



Health Benefits for Members of Congress and Certain Congressional Staff

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November 4, 2013

Congressional Research Service

7-5700

www.crs.gov

R43194

CRS Report for Congress

Prepared for Members and Committees of Congress

Summary

The federal government, as an employer, offers health benefits to its employees, including Members of Congress and congressional staff. Traditionally, Members and staff have had access to many of the same health benefits as other federal employees. For example, Members and staff have been eligible to voluntarily enroll in employer-sponsored health insurance through the Federal Employees Health Benefits Program (FEHBP), and they can choose to participate in other health benefit programs, such as the Federal Flexible Spending Account Program (FSAFEDS).

Section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) generally specifies that the only health plans that the federal government may make available to Members and certain congressional staff (with respect to their service as Members or staff) are either created under ACA or offered through an exchange. A final rule issued by the Office of Personnel Management (OPM) amends FEHBP eligibility regulations to comply with Section 1312(d)(3)(D) of ACA. Under the final rule, beginning January 1, 2014, Members and designated congressional staff will no longer be able to purchase FEHBP plans as active employees; however, if they enroll in a health plan offered through a small business health options program (SHOP) exchange, they will remain eligible for an employer contribution toward coverage. Additionally, the final rule allows Members and designated congressional staff who are eligible for retirement to enroll in a FEHBP plan upon retirement.

This report summarizes the provisions of the final rule and describes how it affects current and retired Members and congressional staff. OPM has indicated that Members and congressional staff will be eligible for other health benefits related to federal employment, and these additional health benefits are outlined in this report. These health benefits include FSAFEDS, the Federal Employees Dental and Vision Insurance Program (FEDVIP), the Federal Long Term Care Insurance Program (FLTCIP), the Office of the Attending Physician, and treatment in military facilities. This report also discusses Members' and staff's eligibility for Medicare, which does not appear to be affected by the final rule.

For information about the health benefits received by other federal employees (i.e., those who are not affected by the aforementioned final rule), see CRS Report RS21974, *Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options*, by Annie L. Mach.

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Introduction

Many private- and public-sector firms offer employer-subsidized health benefits to their employees as part of an employee's compensation package. Among large employers in the United States (those with 200 or more employees), 99% offered health insurance coverage to their employees in 2013.¹ On average, large employers subsidized 81% of the cost of self-only coverage and 74% of the cost of family coverage.² Twenty-eight percent of large employers that offer health benefits to their employees offer retiree coverage. Among firms with 5,000 or more workers, 48% offer retiree coverage.³

The federal government, as an employer, also offers health benefits to its employees and annuitants (retirees). The federal government offers employer-subsidized health insurance through the Federal Employees Health Benefits Program (FEHBP). Prior to 2014, Members of Congress and congressional staff are eligible to participate in FEHBP in the same way that most other federal employees and annuitants are eligible to participate.⁴ That is, Members and staff can purchase a health plan offered under FEHBP, receive an employer contribution toward the coverage, and carry the coverage into retirement (provided they are eligible to do so).

However, Section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) states,

(i) Requirement.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) Definitions.—In this section:

(I) Member of Congress.—The term “Member of Congress” means any member of the House of Representatives or the Senate.

(II) Congressional Staff.—The term “congressional staff” means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

The Office of Personnel Management (OPM) issued a final rule that amends FEHBP eligibility to comply with Section 1312(d)(3)(D) of ACA on October 2, 2013.⁵ Under the rule, Members and

¹ Kaiser Family Foundation and the Health Research & Educational Trust, *Employer Health Benefits*, 2013 Annual Survey, Menlo Park, CA, August 2013, <http://kff.org/private-insurance/report/2013-employer-health-benefits/>.

² *Ibid.*

³ *Ibid.*

⁴ For more information about how FEHBP works for most federal employees, see CRS Report RS21974, *Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options*, by Annie L. Mach.

