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**FEHB Program Carrier Letter**  
**DoD Demonstration**  
**Community-rated Carriers**

U.S. Office of Personnel Management  
Office of Insurance Programs

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**Letter No. 2000-19**

**Date: May 1, 2000**

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Fee-for-service [--] Experience-rated HMO [--] Community-rated [19]

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**SUBJECT: 2001 RATE INSTRUCTIONS**

DoD Demonstration Project -- Community Rated Carriers

The Department of Defense (DoD) has entered into an agreement with the Office of Personnel Management (OPM) to conduct a demonstration project in which Medicare eligible DoD beneficiaries may enroll in health benefit plans offered through the Federal Employees Health Benefit Program (FEHBP). The project will run for three years from January 1, 2000, through December 31, 2002.

Ten sites have been selected for the project, with a limit of 66,000 eligible people. Based on the sites selected, your plan is eligible to participate in the DoD demonstration.

We are enclosing the following:

1. A chart which shows the eligible DoD population over age 65 broken down by site, age, and sex for the ten sites.
2. Documents which, when you have completed and returned them to OPM, will constitute your 2001 rate proposal for the DoD group. The rate instruction document entitled "DoD Rating Guidelines – 2001" is an overall view of the rating policy for 2001.

You must submit your rate proposal and the completed Attachments A, B, B1, and C by the regulatory deadline: **May 31, 2000.**

Please send one copy of your rate submission to this address:

Ms. Nancy H. Kichak  
Director, Office of Actuaries  
Office of Personnel Management  
1900 E Street, NW., Room 4307  
Washington, DC 20415-0001

Please send a second copy to this address:

If by regular mail:

Frank D. Titus  
Assistant Director for Insurance Programs  
Office of Personnel Management  
P.O. Box 707  
Washington, DC 20044-0707

If by overnight delivery:

Frank D. Titus  
Assistant Director for Insurance Programs  
Office of Personnel Management  
1900 E Street, NW, Room 3424  
Washington, DC 20415-0001

Please direct your questions about the 2001 DoD rate submission to Sherry Simon at (202) 606-4119, or at [actuary@opm.gov](mailto:actuary@opm.gov) (e-mail).

Sincerely,

{signed}

Frank D. Titus  
Assistant Director  
for Insurance Programs

Enclosures

## **Table Of Contents**

### **DoD Group Rating Guidelines - 2001**

This discusses OPM's rating policy for DoD demonstration project groups for the 2001 rate year.

### **Attachment A**

This is the DoD demonstration project rate questionnaire. All carriers participating in the DoD demonstration project must complete it and submit it to OPM.

### **Attachment B**

The rate proposal sheet. All carriers participating in the DoD demonstration project must complete this form and submit it to OPM.

### **Instructions for Attachment B**

This gives line-by-line instructions for completing Attachment B.

### **Attachment B-1**

This is a backup sheet on which you provide details of your rate proposal.

### **Attachment C**

This requests the names, telephone and fax numbers of two persons we can contact about your rate proposal. All carriers must submit this form to OPM.

## DoD Demonstration Group Rating Guidelines - 2001

### General Policy For the 2001 Rate Year

The FEHBP has relied on Similarly-Sized-Subscriber Groups (SSSG's) over the last several years to ensure that the Federal Group's rate is equivalent to rates charged similar groups in the private sector. Since most of the enrollees covered by the DoD demonstration project (hereafter called the DoD Demo) will be annuitants over age 65 and will be covered under both Medicare Part A and Part B, the FEHBP plan provided under the DoD Demo will serve mainly as a Medicare supplement policy. We believe it will be difficult for the carrier to find similar employer-sponsored plans for comparison to the DoD group. Therefore, we will not use SSSG's for purposes of comparing rates under the DoD Demo.

Our goal, however, remains to obtain competitively priced premiums developed using a commercial rating methodology in use for pricing similar type products. Therefore, in your rate proposal, you must show that a group covered under the DoD Demo is charged rates equivalent to the rates paid by other groups for similar benefits.

