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# FEHB Program Carrier Letter

## All Carriers

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

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Letter No. 2002-14

Date: April 16, 2002

Fee-for-service [ 13 ] Experience-rated HMO [ 13 ] Community-rated HMO [ 11 ]

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### SUBJECT: Federal Employees Health Benefits Program Annual Call Letter

#### I. RESPONSE PROCESS

This carrier letter provides our annual guidance and negotiations objectives for benefit and rate proposals from Federal Employees Health Benefits (FEHB) plans. Your proposal for the contract term beginning January 1, 2003 is due by **May 31, 2002** – the regulatory deadline for your submission. I encourage you to talk with your contract specialist ahead of time about any changes you are considering. I also strongly encourage you to make arrangements with your contract specialist for **Overnight mail** delivery or **FAX**. Do not rely on regular mail. We are experiencing delays in our regular service because the U.S. Postal Service is irradiating our mail.

We will begin negotiations when we receive your proposals for benefit and rate changes. We will send you specific instructions for your rate proposals in the near future. To assure a timely Open Season, we will operate under a schedule to complete all negotiations – benefits and rates – by **August 16, 2002**.

#### II. OVERVIEW

As President George W. Bush and Director Kay Coles James have observed, the events of September 11, 2001, have greatly impacted the expectations of the American people and the operations of government. American security and confidence were threatened by the heinous acts of terrorism. Innocent civilians, including federal employees, were targeted and harmed by the terrorists' murderous actions. As a nation, however, and as a federal workforce, our resolve has been strengthened and our spirit is unbowed.

I would like to thank you for your extraordinary cooperation in the aftermath of the terrorist attacks. Some of our FEHB carriers and their employees also suffered losses and you have our deepest sympathies. Many plans went the extra mile to provide services to disaster victims. We greatly appreciate your efforts. In these uncertain times, we need to do what we can to ensure our customers will always have adequate access to care. The trauma of terrorism is a national issue. We must be sure that all carriers are taking steps now to rapidly implement a disaster recovery plan. Please provide us with a description of your disaster plan, your health plan's current state of readiness, your health plan's work with your subcontractor(s) on this issue, a timeline and any potential problem areas. A disaster recovery plan must be a top priority.



highly valued by our current employees and retirees, as well as attractive to prospective Federal employees.

The Administration's health care agenda is based on patient-centered health care, preservation of choice, and excellent quality. We are asking for your best ideas to help contain premiums and promote quality. Some plans may want to consider reasonable proposals to **introduce or increase** out-of-pocket costs for some services or adjust deductibles or copay waivers, as well as reasonable proposals for new lower-cost options.

We also are asking you to remain committed to managing **prescription drug costs**. We continue to believe the emphasis should be on benefit structures that encourage sound decision-making rather than those that shift costs to members. You may want to consider proposals that encourage members to use generic drugs through higher copays or coinsurance differentials for brand drugs or other incentives to make cost effective choices. You also may want to consider the use of formularies or preferred drug lists with higher copays for non-formulary or non-preferred drugs and methods to ensure proper dosing. We will not, however, consider changes from the current policy under which you must cover non-formulary drugs when prescribed by a Plan doctor.

We also encourage you to put more emphasis on **care management** for members with chronic conditions. We fundamentally believe that federal employees and their families are intelligent health care consumers, and it is to your benefit to present them with sound information. Programs that provide clear and factual information about chronic conditions and ensure that patients are getting appropriate services improve the quality of care and help use benefit dollars more effectively.

As in past years, we will not accept proposals for benefit increases unless they are cost-neutral through offsetting benefit reductions. And, any savings from managed care initiatives must accrue to the FEHB Program. Also, when 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). We will send specific requirements for submitting your benefit and rate proposals in mid-April. Also, by early May, we will send information on how to prepare your brochure. I would also like to remind you that only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1652.203-70 (Appendix D-a of your Federal contract) may be distributed at or through Federal facilities.

### III. MAJOR OPM INITIATIVES

On March 25, 2002, Director James launched the Administration's long-term-care initiative, a major benefit option that enjoyed bipartisan support during its creation. We are pleased that beginning in 2003, OPM will make group **long-term care** insurance products available to approximately 20 million members of the Federal civilian and uniformed services, their families, and retirees. In addition, the President's Budget outlined a broad approach to provide incentives to Federal employees and annuitants to choose their plans wisely and the President's Budget for Fiscal Year 2003 discusses the coordination of FEHB with Medicare to develop options for retirees that

improve choice by making available a full range of private insurance options. We will keep you informed of any legislative changes, including any that result from the annual budget appropriations process.

