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Federal Employees Health Benefits (FEHB) Program: An Overview

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Summary

The Federal Employees Health Benefits (FEHB) Program provides health insurance to federal employees, retirees, and their dependents. This report provides a general overview of FEHB. It describes the structure of FEHB, including eligibility for the program and coverage options available to enrollees, as well as premiums, benefits and cost sharing, and general financing of FEHB. The report also describes the role of the Office of Personnel Management (OPM) in administering the program.

Eligible individuals include federal employees, retirees, and their family members. As of calendar year 2014, Members of Congress and certain congressional staff are no longer eligible to enroll in plans offered under FEHB as employees but may be eligible to enroll in retirement. Coverage options available to eligible individuals include individual or family coverage in an approved health benefits plan. Beginning in calendar year 2016, individuals have a third coverage option: self plus one coverage for themselves and one eligible family member. Generally, available health benefits plans fall into two broad categories: fee-for-service (FFS) or health maintenance organizations (HMOs). FFS plans tend to be available nationwide, and HMOs tend to be locally available. Premiums are shared between the federal government and the employee or retiree. Benefits and cost sharing vary among FEHB plans, but all plans must cover basic services such as hospital and physician care and may require cost sharing in the form of deductibles, co-payments, or coinsurance. FEHB financing includes government contributions to premiums, contingency reserves in the U.S. Treasury to offset unexpected increases in costs, and administrative expenses incurred by OPM.

The report also discusses how FEHB interacts with the United States Postal Service (USPS) and with Medicare as well as the impact of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) on FEHB. Like most federal agencies, the USPS offers health insurance to its employees through FEHB. However, collective bargaining rights and prefunding obligations for retiree health costs make the USPS unique among federal agencies with regard to health benefits. Most federal employees or retirees aged 65 or older are automatically entitled to Medicare Part A (Hospital Insurance, or HI). They also may choose to enroll in Medicare Part B (Supplementary Medical Insurance, or SMI) and Part D (prescription drug coverage). For individuals covered under an FEHB plan, Medicare is the primary payer, meaning it pays for benefits first, and FEHB is the secondary payer. The ACA established new requirements for FEHB plans in some cases. In others, it had no meaningful effect. For example, the requirement to provide coverage to children up to the age of 26 on their parent's plan was a new requirement for plans, but many plans were already meeting the ACA requirement not to deny coverage based on preexisting conditions.

For information on the current plan year, such as premiums and cost sharing in FEHB and the most recent open season (the period each year during which individuals can enroll or change health plans), see CRS In Focus IF10324, *The Federal Employees Health Benefits (FEHB) Program: Open Season for the 2016 Plan Year*.

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Basics of the Federal Employees Health Benefits Program

The Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored health insurance program in the country. It provides more than $40 billion in health care benefits annually to employees and retirees of the federal government, the largest employer in the United States. In a typical year, FEHB provides health insurance coverage to about 8.2 million federal employees, retirees,[1] and their dependents.[2] Employees and retirees make up roughly half of that figure, or about 4 million policyholders.[3] Of these, about 50% are retirees.[4] Participation in FEHB is voluntary. About 85% of federal employees participate, and about 90% of retirees participate.[5]

The statute governing FEHB is in Title 5, Chapter 89 of the *United States Code*. It specifies that the federal government and the employee or retiree will share the cost of health insurance, with the federal government contributing 72% of the weighted average premium of all plans but no more than 75% of any given plan's premium, with the exception of employees of the USPS, whose share of the premium is collectively bargained.[6] The Office of Personnel Management (OPM) administers the program. (For more detailed information on OPM's role, see the **Appendix**.) OPM has statutory authority to contract with health insurance carriers that offer insurance coverage for comprehensive medical services and to prescribe regulations to carry out that authority.[7] For example, OPM coordinates the administration of FEHB with federal agencies, manages contingency reserve funds for the health plans, and applies sanctions to health care providers according to federal regulations.

Eligibility

Eligible enrollees include federal employees, retirees, and their dependent family members.[8] New federal employees have 60 days from their start date to sign up for an FEHB plan, or they can wait to enroll until the next open season (the period each year during which individuals can enroll

[1] In the statute governing the Federal Employees Health Benefits (FEHB) Program, retirees are referred to as *annuitants*. This report will use the term *retirees*.

[2] Office of Personnel Management (OPM), Director's Blog, "It's Time to Review Your Federal Benefits," November 9, 2015, at https://www.opm.gov/blogs/Director/2015/11/9/Its-Time-to-Review-Your-Federal-Benefits/.

[3] Congressional Research Service (CRS) analysis of OPM data on FEHB enrollment, received from OPM's Congressional, Legislative, and Intergovernmental Affairs office on October 5, 2015. For purposes of this report, *policyholder* refers to the individual who obtains coverage through FEHB for himself or herself and for any eligible dependents.

[4] CRS analysis of OPM data on FEHB enrollment, received from OPM's Congressional, Legislative, and Intergovernmental Affairs office on October 5, 2015.

[5] OPM, "Open Season for Federal Health Benefits, Dental and Vision," press release, September 29, 2015, at https://www.opm.gov/news/releases/2015/09/fehb-press-release-92915-1/ and "OPM Announces 2015 Federal Employees Health Benefits Program Premium Rates," press release, October 7, 2014, at http://www.opm.gov/news/releases/2014/10/opm-announces-2015-federal-employees-health-benefits-program-premium-rates/.

[6] 5 U.S.C. §8906(b). For more information on the USPS and FEHB, see "How the USPS Interacts with the FEHB Program" in this report.

[7] The term *health insurance carrier* refers to the health insurance companies with which OPM contracts and that offer services through one or more health plans.

[8] §8901 of the FEHB statute lists all the eligibility groups. Additionally, eligibility information is provided in the *FEHB Program Handbook*, "Eligibility for Health Benefits," at http://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/eligibility-for-health-benefits/.

or change health plans). Part-time workers are eligible for coverage, but generally they are required to pay a larger share of premiums than full-time employees. Certain temporary, seasonal, and intermittent workers who are identified as full-time employees are also eligible for coverage.[9] Enrollees can choose either individual or family coverage. Starting in calendar year 2016, a self plus one coverage option is also available to enrollees.[10]OPM is offering a limited enrollment period to active federal employees that runs from February 1, 2016, to February 29, 2016. During this time, active employees who did not make the switch during open season have a second opportunity to switch to self plus one coverage.[11]

Members of Congress and Certain Congressional Staff

Members of Congress and certain congressional staff no longer receive health benefits through FEHB as a benefit of their employment but may be eligible to enroll in FEHB in retirement. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) stipulates that the only health plans the federal government can make available to Members of Congress and certain congressional staff are those created under the ACA or offered through a health insurance marketplace as established by the ACA.[12] Specifically, according to a final rule issued by OPM, members and staff must enroll in a health plan offered through the District of Columbia's Small Business Health Options Program (DC SHOP), known as the DC Health Link Small Business Market, to remain eligible for an employer contribution toward their coverage.[13]

Dependent Family Members

Eligible dependent family members include a spouse, children under the age of 26, and qualified disabled children aged 26 years or older who cannot support themselves because of a mental or physical disability.[14] Under the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-

[9] Temporary employees, employees on seasonal schedules working less than 6 months per year, and intermittent employees will be eligible to enroll in an FEHB health plan if they are expected to work a full-time schedule of 130 hours or more per month. These employees will receive the same government contribution as full-time permanent employees. For more information, see OPM, "Federal Employees Health Benefits (FEHB) Program Modification of Eligibility to Certain Employees on Temporary Appointments and Certain Employees on Seasonal and Intermittent Schedules," *Benefits Administration Letter* 14-210, October 20, 2014, at https://www.opm.gov/retirement-services/publications-forms/benefits-administration-letters/2014/14-210.pdf. The final regulation is available at http://www.gpo.gov/fdsys/pkg/FR-2014-10-17/pdf/2014-24652.pdf.

