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Federal Benefits: Health, Dental and Vision Benefits

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Mr. Chairman and members of the subcommittee, my name is Hinda Chaikind and I am a specialist in health care financing with the Congressional Research Service. Thank you for inviting me to speak to you today about the Federal Employees Health Benefits program and the Federal Employees Dental and Vision Insurance Program.

FEHB Background

The federal government is the largest employer in the United States, and the Federal Employees Health Benefits (FEHB) program is the largest employer-sponsored health insurance program. FEHB covers about 8 million current workers, Members of Congress, annuitants, and their families. FEHB offers enrollees a choice of five fee-for-service plans available government-wide and another five plans available to employees of certain small federal agencies (such as the Foreign Service). In total, there are about 300 different plan choices, including all regionally available options, as well as choices offered by plans for standard option, high option, and high-deductible plans. As a practical matter, depending on where an enrollee resides, his or her choice of plans is limited to about five to 15 different plans. Plan details for all FEHB plans are available on the website of the Office of Personnel Management (OPM) — [http://www.opm.gov]. Beginning this year, those eligible for FEHB (whether or not they are actually enrolled) may also enroll in the Federal Employee Dental and Vision Insurance Program (FEDVIP), which provides supplemental dental and vision insurance.

Participation in FEHB is voluntary, and enrollees may change plans during designated annual "open season" periods. Special enrollment periods are also allowed for new employees and for those with a qualifying special circumstance, such as marriage. Contracts must offer enrollees and their family members temporary extension of coverage with an option to convert to a non-group contract, without requiring evidence of good health, for certain qualified employees who lose coverage because of a change in work or family status. Enrollees are not subject to pre-existing condition exclusions.

The government's share of premiums is set at 72% of the weighted average premium of all plans in the program, not to exceed 75% of any given plan's premium. The percentage of premiums paid by the government is calculated separately for individual and family coverage, but each uses the same formula. Individuals may enroll in an individual plan or a family plan, which covers 2 or more family members. Generally, premiums for family plans are more than double the premium for an individual plan. Part-time workers pay a larger share of their premium, depending on the

numbers of hours that they work. Annuitants and active employees pay the same premium amounts, although active employees have the option of paying premiums on a pre-tax basis. Premiums in 2007, when compared to 2006, remained the same for about 63% of enrollees, and another 15% of enrollees had a premium increase of less than 5%. The average premium increase was 1.8%, with the enrollee's share increased by about 2.3% and the government's share increased by about 1.6 %. While overall, the increases are small, some plans have large premium increases. Furthermore, premium increases do not take into account any changes in benefits or cost-sharing in a particular plan from year to year.

Although there is no core or standard benefit package required for FEHB plans, OPM may prescribe reasonable minimum standards for health benefit plans. All plans cover broad categories of services, including basic hospital, surgical, physician, and emergency care. Plans are required to cover certain special benefits including prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity of coverage for mental health and general medical care coverage; child immunizations; and limits on an enrollee's total out-of-pocket costs for a year, called the catastrophic limit. Generally, once an enrollee's covered out-of-pocket expenditures reach the catastrophic limit, the plan pays 100% of covered medical expenses for the remainder of the year. Plans must also include certain cost-containment provisions, such as offering preferred provider organization (PPO) networks in fee-for-service plans and hospital pre-admission certification.

FEHB Plans

FEHB statutes specify three types of participating plans:

- The **government-wide plan** is the fee-for-service plan that pays providers directly for services (this slot has always been filled by Blue Cross and Blue Shield).
- **Employee organization plans** are fee-for-service plans, such as the American Postal Workers Union (APWU) plan. All persons eligible to enroll in FEHB may choose an employee organization plan, subject to small annual membership dues.
- **Comprehensive medical plans** include the HMOs. Availability of these plans varies, depending on where the individual resides.

