Carrier Handbook

Federal Employees Health Benefits Program

United States Office of Personnel Management

RV March 2003

Office of Personnel Management
Human Resources Products and Services
Center for Retirement and Insurance Services

Insurance Services Program
Program Planning and Evaluation Group
March 2003

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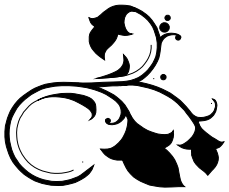
Introduction

Information for FEHB Program carriers



Welcome to the FEHB Program

We have prepared this *Carrier Handbook* to give carrier representatives information about the Federal Employees Health Benefits (FEHB) Program and your role in operating in it. In the Time Line section we highlight yearly events. Throughout the handbook, we focus your attention on the special features of this program vs. other group contracts you may have. We show you how to get answers to your questions and urge you to get the recommended reference materials and become versed in all program features.

We hope this handbook will help you have a long and successful participation in the FEHB Program!

Reference materials

To learn more about the topics discussed in this carrier handbook, review these:

- The Federal Employees Health Benefits law -- Chapter 89 of title 5 of the United States Code (5 USC Chapter 89). The FEHB law is the statutory authority for the federal government's health benefits program and presents the general rules for the Program's structure.

- The FEHB Regulation -- Part 890 of Title 5 of the Code of Federal Regulations (5 CFR Part 890). The FEHB Regulation expands on and provides more detail about the FEHB Law.

- The Federal Acquisition Regulation (FAR) -- Chapter 1 of Title 48 of the Code of Federal Regulations (48 CFR Ch.1). FAR contains the generic procurement rules contractors follow in doing business with the federal government.

- The Federal Employees Health Benefits Acquisition Regulation (FEHBAR) -- Chapter 16 of Title 48 of the Code of Federal Regulations (48 CFR Ch. 16). FEHBAR tailors FAR to the FEHB Program.

- Changes in the regulations are published in the *Federal Register*.

  Government documents are available through GPO Access, a service of the United States Government Printing Office. Free public access is available at http://www.access.gpo.gov/su_docs (no password required).

  You can also view and photocopy the United States Code, the Code of Federal Regulations and the *Federal Register* at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country.

- **FEHB Carrier Page** – (http://www.opm.gov/carrier/index.html) is your primary resource for getting information about your contracting responsibilities under the FEHB Program. For instance, the carrier page has links to reporting requirements, carrier letters, and the laws and regulations.

- **FEHB Program Web Page** -- (http://www.opm.gov/insure/health/index.asp) is one of your best resources for understanding the FEHB Program. For instance, the FEHB Handbook (http://www.opm.gov/insure/handbook/fehb00.asp) is the handbook used by federal agencies and employees.

- **Carrier letters –** We issue FEHB Program carrier letters at various times as necessary throughout the contract year. We maintain and forward carrier letters to you electronically.

ALERT! This handbook will not discuss all requirements and responsibilities placed on Government contractors. It is in your interest to read and become familiar with the law and regulations under which you offer your health plan to federal employees.

Communications:

We need to work together

Who we are and how you can contact us

The Federal Employees Health Benefits (FEHB) Program is the largest employer sponsored health benefits program of its kind. Established by an Act of Congress in 1959, the FEHB Program began covering employees on July 1, 1960. FEHB Program carriers cover most active, full-time civilian employees and retirees of the U.S. Government and U.S. Postal Service and their families. The Program now provides benefits to nearly 8.3 million federal enrollees and dependents and offers our 180 health plan choices to Federal members.

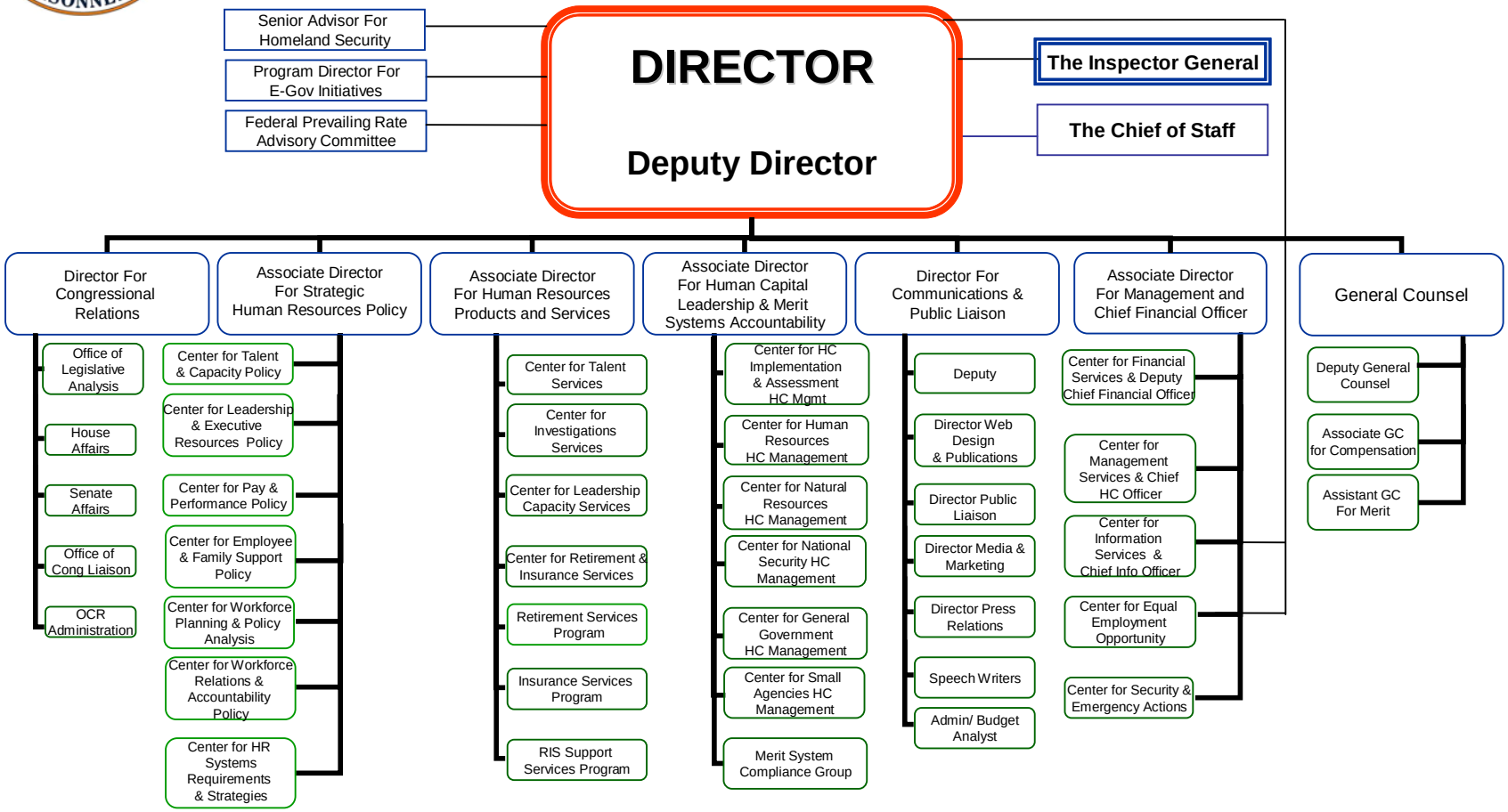
Insurance Services Program (ISP). The FEHB Program is administered by the Office of Personnel Management (OPM). Most of your dealings with the Office of Personnel Management will be with your *OPM contract specialist* and other staff of the Insurance Services Program (ISP), formerly the Office of Insurance Programs.

OPM contract specialist

Your main program contact within the federal government on your health benefits contract is the *OPM contract specialist* assigned to your carrier's contract. Your *OPM contract specialist* and the *Plan carrier contact* from within your organization (you) will work together to negotiate or coordinate your benefits and rates packages, prepare your brochure and other open season material, negotiate your health benefits contract, and so forth. Your OPM *contract specialist* should be the first person you seek out in OPM for any question you may have about the FEHB Program. If necessary, your *OPM contract specialist* will refer you to an appropriate office elsewhere in OPM.

NOTE:
We've reorganized the Office of Personnel Management.
View the latest organizational chart on the following page.

TEAM OPM



January 22, 2003

Team OPM
Reorganization

In the recent OPM reorganization, many functions under the Retirement and Insurance Service are now under OPM's Center for Retirement and Insurance Services, including the Office of Insurance Programs (OIP) – which is now called the Insurance Services Program (ISP).

