FEHB Program Carrier Letter
Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2011-10(b) **Date: May 4, 2011**

Fee-for-service [n/a] Experience-rated HMO [8] Community-rated [8]

SUBJECT: 2012 Technical Guidance and Instructions for Preparing Benefits and Service Area Proposals for New HMOs

Enclosed are the technical guidance and instructions for preparing your benefit and service area proposals for the contract term January 1, 2012, through December 31, 2012. The guidance and instructions are in five parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Changes in Service Area Since You Applied to the Federal Employees Health Benefits (FEHB) Program
- Part Three: Benefits for Newly - Approved HMOs
- Part Four: Preparing Your 2012 Brochure

Please refer to our annual *Call Letter* (Carrier Letter 2011-05 dated March 25, 2011, for *policy guidance*. OPM has benefit policies that remain in effect from year to year. See Part 3 of this letter for details.

Your proposal for benefits and service area changes is due no later than **May 31, 2011**. Please send a copy of your proposal to your contract specialist on a CD-ROM or other electronic means, in addition to a hard copy. Your proposal should include the corresponding language for the brochure. You do not need to send your fully completed 2012 brochure by May 31, only the brochure language to describe your proposed benefits for Section 5 of the brochure.

Each year we assess carriers' overall performance. We consider your efforts to submit benefit and rate proposals timely as well as the accurate and timely production and distribution of brochures. Enclosed is a checklist (Attachment VIII) with the information you must provide. Please return the completed checklist along with your benefit and rate proposals.

Your OPM contract specialist will negotiate your 2012 benefits with you and will finalize the negotiations in a close-out letter. Please send an electronic version of your fully completed 2012 brochure to your contract specialist within five business days following the receipt of the close-out letter **or** by the date set by your contract specialist.

As part of your proposal, please include your carrier's proposed layout for "Going Green." Attachment VII includes additional information on this initiative.

Rate instructions for community-rated plans and experience-rated plans will be provided under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with

HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

In keeping with the spirit of the Call Letter, we remain extremely price sensitive. Although we do not limit HMOs to zero-cost benefit trade-offs, we prefer that benefits remain consistent with your benefit package purchased by the greatest number of your subscribers.

Our experience is that a plan with less than four years experience in the FEHB Program is most at-risk for dropping out of the program. Newer plans that drop out are more likely to cite insufficient FEHB enrollment as the reason for no longer wishing to participate. The FEHB Program is a mature, managed-care market. Your ability to differentiate yourself in terms of pricing, benefits, service, or provider panel will go a long way in determining your program success. Keep your lines of communication open with your OPM contract specialist. Don’t hesitate to call if you have any questions about the Call Letter or the material enclosed in this letter.

Sincerely,

John O’Brien
Director
Healthcare and Insurance

2012 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

Please send the following by May 12, 2011:

- A copy of a fully executed employer group contract (i.e., *certificate of coverage)* that non-Federal subscribers purchased in 2011.

Please send the following by May 31, 2011:

- You must file your proposed benefit package and the associated rate with your state, if required. If you have made changes since your application, submit a copy of the new benefits description and answer the questions below.

- Attach a chart displaying the following information:

  - Benefits that are covered in one package but not the other

  - Differences in co-insurance, co-pays, numbers of days of coverage and other levels of coverage between one package and the other

  - The number of subscribers/contract holders who currently purchase each package.

Community-rated Plans

We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions (as indicated in the *Call Letter* for the 2009 contract year). If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will accept an alternate community package only if it is in the best interest of the Government and FEHB consumers. You also should identify each of the differences between your current benefit package and the proposed offering and include the impact on your community rated price proposal.

The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.

The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there is an impact on premiums.

Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult your contact in the Office of the Actuaries regarding the alternate community package and requirements for the use of Similarly Sized Subscriber Groups (SSSGs) in the rating process.

- Submit a copy of a fully executed community benefit package by May 11, 2011 (a.k.a. master group contract or subscriber certificate), including riders, co-insurance, and deductible amounts (e.g. prescription drugs and durable medical equipment) that non-Federal subscribers purchased in 2011. The material must show all proposed benefits for FEHB for the 2012 contract term, except for those still under review by your state. We will accept the community-benefit package that you *project* will be sold to the majority of your non-Federal subscribers in 2012. If you offer a "national plan" then you need to send us copies of your community-benefit package for each state you cover.

