Getting the Most from Your Federal Health Insurance

Updated for the 2017 Plan Year

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 doesn’t offer health insurance, or maybe ask a private sector retiree who had 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.

In a 2016 survey of federal employees, more than 90 percent said the FEHB meets their needs to a great or moderate extent, that they considered it important or very important to them, and that it is a good or excellent value. Almost all eligible persons who are not enrolled said the reason was that they had health coverage from another source, such as a spouse’s employment or the military Tricare program—not because of FEHB’s cost or coverage terms.

That’s not to say the program is perfect. While the government pays 70 percent of the total premium cost (for both active employees and retirees), some private sector employers pay more, at least for certain categories of enrollees.

Also, FEHB does have coverage gaps in certain areas, and premiums increase yearly like clockwork; that they increase by about the same percentage as private-sector plans is little comfort. 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 for everyone else.

About half of the 4 million enrollees (about an equal number of family members are covered) are retired and one result is that the program is especially vulnerable to increases in prescription drug costs, where inflation has been especially high. That factor alone accounts for about a quarter of the annual increases in premiums (other health care inflation and greater use of care as the covered population in general ages are the others). That’s one reason that a major emphasis in the program in recent years has been to control prescription drug costs, along with encouraging enrollees to participate in disease prevention and wellness programs designed to reduce overall demand for health care.

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The most recent major change was the introduction for the 2016 plan year of a self plus one option, designed for enrollees who have only one eligible family member. In the FEHB, that most commonly means a couple, whether retired or still working, advanced enough in age to have no children under the age 26 cutoff. However, self plus one also is an option for a married couple of any age without eligible children, or a single parent with one eligible child. (Remember, addition of self plus one didn’t change eligibility rules; unmarried domestic partners remain ineligible.)

Generally, self plus one is cheaper than family coverage because fewer people on average are covered by an enrollment; the average family enrollment has about three covered persons. However, in some plans self plus one actually costs the enrollee more, since self plus one enrollees tend to be older on average.

In the fall 2015 open season, only about half of the estimated 1 million enrollees who have only one family member eligible for coverage switched from family coverage—up to then the only option to get insurance on that person—to self plus one. So, even apart from changing plans or switching to a lower coverage level in a plan that has more than one level, many enrollees could reduce costs simply by electing self plus one.

Such considerations underscore how important it is that you take the initiative to get informed and choose wisely to get the most from the FEHB. 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 and pay little attention during open season beyond a look at the new premium rates and at any major changes in coverage in their current plan.

Only single-digit percentages switch plans in any given year, even though all are eligible to change during annual open seasons (some are eligible at other times, on experiencing certain life events such as marriage or birth or adoption of a child). That helps explain, for example, why so many people passed up the chance to change from family to self plus one coverage.

Also, 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 your coverage next year will be just like this year; don’t even assume
that your current plan will be available next year. Each year, some drop out, as did five plans for 2017, and some plans remaining in the program either expand or contract their coverage areas. Subscribe to the free FEDweek newsletter at www.fedweek.com for the latest information on FEHB.

For 2017, several other long-running trends have continued. The average enrollee premium in the FEHB rose 6.2 percent over 2016 costs, following a 7.4 increase for 2016 over 2015. However, as always there was substantial variation in that average, with some increases much higher and other decreasing. Out of pocket costs such as deductibles stayed essentially the same. Premium rates are at www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums.

(Premiums in the separate Federal Dental and Vision Insurance Program meanwhile on average rose over 2016 rates by 1.9 percent for dental plans and by 6.3 percent for vision plans. The number of plans remained the same, four vision and 10 dental, and coverage terms also were largely unchanged. Premium rates are at www.opm.gov/healthcare-insurance/open-season.)

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.

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 the 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.

Of the 245 plans, only 11 are nationally available and even some of those restrict who can enroll in them. Most of the rest are localized health maintenance organization plans. As a practical matter, depending on where an enrollee lives, there is commonly a choice of about 10-15 plans, with potentially about twice that many in certain city areas, much fewer in more rural areas. Some plans offer a choice of a two options with differing cost and coverage terms, 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). Premiums for retirees are the same as for active

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employees, although charged on a monthly rather than biweekly basis, and the employer contribution continues at the same rate.

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 can pay premiums with pre-tax payroll money. Retirees cannot pay through this “premium conversion” arrangement, making the insurance effectively more expensive for them even though the premium rates are the same as for active employees.

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.

There are three 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, and self plus one, which covers you and only one eligible family member.

Eligible family member include spouses (including same-sex spouses) and children under age 26, with no age cutoff if a child is disabled before that age. Foster children can be covered under more limited circumstances, but a prior policy that had allowed coverage of a domestic partner’s children as stepchildren was repealed effective with the 2016 plan year.

