2022 FEHB

Open Season Guide

WAEPA®

Sponsored by Worldwide Assurance for Employees of Public Agencies, Inc.
waepa.org

Getting the Most from Your Federal Health Insurance

Updated for the 2022 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 or waiting periods to enroll, and a continued government contribution toward premiums for retirees at the same rate as for active employees.

And if you even then still have doubts, consider the experience of recent years as the Coronavirus pandemic put new strains on health care programs including the FEHB, yet the program not only pivoted quickly to meet those demands but did so with only relatively moderate premium increases.

It's no wonder that federal employees by and large like their program. In a 2019 survey, the FEHB was ranked behind only retirement benefits as the most important federal employee benefit. Further, 96 percent said the FEHB meets their needs to a moderate extent or more, nearly as many said that they considered it important or very important to them, and three fourths rated it a good or excellent value.

Seventy percent of those survey indicated that the availability of health benefits coverage influenced their decision to go to work for the government. And once they actually experienced being in the FEHB their opinion of it rose: 80 percent said that it influenced their decision to stay.

Almost all eligible persons who are not enrolled said the reason was not dissatisfaction with the FEHB in general, or with its features or cost, but rather that they had health coverage from another source, such as a spouse's employment or the military Tricare program.

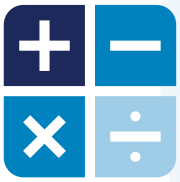
That's not to say the program is perfect. While the government pays 70 percent of the total premium cost (for both active employees and retirees), some private sector

2022 FEHB Open Season Guide for Federal Employees

This resource is sponsored by WAEPA.

WAEPA has been insuring the future of Federal Employees for more than 75 years.

It's clear to see why over 46,000 Civilian Federal Employees and their families choose WAEPA Group Term Life Insurance*:



Members who switched to WAEPA from FEGLI **saved an average of $292**.

WAEPA has given our members more than **$100 million** back in Premium Refunds**.

Coverage is yours to keep, even if you leave Federal service or retire.

Exclusive member benefits tailored specifically to your needs as a Civilian Fed.

Take the time to make the switch. Visit **waepa.org** to compare our rates to FEGLI and see how much you could save.

WAEPA®

*Underwritten by New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010 on Policy Form GMR
**Premium Refunds not guaranteed

employers pay more, at least for certain categories of enrollees. Also, FEHB does have some gaps in coverage, and average premiums do increase yearly like clockwork.

However, with some 275 total plans, including about a dozen available nationally, there always are some decreases within that average (along with larger increases, of course). And while the program sometimes is described as "vanilla" because all plans must comply with certain general requirements, there is much variation among plans.

But it's up to you to take the initiative to get informed and choose wisely to get the most from it. 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 about 5 percent switch plans in any given year, even though all are eligible to change during annual open seasons.

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 several health maintenance organization plans for 2022. That forces enrollees to make a new election, although if they don't, there are procedures for automatically enrolling them in another plan, to protect against losing coverage. Meanwhile, some plans newly join or existing ones expand their offerings—true of the 2022 plan year as well—opening up new possibilities.

The average enrollee premium in the FEHB rose 3.8 percent for 2022 over

2021, about comparable to the increase of most recent years—with the exception of the notably lower 1.5 percent increase for 2019—and about comparable to what state governments and large private sector employers have experienced in their programs. Out-of-pocket costs such as deductibles and copays—which also must be considered along with premium costs when deciding on a plan—remained about the same as in prior years.

For 2022 as in prior years the Office of Personnel Management continued an emphasis on controls over prescription drug costs; expansion of (less expensive) telehealth services; incentives for retirees eligible for Medicare to enroll in that program as well even though it means paying a separate premium; and incentives for covered persons to participate in wellness programs and to better manage chronic conditions.

And under terms of a law applying nationally, the FEHB for 2022 has new protections for enrollees against "surprise billing" from inadvertently using providers outside of a plan's network.

