FEHB Program Carrier Letter
All Carriers

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

Letter No. 2000-17 **Date: April 11, 2000**

Fee-for-service [13] Experience-rated HMO [15] Community-rated [17]

SUBJECT: Call Letter for Contract Year 2001 -- Policy Guidance

This is our annual policy guidance for proposed benefit and rate changes from Federal Employees Health Benefits (FEHB) Plans. As in the past, this letter states our goals for the upcoming negotiations. Your proposals for the contract term beginning January 1, 2001, are due by **May 31st**. While that is the regulatory deadline for your written submissions, I strongly encourage you to talk soon with your contract specialist about any changes you are considering, especially those required by this letter.

To assure a timely Open Season, we will begin negotiations when we receive your request for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations -- benefits and rates -- by **August 25, 2000**.

Before detailing our expectations for contract year 2001, I want to thank you for your continued cooperation and collaboration on the many important initiatives we have undertaken in recent years. With your support, we successfully implemented the President's Patients' Bill of Rights, affording our enrollees and their family members important protections that should be available to all Americans. Your willingness and ability to find effective approaches at minimal cost made this achievement possible. In addition, you helped make Y2K a non-event. You have been effective partners in our initiative to develop customer-focused Plan brochures written in plain language. Together, we implemented an important demonstration project to provide FEHB access to Medicare-eligible Department of Defense retirees and others in selected areas. As we move forward to 2001, I know you will continue to work with us to provide our customers affordable, high quality healthcare.

Last fall, Director Lachance announced her intention to "raise the quality and cost effectiveness of health Plans by raising the standards for participation in the FEHB Program, and achieve efficiencies and economies of scale by contracting directly for selected benefits." We will achieve these goals. To that end, we are developing legislative proposals that we will submit later this year. In the meantime, our specific initiatives for 2001 demand your thoughtful attention. They include the implementation of mental health and substance

abuse parity and the reduction of medical errors to increase patient safety. Again, we will concentrate on desired outcomes and not on prescribed processes for achieving them.

Mental Health and Substance Abuse Parity

Introduction. At the White House Conference on Mental Health held on June 7, 1999, President Clinton directed OPM to achieve mental health and substance abuse parity in the FEHB Program by contract year 2001. Achieving parity means that your Plan's coverage for mental health and substance abuse must be identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. We recognize that there are a variety of benefit design approaches that can meet this standard. This letter sets out the elements that we anticipate will be present in your proposal for introduction of parity in the 2001 contract year. We look forward to working cooperatively with you to implement this initiative.

Background. For the past several years, we have negotiated changes to improve mental health and substance abuse benefits in the FEHB Program. At our 1998 and 1999 carrier conferences, we featured presentations by panels of experts who discussed the desirability and feasibility of achieving mental health and substance abuse treatment parity at an affordable cost. We stated then and in subsequent discussions that we expect your proposals for 2001 to eliminate differences in benefit levels and limitations between coverage for mental health and substance abuse services and medical, surgical, and hospital services. We also provided you with extensive information about this initiative at our carrier conference in October 1999.

To help us develop more specific guidance for implementing parity in the FEHB Program, we contracted with the Washington Business Group on Health (WBGH) for a report on the practices of other large employers. WBGH assembled a group of eight employers who provide parity or near parity benefits in their health plans and collected information from them on best practices and potential pitfalls. They analyzed and synthesized the approaches of the participants and provided recommendations to OPM in a report published March 10, 2000. We sent you a copy by email. The text also is available on both the OPM and WBGH web sites. The OPM web site is www.opm.gov/insure. The WBGH web site is www.wbgh.com/html/new_at_wbgh.html. The report helped us immeasurably to clarify issues and refine our approach.

Delivery Systems. The overriding goal of parity is to expand the range of benefits offered while managing costs effectively. Based on studies by the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and others, we believe that you can deliver parity coverage cost effectively in a fully coordinated managed behavioral health environment. We anticipate that your parity benefit proposals will likely encompass an appropriate care-management structure. For Plans that currently provide unmanaged fee-for-service or point of service mental health

and substance abuse benefits levels that are below those for medical benefits, you may continue to offer these benefits, but you must also provide in-network benefits that meet the parity standards. However you choose to provide parity benefits, access to providers of care should be consistent with the intent of the "Access to Network Providers" discussion below.