⁵ Office of Personnel Management, “Federal Employees Health Benefits Program: Members of Congress and (continued...)”

certain congressional staff will no longer be able to purchase a health plan offered under FEHBP beginning January 1, 2014; however, if they enroll in a health plan offered through an appropriate small business health options program (SHOP) exchange,⁶ they will remain eligible for an employer contribution toward coverage. Additionally, Members and staff who obtain coverage through a SHOP exchange under this arrangement may purchase a FEHBP plan upon retirement from the federal government, provided they otherwise meet the criteria to do so.⁷ This report summarizes the provisions of the final rule and discusses how they affect current and retired Members and congressional staff.

OPM has indicated that the final rule only pertains to Members' and staff's access to health insurance plans offered by the federal government under FEHBP.⁸ This report also describes other health benefits available to Members and staff for which eligibility is not affected by the final rule, including the Federal Flexible Spending Account Program (FSAFEDS); the Federal Employees Dental and Vision Insurance Program (FEDVIP); the Federal Long Term Care Insurance Program (FLTCIP); the Office of the Attending Physician; and treatment in military facilities.

While some of the health benefits described in this report may also be available to federal employees who are not Members or congressional staff, this report does not focus on their health benefits and does not provide a comprehensive picture of the health benefits available to them. For information about what is available to federal employees who are not current Members or congressional staff, see CRS Report RS21974, *Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options*, by Annie L. Mach.

Health Insurance Coverage

Beginning January 1, 2014, Members of Congress and certain congressional staff must obtain health insurance coverage through a SHOP exchange in order to receive a government contribution toward the coverage. Section 1312(d)(3)(D) of ACA defines the terms "Members of Congress" and "congressional staff" as follows:

The term "Member of Congress" means any member of the House of Representatives or the Senate.

The term "congressional staff" means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(...continued)

Congressional Staff," 78 *Federal Register* 60653, October 2, 2013, <http://www.gpo.gov/fdsys/pkg/FR-2013-10-02/pdf/2013-23565.pdf>

⁶ For more information about SHOP exchanges, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

⁷ Neither ACA nor the proposed rule requires Members and staff to enroll in a health plan offered through a SHOP exchange; rather, SHOP plans are the only plans that will be made available to them with respect to their federal service.

⁸ Office of Personnel Management, "Federal Employees Health Benefits Program: Members of Congress and Congressional Staff," 78 *Federal Register* 60653, October 2, 2013, page 60655, <http://www.gpo.gov/fdsys/pkg/FR-2013-10-02/pdf/2013-23565.pdf>

The final rule delegates to the employing office of the Member the responsibility to make the determination as to whether a congressional staff member meets the statutory definition of being employed by an “official office.” OPM indicates that it will not interfere in the process by which a Member or his or her designee determines the designations of his or her staff. Additionally, OPM notes, “Nothing in this regulation limits a Member’s authority to delegate to the House or Senate Administrative Offices the Member’s decision about the proper designation of his or her staff.”⁹

The employing office of a Member (or its designee) must designate its staff prior to November 2013 for the plan year effective January 1, 2014; for subsequent plan years the designations must be made prior to October of the preceding year (or at the time of hiring for individuals whose employment begins during the year).¹⁰ The designation will be made annually, and individuals will maintain their designations for the entire FEHBP plan year, so long as they continue to be employed by the same Member.¹¹ Congressional staff who do not receive a designation of being employed by an official office retain the ability to enroll in a health plan offered under FEHBP.

Coverage for Annuitants (Retirees)

OPM indicates that Members and congressional staff designated as working for an official office of a Member (hereafter “staff” or “designated staff”) who purchase coverage through an exchange will have the ability to enroll in plans offered through FEHBP when they become annuitants, provided they meet the eligibility criteria to do so under 5 U.S.C. Section 8905.¹² The eligibility criteria are generally the same criteria that all other federal employees must meet to continue FEHBP coverage in retirement. The criteria are (1) eligibility for retirement from the federal government,¹³ and (2) continuous enrollment in a health plan offered under FEHBP (or in the case of Members and staff, offered through an exchange) for the five years of service immediately prior to retirement. To be clear, OPM has indicated that Members’ and staff’s SHOP exchange coverage counts toward the five-year requirement.

