FEHB Program Carrier Letter
Health Maintenance Organizations

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2007-13(a) **Date:** April 12, 2007

Fee-for-service [n/a] Experience-rated HMO [7] Community-rated HMO [9]

SUBJECT: 2008 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals

Enclosed are the technical guidance and instructions for preparing your benefit and service area proposals for the contract term January 1, 2008 through December 31, 2008. The guidance and instructions are in five parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Preparing Service Area Changes or Re-designation as a Mixed Model Plan
- Part Three: Benefits for HMOs
- Part Four: Preparing Your Proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA)
- Part Five: Preparing Your 2008 Brochure

Please refer to our annual *Call Letter* (Carrier Letter 2007-07) dated March 7, 2007, for *policy guidance*. Benefit policies from prior years remain in effect.

Your community benefit package that we purchased is due no later than May 11, 2007, and your complete proposal for benefits, clarifications, and service area changes is due no later than May 31, 2007, (see Part One: Preparing Your Benefit Proposal). Please send a copy of your proposal electronically on a CD-Rom or other electronic means to your contract specialist in addition to a hard copy. Your proposal should include the corresponding language that describes your proposed changes for Section 5 of the brochure. You do not need to send your fully revised 2008 brochure by May 31. Your OPM contract specialist will negotiate your 2008 benefits with you and finalize the negotiations in a closeout letter.

As a reminder, each year we assess carriers' overall performance. We take into consideration your efforts in submitting benefit and rate proposals on time and your accurate and timely production and distribution of brochures. Enclosed for your convenience is a checklist (Attachment VII) with the information you need to provide. Please return the completed checklist along with your benefit and rate proposals.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

Robert F. Danbeck
Associate Director
for Human Resources Products and Services

Enclosures

2008 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

- Submit a copy of a fully executed employer group contract (i.e., *certificate of coverage*) that non-Federal subscribers purchased in 2007.

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

Community-rated Plans

Beginning contract year 2008, we are allowing HMOs the opportunity to adjust benefits payment levels in response to local market conditions. If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB consumers. You should also identify each of the differences between your current benefit package and the proposed offering, and include the impact on your community rated price proposal.

1. The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.
2. The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there would be an impact on premiums.
3. Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your contact in the Office of the Actuary regarding the alternate community package and requirements for the use of Similarly Sized Subscriber Groups (SSSGs) in the rating process.

- Submit a copy of a fully executed community benefit package by May 11, 2007 (a.k.a. master group contract or subscriber certificate) including riders as well as copays, coinsurance, and deductible amounts that your non-Federal subscribers purchased in 2007. If the community benefit package is different from the FEHB's, also send a current copy of the benefit package that we purchased also. Please highlight the difference(s) between the FEHB benefits and the package you based it upon. **Note:** If you offer a "national plan" then you need to send us your community benefit package for each state that you cover.

- Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2008 contract term, except for those still under review by your state.

If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. **If you have made changes,** submit a copy of the new benefits description. If your state requires that you file this documentation, file the benefit package and the associated rate with the state first. We will accept the community benefit package that you project will be sold to the majority of your non-Federal subscribers in 2008.

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

All HMOs

1. Attach a chart that compares your proposed 2008 benefit package and the 2007 benefit package that we purchased. Include on your chart:

    A. Differences in copays, coinsurance, numbers of coverage days, and coverage levels in the two packages. For community-rated plans only, indicate whether you include the costs of the differences within your community-rate or in addition to the community-rate you charge to the other groups that purchase this benefit package, and to the FEHB Program; and the number of subscribers/contract holders who purchased the 2007 package and who are expected to purchase the 2008 package;

    B. Describe your state's filing process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to May 31, and you obtain approval and submit approval documentation to us by June 29, 2007. If the state grants approval by default, i.e., it does not object to proposed changes within a certain period after it receives the proposal, please so note. The review period must have elapsed without objection by June 30, 2007.

2. We will contact the state about benefits as necessary. Please provide the name and phone number of the state official responsible for reviewing your plan's benefits. If your plan operates in more than one state, provide the information for each state.

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

Please send the following material by **May 31, 2007**:

Your benefit proposal must be complete. The timeframes for concluding benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

- A comparison of your 2007 benefit package (adjusted for FEHB benefits) and your 2008 benefit package (see #1 above);

- Benefit package documentation (see **Benefit Changes** below);

- A plain language description of each proposed change (in worksheet format) and the revised language for your 2008 brochure;

- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2008 brochure; and

- A signed contracting official's form (see attached)

If there are, or if you anticipate significant changes to your 2008 benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Benefit Changes

Your proposal must include a narrative description of each proposed benefit change. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if there is no rate change. Also, please answer the following questions in worksheet format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incorrectly formatted submissions. ***We require the following format:***

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2008" section in "plain language" that is, in the active voice and from the enrollee's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital copay, indicate whether this change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, please show each change clearly.

- Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefit package or if the change is one you submitted to the state for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2008.

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

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

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

    2. State the percentage of your subscribers/contract holders who now purchase this rider and the percentage you project it will cover by next January 1. What is the

maximum percentage of all your subscribers/contract holders you expect to cover by this rider and when will that occur?

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

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

Benefit Clarifications

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

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

- Explain the reason for the benefit clarification.

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

Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2008 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed care industry, there are geographic areas where our customers have more limited choices than other areas. Please consider expanding your FEHB service area to all areas in which you have authority to operate. **You must submit in an electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose**.

We will provide detailed instructions for submitting your ZIP code files in September. However, please note that we will ask you to provide your ZIP codes in a comma delimited text file format and we will provide instructions for uploading your files to our secure web portal.

- **Service Area Expansion** - You must propose any service area expansion by May 31. We may grant an extension for submitting supporting documentation to us until June 30.

  Service Area Reduction - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain. Please provide a map and precise language to amend the service area description for both expansions and reductions.

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

Important Notices

- The information you provide about your delivery system must be based on executed contracts. We will not accept letters of intent.

- All provider contracts must have "hold harmless" clauses.

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

Instructions

We will evaluate your service area proposal according to these criteria:

- Legal authority to operate;
- Reasonable access to and choice of quality primary and specialty medical care throughout the service area; and
- Your ability to provide contracted benefits.

Please provide the following information:

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

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

- **Authority to operate in proposed area:**

  Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.

- **Access to providers:**

  Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts. Also, please update this information on August 31, 2007. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of your initial submission.

Re-designation as a Mixed Model Plan:

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

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

Include clear language in your brochure ("How we change for 2008" section plus "Facts about this HMO plan", if appropriate) to reflect the changes you propose.

Also answer the following questions:

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

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

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

Federal Employees Health Benefits Program statement about Service Area Expansion

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

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2008 Benefits and Service Area Proposals. Specifically,

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

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

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

_____

Signature of Plan Contracting Official

_____

Title

_____

Plan Name

_____

Date

Part Three – Benefits for HMOs

The policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your contract specialist to develop a complete benefit package for 2008. The policies include the following:

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

1. **Hearing benefits for newborns and children**. As stated in our "Call Letter" we are encouraging proposals for hearing benefits for newborns and children that include screenings, testing, diagnostic evaluations, and treatment by licensed hearing professionals, including audiologists for both professional services as well as hearing aids.

2. **Preventive Care**. As stated in our "Call Letter" we encourage you to review your current preventive benefits for adults and compare them to the United States Preventive Services Task Force (USPSTF) recommendations and propose benefit changes to address any gaps between the two. The USPSTF guidelines are at http://www.ahrq.gov/clinic/uspstfix.htm.

3. **Organ/Tissue Transplants** - Please refer to our guidance in the 2007 Technical Guidance and Instructions for Preparing Benefits and Service Area Proposals for HMOs found at http://www.opm.gov/carrier/carrier_letters/2006/2006-13Aattachment.pdf

4. **Prescription Drugs** – All plans must meet creditable coverage requirements. The prescription drug benefit must be at least as good as the standard Medicare Part D Benefit. All plans must provide at least a minimum coverage level for all medically necessary drugs that require a prescription, including insulin. Prescription drug deductibles may not exceed $600 and coinsurance may not exceed 50 percent. We don't allow lifetime or annual benefit maximums on prescription drugs. You must cover disposable needles and syringes used to administer covered injectables, IV fluids, and medications for home use, growth hormones, and allergy serum. You must also provide benefits for "off-label" use of covered medications when prescribed in accordance with generally accepted medical practice by a Plan doctor. You may not exclude drugs for sexual dysfunction. You may place dollar or dosage limits on drugs for sexual dysfunction. You may use a drug formulary or preferred list as long as the Plan provides benefits for non-formulary or non-preferred drugs when prescribed by a Plan doctor. You cannot use the formulary or preferred list as a means to exclude benefits for drug coverage required through the FEHB Program. We don't allow blanket exclusions of broad categories of drugs such as "non-generics," or "injectables".

