United States Office of Personnel Management

Federal Employees Health Benefits Program

# Application to Participate as a Carrier Under 5 U.S.C. 8903(4) Effective January 1, XXXX

|  |  |
| --- | --- |
| Name of Health Plan:  Mailing Address:  Street:  City, State, Zip Code: | Name of Legal Contracting Entity (“Carrier”):  Mailing Address:  Street:  City, State, Zip Code:  Name of Executing Individual  (Authorized Contracting Official):  Title:  Telephone/Fax Number/Email: |

Name and Title of Contact During Application Review:

Telephone/Email:

Mailing Address (Street, P.O. Box, City, State, Zip Code):

Have you been awarded a Medicare contract by the Centers for Medicaid and Medicare Services?

Yes [ ]   
No [ ]

HHS Compliance Officer (if applicable):

Telephone Number:

Applying as Sponsor of a [See 5 U.S.C. Section 8903(4)]:

Group-Practice Prepayment Plan [ ]

Individual-Practice Prepayment Plan [ ]

Mixed Model Prepayment Plan [ ]

Premium Rating Type:

Experience-rate [ ]

Community-rated [ ]

Date Medical Care Was First Provided Under the Plan to Enrolled Commercial Group Members Who Were Neither Carrier Employees nor Employees of a Carrier Affiliate (if different date than above):

Federal Tax Status:

[ ] For Profit

[ ] Not for Profit

All information and statements made in this application are true, accurate, and current to the best of my knowledge and belief and are made in good faith. See the instructions on the following pages before signing.

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(Signature of the applicant carriers contracting official)

## Instructions to Applicants

### General

The Federal Employees Health Benefits (FEHB) Program is offered under the authority of the FEHB law (Chapter 89 of title 5 of the U.S. Code) and is administered by the Office of Personnel Management (OPM) in accordance with the FEHB law and its implementing regulations (5 CFR Part 89, and 48 CFR Chapter 16. Links to the law, regulations and sample contracts are available on the OPM website at <https://www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Carrier-Application>.

The definitions for this application are as follows:

“Enrollee” means the individual in whose name the enrollment is carried. The term includes [employees](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=b7cbe11be191b3c6d34f7fcb66edbc95&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101), [annuitants](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=25f7c40cadf9aba744b60f3d993d8899&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101), tribal organization employees, former [employees](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=b7cbe11be191b3c6d34f7fcb66edbc95&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101), former spouses, or children who are [enrolled](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=7217c31374a07ff9bc860f46c44b3ab7&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101) after completing an [appropriate request](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=57483fa28a32c1f008ba00e32f772dbd&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101) under the provisions of  [5 CFR § § 890.301](https://www.law.cornell.edu/cfr/text/5/890.301), 890.306, 890.601, 890.803, or 890.1103 or have continued an enrollment as an [annuitant](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=25f7c40cadf9aba744b60f3d993d8899&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101) or survivor [annuitant](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=25f7c40cadf9aba744b60f3d993d8899&term_occur=999&term_src=Title:5:Chapter:I:Subchapter:B:Part:890:Subpart:A:890.101) under [5 U.S.C. 8905(b)](https://www.law.cornell.edu/uscode/text/5/8905#b) or § 890.303.

“Family members” means the enrollee’s spouse (including a valid common law marriage) and children under age 26[[1]](#footnote-1), including legally adopted children, stepchildren, and recognized natural (born out of wedlock) children. [Foster children](https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/family-members/) are included if they live with the enrollee in a regular [parent-child relationship](https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/family-members/).

"Health benefit plan" means a group insurance policy, contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, arranging for, delivering, paying for, or reimbursing any of the costs of health care services.

"Health carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, delivering, paying for, or reimbursing the cost of health care services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, including a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services, in consideration of premiums or other periodic charges payable to the carrier.