OPM indicates that the final rule does not apply to Members or staff who become annuitants *before* December 31, 2013. If these annuitants are enrolled in a plan under FEHBP, nothing would prohibit them from continuing their coverage under a FEHBP plan.

⁹ Office of Personnel Management, “Federal Employees Health Benefits Program: Members of Congress and Congressional Staff,” 78 *Federal Register* 60653, October 2, 2013, page 60653.

¹⁰ 5 CFR § 890.102(c)(9)(ii).

¹¹ *Ibid.*

¹² The final rule allows Members and staff to transfer to coverage offered under FEHBP on becoming annuitants, but the proposed rule did not. Under the proposed rule, Members and staff were unable to return to FEHBP upon becoming annuitants; instead, they could continue to receive the government contribution toward an exchange plan on becoming annuitants. In the preamble to the final rule, OPM notes (page 60654), “Section 1312 only addresses the health benefits plans that the federal government may offer Members of Congress and congressional staff employed by the official office of a member of Congress while they are employed in those positions. This provision neither amended any of the sections of Chapter 89 relating to annuitant health benefits nor otherwise indicated that the provision applies to annuitants. Because we agree with the central premise of these comments, we have deleted the proposed language in § 890.501(h)(1) and (2) referring to annuitants.”

¹³ For information about retirement eligibility, see CRS Report RL30631, *Retirement Benefits for Members of Congress*, by Katelin P. Isaacs.

Election of Coverage and Plan Choices

Under the final rule, all Members of Congress, including representatives of the U.S. Territories, and their designated staff must purchase “health plans offered by an appropriate SHOP as determined by the Director [of OPM] ... ” in order to receive an employer contribution toward the coverage.¹⁴ OPM has indicated that Members and staff must use the District of Columbia’s SHOP exchange (DC Health Link).¹⁵

The open enrollment period for Members and staff begins November 11, 2013, and ends December 9, 2013.¹⁶ Members and staff will be able to select a plan from 112 options offered in the gold tier on the DC SHOP exchange.¹⁷ Coverage will begin on January 1, 2014 for those Members and staff who select a plan during the open enrollment period. (For Members and staff currently covered by a plan offered under FEHBP, their coverage will terminate December 31, 2013.)

Members and staff will be able to select individual coverage or family coverage. OPM notes that, “Under FEHB rules, eligible dependents are limited to your spouse, your children (including step-children and adopted children) and foster children. Regardless of the dependent relationships listed on the DC Health Link webpage when enrolling, these are the only dependents you may enroll.”¹⁸ OPM indicates that enrollment in a SHOP plan will last for one year, unless an employment change occurs (such as a move to a different federal agency). Once Members and staff enroll in a SHOP plan, enrollment in the plan will automatically renew for the next calendar year if the enrollee does not take action during the open enrollment period.

SHOP coverage will terminate once Members and staff separate from federal service, but Members and staff may have the option to enroll in a FEHBP plan under Temporary Continuation of Coverage (TCC) in such situations.¹⁹ TCC is also available to FEHBP enrollees and is similar to COBRA coverage offered to individuals in the private sector. Members, staff, and their dependents who lose their SHOP 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%

¹⁴ 5 CFR § 890.102(c).

¹⁵ In addressing the question as to whether individual who reside outside the D.C. region will be able to obtain a health plan through the D.C. SHOP exchange that provides in-network coverage outside the D.C. region, OPM notes that the DC SHOP offers health plans that have “in-network access to medical providers across the nation and overseas.” OPM, Insurance FAQs: Members of Congress & Staff, <http://www.opm.gov/healthcare-insurance/insurance-faqs/?cid=6bf9dd32-d3b9-4fc7-9416-431e535f933a&page=1>.

¹⁶ The open enrollment period coincides with the FEHBP open enrollment period. OPM, Insurance FAQs: Members of Congress & Staff, <http://www.opm.gov/healthcare-insurance/insurance-faqs/?cid=6bf9dd32-d3b9-4fc7-9416-431e535f933a&page=2>.