[10] §706 of the Balanced Budget Act of 2013 (P.L. 113-67) added the self-plus-one option. For more information about the option, see OPM, "Special Initiatives, Self Plus One," at https://www.opm.gov/healthcare-insurance/special-initiatives/self-plus-one/.

[11] OPM, "OPM Announces a FEHB Program Limited Enrollment Period for Active Federal Employees," press release, January 27, 2016, at https://www.opm.gov/news/releases/2016/01/opm-announces-a-fehb-program-limited-enrollment-period-for-active-federal-employees/.

[12] §1312(d)(3)(D)(ii) of P.L. 111-148, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148. as amended), defines Members of Congress as any Member of the House of Representatives or the Senate. It defines congressional staff as 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.

[13] OPM, "Federal Employees Health Benefits Program: Members of Congress and Congressional Staff," 78 *Federal Register* 60653, October 2, 2013, at http://www.gpo.gov/fdsys/pkg/FR-2013-10-02/pdf/2013-23565.pdf. For more information, see CRS Report R43194, *Health Benefits for Members of Congress and Designated Congressional Staff: In Brief*.

[14] On June 26, 2013, the U.S. Supreme Court ruled that §3 of the Defense of Marriage Act (DOMA) is unconstitutional. As a result of the decision, OPM has stated that all legally married same-sex spouses are considered eligible family members under FEHB. Additionally, the children (including stepchildren) of same-sex marriages are treated the same way as children of opposite-sex marriages for eligibility purposes. For more information, see http://www.opm.gov/

615), certain former spouses (of federal employees, former employees, and retirees) also may qualify to enroll in FEHB.[15] Typically, surviving eligible family members of deceased employees or retirees can keep their enrollment in FEHB with the same level of benefits and government contributions to premiums.[16]

Retirees

To be eligible for FEHB in retirement, an individual (1) must be entitled to retire on an immediate annuity under a retirement system for civilian employees[17] and (2) must have been continuously enrolled (or covered as a family member) under FEHB for the five years of service immediately before the date on which the annuity starts or for the full period(s) of service since the individual's first opportunity to enroll (if less than five years). The five-year requirement can also be met by coverage under TRICARE, the health care program for uniformed servicemembers and their families, as long as the individual was covered under FEHB at the time of retirement.[18] For information on Medicare coverage for FEHB retirees, see "FEHB Enrollees and Medicare."

Members of the Military

FEHB retirees, survivors, and former spouses who are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), TRICARE, or TRICARE for Life may suspend their FEHB enrollment. They may return to FEHB during the open season, or they may return immediately if they involuntarily lose their non-FEHB coverage.[19]

Federal employee reservists who are placed in a leave-without-pay status when called to active duty for more than 30 days in support of a contingency operation can keep their FEHB coverage for up to 24 months.[20]

healthcare-insurance/healthcare/carriers/2013/2013-20.pdf.

[15] For more information, see CRS Report R42741, *Laws Affecting the Federal Employees Health Benefits (FEHB) Program*.

[16] For more information, see OPM's website at http://www.opm.gov/healthcare-insurance/life-events/memy-family/what-happens-if-i-die/.

[17] This includes individuals retiring under the Federal Employees Retirement System (FERS) and the minimum retirement age plus 10 years of service (MRA + 10) provision. A separating FERS employee who is eligible for an immediate annuity under the MRA + 10 provision may receive the benefits immediately or postpone receiving an annuity to lessen the age-related benefit reduction applicable to persons under the age of 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 FEHB when the annuity begins. However, if the individual applied for an immediate annuity under the MRA + 10 provision and later decided to postpone the annuity starting date, he or she would not be able to enroll in FEHB. Individuals retiring under the Civil Service Retirement System who qualify for an immediate annuity must retire on that annuity; they cannot postpone receiving the annuity and therefore cannot postpone receiving FEHB.

[18] OPM has the authority to waive the five-year requirement when it determines that it would be against equity and good conscience not to allow a retiree to enroll in FEHB (P.L. 99-251). For more information, see "Annuitants and Compensationers" in the *FEHB Program Handbook* at http://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/annuitants-and-compensationers/. See also "FEHB Enrollees and Medicare" in this report.

[19]For more information, see OPM, "Suspension of CHAMPVA or TRICARE or TRICARE-for-Life Eligibles Enrollment in the Federal Employees Health Benefits (FEHB) Program," 67 *Federal Register* 41305, June 18, 2002, at http://www.gpo.gov/fdsys/pkg/FR-2002-06-18/pdf/02-15275.pdf.

[20] For more information, see OPM, "Coverage for Federal Civilian Employees Called to Military Duty," at http://www.opm.gov/healthcare-insurance/healthcare/eligibility/#url=Reservists.

Tribal Employees

Since May 1, 2012, eligible Indian tribes, tribal organizations, and urban Indian organizations have been allowed to purchase FEHB for their tribal employees.[21] The tribe or tribal organization is required to pay at least the government's share of the premium, and the enrollee pays the remaining share. Tribes and tribal organizations are allowed to purchase this coverage only for employees and their dependents; coverage is not available to retirees.[22]

Temporary Continuation of Coverage

Certain individuals may be eligible to temporarily continue their FEHB coverage after their regular coverage ends under Temporary Continuation of Coverage (TCC). TCC is similar to COBRA[23] coverage offered to individuals in the private sector. Federal employees and their family members who lose FEHB coverage because of a qualifying event, such as the loss of a job, may be eligible for TCC. TCC enrollees may initially enroll in any FEHB plan and may change plans during open season. 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 the age of 26) and former spouses can continue TCC for up to 36 months.

Coverage Options

FEHB enrollees choose a health plan from a health insurance carrier participating in FEHB. Each carrier offers one or more plans.[24] There are typically more than 250 different health plans to choose from. As a practical matter, depending on where an enrollee resides, his or her choice of plans is limited to about 15 different plans. Generally, health insurance carriers and their health plans fall into two broad categories: fee-for-service (FFS) plans or health maintenance organizations (HMOs). FFS plans are generally available nationwide, and HMOs tend to be locally available.[25]

The most popular insurance carrier in FEHB is Blue Cross and Blue Shield (BCBS). It has the highest level of FEHB enrollment (see **Figure 1**) and offers two popular FFS health plans available nationwide: a Standard Option health plan and a Basic Option health plan. It also includes local HMOs.