Deductibles, copayments, and coinsurance amounts vary across plans. Many plans offer two or more options with different premiums and levels of coverage. Even within individual plans, enrollees are offered a lower deductible and coinsurance amount if they choose to use services, such as a physician or hospital provider, in the plan's network. Additionally, when selecting out-of-network providers, beneficiaries may also be subject to balance billing amounts. Examining the premiums, deductibles, copayment and coinsurance amounts for physician office visits in the Blue Cross and Blue Shield (BCBS) plans provides an example of this variation. For 2007, BCBS offers both a *Standard* plan (its more generous plan) and a *Basic* plan. Under the *Standard* BCBS plan, in 2007, enrollees pay a monthly premium of $124.15 for individual coverage and $290.98 for family coverage, a slight decline from 2006 premium amounts. The 2007 calendar year deductible is $250 per person with a maximum family deductible of $500. Enrollees receiving services from a "preferred" provider are responsible for a $15 copayment for a physician office visit with no requirement to first meet the deductible.

For an office visit with a participating physician, enrollees are responsible for 25% of the plan's allowed amount, after meeting the deductible. For an office visit with a non-participating physician, enrollees are responsible for 25% of the allowed amount, after meeting the deductible, plus all of the difference between the allowed amount and the physician's actual charge.

Under the *Basic* plan, in 2007, enrollees will pay the same monthly premium amount as in 2006, $82.32 for individual coverage and $192.82 for family coverage. There is no calender-year deductible. Enrollees pay a $20 copayment for an office visit to a preferred primary care provider and a $30 copayment for an office visit to a preferred specialist. The *Basic* plan operates similarly to an HMO, in that enrollees may use only preferred providers to receive benefits, except in special circumstances such as emergency care.

High-Deductible Plans Combined with Tax-Advantaged Accounts

In 2003, FEHB began offering high-deductible plans coupled with tax-advantaged accounts that could be used to pay for qualified medical expenses. These plans are believed to help control costs by exposing enrollees to more risk for their health care expenditures. FEHB first offered this arrangement by combining a consumer-driven health plan (CDHP) with a Health Reimbursement Arrangement (HRA). In 2005, FEHB expanded this option to include a high-deductible health plan (HDHP) with either a Health Savings Account (HSA) or an HRA. Currently, both the employee organization plans and the comprehensive medical plans offer CDHPs and HDHPs. While CDHPs and HDHPs are both high-deductible plans, there are major differences between them, which are described below.

Consumer-Driven Health Plans -- For 2007, those choosing APWU's CHDP plan are provided with an HRA (referred to as a Personal Care Account, or PCA, in the APWU plan), which the plan funds in the amount of $1,200 for individuals and $2,400 for families. PCA funds are not taxable. Unused balances of a PCA may be carried over, with a limit of $5,000 for individuals and $10,000 for families, but balances are forfeited when an enrollee leaves the plan.

In APWU's CDHP, all eligible health care expenses (except in-network preventive care) are paid first from the PCA. Eligible expenses include basic medical, surgical, hospital, prescription drug and other services covered under the high-deductible plan, as well as dental and vision services (with a limit of up to $400 per year for self and $800 for family). Once the enrollee has spent the amount contributed by the plan to the PCA (i.e., $1,200 or $2,400), enrollees must pay the "member responsibility." This member responsibility ($600 for individuals and $1,200 for families) is similar to a deductible, except that it is not for first-dollar coverage. Members who have built up the balances in their PCA over time may use any excess funds to meet their member responsibility.[1] Once the deductible has been satisfied, the high-deductible plan starts covering services,

[1] For example, for individual coverage, if the PCA balance is $2,000, the individual could use $1,200 from the fund to pay for services and another $600 from the fund to meet the member responsibility. The enrollee would then qualify for coverage under the high-deductible health care plan while still retaining a PCA balance of $200.

with copayments and coinsurance amounts similar to those found in traditional health plans. The 2007 monthly premium for APWU's CDHP is $88.60 for self and $199.33 for family coverage, the same as in 2006. While enrollees may use either in- or out-of-network providers, the PCA funds will go further for in-network providers. For example, amounts over the plan allowance for out-of-network services do not count toward reducing the member responsibility.

