefits against the premiums. For example, an individual who wears glasses, has a yearly eye exam, and uses a provider in-network may find that paying the premium will result in lower costs than paying for each of these services separately, even with pre-tax FSA funds for employees. On the other hand, an individual who does not wear glasses may not benefit from vision supplemental insurance. There is not, however, a one-to-one correlation between buying any insurance and the expectation of using the services. There is still a large share of unknown risk that any insurance protects

against, so that some individuals may find themselves using services that they did not anticipate using.

FEDVIP versus FSA (or Both)

Both FEDVIP premiums and FSA contributions are pre-tax for employees, so that they may decide to enroll in one, none, or both. (Annuitants can not contribute to an FSA or pay premiums with pre-tax dollars.) Enrollees who choose both can use funds in the FSA for any copayments, coinsurance amounts, deductibles, amounts exceeding annual or lifetime maximums, or amounts above the plan's payment for out-of-network services. Some individuals may decide that they prefer to only contribute to an FSA and not enroll in either the dental or vision plan, and instead use their FSA funds to pay for any dental or vision expenditures. While using FSA funds provides the most flexibility, it may be that the dental and vision premiums cover more than the same dollars in the FSA. Individuals who are not sure they will use the services provided under FEDVIP can "wait and see," and if they do not use dental or vision services, they can use the FSA dollars for other qualified medical expenses. Others may choose to enroll only in FEDVIP and minimize their out-of-pocket expenditures by staying in-network. Decisions about FEDVIP and FSA can be revisited every year during open season.

Author Contact Information

(name redacted)
Specialist in Health Care Financing
/redacted/@crs.loc.gov, 7-....