Name under reorganization	Former name
Insurance Services Program (ISP)	Office of Insurance Programs (OIP)
Health Insurance Groups (HIG) 1, 2, 3	Insurance Contracts Divisions 1, 2, 3
Program Planning and Evaluation Group	Prog. Planning and Evaluation Division

Communicating by letter. To write to your *OPM contract specialist* or others in the Insurance Services Program (ISP), you may use the following address:

Office of Personnel Management
Insurance Services Program
ATTN: [office/person]
1900 E Street, NW.
WASHINGTON DC 20415-[add extended zip code for appropriate office]

NOTE: Because of requirements that regular mail be irradiated, we strongly encourage you to ensure redundancy through the use of **overnight mail** delivery or **FAX**. You may also email your letter to your OPM *contract specialist.*

Extended Zip Codes…

Office	**Extended Zip Code**
Asst. Director for Insurance Programs	3600
Health Insurance Group I (HIG I)	3610
Health Insurance Group II (HIG II)	3620
Health Insurance Group III (HIG III)	3630
Program Planning & Evaluation Group (PPEG)	3650

Communicating with Insurance Services Program (ISP) groups

Communicating by phone/FAX. To call or send a facsimile message to someone in the Insurance Services Program (ISP), use one of these phone numbers:

Insurance Services Program (ISP) Groups:	PHONE:	FAX:
Assistant Director	(202) 606-0770	606-4640
Program Planning and Evaluation Group (PPEG)	(202) 606-0745	606-0036
Health Insurance Group 1 (HIG 1)	(202) 606-0727	606-0751
Health Insurance Group 2 (HIG 2)	(202) 606-3818	606-0208
Health Insurance Group 3 (HIG 3)	(202) 606-0755	606-0418
	(202) 606-0737	606-0767

Electronic communication. Each carrier must be accessible to us through email. We encourage you to maximize your use of email to communicate and exchange information with us. *OPM contract specialists'* email addresses are available upon request.

Our web site **(**http://www.opm.gov/insure/health**)** has the information you need about the health insurance program and related publications -- such as the open season guide and FEHB Program carrier brochures.

Communicating with other OPM offices

Although you will speak most often with your *OPM contract specialist*, you may need to talk with other offices on specific matters. Your *OPM contract specialist* will direct you to other offices.

FEHB Policy staff – In the OPM reorganization, the FEHB policy function formerly in the OIP Program Information and Policy office moved to OPM's new Center for Employee and Family Support Policy.

Actuarial staff – In the OPM reorganization, the FEHB actuarial function formerly in the Retirement and Insurance Service moved to OPM's Center for Workforce Planning and Policy Analysis. Actuarial staff price rate and benefit proposals, negotiate rates, collect information about claims costs and demographics, reconcile community-rated carriers' rates, and perform other tasks associated with your rates.

Financial management staff -- In the OPM reorganization, the FEHB financial management function formerly in the Financial Management Division (FMD) of the Retirement and Insurance Service moved to OPM's Center for Financial Services and Chief Financial Officer. Financial staff account for receipts from federal agency payroll offices; arrange and account for premium transfers to carriers' letter of credit accounts and directly to carriers' accounts, where appropriate; help develop your financial reporting requirements; accept financial statements for program use; arrange and account for transfers of contingency reserve funds, where appropriate; collect headcount information received from federal agencies; and oversee the Employees Health Benefits Fund.

Corporate Audits Division, Office of the Inspector General (OIG). OPM auditors from the Corporate Audits Division of the Office of the Inspector General (OIG) audit carrier performance.

NOTE: The **audit resolution staff** in our Program Planning and Evaluation Group (PPEG) will work with you to resolve audit findings.

Health and Life Insurance Investigations Branch (OIG). The Investigations Branch investigates and seeks prosecutions and other penalties for fraud, abuse, and waste under the FEHB Program.

Special Counsel to the Inspector General. The Special Counsel administers the FEHB Program debarment/sanctions program. Under the program, healthcare providers that have committed offenses against FEHB and/or other federal programs are prevented from participating in the Program.

Office of General Counsel. The Office of General Counsel represents OPM in lawsuits, e.g., for disputed claims.

Retirement Services Program (RSP). The former Office of Retirement Programs (ORP) is now called the Center for Retirement and Insurance Services' Retirement Services Program (RSP). The retirement function is independent of the Insurance Services Program. RSP acts as human resources/payroll office for most retired federal employees and annuitants. Contact the Retirement Services Program for information on the enrollment status of a federal employee retired under the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS) and for information about enrollment reconciliations with payroll office number 24900002 (CSRS and FERS annuitants):

Carrier Help Desk (re CSRS & FERS annuitants)

Office of Personnel Management
PO Box 14172
Washington, DC 20044
(202) 606-5149 (carrier help desk)

Annuitant enrollment information is available in an automated format through the **carrier information system (CIS)** at (478) 757-3164. For information about CIS and other retirement related issues, contact RSP's carrier Help Desk at (202) 606-5149 Monday-Friday from 8:00 to 4:30 Eastern Time. The Help Desk provides service only to FEHB Program carriers. **Never refer an annuitant or employee to the carrier Help Desk.** Refer annuitants to OPM's toll-free number 1-88-US-OPM-RET (1-888-767-6738), TDD for the hearing impaired 1-800-878-5707, or e-mail address retire@opm.gov. Callers within the local Washington, DC, calling area must call (202) 606-0500. Refer active employees to the human resources office of their agency.

How we contact you

Use your carrier code and contract number! Each FEHB carrier has a two-character code -- the carrier code -- that must be on all documents you submit to the Office of Personnel Management. OPM assigns the carrier code and it is on the cover of your FEHB brochure. You may also be asked to identify your plan by its FEHB contract number. If you do not know your carrier code and/or contract number, ask your *OPM contract specialist* (see page 3).

Here are some things to remember about the carrier code:

- ✓ If you report to OPM on more than one plan, you may be asked to send separate reports for each carrier code.
- ✓ Do not split reports for a single carrier code for other reasons, such as to divide by payroll office number, region, or other organizational group, unless the report asks it.
- ✓ Occasionally, someone thinks the carrier code is three characters, e.g., XX2 or XX5. However, only the first two characters are the "carrier code."

The third character is added to show the enrollment type and the three-character code is known as the "enrollment code."

- "1" is for *high option self only* and "2" is for *high option self and family*. Plans with one option complete the "high option" sections of our reports.

- "4" is for *standard option self only* and "5" is for *standard option self and family*. Characters 4 and 5 are used by carriers that offer standard options along with their high option benefits.

The carrier contact -- a VERY important person!

In order for anyone to bind the plan (such as by submitting rates, benefits or accepting brochure text), he or she must be a contracting official and be designated on a current plan contracting officials form in our files. A carrier contracting official designates one employee to be *carrier contact* and thereby authorizes him or her to represent all departments of the carrier. On a day-to-day basis, your *OPM contract specialist* will work closely with your *carrier contact*. Notice given to your *carrier contact* by OPM is considered given to all carrier departments.

Other carrier personnel will furnish reports, process disputed claims, and so forth. It is important that you **update the form as changes occur**; please do not wait to send changes to your *OPM contract specialist*.

The current contracting officials form is on the carrier web page in the FEHB Carrier Routine Reporting Requirements section.

By letter. Most often, your *OPM contract specialist* will phone or email your *carrier contact* to discuss matters of the day. We will write to your plan, individually, when an issue concerns your plan only. For instance, we will write to you in June, July, or August to close out benefit negotiations.

Electronic communication

The successful development of electronic communication between carriers and *OPM contract specialist*s has been an important accomplishment. We continue to upgrade our equipment and software, and will continue to conduct negotiations and develop brochures electronically. The OPM standard for word processing is MSWord.

We use the Internet to send and exchange information. We use email extensively. All carriers must be able to send and receive Internet communications. **Promptly report email address changes to your *OPM contract specialist*.**

FEHB Program carrier letters

- We use FEHB Program carrier letters to send information that affects groups of carriers. For instance, we issue the annual call for benefit changes by way of a carrier letter.

- We post FEHB carrier letters on our carrier web page (www.opm.gov/carrier). As a courtesy we broadcast an email alert when we post a new letter. You should, however, regularly check the web page for the latest information.

- FEHB Program carrier letters are numbered consecutively in the YYYY-NNN format. Occasionally we issue letters to all carriers on the same subject with slight differences in the content according to plan type; in that case, we may append an alpha indicator to the carrier letter number.

- Carrier letters that are of interest only to certain types of carriers are sent only to those carriers. You are not intended to get every carrier letter we issue. You can tell how many of the FEHB Program carrier letters apply to your plan type by checking the additional numbering system on the latest letter you received.

If you find you are missing a carrier letter that you should have gotten, see the carrier letter archives on the carrier web page (www.opm.gov/carrier).

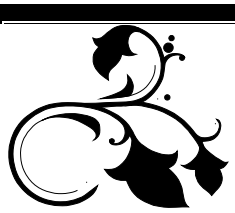
FAX and overnight delivery

We occasionally will FAX or deliver to you. Please report changes in FAX numbers and delivery addresses to your *OPM contract specialist* immediately.

ALERT! FAX operations generally occur after normal work hours. **Please have your FAX machine on -- and operating properly -- at all times.**

Time line

Information when you need it



The FEHB Program year

On the next several pages is a brief look at some of the events you may experience and a rough idea of when they may happen.