Some features of the FEHB Program may be different from the features you are used to. By submitting this application, you agree that you understand and will abide by the following FEHB requirements:

* You must accept the enrollment of all eligible Federal employees and annuitants (retirees) regardless of age or Medicare eligibility.
* You may not require an enrollee or family members to have or enroll in Medicare Parts A or B.
* You may not require a waiting period for a covered benefit offered to any enrollee or family member.
* You may not deny a benefit for an enrollee or family members solely because of a preexisting condition.
* You must cover all children of Federal enrollees until age 26 regardless of student status or financial dependence on the parent.
* You must cover children of enrollees age 26 or older who are incapable of self-support because of a physical or mental disability that began before their 26th birthday.
* You may not require enrollees to pay an initiation, service, or other enrollment fee in addition to premium.
* You must provide each enrollee with an identification card or cards.
* You may terminate an enrollment or disenroll a member only as authorized by FEHB law regulations and guidance.
* You must offer conversion contracts for disenrolled enrollees or family members that are guaranteed renewable except for fraud, nonpayment of premiums, or overinsurance. (Overinsurance can exist when an insured individual has purchased too much coverage and the coverage exceeds the risk that is insured. Enrollment in Medicare does not constitute overinsurance.)
* You must keep reasonable financial and statistical records and furnish such reports as OPM may request.
* You must provide, upon request by OPM, a description of your system for determining and monitoring the adequacy of your provider networks. Information to be provided includes, but is not limited to, frequency of your adequacy analysis, adequacy standards applied in your analysis, and how you ensure the network meets the health care needs of the enrolled population, including those with special needs and those with limited English proficiency and literacy.
* You must make all records and accounts pertaining to the plan available to representatives of OPM and the Government Accountability Office (GAO).
* Any plan provider who is not accepting new patients must agree to accept Federal members who were his/her patients before they enrolled in the plan.

In addition, you should be aware of the premium rating methods used in the FEHB Program:

### Community Rating

The FEHB Program allows three types of community rating.

1. Traditional Community Rating (TCR) usually begins with a capitation (per member per month) rate or a tiered rating system.
2. Community Rating by Class (CRC) usually adjusts a capitation rate by a factor that reflects the distribution of the group by age and sex.
3. Adjusted Community Rating (ACR) is prospective experience rating. You may use actual incurred claims to rate the Federal group but must meet certain criteria for doing so, including using a standard administrative loading, a common trend factor, and a standard set of completion factors for all ACR rated groups.

### Experience Rating

If you use retrospective experience rating, you must meet the following criteria:

1. You must be able to track FEHB claims separately from the claims for other groups.
2. You must be capable of allocating the administrative costs separately for the Federal group.
3. You must carry over gains and losses from year to year and incorporate them into the annual rating process.
4. You must agree to annual limits on your administrative costs.
5. You must be able to demonstrate that you have criteria for retrospective experience rating and that you use these criteria to experience rate other employer groups.

### The Application

**Note:** A separate application must be submitted for each plan you want to offer for participation in the FEHB Program. If you propose more than one service/enrollment area for a plan, the following conditions apply: the areas must be served by the same legal entity with the same license to operate, the areas must all be managed by the same carrier, the benefits must be the same in all areas, all areas must be marketed under the same name, and they must operate as a single entity and be represented by a single plan; otherwise, you must submit separate applications for each area.

**Review these instructions carefully and read the entire application before you start to prepare your response**. To avoid an unacceptable application, you should understand the requirements of the FEHB law and regulations and be able to show how you comply.

**To be considered for participation in the FEHB program, at the time of application you must actually be providing prepaid medical care to enrolled commercial group members who are neither carrier employees nor employees of a carrier affiliate.**

Any information in your application may be subject to public disclosure after your application has been adjudicated by OPM. Please identify each item in your application that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item, in accord with 5 U.S.C. Section 552, and give full justification for your belief that the exemption applies. OPM will decide on disclosure only when a request for information is made. In making the decision, OPM will consider your justification for nondisclosure. If OPM determines that an item of information that you believe is exempt is not exempt from disclosure, you will be informed before the information is disclosed.