  Note: Your FEHB rate must be consistent with the community package on which it is based. Benefit differences must be accounted for in your proposal or you may end up with a defective community rate.

All HMOs

Your benefit proposal must be complete. The timeframes for concluding benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

- Benefit package documentation
- A plain language description of each proposed benefit
- A signed contracting official's form (see attached)
- Describe your state's filing process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent to us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to **May 31, 2011,** and you obtain approval and submit approval documentation to us by **June 30, 2011**. Please let us know if the state grants approval by default; i.e., it does not object to proposed changes within a certain period after it receives the proposal. The review period must have elapsed without objection by June 30, 2011.

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 the information for each state.

- Please highlight and address any state mandated benefits. State-mandated benefits should be reported if finalized by May 1, 2011.

If there are, or if you anticipate, significant changes to your benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Part Two - Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program

Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2012 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed-care industry, there are geographic areas where our customers have more limited choices than in other areas. Please consider expanding your service area for FEHB to all areas in which you have authority to operate. This will allow greater choice for our customers. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose.**

We will provide detailed instructions for submitting your ZIP Code file in September. However, please note that we will ask you to provide your ZIP Codes in a comma delimited text file format and we will provide instructions for uploading your files to our secure web portal.

- **Service Area Expansion** - You must propose any service area expansion by May 31, 2011. We may grant an extension for submitting supporting documentation to us until June 30, 2011.

- **Service Area Reduction** - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain. Please provide a map and precise language to amend the service area description for both expansions and reductions.

Important Notices

- The information you provide about your delivery system must be based on **executed** contracts. We will not accept letters of intent.

- All provider contracts must have "hold harmless" clauses.

Criteria

We will evaluate your service area 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
- Your ability to provide contracted benefits

Please provide the following information:

- **A description of 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. Provide the exact wording of how you will describe the service area change in the brochure.

- **The authority to operate in proposed area:**

  Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.

- **Access to providers:**

  Provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have **executed** contracts. Also, please update this information on August 31, 2011. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of our initial submission.

Service and Additional Geographic Areas:

Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an **additional** geographic area that surrounds, or is adjacent to, your service area, you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to enroll members who **work** but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy in your brochure.

Benefits may be restricted for non-emergency care received outside the service area. Your proposal must include language to clearly describe any additional geographic area as well as your service area.

Federal Employees Health Benefits Program Statement about Service Area Expansion

(COMPLETE THIS FORM ONLY IF YOU ARE PROPOSING A SERVICE AREA EXPANSION)

We have prepared the attached service area expansion proposal in accordance with the requirements found in Part Two: Changes in Service Area, of the Technical Guidance for 2012 Benefit and Service Area Proposals. Specifically,

1. All provider contracts include "hold harmless" provisions.

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 is accurate as of the date of this statement.

_____

Signature of Plan Contracting Official

_____

Title

_____

Plan Name

_____

Date

Part Three – Benefits for Newly-Approved HMOs

The FEHB policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your contract specialist to develop a complete benefit package for 2012. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to *Call Letter* (Carrier Letter 2008-06) dated March 11, 2008. The FEHB policies include the following:

We expect that you cover state-mandated benefits even if your community package does not specifically reference them.

1. **Programs to Manage Patient Care** – In February we issued Carrier Letter 2011-2 Demonstrating Value through Clinical and Financial Integration requesting plans to submit information on bundled payments, the Patient-Centered Medical Home, and Accountable Care Organizations. We encourage you to submit proposals for pilot programs that include detailed operational plans, including outreach and other communications to enrollees.

2. **Programs to Promote Health and Wellness** – We expect you to offer health and wellness programs that have the potential to improve employee productivity by encouraging healthy lifestyles.

3. **Adult and Childhood Obesity** - We encourage you to provide us with proposals for health promotion programs to reduce the incidence of both adult and childhood obesity. Please describe in detail the programs you are offering to encourage healthy lifestyles and to reduce rates of obesity in children and in adults.

4. **Promoting Healthy Lifestyles** – We strongly encourage you to offer incentives such as reduced co-payments and deductibles to enrollees who complete a health risk assessment (HRA), are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Please complete Attachment II: Current Baseline Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan and Attachment III: Projected 2012 Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan.

5. **Reduce Health Disparities** – We encourage you to submit proposals that aim to reduce disparities, such as racial and ethnic disparities, in both health status and healthcare. Please provide us with a description of the specific goals and processes you are undertaking or plan to implement in order to reduce health disparities.

