



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 they will contribute to health insurance, and how risk-averse they are to potential out-of-pocket costs.

The program is administered by the Office of Personnel Management (OPM), which is statutorily given the authority to contract with qualified carriers offering plans and to prescribe regulations necessary to carry out the statute, among other duties.

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended by the Health Care and Education Act, P.L. 111-152) includes a number of provisions that require certain changes to be made to FEHBP plans or by employing agencies.

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FEHBP Basics

The statute governing the Federal Employees Health Benefits Program (FEHBP) is found in Title 5 of the U.S. Code, Chapter 89. The program is administered by the Office of Personnel Management (OPM), which is statutorily given the authority to contract with qualified carriers offering plans and to prescribe regulations necessary to carry out the statute, among other duties. (See the **Appendix** for a description of OPM's role in FEHBP.)

The federal government is the largest employer in the United States, and FEHBP is the largest employer-sponsored health insurance program. FEHBP covers about 8 million individuals, providing an estimated \$40 billion in 2010 in health care benefits. The participation rate among eligible enrollees is about 90% (85% of eligible individuals enroll in FEHBP as the primary policy holder, and another 5% are covered as a family member).

Eligibility

Eligible enrollees include current federal employees, Members of Congress and congressional staff,¹ the President, annuitants, and eligible family members.² Newly hired employees have 60 days from their entry on duty date to sign up for an FEHBP plan. Part-time workers are also eligible for coverage, but generally they are required to pay a larger share of premiums than full-time employees.

In order to be eligible for FEHBP in retirement, an individual (1) must be entitled to retire on an immediate annuity under a retirement system for civilian employees (including FERS MRA + 10 retirements)³ and (2) must have been continuously enrolled (or covered as a family member) under FEHBP for the five years of service immediately before the date the annuity starts, or for the full period(s) of service since their first opportunity to enroll (if less than five years). The five-year requirement period can also include coverage under the Uniformed Services Health Benefits Program (also known as TRICARE) as long as the individual was covered under FEHBP at the time of retirement.

Eligible family members include a spouse (including a valid common law marriage), children under age 26 (beginning in 2011),⁴ and continued coverage for qualified disabled children 26

¹ As discussed later in this report, beginning in 2014, FEHBP will no longer be available to Members of Congress and certain staff, who will then be eligible to enroll in health plans through exchanges.

² Section 8901 of the FEHBP statute lists all of the eligibility groups, including for example, certain employees first employed by the government of the District of Columbia before October 1, 1987, among others. Additionally, eligibility information is provided on the OPM website at <http://www.opm.gov/insure/health/reference/handbook/fehb06.asp#elighb>.

³ A separating Federal Employees Retirement System (FERS) employee who is eligible for an immediate annuity under the minimum retirement age and 10 years of service (MRA + 10) provision may receive the benefits immediately or may postpone receiving an annuity to lessen the age reduction applicable to persons under age 62. If the individual is eligible for an MRA+10 annuity and is not applying for the annuity at the time of separation, he or she may reenroll in FEHBP when the annuity begins. However, if the individual applies for an immediate annuity under the MRA + 10 provisions and later decides to postpone the annuity starting date he or she would not be able to enroll in FEHBP. Individuals retiring under the Civil Service Retirement System, who qualify for an immediate annuity, must retire on an immediate annuity and cannot postpone receiving the annuity (and therefore cannot postpone receiving FEHBP).

⁴ As discussed later in this report, beginning January 1, 2011, PPACA will require certain plans, including FEHBP plans, to cover certain dependent children up to age 26.

years or older who are incapable of self-support because of a mental or physical disability that existed before age 26.⁵ Under the Civil Service Retirement Spouse Equity Act of 1984, certain former spouses (of federal employees, former employees, and annuitants) may qualify to enroll in a health benefits plan under the FEHBP.

TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) eligible FEHBP annuitants, survivors, and former spouses may suspend their FEHBP enrollment and then return to the FEHBP during the open season, or return to FEHBP coverage immediately if they involuntarily lose this non-FEHBP coverage. Annuitants or former spouses who are enrolled in Medicare Parts A and B may suspend FEHBP enrollment to enroll in a Medicare Advantage plan (basically, a Medicare HMO or regional preferred provider organization [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.

Federal employee reservists who are placed in a leave without pay status when called to active duty for more than 30 days can keep their FEHBP coverage for up to 18 months. The reservist is responsible for paying the enrollee share of the premium during the first 12 months, and the agency pays the agency's share.

Finally, certain individuals may be eligible to temporarily continue their FEHBP coverage after their regular coverage ends, under Temporary Continuation Coverage (TCC). TCC is similar to COBRA⁶ coverage offered to individuals in the private sector. Federal employees and family members who lose their FEHBP coverage because of a qualifying event, such as job loss (except for gross misconduct), may be eligible for TCC. TCC enrollees may initially enroll in any FEHBP plan and may also change plans during open season, but they must pay the full premium for the plan they select (that is, both the employee and government shares of the premium) plus a 2% administrative charge. In general, TCC coverage is available to separating employees and their families for up to 18 months after the date of separation. Children aging out of their parent's plan (at age 26, beginning in 2011) and former spouses can continue TCC for up to 36 months.

Election of Coverage and Plan Choices

FEHBP eligible persons may elect coverage in an approved health benefits plan through the "individual" or the "family" options.⁷ For the 2011 plan year, FEHBP offers enrollees a choice of six fee-for-service plans available government-wide and another four plans available to employees of certain small federal agencies (such as the Foreign Service). In total, there are about 207 different plan choices, including all regionally available options. In addition, many plans offer a choice of a standard option, high option, and/or a high-deductible plan. As a practical matter, depending on where an enrollee resides, his or her choice of plans and options is limited to about 6 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>. Since 2007, those eligible for FEHBP (whether or not they are actually enrolled) are also eligible to enroll in the Federal

⁵ Beginning January 1, 2011, when FEHBP dependent coverage is available up to age 26, determining whether or not coverage of certain disabled children can continue will also be tied to age 26.

⁶ For more information on COBRA, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer and Meredith Peterson.

⁷ In 2009, approximately 75.3% of the covered persons in the FEHBP were enrolled through the family option (CRS analysis of "Carrier Summary Report, 2009" data from OPM).

Employee Dental and Vision Insurance Program (FEDVIP), which provides supplemental dental and vision insurance.

