FEHB Program Carrier Letter
All Carriers

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

Letter No. 1999-016 **Date:** April 9, 1999

Fee-for-service [13] Experience-rated HMO [13] Community-rated HMO [14]

SUBJECT: Annual Call Letter for Contract Year 2000

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations. From now through May 31, 1999, we will consider requests for changes for the contract term beginning January 1, 2000. While the end of May is the regulatory deadline for your written submission, I strongly encourage you to discuss with your contract specialist any changes you are considering, including those necessary to bring about the outcomes discussed in this letter.

To assure a timely Open Season, we will begin negotiations upon receipt of your request for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations -- benefits and rates -- by August 27, 1999.

The significant initiatives for contract year 2000 include:

- The Patients' Bill of Rights,
- Quality Healthcare,
- Family-Centered Care,
- Customer Service,
- Provider Contracts (Fee-for-Service plans),
- The DoD/FEHB Demonstration Project, and
- Y2K Compliance.

Patients' Bill of Rights

The President signed an Executive Memorandum on February 20, 1998, directing the Office of Personnel Management (OPM) to take steps necessary to bring the FEHB Program into contractual compliance with the Patients' Bill of Rights requirements by the end of 1999. You gave the Patients' Bill of Rights your full support, implementing a number of important patient protections around information disclosure, access to emergency care, access to obstetricians and gynecologists, access to specialists for people with special health care needs, and access to appropriate providers, even if they are outside of the plan's network. We are pleased that you were able to implement these protections for a minimal cost – less than 25 cents per enrollee.

In order to provide context for the year 2000 requirements, Enclosure 1 summarizes the information you arranged to disclose and the benefit changes you implemented by the beginning of 1999. We discuss the remaining benefit and information requirements below and in Enclosure 2. The program-wide cost of implementing these should be small, as you have already completed many of the requirements. We look forward to working with you over the negotiation cycle to ensure that all of these important protections are in place by January 2000.

- Information Disclosure. Plans that have remaining provisions to implement must meet all the requirements no later than at the beginning of the Open Season for 2000 (November-December 1999), or at the beginning of contract year 2000 (as indicated below).

  The Patients' Bill of Rights requires that certain information be available to a member, or potential member, while he or she is considering an enrollment decision; and that other information be made available upon request. Enclosure 2 lists the information that must be available to members and potential members beginning with the Open Season for 2000. Some of this information will be incorporated into the brochure language we send you this spring for the year 2000 plan brochures. You should make the rest available on your web site, in information sheets, in plan guides, in provider directories, by telephone, or through other means of communication. During the negotiation cycle, we will work with you to develop brochure language that describes the information that members are entitled to receive, and the means by which they can access that information.

Last year the call letter recognized that certain Patients' Bill of Rights changes might require provider contract changes that you could not effect immediately. Accordingly, we gave you until 2000 to make necessary changes or to adopt other compliance strategies. Your response to this letter should reflect the strategies you will put in place for 2000.

- Transitional Care. Members undergoing treatment for chronic or disabling conditions (or in the second or third trimester of pregnancy) at the time they involuntarily change health plans, or at the time their provider is terminated by the plan for reasons other than cause must be able to continue seeing their specialty providers for up to 90 days (or through completion of postpartum care). When providers continue to treat such patients, the patients will pay no more than previously, and providers will give all necessary information to the plan for quality assurance purposes. Providers continuing treatment during the transition period will promptly transfer all medical records to the designated new provider during or upon completion of the transition period, according to the patient's authorization.

  An "involuntary change" is (1) when a plan terminates the member's provider from the plan's network for other than cause, or (2) when a plan leaves the FEHB Program. These two situations could occur at any time during a contract period. If a plan terminates a provider from its network for other than cause, the plan must pay for or provide the member's transitional care. If a plan leaves the FEHB Program, the member may enroll in a new plan. If the member is eligible for transitional care, the new plan must pay for or provide the transitional care.

- Medical Records. The Patients' Bill of Rights requires that patients be allowed to review and obtain copies of their medical records on request and promptly. A patient may also request that a physician amend a record that is not accurate, relevant, or complete. The physician will have sole discretion as to whether to make the requested amendment. If the physician does not amend the record in accordance with the patient's request, the member may add a brief statement to the record. Whenever a medical record is disclosed or transferred, any such statement must be included.

Quality Healthcare

The Institute of Medicine defines *quality healthcare* as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." In an environment where managing patient populations is also important, quality healthcare also must encompass how well a plan performs in meeting members' non-clinical needs and expectations. Our view of the broad range of quality includes the following:

- Accreditation. We believe accreditation is a valuable indicator of a plan's capacity to provide quality care and therefore strongly encourage you to seek accreditation from an external organization.

- Health Plan and Employer Data Information Set (HEDIS). Health plan comparisons are facilitated by standardized plan performance measurements. We will begin to collect and analyze audited HEDIS data in 2000 and expect to provide our enrollees with plan data on specific measures no later than 2002. We will ask plans that report HEDIS to other purchasers to report the same information to us in 2000. We will expect non-reporting plans to collect and report data on HEDIS and HEDIS-like measures that we specify. We intend to work closely with you to facilitate implementation.

- Outcome Measures. This year we participated in a pilot project in conjunction with the Foundation for Accountability (FACCT) and several health plans to gather data on the care provided asthma patients. We intend to replicate this study in 2000 in selected regions to produce data that is comparable across fee-for-service and comprehensive plans in specific geographic areas.

- Consumer Assessment of Health Plans Study (CAHPS). In 2000, we will continue to use the CAHPS Adult and Child Core Questionnaires, following the NCQA Protocols, as our survey instrument.

Family-Centered Care

The Vice President's 7th Annual Family Reunion focused on Families and Health. As a participant in last year's event, the Institute for Family-Centered Care promoted the idea that "the family has significant influence over an individual's health and well-being, and that because of this influence, families must be respected and supported in their roles as care givers and

decision-makers." Spurred by the initiative, we featured a discussion of family-focused health care at last year's plan conference and contracted with the Gallup Organization to conduct focus groups to assess our Program from a family-focused perspective. The following items grew out of these initiatives.

- Childhood Immunization Schedule. We expect participating plans' benefits to be consistent with the American Academy of Pediatrics's recommended schedule for childhood immunizations. In January, the Academy issued a policy statement that recommended inactivated poliovirus vaccine (IPV) at 2 and 4 months of age. For the third and fourth doses of poliovirus vaccine, either IPV or oral poliovirus vaccine can be administered. We expect your practice to be consistent with these recommendations.

- Non-FEHB Dental and Vision Benefits. Enrollees participating in focus groups consistently said that expanding dental and vision benefits would make the FEHB Program more family-centered. We are considering a variety of options in these areas for future years. For 2000, we encourage you to offer dental and vision coverage to FEHB members as non-FEHB benefits and to list such coverage prominently on the non-FEHB page of your plan brochure.

- Colorectal Cancer Screening. All plans currently provide annual coverage of one fecal occult blood test for members age 40 and older. Following guidelines recommended by the American Cancer Society, The American Gastroenterological Association, and others, we expect coverage extended to a screening sigmoidoscopy every five years starting at age 50.

- Other Screenings. The American Medical Association defines "screening" as, "health care services or products provided to an individual without apparent signs or symptoms of an illness, injury, or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition." Your approach to screenings and diagnostic tests must consider risk assessment and family history when making coverage determinations.

- Other Family-Centered Issues. Focus group participants also shared their feelings about customer service. Some perceive that plans need to strengthen their role in communicating information and collaborating with providers in the delivery of care. Although we are not aware of Program-wide problems in these areas, we agree that plans should play a positive role as facilitators in behalf of their members.

  Some FEHB enrollees view the referral process as a barrier to seeing specialists, rather than as a way to assure that necessary and appropriate care is provided. FEHB enrollees with chronic conditions reflect this perception. The Patients' Bill of Rights requirements regarding access to specialists for patients with complex or serious medical conditions should address this concern. Nevertheless, we also encourage you to develop authorization systems that allow you to monitor referral rates and patterns while providing the least disruption to enrollees.

Because coverage decisions are made on the basis of medical necessity and specific contractual provisions, enrollees' expectations are sometimes not met. We believe that increasing enrollee awareness about health coverage through a well-established patient education program and clearly written benefit explanations may promote more realistic expectations.