Generally, premiums for self-only are the least expensive and for family coverage are the most expensive, with self plus one in between. However, there are some plans in which the enrollee share of premiums for self plus one is slightly higher than for family coverage. Be sure to pay close attention to premiums when choosing a plan.

Note: You can choose self plus one even if you have more than one family member who would be eligible, but remember that doing so means that the other family member or members would need to get their health coverage elsewhere. You can change the designation of which family member is covered during an open season, or due to certain life events (the change must be consistent with that event, such as adding a spouse as the second person when a covered child ages out of eligibility).

On an enrollee’s death, eligible family members can continue coverage so long they are eligible for survivors’ benefits due to death in service or upon death of a retiree.

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.

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• 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.

Changes in FEHB

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.

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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. The most prominent recent example of this was the 2013 law that authorized the addition of the self plus one option, which however was not made available until the 2016 plan year.

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 2014, OPM ordered steps for controlling costs and broadening certain benefits. Specifically, OPM: set a goal of having a generic dispensing rate of at least 80 percent for the program as a whole; encouraged the use of lower-cost therapeutic equivalents or alternatives in addition to generics while discouraging the use of specialty drugs; started phasing in a standard four-level prescription drug benefit—generics, preferred brands, non-preferred brands and specialty drugs—with higher levels of enrollee out of pocket costs at each step up; required carriers to set participation goals and propose incentives for enrollees to use health risk assessments and biometric screening; required them to cover screening for all adults for obesity and referrals for behavior change interventions for those with body mass indexes above certain levels; and encouraged them to loosen their standards for bariatric surgery. Benefits covering screening and counseling for alcohol and tobacco use were expanded, as was hepatitis screening, and all plans were required to offer a health risk assessment.

For 2015, OPM once again focused on getting enrollees to participate in wellness programs and on holding down expenses for prescription drugs. It told the companies that they must offer a health risk assessment and be able to demonstrate significant progress toward full implementation of a biometric screening program. It encouraged plans to offer financial incentives for enrollees to participate in wellness programs through credits to purchase health related goods and services, and clarified that they further may pay out cash or gift cards; that authority had existed previously but there was some question about it. On prescription drugs, OPM encouraged more use of cost-saving methods of dispensing prescription drugs such as mail order and programs that offer long-term supplies of maintenance medications.

For 2016, OPM recommended providing cash or other rewards for enrollees to undergo health screening and for taking the recommended action afterward to improve their health; it sent flyers for agencies to post touting the flu shot and tobacco cessation benefits in the FEHB. It also told carriers that they could exclude coverage for drugs that are less effective or less safe than other

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available drugs for the same condition, as well as those that provide little added value at much added cost. Better coordination of benefits between FEHB and Medicare, for enrollees who have both, also was emphasized once again.

For 2017, OPM again urged plans to offer monetary incentives to participate in wellness programs, and mandated that all cover applied behavior analysis for children diagnosed as being on the autism spectrum (some plans had covered that treatment at least partially, although terms varied). It also continued efforts to hold down prescription drug costs. It also encourages them to begin or increase access to “telemedicine” virtual visits and to hospice and advance care planning for those critically ill.

**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 unless they 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 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. Sometimes plans newly join or increase coverage areas, too.

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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 among self only, self plus one or self and family.

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 among the coverage options 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. (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.

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A change in employment status is: you are reemployed after a break in service of more than three 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, depending on the circumstances:

• enroll;
• change your enrollment among the coverage levels;
• change your enrollment to another plan or another option within the plan, for plans that have more than one;
• cancel your enrollment.

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.

If you have self plus one coverage and have more than one family member who would be eligible, you can change the designation of which is covered during an open season, or due to certain specified life events, so long as the choice is consistent with the event.

If you have family coverage and a life event occurs that causes you to have only one eligible family member remaining—for example, a child aging out of eligibility—a switch from family coverage to self plus one is not automatic. You must change your enrollment.

Similar policies apply under FEDVIP.

Details regarding FEHB choices are on the election form, SF-2809, available at www.opm.gov/forms, and for FEDVIP at www.benefeds.com – search for “qualifying life events.”
Note: Entering “phased” retirement is not a qualifying life event for either FEHB or FEDVIP, nor is switching from phased retirement to full retirement (or from phased retirement back to full-time work, if allowed). However, the period of phased retirement does count toward the requirement to have been covered by FEHB for the five years before retirement in order to be eligible to carry that coverage into retirement.

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 to have two self only plans individually. 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.

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 self plus one to obtain coverage for a new child. In that case, it likely would make more sense to switch to one family enrollment.