Plan Facts

Participation in FEHBP is voluntary, and enrollees may change plans during designated annual “open season” periods. The open season for the 2011 plan year is from November 8 to December 13, 2010. Special enrollment periods are also allowed 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 government’s contribution to a plan for a part-time worker is generally prorated.⁸ The maximum annual government contribution for 2011 is \$4,697 for self-only coverage and \$10,503 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. The enrollee’s share of premiums will rise by an average of 7.2% in 2011, a smaller increase than the 8.8% increase in 2010. While some plans had no increases in premiums, others had double-digit premium increases. However, looking only at premium increases may not give a complete picture of plan changes from one year to the next, as plans may also make changes in benefits or cost-sharing.

Although there is no core or standard benefit package required for FEHBP, all plans cover basic hospital, surgical, physician, and emergency care. OPM may prescribe reasonable minimum standards for health benefit plans. FEHBP follows the guidelines on preventive care for children recommended by the American Academy of Pediatrics. FEHBP guidelines on preventive care for adults are based on accepted medical practice.⁹ OPM requires plans 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.

In 2011, all plans will offer tobacco cessation benefits in compliance with the U.S. Public Health Services’ 2008 clinical guidance on tobacco cessation. Enrollees will not pay co-payments for the following benefits: (1) seven FDA-approved medications and (2) four counseling sessions per an attempt to quit smoking (with two covered attempts per year).

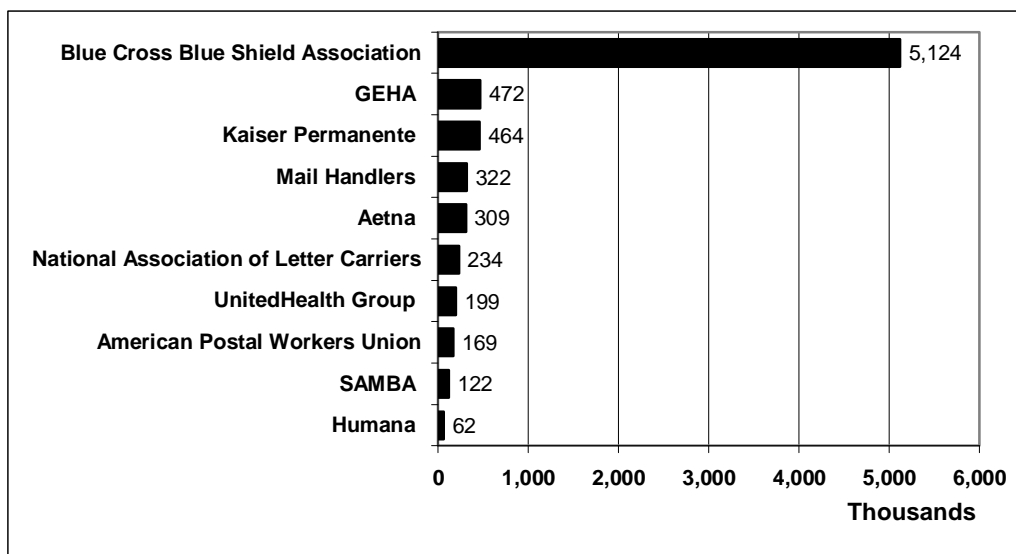
⁸ Part-time workers (working 16 to 32 hours a week) hired on or after April 8, 1979, are entitled to a partial government contribution in proportion to the number of hours they are scheduled to work in a pay period. Part-time workers hired before April 8, 1979 who have continued to serve on a part-time basis without a break in service are eligible for the full government contribution. Additionally, part-time employees who work less than 16 hours or more than 32 hours per week are entitled to the full government contribution. The amount of the prorated government contribution for a part-time employee is the ratio of scheduled part-time work hours to full-time hours (usually 80 hours per biweekly pay period) multiplied by the government contribution for full-time employees enrolled in that plan. The part-time employee pays the difference between the total premium and the prorated government contribution.

⁹ Beginning in January 2011, PPACA requires new plans to provide preventive care with no cost sharing. However, plans can choose to limit waiving cost sharing to apply to in-network providers only.

FEHBP Carriers

The law defines a FEHBP “carrier” to be 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.¹⁰ Each carrier contracts with OPM after a negotiation process that begins with OPM issuing its annual “call letter” asking for benefit and rate proposals.¹¹ Carrier contracts are at the legal entity level and not the parent organization. Therefore, a parent organization, such as Kaiser Permanente, may have multiple carrier organizations within FEHBP.¹² As illustrated by **Figure 1**, FEHBP enrollment is concentrated among a few parent organizations led by the Blue Cross Blue Shield Association (BCBSA).¹³ Approximately 92% of FEHBP covered persons are in the top 10 parent organizations by covered persons.

Figure 1. Top 10 Parent Organizations, by Covered Persons (in thousands), 2010



Source: CRS analysis of “Carrier Summary Report, 2010” data from OPM.

Notes: The Blue Cross Blue Shield Association (BCBSA) includes both the non-profit national carriers operated by the BCBSA and the non-profit independent licensees typically organized at the state level. BCBSA does not include the for-profit Wellpoint-Anthem carriers that use the Blue Cross Blue Shield marketing name.

¹⁰ 5 USC § 8901.

¹¹ U.S. Office of Personnel Management, “FEHB Program Carrier Letter (All Carriers),” Letter No. 2010-06: April 7, 2010. See the **Appendix** for discussion of contract cycle and Annual Call Letters.

¹² A “parent organization” is a company that owns all or enough of another firm to control its management. The controlled firm is considered a subsidiary of the parent company. In some cases, the parent organization is the FEHBP carrier (e.g., GEHA). In other cases, the parent organization may have multiple FEHBP carriers. For example, Kaiser Permanente (KP) has the following subsidiary FEHBP carriers: KP of Georgia, KP of Colorado, KP of Hawaii, KP Mid-Atlantic, KP of Northern California, KP Northwest, KP of Southern California, and KP of Ohio.

¹³ The Blue Cross Blue Shield Association (BCBSA) includes both the non-profit national carriers operated by the BCBSA and the non-profit independent licensees typically organized at the state level. BCBSA does not include the for-profit Wellpoint-Anthem carriers that use the Blue Cross Blue Shield marketing name.

FEHBP Plans

An FEHBP health benefits plan is a group insurance policy or similar group arrangement provided by a carrier to provide, pay for, or reimburse expenses for health services. The FEHBP statute¹⁴ specifies three types of participating plans:

- The **government-wide service benefit plan** is the fee-for-service benefit plan that pays providers directly for services (this slot has always been filled by Blue Cross and Blue Shield, BCBS). As of 2010, BCBS no longer offers a high-deductible plan, just the standard and basic options, as described below.
- **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 any employee organization plan, subject to small annual membership dues. These plans also include options for high-deductible plans.
- **Comprehensive medical plans** are the local Health Maintenance Organizations (HMOs). Availability of these plans varies, depending on where the individual resides. These plans also include options for high-deductible plans.