Individuals may enroll or change plans during designated annual open season periods.[26] Plan offerings in terms of benefits and premiums may change during each open season. Special enrollment periods are also allowed for those with a qualifying life event, such as marriage.[27]

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[21] OPM, "Indian Tribe Participation in the Federal Employees Health Benefits Program," *FEHB Program Carrier Letter* 2012-04, February 16, 2012, at http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-04.pdf.

[22] 25 U.S.C. §1647(b).

[23] For more information on COBRA, see archived CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

[24] The statute, 5 U.S.C. §8903, specifies the types of health plans with which OPM may contract for FEHB.

[25] There is variation between fee-for-service (FFS) plans and health maintenance organizations (HMOs), and even within plans, but both types of plans contract with networks of providers that offer services to enrollees. A key feature of FFS plans is that they generally allow more flexibility than HMOs in enrollee use of out-of-network providers.

[26] For current open season dates, see OPM, "Open Season," at http://www.opm.gov/healthcare-insurance/open-season/.

[27] OPM, "Changes You Can Make Outside of Open Season," at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/changes-you-can-make-outside-of-open-season/.

Details for *all* FEHB plans are available on OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

Health Plans

FFS plans and HMOs are structured differently. Enrollees may base their decision to join a FFS plan or an HMO based on a variety of factors, such as whether they already have a preferred medical provider and where they live. There are many differences between FFS plans and HMOs, including whether the plans are available nationally or locally, how OPM pays the plans, how health plan performance is measured, and financing for each type of plan. However, a key difference for enrollees is the flexibility that FFS plans usually provide around the use of out-of-network providers. FFS plans are more likely to allow access to out-of-network providers, with increased out-of-pocket costs, than HMOs. Each of these differences is discussed in later sections.

FFS

FEHB typically offers about 15 FFS plans that are available nationally across the federal government (although some are open only to certain types of federal employees). Nationwide FFS plans include the BCBS Standard Option and Basic Option plans and plans sponsored by unions and employee organizations, such as those offered by the Government Employees Health Association (GEHA), the National Association of Letter Carriers (NALC), the Mail Handlers Benefit Plan (MHBP), the American Postal Workers Union (APWU), and the Special Agents Mutual Benefit Association (SAMBA).[28]

Many FFS plans have a preferred provider organization (PPO) whereby medical providers have contracted with the health plan to offer discounted charges.[29] Enrollees may choose providers outside of the PPO but will pay a larger share of the cost of services from these providers.[30]

HMO

HMOs are associated with a particular geographic area and are not available nationwide. In an HMO plan, FEHB enrollees receive care through a network of providers in a specific location. Generally, enrollees must see a provider within the HMO's network for their medical care to be covered. Eligibility to enroll in an HMO typically depends on where a prospective enrollee lives.[31]

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[28] OPM, "Non-Postal Premium Rates for the Federal Employees Health Benefits Program," at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums/2016/nonpostal-ffs.pdf.

[29] See OPM, *The 2015 Guide to Federal Benefits for Federal Civilian Employees*, November 2014, p. 31, at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2015-guides/70-1.pdf. See also OPM, "Healthcare: Plan Information," at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/.

[30] Enrollees can choose providers outside of the preferred provider organization (PPO), with the exception of the Blue Cross and Blue Shield (BCBS) Basic Option plan, which requires enrollees to use PPO providers. Enrollees in the BCBS Basic Option plan who choose a non-PPO provider will be responsible for the full cost of services. See OPM, *The 2015 Guide to Federal Benefits*, pp. 31 and 33, at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2015-guides/70-1.pdf. See also OPM, "Healthcare: Plan Information," at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/.

[31] Other options available to enrollees include health maintenance organization (HMO) plans with a point-of-service product. Under this arrangement, enrollees can see providers who are not in the plan's network but will pay more for doing so. For more information, see OPM, "Healthcare: Plan Information," at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/ or OPM's *2015 Guide to Federal Benefits*, p. 37, at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2015-guides/70-1.pdfhttp://

Health Plans Combined with Tax-Advantaged Accounts

Within the FFS and HMO arrangements discussed above, many FEHB insurance carriers offer consumer-driven health plans (CDHPs) and high-deductible health plans (HDHPs). Depending on which arrangement they fall under, CDHPs and HDHPs can be either nationally or locally available. These health plans are often combined with tax-advantaged accounts such as health reimbursement arrangements (HRAs) or health savings accounts (HSAs).[32] These accounts are designed to help enrollees save for future health care expenses, and both the health plan and the enrollee can make contributions to them, in the case of HSAs. The combination of CDHPs or HDHPs and tax-advantaged accounts is intended to help control costs by exposing enrollees to more risk for their health care expenditures. Generally, enrollees in health plans with tax-advantaged accounts have higher cost sharing (the amount an enrollee pays out of pocket, which includes deductibles, coinsurance, and co-payments) than in other types of plans but pay lower premiums. They also tend to have greater flexibility in spending their health care dollars. For example, contributions to an HSA can be used to cover medical expenses[33] that are not usually covered by a health plan, such as the costs of eyeglasses or contact lenses. HSAs can also be used to pay for cost sharing including deductibles. In addition, in CDHPs or HDHPs, enrollees have the flexibility to use providers in or out of the plan's network, although they may pay more for services when using an out-of-network provider. This flexibility is intended to provide incentives for enrollees to shop around for the most cost-effective services. CDHPs and HDHPs offer full coverage for preventive care obtained in their networks at no cost to the enrollee.

Consumer-Driven Health Plans

CDHPs can be difficult to define because they use a variety of different approaches designed to give enrollees more control over their health care expenses. OPM describes CDHPs as health plans that offer full coverage for in-network preventive care as well as flexibility for enrollees in spending on their health care. This flexibility includes using providers outside of the plan's network, although enrollees would pay more to do so. In exchange for that flexibility and full coverage of preventive services, enrollees face higher cost sharing. CDHPs have annual limits on out-of-pocket expenses that may be higher than those in other types of plans, although these limits vary by plan.[34]

CDHPs are often combined with HRAs. Employer contributions are not taxable and do not earn interest. Enrollees cannot contribute to an HRA. In general, unused balances in an HRA may be carried over into the next year. However, balances are forfeited when an enrollee leaves the plan. The HRA also can be used to meet the plan's deductible.

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www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2015-guides/70-1.pdf.

[32] For more information on health savings accounts (HSAs) or health reimbursement arrangements (HRAs), see out-of-print CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison, 2013*, available to congressional clients upon request.

