FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM-FEHB

Nearly all federal employees are eligible to, and do, participate in the government sponsored health insurance program. The FEHB program is the basic federal health insurance plan for the government's civilian employees. It includes federal employees, retirees, and their survivors and dependents. The participants obtain health insurance coverage at group rates through FEHB. Enrollees and the government, with the government contributing the largest part of the established premium, share the cost of the benefit. Employees pay their part through payroll deductions, while retirees pay through annuity deductions.

GENERAL DESCRIPTION

The FEHB is open to almost all of the government's civilian employees on a voluntary basis. Exceptions are those workers serving in their first year of federal employment on a temporary basis, or otherwise excluded by law or regulation. The FEHB contains a number of features that make it the nation's leader in the provision of health insurance.

For example:

- Within 31 days of the date you entered the government, or became eligible, you are entitled to enroll in one of the sponsored health insurance programs.
- Coverage is provided without a medical examination or restrictions because of age, current health or pre-existing conditions.
- There are no waiting periods for benefits after the effective date of enrollment.
- There is catastrophic protection against unusually large medical bills; or
- You have an annual opportunity, during Open Season, to enroll in a health benefits plan if you are not already enrolled, or if you are enrolled to change to another plan or option.

Annually, OPM determines which of the states qualify as medically under-served areas, under the FEHB program. These are states that have a low ratio per person of health care providers. For more detailed information about the federal governments health insurance program and policies, see the Code of Federal Regulations, Part 890.

FEHB RULES AND PROCEDURES

Currently there is one government wide plan, 12 employee organization plans and over 375 Health Maintenance Organization, HMO's. Any employee may enroll in the government wide plan. Generally, to enroll in an employee organization plan you must be a member of the organization sponsoring the plan. HMO's are open to those who live or work in the geographical area serviced by that particular plan. Consult a plan brochure for additional information.

Enrollees in an FEHB insurance plan are entitled to certain levels of protection and health care. For example, protective provisions, effective in 1999, require that all FEHB plans provide the following:

- Direct access to women's health care for routine and preventative services.

- Coverage's for emergency department services for screening and stabilization without authority if you have reason to believe your life is endangered or you would be seriously injured or disabled.

- Direct access to a qualified specialist in your network of providers if you have complex or serious medical conditions that need frequent specialty care. Authorizations, when required by the plan, will be for an adequate number of direct access visits under an approved treatment plan.

- Extensive information about a plans characteristics, performance, provider network characteristics, and care management.

- The elimination of any "gag rules" in provider contracts designed to limit communication about medically necessary treatment.

If a plan denies a claim for payment or service, the plan must reconsider its denial when it receives your written request within one year of the denial. In your written request you should identify the reasons, in terms of the applicable brochure provisions, that you believe that the plan should have paid the claim or provided the service. The plan must respond to your request within 30 days. It must affirm its earlier denial, pay the claim, and provide the service or request additional information in order to make a determination. If the plan affirms its denial or does not respond to your request within 30 days, you may request OPM to review your claim to determine whether the plan acted in accordance with its contract in denying the claim. To request a review, write:

Office of Personnel Management
Retirement and Insurance Group
Office of Insurance Programs
P.O. Box 436
Washington, DC 20044

ELIGIBILITY AND ENROLLMENT RULES

Covered employees also include "cooperatives", that serve "in cooperation" with non–federal agencies and who are paid in whole or in part with non-federal funds. This would include certain employees of the Agricultural Extension Service, certain Agricultural Stabilization and Conservation County Committee workers, employees transferred to public international organizations under the Federal Employees International Organization Act, and U.S. Commissioners. A government employee whose spouse is also a government worker may each enroll for the family. The children of such a couple, however, would be covered if one spouse enrolls under the family option; enrolling individuals does not cover children.

Temporary employee rules appear in FPM Letter 890-39 dated 12/26/89. Over the years these regulations have changed many times due to Congressional actions, making questions in some cases difficult to resolve. If your agency denies you coverage and offers you no supporting documentation, look up the rule yourself in the appropriate publication mentioned above, or contact your agency's headquarters insurance officer.

At the time employees become eligible to enroll, the employing office provides:

- An FEHB guide, Rl 70-7 for overseas employees, and RI 70-8 for temporary employees, which explains the health benefits program, compares the benefits of some plans and contains rates.

