



Association of Federal Health Organizations

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WHITE PAPER

**IMPACT OF THE INSURER FEE AND THE EXCISE TAX ON THE
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM**

PREPARED FOR

THE U.S. OFFICE OF PERSONNEL MANAGEMENT

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Executive Summary to a White Paper Impact of the Insurer Fee and Excise Tax on FEHB Plans

The Federal Employees Health Benefits (“FEHB”) Program provides health benefits to approximately eight million federal and postal employees, annuitants, and eligible dependents. The FEHB Program is comprised of individual benefit plans sponsored by a diverse group of insurers, employee organizations, and other carriers that offer comprehensive health benefits coverage through fee for service or HMO arrangements. The federal government uses the FEHB Program to attract quality applicants for jobs and retain its employees. The members of the Association of Federal Health Organizations (“AFHO”) are carriers of nationwide experience-rated FEHB plans which provide health benefits to over 75% of these enrollees.¹

AFHO’s members annually negotiate their premiums with the U.S. Office of Personnel Management (“OPM”) based on the plan’s actual claims experience and anticipated benefit cost trends, among other factors. Because the federal government provides its employees with lifetime retiree coverage, the average age of an FEHB Program enrollee is about 60 years old. The demographic characteristics of a plan’s enrolled group are a major factor driving the premium cost for experience-rated plans. High premium cost does not equate to so-called “Cadillac” benefits in the FEHB Program.

The FEHB Program has been described as a model health insurance exchange. The government contribution for civil service employees and annuitants is statutorily defined as 72% of the enrollment weighted average premium but no more than 75% of the selected plan premium. The enrolled employee or annuitant pays the balance of the premium. When faced with premium increases or benefit changes, enrollees can freely switch plans during the annual Open Season.

AFHO tracks legislative developments that may impact the FEHB Program. In furtherance of this effort, AFHO has prepared the accompanying White Paper which assesses the FEHB Program impact of two Patient Protection and Affordable Health Care Act provisions (“PPACA,” H.R. 3590) now pending before the Senate, the annual insurer fee and the 40% excise tax.

In 2010, PPACA’s \$6.7 billion annual insurer fee (§ 9010) would increase experience-rated carrier costs, which translates into increased premiums. Our white paper projects the fee would boost premiums by as much as one to two percent depending upon whether or not the party responsible for paying the fee is a taxable entity (see Attachment A). Because the government contribution is capped, federal and postal employees and annuitants would bear the brunt of those increases.

In 2013, the PPACA’s excise tax (§ 9001) would take effect with respect to the full range of health benefits coverage available to federal and postal employees and annuitants, including FEHB Program, the Federal Employees Dental and Vision Program (“FEDVIP”) and the Fedflex healthcare spending account program. The proposed excise tax is 40% of the premium cost above the \$8,500 self only premium threshold and the \$23,000 self and family premium threshold. Based on OPM’s March 2009 headcount report for self only plans, we project that the self only premiums of several FEHB plans, currently covering over 50% of the FEHB Program’s self only enrollment, would exceed the threshold as early as 2015, assuming the rise in health care cost trends is only moderate. The day of reckoning would arrive

¹ AFHO’s members include American Foreign Service Protective Association, American Postal Workers Union, Compass Rose Benefits Group, Government Employees Health Association, Mail Handlers Benefit Plan, National Association of Letter Carriers Health Benefit Plan, National Rural Letter Carriers’ Association, Panama Canal Area Benefit Plan, Special Agents Mutual Benefit Association, and Associate Member Blue Cross Blue Shield Association.

sooner if the enrollee also purchases FEDVIP coverage and/or contributes to a Fedflex healthcare spending account (see Attachment B).

Due to limitations under current law, experience-rated carriers would not be permitted to charge the excise tax as an allowable cost of their FEHB plan contract. Instead, they would have to pay the excise tax out of their own funds.