However, prescription drug costs, especially for new and specialty drugs, continue to push premiums upward—they account for more than a quarter of total costs—as do higher rates of use, the impact of providers using new and more expensive technology, and other types of medical inflation.

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 remained about flat for 2022, increasing by just under 1 percent on average. That program offers similar choices during the open season to those available in the FEHB, except that retirees may also newly enroll in the FEDVIP program. Those rates are at www.opm.gov/healthcare-insurance/dental-vision/plan-information.)

Beyond checking premium and coverage terms, don't neglect to consider your enrollment type. The program offers self-only, self and family and self plus one coverage (the "one" must be someone eligible for coverage as a family member. While there have been exceptions, as explained below, self plus one

generally is significantly less expensive than family coverage within a plan--yet there still are many thousands of family coverage enrollments covering only two people, years after the introduction of self plus one, simply because they haven't paid enough attention.

Then, you need to know what choices you can make and have a strategy for making them. This applies not only during open season but also potentially outside it when certain life events occur such as marriage or the birth of a child, 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 275 plans for 2022, only 10 carriers provide plans that are nationally available (18, if you count as separate plans the high-deductible and consumer-driven options—see below for how they work—offered by some of them) and even some of those restrict who can enroll in them. Most of the rest are localized health maintenance organization plans, at least one of which is available in every state.

As a practical matter, depending on where an enrollee lives, there is commonly a choice of about 15 plans, with more in certain city areas, fewer in more rural areas. Some plans offer a choice of two levels with differing cost and coverage terms, and/or a high-deductible or consumer-driven design.

FEHB provides health insurance coverage to some 8.2 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 employees, although charged on a monthly rather than biweekly basis, and the employer

contribution continues at the same rate. The government contributes on average about 70 percent of the total premium.

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.

The annual open season gives all eligible persons have an opportunity to join the program or make enrollment changes, which also are allowed 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 members include spouses and children up to age 26 (with no age limit if they were disabled before that age). Foster children can be covered under more limited circumstances: the child must live with you as the sponsor in a parent-child relationship, you must be the primary source of support for the child and you must expect to raise the child to adulthood. You must sign a certification that the foster child meets those requirements.

Note: An employing office may require an enrollee to verify eligibility of family members during initial enrollment and when family members are being added to an existing enrollment due to a qualifying life event such as marriage (in the latter case, for retirees OPM may issue such a requirement). FEHB carriers similarly can impose such requirements in situations in which premiums do not change such as adding a family member to an existing family enrollment. Enrollees may be required to produce documents such as a marriage license and proof of common residency for a marriage; a government-issued birth certificate for a child; an adoption certificate or decree for an adopted child; and a medical certificate of disability for a child age 26 or older who is incapable of self-support because of a condition arising before that age. If the documentation is not considered sufficient, enrollees are to be given a chance to produce sufficient documents, and a

reconsideration procedure is available in the case of a decision of ineligibility.

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 have been times in which the enrollee share of premiums for self plus one is higher in some plans than that for family coverage. The reason is that a high percentage of self plus one enrollees are married older employees or retirees with no children eligible for coverage—and in the term used in the insurance industry, older people on average "consume" more health care. Be sure to pay close attention to premiums if choosing between self plus one and family coverage within a plan.

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.

Under certain circumstances voluntary removal from coverage of an eligible family member is allowed, primarily so that the family member may enroll in health insurance sponsored by his or her own employer. With the consent of both spouses, an enrollee may drop a covered spouse. Similarly, an enrollee may drop an eligible child who is past the age of majority in the jurisdiction of the child's residence by providing proof that the child is no longer a dependent; the child also can request to be dropped on providing such proof. (Minor children may be dropped only under a court order.

A family member with other health insurance coverage who is also covered under an FEHB self plus one or self and family enrollment can still carry both coverages and doesn't need to be removed from the FEHB enrollment. That's because FEHB program coverage can be coordinated with other non-FEHB coverage.

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.

- 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.