In 2007, in addition to APWU's nationally available CDHP, two other plans, AETNA and Humana, also offer a CDHP. Although widely available, neither of these plans is nationally available. While these three plans are similar in many ways, there are some significant differences, including (1) the amount the plans place in the HRA, (2) the carryover amount, (3) rules for when the plan begins to cover medical expenses, (4) the catastrophic limit amount, and (5) availability. For example, AETNA's Medical Fund (similar to the PCA) is funded by the plan in the amount of $1,000 for individuals and $2,000 for families with a carryover limit of $4,000 for self and $8,000 for families.

High-Deductible Plans with an HSA or HRA – Since 2005, FEHB has offered several HDHP plans paired with either an HSA[2] or HRA, available both nationally and regionally for 2007. FEHB's HRAs coupled with the HDHP are similar to HRAs offered with CDHPs, in that they (1) cannot exclude FEHB-eligible individuals, (2) can only be used for medical expenses, (3) are not subject to tax, (4) are funded solely by the plan, (5) do not earn interest, and (6) are forfeited when an enrollee leaves the plan. However, FEHB's HRAs connected with HDHPs have no limits on carryover amounts, unlike the HRAs connected with CDHPs.

The rules for FEHB HSAs are very different. HSAs are only available to certain individuals: those who are not enrolled in Medicare, not covered by another health plan, not claimed as a dependent on someone else's federal tax return, and those who have not received Veterans Administration health benefits in the past three months. Enrollees may add additional funds to their HSA, as long as the plan's and the enrollee's combined contributions do not exceed the federal limit (for 2007, the limit is $2,850 for self coverage and $5,650 for family coverage). Enrollees over age 55 can make a "catch-up" contribution, in the amount of $800 in 2007. The plan's contribution to the HSA is tax-free, an enrollee's contribution is tax-deductible (an above-the line deduction, not limited to those who itemize), and any interest earned is tax-free. All unused funds, as well any interest, may be carried over each year without limit. In addition to qualified medical expenses, HSA funds may also be used to for non-medical expenses, subject to the income tax and an additional penalty for those under 65. Each month, the plan automatically deposits a portion of the FEHB HDHP premiums into an HSA or HRA. Individuals enrolled in an HDHP who are not eligible for an HSA, as of the first day of the month, have their funds credited to an HRA. Plans place the same amount into an enrollee's HRA as they do into an HSA.

There are also similarities and differences between the CDHP's and HDHP's high-deductible plans. Both may cover preventive services without first meeting a deductible, both operate similarly to traditional health care once the deductible has been met, both

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[2] For more information on HSAs, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2007*, by Bob Lyke.

save beneficiaries money for using in-network services, and both require higher deductibles and catastrophic limits than other FEHB plans. However, the CDHP's high-deductible plan only covers services after both the amount contributed by the plan for the year has been spent and the member responsibility/deductible has been met, while the HDHP begins to cover services once the deductible has been met. There are exceptions in both cases for preventive care. The minimum deductible for the HDHP is specified in law, as is the maximum catastrophic limit, while neither is specified for the CDHP.

Examining GEHA's HDHP provides an example of premiums, deductibles and HSA/HRAs for these types of plans. For 2007, the self coverage monthly premium is $95.20, the deductible is $1,500, the plan will place $90 per month in the HSA/HRA, and those in the HSA may contribute another $1,770 annually (the difference between the amount contributed by the plan and the federal self coverage limit). For family coverage in 2007, the monthly premium is $217.45; the deductible is $3,000; the plan places $180 per month into the HSA/HRA; and those with an HSA may contribute another $3,490 annually (the difference between the amount contributed by the plan and the federal family coverage limit). Enrollees over age 55 may also make "catch-up" contributions. While the premiums for GEHA's HDHP plan did not increase over the 2006 amounts, both the deductible and the amount contributed by the plan to the HSA/HRA increased.