The PPACA's annual insurer fee and excise tax would have a significant negative impact on the FEHB Program. The annual insurer fee would lead to increased premiums, and in order to avoid the excise tax, plans would be forced to reduce benefits. Additionally, when considered in tandem, the annual insurer fee and the excise tax create a vicious cycle; the annual insurer fee would push premiums ever closer to, or over, the excise tax threshold which in turn would force carriers to reduce benefits at an even faster pace in order to avoid the excise tax. This squeeze play will be exacerbated by the fact that the PPACA indexes the excise tax thresholds to the annual Consumer Price Index for all Urban Consumers (CPI-U) increase plus one point. Because the CPI-U rises much more slowly than the medical costs that make up the vast majority of carriers' costs, upward adjustments to the excise tax thresholds would not be sufficient to mitigate the rate of benefit cuts.

We hope OPM will find this paper useful in analyzing the potential impact of these provisions on the FEHBP.

White Paper

Impact of the Insurer Fee and Excise Tax on High Cost Plans on the FEHBP

The purpose of this White Paper is to explain the adverse effect on the Federal Employees Health Benefits Program (FEHBP) of the insurer fee and the excise tax on certain “high cost” health plans that are included in the proposed Senate amendment in the nature of a substitute to H.R. 3590, which would incorporate the “Patient Protection and Affordable Care Act,” (PPACA).¹ Although modified, these provisions originated in S. 1796, the “America’s Healthy Future Act of 2009.” Accordingly, the Senate Finance Committee’s report on S. 1796 remains very useful in understanding many aspects of these provisions and will be cited in this paper when appropriate.

I. The Insurer Fee

Section 9010 of the PPACA would impose an aggregate fee of \$6.7 billion per year on health insurers. Beginning in 2010, each year the Secretary of the Treasury would apportion the fee among health insurers based on their relative share of the sum of total net premiums written by health insurers and 200% of the aggregate third party administration agreement fees (TPA fees) taken into account². Health insurers would be required to pay this fee for the first time in 2010, based on health insurance premiums written in 2009. The fee would not be deductible for federal income tax purposes.

Employers that self-insure their employees’ health risks are exempt from the fee. (The FEHBP, of course, is a fully insured program.) Governmental entities are also exempt, except to the extent they provide coverage through the community health insurance option established by section 1323 of the PPACA. However, entities that underwrite policies for government-funded insurance programs would be covered.

Under subsection 9010(a)(1), the fee applies to each “covered entity engaged in the business of providing health insurance,” and a “covered entity” is defined in subsection (c)(1) as “any entity which provides health insurance for any United States health risk.” Subsection (d)(1) defines “United States health risk” as the health risk of a citizen of the United States. Since FEHBP carriers cover the health risk of U.S. citizens, it is clear from the plain language of this provision that all FEHBP carriers, including those that are otherwise tax-exempt, would be subject to this fee. The Senate Finance Committee’s report on S. 1796 also specifically states that this fee is intended to apply to insurance issued under the FEHBP³.

¹ This paper is based on the text of the amendment in the nature of a substitute posted on the web site of the Senate Finance Committee at <http://finance.senate.gov/sitepages/leg/LEG%202009/111909%20patient-protection-affordable-care-act.pdf>. Changes to the amendment could alter this analysis.

² Under subsection (b)(2) the percentages of net premiums written and TPA fees an entity must take into account depends upon its totals in each category for the year. The entity must take into account 100% of net premiums written or TPA fees if the totals exceed \$50 million or \$10 million, respectively.

³ S. Rep. No. 111-89, 348 (2009).

Attachment A estimates the FEHBP's share of the \$6.7 billion national fee, the total amount of the fee that will be passed through to FEHBP enrollees considering that the insurer fee is not tax deductible, and the amount by which premiums will have to rise, on average. This estimate does not factor in the graduated scale for determining the amount of premiums and TPA fees taken into account in calculating each specific insurer's portion of the fee. We do not believe that estimating the premiums and fees excluded under the graduated scale would make a material difference in the results. Consequently, the estimates on Attachment A may understate the FEHBP's share of the insurer fee.