An "indemnity benefit plan" is a variant of a fee-for-service plan in which an enrollee may choose any health care provider but may have to pay a portion of the charge and, if it exceeds "usual and customary" rates, the difference.

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 precise standard benefit package in the 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 under standards prevailing in the health insurance industry.

Further, OPM sets standards for providing 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; coverage of certain treatments; 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.

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. Those changes often are in response to trends and developments in health care. In addition, changes to health insurance law in general can affect the program.

Details of changes in coverage and premiums, which become effective with a new plan (calendar) year, typically are announced about a month in advance of the annual open season that begins in early November.

For example, effective with the 2019 plan year OPM began allowing all plans to offer three options or to offer two options plus a high deductible health plan; that previously was the rule for HMO plans but not for fee for service plans. Several carriers since have added third options.

In 2020 an indemnity benefit plan again became available for the first time since 1989. In such plans, an

enrollee may choose any health care provider but may have to pay a portion of the charge and, if it exceeds "usual and customary" rates, the difference.

Also starting in 2020, the FEHB among other health insurance plans expanded their benefits in response to the Coronavirus pandemic. Carriers waive cost-sharing and prior authorization requirements for COVID-19 diagnostic and antibody testing, telehealth or other remote care services. And partly in response to the stresses of the pandemic, telehealth services were expanded in areas including mental and behavioral health and substance abuse.

Those policies continued through 2021 as the program continued to experience higher expenses for testing and treating infections. Those added costs were offset to an extent by enrollees deferring care such as routine medical exams, mammograms, colonoscopies and other preventive services, out of reluctance to go to medical facilities. That however, raised concerns about the long-term health impacts of deferring such care.

Effective in 2022 are new protections against "surprise billing." Those are out-of-pocket costs that can arise for example in emergency and other urgent care settings when enrollees don't have time to check whether facilities are in-network, or when they unknowingly receive care at an in-network facility from providers who are out of network.

Now, emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization. Also, patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.

The provisions also ban out-of-network charges for ancillary care at an in-network facility in all circumstances and ban other out-of-network charges without advance notice. Further, health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

Also effective in 2022 are new price and quality transparency

requirements, expanded coverage for medically recommended foods and for fertility treatments, among other benefits.

Meanwhile, for years the FEHB is continuing to emphasize policies including: cost-containment steps for costly "specialty" and "compound" prescription drugs; restricting prescriptions for opioids; encouraging enrollees to participate in wellness programs; and encouraging greater use of telehealth services when feasible as an alternative to more expensive personal appointments.

Another initiative has been to create financial incentives for retirees to enroll in Medicare Part B (physicians' services), which comes with an added premium but which takes over as the first payer for those who have both. A number of plans offer some type of Medicare Part B incentive –either through copay, coinsurance or deductible waivers or Part B premium reimbursement.

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—in 2021 for 2022, November 8-December 13). Changes outside of open season also are allowed if an enrollee experiences certain "qualifying life events."

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.

Note: Most years, a few plans drop out of the FEHB, restrict their coverage area or eliminate an option. In almost all cases, this is announced in the fall ahead of the open season. If an enrollee makes no new election, agencies (or OPM, in the case of retirees) are to automatically enroll them in the lowest cost nationwide plan available if the plan has dropped out or restricted its coverage area to exclude them, or in the lowest cost remaining plan option provided by the same carrier that is not a high deductible health plan, if only their option is being dropped.

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, in addition to dropouts or coverage restrictions, sometimes plans newly join or broaden existing geographic coverage areas.

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. OPM posts those brochures at www.opm.gov/healthcare-insurance/healthcare/plan-information/guides along with plan comparison features, contact information, and other information.

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, at least be sure your plan is still participating in the program and review its benefits and premiums for the upcoming year.

- 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). Further, to take advantage of the allowable carryovers beyond the end of a plan year allowed in each, you must be enrolled in that type of account for the following year. 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.

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; or
- 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. 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.