To establish a benchmark for the premium for the DoD Demo group, we request information on the following two types of products your plan may offer:

1. Medicare Risk Contracts
2. Medicare Supplement Policies

You may develop the DoD Demo premium using any method you believe is reasonable. **You must fully document this method.** You must justify any differences between your proposed DoD Demo premium and the premium you charge for either a Medicare risk contact or a Medicare supplement policy.

## Attachment A

### DOD DEMONSTRATION PROJECT RATE QUESTIONNAIRE

Questions 1 through 7 pertain to carriers that have a Risk contract with HCFA. If you have more than one risk contract, answer all questions based on the risk contract with the lowest rate for enrollees under that risk contract.

Q1. Does your plan offer a risk contract?

- YES
- NO

If YES, what is the ACR you filed with HCFA?

ACR = \_\_\_\_\_

**Important: Be sure to submit with this proposal a copy of the ACRP spreadsheet you submitted to HCFA with the above ACR on it.**

If NO, Go To Q8.

Q2. What is the bi-weekly self rate that you charge enrollees under your risk contract?

Rate = \_\_\_\_\_

Q3. Are there benefits covered under the DoD Demo benefits package that are **not** covered under the risk contract package?

- YES
- NO

**Attachment A**

Q4. If the answer to Q3 is YES, list these benefits and the bi-weekly self cost for each. Explain in detail how you arrived at each cost. Include all relevant information such as cost and utilization data. Use additional sheets if necessary.

| Benefit | Biweekly Self Cost |
|---------|--------------------|
| 1.      |                    |
| 2.      |                    |
| 3.      |                    |
| 4.      |                    |
| 5.      |                    |
| 6.      |                    |

Total Cost = \_\_\_\_\_

Q5. Are there benefits covered under the risk contract package that are **not** covered under the DoD Demo benefit package?

- YES
- NO

Q6. If the answer to Q5 is YES, list these benefits and the bi-weekly self cost for each. Explain in detail how you arrived at each cost. Include all relevant information such as cost and utilization data.

| Benefit | Biweekly Self Cost |
|---------|--------------------|
| 1.      |                    |
| 2.      |                    |
| 3.      |                    |
| 4.      |                    |
| 5.      |                    |
| 6.      |                    |

Total Cost = \_\_\_\_\_

## Attachment A

Q7. The bi-weekly self cost for the DoD Demo benefits package based on the Risk contract cost is based on the costs in Q2, Q4 and Q6. Show below what this is.

**DoD Premium (Risk Contract Based) = Q2+Q4-Q6 = \_\_\_\_\_**

This cost will be the first benchmark for persons with A and B coverage.

Questions 8 through 14 pertain to carriers that offer a Medicare Supplement policy. If you offer more than one type of Medicare Supplement policy, answer all questions based on the one with the lowest rate for those who purchase it.

Q8. Does your plan offer a Medicare supplement policy?

- YES
- NO

If NO, go to Q15

Q9. What is the bi-weekly self rate that you charge enrollees who purchase a Medicare Supplement policy?

Rate = \_\_\_\_\_

Q10. Are there benefits covered under the DoD Demo benefits package that are **not** covered under the Medicare supplement policy?

- YES
- NO

**Attachment A**

Q11. If the answer to Q10 is YES, list these benefits and the bi-weekly self cost for each. Explain in detail how you arrived at each cost. Include all relevant information such as cost and utilization data. Use additional sheets if necessary.

| Benefit | Biweekly Self Cost |
|---------|--------------------|
| 1.      |                    |
| 2.      |                    |
| 3.      |                    |
| 4.      |                    |
| 5.      |                    |
| 6.      |                    |

Total Cost = \_\_\_\_\_

Q12. Are there benefits covered under the Medicare Supplement policy that are **not** covered under the DoD Demo benefit package?

