FEHB Program Carrier Letter
All Fee-for-Service Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2011-10(c) **Date: May 4, 2011**

Fee-for-Service [8] Experience-rated HMO [n/a] Community-rated HMO [n/a]

Subject: 2012 Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2012, through December 31, 2012. Please refer to our annual *Call Letter* (Carrier letter 2011-05) dated March 25, 2011 for *policy guidance*. Benefit policies from prior years remain in effect.

Your complete proposal for benefit changes and clarifications is due no later than **May 31, 2011.** Please send a copy of your proposal to your contract specialist on a CD-ROM or other electronic means in addition to a hard copy. Your proposal should include the corresponding language that describes your proposed changes for the brochure. Your OPM contract specialist will negotiate your 2012 benefits with you and finalize the negotiations in a close-out letter.

Please send an electronic version of your fully revised 2012 brochure to your contract specialist within five business days following the receipt of the close-out letter **or** by the date set by your contract specialist.

As a reminder, each year we assess carriers' overall performance. We consider your efforts to submit benefit and rate proposals timely as well as the accurate and timely production and distribution of brochures, as major factors in your plan's overall performance. Enclosed for your convenience is a checklist (Attachment X) with the information you need to provide. Please return the completed checklist along with your benefit and rate proposals.

As part of your proposal, please include your carrier's proposed layout for "Going Green." Attachment IX includes additional information on this initiative.

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

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2012 FEHB Proposal Instructions

Preparing Your Benefit Proposal

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 plain language description of each proposed change (in worksheet format) and the revised language for your 2012 brochure;
- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2012 brochure; and
- A signed contracting official's form.

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

Programs to Manage Patient Care

In February we issued Carrier Letter 2011-2 Demonstrating Value through Clinical and Financial Integration requesting plans to submit information on bundled payments, the Patient-Centered Medical Home, and Accountable Care Organizations. We encourage you to submit proposals for pilot programs that include detailed operational plans, including outreach and other communications to enrollees.

Programs to Promote Health and Wellness

As we indicated in last year's Call Letter, we expect you to offer health and wellness programs that have the potential to improve employee productivity by encouraging healthy lifestyles.

Adult and Childhood Obesity

We encourage you to provide us with proposals for health promotion programs to reduce the incidence of both adult and childhood obesity. Please describe in detail the programs you are offering to encourage healthy lifestyles and to reduce rates of obesity in children and in adults.

Promoting Healthy Lifestyles

We strongly encourage you to offer incentives such as reduced co-payments and deductibles to enrollees who complete a health risk assessment (HRA), are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Please complete Attachment IV Current Baseline Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan and Attachment V Projected 2012 Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan.

Reduce Health Disparities

We encourage you to submit proposals that aim to reduce disparities, such as racial and ethnic disparities, in both health status and healthcare. Please provide us with a description of the specific goals and processes you are undertaking or plan to implement in order to reduce health disparities.

Generic drugs

We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically effective therapeutic alternatives. We encourage health plans which have not focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012.

Pharmacy Spending

We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically appropriate therapeutic alternatives. We encourage health plans which have not focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012. Additionally, we expect you to submit proposals that outline a savings plan to reduce your overall pharmacy spending for next year, without simply shifting costs to enrollees. We believe a four percent reduction in overall pharmacy spending should be achievable and each carrier will be required to do its part to help reach that goal. The savings plan should demonstrate how a reduction in pharmacy costs or overall costs is achievable. We will also require Plans to submit information on their current pharmacy costs and current drug benefits structure using standard formats which will be included with the rate instructions. This information will be used to compare pharmacy costs per enrollee, across plans, and for the FEHB Program as a whole.

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.