- Standard Form 2809, which is the registration form used by employees to enroll in a plan or elect not to enroll. Eligible employees may enroll during the annual open season or at other specified times.

Employees in an authorized leave-without-pay status generally can continue health insurance coverage for up to one year of the non-pay period. The 365 days of non-pay status may be continuous or interrupted by periods of paid status that lasts more than four consecutive months. Effective September 30, 1996, employees must pay the premiums for these periods for the FEHB coverage or the agency must advance their salary, in the amount of the worker's share of the health insurance premium, to cover the cost of the extended coverage.

FEHB Open Seasons for making enrollment changes are held each year from Monday of the second full work week in November through Monday of the second full work week in December, or as otherwise announced by the Office of Personnel Management.

During open season, employees may make enrollment decisions or changes affecting the health plan coverage for themselves and eligible family members. "Eligible family member" includes an employee's spouse and any unmarried children under the age of 22, including legally adopted children, recognized children born out of wedlock, and foster children or stepchildren if they live with you in a regular parent-child relationship. Unmarried children may be covered regardless of their age if they are incapable of self-support because of an incapacity that began before they attained their 22nd birthday. Parents and other relatives cannot be covered even though they may live with you.

PLAN OPTIONS

The FEHB generally allows federal employees and annuitants to choose between fee for service plans, which work on a reimbursement model, and health maintenance organizations (HMO), which provide health care by steering enrollees to approved groups or panels of providers. The main government wide health benefit plan is a fee–for-service plan provided through Blue Cross and Blue Shield organizations that any employee might join. It is called a "service benefit plan" because it works on the principle of paying benefits either to the enrolled participant or directly to the doctor or hospital that provides the treatment or service.

Another type of FEHB fee-for-service plan is the employee-organization plan. Within the federal government there are a few employee organizations that sponsor health benefit plans to their members. Any employee that is a member of an organization that sponsors a plan approved by the Office of Personnel Management may enroll and is entitled to the government contribution towards its cost.

In addition to the above plans, the FEHB program offers employees and annuitants the opportunity to enroll in a number of HMO's. Types of HMO options available to FEHB enrollees include:

- Group practice prepayment plans - these plans have their own center or centers and their own doctors that practice as a group. Employees who live in an area where there is a group-practice prepayment plan that participates in the FEHB program may choose to join it rather than one of the other plans.

- Individual practice prepayment plans - in these plans, doctors agree to accept payments from the plan instead of requiring the patient to pay their usual charge. Like the group practice plans these plans operate only in certain areas.

- "Mixed Model" prepayment plans - these are a combination of certain benefits of the two plans described above.

Employees seeking more detailed information about the types of benefits provided by the different plans should consult the plan brochures that can be obtained from most government employment offices.

PREMIUM RATES

The premium rates typically change each year, following the contract negotiations between OPM and each insurance carrier. Any new rates will begin on the first pay of the first pay period of the following year.

The government and the participating employee or annuitant shares FEHB's premium costs. Under the "Fair Share Formula", the maximum government share is set at 72% of the weighted average cost of all plans, not to exceed 75% of the cost of any specific plan. The enrollee is then responsible for the balance of the premium cost.

The government contribution is the same for most federal employees, with the following exceptions:

- Employees appointed under the Federal Part-Time Career Act of 1978 only receive a portion of the government contribution paid to full-time employees, with the government share prorated in proportion to the number of full-time service regularly performed.

- Temporary employees pay the full premium, both the government and employees share.

- The USPS contributes an additional amount, specified in collective bargaining agreements, toward the cost of a postal service employee's enrollment.

PRE-ADMISSION CERTIFICATION PROCEDURES

If you are enrolled in a traditional insurance plan or HMO under the Federal Employees Health Benefits program, you need to remain up to date, not only on your plan's benefits, but also on its cost containment rules and procedures. Under the FEHB program, both the HMO's and the fee-for-service insurance plans have cost containment measures in place. All plans require pre-admission certification of all non–emergency hospital admissions. Some may also require such pre-admission for emergency admissions. Check your plan brochure for additional information.