Flexible Spending Accounts and Their Role in FEHB

Active federal employees (not annuitants) may participate in the federal Flexible Spending Accounts (FSA) program, consisting of a Health Care FSA and a Dependent Care FSA.[3] Contributions to an FSA are voluntary, with accounts funded solely by an employee from his or her pre-taxed salary, thereby reducing taxable income. The government does not make any contribution to the FSA. Funds in a Health Care FSA (HCFSA) can be used to pay for qualified medical expenses that are not reimbursed or covered by any other source. Qualified medical expenses include coinsurance amounts, copayments, deductibles, dental care, glasses, hearing aids, as well as certain over-the-counter medical supplies that are not cosmetic in nature. The FSA program provides a complete list of covered and non-covered medical expenses: [http://www.fsafeds.com].

Employees choosing to participate in an HCFSA must contribute at least $250 and no more than $5,000 per year to an account, and the total pledged contribution for the year is available at the start of the year. One significant limitation of the HCFSA is that funds can only be carried over for 2½ months after the end of the plan year (for example, 2007 contributions to the HCFSA may be used to reimburse expenses incurred during calendar year 2007 continuing through March 15, 2008). Unused funds are forfeited. During the annual FEHB open season, employees may voluntarily make an election for an HCFSA amount to be set aside in the upcoming year. Employees eligible for FEHB (even those not currently enrolled) may elect an HCFSA. Under Internal Revenue Code rules, only current employees and not annuitants are eligible to contribute to an HCFSA.

Individuals who are enrolled in either a CDHP or HDHP coupled with an HRA may also enroll in the HCFSA, as long as they are not annuitants. Individuals enrolled in an

[3] For more information on FSAs, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Chris L. Peterson and Bob Lyke.

HSA may also enroll in a limited expense HCFSA (LEX HCFSA) that can be used to cover qualified dental and vision care. Individuals have to weigh the pros and cons of the LEX HCFSA coupled with an HSA against a standard HCFSA, choosing the one that best fits their needs, especially if they have a large expense that can only be covered by the standard HCFSA, such as a hearing aid. On the other hand, HSAs funds can be carried over from year to year, and some of the funding in the HSA comes from the plan.

Medicare and FEHB

Most federal employees or annuitants reaching age 65 qualify for Medicare. Federal workers and their employer each pay 1.45% of earnings. Individuals must have the required number of quarters of Medicare-covered employment to be eligible for Medicare Part A, Hospital Insurance (HI). Medicare Part B Supplementary Medicare Insurance (SMI) and Part D prescription drug coverage are voluntary, and qualified individuals choosing to enroll must pay a monthly premium. Generally, individuals who do not enroll in Parts B or D during their initial eligibility period are subject to a penalty. However, for Part B, individuals covered by an FEHB plan either through their own or a spouse's active employment (not annuitant coverage), may wait until either they or their spouse retires to enroll without incurring a delayed enrollment penalty. Upon retirement, individuals must enroll in Part B or be subject to a late enrollment penalty. For Part D, the prescription drug coverage included in FEHB plans is determined to be at least actuarially equivalent to Part D, on average. Therefore, if an individual maintains FEHB coverage and at a later date decides to enroll in Part D, there is no late enrollment penalty. The same rules for late enrollment penalties also apply in the private sector. Annuitants or former spouses may suspend FEHB enrollment to enroll in a Medicare Advantage plan (basically, a Medicare HMO or regional PPO), with the option to re-enroll in FEHB during open season, or sooner, if they involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Medicare is the primary payer for services provided to Medicare beneficiaries who are retired, even if they have retiree health insurance coverage through their former employer, such as FEHB. However, the rules for secondary coverage are different for Medicare beneficiaries who are working (often referred to as the "working aged") and offered health insurance through their employer. Employer-sponsored group health insurance, including FEHB, is generally the primary payer for individuals covered through their own or a spouse's current employment. Working aged employees have the option of accepting or rejecting the employer's coverage.

Additionally, the FEHB plan is eligible for the special subsidy payment to employers or unions offering qualified retiree prescription drug coverage. Qualified plans are defined as those offering drug benefits at least actuarially equivalent to "standard coverage. " and the prescription drug coverage offered in FEHB plans meets this standard. Subsidy payments are made on behalf of an individual covered under the retiree health plan who is entitled to enroll under a Medicare Part D prescription drug plan or a Medicare Advantage plan with prescription drugs, but elects not to. In 2007, subsidy payments will equal 28% of a retiree's gross drug costs between $265 and $5,350. OPM has opted not to take the subsidy payment. If it did accept the payment, it is unclear whether or not it would reduce the government's share of premiums, enrollee's premiums, or a combination of both. Employers in the private sector may use the

subsidy payments as they choose. Subsidy payments to employers and unions are not subject to federal tax.