Here are some things you will do throughout the year:

- Keep up-to-date on the requirements of your Government contract with OPM.
- Respond timely to enrollees' inquiries and complaints that you receive. This includes telephone calls about benefits, rates, and service area, provider, and other concerns.
- Work with OPM in resolving disputed health benefits claims.
- When responding to enrollee requests for reconsideration of claim decisions, do all necessary research before responding and provide a full response. When the dispute reaches OPM, we will request your reconsideration file. The reconsideration file should include a full explanation of the denial of benefits and the pertinent brochure provision that supports the denial.
- Priority correspondence requires special attention. OPM may ask you to provide information on a given claim or on your plan operations so that we may respond to a Congressional Representative or other official. All priority correspondence requires your prompt attention.
- Notify your OPM *contract specialist* when the *carrier contact* or another contracting official changes, when there is a change in plan name, address or ownership.
- Each month, if there have been any entity, name, address or personnel changes, during the month, notify your *OPM contract specialist* promptly, even if the changes were overlooked when they happened.

- **Notify your OPM *contract specialist* and when a significant event -- particularly one that generates enrollee concerns -- occurs**, e.g., provider network and/or service area disruptions. A "significant event" also includes events such as lawsuits, strikes, and natural disasters.

January

Specific FEHB Carrier reporting requirements and report forms are available on the carrier web page at www.opm.gov/carrier.

Contract year begins.

- New plans begin serving members

- Benefits and rates change

Effective dates for all open season enrollments and enrollment changes. (Individuals may enroll or change plans at other times, as determined by their employing offices.)

Since November, you will have been issuing ID cards as soon as possible after receiving the open season enrollment documents and not more than 15 days after.

Expect a larger volume of phone inquiries about effective dates and plan changes, including enrollees' complaints about ID cards. (NOTE: Accept the enrollee's enrollment verification and provide benefits. To verify enrollment, contact the individual's employing agency or retirement system. We cannot verify enrollment.

Your **quality assurance** report for the prior year is due. (See Reporting section.)

Your **semiannual report** for the prior year on fraud and abuse cases is due.

You will be responsible for submitting plan membership data for all enrolled commercial members to your selected NCQA approved vendor for the Consumers Assessment of Health Plans Study's (CAHPS) survey.

February

If you are in your 1st contract year, we will send you a Medicare data release agreement to sign and return.

In February or March, OPM may draft language to improve FEHB Program benefit brochures and ask you to comment.

March

If you are a community-rated carrier, you receive **rate reconciliation** instructions (i.e., we tell you how and when to reconcile the current year's premium rates). Start early on your response. You cannot negotiate next year's rate without it.

We send you a **Medicare match data** report that has names and other information on certain individuals that appear on both OPM's annuity rolls and Social Security Administration's rolls. If your carrier has had a change of entity or name, please submit another match agreement BEFORE the data is mailed to you. If the name/address of the person to get the data changes, please email your *OPM contract specialist* BEFORE the data is mailed to the wrong person/address. Use the data to help coordinate benefits with Medicare and to reconcile the community-rated carrier's rate.

Fee-for-service plan carriers submit the ISP **debarment** report. The ISP report (on exclusion of services of providers debarred before 1/92) is no longer required of HMOs, although the OPM/OIG debarment report, which is due in April, is still required of all.

Experience-rated carriers submit financial reports according to the **Audit Guide**.

April

You receive the annual call for benefit and rate proposals, the "**Call Letter**."

You receive the follow-up **technical guidance** to complete your benefit proposal. It will include:

- Brochure language: Review and clear within your organization early; all edits, changes, and clarifications to your FEHB Program brochure must be submitted with your benefits proposal. (You will send the complete brochure draft later.)

- Service area: You also will submit your request for service area changes with your May benefits proposal. Clear changes and get State approval early; properly cleared and approved service area documentation must be submitted by June 30.

You receive the **rate instructions** from OPM in late March/early April; begin immediately to gather the information to prepare your May rate proposal.

Your Table 1, annual **summary of enrollment** report, is due; use data you collect all year.

Your semi-annual report on OPM/OIG **common rule debarments** is due to OPM's Office of the Inspector General (OIG). (In your 1st contract year, the OIG will contact you and work with you to develop your debarment program and set up your reports.)

If you are community-rated, your **community benefits package** is due. Take this opportunity to review your FEHB Program benefits brochure and make note of edits, clarifications and changes that will be needed when you submit it in May.

You receive and review OPM's draft standard health benefits **contract** or contract amendment for the following year. Review the draft thoroughly and clear it through all necessary carrier officials.

May

You submit your **benefit and rate proposal** for the next year, including new or reduced rating areas, and service area expansions or reductions. Before sending the proposals, clear these with all necessary offices in the carrier; **late submissions are not accepted.**

You submit other forms and information related to your benefit and rate proposals as requested in the Call Letter. Carefully compare your benefit and rate proposals against the Call Letter for compliance.

Review and submit any address or contracting official changes that were overlooked when they occurred. (See the Communications section.)

Reminder: If you consider dropping out of the FEHB Program, please decide early and notify OPM before benefits, brochures, and rates are done.

June

You will report the Consumers Assessment of Health Plans Study's (**CAHPS**) survey results to our contractor, The Gallup Organization.

You work with OPM personnel when they contact you to negotiate benefits and rates. **Assure all necessary personnel are available** during this time to work out problems and details.

If you are a new plan, you received your new FEHB Program identification numbers: brochure number, contract number, and carrier and enrollment codes. You will be asked to provide a great deal of information and documentation about where and to whom agencies, employees, and we send enrollment forms, premium payments, complaints, etc; please respond promptly and accurately.

Typically, benefit negotiations are completed in June and early July.

July

You work with OPM personnel when they contact you to negotiate benefits and rates. **Assure all necessary personnel are available** during this time to work out problems and details.

You receive OPM's decisions on any requested service area and rate area changes.

If you are a new carrier, locate and open lines of communication to federal agencies in your locality. (See Marketing section.)

Your semi-annual report on **fraud and abuse** cases is due.

August

Benefits negotiations are completed.

Rate negotiations are completed.

You update your **brochure** to include new text and benefit changes. Make sure the brochure agrees with negotiated benefits. Do not put in new, last minute benefit changes; we will not accept them. If you need any clarifications, discuss them with your OPM *contract specialist* before editing the brochure.

Reminder: Have you updated your employing office contacts list so you will be ready for open season?

September

You receive notice from OPM of the number of brochures you may charge to the contract or reflect in next year's community-rate reconciliation.

OPM produces the open season press release. It lists your and other carriers' rates for next year. This is your first opportunity to see other plans' rates.

You receive **brochure text** (that becomes Appendix A to your health benefits contract) that is ready to be formatted and printed and prepared in Portable Document File (PDF) for our web site (www.opm.gov/insure/health).

October

Prepare any **marketing materials** carefully -- OPM will not review them in advance for conformity with the guidelines in your contract's Appendix D. (New plans: contact your

OPM contract specialist and see the guidelines on the carrier web page.) If problems occur in the final printed product, you may find out about it only after another plan has taken action to have you withdraw or reprint the material.

You distribute printed FEHB Program **brochures and provider directories** after you receive approval from your OPM *contract specialist.*

You send a copy of the new brochure and provider directory to each person enrolled in your plan.

If we determine it is necessary because of errors or omissions, we will direct you to correct and reprint your FEHB Program brochure or mail addenda (and perhaps reject printing charges or impose other penalties).

Your semi-annual report on OPM/OIG **common rule debarments** is due to OPM's Office of the Inspector General.

November

Open season – mid-November through early December. (We will provide the dates in September.)

We encourage you to participate in agencies' local **health benefits fairs** and you may market your plan in any other way that complies with your health benefits contract.

You return your next year's **contract** as directed by OPM.

If you are a carrier that has shown interest in submitting an application for another plan, you receive **new-plan applications**. The applications contain certifications to submit if the plan is approved. Certifications include the drug-free workplace, payments to influence certain federal transactions, and the procurement integrity certificates.

New carriers must submit banking information to assure proper payment.

December

You receive and process the bulk of your **open season enrollments** and changes.

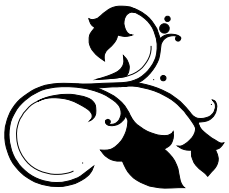
This is a good time to review your reports, forms and certifications to see if you need to submit or update them. (See the Reporting section.)

Experience-rated carriers' fiscal year **accounting statement** reports are due.

Specific FEHB Carrier reporting requirements and report forms are available on the carrier web page at www.opm.gov/carrier.

Contract Administration

For carriers who are newly approved, continuing, or terminating participation



Your authority

The FEHB Program is authorized by and operates under FEHB law (Chapter 89 of title 5 of the United States Code) and FEHB regulations.

Your health benefits contract with us must also conform to the FAR in general and the FEHBAR in particular.

The law and regulations are available online through the carrier web page – www.opm.gov/carrier.

Your responsibility

The carrier time line in this handbook highlights for you some of the periodic or "routine" responsibilities under this contract. Your responsibilities to your federal members are much like your responsibilities handling other employer groups. However, please keep in mind that by serving FEHB Program members, you have a Government contract and there are differences.

ALERT! This handbook will not discuss all requirements and responsibilities placed on Government contractors. It is in your interest to read and become familiar with the law and regulations under which you offer your health plan to federal employees.

