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CLIENT ALERT

FEHBP Community-Rated HMO Carrier Contract Changes

Aug.09.2012

OPM has published the 2013 contract year proposed changes for community-rated HMO carriers and experience-rated HMO carriers via Carrier Letter Nos. 2012-21(a) and 2012-21(b), dated August 8, 2012. Carriers may submit comments on the proposed changes until September 7, 2012. Comments should be sent to Nicole Lohr at OPM along with a copy to the carrier's contract representative.

Significant Proposed Changes Applicable to Community-Rated HMO Carriers

Effective January 1, 2013, all community-rated plans must base their rating methodology on the FEHB-specific medical loss ratio (MLR) threshold, unless their state of domicile requires traditional community rating. The ratio of a plan's incurred claims, including the plan's expenditures for activities that improve health care quality, to total premium revenue must be lower than the FEHB-specific MLR threshold published by OPM in its annual rate instructions. If the plan's MLR is lower than the FEHB-specific MLR, then the plan must pay a subsidization penalty equal to the difference. The subsidization penalty shall be paid into a subsidization penalty account, which shall be held in common with all community-rated carriers and will be distributed to the contingency reserve accounts of all non-TCR community-rated plans on a pro-rata basis annually.

Note that while the proposed change establishes a new rating methodology without needing to identify SSSGs, community-rated carriers must still "use a method based on utilization data or a prospective method based on actual Federal claims data" that must be "completely and clearly explained." FEHB Carrier Letter No. 2012-13 (Apr. 19, 2012), Attach. 1 2013 Community Rating Guidelines at 5. OPM may request the rate development of other groups to determine what rating method a carrier uses, if the carrier does not file or does not have a documented rating manual or methodology. Id.

OPM has also proposed deletion of Section 3.6, Discrepancies Between Enrollment and Payments to Carriers, because there is no longer a one percent loading.

Significant Proposed Changes Applicable to Both Community-Rated and Experience-Rated HMO Carriers

Carriers must now produce and distribute an FEHB Summary of Benefits and Coverage (SBC), as required by the Affordable Care Act (Section 2715 of the Public Health Services Act). The proposed contract changes provide no further guidance with respect to the FEHB-specific SBC. The Department of Labor has published a generalized SBC template that carriers may use when creating their FEHB-specific SBC. Because of a proposed change to the FEHB Supplemental Literature Guidelines, carriers would not required to list their FEHB rates in the SBC.

The proposed changes add a new provision, Section 1.37, setting for the requirements for paperless reimbursement for the federal flexible spending account program (FSAFEDS). The provision includes both the requirements for participation in paperless reimbursement and obligations regarding the submission of incorrect claims information to FSAFEDS.

OPM has also proposed changes to further define the overpayment process and the requirements for collection efforts. The proposal clarifies that carriers should suspend overpayment recovery efforts during both the 5 C.F.R. § 890.104 disenrollment appeal process, as well as the 5 C.F.R. § 890.105 disputed claims process. Additionally, carriers would be required to make available to OPM upon request documentation of all overpayment recovery efforts including, but not limited to, copies of dated notices, offset attempts, certified letter communications, and third-party collection efforts for overpayments that exceed $10,000 per each occurrence.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

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