[33] See Internal Revenue Service (IRS), *Health Savings Accounts and Other Tax-Favored Health Plans*, Publication 969, March 10, 2015, at http://www.irs.gov/pub/irs-pdf/p969.pdf and IRS, *Medical and Dental Expenses*, Publication 502, December 31, 2014, at http://www.irs.gov/pub/irs-pdf/p502.pdf.

[34] For example, see Aetna's 2016 brochure for its consumer-driven health plan (CDHP) at http://www.opm.gov/healthcare-insurance/tribal-employers/plan-information/plan-codes/2016/brochures/73-879i.pdf. Also see the American Postal Workers Union's 2016 brochure for its CDHP at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2016/brochures/71-004.pdf.

High-Deductible Health Plans

OPM has more clearly defined the structure of an HDHP. In an HDHP, enrollees have deductibles for self-only coverage or family coverage of at least $1,300 or $2,600, respectively, in calendar year 2016.[35] Those deductibles must be met before the plan will provide coverage for services, with the exception of preventive care obtained in the plan's network. As with CDHPs, enrollees may have the option to use providers outside of the plan's network but will pay more if they do. Unlike CDHPs, some HDHPs will provide coverage only for services obtained through the plan's network. OPM sets specific annual limits on the amount an enrollee pays out of pocket. These limits include deductibles, co-payments, and coinsurance and cannot exceed $6,550 for self-only coverage and $13,100 for family coverage in calendar year 2016.[36]

As with CDHPs, HDHPs can be combined with an HRA. However, they also can be paired with an HSA. HSAs are only available to HDHP enrollees who are not enrolled in Medicare, covered by another health plan, or claimed as a dependent on someone else's federal tax return and who have not received Department of Veterans Affairs health benefits or Indian Health Service benefits in the past three months. Both the enrollee and the health plan can contribute to an enrollee's HSA, but their combined contribution cannot exceed the statutory limit adjusted annually by the Internal Revenue Service.[37] Enrollees aged 55 to 65 can make "catch-up" contributions of up to $1,000.[38] An enrollee's contribution is tax deductible, and both the plan's contribution to the HSA and any interest earned are tax free. All unused funds in the HSA, as well as any interest earned, may be carried over each year without limitation.

Enrollment Among FEHB Health Insurance Carriers

FEHB enrollment is concentrated among 10 health insurance carriers. Of the approximately 4 million FEHB policyholders, about 67% are enrolled in BCBS, as shown in **Figure 1**. An FEHB carrier is defined in statute as 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."[39] Each carrier contracts with OPM after a negotiation process that begins when OPM issues its annual call letter in March asking carriers for benefit and rate proposals.[40]

[35] See IRS, Rev. Proc. 2015-30, at https://www.irs.gov/pub/irs-drop/rp-15-30.pdf.

[36] Ibid.

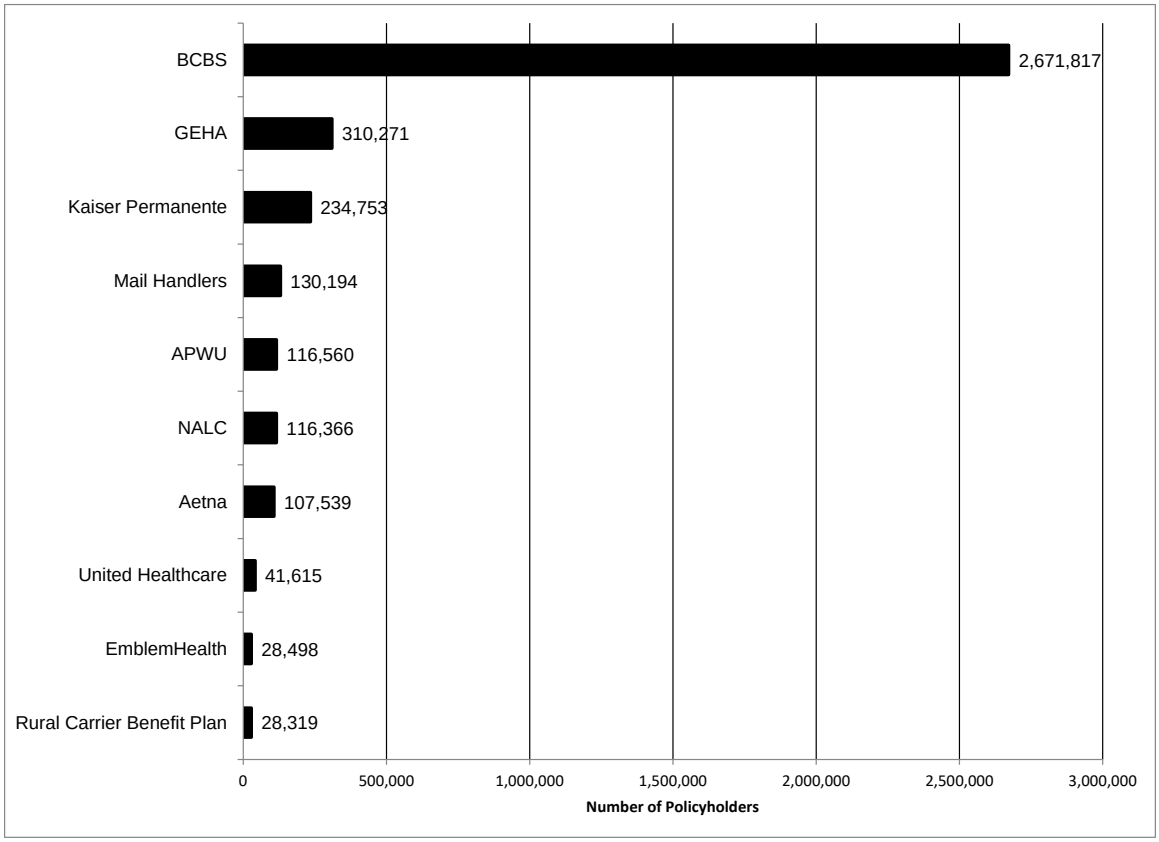
[37] For calendar year 2016, the limit is $3,350 for self-only coverage and $6,750 for family coverage. See IRS, Rev. Proc. 2015-30, at https://www.irs.gov/pub/irs-drop/rp-15-30.pdf.

[38] OPM, "Comparison Chart for Health Savings Account, Health Reimbursement Arrangement, Health Care Flexible Spending Account, and Limited Expense Health Care Flexible Spending Account," at http://www.opm.gov/healthcare-insurance/healthcare/health-savings-accounts/comparison-chart/.

[39] 5 U.S.C. §8901.

[40] OPM's most recent call letter was released on March 13, 2015. See https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-02.pdf.

Figure 1. Top 10 FEHB Carriers, by Covered Policyholders, 2015



Source: Congressional Research Service (CRS) analysis of FEHB enrollment data received from the Office of Personnel Management's (OPM) Congressional, Legislative, and Intergovernmental Affairs office on October 5, 2015.

