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# FEHB Program Carrier Letter

## All Carriers

U.S. Office of Personnel Management  
Healthcare and Insurance

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**Letter No. 2014-03**

**Date: March 20, 2014**

Fee-for-service [2]

Experience-rated HMO [2]

Community-rated HMO [2]

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**SUBJECT: Federal Employees Health Benefits Program Call Letter**

### **SUBMISSION OF PROPOSALS**

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. Your benefit and rate proposals for the contract term beginning January 1, 2015 should be submitted to us on or before **May 31, 2014**. Please send your proposals by **overnight mail, FAX, or email** to your contract specialist. We expect to complete benefit and rate negotiations by mid-August to ensure a timely Open Season.

### **FEHB PROGRAM BENEFITS AND INITIATIVES**

#### **I. Introduction**

The annual call for benefit and rate proposals sets forth the policy goals and initiatives for the FEHB Program for 2015.

This year we are focusing on performance in several areas: 1) optimizing the delivery of prescription drug benefits; 2) enhancing wellness programs; 3) advancing quality of care; 4) ensuring mental health parity; 5) aligning the FEHB Program with the Affordable Care Act; and 6) continuing to encourage programs and benefits that promote enrollment in Medicare Part B. Specific initiatives are discussed below.

Proposed benefit changes must be value-based. That means FEHB carriers should demonstrate that they evaluated proposed changes in light of their impact on delivering the most effective care (i.e., that generally produces the best health outcomes), not just with respect to cost. We encourage innovative proposals designed to control long-term costs by promoting services and behaviors that improve enrollees' health.

#### **II. Prescription Drugs**

OPM is continuing to focus on ways to optimize pharmacy practices to ensure the safe and clinically effective use of prescription medications while managing drug costs. Your proposals should highlight how you will achieve these goals through benefit structure changes, program initiatives, and outreach.

Previously, we established goals for plans in several areas of pharmacy benefits management, including overall pharmacy and specialty drug trends as well as generic dispensing rates. We will collect updated data on these measures of pharmacy performance with your proposals. Most health plans now offer programs such as step therapy, medication therapy management programs, and expanded use of prior authorization for selected drugs. Implementing programs of this type and using tiered drug formularies are positively correlated with better performance on overall and specialty drug trends and generic dispensing rates. We encourage you to add and expand on these types of drug management programs that control costs and improve quality and patient outcomes.

Last year, we asked plans to migrate to the following four-tier prescription drug benefit by 2016:

- Tier One: Generics
- Tier Two: Preferred brands
- Tier Three: Non-preferred brands
- Tier Four: Specialty drugs

Tier structures may also include additional categories, such as preferred and non-preferred specialty drugs. We believe a common tiered benefit structure with consistent definitions will improve member ability to make meaningful decisions about their use of prescription drugs. In that regard, we encourage you also to expand your efforts to improve member understanding of prescription drug benefits. If you have not already done so, you should implement a prescription drug cost calculator that will allow both *current* and *prospective* enrollees to compare the cost of the prescription drugs that they use. We expect all FEHB plans to provide a prescription drug cost calculator tool by the 2016 plan year.

FEHB has traditionally covered all drugs that require a prescription by Federal law, with few exceptions. As the cost of prescription drugs escalates, OPM has noted an emerging trend among employment-based benefit plans to more closely manage their formularies, or lists of covered drugs. A managed formulary excludes from coverage certain drugs that meet one or more of the following criteria:

1. Less efficacious than other available drugs for the same indication
2. Less safe than other available drugs for the same indication
3. Provides little incremental clinical value at substantial additional cost, when compared to other available drugs for the same indication

OPM encourages carriers to consider implementing a managed formulary for benefit year 2016. Carriers who choose to do so are encouraged to share early plans with OPM. A cost calculator that allows current and prospective members to verify coverage of specific drugs will be considered essential, as will an exception process that permits reimbursement of non-covered drugs when justified by patients' individual needs.

We strongly encourage plans to optimize the use of high value medication distribution channels by aligning member incentives with the plan's most cost effective options. This may include mail order or retail programs that offer 90 day supplies of maintenance medications. We expect carriers to develop specific goals for channel distribution that they will work to achieve. And, finally, we support more selective pharmacy network contracting, based on cost and quality criteria, with benefit structures that incent enrollee use of the most cost-effective network.