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 2011, BCBS offers both a *Standard* option (its more generous plan) and a *Basic* option.

Under the *Standard* BCBS option, in 2011, an enrollee's share of monthly premiums increased by about 7% over 2010 rates to \$187.18 for individual coverage and by about 7.5% to \$431.60 for family coverage. The 2011 calendar year deductible is \$350 per person with a family deductible of \$700 (an increase of \$50 and \$100, respectively). Enrollees receiving services from a "preferred" provider are responsible for a \$20 copayment for a primary care physician office visit and \$30 for a specialist physician office visit, with no requirement to first meet the deductible. For an office visit with a participating physician, enrollees are responsible for 35% of the plan's allowed amount, after meeting the deductible. For an office visit with a non-participating physician, enrollees are responsible for 35% of the allowed amount, after meeting the deductible, plus all of the difference between the allowed amount and the physician's actual charge ("balance billing"). Preventive services are not subject to cost-sharing when provided by preferred providers only, but the plan has cost-sharing for preventive services provided by participating and non-participating providers.

Under BCBS's *Basic* option, in 2011, an enrollee's monthly premiums increased about 12.5% over 2010 rates to \$113.37 for individual coverage and \$265.49 for family coverage. There is no calendar-year deductible. Enrollees pay a \$25 copayment for an office visit to a preferred primary care provider and a \$35 copayment for an office visit to preferred specialist. The *Basic* option operates similarly to an HMO, in that enrollees may use only preferred providers to receive

¹⁴ 5 USC § 8903.

benefits, except in special circumstances such as emergency care. Preventive services are not subject cost-sharing when provided by preferred providers.

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. Both the employee organization plans and the comprehensive medical plans offer CDHPs and HDHPs, described below.

Consumer-Driven Health Plans

For example, those choosing APWU's CDHP 2011 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 annual amount contributed by the plan to the PCA (i.e., \$1,200 or \$2,400), enrollees must pay the "member responsibility" (\$600 for individuals and \$1,200 for families). Members who have exhausted their PCA must use their own funds to pay the member responsibility. However, members who have built up the balances in their PCA over time may use any excess funds to meet their member responsibility.¹⁵ Once the member responsibility 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 2011 stayed the same to those of 2010 (\$84.17 for individual and \$189.37 for 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 2011, 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

¹⁵ 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.

\$1,000 for individuals and \$2,000 for families with no limits on carryover amounts, provided the enrollee remains in the plan.

High-Deductible Plans with an HSA or HRA

Since 2005, FEHBP has offered several HDHP plans paired with either an HSA¹⁶ or HRA, available both nationally and regionally for 2011. 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.

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 federal limit (for 2011, the limit is \$3,050 for self coverage and \$6,150 for family coverage). Enrollees over age 55 can make a "catch-up" contribution, in the amount of \$1,000 in 2011.¹⁷ 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, in 2011, HSA funds may also be used for non-medical expenses, subject to the income tax and an additional penalty for those under 65.¹⁸ 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.

Examining GEHA's HDHP provides an example of premiums, deductibles and HSA/HRAs for these types of plans. For individual coverage in 2011, the monthly premium is \$95.20, the deductible is \$1,500, the plan will place \$62.50 per month in the HSA/HRA, and those in the HSA may contribute another \$2,300 annually (the difference between the amount contributed by the plan and the federal self coverage limit). For family coverage in 2010, the monthly premium is \$217.45; the deductible is \$3,000; the plan places \$125 per month into the HSA/HRA; and those with an HSA may contribute another \$4,650 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. For 2011, GEHA's HDHP premiums and deductibles did not change from the 2010 amounts, while the annual HSA/HRA contributions made by the plan increased slightly.

¹⁶ For more information on HSAs, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2010*, by Janemarie Mulvey.

¹⁷ <http://www.irs.gov/pub/irs-drop/rp-10-22.pdf>.

¹⁸ As discussed later in the report, PPACA will change the penalties for withdrawing funds from HSAs beginning in 2011.

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.¹⁹ 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, and hearing aids.²⁰ 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 \$5,000 per year to an account,²¹ 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, 2011 contributions to the HCFSA may be used to reimburse expenses incurred during calendar year 2011 continuing through mid-March 2012). 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, HSA funds can be carried over from year to year, and some of the funding in the HSA comes from the plan.

Medicare and FEHBP

Most federal employees or annuitants reaching age 65 are automatically entitled to premium-free Part A of Medicare, Hospital Insurance (HI), because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years). Federal workers and their employer each pay 1.45% of earnings for Medicare payroll taxes. Medicare Part B Supplementary Medicare Insurance (SMI) and Part D prescription drug coverage are voluntary, and qualified individuals choosing to enroll

¹⁹ For more information on FSAs, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey. As discussed later in the report, PPACA will change the definition of qualified medical expenses beginning in 2011.

²⁰ As discussed later in the report, PPACA will change the definition of qualified medical expenses, beginning in 2011.

²¹ As discussed later in the report, PPACA will establish a contribution limit of \$2,500 for FSAs, beginning in 2013.

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 if they enroll at a later date. 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 if they enroll at a later date. 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.²²As previously mentioned, annuitants or former spouses enrolled in Medicare Parts A and B may suspend FEHBP enrollment to enroll in a Medicare Advantage plan (e.g., 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.

For individuals who are covered under an FEHBP plan through annuitant coverage (not active employment), any Medicare coverage they have would be the primary payer and FEHBP would be the secondary payer. As the secondary payer, FEHBP could cover a share of Medicare deductibles and coinsurance for any services that were covered by both Medicare and the plan. Enrollees may have to pay a share of the cost-sharing or deductibles. Additionally, the plan would continue to provide reimbursement for its covered services that were not covered by Medicare.

For retirees (or spouses) over the age of 65 who do not have either Medicare Part A or B or both, FEHBP plans are the primary payer, and the plan pays hospitals and physicians based upon Medicare rates. For these individuals, the FEHBP benefit payment for inpatient hospital services is equivalent to the Medicare payment (the amount of the payment before the Medicare deductible, coinsurance, and lifetime limits are applied), reduced by any FEHBP deductible, coinsurance, copayment, or readmission certification penalty. For these individuals, the FEHBP payment for physician services is the lower of the Medicare Part B payment or the actual billed charges. The payment is then reduced by any FEHBP deductible, coinsurance, or copayment that is the responsibility of the retired individual. Hospitals may not collect, from either FEHBP or enrollees, more than the amount determined to be equivalent to the Medicare payment. For physician services, (1) Medicare participating providers may not collect from either FEHBP or retired enrollees more than the total Medicare payment under the Medicare participating physician fee schedule, and (2) Medicare nonparticipating providers may not collect from FEHBP plans or retired enrollees more than the Medicare limiting charge amount. (Under Medicare, nonparticipating physicians can balance bill up to 15% higher than the fee schedule amount, but they are paid a slightly lower amount by Medicare.)

