FEHB Program Carrier Letter
All Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2008-06 **Date:** March 11, 2008

Fee-for-service [04] Experience-rated HMO [04] Community-rated HMO [04]

Subject: Federal Employees Health Benefits Program Call Letter

EXECUTIVE SUMMARY

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. Your proposals for the contract term beginning January 1, 2009 are due on or before **May 31, 2008**. Please send your proposals by **overnight mail, FAX, or e-mail** to your contract specialist. We expect to complete benefit and rate negotiations by **August 15, 2008** to ensure a timely Open Season.

Our key initiatives and policies this year are as follows:

1. We encourage proposals for value-based benefit designs. As you develop your benefit proposals, please consider the effect a design element would have on the delivery of health care and the health outcomes of covered individuals.

2. We encourage carriers to offer an alternate choice for Medicare-eligible enrollees as a sub-option within their existing plan option(s). Proposals should be for a pilot, featuring Medicare wrap-around benefits, with the same premium as the high, standard, or basic option for which it would be a sub-option.

3. We strongly encourage proposals for enhanced hearing benefits for adults, including hearing aids.

4. We continue to encourage carriers to expand their health care cost and quality transparency initiatives, to broaden the use of health information technology (HIT) and to educate consumers on the value of HIT and transparency.

5. We continue to encourage proposals for High Deductible Health Plans (HDHP) with Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA).

6. We strongly encourage Health Maintenance Organizations (HMO), which are experiencing high premium increases for enrollees due to local market conditions, to submit remedial proposals for next year.

7. We call your attention to the schedule changes in the American Academy of Pediatrics (AAP) "Recommended Immunization Schedules for Children and Adolescents – United States, 2008."

8. We call your attention to new codes for the screening and referral of alcohol and substance abuse.

9. We request that you review your durable medical equipment coverage to ensure benefits are available for assistive technologies.

10. We reiterate our requirements in the FEHB Carrier Guiding Principles.

11. This fall, we will solicit proposals for a carrier to offer benefits under Section 8903(2) of Chapter 89, 5 U.S.C. as the prime contractor for the Indemnity Benefit Plan effective January 1, 2010.

I. INTRODUCTION

The FEHB continues to be a model employee health benefits program featuring competition and consumer choice. As we move forward into 2009, we encourage FEHB carriers to make innovative proposals to further increase consumer choice and to improve the quality offered through their health care delivery systems.

We would like to see value-based benefit proposals that expand consumer awareness about the importance of maintaining healthy lifestyles and receiving appropriate preventive care. We encourage innovative proposals aimed at controlling long-term health care costs by encouraging the use of services to produce better health outcomes.

Where possible, you should demonstrate that you have evaluated your proposed benefit changes, not just from a cost perspective concerning the proposed benefits, but also with regard to the effect on health outcomes. The goal of health care is the preservation or enhancement of mental and physical well being by preventing, treating, and managing illness or injury. In an environment of increasing costs, we need to stay focused on the goal and provide reimbursement for services so enrollees obtain the maximum value available for their health care dollars.

We expect your benefit proposals to be consistent with the policies outlined in this letter. Proposals should be cost neutral by offsetting any proposed increases in benefits with corresponding medical savings or benefit reductions, unless stated otherwise. As a reminder, we will not entertain any proposals for enhanced FEHB dental benefits and we are not encouraging any changes to current dental or vision benefits for 2009.

II. FEHB PROGRAM BENEFITS AND INITIATIVES

A. Quality and value in benefit design

Reducing barriers to care is an important method of managing disease in the chronically ill. When patients maintain compliance in taking medications or following treatment plans proven to be effective in managing chronic conditions such as high cholesterol, high blood pressure, asthma, diabetes, osteoporosis, depression, etc, overall medical costs can be reduced, and better health can be achieved.

We encourage evidence-based proposals with incentives for patients to maintain compliance with drug or treatment regimens for chronic conditions. In addition, we encourage you to review your programs for targeted condition management and enhance benefits for conditions such as high cholesterol, high blood pressure, asthma, and diabetes, which tend to have the highest drug claims cost under this Program.

Preventive care is an important component of value-based benefit design. We are seeking proposals to expand consumer awareness of the importance of healthy lifestyles to avoid the onset of chronic conditions.

