Getting the Most from Your Federal Health Insurance

The Federal Employees Health Benefits program is one of the most valuable of federal benefits. If you have any doubt about that, ask a private sector employee whose company has dropped its own plan, or a private sector retiree who had employer-sponsored insurance and then lost it when leaving the job.

If you still have doubts, consider that FEHB for years has been held up as a model program of employer-sponsored insurance—good coverage at a competitive cost, a wide range of plan choices, no limits on pre-existing conditions or waiting periods to enroll, and a continued government contribution toward premiums for retirees at the same rate as for active employees.

That's not to say the program is perfect. Coverage gaps remain in certain areas, and premiums increase yearly like clockwork, roughly in line with overall cost increases in health care. When compared with similar employer programs, it is especially vulnerable to increases in prescription drug costs, where inflation has been especially severe for years. And because it has full coverage for retirees, its demographics skew toward older people who tend to consume more health care and thus drive up costs. Also, some private sector employers pay more toward premiums, at least for certain categories of enrollees—if they offer health insurance at all, that is.

Even with shortcomings, FEHB at least is there for you. It's up to you as a federal employee or retiree to get the most from it. This publication is designed to help you do just that.

The first step is to shore up your understanding of FEHB. While that may seem unnecessary—especially for someone who has been in the program for many years—there could well be important features of the program that would benefit you, but which you simply have not paid sufficient attention to.

The reality is, many FEHB-eligible persons treat their health insurance as a file it and forget it benefit. Many have been with the same plan much or even all of their time in FEHB. Only a small percentage switch plans in any given year, even though all are eligible to change during annual open seasons and some are eligible at other times.

In that context, it's important to understand how FEHB evolves over time, both due to new laws and decisions by the Office of Personnel Management, which oversees the program. Don't make the mistake of thinking that FEHB next year will be just like FEHB this year. It won't. Subscribe to the free FEDweek newsletter at www.fedweek.com for the latest information on FEHB.

Then, you need to know what choices you can make and when—and a strategy for making those decisions. For example, outside open seasons, changes are allowed during common life events, when you could benefit from reexamining your health coverage.

When the time comes to choose, staying with what you already have is a decision too, and it may well be the best for you. But whatever you do, make sure your decision is made in a thoughtful way, with all the facts in hand.

Understanding FEHB

A hallmark of FEHB is its range of choice, which provides eligible persons with the opportunity (and responsibility) to make informed decisions to put the program to its best use for their personal situations.

In total, there are about 230 different plan choices, all but about a dozen of them only regionally available however. As a practical matter, depending on where an enrollee resides, his or her choice of plans and options is limited to about 10 to 15 different plans. Within plans, some offer a choice of a standard option, high option, and/or a high-deductible or consumer-driven design.

FEHB provides health insurance coverage to more than eight million people. Almost all federal employees are eligible to participate, and most retirees also remain eligible, so long as they were covered by FEHB for the five consecutive years before retiring on an immediate annuity (there are limited exceptions to that requirement). Spouses can be covered, as well as children under age 26. On an enrollee's death, a surviving spouse and eligible family members can continue coverage, so long as a retirement survivor benefit was provided.

All eligible persons have an annual opportunity in to join the program or make enrollment changes during an open season, as well as at other times due to certain life events, as described below.

For non-postal federal employees and for all retirees, the government contributes on average about 70 percent of the premium; the employer contribution is somewhat higher for active postal employees, but not for postal retirees. Active employees, whether or not employed by the Postal Service, can pay premiums with pre-tax payroll money, effectively lowering the cost. Retirees cannot pay through this "premium conversion" arrangement.

There are two types of enrollment in each FEHB plan: self only, which provides benefits only to you; and self and family, providing benefits to you and all eligible family members. If you elect self only coverage, only your medical needs will be provided for, although the premium costs will be lower.

In addition, there is variation in plan designs. You can choose from among managed fee for service (FFS) plans, regardless of where you live, or plans offering a point of service (POS) product and health maintenance organizations (HMO) if you live (or sometimes if you work) within the area serviced by the plan.

- FFS plans reimburse you or your physician or hospital for covered services rather than provide or arrange for services as prepaid plans do. FFS plans allow you to choose your own physicians, hospitals and other health care providers without a referral. Some are open to all enrollees, but others require that you join the organization that sponsors the plan. Some plans limit enrollment to certain employee groups.
- A plan offering a point of service product has rules about doctor choice and access to specialists, but you can choose any doctor you like and see specialists without referrals if you agree to pay more. Membership requirements and/or limitations also apply to any POS product the FFS plan may be offering.
- In prepaid plans, your covered health services are pre-funded by your premium and the government's contribution toward the cost of your health insurance. Generally you must use specified plan physicians, hospitals and other providers at designated locations, although care elsewhere may be available after a referral.