6. **Generic drugs** – We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically effective therapeutic alternatives. We encourage health plans which have not focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012

7. **Pharmacy Spending** - We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically appropriate therapeutic alternatives. We encourage health plans which have not

focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012. Additionally, we expect you to submit proposals that outline a savings plan to reduce your overall pharmacy spending for next year, without simply shifting costs to enrollees. We believe a four percent reduction in overall pharmacy spending should be achievable and each carrier will be required to do its part to help reach that goal. The savings plan should demonstrate how a reduction in pharmacy costs or overall costs is achievable. We will also require Plans to submit information on their current pharmacy costs and current drug benefits structure using standard formats which will be included with the rate instructions. This information will be used to compare pharmacy costs per enrollee, across plans, and for the FEHB Program as a whole.

8. **Prescription Drugs** – All plans must meet creditable coverage requirements. The prescription drug benefit must be at least as good as the standard Medicare Part D Benefit. All plans must provide at least a minimum coverage level for all medically necessary drugs that require a prescription, including insulin. Prescription drug deductibles may not exceed $600 and co-insurance may not exceed 50 percent. We don't allow lifetime or annual benefit maximums on prescription drugs. You must cover disposable needles and syringes used to administer covered injectables, IV fluids, and medications for home use, growth hormones, and allergy serum. You must also provide benefits for "off-label" use of covered medications when prescribed in accordance with generally accepted medical practice by a plan doctor. You may not exclude drugs for sexual dysfunction; however, you may place dollar or dosage limits on these drugs. You may use a drug formulary or preferred list as long as the plan provides benefits for non-formulary or non-preferred drugs when prescribed by a Plan doctor. You cannot use the formulary or preferred list as a means to exclude benefits for drug coverage required through the FEHB Program. We do not allow exclusions of broad categories of drugs such as "non-generics" or "injectables".

   Plans that use levels or tiers to denote different prescription drug co-pays must clearly describe the coverage and difference between each level or tier in the 2012 brochure. The *2012 Guide to Federal Benefits* will illustrate the prescription drug co-pays at the following levels.

   - Level I – generally includes generic drugs but may include some brand formulary or preferred brands. Usually represents the lowest co-pays.
   - Level II – generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range co-pays.
   - Level III – may include all other covered drugs not on Levels I and II, i.e. non-formulary, or non-preferred, and some specialty drugs.

   If your plan has more than three co-pay levels for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2012 Guide to Federal Benefits.*

9. **Increase FEHB Providers** – We strongly encourage you to increase the number of health care providers in FEHB plan networks who are board certified, or have training in, geriatrics. We will allow you to use incentives to encourage geriatric doctors to participate in your network; however, please provide a cost benefit analysis. Please provide data on the number and percentage of providers with this training in your current networks, including particular focus on those geographic areas with a large older population, and your plan to reach out to providers and

expand your networks with this additional expertise.

10. **Affinity products** - We have encouraged you to add products on the "non-FEHB" page of your plan brochure that would be attractive to Federal members. We especially encourage plans to acknowledge individual policies for extended family members, such as dependents beyond age 26 and domestic partners.

11. **Actuarial Value** – We are requesting additional information on the medical loss ratio for FEHB plans. Please refer to the medical loss ratio defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options.

12. **Facility Fee for an Office Visit** - We would like to clarify that if an enrollee visits a doctor whose office is located in a facility (such as a hospital), the enrollee should only be charged the doctor's co-payment. We have been informed that some enrollees are charged the hospital co-payment in addition to the doctor's copayment. Please ensure that this does not occur.

13. **Eliminate Cost-Sharing** - As stated in last year's Call Letter, benefits for coverage of all recommended in-network preventive care, immunizations, and screenings will be provided with no cost-sharing. A list of recommended preventive services (including immunizations) by the Advisory Committee on Immunizations Practices (ACIP) in conjunction with the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), and Health Resources and Services Administration (HRSA) is included in Attachment IV, Tables 1 – 3.

14. **Smoking Cessation** – Carriers must offer smoking cessation programs without co-payments or co-insurance and which are not subject to deductibles, annual or lifetime dollar limits. The programs must include at least two quit attempts per year with up to four smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling and individual counseling. In addition to the smoking cessation programs, drugs (over-the-counter (OTC) and prescribed) approved by the FDA to treat tobacco dependence for smoking cessation should be available with no co-payments or co-insurance and not subject to deductibles, annual or life time dollar limits (a list of covered OTC drugs is attached). Plans should include OTC drugs in their smoking cessation programs.