We encourage you to make health risk assessment tools available to enrollees on your web sites. We also encourage you to increase your consumer messaging regarding the importance of preventive/screening services, such as breast cancer screening, and other conditions for which we have HEDIS quality measures (cholesterol, diabetes, etc.). Please provide a description of your current consumer outreach activities for these conditions and how you propose to enhance them.

B. Medicare Enrollee Pilot

OPM is encouraging proposals for pilot programs wherein participating carriers offer a sub-option for Medicare eligible annuitants as an alternate choice within their existing option(s). The sub-option may include premium pass-through accounts to be used solely for paying some or all of Medicare premiums (e.g. Part B, C, or D). The uniform contribution amount should provide an adequate incentive for eligible members, but need not represent the full amount of Medicare premiums. Individual Medicare premium amounts vary based on consumer choice, penalties for failure to enroll in Medicare at the first opportunity, or increased premiums based on means testing.

The sub-option must be a Medicare wrap-around benefit design with the same premium as the high, standard, or basic option for which it would be a sub-option. FEHB requirements that apply to all plans, such as mental health parity, also apply to the benefits offered in the sub-option. Individual annuitants enrolled in plans offering a sub-option pilot must be able to elect whether or not to participate in the pilot program.

C. Hearing Benefits

In last year's call letter, we encouraged you to review your hearing benefits for newborns and children. We are pleased many carriers increased benefits with little or no additional premium cost. We are now strongly encouraging you to enhance hearing benefits for adults. We are seeking benefit proposals for professional services as well as hearing aids. Carriers may provide coverage for these hearing services subject to limitations and maximum payable benefits. Proposals for improved hearing benefits need not be cost neutral.

D. Durable Medical Equipment

Carriers should review their coverage for durable medical equipment (DME) in light of advances in technology for assistive devices designed for individuals with special needs; including vision, hearing, mobility and movement, and cognition. Examples include augmentative and alternative communication (AAC) products such as speech generating devices and audible prescription reading devices. Please provide a statement concerning your coverage for these types of benefits.

E. Health Information Technology (HIT) and Transparency

OPM expects all FEHB carriers to continue their important efforts to make fundamental information about health care quality and costs available to consumers. The competitive market for health care can only function efficiently when enrollees can make informed choices to obtain the highest quality care at the most affordable price.

We expect proposals for increased health care cost and quality transparency as well as those promoting the increased use of state-of-the-art HIT. Your proposals should demonstrate how you are: 1) expanding the use of Personal Health Records (PHR); 2) increasing the number of enrollees accessing PHRs; 3) expanding the range of information available to consumers on provider charges and including adjustments for regional differences; 4) expanding information available to consumers regarding provider quality; and, 5) how you are educating consumers on the value of HIT and transparency.

For the 2009 contract year, we will recognize and reward carriers for the following actions:

1. Making consumers aware of the value of HIT;
2. Making PHRs available to enrollees based on their medical claims, lab test results and medication history;
3. Meeting OPM's health care cost and transparency standards;
4. Providing incentives for ePrescribing; and,
5. Ensuring compliance with Federal requirements that protect the privacy of individually identifiable health information.

F. High Deductible Health Plans with Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA)

We continue to encourage proposals to expand the availability of High Deductible Health Plan options. These consumer-driven options continue to increase in popularity and we will work with you on flexible approaches to make them more available to the Federal population.

G. HMO Community Package Requirements

Our goal is to offer a range of competitive choices to Federal employees and retirees in each market. Therefore, we will allow Health Maintenance Organizations (HMO) to adjust benefit payment levels to remain competitive in the FEHB Program. If you would like to offer benefits at a lower price level, you may propose an alternate benefits package from the one purchased by the greatest number of non-Federal subscribers in the prior year. However, the alternate package must be one you are currently selling in the local market.

If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate if it is in the best interest of the Government and FEHB consumers. You should identify each of the differences between your current benefits package and the proposed offering, and include the impact on your community rated price proposal. Your alternate community package must continue to meet the FEHB benefit requirements that apply to all plans. That is, you may have different co-payment or coinsurance levels, but you may not exclude or limit the services required by our benefit guidance.