There are two other major variants. In "consumer-driven" options, enrollees get a sum of money to pay toward health costs, then pay a deductible, and then have standard fee-for-service or HMO coverage. In "high-deductible health plans," enrollees have a tax-favored account—typically, a health savings account for those not eligible to draw Medicare benefits, and a health reimbursement arrangement for those who are—that can be used to pay the deductible and certain other qualifying health expenses.

Although there is no standard benefit package required for FEHB, all plans have certain aspects in common. By law, all of them cover basic hospital, surgical, physician, and emergency care. Within those requirements, OPM sets certain minimums. For example, preventive care standards for children follow guidelines of the American Academy of Pediatrics, while preventive care for adults is based on accepted medical practice standards.

Further, OPM requires plans to cover certain special benefits including prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity of coverage for mental health and general medical care coverage; child immunizations; and limits on an enrollee's total out-of-pocket costs for a year, called the catastrophic limit (generally, once an enrollee's covered out-of-pocket expenditures reach the catastrophic limit, the plan pays all covered medical expenses). Certain program-wide requirements are added nearly every year, as described below.

How FEHB Changes

Although the FEHB is seen as a generally stable program, it does change over time; eligible persons must keep such changes in mind when deciding how to put the program to their best use.

Changes come in two main forms. First, in the spring of each year OPM sets the terms of the program for the following calendar year, the beginning of a process of negotiations between that agency and health insurance carriers over the specifics of coverage and premiums that typically concludes in September. At that time, the details are announced ahead of the fall open season, with the changes effective with the new calendar year.

In addition, changes to health insurance law in general can affect the FEHB program. A recent report for Congress identified just since the 1980s four changes in law affecting coverage terms, four affecting how the government share of premiums is determined and 28 affecting eligibility. The most recent major law affecting FEHB was the 2010 Patient Protection and Affordable Care Act.

Annual Changes—OPM in its annual "call letter" to insurers has for many years emphasized cost-containment steps, quality of care initiatives and certain expansion of benefits. Most recently:

For 2011, OPM told plans to eliminate out of pocket enrollee costs for preventive care, immunizations, and screenings, expand their smoking cessation benefits—including counseling, medications, multiple quit attempts, no annual or lifetime limitations and no enrollee cost sharing—and enhance their efforts in promoting awareness about healthy lifestyles and avoidance of the onset of chronic conditions.

For 2012, OPM told plans to emphasize cost controls over prescription drugs in particular, telling them to take additional steps to promote the use of generic drugs and tighten controls over high-cost pharmaceuticals. It also told them to offer incentives to enrollees who complete a health risk assessment, comply with disease management programs or participate in wellness activities or treatment plans aimed at managing and improving health status.

For 2013, OPM made several changes as required by the 2010 health insurance law described below. It also told carriers to pay closer attention to increased use and cost of "specialty" drugs that are especially costly and again emphasized employee wellness programs, in particular programs aimed at obesity.

For 2014, OPM ordered further steps for controlling the cost of prescription drugs, enhancing wellness programs and advancing quality of care. It also requested pilot programs involving cost sharing reductions for enrollees who also have Medicare coverage.

Affordable Care Act—The 2010 Patient Protection and Affordable Care Act (more commonly known simply as the Affordable Care Act, or ACA; sometimes known as Obamacare) made several changes to FEHB.

First, it's important to be clear on what the ACA did not do: it did not force enrollees into the system of state-based marketplaces, called exchanges, created by that law. The only exception is that members of Congress and their personal staffs (although not other employees of Congress such as committee staffers) have to leave FEHB and get their health care through the exchange system effective in 2014. That was one of the provisions added to the law due to pressures to have members of Congress receive the same health care coverage as the general public.

Other FEHB-eligible persons could, in theory at least, leave that program and enroll in an exchange-based program instead. However, there would be a strong disincentive against doing so, because they would lose the value of the employer contribution toward their health care—which pays about 70 percent of the cost. It's not expected that exchange-based plans could provide coverage anywhere close to what FEHB provides for the cost of the current employee share alone.

Aspects of the ACA do affect FEHB required that:

- For health plans in general, children must remain eligible under family coverage until age 26, or indefinitely if they become disabled before reaching that age. That caused the FEHB program as of 2011 to raise its cutoffs, which used to be 22, and to drop other restrictions on coverage of children, including that they be financially dependent on the enrollee. (Note: Those policies remain in effect in the Federal Dental and Vision Insurance Program, which was not affected by that change.)
- Plans and/or employers must provide applicants and enrollees with a summary of benefits and coverage and a uniform glossary of terms, a requirement that started in the FEHB in 2013.
- Plans may not impose lifetime or annual limits on the dollar value of essential health benefits, effective in 2014. Historically, FEHB had not imposed lifetime limits but some plans had annual limits on certain benefits; beginning in plan year 2013, OPM required plans to eliminate such limits.
- Plans must allow individuals to participate in certain clinical trials, a requirement OPM imposed on the FEHB in 2013.