FEDVIP Background

As required by statute, the Office of Personnel Management (OPM) created the Federal Employees Dental and Vision Insurance Program (FEDVIP), available since December 31, 2006 to federal employees, Members of Congress, annuitants, and dependents. Enrollees are responsible for 100% of the premiums, and OPM does not review disputed claims. Employees who are eligible to enroll in the Federal Employees Health Benefits (FEHB) program, whether or not they are actually enrolled, may enroll in FEDVIP. Annuitants, survivor annuitants, and compensationers (someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation program) may also enroll in FEDVIP.[4] Eligible family members include a spouse, unmarried dependent children under age 22, and continued coverage for qualified disabled children 22 years or older. Former spouses receiving an apportionment of an annuity, deferred annuitants,[5] and those in FEHB temporary continuation of coverage are not eligible to enroll in FEDVIP.

There are four nationwide dental plans, and three additional dental plans that are only available regionally. The nationwide plans also provide coverage overseas. There are three vision plans, which all provide both nationwide and overseas coverage. Eligible individuals may enroll in a FEDVIP plan during the standard open season for FEHB plans. Coverage began on December 31, 2006. Individuals may change plans during open season each year, or following a qualifying life event. As with FEHB, new employees has 60 days to enroll. FEDVIP enrollment can be done through the Internet at [http://www.BENEFEDS.com], or, for those without Internet access, by calling 1-877-888-FEDS.

Individuals may choose a self-only, self +1, or a family plan. This set of options differs from the FEHB plans, which only allow for two choices: a self-only or a family plan. Individuals who choose to enroll in FEDVIP are not required to enroll in both a dental and a vision plan; they may choose only one type of coverage or both. Individuals are not required to enroll in the dental plan offered by their FEHB plan; for example, an individual whose health insurance is provided by GEHA may enroll in MetLife's dental plan and in FEP BlueVision (Blue Cross/Blue Shield vision plan). However, any coverage for dental and/or vision services provided under the individual's FEHB plan is the primary source of coverage, and the FEDVIP supplemental dental and vision plans pay secondary. Additionally, active workers (not annuitants) may still contribute to a Flexible Spending Account (FSA) to cover any qualified unmet medical expenses, such as dental copayments or deductibles.

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[4] Annuitants must have retired with an immediate annuity; those who have a deferred annuity may not be eligible to enroll in FEDVIP. However, unlike FEHB plans, one does not have to be enrolled in FEDVIP five years before retirement to continue enrollment into retirement.

[5] These are individuals who separate from federal service before they could retire and receive a deferred annuity at age 62. Individuals who retire with at least the minimum retirement age + 10 years of service and postpone receipt of an annuity can enroll in FEDVIP (as well as FEHB), when they begin to receive their annuity.

Premiums vary by plan, by whether the enrollment includes other family members, and by residency (for dental plans only). Unlike nationwide FEHB plans, individuals enrolled in a FEDVIP dental plan pay different premiums depending on where they live in the country or overseas. Active employees must pay FEDVIP premiums on a pre-tax basis (called premium conversion). Pre-tax premiums are not available to annuitants, survivor annuitants, or compensationers.

While there are no preexisting condition exclusions for this coverage, there are waiting periods for orthodontia. Individuals must be in the same plan for the entire waiting period, and switching to a new plan may require beginning the waiting period over again. There are no waiting periods for vision services. The statutes allow for more stringent waiting periods for individuals who do not enroll at their first enrollment opportunity. As these plans are new, it is too soon to know whether or not plans will use this authority. Enrollees pay less out-of-pocket costs if they use in-network services.