¹⁷ The D.C. SHOP exchange also offers plans in the other metal tiers – bronze, silver, and platinum – but OPM has indicated that Members and designated staff must purchase plans offered in the gold tier in order to retain the employer contribution. The plans offered in the gold tier must have an actuarial value around 80%. This means that, on average, the plan is responsible for 80% of the cost of all covered benefits and the enrollee is responsible for 20%.

¹⁸ OPM, Insurance FAQs: Members of Congress & Staff, <http://www.opm.gov/healthcare-insurance/insurance-faqs/?cid=6bf9dd32-d3b9-4fc7-9416-431e535f933a&page=2>.

¹⁹ Ibid.

administrative charge. In general, TCC coverage is available to separating employees and their families for up to 18 months after the date of separation.

Employer Contributions

Members and staff will be able to receive an employer contribution toward coverage purchased through the D.C. SHOP exchange. The employer contribution will be calculated using the statutory formula for health plans offered under FEHBP.²⁰ The percentage of premiums paid by the federal government is calculated separately for individual and family coverage, but each uses the same formula. According to the formula, the employer contribution is set at 72% of the weighted average of all FEHBP plan premiums, not to exceed 75% of any given plan's premium.²¹ In 2014, the maximum government contribution for full-time employees is \$426.14 per month for self-only coverage and \$948.18 per month for self and family coverage. The employer contribution to a plan for a part-time worker is generally prorated.²² OPM indicates that Members' and staff's contributions to premiums will be collected by payroll deduction and the contributions will be tax preferred, as they are for FEHBP enrollees.²³

Cost of Coverage

Plans offered under large group coverage arrangements typically offer the same premium to all enrollees. This is the case for plans offered under FEHBP—the premium for any particular plan for self or family coverage is the same for any individual who enrolls in the plan, regardless of the individual's characteristics (e.g., age) or health status. In contrast, plans offered in the small group market, such as those that will be available through SHOP exchanges, are allowed to vary premiums based on an individual's age, geographic location, and whether the individual uses tobacco products. This means that two individuals who have different characteristics (i.e., one is 25 years old and the other is 56 years old) who select the same plan in an exchange could be charged different premiums because of the rating allowances, unlike FEHBP where they would be charged the same premium.

Plans offered through D.C.'s SHOP exchange will only vary premiums based on an enrollee's age.²⁴ **Table A-1** in the **Appendix** illustrates how age-rating could affect the cost of coverage for Members and staff who obtain coverage through the D.C. SHOP exchange.

²⁰ 5 CFR § 890.501(h).

²¹ 5 U.S.C. §8906.

²² 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.

²³ OPM, Insurance FAQs: Members of Congress & Staff, <http://www.opm.gov/healthcare-insurance/insurance-faqs/?cid=6bf9dd32-d3b9-4fc7-9416-431e535f933a&page=2>.

²⁴ Under ACA, state may also allow insurers to vary premiums by geographic rating area and whether or not an enrollee uses tobacco products; however, D.C. only has one geographic rating area and has decided not to allow insurers to vary premiums based on tobacco use.

Other Health Benefits Related to Federal Employment

Section 1312(d)(3)(D) of ACA and the final rule only affect the health insurance coverage the federal government may make available to Members and certain congressional staff as part of their federal employment. Members and staff (hereinafter, “staff” refers to all congressional staff), as well as other federal employees, have access to other health benefits, and their access to these benefits does not appear to be affected by Section 1312(d)(3)(D) and the final rule.²⁵ Some of these health benefits are available to all federal employees and annuitants, while others are only available to active employees or Members.