Pharmacy Benefits Managers (PBMs) and Their Role in FEHBP

Prescription drugs are a significant driver of FEHBP program costs. Prescription drug costs represented about 29% of claims expenditures, or approximately \$10.15 billion in 2008.²³

²² The same rules for Medicare late enrollment penalties also apply to those with coverage through a private-sector employer.

²³ Statement of Nancy H. Kichak, Office of Personnel Management, U.S. Congress, House Committee on Oversight (continued...)

According to the OPM Office of the Inspector General (OPM-OIG), drug costs have increased substantially over the past decade. As an example, the OPM-OIG has cited the Blue Cross Blue Shield (BCBS) Service Benefit Plan, which covers approximately half of FEHBP's enrollees, that had per member pharmaceutical claims costs rise from \$591 in 1999 to \$1,161 in 2008.²⁴ A study conducted by OPM for 2003 FEHBP plans found that increased drug costs contributed to nearly one-third of the average premium increase from the previous year.²⁵

While OPM is not directly involved in negotiating prescription drug prices or discounts, it does attempt to limit prescription drug spending through its annual negotiations with FEHBP carriers.²⁶ For example, in its annual "call letter" for the 2007 plan year, OPM asked carriers to "explore offering appropriate substitution of higher-cost drugs with lower cost clinically effective therapeutic alternatives" and "to pursue the advantages of specialty pharmacy programs aimed at reducing the high costs of infused and intravenously administered drugs."²⁷ To help manage these drug costs and other administrative aspects of the pharmacy benefit, FEHBP carriers have relied on pharmacy benefits managers (PBMs). PBMs are organizations that provide administrative services to health insurance companies or self-insured employer health benefits plans in processing and analyzing prescription drug claims.²⁸ PBMs perform a number of key functions, including establishing the health plan's list of covered prescription drugs, negotiating with pharmaceutical manufacturers for price concessions, conducting the contract negotiations for establishing networks of retail pharmacies, and providing mail-order pharmacy services.²⁹

Because of the pressures placed on FEHBP for the high cost of covering prescription drugs, OPM has recently sought to enhance its oversight of PBMs with additional audits and new transparency requirements such as pass-through pricing.³⁰ In addition to OPM, some stakeholders have also expressed concern with the actions and performance of the PBMs in FEHBP. The issues raised by some stakeholders include the following:

- **Lack of Transparency.** The OPM-OIG, in testimony before the House Subcommittee on the Federal Workforce, Postal Service, and the District of Columbia, stated that "the single most important FEHBP issue that OPM must

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and Government Reform, Subcommittee on Federal Workforce, Post Office, and the District of Columbia, 111th Cong., 1st sess., June 24, 2009.

²⁴ United States Office of Personnel Management, Office of the Inspector General, "Semiannual Report to Congress," September 2009.

²⁵ Office of Personnel Management, "2003 FEHB Premiums: Contributors to the Premium Increase," 2002.

²⁶ John E. Dicken, Government Accountability Office, "Prescription Drugs: Overview of Approaches to Control Prescription Drug Spending in Federal Programs," U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Federal Workforce, Post Office, and the District of Columbia, 111th Cong., 1st sess., June 24, 2009.

²⁷ U.S. Office of Personnel Management, "Federal Employees Health Benefits Program FEHB Program Carrier Letter," Letter No. 2006-09, April 4, 2006, at http://www.opm.gov/carrier/carrier_letters/2006/2006-09.asp.

²⁸ Brian Anderson and Robert G. Cosway, "Effective contracting with pharmacy benefit managers," February 2010, at <http://www.milliman.com/expertise/healthcare/publications/published/pdfs/effective-contracting-with-pharmacy.pdf>.

²⁹ Ibid.

³⁰ Office of Personnel Management, "FY 2010 Office of Personnel Management Congressional Budget Justification," May 2009. Office of Personnel Management, "FEHB Program Carrier Letter: Pharmacy Benefits Management (PBM)," Letter No. 2010-04: February 22, 2010. "Pass-through" drug pricing generally refers to contractual requirements for a PBM to pass along any pricing discounts, including rebates, received from drug manufacturers to the health plan and its members.

resolve is the fact that ... the cost structures of the PBMs are utterly nontransparent. This means that there is no objective basis to determine whether the terms being offered to an FEHBP carrier by a PBM represent an advantageous arrangement.”³¹

- **Higher Drug Prices.** Change to Win, a group that includes the Service Employees International Union, has issued a report suggesting that for nearly 300 generic drugs the PBM and retail pharmacy company CVS-Caremark has overcharged FEHBP enrollees compared to customers using CVS pharmacy’s generics discount program, the Health Savings Pass (HSP).³²
- **Interfering with the Health Provider/Patient Relationship.** The National Community Pharmacists Association alleges that PBMs interfere with the relationship of patients with their pharmacists (1) by reimbursing mail-order pharmacies, owned by the PBM, at a higher rate than they would reimburse community pharmacies for the same prescription, and (2) by a practice known as “drug switching” or “drug substitution,” where the PBM requires the pharmacy to dispense a different drug than what the patient’s doctor prescribed.³³

The PBM industry has responded to these allegations by pointing out that unit prices are just one component of overall program costs, asserting that PBMs help manage the amount and type of drugs used and that the management techniques used by PBMs are in response to the needs of their clients.³⁴ The lack of public data makes verification of stakeholder concerns about PBMs or industry counterpoints elusive.

Recent Legislation

In 2010, Congress passed legislation that has an impact on FEHBP. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended by the Health Care and Education Act, P.L. 111-152)³⁵ includes some provisions that require certain changes to be made to FEHBP plans or to employing agencies. Previously, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5)³⁶ included a number of provisions affecting FEHBP. Both of these laws are discussed below.

³¹ Patrick E. McFarland, “The Federal Employees Health Benefits Program (FEHBP) Prescription Drug Integrity, Transparency, and Cost Savings Act,” Statement before the U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Federal Workforce, Post Office, and the District of Columbia, 111th Cong., 2nd sess., February 10, 2010.

³² Change To Win, “CVS CAREMARK’S Generic Rip Off,” February 2010, at <http://www.alarmedaboutcvscaremark.org/fileadmin/files/pdf/fehbp-generic-rip-off.pdf>.