Prescription drug benefits for Fee-For-Service (FFS) plans listed in the *2012 Guide to Federal Benefits* will be consistent with the prescription drug payment levels listed for Health Maintenance Organizations (HMO). Prescription drug payment levels will be listed as Level I, Level II, and Level III. These levels will show your current co-pays/co-insurance for generic, brand name and non-formulary, as well as other specific drug categories that may apply to your plan. If your plan has multiple (more than three payment levels, i.e., generic, brand name and non-formulary) for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2012 Guide to Federal Benefits.*

Plans must clearly show their prescription drug benefits in terms of co-pays/co-insurance and payment levels in the 2012 brochure. For example, Level I is a $10 copayment for generic drugs (others may apply); Level II is a $30 co-payment for brand drugs (others may apply); and Level III is 50% of the plan allowance ($35 minimum) for non-formulary brand drugs (others may apply).

Increase FEHB providers – We strongly encourage you to increase the number of health care providers in FEHB plan networks who are board certified, or have training in, geriatrics. We will allow you to use incentives to encourage geriatric doctors to participate in your network; however, please provide a cost benefit analysis. Please provide data on the number and percentage of providers with this training in your current networks, including particular focus on those geographic areas with a large older population, and your plan to reach out to providers and expand your networks with this additional expertise.

Affinity products - We have encouraged you to add products on the "non-FEHB" page of your plan brochure that would be attractive to Federal members. We especially encourage plans to acknowledge individual policies for extended family members, such as dependents beyond age 26 and domestic

partners.

Actuarial Value – We are requesting additional information on the medical loss ratio for FEHB plans. Please refer to the medical loss ratio defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options.

Facility Fee for an Office Visit - We would like to clarify that if an enrollee visits a doctor whose office is located in a facility (such as a hospital), the enrollee should only be charged the doctor's copayment. We have been informed that some enrollees are charged the hospital co-payment in addition to the doctor's co-payment. Please ensure that this does not occur.

Grandfathered Plans – If one or more of your plan's options was grandfathered in 2011, and any of those options are anticipated to continue to meet requirements to remain grandfathered for plan year 2012 (based only on benefit changes), please complete Attachment VI Grandfathered Status Certification. The certification lists the regulatory requirements to be considered grandfathered under the Act. Final grandfathered status will only be confirmed once final benefits and rates are negotiated. Plans only need to complete the certification for those options that are anticipated to be grandfathered.

Please note, if one or more of your plan options was grandfathered in 2011 but will no longer meet regulatory requirements for 2012, the option must meet all requirements for non-grandfathered plans under the Affordable Care Act.

Eliminate Cost-Sharing - As stated in last year's Call Letter, benefits for coverage of all recommended in-network preventive care, immunizations, and screenings will be provided with no cost-sharing. A list of recommended preventive services (including immunizations) by the Advisory Committee on Immunizations Practices (ACIP) in conjunction with the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), and Health Resources and Services Administration (HRSA) is included in is included in Carrier Letter 2011- 11a 2011 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals for FFS Carriers..

Assistive Technologies - We again encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. We also encourage you to offer auditory osseointegrated implants / bone anchored hearing aid (BAHA). Please note that the BAHA benefit should be listed under orthopedic/prosthetic devices in your plan brochure. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

Affordability – We will work closely with you to find ways to manage costs and utilization effectively.

Value-Based Benefit Design – Please establish how your complete benefit package is value-based.

Catastrophic Limitations - Please address any changes to the catastrophic limitations.

Health Care Cost and Quality Transparency Initiatives – We continue to encourage you to expand your health care cost and quality transparency initiatives to broaden the use of health information technology (HIT) and to educate consumers on the value of HIT and transparency.

Preventable Medical Errors - We encourage you to review your coverage guidelines with respect to preventable medical errors and to revise your policies as long as you have arrangements in place to protect your members from balance billing.

Organ/Tissue Transplants
We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance.

When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at the time that determination is made. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following tables in Attachment VII:

- Table 1– OPM's **required** list of covered organ/tissue transplants
- Table 2 – Recommended organ/tissue transplants when received as part of a clinical trial

Durable Medical Equipment. Please indicate which items you cover by completing the checklist in Attachment VIII.