Family-centered care should be a collaborative effort between the patient, provider, and health plan. Well-informed case managers can help resolve problems with ancillary providers (e.g., a home health care agency or durable medical equipment provider) when members are not satisfied with the services they receive. Bereavement benefits and benefits for a family member to travel with a patient to a center of excellence outside a commuting area are examples of family-centered benefits some plans provide. We encourage you to review and emphasize your family-centered programs. Tell us about positive activities you undertake and give us examples of family-centered communication you develop for enrollees. We will share best practices with other plans.

Customer Service

- Plain Language. The President and Vice President have made plain language a top priority for Federal agencies. Plain language sends a clear message about what the Government is doing, what it requires, and what services it offers. It saves time, effort, and money. In Carrier Letter 1999-001, we announced an initiative to rewrite FEHB brochures in plain language. Along with a group of plan representatives, we are developing guidelines for written communication. We will forward the guidelines to you this spring and ask you to begin using them to shape correspondence between you and your enrollees. When you receive guidance on brochure development, you will see that the Plain Language Work Group has rewritten a number of mandatory brochure sections. We are excited about this project and believe it will improve our relationships with customers and the clarity of our brochures.

- Electronic Enrollment. Increased electronic processing of health benefits enrollment changes through the use of Employee Express and Annuitant Open Season Express remains a high priority. Last year, a number of plans failed to follow guidelines for reducing paperwork and ensuring a rapid and smooth flow of enrollment and related information. Some plans did not process electronic transmissions even though we sent out specific instructions and tested transmissions. Other plans failed to honor confirmation letters generated by electronic enrollment systems. Some plans even failed to accept electronic enrollments without corroborating paperwork, although these systems are specifically designed to replace paper forms.

  Plans must be proficient in electronic communication. The capability to produce brochures, to receive and send information, and accept enrollment information electronically is critical. Your ability to meet these requirements is an important element of your performance.

Provider Contracts (Fee-for-Service plans)

- Full Disclosure in Use of Provider Discounts. During 1997, the medical community raised concerns about payment schemes that create discounts for payers who are not entitled to the discounts. In 1998, the Inspector General at OPM reported on a special investigation into the use of provider discounts in the FEHB Program and found no unethical conduct on the part of the plans or intermediaries who arrange for provider discounts. We expect plans that secure fee discounts through intermediaries will continue to ensure that discounts are consistent with contracts between the vendor and provider networks, and are properly disclosed to the providers who are the source of discounts.

- Benefits for Services of Non-Physician Providers. As you know, the FEHB statute has been amended a number of times to reference certain non-physician providers as a means of assuring enrollee access to them for covered services. Some plans limited access to non-physician providers to those referenced in statute. Public Law 105-266 clarified this situation by expressly stating that nothing prevents health plans from providing benefits to providers other than those previously listed in statute. The use of qualified health providers in addition to physicians can widen health care options and reduce costs for plans and patients. We encourage plans to provide access to non-physician providers who are qualified to provide covered services, such as audiologists or physician assistants, when it is appropriate and cost effective to do so.

Department of Defense Demonstration Project

We informed you in Carrier Letter 1999-005 that we will be conducting a demonstration project with the Department of Defense (DoD) beginning January 2000. The demonstration, which was mandated by the Congress, will make coverage available to up to 66,000 Medicare eligible military retirees and related beneficiaries. The demonstration will last through the end of the 2002 contract year.

All open Fee-for-Service plans are required to participate in this project. We will identify the HMOs that will also be required to participate, based on their service areas and the defined boundaries of the eight demonstration sites listed in Carrier Letter 1999-005. We also will identify HMOs that may participate but will not be required to do so because their FEHB enrollment is very small, or their service area overlaps only a small portion of a demonstration area.

The legislation requires that a separate risk pool be established for DoD demonstration project enrollees. Therefore, participating plans must submit separate rate proposals, based on benefits identical to those available to all other FEHB enrollees. Affected plans must submit their DoD rate proposal along with their regular rate proposal by May 31, 1999.

Y2K Compliance

Your 1999 contract requires that you report your Y2K compliance status along with your benefit and rate proposal on May 31. You must ensure that the hardware, software firmware and acquired information technology that you use in the performance of your FEHB contract will accurately process date/time data involving dates later than December 31, 1999. On May 31, you must either assure your Contracting Officer that your system is compliant or provide a contingency plan that details how the system will remain operational after December 31, 1999. You also must include a copy of your company's purchasing policy specifying that all hardware and software acquisitions will be Year 2000 compliant.

You should take all necessary steps to provide uninterrupted, complete service to enrollees. Accordingly, you should work with your partners -- including financial institutions, providers and other contractors -- to make sure they have adequate Y2K plans. If they don't, we recommend you help them develop a plan to ensure that you will be able to provide service to your FEHB members. If you are unable to meet these service expectations, you must report the failure to us as a significant event.

Finally, toward the end of 1999, you should anticipate all kinds of increased demands because of enrollee apprehension about year 2000 system breakdowns. For example, you almost certainly will receive a significant number of "premature" requests for prescription refills. There also may be heightened anxiety about receipt of new ID cards. Please plan accordingly. Take whatever steps in advance that you think might allay consumer concerns, but be sure provisions are in place to relax restrictions on access to prescription refills and other services if necessary. In your May 31 submission, tell us how you will deal with these customer concerns.

Planning for 2001- Administrative Issues

- Effective Date for Rates and Benefits. On August 31, 1998, we published a proposed regulation that would adopt January 1st as the effective date of new enrollments and changes in enrollments made during the annual open season. In response to concerns raised by Federal agencies, we decided to postpone implementation of this regulation. We still believe the move to a standard open season effective date will simplify administration of the FEHB Program and reduce the potential confusion and error. However, we want to give agencies ample time to complete their Y2K activities before they undertake new systems reprogramming efforts. We anticipate an implementation date of January 1, 2001. We will issue a Carrier Letter when the regulation is final.

- Enrollment Code Data Field. Given the size and nature of the FEHB Program, the 3-digit enrollment code data field is no longer adequate. Please plan now for expansion to a 10-digit field to allow for maximum flexibility in the future.

Specific Guidance

1. All plan-initiated proposals for benefit changes must be cost neutral. For OPM-initiated proposals, we will consider actuarially-sound rate adjustments.

2. As in past years, we will not accept proposals for second options. We will consider proposals for three-tiered Point of Service products that differentiate between self-referrals to in-network versus out-of-network providers.

3. We would like to see proposals to consolidate rating areas where only small numbers of Federal employees or annuitants are enrolled. You must include any new rating area or service area changes in your May 31 submission. Include these proposed changes in the cover letter as well as your rate submission.

4. This call letter does not affect existing benefit guidelines and policies. New plans should contact their contract specialist for information on these benefits and policies.

Proposal Submission

1. OPM must receive your signed requests for benefit changes and clarifications by May 31, 1999. These requests must be signed by an authorized plan contracting official.

2. Precisely describe your proposed benefit changes and support them with actuarial justification. Additional benefit proposal instructions are discussed in your Enclosure.

3. Use the attached format instructions to submit benefit changes and clarification submissions. This format is mandatory.

4. You must submit your proposed brochure language with your request for benefit changes and clarifications. See the enclosed instructions. You must include language for a "How Benefits Change in 2000" page (except for new plans), as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear, in plain language, and explain how the change will affect the customer from the customer's point of view.

5. Send your proposals to the attention of your contract specialist at:

(Overnight delivery)
U.S. Office of Personnel Management

Office of Insurance Programs
Attn:
1900 E Street, NW, Room 3424
Washington, DC 20415

(Regular mail)
U.S. Office of Personnel Management
Office of Insurance Programs
Attn:
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the quality and balance of your overall health benefits package, the effectiveness of your utilization and cost controls, the economic consequences of the proposal, and the efficiency of your administration of the FEHB contract.

Brochures

Brochure production is your responsibility. We expect a timely, professional document that follows our guidelines including those for the use of plain language. Unless you make other arrangements with your contract specialist, we expect you to incorporate mandatory brochure language changes, together with changes that you propose, to the unformatted text file of your 1999 brochure as the basis for development of the 2000 brochure. You must transmit a copy of this file to us with proposed benefit changes and/or clarifications inserted by May 31, 1999. Please note that the file you transmit to us must be an unformatted text file. If you do not have an unformatted text file which represents your 1999 brochure, request one from your contract specialist. We will work with you to develop brochure language using this file. We will make revisions to it and return it to you electronically. Once benefit negotiations have been completed, we will transmit the final agreed-upon text to you for use in typesetting the 2000 brochure. This text will also be included in your 2000 FEHB contract. Once the contract has been executed, we will give you authorization to print and distribute the 2000 brochure.