Federal Flexible Spending Account Program

OPM administers a Flexible Spending Account (FSA) program, FSAFEDS. Current federal employees (including Members and congressional staff) who are eligible for FEHBP are also eligible to participate in FSAFEDS, whether enrolled in FEHBP or not. There are three options within FSAFEDS:

- The **Health Care Flexible Spending Account (HCFSA)** reimburses eligible health care expenses that are not covered or reimbursed by other insurance coverage, including copayments, over-the-counter drugs, eyeglasses, dental care, and infertility treatments. Employees can choose to deposit between \$250 and \$2,500 each year.
- The **Dependent Care Flexible Spending Account (DCFSA)** reimburses eligible non-medical child day care and elder care expenses. A \$5,000 limit applies.
- The **Limited Expense HCFSA (LEX HCFSA)** is for those enrolled in a high-deductible health plan (HDHP) with a Health Savings Account, and it reimburses only eligible dental and vision expenses that are not covered or reimbursed by other insurance coverage.

The accounts are funded by the employee from pre-tax salary dollars, with no government contribution. FSA money is lost if it is not spent within 2½ months after the end of the calendar year in which the money was allotted.²⁶ During the annual FEHBP open season, employees may change the amount to set aside in the upcoming year or may choose not to deposit money in their FSA.²⁷

²⁵ OPM, Insurance FAQs: Members of Congress & Staff, <http://www.opm.gov/healthcare-insurance/insurance-faqs/?cid=6bf9dd32-d3b9-4fc7-9416-431e535f933a&page=2>.

²⁶ The Treasury Department and the Internal Revenue Service (IRS) recently issued Notice 2013-71, which modifies health FSA (e.g., HCFSA) “use it or lose it” rules. According to the Notice, plan sponsors (e.g., employers) may allow employees to carry over up to \$500 of unused amounts remaining in a health FSA into the next plan year. This carryover option is an alternative to the 2½ month grace period; plan sponsors may not offer both. As of the date of this report, OPM has not announced whether the carryover option will be available to federal employees who have health FSAs.

²⁷ Office of Personnel Management, *Flexible Spending Accounts (FSAFEDS) FastFacts*, <http://www.opm.gov/insure/fastfacts/fsafeds.pdf>.

Federal Employees Dental and Vision Insurance Program

Dental and vision benefits are available to active federal employees and annuitants (including current and retired Members and congressional staff) through the Federal Employees Dental and Vision Insurance Program (FEDVIP) administered by OPM. Employees and annuitants are not required to enroll in FEHBP to enroll in FEDVIP. Enrollees are responsible for 100% of the premiums, and employees' salary contributions are paid with pre-tax dollars. To continue or obtain FEDVIP coverage in retirement, an employee does not have to participate in FEDVIP prior to retirement.

For dental coverage, enrollees have a choice of four nationwide and three regional dental plans covering a variety of preventive and major services, as well as orthodontics for dependents under the age of 19.²⁸ For vision coverage, enrollees can choose from three nationwide vision plans that cover routine eye exams and glasses or contact lenses. Plans vary in the other types of vision services they cover, such as discounts on Lasik surgery, low vision therapy, prosthetic eyes, and other services.²⁹

Federal Long Term Care Insurance Program

Federal employees and annuitants (including current and retired Members and congressional staff) are eligible to apply for long-term care coverage through the Federal Long Term Care Insurance Program administered by OPM. Long-term care includes services and assistance for those who can no longer perform activities of daily living, such as bathing and dressing, due to chronic illness, injury, disability, or aging. Most health insurance plans, including plans offered through FEHBP, do not include coverage for long-term care services. To apply for coverage under FLTCIP, employees must answer questions about their medical history. Some medical conditions will prevent employees from being approved for coverage. Premiums for FLTCIP may be deducted from an individual's salary or annuity, but they are not pre-tax contributions, and employees pay 100% of the premiums.³⁰

Office of the Attending Physician

Current Members are eligible to receive limited services from the Office of the Attending Physician (OAP) in the U.S. Capitol for an annual fee. The annual fee for 2013 is \$576.³¹ Services include routine exams, consultations, and certain diagnostic tests. The office does not provide vision or dental care, and prescriptions can be written but not dispensed.³²

²⁸ Office of Personnel Management, *FastFacts for Dental Insurance*, <http://www.opm.gov/insure/fastfacts/dental.pdf>.

²⁹ Ibid.