Managed behavioral healthcare organizations (MBHO) can provide a range of services to fully implement or supplement your program. They can establish networks of providers for you and manage network services using treatment plans and care coordinators. Alternatively, they can manage the care delivered by your existing network providers. If you decide to contract with a MBHO, please include in your selection criteria such factors as accreditation by an independent organization.

If you do not choose to use an MBHO, we still encourage you to consider approaches such as gatekeeper referrals to network providers, authorized treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs. We will be looking for proposed strategies that will expand access to services and mitigate the cost impact of doing so.

We also expect you to develop benefit packages that will make effective use of available treatment methods. Since much successful treatment for mental health and substance abuse conditions is now being delivered through alternative modalities such as partial hospitalization and intensive outpatient care, we encourage a flexible approach to covering a continuum of care from a comprehensive group of facilities and providers.

The experience of other purchasers has shown that in order to manage care effectively, access should be available 24 hours a day 7 days a week to facilitate immediate referral to appropriate treatment. While the prudent layperson standard will continue to apply to mental health and substance abuse as well as medical emergencies, this level of access can ensure that care is rendered in settings that are most appropriate and cost effective.

Full coordination of care between primary care physicians and behavioral health providers and networks can also improve both outcomes and cost effectiveness. Discharge planning should assure that inpatient treatment is followed by appropriate outpatient care. Coordination of care is especially important for patients with multiple diagnoses.

Covered Services. You must provide coverage for clinically proven treatment for mental illness and substance abuse. We expect that will include all categories of mental health and substance abuse conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)* to the extent that the services for these conditions are included in authorized treatment plans. Treatment plans should be in accordance with standard protocols, and meet medical necessity determination criteria. You may limit parity benefits when patients do not substantially follow their treatment plans. However, you must continue to provide medically necessary services to stabilize

the patient during acute episodes. As before, you are not required to cover services that are currently covered and paid for by public entities, such as state or local government or schools.

Network Cost-Sharing and Day/Visit Limitations. You must provide network or similar medical, hospital, pharmaceutical, outpatient facility, and professional services for the treatment of mental and substance abuse conditions at the same benefit levels as for any other illness or disease. Cost-sharing, including deductibles, coinsurance, copays and catastrophic maximums must be the same. Day and visit limits must also be the same.

Mental health and substance abuse benefit levels should be based on the benefit category for comparable medical treatment, such as, inpatient hospital, professional office visits for specialists, diagnostic tests, and pharmacy benefits. The copayment, coinsurance, or deductible that applies to a specialist office visit for a physical illness will apply to an office visit for therapy from a mental health provider. The same cost sharing that applies to a test to diagnose a physical illness, such as diabetes, must be applied to a test to diagnose depression. The same inpatient deductible, copayment, or coinsurance that applies to an acute inpatient hospital admission for a physical illness or disease should apply to an inpatient hospital admission for a substance abuse or mental health condition.

Where there are no coverage limits for other diagnoses, there should be none for DSM-IV diagnoses. If there are coverage limits or other conditions under your medical benefits for certain services, you may apply the same limits for analogous services under your mental health and substance abuse benefits. For example, the allowable number of visits for speech, occupational, or physical therapy may be no fewer for an autistic child who requires those services than for a person recovering from a stroke who needs the same services.

Out-of-Network Cost-Sharing and Day/Visit Limitations. HMOs may continue to limit services to network providers only, unless your Plan has a point-of-service option. All other delivery systems must give members the option to use non-network providers. However, we do not expect parity for out-of-network coverage so long as you meet reasonable standards for access to network providers and facilities. You may keep cost sharing, day/visit limits, and catastrophic maximums for out-of-network services for mental health and substance abuse at or near year 2000 levels.

Catastrophic Maximums, Deductibles and other Plan Provisions. We will leave to your judgment how you decide to handle deductibles and catastrophic limits, and we will entertain all reasonable proposals. In keeping with the goal of parity, you may propose either to combine or separate deductibles and catastrophic limits for medical services and mental health and substance abuse services. You may also propose other changes to your basic Plan structure such as copayment, coinsurance or deductible levels. We will consider your proposals in the context of your entire benefits package. Proposals from HMOs must be consistent with their community practices.

