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# FEHB Program Carrier Letter

## Health Maintenance Organizations

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

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**Letter No. 2000-21B**

**Date:** May 5, 2000

Fee-for-service [ ] Experience-rated HMO [ 18 ] Community-rated HMO [ 20 ]

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**SUBJECT:** Technical Guidance for Benefit and Service Area Proposals

This is additional guidance on benefit changes, instructions for submitting benefit proposals, and instructions for submitting service area proposals for the upcoming contract term (January 1 through December 31, 2001). You must propose benefit changes according to carrier letter 2000-17, *Call Letter for Contract Year 2001 -- Policy Guidance*, dated April 11, 2000.

Last year's call letter, 1999-016 dated April 9, 1999, included a recap of our policy on selected benefits. **Unless we say otherwise, policies established in prior years remain in effect.** We will not consider proposals that are contrary to policy.

This letter has two parts:

- Part One - Preparing Your Benefit Proposal
- Part Two - Changes in Service Area

**Remember that your brochure language that accompanies and describes your benefit proposals and clarifications must be in plain language and received by your OPM contract specialist by May 31, 2000. Your non-benefit brochure language, using the new format and plain language throughout, is due to your contract specialist July 1, 2000.**

We sent your rate instructions in Carrier Letter 2000-18, dated April 19, 2000. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

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Just as a reminder, your performance evaluation measures include a factor for Customer Service that contains an element for *Timely Closure on Rates and Benefits Consistent with Policy Guidelines*. We will look at how well you meet our expectations in preparing and submitting your benefit and rate proposals when we review your performance.

Sincerely,

(signed)

Frank D. Titus  
Assistant Director  
for Insurance Programs

(HMOs)

## Preparing Your Benefit Proposal

Given our timeframe for concluding benefit negotiations, we expect **every HMO** to prepare a complete proposal according to these instructions and submit it by **May 31, 2000**.

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;
- Comparison of the 2000 community package (adjusted for special FEHBP benefits) and your 2001 community package;
- Narrative description of each proposed change (in worksheet format);
- Narrative description of each proposed clarification (in worksheet format);
- Proposed 2001 brochure language; and
- Signed contracting official form

If you foresee unusual or extensive changes to your community package, please discuss them with your OPM contract specialist before you prepare your submission.

### 2001 FEHB Proposal Instructions

A. Provide the following material **immediately**:

1. Experience-rated Plans - Provide a copy of the fully executed employer group contract OPM purchased for 2000.
2. Community-rated Plans - Provide a fully executed copy of the community benefits package (a.k.a. master group contract or subscriber certificate) that describes the community benefits package, and riders, purchased by the greatest number of your non-Federal subscribers in 2000. If the community benefits package we currently purchase is not the same one, also send us a copy of the package we do purchase.

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B. Provide the following by **May 31, 2000**:

1. Experience-rated Plans - **If you have not made changes to the level of coverage we already purchase**, then submit a statement to this effect. **If you have made changes**, submit a copy of the new benefit description and answer the questions in Section C below. You must file this benefit package and the associated rate with your State if a filing is required by the State.

2. Community-rated Plans - We prefer to purchase the same community benefit package that covers the majority of your subscribers/contract holders, with adjustments for any benefit differences resulting from specific requirements of the FEHB Program. If you offer a variety of community packages, you should propose the core package of benefits that a majority (or the largest number) of plan subscribers or contract holders (not members or employer groups) purchase. You must disclose this package if we purchase a different package so that we are aware of the differences. If we later determine that the community benefits package we purchased is not the community benefits package purchased on behalf of the majority, we will adjust your 2001 FEHB rates.

Please append descriptions of community-based riders (e.g., prescription drugs, durable medical equipment) and other additions to the basic package that reflect previously agreed-upon modifications or mandated additions to the community package. Also identify riders (optional benefits not sold to all plan groups) that are incorporated in the community package. This material must show all benefit changes proposed for the FEHB Program for the 2001 contract term except those still under review by your State as described in Item D below.