You ARE responsible for:

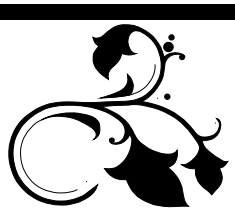
- Providing quality service
- Complying with FEHB Program law, regulations, and contract
- Providing negotiated benefits at agreed-upon rates
- Reconsidering denied claims or services, upon request
- Reconciling enrollment
- Submitting benefit and rate proposals, financial and enrollment data, performance reports, and other required information to OPM by the appropriate deadlines

You are *NOT* responsible for some things you may do for other employer groups, such as:

- Determining eligibility of employees or family members under the Program
- Providing enrollment forms to prospective members
- Determining effective dates
- Premium payment billing
- Sending undeliverable ID cards and mail to the employer (agency or OPM) to deliver to enrollees for you
- Terminating enrollments (see page 32)

Marketing

Information to reach the federal market



Locating your federal market

Marketing to the federal population will be different than marketing to other employer groups. Your FEHB market's primary target will be federal employees at installations of federal agencies and the U.S. Postal Service throughout the localities you serve. You may be able to approach employees at their work sites or through the media but you will not be able to reach them through direct mailing. Neither we nor any federal agency can provide home addresses.

The FEHB Program is not simply one employer. The federal government is actually a collection of many employers, each of which has many sites across the country. During the marketing process, you deal solely with agencies, not OPM. When you market to local agencies, consider each a separate employer group. Several regional installations may be in the same federal building, with each maintaining its own human resources and payroll offices and each carrying out their responsibilities under the FEHB Program independently.

New Carriers: For an approximate count of the employees working in the locality by State and County and other federal employment statistics, visit OPM's Fed Page (http://www.opm.gov/feddata and via the carrier web page). We do not maintain data on where federal employees live. Use the report ***Employment by Geographic Area*** **and other statistics available on FedPage** to develop your marketing strategy by, perhaps, first identifying the larger agencies in your area. Since we do not have a list of agency installations to give to you, start your list by:

- Checking your local telephone directory blue pages of government listings under "United States Government" and
- Checking the payroll offices list on the carrier web page.
- Checking the headquarters level agency benefits officers list on the carrier web page. (We do not have a list of local officers.)

Generally, an agency installation appoints a benefits officer in the local agency human resources office who is responsible for open season activities, including authorizing any on-site presentations -- or health fairs -- during open season.

You should develop a list of area benefits officer contacts as soon as possible after your carrier is approved and then update the list each year.

Agencies will ask you for brochures. Use that contact to develop marketing leads. Before open season, we send a Benefits Administration Letter (BAL) to all agency benefits officers. The BAL lists the name, address, service area (when applicable), and open season contact for your and other carriers. The benefits officers call HMOs directly to order brochures for open season. Consequently, a good way for HMO carriers to expand the list of agency contacts will be the phone calls *from* benefits officers.

Distributing your brochures

You will print your FEHB Program brochures after brochure and benefit language is approved or agreed upon between you and your *OPM contract specialist*. You will distribute your FEHB Program brochures to agencies, as directed by OPM. And you will send brochures to other places, as directed by your *OPM contract specialist*. Each year, you also will send your FEHB brochure and provider directory to each FEHB enrollee of your plan.

ALERT! You are allowed reimbursement for the costs of printing the number of brochures your OPM contract specialist authorizes. Timely shipping of your brochures is essential to a successful open season. Your printing allowance (or, if experience-rated, your service charge) may be reduced or we may impose other penalties for failure to distribute brochures as instructed

Agencies can help

Open season materials. Your plan will be listed in the *Guide to Federal Employees Health Benefits Plans*, which we publish annually to help federal employees select or change plans at open season and which will be online. Generally, brochure copies are available for reference at the agency installation. However, employees may call you at the number in the *Guide* to request a copy. Please send a brochure to each such caller. (The agency will give another brochure to the employee if he or she enrolls in your plan for the first time.)

Health fairs. Agencies are **not** obligated to hold health fairs at open season or to allow you to give presentations to their employees. We encourage agencies to permit carrier representatives to attend health fairs or to address groups of employees at their work sites during open season on carrier benefits, services, and similar matters. Sometimes you will need to make arrangements with each agency's benefits officer for such presentations.

Marketing materials

Provider directories. In addition to brochures, you will distribute a directory of carrier providers and hospitals. As directed, distribute the directory with the brochures.

Physician selection form. You may send a physician selection form along with provider directories. The form, preferably a self-mailer, must include your address, phone number, and instructions to return it directly to you, the carrier (i.e., not via the agency with the enrollment form).

Marketing materials. You may distribute marketing materials to federal employees at their work places as provided in your contract with OPM. Do not forget to follow the guidelines found in your contract (Appendix D) when developing your marketing materials. (New plans: Contact your *OPM contract specialist*.)

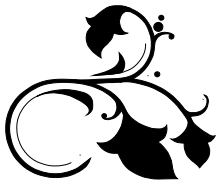
Advertising costs are not reimbursed.

The annuitant market

It is hard to market to retired federal employees. Open season information is mailed to annuitants by OPM's Retirement Services Program; annuitants shopping for a plan can order your brochure in writing, by phone, or online from OPM by using the list of plans they receive. Aside from that, you may need to rely on media advertising or health fairs sponsored by retiree groups to reach federal annuitants in a given area.

Do not send marketing material or physician selection forms to retirees through the retirement office.

NOTES:



Enrollment issues

Enrolling the federal group. Open season enrollments will sometimes arrive as late as February, with the bulk of them arriving much earlier. The enrollee's employing office will send you other enrollment actions, such as new employee enrollments, as they occur. Federal agency (i.e., employing office) human resources and payroll offices take care of the enrollment for their employees, and for the former employees, former spouses, and family members of their employees who become eligible for coverage. Sometimes agencies make arrangements with organizations such as the National Finance Center (NFC) to take care of health benefits enrollments for them. OPM's Retirement Services Program is the employing office for most annuitants.

Individuals enroll or change enrollment using the Standard Form 2809 (SF 2809), Health Benefits Registration Form, or its equivalent. Many will enroll electronically via the *Employee Express* or *Open Season Express* (for federal retirees). These are electronic enrollment systems. You will receive the same information found in the SF 2809, but the information is transmitted electronically through OPM's **HUB** in Macon, Georgia. **You must be set up to receive electronic data transmissions from the HUB.**

Some changes, such as termination of an enrollment, are recorded using the SF 2810, Notice of Change in Health Benefits Enrollment. **Do not require federal members to complete an additional Plan enrollment form.**

Employing offices will notify you about enrollment actions in any of several ways. For instance, the employing office may send you the enrollment forms directly, or may send you a letter or electronic list of changes. The Government is in the process of automating many of its transactions. Several agencies send employee enrollment changes electronically through OPM's HUB in Macon, Georgia, and most annuitant changes during the annual open season are sent through the HUB as well. We anticipate that the use of electronic enrollment changes will increase. Work closely with the employing offices to keep abreast of the ways they will get information to you.

Many of you now receive electronic information through Employee Express. There are a number of federal agencies which use other automated enrollment programs. Those agencies forward their electronic enrollment information to our Macon facility and

Macon transmits it to you using the already established Employee Express interface. (Some agencies, including the U.S. Postal Service do not have electronic enrollment.)

HIPAA. Beginning in October 2003, all enrollment data transmitted electronically must comply with HIPAA regulations, as set forth in the ASC X12N 834 transaction set. OPM, like all other employer groups, must transmit electronic enrollment data in HIPAA compliant format.

Receiving enrollment data in HIPAA compliant format will facilitate your processing of FEHB enrollments. Instead of printing out the electronic enrollment data and then doing manual data entry, HIPAA compliant format will allow you to feed FEHB electronic enrollment data directly into your computer systems.

Enrollee data. The new enrollee's employing office will provide basic information about the individual. You may need to get more information from the enrollee to complete your records. For example, if you require a gatekeeper, you will need to contact enrollees directly to find out the primary care physician they would like to choose.

The human resources office for retirees who retired under the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS) is OPM's Retirement Services Program (RSP). Most retirees' open season changes are processed through the *Open Season Express* system and transmitted electronically to you through the HUB. RSP processes some open season enrollment changes and all non-open season enrollment changes. You will therefore receive enrollment changes for retirees through two sources, the HUB and directly from RSP.

You should treat annuitants the same way as employees and may send them a carrier COB form immediately upon notification of the enrollment. We note also that a lot of information can be collected by phone.

Many "employers" equal one employer group. Federal agencies in the FEHB Program system have enrollment records of their own employees and family members. However, when an individual moves between agencies, human resources offices or payroll offices, he or she will not complete a new enrollment form. (The gaining agency will send you an SF 2810, Notice of Change in Health Benefits Enrollment, notifying you when the enrollment is transferred into the new employing office. The move does not affect the enrollment; however, the new employing office becomes responsible for paying the premium. Keep track of the information for reconciliation purposes. Make sure to change the payroll office number in your database. This will help avoid discrepancies in the Enrollment Reconciliation Clearinghouse.)