³³ Bruce T. Roberts, “Providing Better Health Care for Federal Employees,” *Roll Call*, February 8, 2010.

³⁴ Pharmaceutical Care Management Association (PCMA), “H.R. 4489, the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act,” Statement before the U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Federal Workforce, Post Office, and the District of Columbia, 111th Cong., 2nd sess., February 23, 2010.

³⁵ For more information on PPACA, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom, and CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey.

³⁶ For more information on ARRA, see CRS Report R40420, *Health Insurance Premium Assistance for the* (continued...)

The American Recovery and Reinvestment Act of 2009 and FEHBP

The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) was signed into law on February 17, 2009, and subsequently amended several times. ARRA, as amended, includes a provision to provide temporary subsidies of COBRA premiums, and this provision also covers the Temporary Continuation of Coverage (TCC) program offered to federal employees. Under Title III of ARRA, a 65% subsidy is available for up to 15 months to those individuals who meet the income test and whose qualifying event for TCC coverage is based on involuntary termination occurring on or after September 1, 2008, through May 31, 2010.³⁷ The subsidy period may end sooner than the 15 months if the TCC eligibility period ends or if the individual has access to other group health insurance. ARRA does not modify the length of time that an individual may be covered under TCC. The full subsidy is available for individuals whose modified adjusted gross income (AGI) during the tax year is no more than \$125,000 for single filers (or \$250,000 for joint filers). The subsidy is phased out for higher-income individuals with a reduced subsidy for individuals with modified AGI less than \$145,000 for single filers (and \$290,000 for joint filers).

Health Reform Legislation and FEHBP

PPACA does not require many changes to FEHBP as these plans generally already meet most of the requirements of the law.³⁸ OPM estimates that the PPACA requirements account for about a 1.7 % increase in the 2011 FEHBP premiums

PPACA requires, beginning in January 2011, that adult children up to age 26 can remain/enroll on their parent's plan.³⁹ FEHBP coverage of children will be expanded to include married children (but not a spouse or a child of the covered child). Plans will be required to cover stepchildren (whether or not they live with the enrollee in a parent-child relationship) and foster children. PPACA does not require a child to (1) reside with the parent, (2) be financially dependent upon the parent, or (3) be a student. Additionally, as a result of extending dependent coverage to age 26, Temporary Continued Coverage will be available for three years, when the child ages out of FEHBP at age 26. Similarly, the opportunity for certain disabled children to remain on their parent's plan will also be tied to age 26.

PPACA also requires that new plans offer preventive care and screening with no out-of-pocket costs. FEHBP plans already cover preventive care, but beginning in 2011, all FEHBP plans will waive cost-sharing for these services. Plans may choose to only waive cost-sharing when beneficiaries use in-network providers, so that if beneficiaries use out-of-network providers, they may still be responsible for cost-sharing under the terms and conditions of the plan.

Beginning in 2014, Members of Congress and congressional staff may only enroll in health plans created under PPACA, or offered through an exchange. Congressional staff, for the purpose of

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Unemployed: The American Recovery and Reinvestment Act of 2009, coordinated by Janemarie Mulvey.

³⁷ For those individuals qualifying in May 2010, TTC subsidies could be available through August 2011.

³⁸ For information from OPM, see <http://www.opm.gov/insure/health/reform/index.asp>.

³⁹ Coverage begins on January 1, 2011, if the parent is making no changes to his or her FEHBP coverage, other than adding a child, or if the change is made as a qualifying life event (QLE) based on a change in family status. Coverage begins on January 2, 2011, if the parent is changing plans or changing from self-only to family coverage.

this requirement, will be limited to those part-and full-time employees who are employed by the official office of a Member of Congress (i.e., in a “personal office”).

Another PPACA requirement applicable to grandfathered plans involves the reporting of the ratio of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums, typically referred to as the medical loss ratio (MLR).⁴⁰ Beginning not later than January 1, 2011, large group plans must provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended on clinical claims and health quality costs, after applicable adjustment (e.g., for taxes and regulatory fees), is less than 85%.⁴¹ This provision will likely have no meaningful impact on FEHBP carriers, because they exist in a competitive program where they are expected to keep premiums down and their profits are regulated and can be reduced for defective pricing or use of defective cost or pricing data.⁴² A simple analysis (total hospital and medical expenses divided by total revenues) with no adjustments further suggests that FEHBP carriers will not be affected by this standard, as they collectively had MLRs ranging from 93%-94% from 2006 to 2009.⁴³

PPACA imposes some additional administrative requirements on employers, which affect federal agencies in their role as an employer. For taxable years beginning after December 31, 2010, PPACA requires employers to provide the aggregate cost of applicable employer-sponsored coverage on an employee’s W-2. However, the IRS has indicated that this requirement will be optional for employers in 2011. Beginning in 2014, employers will be required to file a return providing the name of each individual for whom they provide minimum essential coverage, the number of months of coverage, and any other information required by the Secretary. They will also be required to provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange.⁴⁴

PPACA also includes a number of provisions to raise revenues, which may have an impact on FEHBP plans. The law imposes a 40% excise tax on health insurers and health plan administrators for coverage that exceeds certain thresholds, beginning in 2018. The thresholds are \$10,200 for single coverage and \$27,500 for family coverage, and will be indexed to inflation in subsequent years. Coverage for individuals who are retired and ages 55 to 64, and workers engaged in high-risk professions, will be subject to higher thresholds (\$11,850 single and \$30,950 families). Looking at just the health insurance FEHBP plan premiums for 2011 (even though the threshold is in effect in 2018), all plans are below the threshold. However, adding in contributions to tax-advantaged accounts could result in the excise tax applying to at least some of FEHBP plans and tax-advantaged accounts. PPACA will also impose an annual fee on health insurance plans based on their market share, which could affect most FEHBP carriers.

⁴⁰ §1001 of PPACA, as amended by §10101: §2718 PHS. Beginning on January 1, 2014, this calculation would be based on the averages of the premiums expended on the costs for each of the previous three years for the plan. The Secretary would make these reports available to the public on the Internet site of the Department of Health and Human Services.

⁴¹ Ibid.

⁴² U.S. Office of Personnel Management, “Federal Employees Health Benefits Program Call Letter No. 2010-06,” April 7, 2010. 48 CFR §1615.404-70 and §1615.407-1. See the **Appendix** for more detail on profit regulation.

⁴³ Debra A. Donahue, “Health Plans See Revenue Shift Away from Commercial,” May 10, 2010, at <http://www.markfarrah.com/healthcarebs.asp>.