    Plans must follow the FDA guidelines for all approved drugs. Enrollees who use drugs with multiple purposes, such as Zyban which may be used to treat smoking cessation or depression, must be carefully monitored by a health care professional.

    For further information regarding tobacco cessation treatment, please reference the Clinical Practice Guideline, Treating Tobacco Use and Dependence 2008 Update, U.S. Department of Health and Human Services Public Health Service, May 2008. Here is a link to the Guideline: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

15. **Donor Testing Services** - We are enhancing benefits related to donor testing services for bone marrow and stem cell transplants and encourage proposals that include testing for up to four bone marrow transplant donors per year. We encourage proposals that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.

16. **Assistive Technologies** - We encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. We also encourage you to offer auditory osseointegrated implants / bone anchored hearing aid (BAHA). Please note that the BAHA benefit should be listed under orthopedic/prosthetic devices in your plan brochure. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

17. **Coordination of Benefits** - When FEHB Program plans pay secondary COB claims, including those with **Medicare**, they pay the lesser of their allowance or the difference between their allowance and what is paid by the primary plan. You may continue to charge the member co-payments or co-insurance on secondary COB claims. If your benefit design includes co-insurance, it should be based on the remaining charge, not on your allowance. In the following example Medicare is primary and your health plan is secondary. The plan design requires the member to pay 10% co-insurance.

DOS 02/01/10 billed:	$10,000
Medicare allowance:	$9,000
Medicare payment:	$7,200 (80% of allowance)
Balance after Medicare payment:	$1,800
Member responsibility:	$1,800 x 10% = $180
Plan pays:	$1,800 x 90% = $1,620

    If your brochure language does not correctly describe this process currently, please work with your contract specialist to clarify your language for 2012.

18. **Affordability** – We will work closely with you to find ways to manage costs and utilization effectively.

19. **Value-Based Benefit Design** – Please establish how your complete benefit package is value-based.

20. **Catastrophic Limitations** - We expect carriers to fully describe their catastrophic limitations for all benefits as well as balance billing for the services of out-of network providers to ensure FEHB enrollees receive appropriate coverage for medically necessary services. We encourage proposals to mitigate any gaps you may have in the catastrophic coverage that you offer.

    Please provide a full description of your catastrophic limit(s):
    1. Describe the expenses that fall under each of these categories: medical, surgical, mental health and prescription drug benefits.
    2. Please indicate completely what expenses are still the member's responsibilities after the member has reached the limit.
    3. If you have an out-of-network benefit, please include any payments that members could be responsible for after they have met the catastrophic limit, including provider balance billing. We will consider cost neutral proposals that mitigate the potential for high cost sharing.
    4. Given your catastrophic limits, what is the maximum out of pocket expense a member may pay for covered services?

21. **Health Care Cost and Quality Transparency Initiatives** – We encourage you to expand your 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.

22. **Preventable Medical Errors** - We encourage you to review your coverage guidelines with respect to preventable medical errors and to revise your policies as long as you have arrangements in place to protect your members from balance billing.

23. **Preventive Care** – As stated in last year's *Call Letter*, we encourage your review of your current preventive benefits for adults and compare them to the United States Preventive Services Task Force (USPSTF) recommendations and propose benefit changes to address any gaps between the two. The USPSTF guidelines are at http://www.ahrq.gov/clinic/uspstfix.htm.

24. **Organ/Tissue Transplants** – We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance.

    When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following tables in Attachment V:

    - Table 1– OPM's required list of covered organ/tissue transplants
    - Table 2 – Recommended organ/tissue transplants when received as part of a clinical trial

25. **Mental Health Parity** - The Department of Health and Human Services, Department of Labor, and Department of Treasury released interim final regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Under these rules, health plans cannot have separate deductible and out-of-pocket maximum requirements that are applicable only with respect to mental health or substance use disorders. This means plans must accrue member expenses toward the same deductibles and out-of-pocket maximums for both medical and surgical benefits and mental health and substance use disorder benefits. In addition, if a health plan has a lower copayment for Primary Care Physician visits, the Plan must use the same copayment level for outpatient visits to providers of mental health or substance use disorder services.