Notes: Total enrollment in the top 10 carriers shown above is about 3.8 million people, or about 94% of all Federal Employee Health Benefits (FEHB) program policyholders. Policyholders include federal employees and retirees who obtain coverage for themselves and their dependents. This figure does not include dependents. BCBS = Blue Cross and Blue Shield; GEHA = Government Employees Health Association; NALC = National Association of Letter Carriers; APWU = American Postal Workers Union.

Other Programs: FSAFEDS and FEDVIP

In addition to choosing a health plan, federal employees have the option to set up a flexible spending account (FSA) through the Federal Flexible Spending Account Program (FSAFEDS) to pay for out-of-pocket health care expenses on a pretax basis. Anyone eligible for FEHB also has the option to purchase supplemental dental and vision coverage through the Federal Employees Dental and Vision Program (FEDVIP).[41]

FSAFEDS

Federal employees eligible for FEHB (even if they are not enrolled) may participate in FSAFEDS, which offers several different types of FSAs. The Health Care FSA (HCFSA) and the

[41] Members of Congress and certain congressional staff are also eligible for the Federal Flexible Spending Account Program (FSAFEDS) and the Federal Employees Dental and Vision Program (FEDVIP).

Limited Expense Health Care FSA (LEX HCFSA) allow employees to save money for health care expenses on a pretax basis.[42] Funds in an HCFSA can be used to pay for qualified medical expenses including coinsurance amounts, co-payments, deductibles, dental care, glasses, and hearing aids.[43] Funds in an LEX HCFSA can be used to cover qualified dental and vision care expenses. FSAFEDS also offers a Dependent Care FSA (DCFSA) that employees can use to save money for child care or adult dependent care expenses.[44] FSAs are not available to retirees. Employee contributions to FSAs are voluntary and funded from the employee's pretax salary. The federal government does not contribute to FSAs.

FEDVIP

Since 2007, those eligible for FEHB (even if they are not enrolled) have been eligible to enroll in FEDVIP, which provides supplemental dental and vision insurance. More information on FEDVIP is available at https://www.benefeds.com.

Premiums

Many health insurance carriers, such as BCBS, offer two or more health plans with different features and different premiums. A premium is the cost of enrollment in the health plan, charged on a regular basis (e.g., biweekly, monthly). Premiums are the same for retirees and employees (except employees of the USPS), but employees have the option of paying their share of premiums on a pretax basis through a payroll deduction.[45] Premium costs are shared between the federal government and the employee or retiree. The government's share of premiums for all retirees and for non-postal employees is set in statute at 72% of the weighted average premium of all plans in the program, not to exceed 75% of any given plan's premium.[46] For part-time workers (individuals working between 16 hours and 32 hours per week), the government's share is generally prorated. Premiums differ depending on whether an enrollee chooses self or family coverage. The percentage of premiums paid by the government is calculated separately for individual and family coverage, but each uses the same formula. OPM negotiates payments to health plans differently depending on whether a plan is a FFS plan or an HMO, according to detailed regulations.[47]

Payments to FFS Plans

During premium negotiations between OPM and carriers offering experience-rated FFS plans,[48] the *service charge* or *profit* paid to plans by OPM (a component of the premium paid by the

[42] Employees who have an HSA cannot also have a Health Care Flexible Spending Account (HCFSA). They can instead enroll in a Limited Expense Health Care Flexible Spending Account (LEX HCFSA).

[43] The ACA changed the definition of qualified medical expenses, beginning in 2011. The ACA does not allow over-the-counter medicines to be covered by these tax-advantaged accounts unless they are prescribed by a physician, with the exception of insulin. FSAFEDS provides a complete list of covered medical expenses on its website at http://www.fsafeds.com.

[44] For more information on flexible spending accounts (FSAs), see out-of-print CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison, 2013*, available to congressional clients upon request.

[45] For more information on USPS employees and FEHB, see "How the USPS Interacts with the FEHB Program" in this report.

[46] 5 U.S.C. §8906(b).

[47] 48 C.F.R. §1615.4.

[48] Fee-for-service (FFS) plans are experience rated, meaning the premiums are based on the claims experience of federal enrollees in the plan in preceding years. Premiums are also based on administrative costs and profit (limited to a

federal government for each policyholder) is calculated according to detailed regulations.[49] OPM monitors plan performance throughout the year and maintains data that are used to evaluate performance and determine profit. Profit is based on six factors: (1) contractor performance on 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), certain enrollee demographics, and the plan's willingness to assume risk; (3) federal socioeconomic programs, such as programs to deter drug abuse, which are evaluated 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 FEHB); (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. 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.

Payments to HMOs

For community-rated plans,[50] OPM negotiates with the HMOs to establish a capitation rate, a payment to the plan for each federal enrollee. The payment amount is based on comparable rates offered to other plans in the community, plus any negotiated changes to the community benefit package. HMOs may compute their community rates using factors such as age and sex. 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 the community benefit package between the time at which the plan estimated the rates and the plan's implementation 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.) The profit rate HMOs receive based on the community rate may be higher than that available to FFS plans under FEHB.

Benefits and Cost Sharing

Deductibles, co-payments, and coinsurance amounts vary across specific health plans. Even within individual plans, enrollees may be offered a lower deductible and coinsurance amount if they choose to use services in the plan's network. Benefits and cost sharing vary among FEHB plans. OPM relies on statutory requirements and may establish additional requirements during contract negotiations with plans.

Benefits

Although there is no standard benefit package required for plans participating in the FEHB Program, by statute all plans must cover basic hospital, surgical, physician, and emergency care. These basic services include childhood immunizations; screenings for cancer, diabetes, and high blood pressure; and tobacco-cessation services. Furthermore, OPM requires that plans cover certain benefits, such as prescription drugs and mental health parity with general medical care coverage. Other benefits are optional, such as applied behavior analysis for children with autism, which plans could choose to cover beginning in 2013.

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maximum of 1.1% of claims and administrative costs).

[49] 48 C.F.R. §1615.4.

[50] Community-rated plans are generally HMOs.

Cost Sharing

Cost sharing refers to the expenses an enrollee might pay out of pocket for health care. These expenses can include co-payments, coinsurance, and deductibles. Co-payments are a fixed amount that enrollees pay when they obtain services; coinsurance is a percentage of the total cost of the visit that the enrollee could be billed for; and deductibles are an annual amount that an enrollee must pay before the health plan begins paying for services. Deductibles may not apply to all services. For example, many plans do not require that deductibles be met before covering preventive services.

Although cost-sharing requirements vary by plan, there are limits on how much an enrollee can be required to pay out of pocket each year. This limit varies by plan. Generally, once an enrollee's expenses reach the out-of-pocket limit, the plan pays 100% of covered medical expenses for the remainder of the year. For some services, such as the preventive care services outlined in the ACA, plans are not allowed to impose cost sharing.[51] In addition, plans are required to include certain cost-containment provisions in the proposals they submit annually as part of contract negotiations with OPM, such as PPO networks in FFS plans and hospital preadmission certification.

