Part One - Preparing Your Benefit Proposal

Given our timeframe for concluding benefit negotiations, we expect every HMO to submit a complete proposal by **May 31, 2001. We will not consider late benefit proposals.**

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;

- Comparison of the 2001 community package (adjusted for special FEHBP benefits) and your 2002 community package;

- Plain language description of each proposed change (in worksheet format) and the applicable 2002 proposed brochure language;

- Plain language description of each proposed clarification (in worksheet format) and the applicable 2002 proposed brochure language; and

- Signed contracting officials 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.

2002 FEHB Proposal Instructions

A. Provide the following material by **May 11, 2001:**

1. Experience-rated Plans - Provide a fully executed copy of the employer group contract OPM purchased for 2001.

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 2001. If the community benefits package we currently purchase is not the same one, also send us a copy of the package we do purchase.

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 2002 contract term except those still under review by your State as described in Item C below.

To simplify our comparison of your 2002 community benefits package proposal and the benefits package currently purchased for the 2001 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.

B. Provide the following by **May 31, 2001**:

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 as explained in Section D 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 - **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 as explained in Section D below. You must file this benefit package and the associated rate with your State if a filing is required by the State.

C. 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 your 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 usually 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, 2001**. If the State grants approval 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.

D. 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 and 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 benefit change. State the proposed brochure language, including the "How we change for 2002" section. You must write the language for the "How we change for 2002" 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 to eliminate the hospitalization copay, indicate whether this change will also apply to hospitalizations under the emergency benefit. <u>If there are two or more changes to the same benefit, present each change on a separate worksheet</u>. <u>Remember to use plain language.</u>

2. Describe the reason(s) for the proposed benefit change.

3. 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 (include documentation). 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 2002.

4. 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.

5. 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?

    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.

6. If the change requires new providers, 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. <u>Prepare a separate worksheet for each proposed clarification</u>. <u>Remember to use plain language.</u>

2. Describe the reason for the benefit clarification.

Please note that a benefit change is an increase or decrease, however slight, in the benefit shown in your current FEHB brochure, e.g., changing a prescription drug benefit from 31 to 30 days. Clarifications do not affect benefits. **You must show all changes that result in an increase or decrease in benefits as benefit changes, even if there is no rate change.**

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 people 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

_____

_____

_____

_____

_____

By: _____
(Signature of contracting official) (Date)

_____
(Typed name and title)

_____ _____
(Phone number) (FAX Number)

_____
(E-mail address)

Part Two - Changes in Service Areas or Redesignation as a Mixed Model Plan

Unless you inform us of changes, we expect your 2001 service area and provider network to be available for the 2002 contract term.

Service Area Reduction - Explain and support any proposed reduction to your 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 Expansion - You must propose any service area expansion by **May 31**. We will grant an extension for submitting supporting documentation to us until June 30.

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

Please note: You must base the information you provide us about your delivery system on executed contracts. Letters of intent are not acceptable. All contracts with providers must have a "hold harmless" clause. Use the statement form included with this mailing.

Important Notice: If you reduce the service area or establish a new rating area that requires current members to change enrollment codes, we will assign new codes and all of your FEHB members will have to reenroll during the 2001 Open Season.

Instructions

We will evaluate your proposal according to 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:

A. Describe the proposed expansion area in which you are approved to operate:

Provide the proposed service area expansion by ZIP code, county, city or town (whichever applies), and provide a map of the old and new service areas.

B. Authority to operate in proposed area:

Provide a copy of the State approval document authorizing you to 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

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 you formerly operated as a GPP or IPP and now offer 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, 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 we change for 2002" section plus "Facts about this HMO plan", if appropriate) to reflect the changes you propose.

You will need to provide the following information if we approve your proposal:

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?