Disclosure Policy Under the Freedom of Information Act

Any information included in your proposal will be subject to public disclosure after negotiations with all plans are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure if we receive a request for information. We will base our decision on the nondisclosure justification you submit with your proposal. If we intend to release any information that you believe is exempt from disclosure, we will inform you in advance.

2000 Contract Execution

We will send the 2000 FEHB contract to each FEHB plan in time for the contract to be fully executed no later than October 15, 1999. We will send you additional information and requirements shortly.

Enclosures

There are separate enclosures for Fee-for-Service, Health Maintenance Organization and newly approved Health Maintenance Organization plans. You will receive only the appropriate enclosure.

Sincerely,

(SIGNED)

Frank D. Titus
Assistant Director
for Insurance Programs

Enclosures

Information Disclosure and Benefit Changes For 1999

This checklist is being provided to provide context for the year 2000 requirements. The following measures should already be in place.

Information Disclosure

Information That Should Have Been Available During the Open Season For 1999

About the Plan and Care Management:

- Formulary drug inclusion and exception process
- Experimental/investigational determination process
- Compliance with State or Federal licensing, certification, or fiscal solvency requirements, if applicable, including the date the requirements were met. Note where the plan is out of compliance with a requirement and the reason for noncompliance
- Accreditation status
- Disenrollment rate for 1998 (FEHB open season losses / Dec 31 enrollment = %)
- Years in existence (corporate)
- Corporate form (profit/non-profit, private/public)
- Compliance with standards (State, Federal, and private accreditation) that assure confidentiality of medical records and orderly transfer to caregivers

Information That Should Have Been Available Upon Request During 1999

About the Plan and Care Management:

- Preauthorization and utilization review procedures used to approve care
- Clinical protocols, practice guidelines and utilization review standards being used to direct a patient's care
- Mandatory or voluntary disease management programs or programs for persons with disabilities and significant benefit differentials if any
- Whether a patient's medication is included in the plan's formulary, and if not, how the patient can request a waiver to allow coverage for the particular medication at preferred cost-sharing levels
- Disclosure of the credentials of the person, or persons, involved in reviewing the patient's appeal.

Benefit Changes

Women should have access to plan gynecologists, certified nurse midwives, and other qualified providers for routine and preventative women's health care services.

To the extent that certified nurse midwives are eligible to practice under existing State law and meet credentialing requirements, we expect plans to contract with them, and provide access to them, for the provision of covered services within the scope of their license or certification. We expect that plans will either allow plan OB/GYNs to act as primary care providers or allow members direct access to them for routine gynecological examinations.

Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of choice within the plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

You must use the standard brochure language that was distributed to you in May of 1998 to describe this benefit.

Access to Emergency Services

You must be using the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility. Standard brochure language to describe this benefit was distributed to you in May of 1998.

In-Network Provider Access

The Patients' Bill of Rights requires that if a health plan has an insufficient number or type of providers to provide covered benefits with the appropriate degree of specialization, the plan should ensure consumers obtain benefits outside the network at no greater cost than if obtained from in-network providers.

We recognize that under some PPO arrangements there may be limited access to some types of providers and/or providers in certain geographic areas. Where this is the case under a PPO, the plan is responsible for describing such limitations in its brochure as well as its provider directory. There will be no requirement to provide the enhanced PPO benefit where the limitations about provider availability are appropriately described. The description of such limitations must be straightforward and in plain language so that consumers will understand exactly what to expect. However, OPM expects plans to aggressively expand their current PPOs and to establish PPOs in areas where they do not now exist so that enrollee access to preferred providers is maximized.

Information Disclosure For 2000

Carriers may refer members to providers or facilities for the disclosure of information related specifically to these entities. However, if the member is unable to obtain the information, the carrier must intervene and assist the member in securing the information.

We recognize that some plans have already implemented a number of the following requirements.

Information That Must Be Available During The Open Season for 2000:

A. About the Plan:
- ♦ Customer satisfaction measures

B. About Networks and Providers:
- ♦ Number of primary care and specialty providers
- ♦ Name, education, board certification status and geographic location of all contracting primary and specialty care providers; whether they are accepting new patients; language(s) spoken and availability of interpreters (for non-English speaking and those with communication disabilities); and whether their facilities are accessible to the disabled
- ♦ Provider compensation, including base payment method (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withhold, etc.)

Information That Must Be Available Upon Request By January 2000:

A. About the Plan:
- ♦ Methods of compensation, ownership or interest in health care facilities.

B. About All Professional Providers:
- ♦ Corporate form of provider practice
- ♦ Names of hospitals where physicians have admitting privileges
- ♦ Years in practice as a physician and as a specialist if so identified
- ♦ Accreditation status
- ♦ Cancellation, suspension, or exclusion from participation in Federal programs or sanctions from Federal agencies; any suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges
- ♦ Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity
- ♦ Consumer satisfaction, clinical quality and service performance measures

C. About Facilities:

- Names, accreditation status, and geographic location of hospitals, home health agencies, rehabilitation and long-term care facilities; whether they are accepting new patients; language(s) spoken, and availability of interpreters (for non-English speaking and those with communication disabilities), and whether they are accessible to the disabled
- Corporate form
- Consumer satisfaction, clinical quality and service performance measures
- Whether facility specialty programs meet guidelines established by specialty societies or other bodies
- Complaint procedures
- Whether facility has been excluded from any Federal health programs
- Volume of certain procedures performed
- Numbers and credentials of providers of direct patient care
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.

Enclosure for Fee-for-Service Carriers

This enclosure provides Fee-for-Service carriers with additional guidance on benefit changes and instructions on the submission of benefit proposals for the contract term January 1 through December 31, 2000. **It is important that all Fee-for-Service carriers review this entire enclosure.**

There are three parts to this enclosure:

Part One - Guidance on Benefits
Part Two - Preparing Your Benefit Proposal
Part Three - Open Season Materials & Reimbursement of Printing Costs

We will send you any additional forms and materials needed to prepare your brochure and other open season documents later this month. These will include:

1. Revisions to mandated (i.e., non-negotiable) language and required changes for the 2000 brochure.

2. Printing specifications for the 2000 brochure.

We will send you electronic graphics and the OPM authorization block for the cover of your 2000 brochure with your brochure text file. We will send you your brochure quantities form, shipping labels, and related open season instructions in August.

Part One - Guidance on Benefits

Unless otherwise indicated, policies established in prior years remain in effect. We will not consider proposals that are contrary to these policies.

In keeping with the spirit of the call letter, we remain extremely price sensitive. Unless otherwise indicated, we will accept carrier-proposed benefit improvements only to the degree that they are cost neutral. Savings from managed care initiatives must accrue to the FEHB Program. When you prepare your benefit proposal, review the effect of the proposed changes on language throughout the brochure (e.g., Cost Sharing and Catastrophic Protection and Lifetime Maximums). We prefer that benefit enhancements for the next contract term be limited to those described in the call letter. With this in mind, we offer the following guidance for the 2000 contract term:

A. **Full Disclosure in Use of Provider Discounts** – The medical community continues to raise concerns about "silent PPOs" – schemes that create payment discounts for payers who are not entitled to them. In 1998, the independent Inspector General for OPM reported on a special investigation into the use of provider discounts in the FEHB Program and found no unethical conduct on the part of carriers or intermediaries who arrange for provider discounts. We expect carriers who secure fee discounts through intermediaries to continue to ensure that discounts are consistent with contracts between the vendor and provider networks and are properly disclosed to the providers who are the source of discounts.

A. **Benefits for Services of Non-Physician Providers** – Public Law 105-266 clarified FEHB law that requires fee-for-service health plans to pay benefits for services of certain non-physician providers, without supervision or referral by another practitioner, when the service is one the provider is authorized to perform and is otherwise covered by the plan's FEHB contract. The law now expressly states that nothing prevents health plans from providing benefits to a provider other than those listed. We recognize that the use of qualified health providers other than physicians may widen health care options and reduce costs for plan members. We encourage carriers to allow direct access to any provider who is qualified to provide a covered contract service, such as audiologists or physician assistants, if cost effective.

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A. We offer the following as a reminder of our policy on selected benefits

Prescription Drugs. Drug benefit deductibles may not exceed $600 and member coinsurance may not exceed 50%. Lifetime or annual benefit maximums on prescription drugs are not permitted. Coverage must be provided for disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. We will not accept exclusions of broad categories of drugs such as "non-generics", "psychotropic drugs", or "injectables". In addition, benefits must be provided for "off-label" use of covered medication if prescribed for such use by a Plan doctor.