Benefit Changes
Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II as a template for submitting benefit changes. 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 2012" 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 in-patient hospital co-pay, indicate whether this change will also apply to in-patient hospitalizations under the emergency benefit**. If there are two or more changes to the same benefit, please show each change clearly.**

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

- 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 offsets your proposal. Include the cost impact of this change as a bi-weekly 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

Clarifications are not benefit changes. Please use Attachment III as a template for submitting benefit clarifications**.** 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.

Preparing Your 2012 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 generate a 508-compliant PDF.

The *2012 FEHB Brochure Handbook* will be ready by June 13. Plans can download the *Handbook* from the file manager at 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.

We will provide updates to the FEHB Brochure Templates between June 6 and August 11, 2011. We will not issue a second version of the *2012 FEHB Brochure Handbook*; however, we will post the revised FEHB Handbook pages and a revised Brochure Template to the File Manager. We should have all language and shipping labels finalized no later then August 11, 2011. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

The *2012 Brochure Creation Tool (BCT) User Manual* will be available July 1. Also in July, we will provide in-house training to refresh plans on the use of the BCT. There will be 10 separate training sessions held at OPM. We will send an email via the FEHB Carriers listserv as to the dates and times of these trainings. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at angelo.cueto@opm.gov.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 16, 2011. Plans will be unable to make any changes after this date, as we will lock 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)

_____
(Email address)

Attachment II

[Insert Health Plan Name]
Benefit Change Worksheet #1
[Insert Subsection Name]

Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes on page 5 to complete the worksheet.

Benefit Change Description

Applicable options:

High Option	☐	CDHP	☐
Standard Option	☐	HDHP	☐
Basic	☐		

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	
Reason	
Cost Impact / Actuarial Value	

Additional Questions:

I. Actuarial Value:
   (a) Is the change an increase or decrease in existing benefit package?
   (b) If an increase, describe whether any other benefit is off-set by your proposal

II. What is the cost impact of this change as a bi-weekly amount for Self Only and Self and Family rate?
   (a) If there is no 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.

Attachment III

[Insert Health Plan Name]
Benefit Clarification Worksheet #1
[Insert Subsection Name]

Please refer to Benefit Clarifications on page 5 to complete the worksheet.

Please Note: If the benefit clarification equates to a benefit change, you must indicate it as a benefit change in the Benefit Change Worksheet.

Benefit Clarification Description

Applicable options:

High Option	☐	CDHP	☐
Standard Option	☐	HDHP	☐
Basic	☐		

Current Benefit Language	Proposed Benefit Change	Reason For Benefit Clarification

Attachment IV: Current Baseline Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan

INITIATIVE	PROGRAMS & INCENTIVES NOW OFFERED – DESCRIBE HERE	CURRENT ENROLLEES: TOTAL NUMBER & PERCENTAGE OF PLAN
Promote health & wellness		
e.g. comprehensive diabetes care		
e.g. cholesterol management for enrollees with cardiovascular conditions		
e.g. controlling high blood pressure		
Reduce adult & childhood obesity		
Promote healthy lifestyles		
e.g. reduced co-payments & deductibles for enrollees completing health risk assessment (HRA)		
e.g. compliant with disease management programs		
e.g. participate in wellness activities		

Attachment V: Projected 2012 Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan

INITIATIVE	PROPOSED PROGRAMS & INCENTIVES - DESCRIBE HERE	TARGET ENROLLEES: TOTAL NUMBER & PERCENTAGE OF PLAN
Promote health & wellness		
e.g. comprehensive diabetes care		
e.g. cholesterol management for enrollees with cardiovascular conditions		
e.g. controlling high blood pressure		
Reduce adult & childhood obesity		
Promote healthy lifestyles		
e.g. reduced co-payments & deductibles for enrollees completing health risk assessment (HRA)		
e.g. compliant with disease management programs		
e.g. participate in wellness activities		