   Plans that use levels or tiers to denote different prescription drug copays must clearly describe the coverage and difference between each level or tier in the 2008 brochure. The *2008 Guide to Federal Employees Health Benefits Plans* will illustrate the prescription drug copays at the following levels.

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

- Level II – generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range copays.

- Level III - may include all other covered drugs not on Levels I and II, i.e. non-formulary, or non-preferred, and some specialty drugs.

If your plan has more than three copay levels for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2008 Guide to Federal Employees Health Benefits Plans.*

5. **Mental Health and Substance Abuse** - Mental health and substance abuse coverage must be identical to traditional medical care in terms of deductibles, coinsurance, copays. We expect plans to make patient access to adequate mental health services available through managed care networks of behavioral health care providers and innovative benefits design.

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

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

8. **Point of Service Product** - we will consider proposals to offer a Point of Service (POS) product under the FEHB Program. Your plan's proposal must demonstrate experience with a private sector employer who has already purchased the POS product.

9. **Infertility treatment** - We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. This requirement does not include related prescription drugs. Your brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.

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

11. **Dental, Vision and Hearing Benefits** – All plans must cover medically necessary treatment of conditions and diseases affecting eyes and ears, such as glaucoma, cataracts, ruptured ear drums, etc. Beyond treatment for medical conditions by appropriate providers, we will consider dental care (preventive, restorative, orthodontic, etc.), vision care (refractions, lenses, frames, etc.), or hearing care benefits from community-rated

plans when these benefits are a part of the core community benefit package that we purchase. It is important that your 2008 brochure language clearly describes your coverage.

12. **Physical, Occupational and Speech therapy** - You must provide coverage for no less than two consecutive months per condition. You may provide a richer benefit, such as 60 visits per condition, if that is your community benefit. You may apply copays or coinsurance of up to 50 percent if that is your community benefit. All plans must provide speech therapy when medically necessary. If your community package limits speech therapy coverage to rehabilitation only, you must remove that limit for the FEHB Program

Federal Preemption Authority

The law governing the FEHB Program gives the OPM the authority to preempt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not preempt state laws that increase our enrollees' benefits unless the state mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

Department of Health and Human Services (HHS) Benefits

All HMOs *must* offer certain benefits that the Department of Health and Human Services (HHS) requires for federally-qualified plans, *without limits on time and cost***,** except as prescribed in the Public Health Service Act and HHS regulations. These required benefits include:

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

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

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

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

5. Allergy testing and treatment and allergy serum;

6. Well child care from birth;

7. Periodic health evaluations for adults;

8. Home health services;

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

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

11. Implants – you must cover the surgical procedure, but you may exclude the cost of the device if the device is excluded in your community package.

Federally-qualified community-rated plans offer these benefits at no additional cost, since the cost is covered by the community-rate. Community-rated plans that are not federally-qualified should reflect the cost of any non-community benefits on Attachment III of their rate calculation. If there is no additional cost, the cost entry should be zero.

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

High Deductible Health Plans (HDHP)

The Tax Relief and Health Care Act of 2006 signed by President George W. Bush in December 2006 requires the U.S. Department of The Treasury (Treasury) to release its annual cost-of-living adjustment (COLA) numbers no later than June 1. The COLA numbers are used to determine annual HSA contribution limits, HDHP deductible levels and out-of-pocket maximums.

Final numbers have not been released as of the issuance of this Technical Guidance; we anticipate small increases to the maximum contribution amount and the annual out-of-pocked maximum. For 2007, Treasury requires that an HDHP have an annual deductible of at least $1,100 for Self-Only coverage and annual out-of-pocket expenses (deductibles, co-payments, etc.) that do not exceed $5,500. For Self and Family coverage, an HDHP must have an annual deductible of at least $2,200 and annual out-of-pocket expenses that do not exceed $11,000. **Both the deductible minimum and out-of-pocket expense maximums are indexed for inflation**. We will not accept proposals with deductibles less than $1,100 for Self-Only and $2,200 for Self and Family coverage.

An HDHP may not provide benefits for any year until the member meets the annual deductible. However, a plan may offer first-dollar coverage for preventive care (or have only a small deductible) and still be defined as an HDHP. Additional Treasury guidance may be found at: http:/www.treas.gov/offices/public-affairs/hsa/. The following guidance applies for health plans proposing to offer an HDHP for 2008. We have provided a checklist of this guidance in Attachments II - VI. Please include this information in your proposal.

We have revised the HDHP proposal requirements according to the Tax Relief and Health Care Act of 2006.