The estimates for the period 2009-2019 are displayed on Attachment A. (In 2010, carriers would be required to pay the insurer fee based on net written premiums for 2009.) Those estimates show that FEHBP carriers would be required to pay fees totaling almost \$5 billion on premiums earned over this time period. Carriers would be liable for nearly \$420 million in fees based on 2009 premiums.

Because the fee is nondeductible, carriers subject to federal income taxes must actually collect more money than their share of the fee to fully recoup the fee, while tax exempt carriers do not have this concern. The FEHBP includes both taxable and tax-exempt organizations, so the estimates show a range of the amounts that carriers would have to pass through to customers because of the fee. One set of estimates assumes that all carriers are tax-exempt, and the other assumes that all are taxable entities. According to these estimates, if the fee were in effect, the required premium increase in 2009 would have ranged from \$103.33 to \$159.00 per contract and added a total of between \$1,083 and \$1,666 more per contract over the period from 2010 to 2019.

Obviously, the insurer fee would put significant upward pressure on premiums and make it more difficult to offer affordable health care coverage to the active and retired federal employees and their families who depend on the FEHBP for their health benefits.

This analysis assumes that FEHBP carriers will be able to increase their premiums to reflect the additional cost of the insurer fee. However, if that is not the case, many - if not all - carriers would find participation in the FEHBP financially unfeasible because they would be unable to cover their expenses. Their only rational choice would be to leave the Program, reducing enrollees' options. Enrollees who have become accustomed to having the opportunity to choose the plan that best meets their needs from among a number of competing carriers offering a variety of plans, including both HMOs and fee-for-service plans, would find their choices severely restricted.

II. Excise Tax on High Cost Insurance

Under section 9001 of the PPACA, a nondeductible excise tax of 40% would be imposed on FEHBP carriers⁴ and other health insurers on the aggregate value of employer-

⁴ PPACA § 9001(a) (adding a new IRC Section 4980I (d)(1)(E), providing that "any group health plan established and maintained primarily for its civilian employees by the Government of the United States" is covered by this excise tax).

sponsored health coverage, whether insured or self-funded, that exceeds threshold amounts (\$8,500 self, \$23,000 family) for tax years beginning after 2012.

Beginning in 2014, these thresholds will be indexed by the Consumer Price Index for Urban Consumers (CPI-U) plus 1% (CPI+1). Critics of the proposed excise tax note that medical cost inflation will outstrip the thresholds quickly as medical cost inflation exceeds CPI-U.⁵

The thresholds for annuitants age 55 and older and employees in plans covering “high-risk” professions will be increased (\$1,350 self and \$3,000 family), amounts that will also be indexed by CPI+1. High-risk professions are defined to include, for example, law enforcement officers, firefighters, members of rescue squads, ambulance crews, and individuals engaged in the following industries: construction, mining, agriculture (excluding food processing), forestry, or fishing. Only one threshold increase will apply to an individual. For example, the threshold for a 55 year old retiree in a plan covering high-risk occupations would only be raised by \$1,350 for self coverage or \$3,000 for family.

Thresholds for employees who reside in one of 17 “high cost” states designated by the Secretary of Health and Human Services⁶ will also be subject to a series of increases, at declining rates (beginning at 20% and ending at 5%), between 2013 and 2015. These increased thresholds are in lieu of the increased thresholds for high-risk occupations.

The employer – presumably OPM and employing agencies in the case of the FEHBP – will be required to determine on an individual-by-individual basis whether the total value of enrollees’ employer-sponsored health benefits, even employee-pay-all benefits, exceeds the applicable threshold. In making this determination, the employer will have to take into account dental and vision insurance under the FEDVIP program, Health FSAs, HRAs, HSA contributions by the employer or by the employee through a cafeteria plan, as well as the value of the enrollee’s FEHBP coverage. Disability, Long Term Care, and fixed indemnity health coverage bought with after-tax dollars are not included.

OPM will also have to apportion the excess subject to the tax to each carrier based on the relative value of its insurance to the total value of the enrollee’s coverage. For example, if an employee has a health plan with one carrier under the FEHBP, a dental plan with a second carrier, and vision coverage with a third, OPM will have to allocate the taxable excess among the three carriers on a pro rata basis. In addition, OPM would have to notify the carriers, as well as the Secretary of the Treasury, of their share of the taxable excess.

