2007 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

- Submit a copy of a fully executed employer group contract (i.e., *certificate of coverage*) that the greatest number of your non-Federal subscribers purchased in 2006.

- **If you have not made changes to the level of coverage we already purchase,** then submit a statement to that effect. **If you have made changes,** submit a copy of the new benefit description as explained in **Benefit Changes** below. You must file your proposed benefit package and the associated rate with your state, if your state requires a filing.

Community-rated Plans

- Submit a copy of a fully executed community benefit package by May 12, 2006 (a.k.a. master group contract or subscriber certificate) including riders as well as copays, coinsurance, and deductible amounts that the greatest number of your non-Federal subscribers purchased in 2006. If the community benefit package is different from FEHB's, also send a current copy of the benefit package that we purchased also. Please highlight the difference (s) between the FEHB benefits and the package you based it upon. **Note:** If you offer a "national plan" then you need to send us your community benefit package for each state that you cover.

- Attach all community-based riders (e.g. prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2007 contract term, except for those still under review by your state.

If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. **If you have made changes,** submit a copy of the new benefits description. If your state requires that you file this documentation, file the benefit package and the associated rate with the state first. We will accept the community benefit package that you project will be sold to the majority of your non-Federal subscribers in 2007.

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

All HMOs

1. Attach a chart that compares your proposed 2007 benefit package and the 2006 benefit package that we purchased. Include on your chart:

    A. Differences in copays, coinsurance, numbers of coverage days, and coverage levels in the two packages. For community-rated plans only, indicate whether you include the costs of

the differences within your community-rate or in addition to the community-rate you charge to the other groups that purchase this benefit package, and to the FEHB Program; and the number of subscribers/contract holders who purchase the 2006 package and who are expected to purchase the 2007 package;

B. 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 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, and you obtain approval and submit approval documentation to us by June 30, 2006. 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, please so note. The review period must have elapsed without objection by June 30.

2. 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.

3. Please highlight and address any state-mandated benefits that you have not specifically addressed in previous negotiations.

Please send the following material by **May 31, 2006**:

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:

- A comparison of your 2006 benefit package (adjusted for FEHB benefits) and your 2007 benefit package (see #1 above);
- Benefit package documentation (see **Benefit Changes** below);
- A plain language description of each proposed change (in worksheet format) and the revised language for your 2007 brochure;
- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2007 brochure; and
- A signed contracting official's form (see attached)

If there are, or if you anticipate significant changes to your 2007 benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Benefit Changes

Your proposal must include a narrative description of each proposed benefit change. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if

there is no rate change. Also, please answer the following questions in worksheet format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incorrectly formatted submissions. ***We require the following format:***

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2007" section in "plain language" that is, in the active voice and from the enrollee's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital copay, indicate whether this change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, please show each change clearly.

- Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefit package or if the change is one you submitted to the state for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2007.

- State the actuarial value of the change and whether it represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If it is an increase, describe whether any other benefit offsets your proposal.

- If the change is not part of the proposed benefit package, is the change a rider? If yes,

    1. Is it a community rider (offered to all employer groups at the same rate)?

    2. State the percentage of your subscribers/contract holders who now purchase this rider and the percentage you project it will cover by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to cover by this rider and when will that occur?

    3. Include the cost impact of this rider as a biweekly amount for Self Only and Self and Family on Attachment II of your rate calculation. If there is no cost impact or if the rider involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively, on Attachment II to your rate calculation.

- If the change requires new providers, furnish an attachment that identifies the new providers.

Benefit Clarifications

Clarifications are not benefit changes. Clarifications help enrollees understand how a benefit is covered**.** For each clarification:

- Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification. Prepare a separate worksheet for each proposed clarification. When you have more than one clarification to the same benefit you may combine them but you must present the worksheet clearly. Remember to use plain language.

- Explain the reason for the benefit clarification.

Carrier Contracting Officials

The Office of Personnel Management (OPM) will not accept any contractual action from

_____(Carrier),
including those involving rates and benefits, unless it is signed by one of the persons named below (including the executor of this form), or on an amended form accepted by OPM. This list of contracting officials will remain in effect until the carrier amends or revises it.