When the agency sends you health benefits forms, such as enrollment forms, the

transmittal sheet or letter will show the payroll office number and addresses for the human resources and payroll offices. (The actual SF 2811 Transmittal form is no longer required.)

Electronic changes. Federal employees at many agencies and annuitants have the option of making their open season actions electronically. You will receive the same information contained in the SF 2809. **You must be set up to receive electronic data transmission from the HUB.**

Your role in determining eligibility. You have no role in determining whether an employee is eligible to enroll. The employing office determines eligibility for FEHB Program coverage based on the FEHB Program law and regulations and OPM guidance. However, BEFORE ADDING AN INDIVIDUAL TO YOUR ROLLS, confirm the person is eligible for your plan (for instance, if you have a live-or-work requirement, confirm that the person lives -- or works -- in the area specified in your brochure, or confirm that the person is a member of your sponsoring organization if yours is a limited enrollment fee-for-service plan). Bring an erroneous enrollment to the attention of the enrollee and his or her human resources office right away, before medical services are needed.

Covering family members. Covered family members are defined in the FEHB Program law and regulations. Briefly, family members are the employee's spouse and unmarried dependent children under age 22, and unmarried children age 22 or over who are incapable of self-support because of physical or mental incapacity that existed before age 22. FEHB Program dependency definitions are based on FEHB Program law and regulations and, accordingly, override plan or State definitions.

Also read the regulations to learn more about what to do in situations like these:

- When a child turns age 22

- After divorce when children are not children of the federal employee or annuitant

A self and family enrollment automatically covers all eligible members of the enrollee's family. The self and family enrollee does not file additional enrollment forms upon adding new family members. To verify eligibility, contact the enrollee and, if necessary, the employing office or retirement system.

Setting effective dates. The employing office sets the effective date before the enrollment action reaches you. Open season actions are made effective the first day of the first full pay period in January. (January 1 for all annuitants.)

Generally, non-open season enrollment actions are effective on the first day of the pay period that begins after the employing office or retirement system receives the enrollee's request. In the case of the addition of a child, the enrollee's change from self only coverage to self and family coverage is effective the first day of the pay period in which the child is born or otherwise becomes a family member.

Effective dates coincide with an enrollee's pay period. There are several different pay periods in the federal government. Enrollees may be paid weekly, biweekly, semi-monthly, monthly, or every four weeks. Most federal enrollees fit one of four categories: 1) the General Schedule pay period that most employees fall into is two weeks, Sunday to Saturday, 26 biweekly pay periods per year; 2) the Postal pay period is two weeks, Saturday to Friday, 26 biweekly pay periods per year; 3) the annuitant (retiree) pay period is a month, first day to the last day, 12 monthly pay periods per year; and 4) the Compensationers (OWCP) pay period is a 4-week period, Sunday to Saturday every 4 consecutive weeks, usually 13 twice-biweekly pay periods per year.

Retroactive enrollments. Sometimes, due to administrative errors or special circumstance, effective dates of enrollments will be retroactive. We require health plans to accept retroactive effective dates. Premiums are adjusted for this.

Paperwork delays. There may be a lag between the effective date and your receipt of the paperwork. You will begin receiving transmittals of open season changes during November and will have most of them by January. Some agencies are slower due to heavy workloads, and you may get paperwork later. We instruct employees to use their copy of their SF 2809, Health Benefits Registration Form (or equivalent) until you process their change. Employees and annuitants who make changes electronically through the HUB may use their confirmation letter as proof of enrollment. The Retirement Services Program (RSP) also issues a confirmation letter for this purpose. Examples of the confirmation letters are provided to you each year in a carrier letter. **These documents must be honored by both the plan and plan providers, including pharmacies.**

Verifying eligibility. You may verify eligibility. FEHB Program brochures advise enrollees that although there may be a delay before ID cards and member information arrive from you, they are covered by the carrier from the effective date of enrollment and are expected to use carrier providers if that is a requirement of the plan. So, if a federal

enrollee requests service before you get the paperwork, **provide the service** and verify eligibility as follows:

- Ask to see the enrollee's copy of the SF 2809, Health Benefits Registration Form,

confirmation letter, or equivalent.

- Providers check with the carrier. The carrier may check with the enrollee's human resources or retirement office.

For Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants, first call the Office of Retirement Program's carrier information system (CIS) at (478) 757-3164. To verify the enrollment, you will need your plan's PIN and the enrollee's social security number. If you can't verify the enrollment through the CIS, contact RSP's carrier help desk at (202) 606-5149.

- To check your electronic records you receive from the HUB: If you do not have the electronic record, call OPM-Macon's HelpDesk at (478) 757-3030 or email them at EExFEHB@OPM.gov.

- Examine the employee's pay stub; it may include the enrollment code and premium deduction.

Tell your providers -- especially druggists -- how to verify enrollments for federal enrollees who have not yet received their ID cards. Again, keep in mind that OPM does not maintain enrollment records for FEHB Program enrollees (except that the Retirement Services Program maintains annuitant records). Verify enrollment with the enrollee's employing office or retirement system. **When in doubt, always provide the service.**

Paying claims and providing benefits

The statement of benefits under the FEHB Program is Appendix A of your contract with OPM, that is revised annually based upon the benefits language that you negotiate with OPM. Your *OPM contract specialist* will work with you to help you develop your FEHB Program brochure. Your claims payment systems must be set up to pay claims according to the benefits structure in your FEHB Program brochure.

Coordinating benefits. Coordination of benefits is contractually required of all FEHB Program carriers to facilitate proper benefit payments and prevent excessive charges to the Program. We describe COB rules to enrollees in all brochures.

- Group health plans and no-fault auto insurance. Follow the order of precedence established by the National Association of Insurance Commissioners (NAIC) Model Guidelines for Coordination of Benefits appended to your OPM-carrier contract.

- Medicare. Follow the rules of the Social Security Law.

Most annuitants aged 65 and over are eligible for Medicare benefits under either Part A, Part B, or both. This number will increase in the future since all federal employees became subject to the Medicare withholding tax in 1983 and, hence, will be covered for benefits under Part A upon reaching the minimum age for Medicare qualification. **You may not require or expect federal annuitants to enroll in Medicare Part A or Part B.**

Disputed claims, inquiries and complaints. We will refer to you written complaints or inquiries that you should answer; we normally request a copy of your response.

Enrollees or another party acting on the enrollee's behalf with the enrollee's specific written consent to request a review may bring disputes concerning benefits or services to us at OPM for review after asking you to reconsider your initial denial and failing to obtain a satisfactory reply. The Health Insurance Group (HIG) will review the disputed claim to determine whether the enrollee or family member is entitled to the service or supply under the terms of the contract.

- Remember: You must inform the enrollee or family member of his or her right to have us review the denied claim if you, upon reconsideration, uphold your initial denial, in whole or in part.

When we receive a request for a review we will request the complete reconsideration file on the claim, i.e., all medical records and information the plan used to make its determination. By requesting our review of the claim, the member authorizes you to release medical information related to the claim. You must respond promptly, as directed. We will notify both the claimant and you of our decision, either affirming the denial or instructing you to pay the claim or provide the service.

Any litigation regarding a disputed claim decision by OPM must be initiated in a federal district court with OPM as the defendant.

You may <u>not</u> terminate an enrollment under the following circumstances:

- **Impaired doctor patient relationships and unacceptable behavior issues.** If you have a problem with an enrollee or family member you should handle it as you would with your other groups, short of termination. If you believe that the enrollment should be terminated, bring it to our attention and we will try to help resolve the problem.

- **When the member lives outside the service area.** An HMO need not enroll a person who lives outside the area you specify; however, after you accept such an enrollment, you cannot disenroll the person for living outside the area or if you reduce the service area. Further, an enrollee who moves out of the area an HMO serves MAY change to another plan. You may not disenroll the person; rather, you may tell the enrollee that, 1) out-of-area benefits are limited, and 2) a change to another plan may be made at any time after the move (although it is not required).

- **Fraud.** You cannot disenroll an employee for fraud or overinsurance. Further, although Government agencies do not have the statutory authority to terminate or suspend FEHB Program enrollments in cases of enrollee fraud, the federal government expects a high standard of conduct from its employees. Federal agencies are empowered to take disciplinary actions, including termination of employment, against employees who violate that standard. When you identify enrollee activity that appears to be fraudulent, such as making false statements regarding eligibility, submitting false claims for services not actually rendered, or altering prescription information, attempt to resolve the matter with the member. If the fraud is particularly egregious or substantial, or if attempts to resolve the matter are unsuccessful, contact the OPM Office of the Inspector General (OIG) at the FEHB Fraud Hot-Line for further investigation and possible criminal prosecution and/or administrative action.

The FEHB fraud hot-line
(202) 418-3300

You <u>may</u> terminate an enrollment or disenroll members as allowed by regulation:

- When an enrollee of an Employee Organization plan is not a member of the sponsoring organization.

- You may disenroll members in the following instances. Before you may disenroll such members, however, you must first send them a letter of notification that gives the members 31 days to present proof to you that their enrollment in your plan is still valid. At the end of this 31-day period, if you have not received such proof, you may then disenroll. Please refer to FEHB Carrier Letter 1999-07, dated February 9, 1999, for more details and examples of this notification letter. (See the carrier web page at www.opm.gov/carrier.)

