FEHB Program Carrier Letter
All Carriers

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

Letter No. 2000- 54 **Date:** December 7, 2000

Fee-for-service [48] Experience-rated HMO [49] Community-rated [49]

Subject: Reminder of Reporting Requirements for Carriers Participating in the Department of Defense and Federal Employees Health Benefits Program Demonstration Project in 2000

If your plan did not participate in the demonstration project for the year 2000 contract period, please disregard this letter. If your plan participated in the demonstration project and enrolled beneficiaries for the year 2000 contract period, these reporting requirements apply to you.

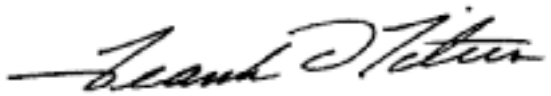
This letter summarizes the reporting requirements for your activities under the DoD/FEHB demonstration project. We are requesting information to include in reports to Congress in accordance with the legislation (Public Law 105-261) that authorized the demonstration project. Our first report is due to Congress April 1, 2001.

You must report on each enrollment code in a demonstration site.

Who Reports?	Report	Reporting Period Ends	Due Date	Submit Report to:
All plans in the demonstration project with enrollments effective in 2000	Summary of DoD Enrollment (Enclosure 1)	12/31/00	2/28/01	OIP
Fee-for-service plans with 25 or more DOD enrollees	C1 and C2 of the Annual Paid Report	12/31/00	2/28/01	Office of Actuaries
HMOs with 25 or more DoD enrollees	Total Benefit Expenses (Enclosure 2)	12/31/00	2/28/01	Office of Actuaries
Experience-rated FFS and HMOs in demonstration	Annual accounting statement for experience under this demonstration project. We will send instructions for completing the statement with our annual accounting instructions.			

If you have any questions regarding this letter please contact Mike Kaszynski at 202-606-0004.

Sincerely,



Frank D. Titus
Assistant Director
for Insurance Programs

Enclosures

Enclosure 1: Summary Of DoD Enrollment

[Enter Year of Report]

Plan Name:			**Plan Code:**	
	Number Of:			
	Enrollees	**Covered Lives** (Enrollees+Dependents)	**Medicare**	
			Part A	**Part B**
High Option				
xx1 Self Only				
xx2 Self and Family				
Standard Option				
xx4 Self Only				
xx5 Self and Family				
Total				

Where xx is your plan's two-character identification code.

☐ Dependent counts are actual. [Check if applies]

☐ Dependent counts are estimates. [Check if applies]

Describe your method of estimating the number of dependents: _____

_____

_____

_____

_____ _____ _____

Signature of Responsible Person *Date* *Telephone Number*

Be sure the **Plan Code** is on the top of the report and that you have signed the report and included your phone number. **Mail this report to:** Office of Insurance Programs, Attention: Mike Kaszynski, PO Box 436, Washington DC 20044. **Fax this form to:** 202/606-0633 or call Mike at 202/606-0004 for information about this form.

Enclosure 2: Total Benefit Expenses as of 12/31/00

Plan Name: **Plan Code:**

Total Benefit Expenses 1/1/00 through 12/31/00

Type	***$ Amount for DoD members***	***$ Amount for regular FEHB members***
Medical (claims plus capitation)		
Prescription Drugs		
Administrative costs		
Total		
Member Months		

_____ _____ _____

Signature of Responsible Person *Date* *Telephone Number*