Access to Network Providers. We have encouraged you to contract with a broad range of

providers and facilities to ensure adequate access to care. In addition, we learned from the WBGH report that patients often get better results with providers with whom they feel comfortable because they share common characteristics such as race, sex, or ethnicity. This finding parallels experience in other areas of our increasingly diverse world. You should consider the advantages associated with providing access to a diverse group of practitioners. We understand that enabling access to providers can be more difficult in some geographic areas. Nevertheless, we expect you to explore every possible option, including contracting with existing community mental health and substance abuse providers and facilities, and incorporating into your networks providers who are already treating some of your members. It is important to provide significant levels of in-network services in 2001 and beyond. We expect you to work continually toward increasing access to network providers, particularly in areas where there may be initial shortages.

Coverage provided outside the United States for mental health and substance abuse services must be handled in the same manner as you provide benefits for treatment of a physical illness for members residing or traveling outside the United States.

Minimum Access Standards. As you know, there are no universally accepted standards for access to network providers. As with preferred provider standards in general, access is typically measured by waiting times for various categories of appointments, such as emergency/critical, or routine, and by distance or travel time to the nearest available provider or facility. We will apply a reasonableness test to your proposals, with the clear understanding that an improvement effort will be ongoing.

Transitional Care. Your current members undergoing services for mental health and substance abuse conditions at the beginning of the new contract year will be eligible for transitional care coverage under specified conditions. Transitional care must be provided if a patient can no longer receive any benefits for services from a specialty provider with whom the patient is already in treatment in January 2001, or if the reimbursement for that provider will be less than it was in contract year 2000. Under either of these circumstances, you must allow members reasonable time to transfer care to a network specialty provider. Note that the transition period may begin with notice given before January 1, 2001. We believe that 90 days will be sufficient except under extraordinary circumstances.

Claims and Coverage Disputes. As you know, all FEHB members have the right to a fair and efficient process for resolving disputes with their Plans. This dispute resolution process will continue under parity. You must continue to review all disputed claims before they are referred to OPM, including those involving your MBHO, if you use one. We expect that you will review all disputed claims involving mental health or substance abuse treatment. We will not accept a dispute for review that has been considered only by your MBHO.

Employee Education and Communication. Where there are significant changes, we must ensure that all FEHB members are thoroughly informed about benefits, network restrictions, network entry procedures, telephone numbers, authorization processes, and referral procedures before January 2001. We will use enrollment guides, communication with

Federal agencies, and the OPM website to provide general information to the Federal population. We will not specify a particular strategy, but will ask you to provide a description of how you intend to educate your members. Plan brochures, Plan websites, fact sheets, newsletters, frequently asked question and answer sheets, provider directories, explanation of benefits documents (EOBs) over the remainder of this year, or other patient mailings, telephone calls, and health fairs are all acceptable means of communication. Acceptable strategies will require multi-faceted efforts.

Plan personnel who will have contact with members and potential members should be knowledgeable about your network entry procedures, point of entry telephone numbers, authorization processes, transfer of care procedures, and referral procedures. It is especially important that your nurse advice telephone staff or customer service staff and your representatives at health fairs be prepared to discuss all aspects of your mental health and substance abuse parity program. If you decide to use a vendor, you may want to bring their representative to health fairs with you.

Provider Network Education. All of your medical providers and facilities should be thoroughly informed about mental health and substance abuse network entry procedures, telephone numbers, authorization process, care transition procedures, and referral processes. If you are introducing a vendor into the process for the first time, it is critical to define lines of communication and acceptable methods for sharing information while preserving patient privacy. You also will need to establish and communicate a clear line of responsibility between you and your vendor.

The American Psychiatric Association can provide guidelines to help primary care providers to identify mental health problems early so that appropriate treatment can be initiated or referrals made.

Interface with EAP Programs. We will provide information to Federal Employee Assistance Programs (EAP) about our new mental health and substance abuse parity benefits. To ensure continuity of care, you should use existing EAP contacts or develop contacts where they do not already exist to facilitate appropriate member referrals. EAP personnel will need to understand your network entry procedures, authorization processes, care transition procedures, and telephone systems. We will facilitate the exchange of information between health Plans and EAP Programs.