    - When the payroll office cannot substantiate the validity of the enrollment.

    - When you receive reliable information that a self only enrollee is deceased.

    - When a child survivor annuitant under a self only enrollment turns age 22 and is not incapable of self-support.

    - When an enrollee notifies you that he is not employed by the federal government and is not entitled to an annuity that would make continued coverage possible.

In addition, see the FEHB handbook (www.opm.gov/insure/health) for complete information about other rules, such as family members you disenroll because of the following circumstances:

- A child loses eligibility for coverage when he or she marries or reaches age 22 (not including the 31 day extension for conversion), unless incapable of self support.

- A spouse loses eligibility when the marriage ends.

We put general information for enrollees about these circumstances in the FEHB brochures.

Reconciling enrollment records

You are obligated to reconcile with payroll offices until all enrollment discrepancies are resolved.

You are required to submit data, electronically, on your FEHB enrollments to the National Finance Center (NFC) every quarter. Your enrollment data is to be "as of" March 1, June 1, September 1, and December 1, and is to be received by NFC by the 19th of each of these months. Federal agencies are required to submit their enrollment data, at the same times, to NFC as well. OPM contracted with NFC to develop and then operate an Enrollment Reconciliation Clearinghouse, which we call "CLER" for short.

NFC then runs a computer match of the data and identifies discrepancies between the agency and carrier data. The discrepancies are reported to the responsible payroll office, who works with the appropriate human resources office to resolve the discrepancies. If it is determined that the carrier's records need correction, the agency will send corrective data to the carrier. The agency may convey this corrective data via phone, fax, mail, or email directly to the carrier, or electronically via the CLER web site. This electronic data is posted once quarterly via the Macon Hub for you to access and download, just as you access and download electronic enrollment files. Corrective data sent directly to you may come at any time. Carriers must then process the corrections, if they agree with them, and report back to NFC what action they took. If carriers disagree with the corrective data, they may contact the appropriate payroll office and discuss resolution of the discrepancy.

You may contact agency enrollment reconciliation personnel directly. The CLER web site contains contact person data for both agency and carrier personnel. You must have an ID and password to access this web site, however.

If you experience difficulties in using CLER, or have questions about using it, you may contact the CLER Operations Unit at NFC by calling (504) 255-3270.

Your responsibility to former enrollees

- **Extension of coverage without additional cost.** You must cover FEHB Program members, without additional cost, for 31 days after they lose FEHB Program coverage for any reason other than voluntary cancellation, to allow them time to arrange other coverage. The cost of providing this temporary extension of coverage is included in the premium. The 31 days can be extended up to 60 additional days for the individual who is hospitalized.

- **Temporary continuation of coverage (TCC).** You must enroll FEHB Program employees and family members when, under circumstances specified in the FEHB Program regulations, they are eligible for TCC and choose to enroll in your plan. (TCC coverage is similar to your other groups' continued coverage provisions. There are significant differences, such as the amount of time the extended coverage lasts. Do not try to apply non-TCC rules to the federal group.) The enrollee will have the 31-day extension of coverage both before and after the TCC coverage.

- **Former spouse coverage.** You must enroll former spouses of FEHB Program enrollees when, under certain circumstances specified in the FEHB Program regulations, they are eligible for coverage under the Spouse Equity Law (Section 8905(c) of title 5 United States Code) and choose to enroll in your plan. This coverage, unlike TCC, may continue indefinitely.

- **Conversion.** You must offer a non-group conversion policy to the individual who loses coverage under the Program and who, if eligible for TCC, either declined TCC or accepted TCC and has reached the end of his or her eligibility under TCC. The conversion opportunity during the 31-days free extension of coverage must be offered without evidence of insurability and without a waiting period.

- **HIPAA requirements.** When an enrollee loses coverage, you must issue a certification of coverage in accordance with regulations issued by the Center for Medicare and Medicaid Services. The certification is required by the Health Insurance Portability and Accountability Act of 1996 *(HIPAA)*.

To learn more about these rules, see the FEHB handbook at www.opm.gov/insure/health.

Financing and audit

Information about rate setting, payment and audit

The FEHB Program law and regulations permit OPM to contract with carriers on either an experience-rated basis or a community-rated basis.

In March we send you a package of instructions for preparing your upcoming year's rates. You will receive a new package of rate instructions each year by way of an FEHB Program carrier letter. The entire contracting process -- from determining the rate, to paying premiums to you, and your reports -- depend on whether you are a community-rated or experience-rated plan. This section provides general descriptions of both types.

As provided under FEHB Program law and regulations, health benefits premiums paid by enrollees include the net-to-carrier amounts agreed upon by OPM and participating carriers, plus amounts for OPM's administrative expenses and for carrier contingency reserves.

Key facts about your premium -- all rate types

Biweekly net-to-carrier rate: You will work with OPM's Actuarial staff to settle on Self Only and Self and Family biweekly net-to-carrier rates. This is the negotiated amount set aside for you. This amount is documented in the rate negotiation "closeout" letter we send to you at the end of contract negotiations.

Contingency reserve: We establish and hold a contingency reserve for your use. We increase the net-to-carrier rate by three percent and set that amount aside in the contingency reserve for your plan. In addition to the three percent that flows into the reserve continuously, funds are added to the reserve from other sources. For instance, funds are added from interest earned on the account, a proportionate share from any disbursement of unused OPM administrative reserve funds, and a proportionate share of the disposition of funds from discontinued plans. The contingency reserve is an FEHB asset, not the carrier's.

Administrative reserve: We increase your net-to-carrier rate by one percent to pay our administrative costs. We periodically prorate and transfer unused administrative reserves to your and other carriers' contingency reserves.

Gross rate: The gross rate, shown in the OPM press release as the Total Premium, is the

net-to-carrier rate increased by 4% for the administrative and contingency reserve loads. The amount actually paid by the federal enrollee is the gross rate reduced by the amount of the Government contribution.

The Government contribution. The maximum amount that the Government contributes toward the cost of health benefits is determined each year, according to the FEHB Program law. The Government contribution is not more than 75 percent of the total premium of any one plan, except that the United States Postal Service contribution can go higher, according to their labor agreements.

The amount of the Government contribution toward any individual enrollment is determined by the enrollee's relationship to the Government. A full-time General Schedule employee will receive the full Government contribution (up to the dollar maximum or 75% of the gross premium). A part-time employee will receive a prorated contribution. Most TCC enrollees and individuals with Former Spouse coverage receive no Government contribution, as is the case with temporary enrollees. These differences will have no impact on you, however, because the enrollee and Government shares are combined before the premiums are forwarded to you.

Enrollee share. The amount that is deducted from the enrollee's pay or annuity check is also determined by the number of days in his or her pay period. After rate negotiations are completed, we publish the employee share and Government contribution toward the premium rates in our September press release about the upcoming open season. At open season, we publish the enrollees' share of the rates for the various enrollment types (e.g., employee, retiree, TCC/former spouse, USPS).

Community-rating

Community-rating in the FEHB Program is a prospective rating method having several forms. Traditional community-rating (TCR) bases the rate for each group on an underlying community-wide capitation (per-member/per month) rate. Community-rating by class (CRC) allows rate adjustments based on the age/sex distribution of each group. Adjusted community-rating (ACR) allows the use of the experience of the particular group.

> **ALERT!** It is important that you fully appreciate the implications of contracting on a community-rated basis. Community rates must be accurate. Defective rates must be corrected by returning any excessive premiums to the FEHB Program. If a higher rate results because you furnish incomplete, inaccurate, or outdated cost or pricing data, **or because you developed our rates with a rating methodology and structure inconsistent with that used to develop rates for your similarly sized subscriber groups**, or you furnished information or data of any description that were not complete, accurate, and current, then the rates must be reduced by as much as they were increased because of the defective data or information and repaid to the Government in a lump sum payment. Further, we will charge interest when you submit defective cost or pricing data and may charge an additional penalty if the submission of the defective data was a knowing submission.

Developing your FEHB Program rate. Our actuaries review your rate proposal and resolve any conceptual or technical problems through telephone discussions with you. Agreement on a net-to-carrier rate is reached between you and the actuaries and is summarized in a letter to you. You must confirm your rates in writing.

> **ALERT!!** FEHB Program premiums are exempt from locally imposed premium taxes. No community-rated carrier may include premium taxes in its community rates.

Rate reconciliation for the community-rated carrier. You submit your rate proposal seven months before the rates take effect, so the proposed FEHB Program rate is based on an estimated community rate. We will perform a reconciliation before setting next year's rate to assure that the premium rate for this year is based on your actual community rate. Such reconciliation will simply be a re-submission of this year's proposal, using the actual community rate instead of the estimate you used in the proposal. Enrollment mix and other demographic assumptions usually must remain the same as in your original proposal.

How the contingency reserve affects your rate. Your premium is divided into 104

parts: 100 parts consist of your biweekly net-to-carrier rate, one part is for deposit to an administrative reserve, and the remaining three parts are for deposit to a contingency reserve for your plan. Thus, your published premium rate (your total premium) is your net-to-carrier rate times 1.04.