Deciding Whether or Not To Enroll in FEDVIP

Several factors are important to consider in deciding whether or not to enroll in FEDVIP, including: 1) coverage of these services in a FEHB plan — more likely for those enrolled in a Health Maintenance Organization (HMO), 2) likelihood of using services covered by the plans, and 3) placing the same dollar amount that would be used toward dental and/or vision benefits premiums in an FSA. Each potential enrollee must weigh these considerations and others against his or her own level of risk aversion, as well as the fact that the individual pays 100% of the premium.

Current coverage in a FEHB plan -- Under the FEDVIP program, coverage provided by an individual's FEHB health plan is primary, and the FEDVIP plans are the secondary payers. However, the nationally available FEHB plans, such as Blue Cross Blue Shield and GEHA, have limited dental and vision coverage. For example, the plans generally do not cover eyeglasses. They may have an arrangement with certain providers for discounted eyewear, but the enrollee would still be responsible for 100% of the discounted cost. In contrast, the FEHB HMO-type plans do offer more comprehensive dental and vision benefits. Some high-deductible plans also provide some coverage. It is important to compare FEHB coverage to determine if also enrolling in FEDVIP is beneficial. For example, M.D. IPA provides for eyeglass frames once every 24 months with copayments, and a $130 retail allowance. This is comparable to the FEDVIP vision coverage, although only one of the factors that needs to be considered.

Likelihood of Using Dental/Vision Services -- While some enrollees know that they will use services, such as the case of an individual who wears glasses or a dependent who will need orthodontics, some services cannot be as easily predicted, such as an individual needing a root canal. Individuals must weigh their expected benefits against the premiums. For example, an individual who wears glasses, has a yearly eye exam, and uses a provider in-network may find that paying the premium will result in lower costs than paying for each of these services separately, even with pre-tax FSA funds for employees. On the other hand, an individual who does not wear glasses may not benefit from vision supplemental insurance. There is not, however, a one-to-one correlation between buying any insurance and the expectation of using the services. There is still a large share of unknown risk that any insurance protects against, so that some individuals

who do not anticipate using these services may find themselves needing the services and the coverage provided by these plans.

FEDVIP versus FSA (or Both) -- Both FEDVIP premiums and FSA contributions are pre-tax, so that employees (annuitants may not contribute to an FSA) may decide to enroll in one, none, or both. Enrollees who choose both can use funds in the FSA for any copayments, coinsurance amounts, deductibles, amounts exceeding annual or lifetime maximums, or amounts above the plan's payment for out-of-network services. Some individuals may decide that they prefer to only contribute to an FSA and not enroll in either the dental or vision plan, and instead use their FSA funds to pay for any dental or vision expenditures. While using FSA funds provides the most flexibility, it may be that the dental and vision premiums cover more than the same dollars in the FSA. Individuals who are not sure they will use the services provided under FEDVIP can "wait and see," and if they do not use dental or vision services, they can use the FSA dollars for other qualified medical expenses. Others may choose to enroll only in FEDVIP and minimize their out-of-pocket expenditures by staying in-network. Decisions about FEDVIP and FSA can be revisited every year during open season.

Comparing the FEHB and FEDVIP to Private Sector

Comparing the access and employer contributions for the health benefits of federal workers to those offered in the private sector, provides some insight into how these benefits measure-up. According to the Department of Labor's March 2006 National Compensation Survey, 71% of private sector workers had access to health benefit plans and 67% had access to prescription drug coverage. Access to health insurance in the private sector increases for firms with more than 100 workers, those who employ white-collar workers, full-time workers, union workers, and those with average wages of $15 per hour or higher. Private sector employers contributed an average of 82% of the health insurance premium for individual coverage and an average of 70% of the premium for family coverage. On average, 46% of private sector employees had access to dental care and 29% had access to vision care.