Medicare Part B covers drugs in several categories (for example, epoetin and clotting factor for hemophilia). Some carriers are coordinating pharmacy benefits for members with Medicare Part B and achieving savings. Plans that are not coordinating benefits should examine the opportunity to reduce unnecessary payments where Medicare Part B provides primary coverage for Part B drugs and supplies. Plans should review their findings with their contract officer. Proposals to coordinate benefits should include estimates of costs and savings, as well as impact on members' timely access to benefits.

### **III. Wellness**

To enhance the overall health of our population, we call your attention to specific aspects of wellness and preventive care.

#### **Comprehensive Wellness Programs**

Although FEHB carriers offer a variety of wellness programs, the overall member participation rate remains low. To achieve a greater impact on enrollee health, we strongly encourage carriers to re-examine the scope of their programs, outreach efforts, and incentives. All carriers must offer a health risk assessment (HRA) and be able to demonstrate significant progress toward full implementation of a biometric screening program. Carriers will be required to report progress toward their annual goal for HRA completion and establish an annual goal for biometric screening. Annual goals should be ambitious enough so that the majority of the plan's enrolled employees and their adult family members will be screened at least every three years. Carriers should describe how they developed their goal and the incentives they will use to achieve it. Proposals must also include a process to make biometric screening results available to members' primary care physicians, consistent with privacy protections, so they can initiate any needed medical follow up.

OPM has established an annual limit for wellness program incentives of up to \$250 per enrollee per year. Plans are encouraged to establish programs that use rewards to purchase health related goods and services, but they may use a modest amount of the total award for cash or gift cards (limited to \$75 per individual or \$200 per family). As a reminder, all wellness programs must comply with the Health Insurance Portability and Accountability Act (HIPAA), Affordable Care Act and implementing regulations, and include an evaluation strategy.

OPM is also interested in supporting initiatives that incentivize tobacco free living and/or active participation in tobacco cessation programs. As with other wellness programs, carriers must adhere to the established limit for incentives.

## **Preventive Care**

In compliance with the Affordable Care Act (ACA), plans must ensure that they provide all preventive services recommended (A or B rating) by the United States Preventive Services Task Force (USPSTF) with no member cost sharing. Carriers should take all necessary steps to prevent enrollees from paying any cost shares associated with USPSTF recommended preventive services when members follow network referral guidelines. For example, enrollees who use a network facility for mammograms should not receive a separate charge if the radiologist does not participate in the plan's network.

The updated USPSTF recommendations are listed at <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm>. Plans must review this list and make necessary changes to their preventive services in accordance with 45 CFR 147.130(b). For plan year 2015, carriers must provide coverage of all preventive services recommended on or before December 31, 2013. Nine recommendations were added to the list or updated in 2013, including one to screen adults born between 1945 and 1965 for hepatitis C virus infection, and one for low dose computed tomography screening of those at high risk for lung cancer. In addition to the recommendations from the USPSTF, all plans must cover preventive services as outlined in the U.S. Department of Labor FAQ Part XII concerning implementation of the Affordable Care Act (<http://www.dol.gov/ebsa/faqs/faq-aca12.html>).

## **Condition Management**

We appreciate efforts plans have made to address prevention and treatment of obesity. To continue our focus on leading causes of mortality, we are also focusing on cardiovascular disease. Eliminating tobacco use and controlling high blood pressure can significantly reduce the risk of heart disease and stroke. FEHB enrollees who use tobacco report they are unaware that their health plans cover tobacco cessation and counseling with no cost sharing. All carrier proposals should include an outreach plan to close this information gap. We also strongly encourage you to ensure primary care providers are fully aware of tobacco cessation benefits and that smokers are assisted in their quit attempts.

Early HEDIS trend data indicate that improving blood pressure control should be a high priority for FEHB. For many plans, 2014 will be the first year performance on this measure is formally scored by OPM. We welcome recommendations from carriers regarding effective interventions to help address this important aspect of population health and look forward to highlighting successful strategies.

## IV. Advancing Quality and Value of Care

We are reassured by ongoing carrier efforts to promote the delivery of high quality coordinated care, including the fact that over 1 million FEHB members are now receiving care in certified Patient Centered Medical Homes and encourage carriers to continue these efforts. Early data on readmission rates are favorable for many plans. To address remaining challenges and ensure continuous improvement, carriers can learn from successful practices highlighted through the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients.<sup>1</sup> Additional resources include lists of hospitals participating in the Partnership<sup>2</sup>; programs sponsored by state Quality Improvement Organizations<sup>3</sup>; and community based care transition programs affiliated with the Agency for Community Living.<sup>4</sup>

We also note that in response to the American Board of Internal Medicine (ABIM) Foundation's *Choosing Wisely Campaign*, many carriers identified antibiotic overuse, reducing early elective delivery, and appropriate imaging for low back pain for focused quality improvement efforts. We will collect updated data on these initiatives with your proposal.