The law also barred plans from having pre-existing condition exclusions, but the FEHB already had such a policy. It further imposed some reporting requirements on employers that federal agencies must comply with, and gave OPM responsibility for setting standards for state-based insurance exchange plans covering more than one state.

In addition, the ACA made certain over-the-counter medicines no longer reimbursable by flexible spending accounts unless they are prescribed by a physician, a requirement the federal government extended to the FSAFEDS program in 2011. The law further reduced the annual maximum for health care FSAs from $5,000 to $2,500 effective in 2013.

Making Health Coverage Decisions

FEHB offers eligible persons regular opportunities to change coverage, as part of the annual benefits open season that runs from early November through early December (exact dates vary by year). Changes outside of open season also are allowed if certain "qualifying life events" have occurred.

Note: Newly hired employees may enroll within 60 days of hiring; otherwise they must wait until the next open season or experience a qualifying life event.

During Open Season—The benefits open season is an annual opportunity to review your health needs. Open season applies to the FEHB and also to the Federal Employees Dental and Vision Insurance Program (FEDVIP) for both active employees and retirees—as well as to the flexible spending account program (FSAFEDS), which is only for active employees. There aren't any waiting periods or pre-existing condition limitations if you are either a new enrollee or an existing enrollee making a change.

Note: Enrollment, or lack of it, in one of these programs does not affect eligibility to be enrolled in any of the others. Also, it is not necessary to enroll for the same type of coverage—an enrollee could have self only coverage under FEDVIP while having self and family coverage under FEHB, for example.

Even enrollees satisfied with their FEHB and FEDVIP coverage can benefit from examining their options in the open season. Plans revise their covered services year to year. Similarly, while premiums on average increase somewhat each year, there is wide variation among plans, potentially making a current plan less affordable, or making more affordable a plan an individual previously ruled out as too expensive. Also, some FEHB plans drop out or reduce their geographic coverage areas, compelling affected enrollees to get new coverage.

FEDVIP plans are more stable but their terms and premiums change somewhat each year too. It's also important to check how a FEDVIP plan's benefits would dovetail with any vision and dental benefits offered through an FEHB plan, especially if you are changing one or the other. FEDVIP always pays benefits secondary to your FEHB coverage, to the extent that it includes dental and vision benefits.

Individual FEHB health plans provide benefit brochures to their existing enrollees online and/or in paper form, which includes and explanation of benefit changes for the next year and new premium rates. In addition, OPM prepares an annual Guide to Federal Benefits and makes other

information available online or in print, including plan brochures, plan comparison features, contact information, and more.

During an open season:

- If you aren't already enrolled in an FEHB plan and/or a FEDVIP plan, you can enroll.
- If you are already enrolled in FEHB and/or FEDVIP and are happy with your current coverage, you don't have to do anything. Your enrollment(s) will continue automatically. However, before you decide to sit on your hands, you at least should check to see if your plan is still participating in the program and if the benefits offered or the premiums have changed.
- If you are already enrolled, but want to make a change, you can change to another plan, change levels of coverage within a plan (for those offering more than one level), or alter your coverage from self only to self and family or vice versa (FEDVIP in addition offers a self plus one option—the "one" must be someone who is eligible for coverage as a family member).

If you wish to participate in FSAFEDS in the following year you must enroll even if you currently are enrolled—enrollments don't continue one year to the next as they do under FEHB and FEDVIP. You can choose a dependent care account and/or a health care account (note: for FEHB enrollees in certain plans offering similar tax breaks, only a "limited expense" FSA is available). As an enrollee in FSAFEDS, you'll be able enjoy the lower taxable income benefits and pay for your FEHB and FEDVIP co-pays and deductibles.

Outside Open Season—Outside of open season, you can enroll in the FEHB, change your plan enrollment, change to self-only or cancel coverage in certain circumstances. The most common of these are in connection with what are called qualifying life events: a change in family status; a change in employment status; or if you or a family member lose FEHB or other health coverage for certain reasons. (In addition, there are some specialized situations in which enrollees may make changes, such as moving to an area in which their current plan is not available.)

A change in family status is: marriage, birth or adoption of a child, acquisition of a foster child, legal separation, divorce, or death of a spouse or dependent.

A change in employment status is: you are reemployed after a break in service of more than 3 days; you return to pay status after your coverage terminated during leave without pay status or because you were in leave without pay status for more than 365 days; your pay increases enough for premiums to be withheld; you are restored to a civilian position after serving in the uniformed services; you change from a temporary appointment to an appointment that entitles you to a government contribution; or you change to or from part-time career employment.