H. Preventive Care Guidelines

As a reminder, the FEHB Program follows the guidelines on preventive care for children recommended by the American Academy of Pediatrics. The American Academy of Pediatrics (AAP) recently released its, "Recommended Immunization Schedules for Children and Adolescents – United States, 2008." It includes updated schedules for children up to age six, ages seven to eighteen, and children with late or incomplete immunizations. Schedule changes include: a single dose of pneumoccoal conjugate vaccine for healthy children ages 24 to 59 months who are incompletely immunized; expansion of the age recommendations for the use of the live attenuated influenza vaccine to include healthy children as young as two years old; a reduced time interval for the administration of the second dose of live attenuated nasal influenza vaccine (when a second dose is required) from six to four weeks; and a single dose of quadrivalent meningococcal conjugate vaccine for all adolescents 11 to 18 year olds, if not previously administered, and for two to ten year-old children at increased risk for meningococcal disease.

The FEHB Program also follows the guidelines for adults based on the recommendations of the United States Preventive Services Task Force (USPSTF).

For your ease of reference, web links to these guidelines are at the following:
http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf
http://www.ahrq.gov/clinic/uspstfix.htm.

I. Alcohol and Substance Abuse Screening

Beginning in 2008, health care practitioners who provide alcohol and substance abuse screening have new codes for these services. Two new CPT codes (99408 and 99409) and two new HCPCS codes (G0396 and G0397) are now available for covered providers to use in filing claims for their screening and brief intervention services. A number of FEHB carriers have already updated their systems to incorporate these codes. All carriers should be aware of these new codes to update their systems so that they can more efficiently provide benefits for these types of services.

J. Program Integrity

We expect timely and accurate processing of claims, including coordination of benefits; prompt and accurate submission of actuarial and financial data, including accounting statements; and, we expect all plans to be well managed and financially secure. The FEHB Program Carrier Guiding Principles are listed on our website at http://www.opm.gov/carrier. All FEHB carriers must adhere to these principles.

K. Indemnity Benefit Plan

The Federal Employees Health Benefits Act of 1959, which established the Federal Employees Health Benefits Program, codified at 5 U.S.C. §§ 8901 *et seq*., authorizes OPM to contract with qualified health benefits plans. The statute limits the participation of fee for service (FFS) plans to one service benefit plan, one indemnity benefit plan, and plans sponsored by federal employee and postal organizations, while allowing for an unlimited number of comprehensive medical plans (commonly known as HMOs). The Act excludes contracts under the FEHB from statutes and regulations requiring competitive bidding. Section 8902 of Title 5 provides that OPM may contract with qualified carriers without regard to section 5 of title 41 the Federal or other statute requiring competitive bidding.

Section 8903 of Title 5 defines the Indemnity Benefit Plan as one governmentwide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of 5 U.S.C. An Indemnity Benefit Plan is required by statute to provide hospital care; surgical care and treatment; medical care and treatment; obstetrical benefits; prescribed drugs, medicines, and prosthetic devices; and other medical supplies and services.

Aetna served as the carrier for the governmentwide Indemnity Benefit Plan from the establishment of the FEHB Program in 1960 until December 31, 1989. Since 1990, there has been no carrier for the Indemnity Benefit Plan.

Later this fall, OPM plans to solicit proposals from health insurance carriers interested in providing health plan benefits under 5 USC, Chapter 89, Section 8903 (2) Indemnity Benefit Plan effective January 1, 2010. We will advise current FEHB contractors at the time OPM's request for proposals is issued.

L. Technical Guidance for Proposals

By April 30, we will send specific requirements for submitting your benefit and rate proposals. By May 30, we will provide you with information on how to prepare your brochures for 2009. As you prepare your benefit proposal, please review the effect of any proposed benefit changes on language throughout your brochure (e.g., cost sharing, catastrophic protection and lifetime maximums), and include your proposals for appropriate language changes in your May 31 submission.

As a reminder, you may only distribute brochures, provider directories or lists, and marketing materials or other supplemental literature that are prepared in accordance with FEHBAR 1652.203-70.

CONCLUSION

Please discuss your benefit changes with your contract specialist before you submit your proposals. Remember, proposed benefit changes should be cost-neutral, except where otherwise noted, and any savings from managed care initiatives must accrue to the FEHB Program. We will begin negotiations when we receive your proposals.

Thank you for your continued commitment to the FEHB Program. We look forward to receiving your timely benefit and rate proposals for the 2009 contract term.

Sincerely,

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