³⁰ Individuals under age 65 can deduct long-term care insurance premiums as medical expenses if total qualified medical expenses exceed 10% of annual adjusted gross income (AGI). Prior to 2017, individuals aged 65 and older can deduct long term care insurance premiums as medical expenses if total qualified medical expenses exceed 7.5% of annual AGI (beginning in 2017 the threshold increases to 10%). The amount of long-term care insurance premiums an individual can deduct is subject to Internal Revenue Service (IRS) limits. For more information, see http://www.ltfefeds.com/start/aboutltci_taxqual.html.

³¹ Committee on House Administration.

³² For background information on the Office of the Attending Physician, see CRS Report RS20305, *The Office of Attending Physician in the U.S. Congress*, by Mildred Amer.

Military Treatment Facilities

Current Members are also authorized to receive medical and emergency dental care at military treatment facilities. There is no charge for outpatient care if it is provided in the National Capital Region.³³ For inpatient care, Members are billed at full reimbursement based on rates set by the Department of Defense. Outside the National Capital Region, charges are at full reimbursement rates for both inpatient and outpatient care provided to Members of Congress. Members pay out of pocket for expenses not covered by insurance. Former Members and dependents are not eligible for care at military hospitals.³⁴

Medicare

Medicare is the nation's health insurance program for individuals aged 65 and over and certain disabled persons. Medicare consists of four distinct parts: Part A, or Hospital Insurance (HI); Part B, or Supplementary Medical Insurance (SMI); Part C, or Medicare Advantage (MA); and Part D, the prescription drug benefit.³⁵ Workers, including all federal employees, Members, and congressional staff, must pay a tax on their wages for Medicare Part A.³⁶ Workers and their employers each pay a tax of 1.45% of earnings.³⁷

Participation in Part B, Medicare Advantage, and Part D is voluntary, and each requires that enrollees pay a monthly premium to participate.³⁸ Medicare beneficiaries may also choose to purchase a Medigap policy, which provides supplemental coverage in the private sector if one enrolls in Medicare Part A and B.

With respect to Members and designated congressional staff, § 1312(d)(3)(D) and the final rule do not appear to affect their eligibility for any Medicare programs. Additionally, OPM indicates that eligibility for Medicare will not affect Members' and staff's ability to obtain coverage through a SHOP exchange:

SHOP coverage is not subject to the same limitation as the individual Exchange which precludes an individual from carrying both Medicare and an individual Exchange policy. You can continue to have Medicare coverage in addition to your employer-sponsored DC SHOP plan.³⁹

³³ The National Capital Region includes Washington, DC, and nearby jurisdictions in Maryland and Virginia.

³⁴ 32 C.F.R. §728.77.

³⁵ For more detail on Medicare eligibility and benefits, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

³⁶ This tax was established for federal employees under the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, effective January 1, 1983).

³⁷ For a full discussion of wage taxes, see CRS Report 94-28, *Social Security and Medicare Taxes and Premiums: Fact Sheet*, by Dawn Nuschler.

³⁸ For Part B, the 2013 monthly premium is \$104.90 for most Medicare beneficiaries. For Part D, the 2013 base beneficiary premium is \$31.17. Premiums vary among Medicare Advantage plans.

³⁹ OPM, Insurance FAQs: Members of Congress & Staff, <http://www.opm.gov/healthcare-insurance/insurance-faqs/?cid=6bf9dd32-d3b9-4fc7-9416-431e535f933a&page=2>.

This information indicates that Members and designated staff who become eligible for Medicare while actively employed can have SHOP coverage and Medicare coverage concurrently. For those Members and designated staff who carry their federally-sponsored health insurance coverage into retirement, they will switch to a plan offered under FEHBP, and their FEHBP coverage will interact with Medicare coverage in the ways outlined for the programs.⁴⁰

⁴⁰ For more information about how FEHBP interacts with Medicare, see CRS Report RS21974, *Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options*, by Annie L. Mach.