The entire application, including assurances and statements of compliance with the FEHB law and regulations, updated transmittals, and signed representations are official documents. Therefore, the application face sheet **must be signed by an authorized contracting official.** Please call the Federal Employees Health Benefits (FEHB) Division 3 at (202) 606-0737 or (202) 606-0755 if you have any questions about the application.

**Your application must be received by OPM no later than January 31st to be considered. Please notify OPM whether or not you decide to apply.**

An application may be withdrawn without prejudice at any time prior to a final determination by OPM. Future applications will be treated as new applications, without regard to previous applications submitted; a completely new application document will be required.

**Applicants should be aware that a false response to any question in this application may be grounds for denial of the application and may be punishable by fine or imprisonment (18 U.S.C. 1001). All statements and information provided are subject to investigation, including confirmation through third parties and other government agencies.**

#### Preparation of the Application

**If you are submitting a paper application:** Bind pages securely along the left margin; three-ring binders are preferred. Binders should not exceed two inches in thickness; use as many binders as necessary. Make sure the plan and carrier names are on the front and side of **each** binder and identify each binder, e.g., 1 of 4, 2 of 4, etc.

Attach index tabs to the first page of each section (e.g., I. Organization) and subsection (e.g., I. A. Overview) and be sure they are clearly visible. Where several copies of contracts are batched together, place a tab on the front page of each contract.

Show the location of all sections and subsections in the Table of Contents that follows this section and place a copy in **each** binder.

Submit any documentation requested immediately after the subsection to which it applies. Place brochures, pamphlets, and other such items in sturdy envelopes and insert them behind the appropriate subsection. Label each envelope.

When executed documents are requested, provide documents that are signed and dated.

Number all pages sequentially, including both the narrative and the documentation. Count envelopes as one page.

Restate each question, single-spaced, before presenting your double-spaced narrative response. Allow an ample left margin.

If you reduce the original material, the final copy should not be reduced to less than 70 percent of the original. Copies of legal documents and other materials must be clear and legible.

**If you are submitting an electronic application:** Submit documents in PDF and include a table of contents that links to the correct document. Submissions should have numbered pages. Digital signatures must be used to electronically sign documents.

**Failure to provide the information called for and/or failure to comply with the specified format may result in rejection of the application as non-responsive.**

#### Submission of the Application

**If submitting a paper application:** Submit one complete application, an additional copy of Section III. Financial Information (if applicable), and one original face sheet signed by an authorized contracting official. Please ship all binders in the same box, if possible. If not possible to ship in one box, please number and mark each box (e.g., Box 1 of 2; Box 2 of 2). **Applications must be received by OPM no later than January 31st.**

Use the following address, by 24-hour delivery or regular mail service:

U.S. Office of Personnel Management

Healthcare and Insurance

1900 E Street, NW

Room 3424

Washington, DC 20415-0001

**If submitting electronically:** To request online submission complete the Carrier Application Information Form at <https://www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Carrier-Application> and we will contact you with instructions on how to submit your application electronically.

## Table of Contents

Please complete this form **after** you have numbered all pages and place a copy in the front of each binder you submit.

1. **Organization**: Page ##
   1. **Overview:** Page ##
   2. **Sponsoring Organization:** Page ##
2. **Marketing and Enrollment:** Page ##
3. **Financial Information:** Page ##
   1. **Fiscal Soundness:** Page ##
   2. **Provisions for the Event of Insolvency:** Page ##
4. **Health Care Delivery and Covered Services:** Page ##
5. **Utilization Controls and Quality Assurance:** Page ##
6. **General Information:** Page ##
7. **Certifications:** Page ##