The people named below have the authority to sign a contract or otherwise to bind the Carrier

for _____(Plan)

Enrollment code(s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX Number)

_____
(E-mail address)

Part Two - Service Area Changes or Re-designation as a Mixed Model Plan

Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2007 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 other areas. Please consider expanding your FEHB service area to all areas in which you have authority to operate. **You must submit in an 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 files at a later date. 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. We may grant an extension for submitting supporting documentation to us until June 30.

  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.

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

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.

- We will assign new codes as necessary. In some cases, rating area or service area changes require a re-enrollment by your FEHB members. We will advise you if this is necessary.

Instructions

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; and
- Your ability to provide contracted benefits.

Please provide the following information:

- **Describe the proposed expansion area in which you are approved to operate:**

  Provide the proposed service area expansion by ZIP code, county, city or town (whichever applies) and provide a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure.

- **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 (by their specialty), and hospitals in the proposed area with whom you have executed contracts. Also, please update this information on August 31, 2006. 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 your initial submission.

Re-designation as a Mixed Model Plan:

This section applies only if you formerly operated as a Group Practice Plan (GPP) or Individual Practice Plan (IPP), now offers both types of providers and you are requesting re-designation as a Mixed Model Plan. Please describe whether you are adding a GPP or IPP provider system.

If you are adding a GPP component to an existing IPP delivery system, you will need to demonstrate that the group includes "at least three physicians who receive all or a substantial part of their professional income from the HMO funds and who represent one or more medical specialties appropriate and necessary for the population proposed to be served by the plan." (5 USC 8903(4)(A))

Include clear language in your brochure ("How we change for 2007" section plus "Facts about this HMO plan", if appropriate) to reflect the changes you propose.

Also answer the following questions:

1. Do you require all members of a family to use the same delivery system, or may some members of a family use GPP doctors while others use IPP doctors?

2. If you restrict members to one type of delivery system, what must a member do to change from one delivery system to the other during a contract term? How soon after it is requested would such a change be effective?

3. If a member wants to change primary care doctors (centers for GPPs), what must the member do? Is there a limit on the number of times that a member may change primary care doctors (centers)? If yes, will you waive the limit for FEHB members? How soon is a requested change effective?

Federal Employees Health Benefits Program statement about Service Area Expansion

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

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2007 Benefits and Service Area Proposals. Specifically,

1. All provider contracts have hold harmless provisions in them.

2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.

3. All of the information provided is accurate as of the date of this statement.

_____

Signature of Plan Contracting Official

_____

Title

_____

Plan Name

_____

Date

Part Three – Benefits for HMOs

The 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 2007. The policies include the following:

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

1. **Organ/Tissue Transplants** - This year, we have included specific lists of diagnoses and/or conditions for organ/tissue transplants in Attachment I. We have divided Attachment I into three tables as follows:

   - **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
   - **Table 3** – Recommended organ/tissue transplants

   OPM based its organ/tissue coverage requirements on the Blue Cross Blue Shield Association (BCBSA) Technology Evaluation Committee's review of scientific literature and accepted standards of practice within the oncology community. The BCBSA Committee is comprised of a group of clinical physician experts and also includes clinical experts from the Kaiser Permanente Foundation. OPM has included additional organ/tissue transplant recommendations from an external review by The National Cancer Institute of the National Institutes of Health.

   Plans must provide coverage for the organ/tissue transplants that appear in Table 1. Each plan must specify whether or not it will provide coverage in 2007 for the organ/tissue transplants that appear on Tables 2 and 3 and return this information with its 2007 benefit proposal. Plans may cover additional organ/tissue transplants that do not appear on the tables. If your Plan covers an organ/tissue transplant that does not appear on the tables, please submit the additional transplant(s) and include the specific diagnosis and disease staging in the 2007 benefit proposal.

   Plans must update their 2007 brochures fully to reflect specific organ/tissue transplant coverage including the corresponding diagnosis and disease staging. Plans must base their organ/tissue transplant coverage decisions strictly on the list of covered diagnoses and disease staging as it appears in their 2007 brochure. Plans may continue to fully review solid organ transplants for medical necessity. However, plans must limit their medical necessity review for all other transplants to the diagnosis and/or the staging of the illness (e.g., acute, chronic, etc.). If plans deny coverage, they must be strictly a contractual denial (e.g., diagnosis and staging of the illness is not listed as covered). Plans may not deny organ/tissue transplants as experimental/investigational. The experimental/investigational exclusion will no longer apply to organ/tissue transplants under the FEHB Program and OPM will not uphold the denial.