In addition, we continue to strongly support the important work taking place under the auspices of the Centers for Medicare and Medicaid Services (CMS). We appreciate carrier efforts to include FEHB enrollees in the Comprehensive Primary Care Initiative. We welcome carrier proposals for participation in other CMS sponsored multi-payer initiatives or state-level innovation projects.

As discussed at the 2013 FEHB Carrier Conference, we are developing a comprehensive health plan assessment tool that will integrate multiple dimensions of performance. Domains will include quality of care, member satisfaction, cost accountability, and contract administration. The methodology will build on existing OPM processes that evaluate HEDIS and CAHPs results. We will use the tool to measure and reward carrier performance. In addition, we are actively reviewing the accreditation status of all plans in advance of updating our program requirements.

## V. Mental Health Parity

The Department of Health and Human Services, Department of Labor, and Department of Treasury released final regulations on November 13, 2013 (<http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>) that implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. OPM

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<sup>1</sup> <http://partnershipforpatients.cms.gov/>

<sup>2</sup> <http://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html>

<sup>3</sup>

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793>

<sup>4</sup> <http://partnershipforpatients.cms.gov/about-the-partnership/community-based-care-transitions-program/community-basedcaretransitionsprogram.html>

issued Carrier Letter 2013-24 dated December 3, 2013 describing these new requirements for FEHB carriers. Plans are expected to assess the regulation's requirements and submit any benefit structure changes, with supporting documentation, that are needed to comply with this rule. OPM will expect carriers to certify compliance with these regulations.

## **VI. Consistency with the Affordable Care Act**

### **Habilitative Services**

We recognize that under the Affordable Care Act, coverage of habilitative services is evolving. Lacking a standard definition, many carriers are now offering habilitation in parity with rehabilitative services. However, the duration and scope of services individuals may need to acquire skills for the first time may differ from what is needed to regain function after illness or injury. To accommodate such unique circumstances, we encourage carriers to provide a reasonable “exceptions process” to consider requests for additional habilitative services when such services are medically necessary to achieve a therapeutic milestone or avoid significant deterioration in health status.

### **Cost-Sharing Limits**

The out-of-pocket maximum (OOP) cannot exceed IRS guidelines for HDHP maximums. Currently, the maximum OOP is \$6,350 for self only and \$12,700 for self and family. The 2015 maximums will be \$6,600 for self only and \$13,200 for self and family. The OOP maximum applies to all in-network deductibles, co-payments and co-insurance for Essential Health Benefits including prescription drugs. If a plan has a third party vendor, such as, for drugs or mental health services, they may have separate OOP maximums for those benefits in 2014, but the OOP maximums cannot exceed the IRS guidelines for HDHP maximums. Beginning in 2015, plans may continue to have separate limits if they have multiple service providers (e.g., pharmacy benefits managers) provided that the combined amount of any separate OOP maximums does not exceed the annual limit established the Departments of Labor, Health and Human Services, and the Treasury. Carriers should refer to the following FAQs for specific guidance: <http://www.dol.gov/ebsa/faqs/faq-aca18.html>.

## **VII. Medicare Population Programs and Benefits**

OPM continues to encourage proposals that allow members to maximize their benefits under Medicare and FEHB. For example, some carriers offer programs for Medicare eligible annuitants that include premium pass-through accounts for plans to pay Medicare Part B premiums. Carriers also offer cost sharing reductions for members with Medicare Part B (e.g., waived or reduced copays and deductibles) that encourage members to purchase Medicare Part B. To ensure success of these programs, increased communication and education to enrollees is essential. Your proposals should include your plans to inform members about their coordination of benefits.

## **VIII. Technical Guidance**

We will provide specific requirements to submit benefit and rate proposals and information for preparing 2015 brochures at a later date, including Technical Guidance and an automated data collection tool.

As a reminder, all FEHB carriers must adhere to the Guiding Principles available at: <http://www.opm.gov/carrier>. 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 that all plans are well managed and financially secure. In addition, all carriers must have a vigorous and effective fraud detection and prevention program along with programs to prevent and collect any improper payments.

## **CONCLUSION**

Please discuss any benefit changes with your contract specialist. All savings from managed care initiatives must accrue to the FEHB Program. We will begin negotiations when we receive your proposals.

We look forward to the negotiations for the upcoming contract year. Thank you for your commitment to the FEHB Program.

Sincerely,

John O'Brien  
Director, Healthcare and Insurance