Financing

FEHB is funded through discretionary spending, which is subject to appropriation, and mandatory (or direct) spending. Agency payments for government contributions to their employees' premiums are classified as discretionary spending. Payments for the government share of non-postal retiree premiums are classified as mandatory spending. The federal government contribution for FEHB enrollees, or the government share, is set in statute.

In the event of unexpected increases in costs or premiums, OPM maintains a contingency reserve fund that can be used to disburse funds to plans to offset those costs. OPM also incurs administrative expenses for administering the program.

Government Contributions to Premiums

The agency responsible for paying the government share of an enrollee's FEHB premium depends on whether the enrollee is an employee, a retiree, or a USPS employee or retiree. For an employee, the agency at which that employee works pays the government share of his or her FEHB premium out of the agency's appropriations for payment of salaries. Because this type of spending is subject to appropriation, it is classified as discretionary in the federal budget. For non-postal retirees, OPM pays the government share of FEHB premiums through an appropriated entitlement it receives for that purpose. This spending is classified as mandatory in the federal budget.

The government share of premiums for all non-postal employees and all retirees is fixed in statute at no more than 75% of any given plan's premium. However, for postal employees, the government share is negotiated between the USPS and the postal unions through collective bargaining. For non-postal employees and non-postal retirees, the government share is paid from general revenues. For postal employees and postal retirees, the USPS pays the government share.

[51] For more information on ACA benefits, see CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

Contingency Reserves

OPM maintains in the U.S. Treasury contingency reserve funds for all FEHB plans. In general, contingency reserves are used to offset unexpected increases in spending or premium increases in later years. How these reserves are maintained and used differs for FFS plans and HMO plans.

For FFS plans, OPM is authorized to charge plans up to 3% of their premium to establish and maintain contingency reserves.[52] The preferred minimum fund balance is 1½ times the sum of the plan's paid claims in an average month plus the plan's administrative expenses in an average month. FFS plans can use their reserves to offset larger-than-anticipated claims, or, if the balance becomes larger than necessary, the reserves can be drawn down and used to offset a premium increase in the subsequent year. FFS plans can draw down these reserves as claims are paid.

For HMO plans, OPM also charges plans up to 3% of their premium to establish and maintain contingency reserves. However, unlike those for FFS plans, the contingency reserves for HMO plans can be used only by OPM if OPM approves an adjustment during an annual reconciliation process that usually takes place in March. OPM pays the plans specified amounts in installments throughout the year.

Administrative Costs

The only explicitly identifiable administrative costs to the federal government for FEHB are the costs of OPM's headquarters staff. OPM employs about 117 full-time equivalent employees who are responsible for FEHB.[53] This staff includes 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 by law to 1% of the premium, to cover these administrative costs.[54] 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 FEHB and 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 the basis of premiums, there may be an incentive for administrative efficiency. However, OPM does not ask for detailed administrative cost data, although it periodically audits certain overhead charges.

How the USPS Interacts with the FEHB Program

Similar to most other federal agencies, the USPS offers health care benefits to its employees, retirees, and their dependents through FEHB. However, as an agency, the USPS is governed by arrangements that are unique within the federal government in regard to its contributions to health care benefits.

Premiums and Collective Bargaining

USPS employees have collective bargaining rights, including for compensation and benefits. The Postal Reorganization Act of 1970 (PRA; P.L. 91-375) gives USPS employees these rights and requires that fringe benefits, including health insurance, offered to employees be at least as

[52] 5 C.F.R. §890.503.

[53] OPM, *Congressional Budget Justification Performance Budget: Fiscal Year 2016*, February 2015, at https://www.opm.gov/about-us/budget-performance/budgets/congressional-budget-justification-fy2016.pdf.

[54] 5 C.F.R. §890.503.

favorable as the fringe benefits that were in effect when PRA was enacted in 1970. As a result, the USPS contribution to employees' premiums is determined through collective bargaining agreements (unlike at other federal agencies, where premium contributions for employees and retirees are determined by a formula set in law).

The USPS generally pays a larger share of employees'[55] health insurance premiums than most other federal agencies.[56] According to a recent U.S. Government Accountability Office report, the USPS's contribution rates will decrease in coming years under current agreements with its unions and management associations. Under the current collective bargaining agreements and arbitration awards, the USPS contribution to health care premiums for employees covered by collective bargaining will decrease to approximately 76% in 2016, as compared with a maximum of 75% of any given plan's premium for other FEHB enrollees.[57]

Paying for Retiree Health Care

In most federal agencies, the government contribution to health benefits for retirees is paid not by the agency but by OPM, through an appropriated entitlement it receives for that purpose.[58] However, the Consolidated Omnibus Budget Reconciliation Act (COBRA; P.L. 99-272) requires the USPS to pay the government share of health benefits for USPS retirees. Additionally, the Postal Accountability and Enhancement Act (PAEA; P.L. 109-435) creates for the USPS a prefunding obligation for its retiree health care costs. PAEA requires the USPS to pay more than $5 billion annually from FY2007 to FY2016 to the Postal Service Retiree Health Benefits Fund, from which retirees and employees will be paid starting in FY2017. The USPS has defaulted on these payments in recent years. The last payment that occurred was in 2010. As a result, there have been proposals in both the House and Senate to change the way the USPS provides health benefits to retirees, current employees, and their dependents.[59]

FEHB Enrollees and Medicare

Federal retirees and employees aged 65 or older have the option of enrolling in Medicare in addition to continuing coverage in FEHB. Although most FEHB enrollees continue their coverage into retirement, not all enrollees take up the Medicare coverage available to them. Several coverage options are available through the Medicare program: the Hospital Insurance (HI) program in Medicare Part A, the Supplementary Medical Insurance (SMI) program in Medicare Part B, and prescription drug coverage in Medicare Part D.

Eligibility for Medicare

Most FEHB enrollees (retirees and employees) aged 65 or older are entitled to Medicare Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters. As a result, they are automatically enrolled when they become eligible. Federal workers and their employers each

[55] For retiree coverage, the USPS contribution to premiums is the same as it is in other federal agencies.

[56] U.S. Government Accountability Office (GAO). *U.S. Postal Service: Modernization and Restructuring Needed to Address Financial Challenges*, GAO-11-428T, March 2011, at http://www.gao.gov/new.items/d11428t.pdf.

[57] GAO, *U.S. Postal Service: Proposed Health Plan Could Improve Financial Condition, but Impact on Medicare and Other Issues Should Be Weighed before Approval*, GAO-13-658, July 2013, p. 9, at http://gao.gov/assets/660/656011.pdf.

[58] 5 U.S.C. §8905(g)(1).

[59] See CRS Report R43349, *U.S. Postal Service Retiree Health Benefits and Pension Funding Issues*.

pay 1.45% of earnings for Medicare payroll taxes. Most enrollees do not pay any premiums for Part A coverage.