2. **Mental Health and Substance Abuse** - Mental health and substance abuse coverage

must be identical to traditional medical care in terms of deductibles, coinsurance, copays. We expect plans to make patient access to adequate mental health services available through managed care networks of behavioral health care providers and innovative benefits design.

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

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

5. **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.

6. **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.

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

8. **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 2007 brochure language clearly describes your coverage.

   Prescription Drugs – 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 coinsurance 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. You may place dollar or dosage limits on drugs for sexual dysfunction. 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 don't allow blanket exclusions of broad categories of drugs such as "non-generics," or "injectables".

Plans that use levels or tiers to denote different prescription drug copays must clearly describe the coverage and difference between each level or tier in the 2007 brochure. The *2007 Guide to Federal Employees Health Benefits Plans* will illustrate the prescription drug copays at the following levels.

- Level I – generally includes generic drugs but may include some brand formulary or preferred brands. Usually represents the lowest copays.

- 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 copays.

- 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 copay levels for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2007 Guide to Federal Employees Health Benefits Plans.*

9. **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 copays or coinsurance 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 the OPM the authority to preempt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not preempt state laws that increase our enrollees' 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:

1. Non-experimental bone marrow, cornea, kidney, and liver transplants;

2. Short-term rehabilitative therapy (physical, occupational, and speech therapy), if significant improvement in the patient's condition can be expected within two months;

3. Family planning services, including all necessary non-experimental infertility services, to include artificial insemination with either the husband's or donor sperm. You don't have to cover the cost of donor sperm if it is not in your community package. You may exclude other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) to the extent permitted by applicable state law and excluded in your community package;

4. Pediatric and adult immunizations, in accordance with accepted medical practice;

5. Allergy testing and treatment and allergy serum;

6. Well child care from birth;

7. Periodic health evaluations for adults;

8. Home health services;

9. In-hospital administration of blood and blood products (including "blood processing");

10. Surgical treatment of morbid obesity, when medically necessary; and

11. 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 2007 Brochure

We have implemented a new brochure process for 2007. The new process is a web-based application that uses database software. Plans may begin using the web-based application on July 7, 2006. The *2007 FEHB Brochure Handbook* will be ready by the first week of May. Plans can download the *Handbook* from the file manager at http://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.

We will send plans a *2007 FEHB Program Brochure Application User Manual* by mid-June and we will hold two web-based trainings for all plans following the *Manual's* release. In August, we will issue a second version of the *2007 FEHB Brochure Handbook* with final language changes and shipping labels. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

Before plans begin using the web-based application, OPM will enter all general brochure (boiler plate) language. Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information by October 15, 2006. Also, until the new process is complete, plans will continue to use the FEHB Word brochure template to develop their plan brochure during negotiations and to print their brochures. Once plans have received approval to print their brochures, plans can cut and paste Section 5 Benefits and any other plan specific information into the web-based form. The new fillable form will be used to automatically generate a 508 compliant PDF. We will post the 508 compliant PDF on the FEHB website.

Part Five – Preparing Your Proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA)

High Deductible Health Plans (HDHP)

The U.S. Department of The Treasury (Treasury) requires that an HDHP have an annual deductible of at least $1,100 for Self-Only coverage and annual out-of-pocket expenses (deductibles, co-payments, etc.) that do not exceed $5,250. For Self and Family coverage, an HDHP must have an annual deductible of at least $2,200 and annual out-of-pocket expenses that do not exceed $10,500. **Both the deductible minimum and out-of-pocket expense maximums are indexed for inflation**. Because we anticipate an increase in the minimum annual deductible amount, we will not accept proposals with deductibles less than $1,100 for Self-Only and $2,200 for Self and Family coverage.

An HDHP may not provide benefits for any year until the member meets the annual deductible. However, a plan may offer first-dollar coverage for preventive care (or have only a small deductible) and still be defined as an HDHP. Additional Treasury guidance may be found at: http:/www.treas.gov/offices/public-affairs/hsa/. The following guidance applies for health plans proposing to offer an HDHP for 2007. We have provided a checklist of this guidance in Attachments II - VI. Please include this information in your proposal.

- HDHPs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). These requirements are included in Attachment III.