- YES
- NO

Q13. If the answer to Q12 is YES, list these benefits and the bi-weekly self cost for each. Explain in detail how you arrived at each cost. Include all relevant information such as cost and utilization data. Use additional sheets if necessary.

| Benefit | Biweekly Self Cost |
|---------|--------------------|
| 1.      |                    |
| 2.      |                    |
| 3.      |                    |
| 4.      |                    |
| 5.      |                    |
| 6.      |                    |

Total Cost = \_\_\_\_\_



## Attachment A

Q14. The bi-weekly self cost for the DoD Demo benefits package based on the Medicare supplement policy cost is based on the costs in Q9, Q11 and Q13. Show below what this is.

**DoD Premium (Supplement Based)= Q9+Q11-Q13 = \_\_\_\_\_**

This cost will be the second benchmark premium for persons with A and B coverage.

Questions 15 through 27 are for all carriers.

Q15. Do you have any other benchmark premiums for persons with Medicare Parts A and B coverage?

- YES
- NO

If YES, please give details below.

Q16. Are you basing your DoD Demo proposal solely on the premiums shown in either Q7 or Q14?

- YES
- NO

**Attachment A**

Q17. What do you estimate is the total bi-weekly cost (without reimbursement from HCFA) per person to provide the FEHB benefits for the DoD enrollees? Give below a detailed explanation of how you arrived at this cost. Include additional sheets if necessary.

Total Cost = \_\_\_\_\_

**Attachment A**

Q18. How much (average per person) are you reimbursed bi-weekly from HCFA for individuals covered under Medicare Part A?

Reimbursed Amount (Part A) = \_\_\_\_\_

Q19. How much (average per person) are you reimbursed biweekly from HCFA for individuals covered under Medicare Part B? Give below a detailed explanation of how you obtain this amount.

Reimbursed Amount (Part B) = \_\_\_\_\_

Q20. For carriers with risk contracts with HCFA, what is your bi-weekly Revenue Requirement (i.e. the ACR x 12/26). Use ACR on line 17 of the ACRP spreadsheet.

ACR x 12/26 = Biweekly Revenue Requirement = \_\_\_\_\_

Q21. For carriers with risk contracts, is the cost in Q17 equal to the cost in Q20 plus the cost in Q4 minus the cost in Q6? That is, does **Q17 = Q20+Q4-Q6**?

- YES
- NO
- N/A

If NO, explain.

**Attachment A**

Q22. For carriers offering a Medicare Supplement policy, is the cost in Q17 equal to the cost in Q14 plus the cost in Q18 plus the cost in Q19?

That is, does **Q17 = Q14+Q18+Q19?**

- YES
- NO
- N/A

If NO, explain.

Q23. Your total cost for DoD enrollees with Medicare Parts A and B should be the total cost you stated in Q17 minus the HCFA reimbursements you stated in Q18 and Q19. That is,

$$\text{Total Cost} = \text{Q17} - \text{Q18} - \text{Q19}.$$

Is this true?

- YES
- NO

If NO, explain why. Also, state what the cost is and give a detailed explanation of how you derived it. Use additional sheets if necessary.

**Attachment A**

Q24. Your total cost for DoD enrollees with Medicare Part A only should be the total cost you stated in Q17 minus the HCFA reimbursement you stated in Q18.

That is

$$\text{Total Cost} = \text{Q17} - \text{Q18}$$

Is this true?

- YES
- NO

If NO, explain why. Also, state what the cost is and give a detailed explanation of how you derived it. Use additional sheets if necessary.

Q25. What percentages of DoD enrollees who sign up for your plan do you assume will have Part A coverage only?

Percentage = \_\_\_\_\_

Q26. **Example**

The following is an example of how to derive the final rates by taking a weighted average of the rate for persons with Medicare Parts A and B and the rate for persons with Medicare Part A only.

|                | Percent Covered | Self Premium | Family Premium |
|----------------|-----------------|--------------|----------------|
| 1. Parts A & B | 90              | \$100        | \$200          |
| 2. Part A only | 10              | \$150        | \$300          |

$$\text{Self Rate} = [(.90 \times 100) + (.10 \times 150)] = \$105$$

$$\text{Family Rate} = [(.90 \times 200) + (.10 \times 300)] = \$210$$

**Attachment A**

Q27. Following the example in Q26, fill in the table below using the following information:

1. The percentage covered under Medicare Part A only as stated in Q25.
2. The cost for persons covered under Medicare Parts A and B as stated in either Q7, Q14, or Q23.
3. The costs for persons covered under Medicare Part A as stated in Q24.

|                | Percent<br>Covered | Self<br>Premium | Family<br>Premium |
|----------------|--------------------|-----------------|-------------------|
| 1. Parts A & B | _____              | _____           | _____             |
| 2. Part A only | _____              | _____           | _____             |

Following the example in Q26, compute the rates.