Most plans make you responsible for pre-admission certification, if that does not happen, your benefit will be reduced by $500.00 not to exceed the cost of the admission.

TEMPORARY CONTINUATION OF COVERAGE

TCC is a feature of the FEHB program that allows certain people, typically separated employees and their dependents, to temporarily continue their coverage after their regular coverage ends. TCC enrollees must pay the full premium for the plan they select, plus 2% administrative charges.

Generally, federal employees and members of their families who lose the FEHB coverage due to the occurrence of a "qualifying event" are eligible for TCC. In most cases the "qualifying event" that triggers TCC rights is an employee's separation from government service, including separating retirees who are ineligible to continue coverage because they failed to meet length-of-enrollment requirements. Employees are not entitled, however, to TCC if they are involuntarily separated due to gross misconduct.

A separating employee's dependent children normally are eligible for TCC coverage until the occurrence of one of the following:

- Marriage
- Reaching age 22
- Loss of status as stepchild, foster child or recognized natural child

In the case of children whose coverage has continued beyond age 22 because of their inability to support themselves due to a disability that occurred before they reached age 22, TCC coverage ends when they recover from the disability or become self-supporting.

A former employee's election of TCC family enrollment covers the same family members as were covered under the regular family enrollment. A new family member such as a spouse or newborn child, who is added during the period of TCC enrollment, is also covered as a family member.

Separating can continue TCC for up to 18 months after the date of separation. The employee's children or former spouse can continue TCC coverage for up to 36 months after:

- The date of the qualifying event if it occurs while the children of the former spouse is covered as a family member of an employee or an annuitant under a regular FEHB enrollment; or

- The date of the qualifying event if the qualifying event occurs while the children of the former spouse is covered under the TCC enrollment of a former employee.

Employees should ask their agency to provide them with TCC information before or on the day they separate. TCC enrollment, and premiums, always begins on the 32nd day after an employee's regular coverage ends, which happens on the last day of the pay period in which the employee separates. The earlier a TCC enrollment is submitted, the earlier the agency can process it, and the less likely a worker will receive a large bill for retroactive TCC coverage.

Employees who retire and are eligible to continue their regular FEHB coverage are not eligible for TCC coverage, since their regular FEHB coverage does not stop.

Enrollees may elect either self or self and family enrollment; however, the individuals who qualify under a TCC family enrollment vary depending on whether the enrollee is a former employee, child, or former spouse.

COVERAGE AFTER RETIREMENT

Generally, to continue FEHB coverage as a retiree, you must be retiring on an immediate annuity and you must have been continuously enrolled under the FEHB program, or covered as a family member, either:

- Since your first opportunity to enroll.
- For the five years of service immediately preceding your annuity start date.
- During all service for which you were eligible for enrollment, beginning with an enrollment that became effective no later than 12/31/1964, whichever is the shortest period of time.

In a few circumstances, OPM may waive these requirements when it determines it would be against "equity and good conscience" not to allow an individual to enroll in FEHB as an annuitant.

Employees who separate and are eligible for a deferred annuity cannot begin health insurance coverage when their deferred annuity begins. Employees must retire on an immediate annuity to be eligible to continue their health insurance coverage. Under FERS, an immediate annuity includes one based on a minimum retirement age and ten years of service, MRA plus 10, even though they may decide to postpone receipt of their annuity.

The application rate of a retiree's health insurance premium will be deducted from the monthly retirement annuity check. If the annuity is not enough to cover the cost, you may make payments directly to OPM.

Retirees who are enrolled for self and family can have family members continue until such time as they become ineligible, for example, when a covered child reaches age 22 or marries. The widow of a federal retiree who did not elect the survivor benefit cannot continue coverage through the FEHB program. The deceased must have been enrolled for self and family at the time of death.

Federal employees who are retiring as a result of downsizing may be entitled to use their accrued annual leave to establish service time needed to gain eligibility to carry their FEBH insurance into retirement.

Effective 1/1/1995, FEHB plans are limited to paying the Medicare fee schedule amount for physician services provided to FEHB enrollees age 65 and over and who are not enrolled in Medicare Part B. Medicare participating providers can collect no more than the Medicare fee schedule amount from these enrollees. Non-participating Medicare providers can collect no more than the limiting charge amount, which is 115% of the fee schedule amount.