C. To simplify our comparison of your 2001 community benefits package proposal and the benefits package currently purchased for the 2000 contract term, please **attach a chart** displaying the following information:

1. Benefits you cover in one package but not the other;
2. Differences in copays, coinsurance, numbers of days of coverage and other levels of coverage between one package and the other;
3. Whether you include the costs of the differences at (1) and (2) within or in addition to the community rate you charge to the other groups that purchase this community benefits package, and to the FEHB Program;
4. The number of subscribers/contract holders who currently purchase each package.

D. Describe the procedure in your State for filing and/or obtaining approval of community benefit packages and changes. If the State requires filing and/or approval, provide a copy of the plan's most recent submission applicable to the community benefits package you submit in response to B(2) and provide a copy of the approval the State issued. Please highlight and address any State mandated benefits that you have not specifically addressed in previous negotiations with us. Please note that we will accept proposed benefit changes only if: (1) you submitted the changes to your State prior to **May 31** and (2) you obtained approval and submitted documentation of the approval to us by **June 30, 2000**. If the State grants approval

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by default, i.e., the State does not object to proposed changes within a certain period after they receive the proposal, please so note; the review period must have elapsed without objection by June 30.

We will contact the State about benefits as necessary; please provide the name and phone number of the State official responsible for reviewing your plan's benefits. If your plan operates in more than one State, provide this information for each State.

- E. You must provide a narrative description of each proposed benefit change and clarification. Answer the following questions in worksheet format for each proposed benefit change or clarification. Please indicate if a particular question does not apply. Use a separate page for each change or clarification you propose. We will return any incorrectly formatted submissions. **We require the following format:**

### **Benefit Changes**

1. Describe the existing benefit and how you propose to change it. State the proposed brochure language, including the "How the Plan Changes" section. You must write the language for the "How the Plan Changes" section plainly, that is, in the active voice, from the enrollees' perspective, and make clear how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing elimination of the plan's hospitalization copay, indicate whether this change will also apply to hospitalizations under the emergency benefit. If there is more than one change to the same benefit, present each change on a separate worksheet. Remember to use plain language.
2. Describe the rationale or reasoning for the proposed benefit change.
3. State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If an increase, describe whether any other benefit is offset by your proposal.
4. State whether this change is part of your proposed community benefits package (see Item B.2.) or a change that you have submitted to the State for approval. State how the change will be introduced to other employers (e.g., group renewal date). State what percentage of your contract holders/subscribers now have this benefit and the percentage you project will be covered by January 2000.
5. Has the change been submitted to and approved by the appropriate State authorities? If so, when? Please submit supporting documentation (see Item D above).
6. If not part of the proposed community benefits package, is the change a rider? If yes,
  - a. Is it a community rider (offered to all employer groups at the same rate)?
  - b. State the percentage of your subscribers/contract holders who now purchase this and the percentage you project will be covered by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to be covered by this rider and when will that occur?

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c. Include the cost impact of this rider as a biweekly amount for Self Only and Self and Family on Attachment 2 of your rate calculation. If there is no cost impact or if the rider involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively, on Attachment 2 to your rate calculation.

7. Will the change require new providers (e.g., chiropractors)? Furnish an updated provider directory that includes these new providers.

### **Benefit Clarifications**

1. Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification. Prepare a separate worksheet for each proposed clarification. Remember to use plain language.

2. Describe the rationale and need for the benefit clarification.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g., changing the number of days for a prescription drug supply from 31 to 30 days. Clarifications, on the other hand, comprise changes that do not affect the level of benefits provided. **You must show all changes that result in an increase or decrease in benefits as benefit changes, even if there is no change in rates.**

We will provide Program-wide language for the mental health parity and plain language initiatives. You do not have to list each benefit change or clarification attributable to these two areas.

## Carrier Contracting Officials

The Office of Personnel Management (OPM) will not accept any contractual action from

\_\_\_\_\_ (Carrier),  
including those involving rates and benefits, unless it is signed by one of the persons named below  
(including the executor of this form), or on an amended form accepted by OPM. This list of  
contracting officials will remain in effect until the carrier amends or revises it.