The percentage of employers offering retiree coverage has been declining since the late 1980s. The Henry Kaiser Family Foundation and the Health Research and Educational Trust 2005 Survey on Retiree Health Benefits, found that the percentage of firms with more than 200 workers offering retiree coverage fell by half between 1988 and 2005, from 66% to 33%. Furthermore, between 2004 and 2005, of the 300 firms in their survey with more than 1000 employees, 71% of those companies had increased the share of the premiums paid by the retiree, 34% had increased retiree coinsurance or copayments, 39% indicated that they had increased the amount enrollees pay for prescription drugs through increased drug copayments or coinsurance, and 12% had eliminated subsidized retiree health benefits for their new employees. Employers are also managing their retiree health insurance costs by providing different benefits for current and future retirees. Some employers who offer retiree health insurance to their current retirees will not provide coverage for individuals who retire in the future. Other firms may only provide group access to health insurance for future retirees, requiring them to pay 100% of the premiums. Firms may also use a sliding scale based on factors such as age at retirement, years of service at retirement, or a combination of the two to determine their premium contributions for retirees. According to 2004 Mercer National Survey of Employer-Sponsored Health Plans, 2004 Survey Tables, 28% of

pre-Medicare retirees and 30% of Medicare-age retirees of firms offering retiree health based their share of premium contributions on age and years of service. Among large employers (500 or more employees) pre-Medicare retirees are more likely to pay 100% of their health insurance than their Medicare counterparts.

Issues

Finally, turning to current issues, Congress is considering legislation that encompasses a wide-range of changes to the FEHB program, including but not limited too: (1) allowing Federal civilian and military retirees to pay health insurance premiums on a pre-tax basis; (2) expanding the program to cover individuals who are not federal employees, such as employees of small private businesses or employees of Federally-qualified health centers; (3) expanding required benefits to include additional services, such as hearing aids and disease screenings; (4) increasing the level of government contributions; (5) eliminating the time-limit on continuation coverage for employees who leave federal service; and (6) requiring plans to establish and maintain electronic individual personal health records.

Other issues facing the program include maintaining the integrity of the risk pool, containing costs, and eliminating fraud and abuse. HSAs are often associated with attracting the healthiest individuals, altering the composition of the risk pools for other plans because these plans: (1) expose enrollees to more risk for their health care expenditures, at least up to the large deductible amount; and (2) generally have lower premiums than other types of health insurance. For the FEHB program, the structure of the premiums for these plans has worked to try to minimize both of these issues. For example, in the GEHA program, the premium for the HSA plan is set in-between the premiums for the high and the standard plan. Thus, the calculation of the federal contribution is not greatly affected by these plans, and the choice to enroll in one of these plans is not solely driven by lower premiums.

Containing costs, is not a unique problem for FEHB, but rather one that is faced by all employers who offer health insurance to their workers and retirees. Of particular concern to many employers is health insurance for their retired workers, and as discussed above, employer-sponsored retiree health insurance benefits are eroding as employers attempt to control their costs by tightening eligibility requirements and shifting costs to retirees through increased premium contributions, deductibles, and co-payment amounts.

Eliminating fraud and abuse is an effective tool for containing costs. For example, the pharmacy benefit manager Medco Health Solutions settled with the Justice Department to end the probe of allegations that they submitted false claims to the government, solicited and received kickbacks from pharmaceutical manufacturers to favor their drugs, and paid kickbacks to health plans to obtain business. They agreed to pay the United States $155 million and were required to enter into an extensive corporate compliance agreement of the Office of the Inspector general, Department of Health and Human Services and the Inspector General of the Office of Personnel Management.

For enrollees, FEHB's wide range of options allows them to use their own authority to hold down their health insurance costs, and because premiums are based on an average of all plan costs, individual decisions ultimately affect all enrollees. Eligible enrollees must weigh personal factors, such as how much of their wages they are willing to

contribute to health insurance and how risk-averse they are to potential out-of-pocket costs. Choosing the best plan for their needs is a difficult task. However, FEHB-eligible individuals may revisit their decision every year during the annual open season. Individuals who find themselves with too much or too little risk, under- or over-coverage, and those whose health status changes, may change plans each year. In the past, however, there has been very little movement from one plan to another each year. More than one-half of all FEHB eligibles are enrolled in a Blue Cross and Blue Shield plan, and similarly those enrolled in other FEHB plans tend to remain in their plan from year to year. Perhaps this will change as more individuals become aware of the newer options.

This concludes my statement. I would be happy to answer any questions that members of the subcommittee might have.