Absent a change in the treatment of excise taxes, FEHBP carriers will not be able to charge the amount of the tax to the contract because excise taxes under chapter 43 of the Internal Revenue Code are unallowable costs. The Federal Acquisition Regulation

⁵ See, e.g., Milliman Health Reform Briefing Paper, “No Room to Stand,” September 2009, noting that while CPI-U *decreased*, medical cost inflation *increased*.

⁶ The Secretary will make these designations based on the average cost of employer-sponsored health plans.

provides that certain types of costs are not allowable, including “[a]ny excise tax in subtitle D, chapter 43 of the Internal Revenue Code of 1986....” 48 C.F.R. § 31.205-41(b)(6). The proposed excise tax would be codified in subtitle D, chapter 43 of the Internal Revenue Code, so it is specifically not an allowable charge under the regulation. As noted above, the tax cannot be deducted from federal income taxes, so it would have to be absorbed by FEHBP carriers.

Attachment B estimates when various selected plans currently offered through the FEHBP would become subject to the 40% excise tax, under a variety of scenarios. The estimates show when the plan would become subject to the tax if the enrollee has:

- Only FEHBP coverage;
- FEHBP coverage and dental and vision insurance through the FEDVIP program; or
- FEHBP coverage, dental and vision insurance through the FEDVIP program, and a Health FSA.

This analysis shows that Self Only plans in the FEHBP are particularly vulnerable to the excise tax. Based on OPM data for 2008, annuitants over 65 with Self Only coverage make up about 20% of all enrollees in the FEHBP.

If there is a moderate trend of medical inflation, the estimate shows that one of these Self Only plans (Kaiser Northern California High Option) would become subject to the tax in 2013. Three more (BCBS Standard Option, GEHA High Option, and Mailhandlers Standard), which currently cover over 1.1 million enrollees (about one out of every four), would cross the threshold in 2015. By 2018, six of these Self Only plans and one Family plan would come under the tax.

For members that also have dental and vision coverage, the tax would hit one of these Self Only plans (Kaiser Northern California High Option) in 2013 if medical inflation is low, and three more (BCBS Standard Option, GEHA High Option, and Mailhandlers Standard) in the next year with moderate medical inflation. One of these Family plans would exceed the threshold in 2015 with moderate medical inflation (Kaiser Northern California High Option); three more Family plans and a total of seven of the Self Only plans would join it by 2018.

Adding a \$1,500 Health FSA to the other coverage dramatically accelerates the trend. Even with low medical inflation, six of these Self Only Plans and a Family plan would become subject to the excise tax by 2013. Moderate medical inflation would also push two more of the Family plans and three more Self Only plans across the threshold by 2016.

Attachment B also presents a summary total of all FEHBP plans to be offered in 2010 that would be affected by the excise tax in 2013. Altogether, even if medical inflation is low and enrollees are not covered by a Health FSA or FEDVIP dental and vision plans, the tax would apply to a total of sixteen Self Only and six Family plans. Dental and

vision coverage would raise those numbers to twenty-four and ten, respectively, and a \$1,500 Health FSA brings them to one hundred and eight Self Only and eighteen Family plans.

Since carriers would not be able to charge the excise tax to the contract, they would be forced to begin cutting benefits in order to avoid it, and they would have to cut aggressively.

Combined Effect of the Taxes

The insurer fee and the excise tax would both have a significant negative impact upon the FEHBP. The insurer fee would lead to increased premiums, and the excise tax would lead to reduced benefits. Additionally, when considered in tandem, the insurer fee and excise tax create a vicious cycle, with the insurer fee forcing premiums ever higher and thus subject to the excise tax, which in turn compels carriers to reduce benefits even faster. This squeeze play will be further exacerbated because the thresholds, which are indexed to CPI + 1, will rise more slowly than the medical costs that make up the vast majority of carriers' costs.