    These regulations require parity between medical/surgical and mental health/substance use disorder benefits with respect to financial requirements (copayment, co-insurance, deductibles, and out-of-pocket maximums) or treatment limitations (visit or treatment limit) in the following six classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drug benefits. A financial requirement or treatment limitation must be compared only to a financial requirement or treatment limitation of the same type (co-payments, co-insurance, etc.). For instance, co-payments are compared only to other co-payments; co-payments cannot be compared to co-insurance and vice versa.

    In addition, the regulations state a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (level of type of financial requirement applied to more

than one half) financial requirement or treatment limitation of that type that is applied to substantially all (at least two-thirds) medical/surgical benefits in the same classification. In other words, if co-payments are identified as the financial requirement applied to substantially all medical/surgical benefits (measured by plan costs) in that classification and there are multiple levels of co-payments, the level that applies to more than one half would be considered the "predominant" financial requirement for that classification. Similarly, if a single level applies to at least two-thirds of medical/surgical benefits in a classification, then that level is considered the predominant level that applies to mental health/substance use benefits in that classification. Example: Plan A co-payments apply to at least two-thirds of inpatient/in-network classification and there are two levels of co-payments ($20 & $30); however, the $30 copayment applies to more than one-half of the benefits in that classification, in this case the $30 copayment would be the predominant level.

The regulations prohibit discrimination in the application of non-quantitative treatment limitations, such as medical management standards, prescription drug formulary design, determinations of usual, reasonable and customary amounts, step therapy, and requiring benefits be subjected to a condition such as completing a course of treatment. Any elements used in non-quantitative treatment limitations for mental health benefits must be comparable to those used for medical and surgical benefits. The regulations allow variations to this rule to the extent that recognized clinically appropriate standards of care permit a difference; therefore, concurrent review of mental health care can be required even if the same is not required for medical surgical care.

For further guidance refer to carrier Letter No. 2008-17 and Letter No. 2009-08 as well as the Interim Final Rules implementing the Act: http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf

26. **Durable Medical Equipment.** Please indicate which items you cover by completing the checklist in Attachment VI.

27. **Maternity and Mastectomy Admissions** – All plans must provide for maternity benefits. Benefits must be for coverage of admissions of at least 48 hours after a regular delivery and 96 hours after a cesarean delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an in-patient basis and remaining in the hospital for at least 48 hours after the procedure.

28. **Pre-existing Conditions** – Pre-existing condition limitations are not permitted for any required benefits.

29. **Point of Service Product** – We will consider proposals to offer a Point of Service (POS) product under the FEHB Program. Your plan's proposal must demonstrate experience with a private sector employer who has already purchased the POS product.

30. **Infertility treatment** – We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. **This requirement does not include related prescription drugs.** Your brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.

31. **Immunizations for Children** – All FEHB plans must provide coverage for childhood

immunizations, including the cost of inoculations or serums.

32. **Dental, Vision and Hearing Benefits** – All plans must cover medically necessary treatment of conditions and diseases affecting eyes and ears, such as glaucoma, cataracts, ruptured ear drums, etc. Beyond treatment for medical conditions by appropriate providers, we will consider dental care (preventive, restorative, orthodontic, etc.), vision care (refractions, lenses, frames, etc.), or hearing care benefits from community-rated plans when these benefits are a part of the core community benefit package that we purchase. It is important that your 2012 brochure language clearly describes your coverage.

33. **Physical, Occupational and Speech therapy** – You must provide coverage for no less than two consecutive months per condition. You may provide a richer benefit, such as 60 visits per condition, if that is your community benefit. You may apply co-pays or co-insurance of up to 50 percent if that is your community benefit. All plans must provide **speech** therapy when medically necessary. If your community package limits speech therapy coverage to rehabilitation only, you must remove that limit for the FEHB Program.