Appendix. Selected Premiums in the D.C. SHOP Exchange

Table A-1 shows the monthly premiums for self-only coverage from selected gold level health plans available to individuals (age 27, 40, and 55) through the D.C. SHOP exchange (D.C. Health Link) beginning January 2014.⁴¹ **Table A-1** also shows the potential federal government contribution to that coverage. The federal government contribution was calculated using the statutory formula for FEHBP—the government’s contribution is 72% of the weighted average of all FEHBP plans not to exceed 75% of any given plan’s premium. The maximum monthly federal government contribution in 2014 for self-only coverage under FEHBP is \$426.14 (i.e., \$426.14 is 72% of the weighted average of all self-only FEHBP plans for 2014).

The information in **Table A-1** is illustrative only; it does not provide comprehensive information about all of the plan options that may be available to Members and designated staff through the D.C. SHOP exchange. Individuals interested in a more comprehensive examination of the plans available through D.C.’s SHOP exchange should visit www.dchealthlink.com.

⁴¹ The D.C. SHOP exchange also offers plans in the other metal tiers—bronze, silver, and platinum—but OPM has indicated that Members and designated staff must purchase plans offered in the gold tier in order to retain the employer contribution. Plans offered in the gold tier must have an actuarial value around 80%. This means that, on average, the plan is responsible for 80% of the cost of all covered benefits and the enrollee is responsible for 20%.

Table A-I. Monthly Self-Only Premiums for Selected Gold Level Health Insurance Plans Available Through the District of Columbia’s SHOP Exchange

	Individuals Aged 27			Individuals Aged 40			Individuals Aged 55		
	Total Premium	Gov’t. Contribution	Employee Contribution	Total Premium	Gov’t. Contribution	Employee Contribution	Total Premium	Gov’t. Contribution	Employee Contribution
Aetna – PPO									
Low	\$324.16	\$243.12	\$81.04	\$434.74	\$326.06	\$108.69	\$772.72	\$426.14	\$346.58
High	\$403.13	\$302.35	\$100.78	\$540.65	\$405.49	\$135.16	\$960.98	\$426.14	\$534.84
Aetna – HMO									
Low	\$242.29	\$181.72	\$60.57	\$324.94	\$243.71	\$81.24	\$577.57	\$426.14	\$151.43
High	\$314.03	\$235.52	\$78.51	\$421.15	\$315.86	\$105.29	\$748.57	\$426.14	\$322.43
CareFirst – PPO									
Low	\$272.72	\$204.54	\$68.18	\$365.75	\$274.31	\$91.44	\$650.10	\$426.14	\$223.96
High	\$329.07	\$246.80	\$82.27	\$441.32	\$330.99	\$110.33	\$784.43	\$426.14	\$358.29
CareFirst – HMO									
Low	\$226.27	\$169.70	\$56.57	\$303.46	\$227.60	\$75.87	\$539.38	\$404.54	\$134.85
High	\$256.30	\$192.23	\$64.08	\$343.73	\$257.80	\$85.93	\$610.95	\$426.14	\$184.81
Kaiser – HMO									
Low	\$226.78	\$170.09	\$56.70	\$303.75	\$227.81	\$75.94	\$539.01	\$404.26	\$134.75
High	\$267.96	\$200.97	\$66.99	\$358.98	\$269.24	\$89.75	\$637.17	\$426.14	\$211.03
United – PPO									
Low	\$256.85	\$192.64	\$64.21	\$344.47	\$258.35	\$86.12	\$612.27	\$426.14	\$186.13
High	\$311.92	\$233.94	\$77.98	\$418.32	\$313.74	\$104.58	\$743.54	\$426.14	\$317.40
United – HMO									
Low	\$240.05	\$180.04	\$60.01	\$321.94	\$241.46	\$80.49	\$572.22	\$426.14	\$146.08
High	\$295.14	\$221.36	\$73.79	\$395.82	\$296.87	\$98.96	\$703.55	\$426.14	\$277.41

Source: The premium information was obtained at <http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/FINALRates72313.pdf>.

Notes: The “low” premium is for the lowest cost plan offered in the category; the “high” premium is for the highest cost plan offered in the category.

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