Immunizations for children. All plans must provide coverage for childhood immunizations, not subject to deductibles or coinsurance. This includes the cost of serum or innoculate. Benefits for associated office visits or diagnostic tests may be subject to applicable deductibles and/or coinsurance.

Diagnosis and treatment of infertility. All plans are to provide benefits for the diagnosis and treatment of infertility problems. This does not mandate coverage for ART (artificial reproductive technology) procedures, such as artificial insemination, in vitro fertilization, and embryo transfer.

Part Two - Preparing Your Benefit Proposal

Because we must conclude negotiations in a few weeks, we expect every Fee-for-Service Carrier to prepare and submit a complete proposal in accordance with these instructions by May 31, 1999.

Your actual benefit proposal will consist of several parts:

- Narrative description of each proposed change (in worksheet format);

- Narrative description of each proposed clarification (in worksheet format);

- Proposed 2000 brochure language; and,

- Signed contracting official form.

We are seeking stability in FEHB Program benefit packages and are not encouraging benefit changes beyond those noted in the call letter. If you foresee unusual or extensive changes, please discuss them with your OPM contract representative before you prepare your submission.

FEHB Proposal Instructions

You must include a narrative description of each proposed benefit change and clarification in your proposal. **Answer the following questions in worksheet format for each proposed benefit change or clarification. If a particular question does not apply, please so indicate. Use a separate page for <u>each</u> change or clarification you propose.** Incorrectly formatted submissions will be returned to you for correction. **The following format is <u>required:</u>**

Benefit Changes

1. Describe the existing benefit and your proposed change. State the proposed brochure language, including the "How the Plan Changes" section. The language for the "How the Plan Changes" section must be written from the enrollees' perspective and make clear to enrollees how the change will affect them. Be sure to show the complete range of the change. For example, if you are proposing to eliminate an inpatient deductible, indicate whether the change will also apply to hospitalizations under mental health benefits as well. <u>If there is more than one change to the same benefit, present each change on a separate worksheet</u>.

2. Describe the rationale or reasoning for the proposed benefit change.
3. State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package.

If an increase, describe whether any other benefit is offset by your proposal. Include the cost impact of this change as a biweekly amount for the Self Only and Self and Family rate. If there is no cost impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, as appropriate.

Benefit Clarifications

1. 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.

2. Describe the rationale and need for the language change.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g., changing the number of days for a prescription drug supply from 31 to 30 days. Clarifications, on the other hand, comprise changes in wording that do not affect the level of benefits provided. **A proposed change that results in an increase or decrease in benefits must be shown as a benefit change, even if there is no change in rates.**

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Carrier Contracting Officials

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

_____(Carrier), including those involving rates and benefits, that is not 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 amended or revised by the Carrier.

The persons 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)

Enclosure 3 (Fee For Service)

Part Three - Open Season Material & Reimbursement of Printing Costs

A. Your FEHB Brochure - As in past years, we expect you to typeset and print your brochures for the FEHB Program. The brochure production schedule and the distribution deadlines that must be met remain unchanged. Carriers will again bear full responsibility for the accuracy and timeliness of their FEHB brochures, and will be held accountable for any brochure errors.

The Office of Insurance Programs will concentrate our attention on the benefit proposals, obtaining agreement with the carriers on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Carriers will have sole responsibility for preparing the camera ready proof and printing the brochure.

We will advise you about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General Advisory on Fraud section, etc.). Additional information about the brochure production process will be forthcoming.

Unless you make other arrangements with your contract specialist, we expect you to work from a clean, unformatted electronic copy of your 1999 brochure text. You will make mandatory brochure language changes to this text as well as proposed benefit changes and/or clarifications and transmit it back to us by May 31, 1999. During the benefit negotiation process, if necessary, we will electronically transmit this text back to you with our edits reflecting whether or not we have accepted your proposals, for your review. If you do not possess an unformatted text copy of your brochure, your contract specialist can supply one.

Once the benefit negotiation process is complete, we will electronically transmit to you the agreed-upon brochure text language that is to be printed in your 2000 brochure. This text **cannot** be altered. You should begin the process of having the brochure typeset and readied for printing, but you may **not** proceed with the actual printing until your 2000 FEHB contract has been signed by OPM and by an authorized carrier contracting official. A copy of the agreed-upon brochure text language will be incorporated as Appendix A to the 2000 FEHB contract between OPM and the carrier, and the entire contract will be sent to you for signature.

After the 2000 FEHB contract is signed by OPM and by an authorized carrier contracting official, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that the brochure is correct. You are also required to create a Portable Data File (PDF) of your brochure and submit it to OPM for posting on our website. **You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure.**

You will be held accountable for any errors in the final printed brochure and PDF file. After printing the brochure, please send 25 copies to your OPM contract specialist.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will be required to reprint and redistribute corrected brochures at your expense. In addition, you will be required to notify all enrollees of the error and of the correct available benefit, and to absorb the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing corrected brochure language, rather than reprinting the brochure. Your OPM Contracting Officer will advise you what corrective action will be required. **It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure its accuracy.**

B. Rates - For 2000, the rates will appear on the back cover of your brochure. The rates will be sent to you when they are released in early September.

C. Reimbursement of Printing Costs - As in previous years, we will reimburse you for costs associated with printing the quantity of brochures that we authorize the carrier to print. We will not reimburse the costs of printing open season marketing materials, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Carriers that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our brochure production process provides them. However, carriers that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect participating FEHB carriers to devote the resources necessary to assume responsibility throughout the brochure production process for the accuracy and content of their brochures.

Penalties will be assessed for errors based on the significance of the error. Carriers will also be required to take appropriate corrective action (at carrier expense) to assure that FEHB members receive the correct information. Penalties and the cost of corrective action are not chargeable to the FEHB Program. Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than $500, but if more, not more than 50 percent of your brochure printing allowance.

The cost of reprinting and redistribution of corrected brochures, addendum sheets, or other corrective action will not be reimbursed or chargeable to the FEHB contract. In addition, failure to efficiently produce accurate FEHB brochures will be taken into consideration in determining your service charge.

E. Penalties for Late Brochure Distribution - In the past, we've experienced problems with carriers failing to ship requested brochure quantities to OPM's delivery point in Cedar Rapids, Iowa in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures are delivered on time. **However, if you do not ship timely, you may be subject to the penalties in Item D above against your brochure printing allowance** (The penalty will be increased as warranted by the delay.). In addition, your failure to ship timely will be taken into consideration in determining your service charge. To avoid such actions, please make timely shipping to Cedar Rapids and Federal agencies a priority when you distribute Plan brochures this Fall.

Carrier Letter 1999-016

Enclosure for Health Maintenance Organizations

This enclosure provides Health Maintenance Organizations (HMO) with additional guidance on benefit changes and instructions on the submission of benefit and service area proposals for the upcoming contract term (January 1 through December 31, 2000). We expect you to propose benefit changes in accordance with the call letter. **Please review this entire enclosure; certain information applies to all plans.**

There are four parts to this enclosure:

Part One - Guidance on Benefits
Part Two - Preparing Your Benefit Proposal
Part Three - Changes in Service Area
Part Four- Open Season Materials and Reimbursement of Printing Costs

If you have any questions about your benefits submission, please call your contract representative.

We will send you any additional forms and materials needed to prepare your brochure and other open season documents later this month. These will include:

1. Revisions to mandated (i.e., non-negotiable) language and required changes for the 2000 brochure.

2. Printing specifications for the 2000 brochure.

After we complete negotiations, we will send you your brochure text file for 2000, along with electronic graphics and the OPM authorization block for the cover of your 2000 brochure. We will send you your brochure quantities form, shipping labels, and related open season instructions in August.

You will receive rate instructions under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. The FEHB rates and their supporting documentation are subject to audit to ensure their accuracy and reasonableness. Misrepresentation of your FEHB Program rates can result in criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation with respect to rates.

Just as a reminder, 1999 is the first full calendar year for which we will judge community-rated plans against our performance evaluation measures. One factor B Customer Service B includes an element for *Timely Closure on Rates and Benefits Consistent with Policy Guidelines.* Remember that your benefit and rate submissions are subject to a performance review.

Carrier Letter 1999-016

Part One - Guidance on Benefits

Unless otherwise indicated, policies established in prior years remain in effect. Newly-approved HMOs should see Part Five of their enclosure for details. We will not consider proposals that are contrary to these policies.

