

**Health Policy  
Fact Sheet  
July 2009**

## **Basic Facts about the Federal Employee Health Benefit Program**

### **SUMMARY**

The Federal Employee Health Benefits (FEHB) program is often held up as a model for health reform. The idea has a nice ring to it: “Everyone should have health care as good as members of Congress.” This fact sheet summarizes some basic facts about this program. FEHB program is generally considered to do a good job providing coverage, but it’s certainly not perfect.

### **What is the FEHB Program?**

The Federal Employee Health Benefits (FEHB) program provides health insurance, through a choice of different plans, to most federal employees and retirees, including members of Congress. In 2008, the FEHB program provided health coverage to about eight million current and former federal employees and their families.

The program is administered by the U.S. Office of Personnel Management (OPM). OPM negotiates premiums and benefits with private insurers and oversees the plans’ compliance with consumer protections.

### **What Type of Health Plans are Available?**

Because the FEHB program represents such a large number of potential customers, all major health plans offer coverage through the program. FEHB enrollees are offered a choice of plans, including several nationwide plans, and, depending on the region, one or more managed care models. About 70 percent of total FEHB enrollment is concentrated in health plans that use networks of “preferred providers” (termed Preferred Provider Organizations or PPOs), about 27 percent in Health Maintenance Organizations

(HMOs), and around two percent in high-deductible health plans (Exhibit 1).<sup>1</sup>

### Exhibit 1 –The FEHB Program: 2008 Basic Facts

Employee Policyholders*	2,159,533
Average Annual Premium (single coverage)	\$5,037
Average Age of Policyholder	47
Distribution by Plan Type:	
Preferred Provider Organizations (PPOs)	71%
Health Maintenance Organizations (HMOs)	27%
Other**	2%

Source: FOIA Communication from the U.S. Office of Personnel Management, July 7, 2009.

\* Approximately 3 million dependents and 3 million retired enrollees bring the total covered to over 8 million.

\*\* "Other" plan type includes Consumer Directed Health Plans and High Deductible Health Plans.

## Adequacy of FEHB Plan Benefits

Congressional policymakers working on health reform face the difficult but critical challenge of defining what constitutes "adequate health insurance." One potential benchmark that is often mentioned is the Blue Cross Blue Shield Standard Option plan (BCBS-SO) offered through the FEHB program. The BCBS-SO plan is the most popular plan option in the program, covering approximately 60 percent of all program participants.

The BCBS-SO plan offers services through a "Preferred Provider Organization" or PPO. This means that certain hospitals, doctors and other health care providers are "preferred" providers. When patients use the PPO (Preferred) providers, they receive covered services at a reduced cost. Patients have to pay a larger share of the cost if they use non-preferred providers (for example, if they seek specialist care from a doctor that is not in the network).

On average, the BCBS-SO plan is about as generous as other large employer health plans.<sup>2</sup> These covered services include:

- Medical and surgical care
- Lab, X-ray, and other diagnostic tests
- Preventive care
- Maternity care
- Family planning
- Physical therapy
- Hearing and vision care

- Home health services
- Chiropractic

Cost-sharing for routine care is modest and “on par” with coverage offered by other large employers (see Exhibit 2). However, the overall patient liability for covered services (the “out-of-pocket maximum”) has increased significantly in recent years. In 2008, this maximum stood at \$5,000 per year for in-network services and \$7,000 for out-of-network services.<sup>3</sup> These out-of-pocket amounts are difficult for lower income families to afford, especially if their illness requires expensive treatment over more than one plan year.<sup>4</sup>

#### Exhibit 2 – 2009 Federal Blue Cross Blue Shield Standard Option Plan – Selected Benefits

	In-Network	Out-of-Network
Annual Deductible (individual/family maximum)	\$300/\$600	
Copay per Hospital Admission	\$200	\$300
Copay for Office Visit	\$20	30% of allowed amount, plus any excess over the allowed amount
Annual Out-of-pocket Maximum	\$5,000	\$7,000

Source: Blue Cross and Blue Shield Service Benefit Plan, [http://www.fepblue.org/benefitplans/2009-sbp/SBP2009Brochure\\_English.htm](http://www.fepblue.org/benefitplans/2009-sbp/SBP2009Brochure_English.htm)

## What Do FEHB Plans Cost?

The FEHB program offers many different health plans and the total premium varies depending on the plan selected. As the employer, the federal government contributes up to 75 percent of an individual plan’s premium.

The FEHB premium contribution is a little lower than the typical employer contribution. On average, private employers contributed about 81 percent to the cost of single coverage and about 75 percent to the cost of family coverage in 2006.<sup>5</sup> Most private employers offer just one or two coverage choices and hence the formula that determines their contribution is somewhat less complicated.<sup>6</sup>

*This Fact Sheet was prepared by Lynn Quincy and Bob Williams.*

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<sup>1</sup> A Health Savings Account (HSA) is an account employees can put money into to save for future medical expenses. An HSA can only be opened in conjunction with an HSA-qualified “high deductible health plan” (HDHP). These HDHPs have cost-sharing provisions that are determined by Federal law. In 2009, for example, such plans must have deductibles of at least \$1,150 for self-only coverage and \$2,300 for family coverage. For more information: <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf>

<sup>2</sup> C. Peterson. *Setting and Valuing Health Benefits*, CRS Report to Congress, April 6, 2009.

<sup>3</sup> Karen Pollitz. *Statement before the Committee on Ways and Means, Hearing on the Tri-committee Draft Proposal for Health Care Reform*, June 24, 2009.

<sup>4</sup> A study of families who declared bankruptcy for reasons related to medical spending *and had private insurance* found that the average debt was \$18,000. David Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler “Medical bankruptcy in the United States, 2007: Results of a national study,” *American Journal of Medicine*, June 4, 2009.

<sup>5</sup> 2006 Medical Expenditure Panel Survey – Insurance Component, data for private sector establishments.

<sup>6</sup> *Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2008*, The Kaiser Family Foundation and Health Research & Educational Trust, September 2008.