### Organization

#### **Overview**

* + 1. Briefly describe your plan's history and present operations. Cite significant aspects of your current financial, marketing, management, and health services activities. Discuss your recent legal history, including reorganizations, mergers, changes of ownership, and name changes. State your current type of legal entity.
    2. Provide copies of **executed** articles of incorporation, bylaws and, if applicable, partnership agreement(s).
    3. Any prior FEHB Program participation? If yes, when and why did it cease?
    4. Are you a governmental entity or affiliated with one? If yes, explain.
    5. Provide a signed opinion by legal counsel that you comply with all State HMO laws and regulations and any other applicable health or insurance laws and regulations. This opinion must cover all States in which your plan intends to participate.
    6. Describe, and provide copies of, any licenses, certifications, and other approvals applicable to the plan.
    7. Provide a signed opinion by legal counsel that you are not debarred, suspended, or ineligible to participate in Government contracting for any reason, including fraudulent health care practices in other Federal health care programs.

#### **Sponsoring Organizations**

* + 1. Are you owned by, affiliated with, or sponsored by another organization that provides management and/or financial support? If yes, identify the organization and answer the next three questions. If not, proceed to II.
    2. Does the organization sponsor more than one health plan? If yes, identify each by name and location.
    3. What administrative, management, financial or other services does the sponsor provide?
    4. To what extent does the sponsor provide financial support to you?
    5. Explain the legal relationship between the sponsoring organization and the carrier of the plan and state whether this relationship creates any financial liability on the part of the sponsor.
    6. Please submit a copy of your articles of incorporation and any parent organization charts.

### Marketing and Enrollment

* + 1. List all employer groups enrolled as of December 31 of the year prior to your submission and show the number of enrollees (subscribers) and members in each group. If you offer other options, such as Point of Service, show those enrollees and members in separate columns.
    2. Provide actual and projected membership data (enrollees and members) by quarter for the last three years. Include your disenrollment rates for these years.
    3. Provide the total cumulative member months for your most recent fiscal year.
    4. On what date did your first employer group enroll in the plan? If that date falls within the 12 months preceding this application, provide a copy of a signed contract with an employer group.
    5. Describe the service area(s) in which you are approved to operate in terms of ZIP codes or geographic subdivisions, such as counties, cities, or townships. Is this service area(s) the same as the service area to be proposed to the FEHB Program? If no, describe the service area to be proposed to the FEHB Program.
    6. Provide a copy of the State's approval of the plan's service/enrollment area. The document must include a description of the approved area.

### Financial Information

#### **Fiscal Soundness**

* + 1. When does your fiscal year end?
    2. List the total amount and sources of financing currently available to you.
    3. Provide the following financial information for your most recent fiscal year: current ratio, working capital, debt/equity ratio, gross profit margin, fund balance, retained earnings (accumulated deficit), and cash and cash equivalents. Also provide this information for your sponsor, if applicable. Financial statements should include balance sheet, income statement, and statement of cash flow.
    4. Has the plan operated for less than six months preceding the date of the application**?** If yes, provide the following information on a monthly basis until you have been notified of the results of our review. Submit the January information by February 20, the February information by March 20, etc.
       1. Actual and projected\* balance sheet, change in financial condition statement, and revenue and expense statement; and
       2. Actual and projected\* enrollment (enrollees and members) and the number of employer groups.

\* *Submit your projections with the application.*

* + 1. Provide a CPA statement, with management letters, for the most recent fiscal year.
    2. In addition, provide a copy of the most recent annual financial statement you submitted to your State's Insurance Commissioner (or equivalent).
    3. If you are not required to submit a financial statement to your State’s Insurance Commissioner (or equivalent) and your CPA statement is more than six months old or is not available, provide an unaudited balance sheet, income statement, and statement of cash flow as of December 31 of the year preceding the date of your application.
    4. If you have received a qualified opinion about the plan from your audit firm in the last three years, include those opinions and associated management letters, and describe the steps taken to resolve them.
    5. If your financial statements for the plan show a negative cash flow, describe the sources of financing available to cover shortages and the agreements covering the financing arrangements.
    6. Also provide the information requested by the preceding two questions for your sponsoring organization, if applicable.
    7. Provide a copy of your projected balance sheet as of December 31 of the year of the application.