In keeping with the spirit of the call letter, we remain extremely price sensitive, but do not limit HMOs to zero cost benefit tradeoffs. However, we do prefer that benefits remain stable.

1. The following is a reminder of our policy on selected benefits.

Prescription drugs. Drug benefit deductibles may not exceed $600 and member coinsurance may not exceed 50%. We will not permit lifetime or annual benefit maximums on prescription drugs. You must cover disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. You may use a drug formulary as long as you provides benefits for non-formulary drugs when prescribed by a plan doctor. We will not accept blanket exclusions of broad categories of drugs such as “non-generics”, “psychotropic drugs”, or “injectables”. In addition, you must provide benefits for “off-label” use of covered medications if prescribed for such use by a plan doctor in accordance with generally accepted medical practice.

DHHS-mandated benefits. All HMOs must offer certain benefits that are mandated for plans Federally qualified by the Department of Health and Human Services, without limitation as to time and cost. Exceptions are prescribed in the Public Health Service Act and DHHS regulations. These required benefits include:

- Nonexperimental bone marrow, cornea, kidney, and liver transplants. You may contact your contract specialist for additional FEHB requirements in this area;
- Short-term rehabilitative therapy (physical, speech, and occupational), the provision of which can be expected to result in significant improvement in the patient=s condition within two months;
- Family planning services, including all necessary nonexperimental infertility services, to include artificial insemination with either the husband’s or donor sperm. The cost of the donor sperm need not be covered. Other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) may be excluded to the extent permitted by applicable State law;
- Home health services
- Inhospital administration of blood and blood products, including blood processing;

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- Surgical treatment of morbid obesity when medically necessary Implants. The procedure must be covered, although the cost of the device may be excluded.

Federally-qualified community-rated plans offer these benefits at no additional cost, i.e., it's covered by the community rate. Plans that are not Federally-qualified should reflect the cost of any non-community benefits in their rate calculation.

2. Consumer Assessment of Health Plans Study (CAHPS)

We will reimburse you up to $7,000 for administering the CAHPS Child Core Questionnaire. The Office of Actuaries will include instructions for claiming this reimbursement as part of your 2000 rate reconciliation.

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Part Two - Preparing Your Benefit Proposal

Because we must conclude negotiations in a few weeks, we expect **every HMO** to prepare and submit a complete proposal in accordance with these instructions by **May 31, 1999.**

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;

- Comparison of 1999 community package (adjusted for special FEHBP benefits) and the proposed 2000 community package;

- Narrative description of each proposed change (in worksheet format);

- Narrative description of each proposed clarification (in worksheet format);

- Proposed 2000 brochure language; and,

- Signed contracting official form

If you foresee unusual or extensive changes to your community package, please discuss them with your OPM contract representative before you prepare your submission.

As a reminder, in calculating your rate, you should adjust your community rate for the package you propose to reflect the additional cost - or savings - of increased, reduced, or excluded benefits resulting from OPM benefit requirements that are specific to the FEHB group, such as improved mental benefits. If there is no change to the rate because of such requirements, identify each benefit difference nonetheless, by a zero on Attachment 2 (line 2) of your rate calculation.

2000 FEHB Proposal Instructions

A. Provide the following material by **May 3, 1999:**

1. Experience-rated Plans - Provide a copy of a fully executed employer group contract evidencing the highest level of coverage offered for 1999.

2. Community-rated Plans - Provide a fully executed copy of the community benefits package (aka master group contract or subscriber certificate) that describes the community benefits package, and riders, purchased by the greatest number of the carrier's non-Federal subscribers in 1999. If the community benefits package we currently purchase is not the same one, also send us a copy of the package we do purchase.

B. Provide the following by **May 31, 1999,** to document your proposal:

1. Experience-rated Plans - We prefer to purchase the highest level of coverage offered to employer groups by you (or current FEHB benefits, whichever is higher). **If you have not made changes to the highest level of coverage submitted in response to A(1) above, then submit a statement to this effect, along with an additional copy of the benefit description. If you have made changes, submit a copy of the new benefit description and answer the questions in Section C below.** You must file this benefit package and the associated rate with your State if a filing is required by the State.

2. Community-rated Plans - We prefer to purchase the same community benefit package that covers the majority of your subscribers/contract holders, with adjustments for any benefit differences resulting from specific requirements of the FEHB Program. If you offer a variety of community packages, you should propose the core package of benefits purchased by a majority (or the largest number) of plan subscribers or contract holders (not members or employer groups.) This package must be disclosed even in instances where we purchase a different package so that we are aware of the differences. If such disclosure was not made and we later determine that the community benefits package we purchased is not the community benefits package purchased on behalf of the majority, we will adjust your 2000 FEHB.

Please append descriptions of community-based riders (e.g., prescription drugs, durable medical equipment) and other additions to the basic package that reflect previously agreed-upon modifications or mandated additions to the community package. Also identify riders (optional benefits not sold to all plan groups) that are incorporated in the community package. This material must evidence all benefit changes proposed for the FEHB Program for the 2000 contract term except those still under review by your State as described in Item D below.

C. To simplify our comparison of your 2000 community benefits package proposal and the benefits package currently purchased for the 1999 contract term, please **attach a chart** displaying the following information:

1. Benefits that are covered in one package but not the other;

2. Differences in copays, coinsurance, numbers of days of coverage and other levels of coverage between one package and the other;

3. Whether the costs of the differences at (1) and (2) are included within or are in addition to the community rate charged to the other groups that purchase this community benefits package, and to the FEHB Program;

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

D. Describe the procedure in your State for filing and/or obtaining approval of community benefit packages and changes. If filing and/or approval is required, **provide a copy of the plan's most recent submission applicable to the community benefits package you submit in response to B(2) and provide a copy of the approval issued by the State.** Please highlight and address any State mandated benefits that you have not specifically addressed in previous negotiations with us. Please note that we will accept proposed benefit changes only if: (1) you submitted the changes to your State prior to May 31 and (2) you obtained approval and submitted documentation of the approval to us by June 30, 1999. If State approval is granted by default, i.e., the State does not object to proposed changes within a certain period after receipt of the proposal, please so note; the review period must have elapsed without objection by June 30.

We will contact the State about benefits as necessary; please provide the name and phone number of the State official responsible for review of your plan's benefits. If your plan operates in more than one State, provide this information for each State.

E. You must provide a narrative description of each proposed benefit change and clarification in your proposal. **Answer the following questions in worksheet format for <u>each</u> proposed benefit change or clarification. Use a separate page for <u>each</u> change or clarification you propose.** We will return to you for correction any incorrectly formatted submissions. **The following format is <u>required</u>:**

Benefit Changes

1. Describe the existing benefit and how you propose to change it. State the proposed brochure language, including the "How the Plan Changes" section. Write the language for the "How the Plan Changes" section from the enrollees' perspective and make clear to enrollees how the change will affect them. Be sure to show the complete range of the change. For instance, if you are proposing elimination of the plan=s hospitalization copay, indicate whether this change will also apply to hospitalizations under the emergency and mental health benefits. <u>If there is more than one change to the same benefit, present each change on a separate worksheet</u>.

2. Describe the rationale or reasoning for the proposed benefit change.

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

4. State whether this change is part of your proposed community benefits package (see Item B.2.) or a change that has been submitted to the State for approval. State how the change will be introduced to other employers (e.g., group renewal date). State what percentage of your contract holders/subscribers now have this benefit and the percentage you project will be covered by January 2000.

5. Has the change been submitted to and approved by the appropriate State authorities? If so, when? Please submit supporting documentation (see Item D above).

6. If not part of the proposed community benefits package, is the change a rider? If yes,

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

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

c. Include the cost impact of this rider as a biweekly amount for Self Only and Self and Family on Attachment 2 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 2 to your rate calculation.

7. Will the change require new providers (e.g., chiropractors)? Furnish an updated provider directory that includes these new providers.

Benefit Clarifications

1. 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.

2. Describe the rationale and need for the language change.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g., changing

the number of days for a prescription drug supply from 31 to 30 days. Clarifications, on the other hand, comprise changes in wording which do not affect the level of benefits provided. **A proposed change that results in an increase or decrease in benefits must be shown as a benefit change, even if there is no change in rates.**

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Carrier Contracting Officials

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

_____(Carrier), including those involving rates and benefits, that is not 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 amended or revised by the Carrier.