The funds assigned to your contingency reserve belong to the FEHB Program, not the carrier, and are used for the benefit of the enrollees who contributed them. The contingency reserve funds set aside for the plan may be used to defray future premium increases or reduce contributions by the Government or enrollees or to increase benefits. When we find during the rate reconciliation that your actual rates are higher than your estimated rates were, we may make up the difference from your contingency reserve when sufficient funds are available. (If the contingency reserves are insufficient, OPM increases the next year's rate.)

Preferred minimum balance for the community-rated plan. The contingency reserve must be kept at a minimum balance based on the average subscription income paid to you from the Employees Health Benefits Fund during the prior year. The preferred minimum balance for a community-rated plan is one month's premium. If you are a new carrier, our actuaries estimate the preferred minimum balance based on OPM's projection of your plan's ending contingency reserve balance. The target level of reserves is your preferred minimum balance. If the contingency reserve set aside for your plan exceeds its preferred minimum balance, our policy is to return the excess to the federal enrollees who contributed the extra three percent of premium to this reserve. We accomplish this by reducing the negotiated rate.

Rate Loadings. We allow standard loadings to your rate for program requirements (such as our Medicare and 31-day free extension of coverage loadings) and, occasionally, we allow special benefit loadings.

About the Medicare loading for community-rated plan carriers - A community-rated carrier usually benefits financially from those retired federal enrollees age 65 and over who are also covered under Parts A and B of Medicare because, through coordination of benefits or some other arrangement with CMS, you receive reimbursement in addition to the FEHB Program premium. On the other hand, you may lose money on enrollees age 65 and over who are not covered under Medicare. We allow for a Medicare loading to remedy a possible cost disparity. If you experience an overall loss because of such enrollees, we allow a positive loading. Similarly, an overall gain requires a negative loading.

You derive the loading using actual cost and enrollment data; therefore, **it is important that you closely monitor your experience with federal enrollees who are covered under Medicare.** (The rate package we send to community-rated plan carriers will

include a *Community-Rate Questionnaire* with detailed instructions and information.)

For more detail about the rate setting process for the community-rated carrier, see your rate reconciliation instructions and your rate proposal instructions.

Performance review. At the end of each contract year, we will review the community-rated carrier's performance to determine if there were areas that did not meet our goals of acceptable performance in administrative or customer service areas. If a performance element is deficient we will notify you.

Experience-rating

Experience-rating in the FEHB Program is retrospective, that is, gains and losses are carried forward in the next year's premium. Premium is based on the specific claims of the carrier's federal enrollees. Experience-rating in the FEHB Program contemplates that any excess of premium over obligations and agreed-upon profit with respect to the federal group will be returned to the group, or held for the group's benefit.

Developing your FEHB Program rate. If you are a new experience-rated carrier, we will purchase your community package of benefits and adjust it as needed during negotiations. If you are a fee-for-service carrier or an experience-rated HMO that has been in the FEHB Program at least one contract term, your gains and losses from the previous year are carried forward. Your premium will be adjusted depending on the amount of the contingency reserves OPM holds for your plan, the accrued claims reserve you hold, and the positive or negative difference between your income and expenses (special reserve).

Our Actuarial staff review your rate proposal and resolve any conceptual or technical problems through telephone discussions with you. You and the actuaries agree on a net-to-carrier rate and the actuaries summarize the agreement in a letter to you. You must confirm your rates in writing.

Service charge. Experience-rated plans may receive a profit referred to as a "service charge." The service charge is determined by a weighted guidelines method in which we apply several factors to projected incurred claims and allowable administrative expenses. The factors include the carrier's performance, share of cost risk, efforts at advancing federal socioeconomic programs, capital investments not allowable as administrative expenses, efforts to control costs, and independent development that is of demonstrated value to the FEHB Program. OPM does not guarantee a minimum service charge.

FEHB Program costs. Costs allowed to be charged to your experience-rated contract are the actual, necessary and reasonable amounts you incur as determined in accordance with the contract, the FAR, and FEHBAR. Contract costs consist of benefit costs and administrative costs. Benefit costs consist of the payments you make and the liabilities you incurred for covered health care services on behalf of FEHB Program members, less any refunds, rebates, allowances or other credits you receive. Administrative costs are all allocable, allowable, and reasonable expenses you incur in the adjudication of member

benefit claims or in your overall operation of the contract. Administrative expenses generally include such things as taxes (excluding premium taxes), insurance and reinsurance premiums, medical and dental consultants used in the adjudication process, utilization review, carrier personnel, equipment, and facilities directly used in the delivery of health care services, and the expense of managing the FEHB Program investment program. Administrative expenses are subject to a limitation, or a ceiling, which is negotiated each year and included in experience-rated contracts.

> **ALERT!!** FEHB Program premiums are exempt from locally imposed premium taxes. No experience-rated carrier may charge premium taxes to its contract.

Reserves. *Reserves* affect your rate. Your experience-based rates are calculated considering three types of reserves specific to each experience-rated carrier: 1) the contingency reserve we hold; 2) the accrued claims reserve you hold to pay claims that have been incurred to date but are not yet paid; and 3) the special reserve (i.e., the positive or negative difference between your income and expenses).

Your *total income* comes from the FEHB Program premiums, plus the yield on investments, plus any payments we authorize from the contingency reserve. Your *total outgo* goes to benefit expenses and the administrative expenses you incur in connection with your FEHB Program contract. Total income, plus last year's ending special reserve, minus the total outgo produces this year's ending special reserve balance.

If the sum of the contingency reserve and special reserve is in excess of a targeted reserve balance, the premium is set low so excess reserve funds will be drawn down. If, on the other hand, experience has been greater than expected and the reserves are less than the targeted reserve balance, the premium will be increased to replenish the reserve funds. In this manner, gains and losses are carried forward from year to year.

Preferred minimum balance for the experience-rated carrier. The contingency reserve must be kept at a preferred minimum balance. The preferred minimum balance for an experience-rated carrier is one and one-half times an average month's paid claims and expenses. If you are a new experience-rated HMO, our actuaries estimate the preferred minimum balance based on the average paid claims and administrative expenses obtained from your latest annual accounting statement. (The target level of all reserves for an experience-rated carrier is three and one-half months.) A new carrier typically takes three or four years to accumulate the preferred minimum balance. Excess funds are drawn down, as negotiated with OPM.

Investment of excess funds. You are required to invest and reinvest all FEHB Program funds on hand, including any in the special reserve or any attributable to the reserve for incurred but unpaid claims, that are in excess of the funds needed to discharge promptly the obligations incurred under the contract.

For more detail about the rate setting process for the experience-rated carrier, see your rate proposal instructions.

How we pay premiums to you

The agency payroll office withholds premiums from employees' salaries, adds the Government contribution and each pay period sends the amount to the Employees Health Benefits (EHB) Fund maintained by the U.S. Treasury. At that time, the payroll office electronically transmits employee benefit program information to OPM's Retirement and Insurance Transfer System (RITS) on the "Report of Withholdings and Contributions for Health Benefits, Life Insurance, and Retirement" (SF 2812 and SF 2812A). Health benefits funds are invested in U.S. Treasury securities until needed for payments. When the EHB Fund receives the withholdings and Government contributions from the payroll offices, three one-hundred-and-fourths of the amount is credited to the plan's contingency reserve. One one-hundred-and-fourth is set aside in an administrative reserve for payment of administrative expenses. The remaining net premiums are credited to the respective carriers.

Community-rated carriers. We send your and other community-rated carriers' payments bimonthly based on the amount of premiums collected during the deposit/collection period, as follows:

- Premiums collected in the Fund during the first 15 days of the month are sent on the fourth Thursday of the month.

- Collections from the 16th through the end of the month are sent on the second Thursday of the following month.

The transfer of premiums from the Fund to you is accomplished through the Automated Clearing House Vendor Payment System. This system transfers funds directly into your account in a commercial bank.

Experience-rated carriers. Premium payments to experience-rated carriers are made through a Letter of Credit (LOC) arrangement. We use a computer program that allows you to create LOC requests and electronically send them to us for payment.

NOTE: Your contract requires that you draw funds on a "checks presented" basis, and that you not commingle FEHB money with other corporate accounts. We will send you a *carrier user manual* for the LOC. Consult it to see when you can draw down from your account.

Regardless of whether you are **community-rated or experience-rated**, if you change banks, or if certain bank information changes, you must notify OPM's financial management staff.

We send a "payment advice" to you before each transfer. This advice shows the payment amount to be transferred. The first transfer is about 45 days after the effective date of your first enrollments. The 45-day lag period will exist indefinitely.

Please remember your premium payments are based solely on the amount of funds submitted by payroll offices in a specific time period. **Do not bill OPM or agencies for premiums.** Remove the FEHB Program from any automatic billing system. If you have a problem regarding a payment, contact OPM's financial management staff.

Maintain accurate records by payroll office. Payroll offices collect premiums. Money moves on a payroll office basis. You will need to reconcile your FEHB Program enrollment records on a payroll office basis.