Federal Preemption Authority

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not pre-empt state laws that increase our enrollee's benefits unless the state mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

Department of Health and Human Services (HHS) Benefits

All HMOs *must* offer certain benefits that the Department of Health and Human Services (HHS) requires for Federally-qualified plans, **without limits on time and cost,** except as prescribed in the Public Health Service Act and HHS regulations. These required benefits include:

- Non-experimental bone marrow, cornea, kidney and liver transplants
- Short-term rehabilitative therapy (physical, occupational, and speech), if significant improvement in the patient's condition can be expected within two months
- Family planning services include all necessary non-experimental infertility services such as artificial insemination with either the husband's or donor sperm. You do not have to cover the cost of donor sperm if it is not in your community package. You may exclude benefits for conception by artificial means or assisted reproductive technology to the extent permitted by applicable state law and excluded in your community package
- Pediatric and adult immunizations, in accordance with accepted medical practice
- Allergy testing, treatment and allergy serum
- Well-child care from birth
- Periodic health evaluations for adults

- Home health services
- In-hospital administration of blood and blood products (including "blood processing")
- Surgical treatment of morbid obesity, when medically necessary
- Implants – you must cover the surgical procedure, but you may exclude the cost of the device if the device is excluded in your community package

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 II of their rate calculation. If there is no additional cost, the cost entry should be zero.

Part Four – Preparing Your 2012 Brochure

The brochure process is a web application that uses database software. The web application will generate a 508-compliant PDF.

The *2012 FEHB Brochure Handbook* will be ready by June 13. Plans can download the *Handbook* from the file manager at www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal. In August, we will also send you a brochure quantity form and other related Open Season instructions.

We will provide updates to the FEHB Brochure Templates between June 6 and August 11, 2011. We will not issue a second version of the 2012 FEHB Brochure Handbook; however, we will post the revised FEHB Handbook pages and a revised Brochure Template to the File Manager. We should have all language and shipping labels finalized no later then August 11, 2011. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

The *2012 Brochure Creation Tool (BCT) User Manual* will be available July 1. Also, in July, we will provide in-house training to refresh plans on the BCT. There will be 10 separate training sessions held at OPM. We will send an email via the FEHB Carriers listserv as to the dates and times of these trainings. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at angelo.cueto@opm.gov.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 19, 2011. Plans will be unable to make any changes after this date, as we will lock the tool to enable contract specialists to review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.

Attachment I: 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)

_____
(Email address)

Attachment II: Current Baseline Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan

INITIATIVE	PROGRAMS & INCENTIVES NOW OFFERED – DESCRIBE HERE	CURRENT ENROLLEES: TOTAL NUMBER & PERCENTAGE OF PLAN
Promote health & wellness		
e.g. comprehensive diabetes care		
e.g. cholesterol management for enrollees with cardiovascular conditions		
e.g. controlling high blood pressure		
Reduce adult & childhood obesity		
Promote healthy lifestyles		
e.g. reduced co-payments & deductibles for enrollees completing health risk assessment (HRA)		
e.g. compliant with disease management programs		
e.g. participate in wellness activities		

Attachment III: Projected 2012 Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan

INITIATIVE	PROPOSED PROGRAMS & INCENTIVES - DESCRIBE HERE	TARGET ENROLLEES: TOTAL NUMBER & PERCENTAGE OF PLAN
Promote health & wellness		
e.g. comprehensive diabetes care		
e.g. cholesterol management for enrollees with cardiovascular conditions		
e.g. controlling high blood pressure		
Reduce adult & childhood obesity		
Promote healthy lifestyles		
e.g. reduced co-payments & deductibles for enrollees completing health risk assessment (HRA)		
e.g. compliant with disease management programs		
e.g. participate in wellness activities		

Attachment IV: Recommended Preventive Services

Table 1: U.S. Preventive Services Task Force (USPSTF)

USPSTF	Current FEHB Preventive Services	Adults		Special Populations	
		Men	Women	Pregnant Women	Children
Abdominal Aortic Aneurysm, Screening	Abdominal Aortic Aneurysm, Screening	X			
Alcohol Misuse Screening and Behavioral Counseling Interventions	Alcohol Misuse Screening and Behavioral Counseling Interventions	X	X	X	
Aspirin for the Prevention of Cardiovascular Disease	Aspirin for the Prevention of Cardiovascular Disease	X	X		
Asymptomatic Bacteriuria in Adults, Screening	Asymptomatic Bacteriuria in Adults, Screening			X	
Breast Cancer, Screening	Breast Cancer, Screening		X		
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing	Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing		X		
Breastfeeding, Primary Care Interventions to Promote	Breastfeeding, Primary Care Interventions to Promote		X	X	
Cervical Cancer, Screening	Cervical Cancer, Screening		X		
Chlamydial Infection, Screening	Chlamydial Infection, Screening		X	X	
Colorectal Cancer, Screening	Colorectal Cancer, Screening	X	X		
Congenital Hypothyroidism, Screening					X

