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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. 2015-02**

**Date: March 13, 2015**

Fee-for-service [2]

Experience-rated HMO [2]

Community-rated HMO [1]

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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, 2016 should be submitted on or before Sunday, **May 31, 2015**. 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. As a reminder, your Contracting Officer will consider responses to the topics in the Call Letter in evaluating your responsiveness to OPM. Responsiveness to OPM will remain an important element as we implement the new Plan Performance Assessment program.

### **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 2016 and beyond. We encourage all FEHB carriers to thoroughly evaluate their health plan options to find ways to improve affordability, reduce the cost and improve the quality of care, and improve the health of the enrolled population. Benefit proposals must be cost neutral in that proposed benefit enhancements must be offset by proposed reductions so that premiums are not increased due to benefit changes. OPM will make exceptions to this requirement for proposed benefit changes in response to the Medicare and Applied Behavior Analysis (ABA) initiatives described below. This year, we are focusing on several areas:

- implementing Self Plus One coverage;
- encouraging participation in Medicare Part B;
- expanding access to care;
- optimizing delivery of prescription drug benefits;
- promoting preventive care and wellness;
- advancing quality and value of care; and
- preparing for the Excise Tax in 2018.

Specific initiatives are discussed below.

## **II. Implementation of Self Plus One Coverage**

Section 706 of the Bipartisan Budget Act of 2013 adds to chapter 89 of title 5 United States Code a Self Plus One enrollment type for Federal employees and retirees under the FEHB Program.

As FEHB plans prepare their proposals for 2016 rates and benefits including Self Plus One enrollment types, we expect proposals for Self Plus One rates to be lower than Self and Family rates. In no event can Self Plus One rates be higher than Self and Family rates. Likewise, benefits that vary between enrollment type, such as catastrophic maximum, deductibles and wellness incentives should be for dollar amounts that are less than or equal to corresponding benefits in Self and Family enrollment. All other benefits, such as copays and coinsurance amounts, should be the same regardless of enrollment type. FEHB plans with High Deductible Health Plans must be cognizant of Treasury/IRS - 26 U.S. Code § 223 which for deductibles, catastrophic maximums and premium pass-through contributions require twice the dollar amount for Self Plus One or Self Plus Family than for Self Only coverage. Note that family coverage is defined under 26 CFR 54.4980G-1 as including the Self Plus One coverage category.

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

Newly Medicare-eligible Federal retirees are enrolling in Medicare Part B in declining rates. In the past 15 years, the participation rate in Part B for newly eligible annuitants has declined by twenty percent among fee for service plans and by ten percent for HMOs.

FEHB is experiencing declining participation rates because members often do not have a clear enough incentive to enroll. Plans should propose benefit changes that allow members to maximize their benefits under FEHB and Medicare, such as reduced cost sharing under hospital, medical or pharmacy benefits for members with Part B. We also encourage plans to improve their coordination activities for pharmacy benefits covered under Part B and FEHB. As noted earlier, enhancements to benefits that encourage Medicare participation will not need to be offset by decreases in other benefits.

## **IV. Access to Care**

OPM strongly encourages plans to reassess their benefit offerings as the needs of our population evolve. In recent years, FEHB has welcomed young adults up to the age of 26 and same sex spouses as covered family members. To further ensure that members can access appropriate care, we provide the following guidance:

**Applied Behavior Analysis (ABA)** - OPM has encouraged FEHB plans to offer ABA benefits for children with autism spectrum disorders since 2013. Since then, the availability of appropriate credentialed and/or licensed providers has greatly increased, and the Agency

for Healthcare Research and Quality (AHRQ)<sup>1</sup> has summarized new research linking behavioral interventions with positive outcomes. We appreciate efforts some FEHB plans have made to provide ABA services. However, many Federal families still have no FEHB plan option that includes ABA.

To increase access to ABA services, we will pursue active negotiations with all plans that have not yet added this benefit. We are prepared to allow an exception to cost neutrality if ABA is included as a new service. Consistent with each plan's benefit design, OPM will consider proposals for ABA as a fully case managed benefit, a pre-authorized service, or an in-network benefit only. Additionally, national plans may present proposals that phase in coverage beginning in 2016. Please consult the Technical Guidance for additional details regarding ABA benefit implementation.