ATTACHMENT A

"Patient Protection and Affordable Care Act" Annual Insurer Fee
Impact upon the FEHBP

FEHBP Premiums	FY2008 *	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total 2010 - 2019
Employer Contributions	\$ 22,006,000,000												
Participant Contributions	\$ 9,852,000,000												
Total premiums for FY2008	\$ 31,858,000,000	\$ 34,525,724,244	\$ 36,942,524,941	\$ 39,528,501,687	\$ 42,295,496,805	\$ 45,256,181,581	\$ 48,424,114,292	\$ 51,813,802,292	\$ 55,440,768,453	\$ 59,321,622,245	\$ 63,474,135,802	\$ 67,917,325,308	

Number of Insured Contracts	4,026,575	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084	4,063,084
Average Premium per contract	\$ 7,911.94	\$ 8,497.42	\$ 9,092.24	\$ 9,728.69	\$ 10,409.70	\$ 11,138.38	\$ 11,918.07	\$ 12,752.33	\$ 13,645.00	\$ 14,600.15	\$ 15,622.16	\$ 16,715.71	

FEHBP Share of PPACA Fee (As if PPACA in Effect in FY2008)													
Total Industry Premiums	\$ 492,000,000,000	\$ 551,000,000,000	\$ 584,611,000,000	\$ 620,272,271,000	\$ 658,108,879,531	\$ 698,253,521,182	\$ 740,646,965,975	\$ 786,038,652,119	\$ 833,987,009,698	\$ 884,860,217,502	\$ 938,836,690,770	\$ 996,105,728,907	
Divide total FEHBP net written premiums by total industry premiums [1]	6.5%	6.3%	6.3%	6.4%	6.4%	6.5%	6.5%	6.6%	6.6%	6.7%	6.8%	6.8%	
FEHBP portion of \$6.7 billion annual fee	\$433,838,618	\$419,822,781	\$423,383,955	\$426,975,336	\$430,597,181	\$434,249,749	\$437,933,301	\$441,648,098	\$445,394,406	\$449,172,492	\$452,982,626	\$456,825,080	\$4,399,162,224

Amount Per Insured Contract Passed Through to Customers Assumes Insurer is Tax Exempt													
Additional average required premium per enrollee	\$107.74	\$103.33	\$104.20	\$105.00	\$105.08	\$106.88	\$107.78	\$108.70	\$109.62	\$110.55	\$111.49	\$112.43	\$1,083

Total Passed Through to Customers: Assumes Insurer is a Taxable Entity and the PPACA Fee Not Tax Deductible													
FEHBP portion of \$10.31 billion [2]	\$667,593,455	\$646,025,802	\$651,505,757	\$657,032,196	\$662,605,513	\$668,226,107	\$673,894,377	\$679,610,729	\$685,375,571	\$691,189,312	\$697,052,370	\$702,965,161	\$6,769,457,094

Amount Per Insured Contract Passed Through to Customers Assumes Insurer is a Taxable Entity and the PPACA Fee Not Tax Deductible													
Additional average required premium per enrollee	\$165.80	\$159.00	\$160.35	\$161.71	\$163.08	\$164.46	\$165.86	\$167.26	\$168.68	\$170.11	\$171.56	\$173.01	\$1,666

[1] \$505 billion is the estimate of total net written premiums for 2009. We have added 200% of our estimate of TPA fees (\$23 billion)

[2] Because increased FEHBP premiums paid by customers to offset the cost of the PPACA Fee will be subject to the 35% corporate income tax, it would be necessary for taxable entities to increase premiums by \$10.31 billion - enough to pay for both the \$6.7 billion and the tax on that amount

Put mathematically: \$10.31 billion - (\$10.31 billion x 35%) = \$6.7 billion

* - Source: OPM Agency Financial Report FY2008, p. 88

ATTACHMENT A ASSUMPTIONS

Total premiums for FY2008: 2008 amount is from OPM Financial Report. For all other years, the number of insured contracts is multiplied by the average premium per contract.

Number of Insured Contracts: 2008 and 2009 from OPM headcount reports. We assume a constant enrollment beyond 2009.