⁴⁴ For a complete description of all employer requirements, see CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind.

Beginning in 2011, PPACA modifies the definition of qualified medical expenses, which will affect FSAs, HSAs, and HRAs; the law does not allow over-the-counter (OTC) medicines to be covered by these tax-advantaged accounts unless they are prescribed by a physician. The only exception is insulin. Other currently eligible OTC items that are not medicines or drugs, such as bandages, will not require a prescription. In addition, the law raises the penalty from 10% to 20% for those under 65 who make a non-qualified withdrawal from an HSA. FSAs may be used to pay for qualified expenses for children who have not attained age 27 as of the end of the taxable year, regardless of their financial dependence.

Beginning in 2013, PPACA will lower maximum allowed annual contributions to an HCFSA under FEHBP from \$5,000 to \$2,500. The threshold will be indexed to inflation in subsequent years.

PPACA also includes an option for health insurance coverage offered through an exchange to be overseen by the Director of OPM. The Director of OPM will enter into contracts with health insurance issuers (which may include a group of issuers affiliated either by common ownership and control or by common use of a nationally licensed service mark) to offer at least two multi-state qualified health plans (MSQHPs) through each exchange in each state (without regard to statutes requiring competitive bidding). Such plans will provide individual or, in the case of small employers, group coverage.

While administering MSQHPs, the Director of OPM cannot reduce financial or personnel resources to the functions of OPM related to the administration of FEHBP. Enrollees in an MSQHP will be treated as a separate risk pool from FEHBP. The Director can establish separate units or offices within OPM, to ensure that the administration of MSQHPs does not interfere with the administration of FEHBP. The Director can appoint additional personnel to carry out activities under this section, but must ensure that the MSQHP program is separate from FEHBP. Finally, FEHBP plans are not required to offer a MSQHP.

Beginning in 2014, PPACA includes a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance. Individuals will be required to maintain minimum essential coverage for themselves and their dependents. Enrollment in an FEHBP plan will satisfy this requirement.

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 eligible individuals 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.

Appendix. OPM's Role in the FEBHP

FEHBP is offered under the authority of statute (Chapter 89 of title 5 of the U.S. Code) and is administered by the Office of Personnel Management (OPM) in accordance with the statute and its implementing regulations (5 CFR Part 89, and 48 CFR Chapter 16). The FEHBP statute establishes the basic rules for benefits, enrollment, and participation in FEHBP among other general requirements, while still allowing OPM wide authority in implementing regulations, contracting with plans, establishing benefits, and administering FEHBP.

In general OPM, the employing offices of agencies (such as the Department of Labor), and the plans, each have defined roles in FEHBP. OPM is authorized to contract with insurance carriers; approve qualified health benefits plans for participation in the program; negotiate with plans about benefit and premium levels; determine the times and conditions for open seasons during which eligible individuals may elect coverage or change plans; make information available to employees concerning plan options; apply administrative sanctions to health care providers who have committed certain violations; and administer the financing of the program. OPM is responsible for maintaining the funds that hold contingency reserves for the plans and the fund that receives premium payments from enrollees and employing agencies, from which premiums are disbursed to participating plans.

OPM supervises all health insurance activities for annuitants. OPM determines whether retiring employees or survivor annuitants meet the requirements to continue health insurance coverage; takes the action necessary to terminate, accept, or continue enrollment; oversees the automatic deduction of premiums from monthly annuity checks and credits the premiums, along with the applicable government contribution, to the proper account; processes all enrollment changes; notifies affected carriers of enrollment changes; and keeps enrolled annuitants advised of rate and benefit changes within their plan.

The employing offices manage FEHBP for their employees according to OPM requirements, administer open season, and are responsible for payroll withholdings and the government contribution. The plans process and pay claims, print brochures according to OPM specifications, and maintain data on enrollment, claims, and financial information. Plans assume the risk for covering claims.

Annual Cycle of FEHBP Activity for OPM

OPM enters into an annual contract with carriers, following the negotiation process. Each spring, the annual negotiation process begins when OPM sends all current and newly approved qualified health plans an annual call letter to advise them on goals and procedures for negotiating contracts for the following calendar year and to request participating plans to submit their benefit and rate proposals for the next year. The call letter includes any changes in the services OPM seeks to make available for federal workers and annuitants, as well as notification of services that OPM discourages.

Next, OPM reviews proposals for rates (premiums) for the fee-for-service plans in relation to many factors, including the cost of covered services, managed care initiatives, the plan's past experience, health care utilization patterns of the enrolled group, and health care cost inflation in general. Pursuant to the negotiations, OPM and the plans (including both fee-for-service plans and HMOs) agree to specific terms and conditions each party is obligated to meet in the next

contract year. Descriptions of both covered and excluded services are incorporated into the final contracts, and the plans print brochures describing the benefits and costs according to a standard format specified by OPM. The brochures are binding statements of benefits and exclusions that plans must follow as parties to FEHBP contracts. OPM then announces an open season (which generally runs for one month, beginning in early November).

OPM prints and distributes to personnel offices and annuitants a guide describing the major features and premiums for all participating plans. This guide includes the findings of surveys of enrollee satisfaction with the different plans and includes information about the factors participants should consider in making their selection. Personal advice is not provided, although OPM's Internet website provides information about how to select a plan (<http://www.opm.gov/insure>). Employees are responsible for obtaining from their personnel office a copy of OPM's general guide and the detailed brochures of the specific plans in which they are interested. Annuitants are responsible for obtaining detailed plan brochures by calling the individual carriers and requesting that a brochure be mailed to them. Information about the different plans is also available on OPM's web page on the Internet (<http://www.opm.gov/insure>).

Following is a summary of the annual cycle of OPM's activities regarding plan contracts:

- End of March/early April—Call letter distributed to plans
- May 31—Plan responses due to OPM (electronic format)
- June through August—Contract negotiations
- September/October—Print and distribute OPM guides and plan brochures
- November/December—Open season
- Early December/January 1—Enrollment data distributed to plans
- January 1—Plan year starts
- March—Reconciliation of HMO premiums

OPM's Annual Call Letters

Each spring, OPM issues a carrier letter to plans detailing the annual call for benefit and rate proposals from FEHBP carriers and outlining its policy goals for the following calendar year. For example, in the call letter for the 2010 contract year, OPM included the following statement:

Your overall proposal should be cost neutral by offsetting any proposed benefit increases with corresponding medical savings or benefit reductions, with the exception of benefit changes necessary to meet the requirements for mental health parity discussed below. Your benefit proposal must be consistent with the policies outlined in this letter.⁴⁵

The effect of this statement is that plans may only introduce new benefits or increase coverage of existing benefits if the costs for these benefits unless they are cost neutral through offsetting benefit reductions. Additionally, in general, plans may not increase premiums to cover the costs of new benefits. One exception to these limitations may occur when OPM requires plans to offer

⁴⁵ FEHB Program Carrier Letter, Letter No. 2009-08, April 20, 2009.

a new benefit, such as the requirements to offer mental health parity for out-of-network benefits in compliance with Subtitle B of *Emergency Economic Stabilization Act of 2008*, entitled the “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.”