- HDHPs must continue to maintain full compliance with the Internal Revenue Code and all applicable Treasury rulings. These requirements are included in Attachment III.
- HDHPs must be open to everyone within the defined service area eligible to enroll in the FEHB Program.
- HDHPs must offer a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for enrollees who are not eligible to make contributions to an HSA. Attachment IV includes a list of components
- We will evaluate HDHP proposals in accordance with OPM premium rating guidelines.
    - Premium pass-through amounts should not exceed 50% of the plan's deductible.
    - Premium pass-through amounts should not exceed 25% of the net-to-carrier premium.

- FEHBP plans, including HDHPs, must meet creditable coverage requirements for prescription drug coverage.
- Proposals should reflect costs only, including the amounts the Plan will deposit/credit to the enrollee's HSA or HRA. Attachment V includes a list of costs.
- Proposals should clearly describe the health benefits that the Plan offers, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.
- Proposals should include a description of catastrophic limitations and how they apply to Self Only and Self and Family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).
- You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.
- Proposals should include a description of the HDHP health education program components that the Plan offers.
- Proposals should also include a description of the consumer education program the health plan intends to provide including appropriate use of HSA/HRA funds for necessary medical expenses.
- Proposals should include a complete description of the geographic service area.
- Proposals should include a certification that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.

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

Tax-favored HSAs are available to those who have an HDHP. However, HSAs are not open to people enrolled in Medicare or another medical benefit health plan (with certain exceptions as provided in Treasury's guidance). Therefore, health plans that are proposing HDHP/HSAs should also propose an HRA of equivalent value for enrollees who are ineligible for an HSA. The HRA could be used for medical expenses, including Medicare premiums. The following guidance applies for health plans proposing to offer an HDHP and HSA/HRA for 2008:

- Health Savings Accounts (HSA) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury Guidance.
- The pass-through contribution to an HRA must be of equivalent value to the HSA offered under the plan.
- Deductible amounts should not exceed the IRS maximum HSA contribution limit for the year in question. (Conservative estimates should be used with respect to the IRS indexed amounts if they have not been published when benefit proposals are submitted.)
- If an enrollee with an HRA becomes eligible to make HSA contributions, any balance remaining in the HRA may be transferred to the HDHP's HSA, subject to IRS rules and limitations. This transfer may only take place at the end of the plan year. The HSA will be effective the following plan year.
- FEHBP carriers that offer HDHPs and HSAs/HRAs must provide assurances that

their trustees are financially stable. Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level. If the carrier manages the HSA and HRA accounts itself, it must provide assurance that it meets IRS fiduciary requirements.

- Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.
- Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRA financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.
- HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how the Plan will manage and monitor them, including accounting for earned interest.
- Proposals should state how fees and ancillary charges to individual accounts will be paid for.
- Health Reimbursement Arrangements (HRA) must meet applicable Treasury requirements.

Part Five – Preparing Your 2008 Brochure

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software. The web application will automatically generate a 508 compliant PDF.

The *2008 FEHB Program Application User Manual* will be available April 1st. Each plan will be required to show proficiency in using the brochure application tool by April 16th by entering data from a sample brochure into the tool. In May, we will provide in-house training for all plans who did not meet our proficiency requirements. There will be four separate training sessions held at OPM from 9am to 2pm on the following dates: May 2nd, 15th, 22nd, and 29th. Each plan must also send its 2008 508 compliant brochure from the tool to the printer for testing. Please provide us with comments indicating any issues the printer experienced by May 16, 2007.

The *2008 FEHB Brochure Handbook* will be ready by June 1st. Plans can download the *Handbook* from the file manager at http://www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal. In August we will also send you a brochure quantity form and other related Open Season instructions

By August 10, 2007, we will issue a second version of the *2008 FEHB Brochure Handbook* with final language changes and shipping labels. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 15, 2007. Plans will be unable to make any changes on September 16, 2007 as we will lock down the tool to enable contract specialists to review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.

Attachment I: Carrier Contracting Officials

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

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

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

for _____(Plan)

Enrollment code(s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX Number)

_____
(E-mail address)

Attachment II: HDHP Checklist

High Deductible Health Plan Proposal Information	
1. HDHPs must continue to maintain full compliance with the Internal Revenue Code and all applicable Treasury rulings. These requirements are included in Attachment III.	
2. HDHPs must be open to everyone within the defined service area eligible to enroll in the FEHB Program.	
3. HDHPs must offer a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for enrollees who are not eligible to make contributions to an HSA. Attachment IV includes a list of components.	
4. We will evaluate HDHP proposals in accordance with OPM premium rating guidelines. a. Premium pass-through amounts should not exceed 50% of the plan's deductible. b. Premium pass-through amounts should not exceed 25% of the net-to-carrier premium.	
5. FEHBP plans, including HDHPs, must meet creditable coverage requirements for prescription drug coverage.	
6. Proposals should reflect costs only, including the amounts the Plan will deposit/credit to the enrollee's HSA or HRA. Attachment V includes a list of costs.	
7. Proposals should clearly describe the health benefits that the Plan offers, including deductibles, copayments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.	
8. Complete Attachment VI.	