Average Premium per contract: 2008 is calculated by dividing total premiums by total contracts. 2009 and 2010 reflect the actual average premium increase of 7.6% and 7.0% respectively. All other years reflect an annual 7.0% increase, based on the 2010 experience.

Total Industry Premiums: 2008 estimate of Barclays Capital. 2009 estimate of a consultant, supported by Oppenheimer. We estimate \$23 billion in TPA fees by averaging estimates from Barclay and Oppenheimer. Later years reflect an average 6.1% annual increase, projected by Kaiser.

FEHBP portion of \$6.7 billion annual fee: $\text{FEHBP premiums} / \text{total industry premiums} \times \6.7 billion .

Amount Per Insured Contract Passed Through to Customers

Assumes Insurer is Tax Exempt

Additional amount of required premium per enrollee: $\text{FEHBP portion of fee} / \text{FEHBP contracts}$.

Total Passed Through to Customers:

Assumes Insurer is a Taxable Entity and the PPACA Fee Not Tax Deductible

FEHBP portion of \$10.31 billion: $\text{FEHBP premiums} / \text{total industry premiums} \times \10.31 billion .

Amount Per Insured Contract Passed Through to Customers

Assumes Insurer is a Taxable Entity and the PPACA Fee Not Tax Deductible

Additional amount of required premium per enrollee: $\text{FEHBP portion of } \$10.31 \text{ billion} / \text{FEHBP contracts}$.

ATTACHMENT B

Case 1: Enrollee only takes health insurance offered under the FEHBP. The single threshold is \$8,500 and the Family threshold is \$23,000. These are indexed for inflation, using CPI plus 1% annually from 2013. For purposes of this and other illustrations, we assume CPI inflation of 2.7%, low healthcare trend of CPI plus 3% (or 5.7%) and moderate healthcare trend of CPI plus 5% (or 7.7%).

The illustrations do not take into consideration the exceptions for retired employees or the exceptions for high risk employment. Additionally the illustrations do not consider the transition rules for high cost states.

	Self Only Coverage					Self and Family Coverage				
				Year that Excise Tax Applies					Year that Excise Tax Applies	
	2010 Premium	2009 Headcount	% Total Headcount	Low Trend	Moderate Trend	2010 Premium	2009 Headcount	% Total Headcount	Low Trend	Moderate Trend
FEHBP Plan (2009 Market Share)										
Kaiser North CA High (1.2%)	\$6,867	28,499	0.7%	2016	2013	\$16,393	21,495	0.5%	2023	2017
BCBS Standard (47.6%)	\$6,459	950,546	23.4%	2019	2015	\$14,589	981,605	24.2%	2029	2020
GEHA High (3.0%)	\$6,426	62,665	1.5%	2019	2015	\$14,615	58,348	1.4%	2029	2020
Mailhandlers Standard (4.9%)	\$6,350	100,636	2.5%	2020	2015	\$14,532	99,688	2.5%	2029	2020
NALC (2.9%)	\$6,122	51,419	1.3%	2022	2016	\$13,374	67,270	1.7%	2033	2022
M.D. IPA (1.4%)	\$5,813	22,384	0.6%	2025	2018	\$13,404	35,372	0.9%	2033	2022
Kaiser South CA High (1.3%)	\$5,496	25,351	0.6%	2028	2019	\$12,702	28,903	0.7%	2036	2023
APWU High (1.8%)	\$5,350	39,405	1.0%	2029	2020	\$12,098	32,378	0.8%	2038	2025
BCBS Basic (12.2%)	\$4,837	195,152	4.8%	2034	2023	\$11,327	302,875	7.5%	2042	2026
APWU CDHP (0.3%)	\$4,040	5,327	0.1%	2044	2027	\$9,090	7,570	0.2%	2053	2032
GEHA Standard (2.6%)	\$3,851	45,475	1.1%	2046	2029	\$8,750	59,516	1.5%	2055	2033
Total Number of FEHBP 2010 Plans Hitting Threshold in 2013				16	26				6	10

Case 2: Enrollee takes health insurance offered under the FEHBP as well as FEDVIP Dental and Vision offerings. The plans assumed to be selected are the Met Life Dental (Region 3) Standard Option and the BCBS BlueVision High Option. These plans are assumed to increase annually from 2010 at a rate equivalent to the CPI assumption (i.e., 2.7%). The 2010 cost of these plans are \$395 for Self and \$1,185 for Self and Family (the illustrations do not take into consideration Self + One rates available in FEDVIP).