Program Evaluation. We are working with the Department of Health and Human Services (HHS) to evaluate the implementation and operation of our mental health and substance abuse parity initiative. We look forward to your cooperation as we undertake this effort to understand more systematically the implications of parity for employers, health plans and participants.

Quality Assessment and Performance Management. This year our focus is on meeting the requirements for implementing mental health and substance abuse parity in 2001, but we look forward to the time when we work with you to institute performance measurement and

quality assessment activities. We will continue to work with accrediting organizations and others toward the goal of identifying a set of standards and measures that are generally accepted by the industry and by both public and private purchasers. We will keep you informed and seek your collaboration and cooperation in this process.

Improving the Quality of Healthcare by Reducing Medical Errors and Increasing Patient Safety

Background. The November 1999 Institute of Medicine (IOM) report, *To Err Is Human: Building A Safer Health System*, focused attention on medical errors and patient safety. The report indicated that as many as 44,000 to 98,000 people die in hospitals each year as a result of medical errors. We know that errors occur not only in hospitals, but also in other healthcare settings including physicians' offices and pharmacies. Medical errors carry not only a high human cost, but also a high financial cost. The IOM report estimates that medical errors cost the Nation approximately $37.6 billion each year; about $17 billion of those costs are associated with preventable errors.

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. While experts agree that there is no single magic bullet that will fix the problem, there are steps that organizations, including health Plans, can take to encourage systems improvements that will reduce error rates and improve the quality of healthcare.

On December 7, 1999, the President directed the Quality Interagency Coordination Task Force (QuIC) to develop and submit recommendations to him on improving healthcare quality and protecting patient safety in response to the IOM report. The White House released the QuIC report, *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*, on February 22. Copies are available at www.quic.gov. OPM is an active participant in QuIC coordinating activities designed to improve healthcare and enhance the effectiveness and efficiency of efforts by Federal agencies with healthcare responsibilities. We had a key role in drafting the report to the President.

For contract year 2001, we expect all FEHB Plans, at a minimum, to do the following:

1. Report to us on your current patient safety initiatives;
2. Report to us on how you will strengthen your patient safety program for the future;
3. Help us provide Plan members with consumer information and education regarding patient safety;
4. Work with your providers, independent accreditation agencies, and others to implement patient safety improvement programs.

The President set a goal for the Nation of a 50 percent reduction in errors in 5 years. The report identifies a number of actions for OPM to initiate in conjunction with other Federal agencies and outlines collaborative activities for public and private purchasers of healthcare coverage. Achieving the results is essential to the patients served by our healthcare system.

Your action is critical.

The Foundation for the Future. Beginning in 2001, all FEHB Plans must implement patient safety initiatives. During the health benefits open season this fall, we will make patient safety information available in both print and electronic format. To help us in that effort, we need to know about the error-reduction initiatives you already have in place. A system within your pharmacy programs that identifies the potential risk of a drug interaction and generates an alert is an example of an error reduction strategy. Case management, disease management, or health support systems that provide information and monitor the care of patients with chronic diseases to ensure that there are no errors or omissions in treatment are other examples. Complaint and grievance systems used to identify systemic problems might also be mentioned. We are eager to learn from and share your best practices, and will report on your initiatives on our website.

The Public-Private Partnership. The IOM report, the QuIC report, and the President's response have mobilized Federal agencies, private-sector healthcare purchasers, independent accrediting organizations, and healthcare quality coalitions to begin looking at approaches that will have a positive impact based on scientific evidence. We appreciate that you may receive multiple demands from multiple organizations and that contradictory requirements may dilute your effectiveness. To avoid that, we will collaborate with others to develop an effective strategy, a cohesive message and an implementation plan that focus efforts on a single goal – to improve healthcare quality.

As in so many other efforts, we will enlist your help. We encourage you to appoint an individual or office within your organization to manage your patient safety efforts. We will call upon them for advice and assistance and will count on them to bring to our attention issues and concerns regarding the direction, coordination or timing of our efforts as well as the efforts proposed by others.

In developing and enhancing your error-reduction program, we encourage you to consider strategies endorsed by others, such as the Leapfrog Group, a group of major healthcare purchasers sponsored by the Business Round Table. We expect you to work with your network providers to implement accountability systems and ensure that sound practices are noted and rewarded. While we recognize that there is no absolute agreement on any approach, the evidence suggests that if more consumers choose organizations that implement initiatives such as the following, there will be fewer errors.