Self Rate =

Family Rate =

From which question does the amount in line 1 come from?

Q7, Q14 or Q23.      **(Circle One)**

**Attachment B**

**PROPOSED BI-WEEKLY NET-TO-CARRIER RATES  
FOR DoD ENROLLEES FOR THE 2001 RATE YEAR**

**Carrier NAME:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **CODE:** \_\_\_\_\_

|  | <u>SELF</u> | <u>FAMILY</u> |
|--|-------------|---------------|
| 1. Proposed DoD Group Rates<br>For January 1, 2001<br>(Without Prescription Drugs) | _____       | _____         |
| 2. Prescription Drugs  | _____       | _____         |
| <b>3. Total Rates [(1)+(2)]</b>  | _____       | _____         |
| 4. Extension of Coverage Loading<br>[.004 x (3)]                                   | _____       | _____         |
| <b>5. Subtotal [(3)+(4)]</b>   | _____       | _____         |
| 6. Enrollment Discrepancy Loading<br>[.01 x (5)]                                   | _____       | _____         |
| <b>7. Proposed DoD Rates for 2001<br/>[(5)+(6)]</b>                                | _____       | _____         |

## Instructions For Attachment B

### 1. Proposed DoD Group Rates for January 1, 2001 (Without Prescription Drugs)

This is the carrier's proposed 2001 bi-weekly self and family rates for the DoD group (excluding prescription drugs).

You must show in detail how you obtained the Line 1 rates. We provide work space for this in Attachment B-1 (DoD ENROLLEE RATE PROPOSAL BACKUP SHEET).

### 2. Prescription Drugs

This is the proposed 2001 bi-weekly self and family prescription drug rates for the DoD group.

### 3. Total Rates

The sum of lines 1 and 2.

### 4. Extension of Coverage Loading

Each carrier in the FEHBP must provide the following coverage without charge to the enrollee or employing agency:

1. Employees terminated from employment have 31 days additional coverage.
2. Employees or dependents confined in a hospital on the 31st day after termination have coverage continued until discharge, up to a maximum of 91 days after termination.

These coverage requirements apply whether or not the enrollee later converts his or her group coverage to an individual contract with the carrier.

We recommend a loading of .4 percent of the proposed rate for this benefit. Unless you have specific experience to justify another figure, or the community rate includes the coverage, you should use .4 percent of line 3.

### 5. Subtotal

The sum of lines 3 and 4.



## **Instructions For Attachment B**

### **6. Enrollment Discrepancies Loading**

This is a special 1% load to the rates which compensates the carrier for possible enrollment discrepancies.

### **7. Proposed DoD Group Rates For 2001**

The sum of lines 5 and 6.

## Attachment B-1

### DoD ENROLLEE RATE PROPOSAL BACKUP SHEET

Please provide the details of the rate proposal on this sheet. Specifically, show how you derive the numbers on Attachment B.

1. Proposed DoD Group Rates For January 1, 2001  
(Without Prescription Drugs)

In this section, explain how you derived your Line 1 rates. We want a simple explanation here, but include any appropriate back-up documents. Please remember that all calculations are subject to audit.

2. Prescription Drugs

In this section, explain how you derived your rates for prescription drugs. We want a simple explanation here, but include any appropriate back-up documents.

**Attachment B-1**

**Attachment C**

**Carrier Contacts**

For information about your rate submission, we should contact:

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

E-Mail \_\_\_\_\_

**OR**

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

E-Mail \_\_\_\_\_

Our counterproposal letter should be addressed to:

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

E-Mail \_\_\_\_\_