The persons 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)

Part Three - Changes in Service Areas or Redesignation as a Mixed Model Plan

We expect that your plan's present service area and the individual doctors or medical groups with whom you contract to offer services to the FEHB will remain available to our members for the 2000 contract term. You must inform us of any expected changes.

Service Area Reductions - Explain the reason for and provide supporting documentation (e.g., withdrawal notice from medical group) regarding any proposed reduction to the plan's service area. Does this reduction apply only to the Federal group? Describe precisely, and provide a map of, the area you propose to eliminate.

Service Area Expansions - You must propose any service area expansion by **May 31**. We will grant an extension for submitting to OPM any supporting documentation described below, including all necessary State authorizations, until no later than June 30. We cannot grant exceptions to this date.

Redesignation as a Mixed Model Plan - If your plan formerly operated as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) and now offers both types of providers, redesignation as a Mixed Model Plan (MMP) may be appropriate. You must request redesignation and describe the delivery system that you added.

Please note: You must indicate to us that the information you provide us concerning your delivery system is based on providers with whom you have executed contracts; letters of intent are not acceptable in lieu of executed contracts. We also require that you state that all contracts with providers contain a "hold harmless" clause. Use the statement form on page 14.

Important Notice: If your plan has a service area reduction or you establish a new rating area that requires current members to change enrollment codes, we will assign new codes and all of the Plan's FEHB members will have to reenroll during the 1999 Open Season.

We will evaluate your proposal in accordance with these criteria: legal authority to operate, adequate access to plan doctors and hospitals, and plan ability to provide contracted benefits. Accordingly, please provide the following information:

Carrier Letter 1999-016

Instructions

A. Provide a description of the proposed expansion:

1. Describe the proposed service area expansion by zip code, county, city or town.

2. Provide a map of the old and new service areas.

3. In addition to the access to providers within the proposed expansion you describe in C. below, be sure to describe access to care in contiguous areas within your existing service area. Show the distance in miles/minutes from the furthest point of the proposed expansion to current locations of Plan primary care doctors and to contracting hospitals in your existing service area. (If your plan is a GPP, show the distance to a current center (not satellite) in the existing service area.)

4. Include proposed language for this expansion in your brochure language submission, in the Service Area description.

B. Authority to operate in proposed area:

1. Please provide a copy of the State approval document authorizing you to both market and provide services in the proposed expansion area, and the name and telephone number of the person at the state agency who worked on the authorization. If you have not obtained State approval, note the June 30 deadline for our receipt of this documentation

2. If the new service area is not contiguous to your current service area, indicate whether or not the Plan operates in the proposed area with the same articles of incorporation, license, management, benefits and rate as in your current service area. If not, explain in detail..

C. Access to Providers - Please submit statements (signed by an authorized contracting official) of the following information concerning the availability of services in your proposed expansion, for each zip code, county, city or town, as described in your proposed expansion. Please note that a provider directory is not sufficient.

1a. The number of primary care physicians in the proposed area with whom you have <u>executed</u> contracts.

1b. The total number of primary care physicians in the proposed area.

2a. The number of specialists in the proposed area with whom you have executed contracts.

2b. The total number of specialists in the area.

3a. The number of hospitals in the proposed area with whom you have executed contracts. List them.

3b. The total number of hospitals in the area.

4. The average drive time to a primary care doctor.

5. The average drive time to a specialist.

6. The average drive time to a hospital.

7. The approximate size of the proposed area at its longest (north to south) and widest (east to west) points.

8. Description of the general area (e.g., rural vs. urban, population, geographic boundaries to access, etc.).

9. Description of other services and their locations (e.g., pharmacies, DME, etc.).

D. Redesignation as a Mixed Model Plan - This section applies only if your plan formerly operated as a GPP or IPP and now offers both types of providers, and you are requesting redesignation as a Mixed Model Plan. Please indicate the provider system being added.

If you are adding a GPP component to an existing IPP delivery system, please note that in order to meet FEHB requirements, you must 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 brochure language in your brochure ("How the Plan Changes" section plus "Information About This Plan", if appropriate) to reflect the proposed changes.

If we approve your proposal, you will need to provide the following information:

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 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?

Carrier Letter 1999-016

Federal Employees Health Benefits Program
Statement About Service Area Expansion

We have prepared the attached service area expansion proposal in accordance with the requirements found in Part III, Changes in Service Areas, of Carrier Letter 1999-016. 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 in response to Part III, Paragraph C (Access to Providers) is accurate as of the date of this statement.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

Part Four - Open Season Material & Reimbursement of Printing Costs

A. Your FEHB Brochure - As in past years, we expect you to typeset and print your brochures for the FEHB Program. The brochure production schedule and the distribution deadlines that you must meet remain unchanged. You will again bear full responsibility for the accuracy and timeliness of your FEHB brochure, and we will hold you accountable for any brochure errors.

The Office of Insurance Programs will concentrate our attention on the benefit proposals, obtaining agreement with the carriers on those proposals, and assuring the use of plain language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Carriers will have sole responsibility for preparing the camera ready proof and printing the brochure.

We will advise you about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General Advisory on Fraud section, etc.). We will forward additional information about the brochure production process later.

Unless you make other arrangements with your contract specialist, we expect you to work from a clean, unformatted electronic copy of your 1999 brochure text. You will make mandatory brochure language changes to this text as well as your proposed benefit changes and/or clarifications and transmit it to us by May 31, 1999. If you do not have a clean unformatted text file, your contract specialist can supply one. During the benefit negotiation process, if necessary, we will electronically transmit this text back to you with our edits reflecting whether or not we have accepted your proposals, for your review.

Once the benefit negotiation process is complete, we will electronically transmit to you the agreed-upon brochure text language that is to be printed in your 2000 brochure. You cannot alter this text. You should begin the process of having the brochure typeset and readied for printing, but <u>you may not proceed with the actual printing until your 2000 FEHB contract has been signed by OPM and by an authorized carrier contracting official</u>. Appendix A to the 2000 FEHB contract between OPM and you will include a copy of the agreed-upon brochure text language, and we will send you the entire contract for signature.

After the 2000 FEHB contract is signed by OPM and by an authorized carrier contracting official, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that it is correct. We also require you to create a Portable Data File (PDF) of your brochure and submit it to us for posting on our website. **You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure. We will hold you accountable for any errors in the final printed brochure and PDF file.** After printing the brochure, please send 25 copies to your OPM contract specialist.

Many FEHB plans are affiliated with other FEHB plans, or are members of a group of several subsidiary plans in the FEHB Program under a larger parent organization. We urge you to discuss your brochure production process with related plans and find ways to coordinate your efforts, increase efficiency, and eliminate duplication of effort. Newly-approved FEHB plans producing FEHB brochures for the first time can benefit from the guidance and experience of related affiliate plans who have produced FEHB brochures previously.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will reprint and redistribute corrected brochures at your expense. In addition, you will notify all enrollees of the error and of the correct available benefit, and to absorb the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing corrected brochure language, rather than reprinting the brochure. Your OPM Contracting Officer will advise you what corrective action will be required. **It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure the accuracy of your brochures.**

B. Rates - For 2000, the rates will appear on the back cover of your brochure. We will send the rates to you when they are released, in early September.

C. Reimbursement of Printing Costs - As in previous years, we will reimburse community-rated plans for costs associated with printing the quantity of brochures that we authorize the plan to print. These charges to the FEHB Program will be accounted for as part of the rate reconciliation process. We will not reimburse the costs of printing open season marketing materials, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Carriers that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our brochure production process provides them. However, carriers that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect participating FEHB carriers to devote the resources necessary to ensure the accuracy and content of their brochures.

We will assess penalties for errors based on the significance of the error. We will also require you to take appropriate corrective action (at your expense) to assure that FEHB members receive the correct information. You may not charge penalties and the cost of corrective action to the FEHB Program. Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than $500, but if more, not more than 50 percent of your brochure printing allowance.

We will not reimburse you for the cost of reprinting and distribution of corrected brochures, addendum sheets, or other required corrective action. If your plan is experience-rated, we will

consider failure to efficiently produce accurate FEHB brochures when we determine your service charge. If your plan is community-rated, we will factor your non-conformance into your performance evaluation.