- HDHP proposals should reflect that these choices will be open to everyone within the defined service area eligible to enroll in the FEHB Program.

- We will evaluate HDHP proposals in accordance with OPM premium rating guidelines.

- Your HDHP proposal must include an HSA and an HRA component. The HRA component is available only to enrollees who are ineligible for an HSA. Attachment IV includes a list of components.

- Proposals should reflect costs only, including the amounts the Plan will deposit/credit to the enrollee's HSA or HRA. Attachment V includes a list of costs.

- Proposals should clearly describe the health benefits that the Plan offers, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.

- Please complete Attachment VI.

- Proposals should include a description of catastrophic limitations and how they

apply to Self Only and Self and Family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).

- You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.

- Proposals should include a description of the HDHP health education program components that the Plan offers.

- Proposals should also include a description of the consumer education program the health plan intends to provide including appropriate use of HSA/HRA funds for necessary medical expenses.

- Proposals should include a complete description of the geographic service area.

- Proposals should include a certification that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.

Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA)

Tax-favored HSAs are available to those who have an HDHP. However, HSAs are not open to people enrolled in Medicare or another medical benefit health plan (with certain exceptions as provided in Treasury's guidance). Therefore, health plans that are proposing HDHP/HSAs should also propose an HRA of equivalent value for enrollees who are ineligible for an HSA. The HRA could be used for medical expenses, including Medicare premiums. The following guidance applies for health plans proposing to offer an HDHP and HSA/HRA for 2007:

- Health Savings Accounts (HSA) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury Guidance.

- Health Reimbursement Arrangements (HRA) must meet applicable Treasury requirements.

- Fiduciary institutions for HSAs and HRAs must be banks or other non-bank trustees or custodians approved by Treasury. However, the health plan may choose to manage the HRA component in-house.

- Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities.

- Health plan proposals must include assurances that its fiduciary is financially stable. At a minimum, a major financial rating service must rate the trustee/custodian in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating

level.

- Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.

- Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRA financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.

- HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how the Plan will manage and monitor them, including accounting for earned interest.

- Proposals should state how fees and ancillary charges to individual accounts will be paid for.

NOTE: Final brochure language is <u>not</u> required with your May 31 submission. OPM will work with you to jointly develop brochure language.

Attachment I: 2007 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) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/double	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the Staging of the Diagnosis (e.g. acute, chronic).	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma	
Advanced non-Hodgkin's lymphoma	
Chronic myelogenous leukemia	
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	Call Letter 96-08B
Advanced neuroblastoma	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma	Call Letter 96-08B
Autologous tandem transplants for:	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14
III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic 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

Table II: Recommended For Coverage. Transplants Under Clinical Trials

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2007?	
	Yes	**No**
Allogeneic transplants for:		
Chronic lymphocytic leukemia		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Nonmyeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced forms of myelodysplastic syndromes		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Myeloproliferative disorders		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Autologous transplants for:		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		

Table III: Recommended For Coverage

Solid Organ Transplants	Does your plan cover this transplant for 2007? Yes?	No?
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Lung: Lobar		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced forms of myelodysplastic syndromes		
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		
Thalassemia major (homozygous beta-thalassemia)		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Amyloidosis		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		

Attachment II: 2006 Call Letter and Technical Guidance Checklist

High Deductible Health Plan Proposal Information	
1. High Deductible Health Plans (HDHP) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). (See Attachment III)	
2. HDHP proposals should reflect that these choices will be open to everyone within the defined service area eligible to enroll in the FEHB Program.	
3. HDHP proposals will be evaluated in accordance with OPM premium rating guidelines.	
4. HDHP proposals must include both Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) components. The HRA component is available only to enrollees who are ineligible for an HSA. (See Attachment IV)	
5. Proposals should reflect costs only, including the amounts to be deposited/credited to the enrollee's HSA or HRA. (See Attachment V)	
6. Proposals should specify the annual dollar amounts of the deposits from premium for the enrollee's HSA or HRA. (See Attachment V)	
7. Proposals should clearly describe the health benefits to be offered, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable. (See Attachment VI)	

Attachment II: 2006 Call Letter and Technical Guidance Checklist (Cont.)