Attachment VI: Grandfathered Status Certification

The Patient Protection and Affordable Care Act, as amended ("the Act"), imposes coverage, premium and notification requirements for group health plans. Certain existing group health plans, referred to as "grandfathered plans," are exempt from some of those requirements.
According to regulations published jointly by the Departments of Treasury, Labor and Health and Human Services (http://cciio.cms.gov/programs/marketreforms/grandfathered/index.html), health plans existing on March 23, 2010 may meet the definition of a grandfathered health plan by making only certain limited changes to benefits and rates each year and by complying with certain notification and records retention requirements.

For plan year 2011, we asked FEHB carriers to certify whether each plan option offered was grandfathered under the Act. For plan year 2012, we are asking plans to complete the certification below for options that continue to meet the requirements to remain grandfathered.

The checklist below lists the requirements in the regulations. If an FEHB plan chooses to assert grandfathered status for plan year 2012, the plan must certify that the applicable plan option, based on the benefit changes from **2010 to 2012**, meets the definition of a grandfathered plan for plan year 2012. (Be aware that a group health plan ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010. You are not certifying to this requirement.) If the plan option meets all the requirements listed below, plans should certify that this option is considered grandfathered under the Act (pending final rate determinations.)

You only need to submit this certification if you are choosing to assert that a particular plan option is grandfathered for 2012. Please do not complete a certification for plan options that do not meet the requirements below.

Plans should also be aware of record keeping and notification requirements if the plan is to remain grandfathered for 2012. In addition, grandfathered plans must:

- Include a statement in plan materials describing benefits (plan brochure) that the plan believes it is a grandfathered health plan and include contact information for enrollee complaints. OPM will provide standard plan language for FEHB brochures disclosing a plan's grandfathered status.

- Maintain records documenting the terms of the plan that were in effect on the date of enactment.

Grandfathered Status Certification

Plan Name and Option:

Carrier Codes:

Category	Requirement (Change from 2010)	Met by 2012 Benefit Package- (Yes or No)
Benefits	Benefit option has not eliminated all or substantially all benefits to diagnose or treat a particular condition. Plan has not eliminated benefits considered necessary to treat a particular condition.	
Cost Sharing (coinsurance)	Benefit option has not made any increase in percentage cost sharing amount.	
Fixed Cost Sharing (Deductible or Out-of-Pocket Limit)	Benefit option has not increased deductibles or out-of-pocket- limits more than medical inflation* plus 15 percentage points.	
Fixed- Amount Copayment	Benefit option has not increased copayments more than the greater of: 1) $5 increased by medical inflation* ($5 plus medical inflation times $5) or 2) medical inflation plus 15 percentage points (by expressing copayment as a percentage).	
Changes in annual limits	Benefit option has not imposed an overall annual limit on the dollar value of all benefits.	

* Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted). Increase is computed by subtracting 387.142 (CPI-U for March 2010) from the indexed amount for any months before the new change is to take effect.

I certify that this plan option meets the requirements of the Patient Protection and Affordable Care Act as a Grandfathered plan (pending final rate determinations.)

Signature of authorized contracting official:

Name **Date**

Title

Please return this page to your OPM contract specialist for each grandfathered plan option under the FEHB Program. Your contract specialist will advise you of the deadline for returning the certification.

Attachment VII: 2012 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	Reference
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis.	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Hemoglobinopathy	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)	
Myelodysplasia/Myelodysplastic Syndromes	
Paroxysmal Nocturnal Hemoglobinuria	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B
Amyloidosis	
Neuroblastoma	Call Letter 96-08B

III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
Childhood rhabdomyosarcoma	
Advanced Ewing sarcoma	
Advanced Childhood kidney cancers	
Mantle Cell (Non-Hodgkin lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2012?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Small cell lung cancer		

Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		
Sclerodema		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2012?	
Solid Organ Transplants	**Yes**	**No**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment VIII: Durable Medical Equipment

Plan Name: _____

Plan Code(s): _____

Please indicate which items you cover and describe the type of coverage you provide.