The persons named below have the authority to sign a contract or otherwise to bind the Carrier

for \_\_\_\_\_ (Plan)

Enrollment code(s): \_\_\_\_\_

Typed name

Title

Signature

Date

Typed name	Title	Signature	Date

By: \_\_\_\_\_  
(Signature of contracting official) (Date)

\_\_\_\_\_  
(Typed name and title)

\_\_\_\_\_ (Phone number)      \_\_\_\_\_ (FAX Number)

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## Changes in Service Areas or Redesignation as a Mixed Model Plan

We expect that your plan's present service area and the individual doctors or medical groups with whom you contract to offer services to the FEHB will remain available to our members for the 2001 contract term. You must inform us of any expected changes.

**Service Area Reductions** - Explain the reason for and provide supporting documentation (e.g., withdrawal notice from medical group) regarding any proposed reduction to the plan's service area. Does this reduction apply only to the Federal group? Describe precisely, and provide a map of, the area you propose to eliminate.

**Service Area Expansions** - You must propose any service area expansion by **May 31**. We will grant an extension for submitting to OPM any supporting documentation described below, including all necessary State authorizations, until no later than June 30. We cannot grant exceptions to this date.

**Redesignation as a Mixed Model Plan** - If your plan formerly operated as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) and now offers both types of providers, redesignation as a Mixed Model Plan (MMP) may be appropriate. You must request redesignation and describe the delivery system that you added.

**Please note:** You must indicate to us that the information you provide concerning your delivery system is based on providers with whom you have executed contracts; letters of intent are not acceptable in lieu of executed contracts. We also require that you state that all contracts with providers contain a "hold harmless" clause. Use the statement form included with this mailing.

**Important Notice:** If your plan has a service area reduction or you establish a new rating area that requires current members to change enrollment codes, we will assign new codes and all of the Plan's FEHB members will have to reenroll during the 2000 Open Season.

We will evaluate your proposal in accordance with these criteria: legal authority to operate, reasonable access to and choice of quality primary and specialty medical care throughout the service area, and your ability to provide contracted benefits. Please provide the following information:

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## Instructions

### A. Provide a description of the proposed expansion area in which you are approved to operate:

1. Describe the proposed service area expansion by zip code, county, city or town, and provide a map of the old and new service areas.

### B. Authority to operate in proposed area:

1. Please provide a copy of the State approval document authorizing you to both market and provide services in the proposed expansion area, and the name and telephone number of the person at the state agency who worked on the authorization. The document must include a description of the approved area.

### C. Access to Providers

1. Please provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have executed contracts.

**D. Redesignation as a Mixed Model Plan** - This section applies only if your plan formerly operated as a GPP or IPP and now offers both types of providers, and you are requesting redesignation as a Mixed Model Plan. Please indicate the provider system being added.

If you are adding a GPP component to an existing IPP delivery system, please note that in order to meet FEHB requirements, you must demonstrate that the group includes "at least three physicians who receive all or a substantial part of their professional income from the HMO funds and who represent one or more medical specialties appropriate and necessary for the population proposed to be served by the plan." (5 USC 8903(4)(A))

Include clear language in your brochure ("How the Plan Changes" section plus "Information About This Plan", if appropriate) to reflect the changes you propose.

If we approve your proposal, you will need to provide the following information:

1. Do you require all members of a family to use the same delivery system, or may some members of a family use GPP doctors while others use IPP doctors?
2. If you restrict members to one type of delivery system, what must a member do to change from one delivery system to the other during a contract term? How soon after it is requested would such a change be effective?
3. If a member wants to change primary care doctors (centers for GPPs), what must the member do? Is there a limit on the number of times a member may change primary care doctors (centers)? If yes, will you waive the limit for FEHB members? How soon is a requested change effective?

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**Federal Employees Health Benefits Program  
Statement About Service Area Expansion**

We have prepared the attached service area expansion proposal according to the requirements found in Part Two, Changes in Service Areas, of Carrier Letter 2000-21B. Specifically,

1. All provider contracts have hold harmless provisions in them.
2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.
3. All of the information provided in response to Part Two, Paragraph C (Access to Providers) is accurate as of the date of this statement.

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Signature of Plan Contracting Official

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Title

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Plan Name

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Date

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