**Infertility Benefits** - FEHB eligibility includes same-sex spouses. Accordingly, while plans are not required to offer infertility benefits, if they do, they must ensure that benefit definitions and coverage descriptions use terms that are relationship neutral. We also note that OPM no longer requires plans to comply with benefit requirements for federally qualified Health Maintenance Organizations<sup>2</sup>. All brochures should clearly describe how members qualify for any available diagnostic and therapeutic infertility benefits; examples of updated brochure language are included in the Technical Guidance.

**Transgender Services** - In June 2014, OPM recognized the evolving professional consensus that treatment may be medically necessary for gender dysphoria, and removed the FEHB requirement to exclude services, drugs, or supplies directly related to transition<sup>3</sup>. Due to the short timeframe for network development and benefit design, OPM permitted plans to retain the general exclusion of these services for the 2015 plan year. For 2016, plans may propose services for members with gender dysphoria as they do for all other medical conditions. Plans offering surgical services must include details of preauthorization or case management requirements to facilitate referrals to qualified providers of this specialized care.

**In-Network Benefits** – FEHB members still receive bills from non-network providers who render services in network hospitals, such as anesthesiologists, radiologists, pathologists, and neonatologists. We encourage all plans to work with their contracting institutional providers to address this issue, which can have a significant cost-sharing impact on members, and to ensure that consumers are provided in-network options whenever practicable and sufficient notice before non-network services are delivered. Please include a description of how you are addressing this concern in your proposal.

## V. Prescription Drugs

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<sup>1</sup> <http://effectivehealthcare.ahrq.gov/ehc/products/544/1945/autism-update-report-140806.pdf>, AHRQ Publication No. 14-EHC036-EF, August 2014

<sup>2</sup> HMO Act of 1973, 42 U.S. Code Section 300e.

<sup>3</sup> <http://www.opm.gov/healthcare-insurance/healthcare/carriers/2014/2014-17.pdf>

OPM continues to emphasize ways to ensure the 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. Key strategies include tiering, managed formularies, tailored networks, and utilization management techniques.

**Managed Formularies** - FEHB has traditionally covered all drugs that require a prescription by Federal law, with few exceptions. As the cost of prescription drugs has increased, a larger number of drug benefit plans now manage their formularies to exclude certain drugs. OPM encourages plans to consider a managed formulary for the 2016 plan year. Such a formulary may exclude drugs that are less efficacious or less safe than other available drugs for the same indication, as well as those that provide little incremental clinical value at substantial additional cost when compared to other available drugs for the same indication. Plans proposing a managed formulary should include a description of their communication plan to ensure appropriate outreach to members and providers.

**Formulary Tiers** - By the 2016 plan year, all plans must offer a prescription drug benefit that includes at least four tiers: Generics, Preferred Brands, Non-preferred Brands, and Specialty Drugs. Formulary tiers may also include additional categories, such as preferred and non-preferred specialty drugs. As biosimilar specialty products find their way to market, it will be important to differentiate between preferred and non-preferred specialty products.

**Transparency** - Both *current* and *prospective* enrollees should have easy and convenient access to user friendly information about the formulary tier and member cost-share for prescription drugs. As described in Carrier Letter 2014-03, we expect all FEHB plans to make available such a cost comparison tool by this year's Open Season.

**Pharmacy Networks** - There are more than 65,000 licensed pharmacy outlets in the United States. Many FEHB plans include nearly all of them in their participating provider network. Evidence suggests that reductions in the size of the network can result in significantly enhanced discounts while pharmacy access is maintained, and member disruption is minimized. We encourage plans to consider savings opportunities related to pharmacy network management. Any proposals to implement a managed network should be accompanied by an assessment of the impact on members and a robust communication plan.

**Utilization Management** - We expect plans to implement, operate, and reinforce drug utilization management strategies that have been shown to be effective in assuring high quality care and clinically appropriate cost savings. These include prior approval, step therapy, quantity limits, and medication therapy management as follows:

- Last year, fewer than half of FEHB members were enrolled in a plan using step therapy. Additional opportunities exist to reduce costs by more broadly utilizing step-therapy.
- Most FEHB plans have quantity limits for narcotics and sleep medications. We encourage plans to consider quantity limits for stimulants.