Item	Yes	No
•Hearing Aids Description:		
•Prescription Drug Readers Description:		
•Scooters Description:		
•Speech Generating Devices Description:		
•Story Boards (graphic organizers such as a series of illustrations or images displayed in sequence) Description:		
•Talkers Description:		

Attachment IX: Going Green Initiative

We encourage plans to "go green" where possible. Examples of "going green" are as follows:

- **Delivering Plan Brochures -** If you have not responded to our FEHB carrier listserv of March 30, please provide us with a plan of action detailing how you will promote the use of electronic copies of your brochures.
- **Sending Explanation of Benefits electronically (EOB)**
- **Using summary EOBs**
- **Distributing health plan newsletters**

Please provide us with how your plan will "go green" for the items indicated above as well as any other areas your plan has undertaken. Please include a cost benefit analysis for the items your plan has addressed.

Delivering Plan Brochures	**Plan Response**
A timeframe for the process carriers will use for gathering information, processing requests, the cut-off point for determining the number of hard copy and electronic copy requests, etc.	
How carriers will determine if enrollees want an electronic brochure (via postcard, phone call, etc.)	
If enrollees will be able to request both an electronic and hard copy of the brochure.	
If enrollees request an electronic brochure and then decide to change to a hard copy, will this request be honored.	
How carriers will collect and maintain current email addresses.	
How carriers will ensure enrollees have received the brochure.	
A cost/benefit analysis	
Sending Explanation of Benefits (EOB) electronically	
Using Summary EOBs	
Distributing health plan newsletters	
Other areas	

Attachment X: Checklist

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

Topic	Included in Proposal
1. Programs to manage patient care – Pilot programs that include detailed operational plans, including outreach and other communication to enrollees.	
2. Programs to promote health and wellness aimed at improving employee productivity, enhancing healthy lifestyles and lowering long-term healthcare costs.	
3. Programs to reduce adult and childhood obesity described in detail	
4. Incentives to promote healthy lifestyles such as reduced co-payments and deductibles for enrollees who complete a health risk assessment (HRA), are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Completed Attachments IV and V.	
5. Proposal to reduce disparities that includes a description of specific goals and processes your plan is undertaking or plan to implement to reduce health disparities.	
6. Expanded program to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically effective therapeutic alternatives.	
7. Plan to reduce overall pharmacy spending	
8. Increase FEHB providers and include data on the number and percentage of providers with geriatric training in your current network, including particular focus on those geographic areas with a large older population. In addition, include your plan to reach out to providers and expand your networks with this expertise.	
9. Describe affinity products on the "non-FEHB" page of your brochure that are attractive to FEHB enrollees.	
10. Actuarial value – include information on medical loss ratio	
11. Eliminate cost-sharing for all recommended in-network preventive care, immunizations, and screenings	
12. Assistive Technologies – Increased dollar amounts on assisted technologies	

such as hearing aids, speech generating devices, and prescription drug readers, if applicable.	
13. Value-Based Benefit Design – Establish how your benefit package is value based.	
14. Changes to your catastrophic limit(s), if applicable.	
15. Revised policies regarding preventable medical errors to protect members from balanced billing.	
16. Grandfathered Status Certification, if applicable	
17. Completed Organ/Tissue Transplants Tables.	
18. Completed Durable Medical Equipment Checklist.	
19. Benefit Change Worksheets for each proposed benefit change (include answers to the value based benefits questions for each benefit change).	
20. Benefit Clarification Worksheet for each proposed benefit clarification.	
21. "Going Green" initiative.	

Please return this checklist with your CY 2012 benefit and rate proposal