High Deductible Health Plan Proposal Information	
8. Proposals should include a description of all preventive care benefits and any applicable out-of-pocket amounts. (See Attachment V)	
9. Proposals should include a description of catastrophic limitations and how they will be administered for Self Only and for Self and Family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).	
10. The HDHP provider network to be used should be described and evidence provided that there will be sufficient access to in-network primary, specialty and tertiary providers.	
11. Proposals should include a description of the HDHP health education program components to be offered.	
12. Proposals should also include a description of the consumer education program the health plan intends to provide including appropriate use of HSA/HRA funds for necessary medical expenses.	
13. Proposals should include a complete description of the geographic service area.	
14. Proposals should include a statement that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.	

Attachment II: 2006 Call Letter and Technical Guidance Checklist (Cont.)

HSA and HRA Proposal Information	
15. Health Savings Accounts (HSA) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Internal Revenue Service (IRS) Guidance.	
16. Health Reimbursement Arrangements (HRA) must meet applicable IRS requirements.	
17. Health plan proposals should clearly state how they intend to meet IRS requirements pertaining to HSA and HRA fiduciary responsibilities.	
18. Fiduciary institutions for HSAs and HRAs must be banks or other non-bank trustees or custodians approved by the IRS.	
19. Health plan proposals must include assurances their fiduciary is financially stable. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level.	
20. Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.	
21. Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.	
22. HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how these would be managed and monitored, including accounting for earned interest.	
23. Proposals should state how fees and ancillary charges to individual accounts will be paid for.	

Attachment III: Medicare Prescription Drug, Improvement and Modernization Act of 2003

HDHPs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Requirement	Plan's Federal HDHP
''(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—	
''(i) which has an annual deductible which is not less than— ''(I) $1,100 for self only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage, and	
''(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—	
''(I) $5,250 for self-only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage.	
''(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). ''(1) ELIGIBLE INDIVIDUAL.— ''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if— ''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and ''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan— ''(I) which is not a high deductible health plan, and ''(II) which provides coverage for any benefit which is covered under the high deductible health plan. **''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—** **''(i) coverage for any benefit provided by permitted insurance, and** **''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.**	
''(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).	

Attachment III: Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Cont.)

Requirement	Plan's Federal HDHP
''(D) SPECIAL RULES FOR NETWORK PLANS.—In the case of a plan using a network of providers—	
''(i) ANNUAL OUT-OF-POCKET LIMITATION.—Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).	
''(ii) ANNUAL DEDUCTIBLE.—Such plan's annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).	

Attachment IV: Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) Components

HDHP proposals must include both HSA and HRA components. The HRA component is available only to enrollees who are ineligible for an HSA.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator		
Fees		
Eligibility		
Funding		
• **Self Only coverage**		
• **Self and Family coverage**		
Contributions/credits		
• **Self Only coverage**		
• **Self and Family coverage**		
Access funds		
Distributions/withdrawals • **Medical**		
• **Non-medical**		
Availability of funds		
Account owner		
Portable		
Annual rollover		

Attachment V: Costs

Proposals should reflect costs only, including the amounts to be deposited/credited to the enrollee's HSA or HRA.

ITEM	HSA	HRA
Premium Pass Through Amount		
Account set-up fee		
• Option 1: Electronic enrollment		
• Option 2: Manual enrollment		
Account maintenance fee		
• Option 1: Paid by account holder		
• Option 2: Paid by employer		
Account Miscellaneous Fees		
Monthly service charge		
Paper statement		
Excess contribution adjustment		
Debit card for new accounts		
Debit card reorder		
Debit card additional card order		
Tax statement copy		
Check transactions		
Debit card transactions		

Attachment VI: SUMMARY OF HIGH DEDUCTIBLE HEALTH PLAN FOR FEDERAL MEMBERS

Lifetime Maximum	Not Applicable	
	Plan Providers	**Non-Plan Providers**
Annual Deductible (Except Preventive Services if applicable)	Self: $XX Self and Family: $XX	Self: $XX Self and Family: $XX
Maximum Annual Copayment (stoploss)	Self: $XX Self and Family: $XX	Self: $XX Self and Family: $XX