Participation in Medicare Parts B and D is voluntary, and qualified individuals choosing to enroll must pay a monthly premium. Generally, individuals who do not enroll in Parts B or D when they are first eligible are subject to a penalty if they enroll at a later date. However, for Part B, individuals covered by an FEHB plan, either through their own or a spouse's current employment, may wait until they or their spouse retires before enrolling without incurring a late-enrollment penalty. Upon retirement, individuals must enroll in Part B or be subject to a late-enrollment penalty. For Part D, OPM has determined that the prescription drug coverage included in FEHB plans is comparable to Medicare Part D, on average.[60] There is no late-enrollment penalty if an individual maintains FEHB coverage and at a later date decides to enroll in Part D coverage.[61]

Another option available to FEHB enrollees who are eligible for Medicare is a Medicare Advantage Plan (sometimes called Part C). Medicare Advantage Plans are private plans that contract with Medicare to provide Part A and Part B coverage. Retirees or former spouses enrolled in Medicare Parts A and B may suspend their FEHB coverage to enroll in a Medicare Advantage Plan (e.g., a Medicare HMO or regional PPO), with the option to reenroll in FEHB during open season. They can reenroll sooner if they involuntarily lose coverage or move out of their Medicare Advantage Plan's service area.

Coordinating Medicare Benefits with FEHB

When a retiree enrolled in Medicare also has coverage under FEHB, Medicare's coordination of benefits policy specifies that Medicare is the primary payer and FEHB is the secondary payer. This means that Medicare pays first and then FEHB pays for care not covered by Medicare (assuming that care is covered under the FEHB policy). As the secondary payer, FEHB may cover an enrollee's Medicare deductibles and coinsurance for care covered by both programs. For retirees (or their spouses) over the age of 65 who do not have either Medicare Part A or Medicare Part B (or both), FEHB is the primary payer. For individuals who have Part A but choose not to take up Part B, FEHB is the primary payer for Part B services but Medicare is the primary payer for Part A services.

When FEHB is the primary payer, the FEHB plan pays hospitals and physicians based on Medicare rates. The benefit payment for inpatient hospital services is equivalent to what Medicare Part A would have paid for those services; that is, the amount of the Medicare payment (before the Medicare deductible, coinsurance, and lifetime limits are applied) reduced by any FEHB deductible, coinsurance, or co-payment that is the responsibility of the FEHB enrollee or any hospital readmission penalty.[62] Hospitals may not collect, from either the FEHB program or retirees, more than the amount determined to be equivalent to the Medicare payment. The benefit payment for physician services is the lower of the amount that Medicare Part B would have paid

[60] OPM, "Letter from OPM about Medicare Part D," http://www.opm.gov/healthcare-insurance/healthcare/medicare/letter-from-opm-about-medicare-part-d/.

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

[62] §3025 of the ACA established the Hospital Readmissions Reduction Program, which required the Centers for Medicare & Medicaid Services to reduce payments to hospitals with excess readmissions beginning on October 1, 2012. See also http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/.

for those services or the actual billed charges. The payment is then reduced by any FEHB deductible, coinsurance, or co-payment that is the responsibility of the FEHB enrollee.[63]

Medicare Participation by FEHB Enrollees

Approximately 1.2 million FEHB retirees aged 65 and older had Medicare coverage in FY2013.[64] **Table 1** shows the proportion of those retirees with coverage in Medicare Part A and the proportion who chose to enroll in Medicare Parts A and B, by type of plan over time. Although Medicare Part A is an entitlement, enrollment in Medicare Part B is voluntary. The proportion choosing to enroll in Part B varies depending on how eligible individuals receive their benefits, either through a FFS plan or an HMO.

Table 1. FEHB Retirees Aged 65 and Older with Medicare Coverage

Medicare Coverage by Type of FEHB Plan	FY1998	FY2003	FY2008	FY2013
FFS Plan				
Part A only	8%	8%	10%	14%
Part A and B	92%	92%	90%	86%
HMO Plan				
Part A only	37%	39%	42%	44%
Part A and B	63%	61%	58%	56%

Source: Congressional Research Service (CRS) analysis of Office of Personnel Management (OPM) data, received from OPM's Congressional, Legislative, and Intergovernmental Affairs office on October 14, 2014.

Notes: This table includes federal retirees aged 65 and older who are enrolled in the Federal Employees Health Benefits (FEHB) Program and have Medicare coverage. Federal retirees under the age of 65 and those without Medicare coverage are excluded. Federal employees aged 65 and older who are still working are also excluded.

Of those retirees enrolled in an HMO plan in FY2013, roughly 56% had coverage under both Medicare Part A and Medicare Part B. That rate was higher, at about 86%, for retirees receiving benefits through a FFS plan. As shown in **Table 1**, the proportion of retirees with coverage under both Medicare Part A and Medicare Part B has declined over time, from about 92% to about 86% in FFS plans and from about 63% to about 56% in HMO plans. In contrast, coverage rates for Part A alone have increased.

Various actors have shown interest in encouraging FEHB beneficiaries to enroll in Medicare Part B to reduce FEHB spending. For enrollees who choose not to take up Part B, FEHB pays for services that Medicare otherwise would have paid for because Medicare is the primary payer when a beneficiary is enrolled in both programs. In its annual call letter for the 2016 plan year, OPM encouraged health plans to submit proposals that will allow members to maximize benefits

[63] For physician services, (1) Medicare participating providers may not collect from either FEHB plans or Medicare-eligible enrollees more than the total Medicare payment under the Medicare participating physician fee schedule, and (2) Medicare nonparticipating providers may not collect from FEHB plans or Medicare-eligible enrollees more than the Medicare limiting charge amount. (Under Medicare, nonparticipating physicians can balance bill the Medicare enrollee up to 15% higher than the fee schedule amount, but they are paid a slightly lower amount by Medicare.)

[64] The 1.2 million does not include retirees under the age of 65 or those without Medicare coverage. In total, there are about 2 million retirees in FEHB in a typical year.

under FEHB and Medicare.[65] OPM noted that some health plans offer cost-sharing reductions for members who enroll in Part B. In addition, there has been congressional interest in encouraging Part B enrollment. Recent legislation to reform the USPS included enrollment in Part B as a condition of obtaining health coverage in retirement for USPS retirees.[66]

Impact of the Affordable Care Act

The ACA passed in 2010 and included a number of provisions that established new requirements for all private health plans, including FEHB health plans. For example, the new law allowed all adult children (including those who are married) to enroll in or remain on their parents' plan until the age of 26. However, many ACA provisions had no meaningful effect on FEHB because many FEHB plans already met the requirements established under the law, such as the provision that people with preexisting conditions cannot be denied health coverage.