Another example of OPM using its authority is the requirement that all plans include coverage of prescription drugs, as first detailed in the annual call letter for the 1990 contract year. That letter stated:

We believe at least minimum coverage for prescription drugs should be provided in all FEHBP plans (both options if plan has more than one), as it is for hospital and medical expense. We consider a minimum drug benefit as one with a deductible no greater than \$600 and coinsurance of at least 50%....Our decision on a mandatory minimum drug benefit will be communicated to you during the negotiations.⁴⁶

Subsequent annual call letters have expanded and modified OPM’s prescription drug requirements for plans.

OPM’s Role with Employing Offices

Personnel offices in every federal agency manage participation in FEHBP for their employees according to procedures prescribed by OPM. They administer the annual open seasons; adjust coverage and payroll withholding when workers’ family or employment situations change and when new workers enter. Agencies are responsible for withholding employee premium payments, adding the government’s share (which is appropriated to agencies annually), and providing documentation of these actions to OPM. They keep records and information on withholdings from employee salaries and agency contributions, enrollment statistics, and other necessary data.

The government’s share of active workers’ FEHBP premiums is paid by the government agency for which the employee works. The money for agency payments is appropriated annually to every agency’s salary and expense accounts, and, for federal budget purposes, is categorized as discretionary spending. The government’s share of nonpostal annuitants’ premiums is appropriated annually to OPM and is categorized in the federal budget as direct, or mandatory spending. The government’s share of premiums for all nonpostal enrollees is paid from general revenues. The U.S. Postal Service (USPS) pays the employer share of FEHBP premiums with funds taken in by the USPS from postal rate receipts, although the postal unions and the USPS collectively bargain the cost-sharing ratio for active workers.

OPM’s Role with the Plans

FEHBP plans are required to allow eligible individuals to enroll during open season and other special election periods and may not discriminate on the basis of health status, race, sex or age.⁴⁷ The carriers process and pay claims, answer enrollee questions, respond to claims disputes, print annual open season brochures according to the OPM-specified format, and maintain data regarding enrollment, claims, and other financial information required by OPM. In addition, carriers assume all insurance risk.

⁴⁶ FEHB Program Carrier Letter, March 30, 1989.

⁴⁷ 5 CFR § 890.201.

Contracts: Contracts with FEHBP plans are made for at least one year and may be made automatically renewable in the absence of notice by either party of intention to terminate. OPM may terminate the contract of a carrier at the end of the year, if at no time during the preceding two contract terms did the carrier have 300 or more enrolled employees and annuitants, exclusive of family members. Each contract must contain a detailed statement of benefits. Contracts must offer enrollees and their family members temporary extension of coverage with an option to convert to a non-group contract, without requiring evidence of good health. Plans that are discontinued, other than through a merger, may re-enter after three contract years from the time they left the program.

Licensure: An FEHBP plan must be licensed to sell group health insurance under state law in every area of a state in which it operates as an FEHBP plan. Nationwide plans must be licensed in every state. HMOs must have an internal quality assurance program, and must credential and periodically re-credential participating providers.

Quality: Each year FEHBP plans with 500 or more subscribers must mail the Consumers Assessment of Health Plan Survey (CAHPS) to a random sample of plan members. For HMOs, and Point-of-Service (POS) plans, the sample includes all commercial plan members, including non-Federal members. For Fee-for-Service (FFS)/Preferred Provider Organization (PPO) plans, the sample includes federal members only. The CAHPS survey consists of a set of standardized health plan performance measures that evaluate members' satisfaction with their health plans. Independent vendors certified by the National Committee for Quality Assurance (NCQA) administer the surveys.

All plans must also complete quality assurance reports as well as fraud and abuse case reports. Additionally, HMOs with more than 500 FEHBP enrollees must complete the Health Plan and Employer Data Information Set (HEDIS), which includes clinical performance measures based on information such as members' medical records. These measures help to compare how well plans prevent and treat illness.

Provider Networks: OPM reviews applications for health benefit plans for evidence of a plan's ability to provide reasonable access to and choice of quality primary and specialty medical care throughout the service area, specifically (1) in the individual practice setting, contractual arrangements for the services of a significant number of primary care and specialty physicians in the service area; and (2) in the group practice setting, compliance with statutes, preferably demonstrated by full-time providers specializing in internal medicine, family practice, pediatrics, and obstetrics/gynecology.

OPM's Role with the Reserve Funds

A contingency reserve fund is maintained in the U.S. Treasury by OPM for all FEHBP plans. OPM is authorized to levy a surcharge of up to 3% of a plan's premium to establish and maintain contingency reserves.⁴⁸ The preferred minimum for each experience-rated plan's contingency reserve⁴⁹ is 1½ times the sum of the plan's average month's paid claims plus the average month's

⁴⁸ 5 CFR § 890.503.

⁴⁹ All fee-for-service plans (and a small number of comprehensive plans) are "experience rated," meaning the premiums are based on the claims experience of the federal enrollees in the plan in preceding years. Experience rate plan premiums are based on claim experience of enrollees in previous years, administrative costs, and profit (limited to (continued...))

administrative expenses and retention, with a target level that is 3½ times that amount. Experience rated plans may use their contingency reserve funds to offset larger than anticipated claims, or, if the fund balance becomes larger than necessary, it can be drawn down and used to offset a premium increase in the subsequent year. Since January 1989, FEHBP fee-for-service plans have had their federal premium funds disbursed throughout the year under a letter-of-credit arrangement whereby the plans draw down funds in their accounts as claims are paid.

OPM maintains in the U.S. Treasury contingency reserve funds for community-rated plans,⁵⁰ and may charge up to 3% of a plan's premium to establish and maintain the fund. However, unlike that for experience rated fee-for-service plans, the contingency reserve fund for community-rated plans can be used only by OPM (not the plan) if OPM approves an adjustment during a "reconciliation" process that usually takes place in the month of March. For instance, HMOs generally estimate their rates in the spring and negotiate their contracts with OPM in August. The plan year begins the following January. If there are changes in the program or in the community benefit package between the time the plan estimated the rates and implementation of the plan in January, OPM reconciles those changes with the previously established premiums and negotiates an adjustment. (OPM allows adjustment only for specified reasons, excluding a plan's underestimate of costs based on group demographics.) Because payments to HMOs are not based on claims, the government does not use the letter-of-credit draw-down approach to disburse funds to the plans, but pays the plans specified amounts in installments throughout the year.