Federal Employees Health Benefits Program
Statement About Service Area Expansion
(ONLY COMPLETE IF YOU ARE PROPOSING A 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 the Technical Guidance for 2002 Benefits and Service Area Proposals. 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.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

Part Three - Benefit Requirements for HMOs

Policies established in prior years remain in effect unless we say otherwise. We have highlighted some here as an aid to you in preparing your proposal. We will not accept benefits that are contrary to policy. You should work closely with your contract specialist to develop a complete benefit package for 2002. These policies include the following:

a. **Mental Health and Substance Abuse** - Under mental health and substance abuse parity, your 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 would like to see you make patient access to adequate mental health services happen through managed care networks of behavioral health care providers and innovative benefits design.

b. **Maternity and Mastectomy Admissions** - All plans must provide for maternity admission lengths of stay of at least 48 hours after a regular delivery and 96 hours after a caesarian delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.

c. **Pre-existing Conditions** - We do not allow pre-existing condition limitations on any benefit, except cosmetic surgery and dental benefits.

d. **Point of Service Product** - We will consider proposals to offer a Point of Service product under the FEHB Program only if you can demonstrate experience with a private sector employer who has purchased this product.

e. **Waiver of Office Visit Copayments for Prenatal and Postnatal Care** - A number of plans waive these copayments to help assure that pregnant members obtain adequate pre- and post-natal care, and thereby increase the likelihood that their babies will be born without complications. We encourage other HMOs to do the same.

f. **Infertility treatment** - We require you to cover treatment of infertility, but this requirement does not include related prescription drugs. Brochure language should clearly indicate whether you cover fertility drugs or not, in both the infertility benefit description and the prescription drug benefit description.

g. **Immunizations for Children** - All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or sera.

h. **Transplants** -All plans must provide coverage for all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney transplants. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. You may limit coverage for these three conditions to services provided at a recognized Center of Excellence and received in clinical trials, as long as

both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but you must provide necessary follow-up care to the experimental procedure. All HMOs must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors, you will coordinate benefits according to NAIC guidelines, as with any other benefit.

You may exclude from your FEHB benefits other transplants not mandated by us if they are not in the community benefit package we purchase, and as permitted by applicable State law.

i. **Dental and Vision Benefits** - We will consider dental or vision care benefits only from community-rated plans and only when they are a part of the core community benefits package we purchase.

j. **Prescription Drugs** - All plans must provide at least a minimum level of coverage for all medically necessary drugs that require a prescription for their use, and insulin. Drug benefit deductibles may not exceed $600. Member coinsurance may not exceed 50%. We don't allow lifetime or annual benefit maximums on prescription drugs.

You must cover disposable needles and syringes to administer covered injectables, IV fluids, and medications for home use, growth hormones, and allergy serum. In addition, you must provide benefits for "off-label" use of covered medications if prescribed for such use by a plan doctor in accordance with generally accepted medical practice.

You may not exclude drugs for sexual dysfunction (impotence), but you may place limits on the benefit.

You may use a drug formulary as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. You cannot have a closed formulary. You cannot use the formulary as a means to exclude benefits for the types of drugs mandated for the FEHB. We don't allow blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables".

Preemption Authority. The law governing the FEHB Program gives the Office of Personnel Management the authority to preempt State laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. In the best interests of our enrollees, we will not preempt State law that would have the effect of increasing the carrier's contractual benefits, unless the State mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

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DHHS-Mandated Benefits

All HMOs **must** offer certain benefits that are mandated for Federally qualified plans by the Department of Health and Human Services (DHHS), **without limitation as to time and cost,** other than as prescribed in the Public Health Service Act and DHHS regulations. These required benefits include:

a. Nonexperimental bone marrow, cornea, kidney, and liver transplants (see 2h. below for other FEHB

requirements in this area);

b. Short-term rehabilitative therapy (physical, speech, and occupational), if significant improvement in the patient's condition can be expected within two months;
c. Family planning services, including all necessary nonexperimental infertility services, to include artificial insemination with either the husband's or donor sperm. You don't have to cover the cost of donor sperm. You may exclude other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) to the extent permitted by applicable State law;
d. Pediatric and adult immunizations, in accordance with accepted medical practice;
e. Well child care from birth:
f. Periodic health evaluations for adults;
g. Home health services;
h. In-hospital administration of blood and blood products (including "blood processing");
i. Surgical treatment of morbid obesity, when medically necessary;
j. Implants - the surgical procedure must be covered, although the cost of the device may be excluded.

Federally qualified community-rated plans offer these benefits at no additional cost, since the cost is covered by the community rate. Community-rated plans that are not Federally-qualified should reflect the cost of any non-community benefits on Attachment 2 of their rate calculation. If there is no additional cost, the cost entry should be zero.