In some cases, how an ACA provision could impact FEHB is unknown. For example, it is unclear how many FEHB health plans could be subject to the ACA's excise tax on high-cost health plans, often referred to as the *Cadillac tax*, which goes into effect in 2020.[67] In addition, the employer mandate could result in penalties to FEHB, starting in 2015, if any full-time federal worker obtains a subsidy for health insurance on the exchange.[68] The employer requirements and penalty will be phased in—the requirement will apply to large firms with 100 or more full-time equivalent (FTE) employees in 2015 and employers with 50 or more FTE employees in 2016.[69]

OPM has published guidance on implementing ACA provisions, and in some cases it has expanded the scope of those provisions. For example, although most FEHB plans do not impose annual limits on what they will pay for essential health benefits,[70] some plans had established such limits prior to passage of the ACA. Beginning in plan year 2013, OPM directed all FEHB plans to eliminate annual limits on essential health benefits.[71] That deadline for FEHB plans came a full year earlier than the effective date specified in the ACA. For a detailed list of the ACA

[65] OPM, "FEHB Program Carrier Call Letter," March 13, 2015, p. 2.

[66] For example, in the 113th Congress, the Senate introduced S. 1486, the Postal Reform Act of 2014. §104 of the bill included a requirement to enroll in Medicare.

[67] §9001 of the ACA added an excise tax on high-cost employer-sponsored coverage. It was scheduled to take effect in 2018 but the effective date was delayed until 2020 in §101 of the Consolidated Appropriations Act, 2016 (P.L. 114-113) which was signed into law on December 18, 2015. Beginning in 2020, health insurers and health plan administrators are to pay a 40% excise tax for coverage that exceeds certain thresholds.

[68] The Employer Shared Responsibility provisions under 4980H of the Internal Revenue Code, as amended by the ACA, require that certain large employers offer affordable health coverage or pay a penalty if a full-time employee receives a premium tax credit toward a plan offered through an exchange. This requirement also applies to government entities, according to the IRS. See IRS, "Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act," at http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act.

[69] CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

[70] §1302 of the ACA established requirements that health plans offer at least 10 benefits as part of an "essential health benefits package." These 10 essential health benefits (EHBs) are as follows: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[71] Specifically, the ACA prohibits lifetime and annual limits on the dollar value of EHBs. Plans that do not have to offer the EHBs (such as FEHB plans) are asked to make a "good faith effort" to comply with a reasonable interpretation of EHBs with respect to their own plans.

provisions that affect FEHB, see CRS Report R42741, *Laws Affecting the Federal Employees Health Benefits (FEHB) Program*.

Appendix. OPM's Role in Administering FEHB

The Federal Employees Health Benefits (FEHB) Program is administered by the Office of Personnel Management (OPM) in accordance with the statute (Title 5, Chapter 89of the *U.S. Code*) and its implementing regulations (Title 5, Part 890 and Title 48, Chapter 16 of the *Code of Federal Regulations*). The FEHB statute establishes the basic rules for benefits, enrollment, and participation, among other general requirements, while still allowing OPM broad authority to implement regulations, contract with plans, establish benefits, and administer the program. In general, OPM, federal agencies, and the health insurance carriers each have defined roles in FEHB.

OPM is authorized to contract with health insurance carriers; approve health plans for participation in the program; negotiate with carriers 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 that have committed certain violations; and administer the program's financing. OPM is responsible for maintaining the funds that hold contingency reserves for the plans and the fund that receives premium payments from enrollees and federal agencies, from which premiums are disbursed to participating plans.

OPM supervises all health insurance activities for retirees. It determines whether retiring employees or survivor retirees 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 retirees advised of rate and benefit changes within their plan.

Annual Cycle of FEHB Activity for OPM

OPM enters into an annual contract with carriers following a negotiation process. Each spring, that annual negotiation process begins when OPM sends all health plans a *call letter* to advise them on goals and procedures for negotiating contracts for the following calendar year and to request that participating health plans 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 retirees, as well as notification of services that OPM discourages.

Next, OPM reviews proposals for rates (premiums) for the fee-for-service (FFS) plans in relation to many factors, including the cost of covered services, managed care initiatives, a 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 FFS plans and health maintenance organizations, or HMOs) agree to specific terms and conditions that 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 FEHB 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 retirees 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 information about the factors participants should consider in making their selection. Personal advice is not provided, although OPM's 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. Retirees are responsible for obtaining detailed plan brochures by contacting the individual carriers. Information about the different plans also is available on OPM's website at http://www.opm.gov/healthcare-insurance/.

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 Role with Federal Agencies

Personnel offices in every federal agency manage participation in FEHB for their employees according to procedures prescribed by OPM. They administer the annual open seasons and 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 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.

OPM's Role with the Plans

FEHB 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.[72] The carriers process and pay claims, answer enrollee questions, respond to claims disputes, print annual open season brochures according to a format specified by OPM, and maintain data regarding enrollment, claims, and other financial information required by OPM. In addition, carriers assume all insurance risk.

Contracts

The contracts OPM enters into with FEHB plans are for at least one year and may be automatically renewable in the absence of notice by either party of intention to terminate. OPM may terminate a carrier's contract at the end of the year if the carrier did not have 300 or more enrolled employees and retirees, exclusive of family members, at any point during the preceding two contract terms. 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 nongroup contract without requiring evidence of good health. Plans that are discontinued, other than through a merger, may reenter after three contract years from the time they left the program.

[72] 5 C.F.R. §890.201.

Licensure

An FEHB plan must be licensed to sell group health insurance under state law in every area of a state in which it operates as an FEHB 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. OPM requires that each FEHB plan submit copies of its state license(s) with its application to participate in FEHB; in addition, as part of the plan's contract with FEHB the plan is required to inform OPM if a state has withdrawn, or intends to withdraw, the plan's license.

Quality

Each year, FEHB 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 plans, the sample consists of all commercial plan members, including nonfederal members. For FFS or preferred provider organization 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 administer the surveys. OPM sets CAHPS requirements for the plans each year, which include instructions to send OPM a copy of any survey results.

All plans also must complete quality-assurance reports as well as fraud and abuse case reports and submit these reports to OPM. Additionally, HMOs with more than 500 FEHB 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. Each year, OPM outlines the procedures for collecting the HEDIS measures; 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 and gynecology.

Other Administrative Responsibilities

OPM's other administrative responsibilities include data warehousing, considering appeal of denials of coverage or payment, applying sanctions against providers, and determining applicability of state and local laws.

Data Warehousing

OPM is continuing to develop a Health Claims Data Warehouse that will, among other things, be used to collect, manage, and analyze health services data for FEHB.[73] Generally, OPM analysts will use de-identified data for analytic purposes, such as examining health trends, developing

[73]OPM, *Congressional Budget Justification Performance Budget Fiscal Year 2016*, February 2015, p. 198.

risk-adjustment methodologies, and conducting oversight of pharmacy pricing and negotiation. Data with personal identifiers also may be used within OPM, 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.[74]

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 six 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.[75]

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.[76] 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 and Local Laws

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. Although OPM requires HMOs to provide their FEHB plan enrollees with the mandated benefits of the state in which they live, OPM has the authority to override these state requirements if it determines that doing so would be in the best interest of federal enrollees.

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[74] Under the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191), identifiable information refers to data that are 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 security number; voice and fax telephone numbers; email 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. Only de-identified data will be released outside of OPM.

[75] 5 C.F.R. §890.105.

[76] 5 C.F.R. §890.1001.

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