Dental Caries in Preschool Children, Prevention	Dental Caries in Preschool Children, Prevention				X
Depression (Adults), Screening	Depression (Adults), Screening	X	X		
Diabetes Mellitus in Adults, Screening for Type 2	Diabetes Mellitus in Adults, Screening for Type 2	X	X		
Diet, Behavioral Counseling in Primary Care to Promote a Healthy Diet	Diet, Behavioral Counseling in Primary Care to Promote a Healthy Diet	X	X		
Gonorrhea, Screening	Gonorrhea, Screening		X	X	
Gonorrhea, Prophylactic Medication	Gonorrhea, Prophylactic Medication				X
Hearing Loss in Newborns, Screening					X
Hepatitis B Virus Infection, Screening	Hepatitis B Virus Infection, Screening			X	
High Blood Pressure, Screening	High Blood Pressure, Screening	X	X		
HIV, Screening	HIV, Screening	X	X	X	X
Iron Deficiency Anemia, Prevention	Iron Deficiency Anemia, Prevention				X
Iron Deficiency Anemia, Screening	Iron Deficiency Anemia, Screening			X	
Lipid Disorders, Screening	Lipid Disorders, Screening	X	X		
Major Depressive Disorder in Children and Adolescents, Screening					X
Obesity in Adults, Screening	Obesity in Adults, Screening	X	X		
Osteoporosis in Postmenopausal Women, Screening	Osteoporosis in Postmenopausal Women, Screening		X		
Phenylketonuria, Screening					X
Rh (D) Incompatibility, Screening	Rh (D) Incompatibility, Screening			X	

Sexually Transmitted Infections. Counseling		X	X		X
Sickle Cell Disease, Screening	Sickle Cell Disease, Screening				X
Syphilis Infection, Screening	Syphilis Infection, Screening	X	X	X	
Tobacco Use and Tobacco-Caused Disease, Counseling to Prevent	Tobacco Use and Tobacco-Caused Disease, Counseling to Prevent	X	X	X	
Visual Impairment in Children Younger than Age 5 Years, Screening	Visual Impairment in Children Younger than Age 5 Years, Screening				X

Table 2: Advisory Committee on Immunizations Practices (ACIP)

ACIP Recommended Vaccine Immunizations (Ages 0 through 6 years)	ACIP Recommended Vaccine Immunizations (Ages 7 through 18 years)	ACIP Recommended Adult Immunizations	FEHB Immunizations
Diphtheria, Tetanus, Pertussis	Diphtheria, Tetanus, Pertussis	Hepatitis A	**X**
Haemophilus Influenzae, Type B	Hepatitis A	Hepatitis B	**X**
Hepatitis A	Hepatitis B	Human Papillomavirus	**X**
Hepatitis B	Human Papillomavirus	Influenza	**X**
Inactivated Poliovirus	Inactivated Poliovirus	Measles, Mumps, Rubella	**X**
Influenza	Influenza	Meningococcal	**X**
Measles, Mumps, Rubella	Measles, Mumps, Rubella	Pneumococcal	**X**
Meningococcal	Meningococcal	Tetanus, Diphtheria, Pertussis	**X**
Pneumococcal	Pneumococcal	Varicella	**X**
Rotavirus	Rotavirus	Zoster	**X**
Varicella	Varicella		**X**

Table 3: Health Resources and Services Administration (HRSA)

HRSA Recommendations for Women	HRSA Recommendations for Infants, Children, and Adolescents	Current FEHB Preventive Services
Cholesterol Screening		**X**
Mammograms		**X**
Pap Smears		**X**
	Influenza	**X**
	Hepatitis B	**X**
	Human Papillomavirus	**X**

Attachment V: 2012 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	**Reference**
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis.	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Hemoglobinopathy	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)	
Myelodysplasia/Myelodysplastic Syndromes	
Paroxysmal Nocturnal Hemoglobinuria	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B
Amyloidosis	
Neuroblastoma	Call Letter 96-08B

III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
Childhood rhabdomyosarcoma	
Advanced Ewing sarcoma	
Advanced Childhood kidney cancers	
Mantle Cell (Non-Hodgkin lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2012?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Small cell lung cancer		

Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		
Sclerodema		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2012?	
Solid Organ Transplants	**Yes**	**No**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment VI: Durable Medical Equipment

Plan Name: _____

Plan Code(s): _____

Please indicate which items you cover and describe the type of coverage you provide.