A qualifying loss of coverage is: under another FEHB enrollment because the covering enrollment was terminated, canceled, or changed to self only; when enrolled in a prepaid health maintenance organization and you or a covered family member move or change worksite outside of the HMO's enrollment area; under another federally-sponsored health benefits program; under Medicaid or similar State-sponsored program for the needy; under CHAMPVA, TRICARE, or TRICARE-for-Life; when you had previously suspended your FEHB coverage to participate in one of these programs; or when your membership in the employee organization sponsoring the FEHB plan terminates under a non-federal health plan.

When one of these events occurs, you may:

- enroll;
- change your enrollment from self only to self and family;
- change your enrollment to another plan or option;
- change your enrollment to self only; or
- cancel your enrollment.

In the latter two, a change to self only may be made only if the event causes the enrollee to be the last eligible family member under the FEHB enrollment. A cancellation may be made only if the enrollee can show that as a result of the event, he or she and all eligible family members now have other health insurance coverage.

Note: Similar policies apply under FEDVIP, with the added consideration of the self plus one option available in that program.

Issues to Consider—Within the general structure of FEHB, there is wide variation among how plans operate and exactly what they cover, under what terms. Failure to consider your health plan choices—whether during an open season or if you have the opportunity due to a qualifying life event—could leave you without the health care services or supplies you need or paying higher premiums than are necessary for your consumption of health care. Dental and/or vision coverage can fill in the gaps of any coverage you now have, or pay for services you now don't get.

One question is what type of plan would work best for you. Each type of plan has several important general aspects that may be especially positive or negative for you:

A fee for service plan without a preferred provider feature is a traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have filed an insurance claim for each covered medical expense. When you need medical attention, you visit the doctor or hospital of your choice. This approach may be more expensive for you and require extra paperwork.

A fee for service plan with a preferred provider option (PPO) allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork.

However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. Also, the network may not have all the doctors or hospitals you want. If you don't use the network, you will generally pay more when you get care; fewer preventive health care services may be covered; and you will have to file claims for services yourself.

In "PPO-only" options, you must use PPO providers to get benefits. You will generally pay copayments, but will have no deductibles, and will have little, if any, paperwork.

Health maintenance organization plans charge a copayment for primary physician and specialist visits and generally have no deductible or coinsurance for in-hospital care. More preventive health care services may be covered than under a fee for service plan, and you will have little, if any, paperwork. You will have limitations on the doctors and other providers you can use, however, and care received from a provider not in the plan's network is not covered unless it's emergency care or the plan has a reciprocity arrangement.

In HMO plans with a point of service (network) feature, if you use the network you will get full network benefits and coverage with little paperwork. Such plans let you use providers who are not part of their network but you would pay more and usually pay higher deductibles and coinsurances than you pay with a network provider. Also, some services may not be covered and you will need to file a claim for reimbursement.

In a consumer-driven health plan, you have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

In a high deductible health plan, the enrollee pays a deductible and other out of pocket costs up to certain limits. They can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers.

In addition, consider these personal questions when comparing types of plans, or different plans within a category:

While your exact need for health care is unpredictable, you can act on what you reasonably can foresee. Then examine whether your existing plan is best for such considerations, or whether a change would better fit your needs.

Do you expect to have any medical costs in the coming year that you didn't have in the current year? For example, are you expecting upcoming surgery? Or can you reasonably expect different types of care or procedures than you currently experience, such as chiropractic care, laser eye

surgery or extensive dental work? If you have family members on your plan, don't forget to think through those same issues regarding them.

What would be your share of the cost of prescription drugs you reasonably expect to be taking? Could your medication needs foreseeably change, and what would be your cost for them?

What deductibles, copays, and coinsurances would you pay under your various options? Can you (if an active employee) make them effectively more affordable by paying for more of them through a health care flexible spending account?

One valuable feature of FEHB is that you can change your coverage each year. That is, you could switch plans to capture the benefits of an attractive feature that you may need in only one year—related to the upcoming birth of a child, for example—and then switch back again the following year.

Finally, there are circumstances in which a married couple without eligible children may wish to choose the self only option rather than self and family coverage. It's not uncommon for both halves of a couple to work for the federal government and have an entitlement to enroll in the FEHB program on their own. One attraction of having separate coverage is that it allows each of them to tailor their plan selection to their specific needs. Another is that there are times when the premium cost of two self only enrollments will be less than that for one self and family enrollment.

However, keep in mind that each enrollee will have to meet the co-insurance and deductible requirement plus the catastrophic limit on his or her own. This may or may not make a difference in the decision; circumstances would vary. Also, remember that one of the enrollees would have to elect a self and family plan to obtain coverage for any eligible children. In that case, the family coverage would insure the other member of the couple as well and there would be no point in having a second enrollment.