	Member Pays	
	Plan Provider	**Non-Plan Provider**
1ST DOLLAR BENEFITS (not subject to the annual deductible)		* Plus any difference between our payment and the actual charges
PREVENTIVE AND SCREENING SERVICES		
Immunizations		
Well Child Immunizations		
TB Skin Test		
Bone Density Screening		
Pap Test		
Well Woman Exam		
Glucose Screening		
Chlamydia Infection Screening		
Colorectal Screening (FOBT, colonoscopy and Sigmoidoscopy)		
Mammography – Screening		
Well Child Care Physician Office Visits (through age)		
Well Child Care Laboratory Tests		
HEALTH ASSESSMENT AND DISEASE MANAGEMENT SERVICES		
COVERED SERVICES		
PHYSICIAN SERVICES		
Physician Office Visits		
Physician Home Visits		
Physician Hospital Visits		
Physician Skilled Nursing Facility Visits		
ER Visits (Physician Charge)		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Urgent care	• Primary Care Physician: • Specialist:	
Consultation Visits (inpatient)		
BEHAVIORAL HEALTH PHYSICIAN SERVICES		
Mental Health Physician Visits		
Substance Abuse Physician Visits		
DIAGNOSTIC TESTS, LABORATORY AND RADIOLOGY		
Diagnostic Tests (Pre-surgical, X-rays)		
Evaluation for Hearing Aids		
Allergy Testing and Treatment Materials		
Laboratory and Pathology		
Radiology		
MATERNITY AND NEWBORN CARE		
Maternity Care		
Newborn Care		
Circumcision		
SURGICAL SERVICES		
Anesthesia		
Assistant Surgeon		
Surgery		
Treatment of Morbid Obesity		
ORGAN TRANSPLANT SERVICES (Transplants must receive prior authorization unless otherwise noted)		
Corneal Transplants (no pre-auth)		
Kidney Transplants (no pre-auth)		
Simultaneous Small Bowel/Multivisceral Transplant		
Small Bowel Transplant		
Organ Donor Services		
Transplant Evaluation		
	Contracted Provider	**Non-Contracted Provider**
Bone Marrow Transplants		
Heart and Lung Transplants		
Heart Transplants		
Liver Transplant		
Lung Transplants		
Simultaneous Kidney/Pancreas Transplant		
EMERGENCY FACILITY SERVICES		
Ambulance (Ground)		
Ambulance (Air)		
Emergency Service		
FACILITY SERVICES		
Ambulatory Surgical Center		
Birthing Center		
Hospital • Based on semi-private room rate • Intermediate care, ICU, CCU		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Observation Care		
Skilled Nursing Facility (___days per year)		
CANCER TREATMENT		
Chemotherapy		
Radiation Therapy		
HOME SERVICES		
Home Health Care		
Hospice		
APPLIANCES, EQUIPMENT AND SUPPLIES		
Durable Medical Equipment, Orthotics and Prosthetics		
Hearing Aids		
REHABILITATIVE SERVICES		
Physical Therapy and Occupational Therapy		
Speech Therapy		
OTHER MEDICAL SERVICES		
Blood and Blood Products		
Dialysis and Supplies		
Inhalation Therapy		
Medical Foods		
PRESCRIPTION DRUGS		
Home IV Therapy		
Human Growth Hormone Therapy		
Injectable Drugs (physician administered)		
Prescription Drugs	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Insulin	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Diabetic Supplies	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Spacers	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)**	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a Benefit
Oral Contraceptives	**Retail Pharmacy: (30 day supply)** Regular Plan benefits **Mail Order: (90 day supply)** Regular Mail Order Benefits	**Retail Pharmacy: (30 day supply)** Regular Plan benefits **Mail Order: (90 day supply)** Not a Benefit
Contraceptive Diaphragms	**Retail Pharmacy and Mail Order**	**Retail Pharmacy**
Treatment of Erectile Dysfunction due to organic cause		
FAMILY PLANNING, FERTILITY AND INFERTILITY SERVICES		
Contraceptive Implants		
Contraceptive IUD		
Diagnosis of Infertility		
In Vitro Fertilization		
Artificial Insemination		
Tubal ligation		
Vasectomy		

Attachment VII: Checklist

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

Topic	***Included in Proposal***
▪ Health Care Costs and Quality Transparency Initiatives	_____
▪ Health Information Technology Initiatives	_____
▪ Enhanced Prescription Drug Management Initiatives	_____
▪ Preventive Care Initiatives	_____
▪ Organ / Tissues Transplants Checklists	_____
▪ High Deductible Health Plan	_____

Please return this checklist with your CY 2007 benefit and rate proposal