FEHBP Plan (2009 Market Share)	Self Only Coverage					Self and Family Coverage				
				Year that Excise Tax Applies					Year that Excise Tax Applies	
	2010 Premium	2009 Headcount	% Total Headcount	Low Trend	Moderate Trend	2010 Premium	2009 Headcount	% Total Headcount	Low Trend	Moderate Trend
Kaiser North CA High (1.2%)	\$6,867	28,499	0.7%	2013	2013	\$16,393	21,495	0.5%	2020	2015
BCBS Standard (47.6%)	\$6,459	950,546	23.4%	2017	2014	\$14,589	981,605	24.2%	2026	2018
GEHA High (3.0%)	\$6,426	62,665	1.5%	2017	2014	\$14,615	58,348	1.4%	2026	2018
Mailhandlers Standard (4.9%)	\$6,350	100,636	2.5%	2017	2014	\$14,532	99,688	2.5%	2026	2018
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APWU CDHP (0.3%)	\$4,040	5,327	0.1%	2042	2026	\$9,090	7,570	0.2%	2051	2031
GEHA Standard (2.6%)	\$3,851	45,475	1.1%	2044	2027	\$8,750	59,516	1.5%	2053	2032
Total Number of FEHBP 2010 Plans Hitting Threshold in 2013				24	37				10	15

Impact of the Insurer Fee and Excise Tax on High Cost Plans on the FEHBP
Attachment B

Case 3: Enrollee takes health insurance offered under the FEHBP as well as FEDVIP Dental and Vision offerings and makes a \$1,500 contribution to an FSA.

FEHBP Plan (2009 Market Share)	Self Only Coverage					Self and Family Coverage				
				Year that Excise Tax Applies					Year that Excise Tax Applies	
	2010 Premium	2009 Headcount	% Total Headcount	Low Trend	Moderate Trend	2010 Premium	2009 Headcount	% Total Headcount	Low Trend	Moderate Trend
Kaiser North CA High (1.2%)	\$6,867	28,499	0.7%	2013	2013	\$16,393	21,495	0.5%	2016	2013
BCBS Standard (47.6%)	\$6,459	950,546	23.4%	2013	2013	\$14,589	981,605	24.2%	2023	2016
GEHA High (3.0%)	\$6,426	62,665	1.5%	2013	2013	\$14,615	58,348	1.4%	2023	2016
Mailhandlers Standard (4.9%)	\$6,350	100,636	2.5%	2013	2013	\$14,532	99,688	2.5%	2024	2017
NALC (2.9%)	\$6,122	51,419	1.3%	2013	2013	\$13,374	67,270	1.7%	2028	2019
M.D. IPA (1.4%)	\$5,813	22,384	0.6%	2013	2013	\$13,404	35,372	0.9%	2028	2019
Kaiser South CA High (1.3%)	\$5,496	25,351	0.6%	2015	2013	\$12,702	28,903	0.7%	2031	2020
APWU High (1.8%)	\$5,350	39,405	1.0%	2017	2013	\$12,098	32,378	0.8%	2034	2022
BCBS Basic (12.2%)	\$4,837	195,152	4.8%	2025	2016	\$11,327	302,875	7.5%	2038	2024
APWU CDHP (0.3%)	\$4,040	5,327	0.1%	2037	2022	\$9,090	7,570	0.2%	2050	2030
GEHA Standard (2.6%)	\$3,851	45,475	1.1%	2040	2024	\$8,750	59,516	1.5%	2052	2031
Total Number of FEHBP 2010 Plans Hitting Threshold in 2013				108	130				18	28