#### **Provisions for the Event of Insolvency**

* + 1. Describe your approach to the risk of insolvency:
       1. To pay for continuation of services until a hospitalized member is discharged, and
       2. Protect members from liability for services provided prior to your insolvency.
    2. Describe any insolvency insurance as well as any reinsurance/stop-loss insurance you have for excessive operating losses.
    3. Provide signed copies of any reinsurance contracts.
    4. Describe the reserve requirements and other financial requirements imposed by the State in which you are domiciled and explain how those requirements are met. If you are not in compliance with those requirements, please explain. Describe any corrective action plan that may be underway.
    5. Are reserves held by you or by the State? Show the reserves accumulated to date and describe any restrictions on using those reserves. From what source(s) did you meet your reserve requirements?

### Health Care Delivery and Covered Services

* + 1. Does your State require hold-harmless clauses in contracts with providers? If not, do your contracts with physicians, hospitals, and ancillary providers contain hold-harmless clauses? If they do, provide a sample copy of each type of provider contract containing a hold-harmless clause.
    2. Do you contract with an IPA or other physician organization? If so, identify each by name.
    3. Provide a copy of your most recent provider directory, including primary and specialty physicians, hospitals, and ancillary providers. If the directory does not do so, indicate which physicians are not accepting new patients.
    4. Do you contract with physicians practicing in groups? If so, please identify the groups.
    5. Provide a copy of your standard community package of benefits, as well as any standard riders. This should be in contractual form, such as a Group Subscription Agreement or Master Group Contract. If experience-rated, provide a copy of the benefits package purchased by most employer groups.

### Utilization Controls and Quality Assurance

* + 1. Are you currently accredited by any national HMO accrediting organizations, such as the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC), URAC or The Joint Commission? If so, by which organization are you accredited, what type of accreditation do you have? (full, provisional, etc.), and when does it expire? Provide evidence of the accreditation. If not accredited, are you planning to seek accreditation? From which organization? When?
    2. Are you able to supply information in Healthcare Effectiveness Data and Information Set (HEDIS) format? OPM requires HEDIS information to be reported. If not, do you expect to be able to do so in the future? When?
    3. Discuss the process you use to determine or verify that providers are and remain appropriately licensed.
    4. Discuss any requirements you have concerning board certification of primary and specialty physicians under the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association.
    5. Discuss how you monitor utilization of the following:
       1. Physician inpatient services
       2. Laboratory and X-ray services
       3. Out-patient physicians
       4. Hospital services
       5. Out-of-area hospital and inpatient physician’s services
       6. Pharmacy services
    6. Discuss your approach to quality control, including control of primary care services, referrals, and hospitalization, with emphasis on how you evaluate (and correct, if necessary) whether inappropriate or substandard care services have been furnished.
    7. Describe your procedures for handling member complaints and submit the results of the most recent member satisfaction survey, if any. Describe how member appeals of denied claims or services are handled. How are malpractice claims handled?

### General Information

* + 1. List, by name, title, and phone number and email of the persons who are responsible for the following key management functions of the plan: executive, medical, utilization review, finance, and marketing. Provide a current resume’ for each person.
    2. List State regulatory officials with authority over you, including your usual contact, with phone numbers and email.
    3. Describe how your physicians are paid (salary, fee-for-service, capitation, etc.).
    4. Discuss your risk-sharing features with respect to primary care physicians, referral physicians, hospitals, and ancillary providers. Are providers required to have reinsurance when they assume direct risk? Summarize how any risk pools operate. May you use risk pool funds, or increase the withhold to cover deficits?

### Certifications

Complete the attached Drug Free Workplace and Anti-Lobbying certifications and have them signed by a carrier contracting official.

1. See 5 U.S.C. 8901, amended by P.L. 111-148, the Patient Protection and Affordable Care Act (as amended). [↑](#footnote-ref-1)