1. **Computer Physician Order Entry (CPOE) Systems.** When CPOE systems with intercept capability based on protocols specified by the Institute for Safe Medication Practices are used in hospitals, they have been shown to reduce serious prescribing errors by more than 50 percent -- yet less than 1 percent of hospitals use them. CPOE systems can eliminate errors caused by misreading or misinterpreting handwritten instructions. They also can intercept orders that might result in adverse drug reactions or that deviate from standard protocols.

2. **Evidence-based Hospital Referral (EHR).** These referrals to specific institutions, sometimes called Centers of Excellence, offer the best survival odds based on scientifically valid criteria such as a hospital's volume of experience in treating a given condition. For example, EHR for the conditions below show strong statistical relationships between patient survival and a hospital's annual volume of such procedures or teaching status.

Condition/Procedure	Favorable Hospital Volume Characteristic
Coronary artery bypass	Volume ≥ 500/year
Coronary angioplasty	Volume ≥ 400/year
Abdominal aortic aneurysm repair	Volume ≥ 30/year
Carotid endarterectomy	Volume ≥ 50/year
Esophageal cancer surgery	Volume ≥ 7/year
Delivery with expected birthweight <1500 grams or gestational age < 32 weeks; or	Regional neonatal ICU[1] with average daily census ≥15
Delivery with pre-natal diagnosis of major congenital anomalies. Diagnosis[2] codes 741.XX, 742.0X. 742.2-742.9, 745.XX, 746.00-746.85, 747.1X-747.9, 748.0, 748.2-748.8X, 750.16, 750.3, 750.4, 750.6, 751.XX, 752.7, 753.1X, 753.3, 753.6, 756.4, 756.51, 756.55, 756.59, 756.6, 756.7X, 756.89, 756.9	Regional neonatal ICU[1] with average daily census ≥15

[1]Applies in states in which hospital licensing agency makes such a designation.

[2]This code list is receiving expert peer review and refinement.

EHR could prevent over 7,000 American deaths annually, based on estimates by University of California at San Francisco (UCSF) researchers. Research further indicates that such referrals could reduce a patient's risk of dying by more than 30 percent for some treatments.

3. **ICU Physician Staffing (IPS).** There is evidence of a direct correlation between the level of training of ICU personnel and the quality of patient care. When ICUs are staffed with physicians who have credentials in critical care medicine, or when intensive care specialists are available to respond to 95 percent of pages within 5 minutes, the risk of patients dying in the ICU has been shown to reduce by more than 10 percent.

We encourage you to gather information about the institutions that adopt these measures. At a minimum, we urge you to annotate your provider directories accordingly and to begin to educate your members about these and other patient safety initiatives. Additionally, we suggest that you encourage your network providers to participate in error reporting that facilitates the identification and correction of systemic problems.

The Role of Accreditation. We believe we are well positioned to encourage and support the efforts of accrediting organizations to add patient safety standards to their accreditation protocols. In 2002, we will require FEHB Plans to begin seeking accreditation from a nationally recognized organization that has incorporated appropriate standards into its accreditation surveys.

Education and Information Programs. OPM, in cooperation with HCFA and the Agency for Healthcare Research and Quality (AHRQ) was given responsibility for developing and coordinating a public information campaign on medical errors and safety. We will need your advice and cooperation as we determine what information consumers find useful and how best to present it. As products are developed, we will ask you to help us test their effectiveness and disseminate those we find useful.

Other Benefit Issues

Drug Formularies. We are reviewing our formulary policy. If you have a three-tier formulary benefit or are proposing to go to a 3-tier benefit, you must manage the benefit so that the majority of the savings come from changing practice patterns (or discounts or lower ingredient costs). We believe members should shoulder the consequences of their desire for one drug over another and have allowed benefit designs that place the cost of those decisions on them. However, we have seen 3-tier formularies that save money primarily from cost shifting, rather than from discounts obtained from drugs on the formulary. You may not use the third tier simply to shift the cost of the non-formulary or non-preferred drugs to the FEHB enrollee. We expect any new proposals for 3-tier benefits to document that the majority of savings will be from discounts, not cost shifting. Similarly, we expect Plans with existing 3-tier benefits to evaluate their existing programs. In future years, we will ask you to support the appropriateness of the 3-tier structure with data on cost savings and cost shifting.