E. Penalties for Late Brochure Distribution - In the past, we've experienced problems with carriers failing to ship requested brochure quantities to OPM's delivery point in Cedar Rapids, Iowa in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures are delivered on time. **However, if you do not ship timely, you may be subject to the penalties cited in Item D above** (The penalty will be increased as warranted by the delay.). If your plan is community-rated, we will deduct the penalty as a part of the rate reconciliation. If your plan is experience-rated, we will consider the untimely shipping when we determine your service charge. To avoid such actions, please make timely shipping to Cedar Rapids, Iowa and Federal agencies a priority when you distribute Plan brochures this Fall.

Enclosure for Newly-Approved Health Maintenance Organizations

Carrier Letter 1999-016

This enclosure provides newly-approved Health Maintenance Organizations (HMO) with additional guidance on benefits and with instructions on the submission of benefit and service area proposals for the upcoming contract term (January 1 through December 31, 2000). We expect you to propose benefits in accordance with the call letter. **Review this entire enclosure; certain information applies to all plans.**

There are four parts to this enclosure:

Part One - Preparing Your Benefit Proposal
Part Two - Changes in Service Area Since You Applied to the FEHB Program
Part Three - Open Season Materials and Reimbursement of Printing Costs
Part Four- Benefit Requirements for Newly-Approved HMOs

We will send you additional forms and materials needed to prepare your brochure and other open season documents later this month. These will include:

1. A disk and hard copy of mandated (i.e., non-negotiable) language and standard language, that may be modified to reflect the specifics of your plan, for the 2000 brochure.
2. Printing specifications for the 2000 brochure.

After we complete negotiations and finalize benefits, we will send you your brochure text file for 2000, along with electronic graphics and the OPM authorization block for the cover of your 2000 brochure. In August, we will send you your brochure quantities form, shipping labels, and related open season instructions.

We will send rate instructions under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. The FEHB rates and their supporting documentation are subject to audit to ensure their accuracy and reasonableness. Misrepresentation of your FEHB Program rates can result in criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation with respect to rates.

This calendar year is the first full year that we will judge community-rated plans against our performance evaluation measures. One factor - Customer Service - includes an element for *Timely Closure on Rates and Benefits Consistent with Policy Guidelines.* We want you to be aware that your benefit and rate submissions are subject to a performance review.

Policies established in prior years remain in effect unless otherwise indicated. **See Part IV of this enclosure for details.** We will not consider proposals that are contrary to these policies.

In keeping with the spirit of the call letter, we remain extremely price sensitive but do not limit HMOs to zero cost benefit tradeoffs. However, we prefer that benefits remain consistent with your community package.

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

Carrier Letter 1999-016

Part One - Preparing Your Benefit Proposal

We expect every HMO to prepare and submit a complete proposal in accordance with these instructions by **May 31, 1999.**

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;

- Proposed 2000 brochure language; and,

- Signed contracting official form

If you foresee unusual or extensive changes to your community package, please discuss them with your OPM contract representative before you prepare your submission.

You should adjust your community rate for the package you propose to reflect the additional cost - or savings - of increased, reduced, or excluded benefits resulting from OPM benefit requirements that are specific to the FEHB group, such as improved mental benefits. If there is no change to the rate because of such requirements, identify each benefit difference nonetheless, by a zero on Attachment 2 (line 2) of your rate calculation.

2000 FEHB Proposal Instructions

A. Provide the following material by **May 31, 1999:**

1. Experience-rated plans - Provide a copy of a fully executed employer group contract evidencing the highest level of coverage offered for 1999. If you have not made changes to the highest level of coverage since filing your application to participate in the FEHB Program, then submit a statement to this effect. If you have made changes, submit a copy of the new benefit description and answer the questions below (you must have filed this benefit package and the associated rate with your State if a filing is required by the State):

Attach a chart displaying the following information:

a. Benefits that are covered in one package but not the other;
b. Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other;

c. Whether the costs of the differences in a. and b. are included within or are in addition to the community rate charged to other groups that purchase this community benefits package; and

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

2.Community-rated plans - We prefer to purchase the same community benefit package that covers the majority of your subscribers/contract holders, with adjustments for any benefit differences resulting from specific requirements of the FEHB Program. If you offer a variety of community packages, propose the core package of benefits purchased by a majority (or the largest number) of plan subscribers or contract holders (not members or employer groups.) If we later determine that the community benefits package we purchased is not the community benefits package purchased on behalf of the majority, we will adjust your 2000 FEHB rates.

Please append descriptions of community-based riders (e.g., prescription drugs, durable medical equipment) and other additions to the basic package that reflect changes, or mandated additions, to the community package. This material must evidence all benefits proposed for the FEHB Program for the 2000 contract term except those still under review by your State as described in Item B. below.

B. Describe the procedure in your State for filing and/or obtaining approval of community benefit packages and changes. If filing and/or approval is required, **provide a copy of the approval issued by the State applicable to the community package you submit in response to A1 or A2 above.** Please highlight and address any State mandated benefits that you have not specifically addressed in previous negotiations with us. Please note that we will accept proposed benefit changes only if: (1) you submitted the changes to your State prior to May 31 and (2) you obtain approval and submit documentation of the approval to us by June 30, 1999. If State approval is granted by default, i.e., the State does not object to proposed changes within a certain period after receipt of the proposal, please so note; the review period must have elapsed without objection by June 30.

We will contact the State about benefits as necessary; please provide the name and phone number of the State official responsible for review of your plan's benefits. If your plan operates in more than one State, provide this information for each State.

Carrier Letter 1999-016

Carrier Contracting Officials

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

_____(Carrier), including those involving rates and benefits, that is not 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 amended or revised by the Carrier.

The persons 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)

Enclosure 3 (New HMOs)

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

We expect that your present service area and the individual doctors or medical groups with whom you contract to offer services to the FEHB will be available to our members for the 2000 contract term. You must inform us of any changes.

Service Area Reduction - Explain the reason for and provide supporting documentation (e.g., withdrawal notice from medical group) regarding any proposed reduction to your service area. Does this reduction apply only to the Federal group?

Service Area Expansion - You must propose any service area expansion by **May 31**. We will grant an extension no later than June 30 for submitting supporting documentation described below, including all necessary State authorizations. We cannot grant exceptions to this date.

Redesignation as a Mixed Model Plan - If you applied as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) during the application process and you now offer both types of providers, redesignation as a Mixed Model Plan (MMP) may be appropriate. You must request redesignation and describe the delivery system that you added.

Please note: You must indicate to us that the information you provide concerning your delivery system is based on providers with whom you have executed contracts; letters of intent are not acceptable in lieu of executed contracts. We also require that you state that all contracts with providers contain a "hold harmless" clause. Use the statement form on page 10.

OPM will evaluate your proposal in accordance with these criteria: legal authority to operate, adequate access to plan doctors and hospitals, and plan ability to provide contracted benefits. Accordingly, please provide the following information:

A. Provide a description of the proposed change (if different from what you proposed and what we accepted in your application):

1. Describe the proposed service area change by zip code, county, city or town, whichever is applicable.

2. Provide a map of the old and new service areas.

3. In addition to the access to providers within the proposed change you describe in C. below, be sure to describe access to care in contiguous areas within your existing service area. Show the distance in miles/minutes from the furthest point of the proposed change to current locations of plan primary care doctors and to contracting hospitals in your existing service area. (If your plan is a GPP, show the distance to a current center (not satellite) in the existing service area.)

4. Include proposed language for this expansion in your brochure language submission in the Service Area description.

B. Authority to operate in proposed area:

1. Please provide a copy of the State approval document authorizing you to both market and provide services in the changed area, and the name and telephone number of the person at the State agency who worked on the authorization. If you have not received State approval, note the June 30 deadline for our receipt of this documentation.

2. If the new service area is not contiguous to your current service area, indicate whether or not you operate in the proposed area with the same articles of incorporation, license, management, benefits and rate as in your current service area. If not, explain in detail.

C. Access to Providers (if the service area you are proposing is different from your application's) - Please submit statements (signed by an authorized contracting official who is listed on the form concerning the availability of services in your new area, for each zip code, county, city or town, whichever is applicable, as described in your proposal. Please note that a provider directory is not sufficient.

1a. The number of primary care physicians in the proposed area with whom you have executed contracts.

1b. The total number of primary care physicians in the proposed area.

2a. The number of specialists in the proposed area with whom you have executed contracts.

2b. The total number of specialists in the area.

3a. The number of hospitals in the proposed area with whom you have executed contracts. List them.

3b. The total number of hospitals in the area.