Attachment II: HDHP Checklist (Cont.)

High Deductible Health Plan Proposal Information	
9. Proposals should include a description of catastrophic limitations and how they apply to self- only and family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).	
10. You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.	
11. Proposals should include a description of the HDHP health education program components that the Plan offers.	
12. Proposals should also include a description of the consumer education the health plan intends to provide including appropriate use of HSA/HRA funds for necessary expenses.	
13. Proposals should include a complete description of the geographic service area.	
14. Proposals should include a certification that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.	

Attachment II: HDHP Checklist (Cont.)

HSA and HRA Proposal Information	
15. HSAs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury Guidance.	
16. The pass-through contribution to an HRA must be of equivalent value to the HSA offered under the plan.	
17. Deductible amounts should not exceed the IRS maximum HSA contribution limit for the year in question. (Conservative estimates should be used with respect to the IRS indexed amounts if they have not been published when benefit proposals are submitted.)	
18. If an enrollee with an HRA becomes eligible to make HSA contributions, any balance remaining in the HRA may be transferred to the HDHP's HSA, subject to IRS rules and limitations. This transfer may only take place at the end of the plan year. The HSA will be effective the following plan year.	
19. FEHBP carriers that offer HDHPs and HSAs/HRAs must provide assurances that their trustees are financially stable. Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level. If the carrier manages the HSA and HRA accounts itself, it must provide assurance that it meets IRS fiduciary requirements.	
20. Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.	
21. Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.	
22. HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how these would be managed and monitored, including accounting for earned interest.	
23. Proposals should state how fees and ancillary charges to individual accounts will be paid for.	
24. HRAs must meet applicable Treasury requirements.	

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

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

Requirement	Plan's Federal HDHP
''(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—	
''(i) which has an annual deductible which is not less than— ''(I) $1,100 for self only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage, and	
''(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—	
''(I) $5,500 for self-only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage.	
''(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). ''(1) ELIGIBLE INDIVIDUAL.— ''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if— ''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and ''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan— ''(I) which is not a high deductible health plan, and ''(II) which provides coverage for any benefit which is covered under the high deductible health plan. **''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—** **''(i) coverage for any benefit provided by permitted insurance, and** **''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.**	
''(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).	

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

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

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

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

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

Attachment V: Costs

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

ITEM	HSA	HRA
Premium Pass Through Amount Premium Pass through should not exceed 50% of plan's deductible and 25% of net-to-carrier premium.		
Account set-up fee		
• Option 1: Electronic enrollment		
• Option 2: Manual enrollment		
Account maintenance fee		
• Option 1: Paid by account holder		
• Option 2: Paid by employer		
Account Miscellaneous Fees		
Monthly service charge		
Paper statement		
Excess contribution adjustment		
Debit card for new accounts		
Debit card reorder		
Debit card additional card order		
Tax statement copy		
Check transactions		
Debit card transactions		

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

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

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

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

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

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

Attachment VII: Checklist

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

- Your proposal should describe your commitment to the four "cornerstones" for Federal health care programs to implement health information technology as described in the 2007 Call Letter along with specific examples of how you are implementing these cornerstones for your health plan population.

- In addition you are required to submit a report by August 31, 2007, on the specific actions you have taken on the following steps:
  1. Actions to make consumers aware of the value of HIT;
  2. Actions to make personal health records available to enrollees based on their medical claims, lab test results and medication history;
  3. Actions to meet our healthcare cost and transparency standards;
  4. Actions to provide incentives for ePrescribing; and,
  5. Actions to ensure compliance with Federal requirements that protect the privacy of individually identifiable health information.

Topic	***Included in Proposal***
▪ Health Care Costs and Quality Transparency Initiatives	_____
▪ Health Information Technology Initiatives	_____
▪ Preventive Care Initiatives	_____
▪ Proposed Coverage of Hearing Benefits For Newborns and Children	_____
▪ High Deductible Health Plan Proposal and All Attachments	_____

Please return this checklist with your CY 2008 benefit and rate proposal