We also want you to tell your members about material changes in your formulary policy, especially when the change is effective after January 1. This means you have to tell affected members about drugs they use that are no longer preferred and describe the dollar consequence.

ABMT for Breast Cancer. Recently, we have received questions about coverage for autologous bone marrow transplants with high dose chemotherapy treatment (ABMT/HDCT) for breast cancer. Our basic coverage requirements for this treatment have not changed. Currently, some Plans limit such treatment to Centers of Excellence or

services received as part of clinical trials. Where such proposals ensure that the provision of ABMT/HDCT for breast cancer is performed in an optimal setting and in accordance with current medical practice, we will entertain them. Our goal is to bring about the most positive outcomes for our enrollees.

Other Issues

Plain Language. Through Carrier Letters and the 1998 and 1999 Fall Conferences, we have emphasized our strong commitment to plain language. Together we re-wrote the administrative portions of your brochures for contract year 2000. Plan representatives and Office of Insurance Programs staff have worked diligently to develop benefit descriptions that are clear, are customer-focused and facilitate Plan-to-Plan comparison. We will send you the new language and format soon. Plan brochures for 2001 must be in the new format and use plain language throughout, including Plan-specific text. Your brochure language is due to your contract specialist **July 1, 2000**. Please note, however, that the brochure language that accompanies and describes your benefit proposals must be in plain language and received by **May 31, 2000**. Finally, you should review all of your Plan's consumer information, including explanation of benefit forms, to be sure you consistently use plain language.

Service Area expansions. We are reducing the paperwork requirements for service area expansions. You may support your service or enrollment area expansion by submitting your state approval for the proposed expansion. The state approval and your documentation must include a detailed geographic description including ZIP codes and political descriptions.

DoD/FEHB Demonstration Project. DoD staff notified us that they plan to expand this demonstration project to two additional sites. Our guidance for including the new sites will mirror that which is currently in place. Specifically, we will require that all open fee-for-service Plans add the additional sites. We will identify other participating Plans based on their service area and FEHB enrollment. We expect further information by mid-April and will notify you as soon as we receive it.

Fee-for-Service Plans and the Cost of Managed Care. Since 1991, we have allowed fee-for-service Plans to account for costs associated with managed care and cost-containment programs, such as pre-certification, outside of the contractual administrative expense limitation. These activities are now an integral part of each Plan's benefit structure and Plans have had ample opportunity to integrate them into their business systems. Beginning in 2001, we will account for these like any other administrative cost, and subject them to the annual limitation set forth in Appendix B of your contract. We will work with fee-for-service Plans to implement this change and to determine the appropriate adjustment to the limitation for contract year 2001.

Enrollment Code Data Field. In last year's call letter, we informed you of the inadequacy of a 3-digit enrollment code data field and the need to expand it to 10-digits. We still

believe this change will be necessary in future years; however, we have no immediate implementation plans. At a future date, we will convene a working group with Plan and Federal agency representation to develop system requirements and file formats. Plan for the 10-digit field if you make system changes.

Effective Date for Rates and Benefits. We notified you last year that we wanted to establish January 1 as the standard effective date for all open season changes and that we anticipated implementing this on January 1, 2001. Based upon comments from you and from Federal agencies, we will delay implementation of this change until January 1, 2002.

Conclusion

In previous years, we enclosed information on preparing benefit and rate proposals and producing brochures with the call letter. This year, we will send that information in separate carrier letters by mid April. In the meantime, please remember that all previous policy guidance remains in effect unless specifically changed by this letter.

Finally, we remain extremely price sensitive. We will accept carrier-proposed benefit improvements only to the degree that they are cost neutral. Savings from managed care initiatives must accrue to the FEHB Program. When you prepare your benefit proposal, review the effect of any proposed changes on language throughout your brochure (e.g., cost sharing, catastrophic protection and lifetime maximums). We prefer that you limit benefit enhancements to those described in this letter.

We look forward to receiving your rate and benefit proposals. Again, please discuss any changes you are considering with your contract specialist as soon as possible.

Sincerely,

(signed)
Frank D. Titus
Assistant Director
for Insurance Programs