4. The average drive time to a primary care doctor.

5. The average drive time to a specialist.

6. The average drive time to a hospital.

7. The approximate size of the proposed area at its longest (north to south) and widest (east to west) points.

8. Description of the general area (e.g., rural vs. urban, population, geographic boundaries to access, etc.).

9. Description of other services and their locations (e.g., pharmacies, DME, etc.).

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

Since benefits may be restricted for nonemergency care received outside the service area where plan providers are generally located, your proposal must include language to clearly describe this additional geographic area as well as your service area.

D. Redesignation as a Mixed Model Plan - This section applies only if you applied as a GPP or IPP and, since the application approval, now offer both types of providers. Please indicate the provider system you are adding.

If you are adding a GPP component to an existing IPP delivery system, please note that in order to meet FEHB requirements, you must 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))

If we approve your proposal, you will need to provide the following information:

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 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?

Carrier Letter 1999-016

Federal Employees Health Benefits Program
Statement About Service Area Expansion

We have prepared the attached service area expansion proposal in accordance with the requirements found in Part II, Changes in Service Area, of Carrier Letter 1999-016. 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 in response to Part II, Paragraph C (Access to Providers) is accurate as of the date of this statement.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

Part Three - Open Season Material & Reimbursement of Printing Costs

A. Your FEHB Brochure - We expect you to typeset and print your brochures for the FEHB Program. You must meet the brochure production schedule and the distribution deadlines. You will bear full responsibility for the accuracy and timeliness of your FEHB brochure, and we will hold you accountable for any brochure errors.

The Office of Insurance Programs will concentrate our attention on the benefit proposals, obtaining agreement with the carriers on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Carriers will have sole responsibility for preparing the camera ready proof and printing the brochure.

We will advise you about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General Advisory on Fraud section, etc.). We will forward additional information about the brochure production process later.

Once the benefit negotiation process is complete, we will electronically transmit to you the agreed-upon brochure text language that is to be printed in your 2000 brochure. You cannot alter this text. You should begin the process of having the brochure typeset and readied for printing, but you may **not** proceed with the actual printing until your 2000 FEHB contract has been signed by OPM and by an authorized carrier contracting official listed on the form on page 5. Appendix A to the 2000 FEHB contract between OPM and you will contain the agreed-upon brochure text language, and we will send you the entire contract for signature.

After the 2000 FEHB contract is signed by OPM and by an authorized carrier contracting official, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that the brochure is correct. You are also required to create a Portable Data File (PDF) of your brochure and submit it to OPM for posting on our website. **You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure.** After printing the brochure, please send 25 copies to your OPM contract specialist.

Many FEHB plans are affiliated with other FEHB plans, or are members of a group of several subsidiary plans in the FEHB Program under a larger parent organization. We urge you to discuss your brochure production process with related plans and find ways to coordinate your efforts, increase efficiency, and eliminate duplication of effort. Newly-approved FEHB plans producing FEHB brochures for the first time can benefit from the guidance and experience of related affiliate plans who have produced FEHB brochures previously.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will reprint and redistribute corrected brochures at your expense. In addition, you will notify all enrollees of the error and of the correct available benefit, and be subject to the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing corrected brochure language, rather than reprinting the brochure. Your OPM Contracting Officer will advise you of the necessary corrective action. **It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure the accuracy of your brochures.**

B. Rates - For 2000, the rates will appear on the back cover of your brochure. We will send you the rates when they are released, in early September.

C. Reimbursement of Printing Costs - We will reimburse community-rated plans for costs associated with printing the quantity of brochures that we authorize the plan to print, and we recognize these as allowable charges for experience-rated plans. These charges to the FEHB Program will be accounted for as part of the community-rated plans' rate reconciliation process. We will not reimburse or allow the costs of printing open season marketing materials, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Carriers that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our brochure production process provides them. However, carriers that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect FEHB carriers to devote the resources necessary to ensure the accuracy and content of their brochures.

We will assess penalties based on the significance of the error. You will also be required to take appropriate corrective action (at your expense) to assure that FEHB members receive the correct information. You may not charge penalties and the cost of corrective action (e.g., reprinting and redistributing corrected brochures or addendum sheets) to the FEHB Program.

Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than $500, but if more, not more than 50 percent of your brochure printing cost.

We will also take the error into account when we conduct community-rated plans' annual performance evaluation and determine experience-rated plans' service charge.

E. Penalties for Late Brochure Distribution - We've experienced problems with carriers failing to ship requested brochure quantities to OPM's delivery point in Cedar Rapids, Iowa in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures are delivered on time. **However, if you do not ship timely, you may be subject to the penalties cited in Item D. above.** (The penalty will be increased as warranted by the delay.) If your plan is community-rated, we will deduct the penalty as a part of the rate reconciliation and when we consider your performance evaluation. If your plan is experience-rated, we will consider failure to ship timely when we determine your service charge. To avoid such actions, please make timely shipping to Cedar Rapids and Federal agencies a priority when you distribute Plan brochures this Fall.

Part IV - Benefit Requirements for Newly-Approved HMOs

Policies established in prior years remain in effect unless otherwise indicated. Some of them are highlighted here as aids to you in preparing your proposal. We will not consider proposed benefits that are contrary to these policies. You should work closely with your contract specialist to develop a complete benefit package for 2000.

A. **Mental Health and Substance Abuse** - We do not accept annual dollar limits or lifetime maximums on benefits for the treatment of mental illness. This does not apply to benefits for inpatient treatment of alcoholism and drug abuse. In addition, we encourage plans to move away from contractual day and visit limitations and high deductibles for treatment of mental conditions. We would like to see you make patient access to adequate mental health services happen through managed care networks of behavioral health care providers and innovative benefits design.

B. **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 caesarian 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.

C. **Pre-existing Conditions** - We do not allow pre-existing condition limitations on any benefit, including cosmetic surgery and dental benefits.

D. **Point of Service Product** - We will consider proposals to offer a Point of Service product under the FEHB Program <u>only if you can demonstrate experience with a private sector employer who has purchased this product</u>.

E. **Waiver of Office Visit Copayments for Prenatal and Postnatal Care** - A number of plans waive these copayments to help assure that pregnant members obtain adequate pre- and post-natal care, and thereby increase the likelihood that their babies will be born without complications. We encourage other HMOs to do the same.

F. **Coverage for Fertility Drugs** - We require you to cover treatment of infertility, but this requirement does not include related prescription drugs. Brochure language should clearly indicate whether you cover fertility drugs or not, in both the infertility benefit description and the prescription drug benefit description.

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

H. **Transplants** -All plans must provide coverage for all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney transplants. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. You may limit coverage for these three conditions to services received in clinical trials, provided both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but you must provide necessary follow-up care to the experimental procedure. All HMOs must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors,you will coordinate benefits according to NAIC guidelines, as with any other benefit.

You may exclude from your FEHB benefits other transplants not mandated by us if they are not in the community benefit package we purchase, and as permitted by applicable State law.

I. **Dental and Vision Benefits** - We will consider dental or vision care benefits only from community-rated plans and only when they are a part of the core community benefits package we purchase.

J. **Prescription Drugs** - All plans must provide at least a minimum level of coverage for all medically necessary drugs that require a prescription for their use, and insulin.

Drug benefit deductibles may not exceed $600 and member coinsurance may not exceed 50%. We don’t allow lifetime or annual benefit maximums on prescription drugs.

You must cover disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. In addition, you must provide benefits for "off-label" use of covered medications if prescribed for such use by a plan doctor in accordance with generally accepted medical practice.

You may use a drug formulary as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. You cannot use the formulary as a means to exclude benefits for the types of drugs mandated for the FEHB. We don’t allow blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables".Coverage for Contraceptives -You must provide coverage for all FDA-approved prescriptions and devices for contraception.

L.. **DHHS-Mandated Benefits** - All HMOs **must** offer certain benefits that are mandated for Federally qualified plans by the Department of Health and Human Services (DHHS), **without limitation as to time and cost,** other than as prescribed in the Public Health Service Act and DHHS regulations. These required benefits include:

✓ Nonexperimental bone marrow, cornea, kidney, and liver transplants (see H. above for other FEHB requirements in this area);

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

✓ Family planning services, including all necessary nonexperimental 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. You may exlude 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;

✓ Home health services;

✓ Inhospital administration of blood and blood products (including "blood processing");

✓ Surgical treatment of morbid obesity, when medically necessary;

✓ Implants - the surgical procedure must be covered, although the cost of the device may be excluded.

Federally qualified community-rated plans offer these benefits at no additional cost, i.e., 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 2 of their rate calculation (if there is no additional cost, the cost entry should be zero).