Many of you recently sent us an update on your *patient safety initiatives* and your future plans to strengthen your programs. We want you to know how much we appreciate the steps you are taking to reduce medical errors and increase patient safety. We are also very proud to report that about three-fourths of FEHB plans are now *accredited* by a nationally recognized, independent accrediting organization. For those plans not yet accredited, we believe our partnering with you to develop a timeline and work toward accreditation has been very productive. Obtaining accreditation is one way to demonstrate a significant commitment to providing quality, cost-effective health care.

We are developing a data repository that will consolidate plan performance data, including the Quality Assurance (QA) and Fraud and Abuse Reports, The Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans (CAHPS) data, accreditation status, disputed claims, and financial information. This data repository will allow us to better analyze contract compliance and plan performance. Section 1.9 of the contract addresses a number of requirements including the annual QA Report, the semi-annual Fraud and Abuse Reports, annual HEDIS clinical data collection for HMOs, and an annual consumer survey, CAHPS. As announced in Carrier Letter 2002-01, we have begun simplifying the reporting and data collection process by using standard electronic reporting spreadsheets for the QA and Fraud and Abuse Reports. We now are reexamining our Fraud and Abuse reporting requirements to see how we can bring them in line with today's standard industry practices.

Additionally, we reviewed our Quality Assurance standards on access and service and decided not to change these for 2003. Rather, we are working with our quality business partners who are establishing new industry-wide access and service standards. We expect to institute new performance standards beginning in 2004. We will keep you informed about the process and our requirements. Information also will be available at the *National Committee for Quality Assurance* [www.ncqa.org](http://www.ncqa.org) during 2002.

Most of you are involved to some degree in our evaluation, with the Department of Health and Human Services, of our *mental health and substance abuse* initiative. We appreciate your continued support of this effort so we can assess how the initiative is affecting access and cost.

We have reviewed our guidelines on *preventive care benefits* and have determined that some industry norms have changed. Current clinical recommendations on preventive care benefit for cholesterol and colorectal cancer screenings are:

- A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) once every 5 years for adults 20 or over; and
- Colorectal Cancer Screening, including Fecal occult blood test:

- Sigmoidoscopy screening - every 5 years starting at age 50; or
- Colonoscopy - once every 10 years at age 50; or
- Double contrast barium enema (DCBE) - once every 5-10 years at age 50.

In addition, we asked the National Cancer Institute (NCI) to review conditions/diagnoses under FEHB plans for which bone marrow transplants are covered benefits. The NCI has recommended we include *autologous tandem transplants* as accepted treatment for testicular and other germ cell tumors. Your health plan may want to review these recommendations and decide whether to propose any benefit changes.

***Coordination of benefits (COB) with Medicare*** is an important health plan responsibility and is an important part of your contract requirements. It helps you control health care expenditures and ensures accountability throughout the health care system. In order to keep our enrollees' premiums as low as possible, you all must make sure your Medicare billing practices support correct COB administration. Last year, we asked you to report on your service and billing practices for your age 65 and older members. This year, we want you to report on changes or improvements to your coordination of benefits activities with Medicare.

#### IV. OTHER ISSUES

Consistent with the President's agenda and the Director's high standards for service excellence, all carriers are expected to conduct e-Business – to be capable of accepting and processing electronic enrollments expeditiously. Our objective is to manage a system that handles electronic enrollments from agencies through carriers' entire enrollment processing systems, without dumping to paper. We are currently working with some agencies that are not at this level to improve their enrollment processes. We need to be sure that carriers have the capacity to accept electronic enrollments from all agencies, input directly to their databases, and continue to meet OPM's service standards.

Director James also has directed the agency to re-work our ***regulations in plain language*** so that readers can easily understand them. Since these changes focus on plain language, the supplementary information will include this remark: "Unless otherwise stated, the purpose of this revision to part 890 CFR is not to make substantive changes but, rather, to make it more readable." The plain-language regulations will be published later this year, as proposed rule making and all interested parties will have an opportunity to comment.

Also, Government agencies are required by section 508 of the Rehabilitation Act to make their web sites accessible. In general, section 508 requires that when Federal agencies procure, develop, maintain or use electronic and information technology (EIT), agencies must ensure that Federal employees with disabilities have access to and use of information and data comparable to the access to and use by Federal employees who are not individuals with disabilities. While we have determined that this requirement does not apply to FEHB carriers, we encourage you to provide plan web sites with comparable access through voluntary compliance.

We still plan to expand the *enrollment code data field* from three digits to ten. At some point, we will convene a work group with Plan and Federal agency representatives to develop system requirements and file formats. Although we do not know when we will start using ten digits, you should nevertheless include this change as you plan any systems modifications.

## V. CONCLUSION

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. We look forward to receiving your rate and benefit proposals. And, we encourage you to take this opportunity to provide us with your best creative approach to keep your FEHB health plan competitive and affordable. Again, please discuss any changes you are considering with your contract specialist as soon as possible.

Sincerely,

A handwritten signature in black ink that reads "Abby L. Block". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Abby L. Block  
Assistant Director  
for Insurance Programs