- Specialty drugs present challenges due to their high cost and the established practice of reimbursing these drugs through the medical benefit. Reimbursing specialty drugs under the drug benefit can offer better discounts, and may result in better medication adherence and clinical outcomes for patients. Our data reveals that plans representing the majority of FEHB enrollees still reimburse for specialty medications through the medical benefit. We encourage carriers to consider potential savings and improvements to quality of care that can be accomplished by limiting the reimbursement of specialty drugs to the pharmacy benefit.

Plans proposing to strengthen drug utilization management should include a description of the initiative, its rationale, implementation strategy, and member impact, along with a communication plan to minimize member disruption.

## **VI. Preventive Care and Wellness**

OPM has a strategic goal that emphasizes the importance of population health and preventive service delivery for Federal employees, retirees, and their families. We call your attention to specific strategies to help us meet this goal.

Carrier Letters 2013-04 and 2014-03 described OPM's requirements for health risk assessments (HRA) and biometric assessments. We recognize the challenges in engaging members and appreciate your efforts to improve participation rates. Many plans still need to supplement their outreach to achieve our goal to screen the majority of adults at least once every three years. At a minimum, we strongly recommend all plans highlight the availability and importance of screening in targeted communications with new members and those experiencing Qualifying Life Events. Plans proposing cash or other rewards for positive behaviors may improve results by structuring the incentive program so that members receive a portion for completing the HRA/biometric screening and the full amount for taking action to improve their health. Plans offering cash or other rewards must be in compliance with rules governing incentives for non-discriminatory wellness programs in group health plans.<sup>4</sup>

In compliance with the Affordable Care Act (ACA), FEHB plans must provide all preventive services recommended with an A or B rating<sup>5</sup> by the United States Preventive Services Task Force (USPSTF) with no member cost sharing. Nine items were added to the list or updated in 2014, including screening for gestational diabetes, screening for a variety of infections, and intensive behavioral counseling for adults who are overweight or obese and have cardiovascular risk factors.

Additional approaches to increase enrollee participation in wellness activities, promote preventive services, and reduce cardiovascular risk will be highlighted in the Technical Guidance.

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<sup>4</sup> <https://www.federalregister.gov/articles/2013/06/03/2013-12916/incentives-for-nondiscriminatory-wellness-programs-in-group-health-plans>

<sup>5</sup> <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

## **VII. Advancing Quality and Value of Care**

OPM's goal is to improve the health of the populations we serve, ensure the delivery of high quality consumer focused health care, and provide Federal employees and retirees with affordable insurance benefits. We encourage plans to achieve these goals through innovative delivery systems and payment reforms. OPM's Carrier letter 2013-01, [Patient Centered Medical Homes within the FEHB](#) outlines the recognition, payment, accountability, and reporting requirements for carriers seeking to achieve these goals through implementation of PCMH. We encourage carriers to become active in the Health Care Payment Learning and Action Network<sup>6</sup>, which HHS has recently established as a means for promoting proven payment-for-value models among private payers.

We evaluate all FEHB plans on key parameters of clinical quality, customer service, resource use, and contract oversight. We congratulate FEHB plans for their focus on quality improvement, especially those achieving OPM's "Exemplary" or "Most Improved" designations. Recent HEDIS measures show that more members are receiving timely, evidence-based care that will keep them healthy.

This culture of performance improvement will serve plans well as we transition to the new FEHB Plan Performance Assessment. Carrier Letter 2014-28 provides details on the specific measures that will be tied to plan profit factors. Please note that data reporting for the first year of the Performance Assessment begins in 2016. As always, plans may submit comments and questions to [fehbp@opm.gov](mailto:fehbp@opm.gov) with a copy to their contract specialist.

## **VIII. Preparations for Excise Tax**

Title IX, Subtitle A, section 9001 of the Affordable Care Act (ACA), establishes an excise tax on high cost employer-sponsored health coverage that will go into effect in 2018. We encourage plans to begin reviewing their plan design, network and benefit management strategies in the context of the excise tax. Plans must provide Contracting Officers with an initial three-year assessment of any changes they may be making for their FEHB plan offerings in advance of the 2018 plan year.

## **IX. Technical Guidance**

We will provide specific requirements to submit benefit and rate proposals and information for preparing 2016 brochures, 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.

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<sup>6</sup> <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>

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