OPM's Role with Setting Profits

The "service charge" (profit) paid to fee-for-service plans by OPM is calculated according to detailed regulations.⁵¹ There is no guaranteed minimum amount, but the maximum is 1.1% of projected incurred claims and administrative costs. OPM contract officers monitor plan performance throughout a plan year and maintain data which are used to evaluate plan performance and determine profit. Profit is based on six factors: (1) contractor performance regarding such responsibilities as accurate and timely claims processing, handling of claims disputes, and general beneficial innovations; (2) contract cost risk factors, including group size (smaller enrollments receive credit for higher risk), and certain demographics and the plan's willingness to assume risk; (3) federal socioeconomic programs, such as programs to deter drug abuse by considering the quality of the contractor's policies and procedures and the extent of unusual effort or achievement demonstrated; (4) capital investments (this is a general federal acquisition factor but seldom applicable under FEHBP); (5) cost control, such as contractor-initiated efforts to improve benefit design, cost-sharing, or innovative peer review procedures; and (6) independent development of administrative systems that improve cost efficiency and for which the contractor assumed the development costs.

(...continued)

1.1% of claims and admin.). There is little risk because they make up for losses with premium increases the following year or by drawing down on contingency reserve.

⁵⁰ Community rated plans are basically the local HMOs, whose payment is based on rates the plan charges for enrollees in the 2 largest non-federal employer-sponsored groups in that community. Additionally, these plans may negotiate upgrades and/or required services. The profit for community rated plans may be larger than experience rated plans, as well as the risk.

⁵¹ 48 CFR § 1615.4.

Each of these profit factors is scored with regard to the plan's performance in the previous year, and the sum of the scores determines the profit percentage. The "profit" margins for FEHBP fee-for-service plans are not large, but the plans in the program experience little risk because they may make up losses experienced in the past year through increases in premiums in the following year (or they may draw down surplus contingency reserves). Plan income in excess of that which had been estimated when premiums were set for a given year may be carried forward and used to limit premium increases in the following year.

For the community-rated plans, OPM negotiates the HMO plans to receive a capitated payment for each federal enrollee, basing the payment amount on the rates the plan charges for enrollees in the two largest nonfederal employer-sponsored groups in that community, plus negotiated upgrades to the community benefit package. HMOs may compute their community rate using factors such as age and sex. OPM requires large HMOs to document the basis of their charges to nonfederal participating employers in the community. The profit rate HMOs receive based on the community rate may be larger than that available to fee-for-service plans under FEHBP.

Financing OPM's Costs for Administering FEHBP

The only administrative costs of the federal government for FEHBP that can be identified explicitly are the costs of OPM's headquarters staff. For 2009, OPM employed about 191 FTEs who are responsible for FEHBP.⁵² This staff include the actuaries and employees who negotiate with carriers, monitor plans and contracts, and generally oversee all aspects of program administration. OPM adds a charge to each plan's premium, limited to 1% of the premium, to cover these administrative costs.⁵³ Generally the charge is less than 1%. There is no separate accounting for the costs associated with agency personnel who carry out administrative tasks associated with FEHBP as well as the other pay and benefit programs for federal workers. Plan carriers' administrative costs are included in their premiums. To the extent that plans compete for enrollees on basis of premiums, they have an incentive for administrative efficiency. However, OPM does not ask for detailed administrative cost data, although it periodically audits certain overhead charges.

Other Administrative Roles/Activities

Data Warehousing: October 5, 2010, OPM announced in the *Federal Register* the creation of a new health information management system that will, among other things, be used to collect, manage, and analyze health services data for FEHBP.⁵⁴ Generally, the data will be de-identified to allow for such analytic purposes as the examination of health trends, development of risk adjustment methodologies, and oversight of pharmacy pricing and negotiation. Data with personal identifiers may be used, in accordance with applicable privacy standards, for the purposes of a congressional inquiry, for judicial and administrative proceedings, and for investigations by law enforcement officials.⁵⁵ The initial notice for this system established a

⁵² FY2010, Office of Personnel Management Congressional Budget Justification Performance Budget.

⁵³ 5 CFR § 890.503.

⁵⁴ 75 FR 61532.

⁵⁵ Under the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191), identifiable information refers to data that is explicitly linked to a particular individual and data items that reasonably could be expected to allow individual identification. Potential identifiers include, but are not limited to, name and social (continued...)

comment period deadline of November 15, 2010, after which the system would become operational. Based on the comments received, OPM is considering revisions to the initial systems notice to “provide greater specificity regarding the authorities for maintaining the system, clarify its intent to significantly limit the circumstances under which personally identifiable records may be released, and provide a more detailed explanation of how the records in this system will be protected and secured.”⁵⁶ The effective date of the system has been moved back to December 15, 2010.

Grievance and Appeals: All plan brochures include an explanation of the procedures enrollees should follow if they disagree with a denial of coverage or payment. An enrollee must first submit a written request to the plan for reconsideration within 6 months of the denial of coverage. Within 30 days of receiving the request, the plan must approve the claim, request additional information or provide a written statement explaining the denial.⁵⁷

If the plan decides against the enrollee, a written appeal can be filed with OPM within 90 days of the plan’s second denial. If OPM determines the enrollee is entitled to coverage, the plan must provide or pay for the care. If OPM decides against the enrollee, he or she can appeal in federal district court.

Sanctions: OPM may, and in some cases must, apply sanctions to health care providers.⁵⁸ These sanctions include debarment, suspension, civil monetary penalties, and financial assessments. The regulations establish the circumstances under which these sanctions may occur, along with procedures for appeals.

State Law Exemptions: The terms of a contract relating to coverage or benefits, including payments, supersede and preempt any State or local laws and regulations relating to health insurance or plans. While OPM requires HMOs to provide their FEHBP plan enrollees with mandated state benefits, OPM has the authority to override these requirements.

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security number; voice and fax telephone numbers; electronic mail addresses; medical record numbers, health plan beneficiary numbers, or other health plan account numbers; biometric identifiers, including finger and voice prints; and full face photographic images.

⁵⁶ OPM extended the comment period to December 15, 2010. For more information, see 75 FR 69715.

⁵⁷ 5 CFR § 890.105.

⁵⁸ 5 CFR § 890.1001.

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