Improving Carrier Performance

Through the FEHB regulations, we have an initiative to improve community-rated carrier customer service and contract compliance to ensure high quality customer service to Federal Employees Health Benefits (FEHB) enrollees. We established a performance evaluation program that will hold community-rated carriers accountable for their performance in such areas as timely closure on rates and benefits, providing customer information, meeting customer service performance standards, cooperation in surveys, reconsideration and disputed claims, and informing OPM of significant events. In addition, the FEHBAR *Payments* clause for both community-rated and experience-rated carriers enables OPM to withhold monies from premium payments for other contractual obligations.

Onsite audits

The OPM Office of the Inspector General (OIG) periodically audits all carriers. When you are chosen for review, the auditors generally will notify you 60 days in advance and ask you to furnish them with background information. Agendas of the visits vary for experience and community-rated carriers. (While the auditors try to give at least 60 days notice on most audits, rate reconciliation audits may have only 2 weeks' notice and there may be circumstances where even less advance notice can be provided.)

Community-rated carriers' records are reviewed to determine whether the rate charged to the FEHB Program was developed according to the contract, the FAR, and the FEHBAR. Routine community-rated carrier audits consist of two types: a) an historical audit that generally covers 5 contract years; and b) a rate reconciliation audit that covers only the current year's proposed rate reconciliation. Both types of audits will analyze your methodology and supporting documentation underlying the federal premium rates (with emphasis on similarly sized subscriber group issues), including the special benefits and loadings. The auditors will also evaluate your financial and managerial resources and your ability to fulfill your FEHB Program contract obligations.

Experience-rated carriers' financial and claims records are reviewed to determine whether the carrier charged expenses to the contract in accordance with the contract, the FAR, and the FEHBAR. Specific review areas may include coordination of benefits, cost containment efforts, economy and efficiency reviews, and the allowability, allocability and reasonableness of costs.

All audits encompass carrier fraud and abuse detection and prevention procedures, as well as a review of internal controls.

Financing when the plan terminates

Community-rated carriers. If the community-rated carrier leaves the Program on December 31, we generally will make two premium payments in January and retain any premiums received after that for a final distribution. We do not pay the remaining premiums until we determine that federal agency payroll offices' adjustments for premiums submitted in error or for other purposes are clear. We will review the final amount due and, if the carrier has no outstanding audit findings, we will pay the remaining premium to the carrier. You must make sure we have proper information such as banking information for such payments to be made. When the contract terminates, the carrier is not entitled to contingency reserve funds except in certain limited circumstances.

Experience-rated carriers. When OPM withdraws approval for a plan or a plan terminates its operations under the FEHB Program, we require a final comprehensive close-out accounting statement. A discontinued experience-rated carrier may initiate the close-out process after sending us written confirmation that all claims and administrative expenses pertaining to your last year in the Program have been paid.

It will take at least a year to run out all claims after the contract terminates. If we do not receive your request for close-out instructions within a reasonable time -- generally two years -- after the contract terminates, we will initiate the close-out process.

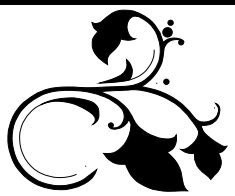
After receiving your request for close-out instructions, OPM's financial management staff sends you a specific set of financial information and accounting instructions, to be responded to within 60 days of receipt. We will review your submission to ensure it is complete and prepared in conformity with the close-out instructions.

For more information about termination of contracts under the FEHB Program, see the law (sections 8902(a) and (e) of title 5 of the United States Code) and the regulations (Part 1649 of Title 48 of the Code of Federal Regulations).

Residual contingency reserve funds for discontinued community-rated and experience-rated plans are distributed to the remaining plans in the Program.

Reporting

Information we need from you



Specific FEHB Carrier reporting requirements and report forms are available on the carrier web page at www.opm.gov/carrier.

Reports

According to the FEHB Program regulations, you must furnish "such reasonable reports as OPM determines to be necessary to carry out its functions under the FEHB Program law." For instance, we need you to keep us informed about your enrollment, demographics, financial activity, compliance with FEHB Program quality assurance standards, the incidence of fraud and abuse, and actions regarding debarred providers.

- **Enrollment.** New carriers receive a package of reporting requirements in January or February of their first year of participation in the FEHB Program. One enrollment report will be due shortly thereafter and then due annually. The report form and its due dates will be sent to you.

- **Demographics.** You will collect and annually report certain information on all enrollees and dependents, as specified by our actuaries; our actuaries will send you the record layouts listing the enrollment/demographic data you will need to collect and report to them.

- **Financial reports -- community-rated carriers**. You will submit two copies of your annual Certified Public Accountant's Report covering the carrier's financial operations -- one for your *OPM contract specialist* and the other for OPM's financial management staff. From time-to-time, we will ask for additional revenue/expenses data, but usually only in summary form.

- **Financial reports -- experience-rated carriers**. You also will submit your annual Certified Financial Statements. As directed by OPM's financial management staff, you will submit an annual accounting statement according to the FEHB Audit Guide. From time-to-time, we will ask for other information concerning FEHB Program financial operations.

- **Quality assurance**. You will report annually on your performance on the quality assurance standards required by your FEHB Program contract.

- **Fraud and abuse**. You will report semi-annually to the Office of the Inspector General on the number, type, and disposition of fraud cases pursued during the preceding six months and the number of emerging fraud cases. As a related matter, you will contact OPM's Office of the Inspector General and Insurance Services Program about investigative actions, settlement agreements, and subpoenas pertaining to incidents of fraud or abuse that meet certain criteria.

- **Debarred providers**. You will report semi-annually to OPM's Office of the Inspector General (OIG) on the actions you take in connection with providers barred from participation in the FEHB Program. The OIG will write to you directly about this report.

Certifications, agreements, and forms

- **Payments to influence certain federal transactions**. You submitted this certification before your first year of contracting. Subsequently, if funds are used to exert influence on any federal contract, grant, loan, or cooperative agreement in connection with this contract, submit Standard Form (SF) LLL, Disclosure of Lobbying Activities. SF LLL is in your FEHB Program contract.

- **Drug-free workplace**. You submitted this certification before your first year of contracting.

- **Procurement integrity**. You submitted this certification before your first year of contracting.

- **HIPAA**. Under Public Law 104-191 (Health Insurance Portability and Accountability Act of 1996) you will issue a certification of coverage for enrollees in accordance with regulations issued by the HHS Center for Medicare and Medicaid Services.

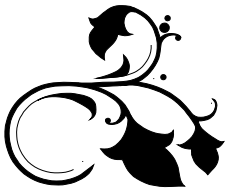
- **Medicare data release agreement** to safeguard enrollee information we send you in connection with the annual match of enrollment records done between Retirement Services Program's annuitant rolls and the Social Security Administration rolls. You submit this form during your first contract year and update it as directed.

- **Plan contracting officials form**. Through the year, please notify your *OPM contract specialist* when any of the various addresses on the form changes.

Specific FEHB Carrier reporting requirements and report forms are available on the carrier web page at www.opm.gov/carrier.

Information updates

See the carrier web page



The most current source for information about your participation in the Federal Employees Health Benefits Program is the carrier web page -- www.opm.gov/carrier, particularly FEHB Carrier Letters.

We also suggest that you attach FEHB Carrier conference materials. The 2003 FEHB Carrier conference was held March 6-7, 2003, in Washington, DC.

Attach Carrier Conference materials at back.

Acronyms we use

ACR - Adjusted Community Rating

AD - the Assistant Director for Insurance

BAL - Benefits Administration Letter

CIS - Carrier information system

CLER - Enrollment Reconciliation Clearinghouse

CFR - Code of Federal Regulations

CMS - HHS' Center for Medicare and Medicaid Services

CRC - Community Rating by Class

CSRS - Civil Service Retirement System

DoD - Department of Defense

EHB Fund - Employees Health Benefits Fund

FAR - Federal Acquisition Regulation

FEHBAR - Federal Employees Health Benefits Acquisition Regulation

FEHBP - Federal Employees Health Benefits Program

FERS - Federal Employees Retirement System

FFS - Fee-for-service plan/carrier

FY - Fiscal Year

GAO - General Accounting Office

GPO - Government Printing Office

HHS - U.S. Department of Health and Human Services

HIG - ISP's Health Insurance Group

HIPAA - Health Insurance Portability and Accountability Act of 1996

ISP - OPM's Insurance Services Program

HMO - Health Maintenance Organization

LOC - Letter of Credit

NAIC - National Association of Insurance Commissioners

PIN - Personal identification number

OIG - OPM's Office of the Inspector General

OIP - Office of Insurance Programs, now the Insurance Services Program

OMB - Office of Management and Budget

OPM - United States Office of Personnel Management

RSP - Retirement Services Program

PBR - Patient Bill of Rights

PDF - Portable Document File

PPEG - ISP's Program Planning and Evaluation Group

RIS - Retirement and Insurance Service, now the Center for Retirement and Insurance Services

RITS - OPM's Retirement and Insurance Transfer System

SF - Standard Form

SSA - Social Security Administration

TCC - Temporary Continuation of Coverage

TCR - Traditional Community Rating

USC - United States Code

USPS - United States Postal Service