Item	Yes	No
Durable Medical Equipment		
•Hearing Aids Description:		
•Prescription Drug Readers Description:		
•Scooters Description:		
•Speech Generating Devices Description:		
•Story Boards (graphic organizers such as a series of illustrations or images displayed in sequence) Description:		
•Talkers Description:		

Attachment VII: Going Green Initiative

We encourage plans to "go green" where possible. Examples of "going green" are as follows:

- **Delivering Plan Brochures -** If you have not responded to our FEHB carrier listserv of March 30, please provide us with a plan of action detailing how you will promote the use of electronic copies of your brochures.
- **Sending Explanation of Benefits Electronically (EOB)**
- **Using summary EOBs**
- **Distributing health plan newsletters**

Please provide us with how your plan will "go green" for the items indicated above as well as any other areas your plan has undertaken. Please include a cost benefit analysis for the items your plan has addressed.

Delivering Plan Brochures	**Plan Response**
A timeframe for the process carriers will use for gathering information, processing requests, the cut-off point for determining the number of hard copy and electronic copy requests, etc.	
How carriers will determine if enrollees want an electronic brochure (via postcard, phone call, etc.)	
If enrollees will be able to request both an electronic and hard copy of the brochure.	
If enrollees request an electronic brochure and then decide to change to a hard copy, will this request be honored.	
How carriers will collect and maintain current email addresses.	
How carriers will ensure enrollees have received the brochure.	
A cost/benefit analysis	
Sending Explanation of Benefits (EOB) electronically	
Using Summary EOBs	
Distributing health plan newsletters	
Other areas	

Attachment VIII: Checklist

Federal Employees Health Benefits Program Annual Call Letter --- Checklist

Topic	Included in Proposal
1. Programs to manage patient care – Pilot programs that include detailed operational plans, including outreach and other communication to enrollees.	
2. Programs to promote health and wellness aimed at improving employee productivity, enhancing healthy lifestyles and lowering long-term healthcare costs.	
3. Programs to reduce adult and childhood obesity described in detail.	
4. Incentives to promote healthy lifestyles such as reduced co-payments and deductibles for enrollees who complete a health risk assessment (HRA), are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Completed Attachments II and III.	
5. Proposal to reduce disparities that includes a description of specific goals and processes your plan is undertaking or plan to implement to reduce health disparities.	
6. Expanded program to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically effective therapeutic alternatives.	
7. Plan to reduce overall pharmacy spending.	
8. Increase FEHB providers and include data on the number and percentage of providers with geriatric training in your current network, including particular focus on those geographic areas with a large older population. In addition, include your plan to reach out to providers and expand your networks with this expertise.	
9. Describe affinity products on the "non-FEHB" page of your brochure that are attractive to FEHB enrollees.	
10. Actuarial value – include information on medical loss ratio.	
11. Eliminate cost-sharing for all recommended in-network preventive care, immunizations, and screenings.	

12. Donor Testing Services - Enhanced benefits related to donor testing services for bone marrow and stem cell transplants and proposals that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.	
13. Assistive Technologies – Increased dollar amounts on assisted technologies such as hearing aids, speech generating devices, and prescription drug readers, if applicable.	
14. Coordination of Benefits - Benefit designs that include co-insurance should be based on the remaining charge, not the plan's allowance.	
15. Value-Based Benefit Design –Establish how your benefit package is value based.	
16. Full description of your catastrophic limits.	
17. Health Care Cost and Quality Transparency Initiatives.	
18. Revised policies regarding preventable medical errors to protect members from balanced billing.	
19. Preventive Care benefits for adults.	
20. Completed Organ/Tissue Transplants tables.	
21. Mental Health and Substance Use Parity Benefits – benefit proposals that comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.	
22. Prescription drugs – Plans must meet creditable coverage requirements.	
23. Completed Durable Medical Equipment Checklist.	
24. Maternity and Mastectomy Admissions requirements	
25. No pre-existing condition limitations.	
26. Point of Service Product, if applicable.	
27. Required infertility treatment.	
28. Required immunizations for children.	
29. Dental, vision and hearing benefits as indicated in Part Three.	
30. Required physical, occupational and speech therapy.	

31. "Going Green" initiative.	

Please return this checklist with your CY 2012 benefit and rate proposal