
FEHB Program Carrier Letter

Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2019-05 (b)

Date: April 30, 2019

Fee-for-service [n/a] Experience-rated HMO [4] Community-rated HMO [5]

Subject: 2020 Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMOs

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2020 through December 31, 2020. The Federal Employees Health Benefits (FEHB) Carrier guidance for health benefit proposals is issued in three documents:

1. The annual Call Letter (Carrier Letter [2019-01](#)) dated March 14, outlines policy goals and initiatives for the 2020 plan year.
2. The Technical Guidance and Instructions for Preparing Proposals for New HMOs provides more technical requirements for the items listed in the Call Letter that must be addressed in your benefit proposals as well as supplemental instructions.
3. The 2020 Rate Instructions for Community-Rated Carriers are not included with these benefit instructions, but will be released shortly.

The Guidance and Instructions are in three parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program
- Part Three: Benefits for Newly-Approved HMOs

This year's deadlines are as follows:

- **Due by May 6, 2019:** Please send your community benefit package and most commonly offered group benefit package.
- **Due by May 31, 2019:** Please send your complete proposal for benefit changes and clarifications to your Health Insurance Specialist by email and overnight mail. Your proposal should include language describing all proposed brochure changes. Your Health Insurance Specialist will discuss your proposal with you and document accepted benefits and finalize negotiations in a close-out letter.
- **Please see Attachment IV - Preparing Your 2020 Brochure and Benefits Plus Data Submission** for additional deadlines.

As stated in the Call Letter, we are encouraging all FEHB carriers to thoroughly evaluate their health plan options to find ways to improve affordability, reduce costs, and improve quality of care and the health of the enrolled population.

Enclosed is the 2020 Technical Guidance Submission checklist (Attachment V) showing all the information to include with your benefit and rate proposals. Please return the completed checklist with your submission.

It is incumbent upon you to ensure that each of your benefit proposals is in accordance with all applicable Federal laws and regulations. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the OPM Office of the Inspector General and the Justice Department, will aggressively pursue any misrepresentation.

As a reminder, all Carriers must adhere to the FEHB Guiding Principles available at www.opm.gov/healthcare-insurance/healthcare/carriers/reference/principles/. In addition, all Carriers must have a vigorous and effective fraud detection and prevention program along with programs to prevent, identify, and recoup any improper payments.

We appreciate your efforts to submit benefit proposals in a timely manner and to produce and distribute brochures. We look forward to working closely with you on these activities to ensure a successful Open Season this year.

Sincerely,

Alan P. Spielman
Director
Healthcare and Insurance

Attachments:

Attachment I – FEHB Carrier Contracting Official

Attachment II (Community-Rated Plans Only) – FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet

Attachment III – Preparing Your 2020 Brochure and Benefits Plus Data Submission

Attachment IV – 2020 Organ/Tissue Transplants and Diagnoses

Attachment V – 2020 Technical Guidance Submission Checklist

2020 FEHB Proposal Instructions

Part One: Preparing Your 2020 Benefit Proposal

I. All HMOs

A. 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:

1. Benefit package documentation.
2. A plain language description of each proposed benefit.
3. A signed contracting official's form (Attachment I).
4. In a cover letter accompanying your community package, 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 to 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, 2019**, and you obtain approval and submit approval documentation to us by **June 28, 2019**. Please let us know 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. The review period must have elapsed without objection by June 28, 2019.

Please include 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. If applicable, please include which state you have designated as the situs state. We will contact a state about benefits as necessary.

B. The Federal Employees Health Benefits Program has three enrollment types:

1. Self Only (codes ending in 1 and 4) - A Self Only enrollment type only provides benefits for the enrollee.
2. Self Plus One (codes ending in 3 and 6) - A Self Plus One enrollment type only provides benefits for the enrollee and one designated eligible family member. See website: www.opm.gov/healthcare-insurance/healthcare/eligibility/ for eligibility criteria.
 - i. The catastrophic maximum, deductibles, and wellness incentives should be for dollar amounts that are less than or equal to corresponding benefits in the Self and Family enrollment.
 - ii. All other benefits, such as copays and coinsurance amounts, must be the same regardless of enrollment type.
 - iii. FEHB Plans with High Deductible Health Plans must be cognizant of 26 U.S. Code § 223, which requires that deductibles, catastrophic maximums, and premium pass-through contributions for Self Plus One or Self and Family coverage be twice the dollar amount of those for Self Only coverage. Note

that family coverage is defined under 26 CFR 54.4980G-1 as including the Self Plus One coverage category.

3. Self and Family (codes ending in 2 and 5) - A Self and Family enrollment type provides benefits for the enrollee and all eligible family members.

C. The Community Benefit Package (Certificate of coverage or Evidence of coverage) is the commercial health plan sold to the majority of non-Federal employees. Your proposal should reflect this package of benefits unless specific changes are approved in advance by your Health Insurance Specialist. A piece-meal collection of the most commonly purchased benefits taken from a number of different commercial health plan packages does not meet OPM's requirement.

D. Complete Attachment II - (Community-Rated Plans Only) Benefit Difference Comparison Chart. Include on your chart:

1. Differences in copays, coinsurance, numbers of coverage days, and coverage levels in the three packages. In-network benefits are entered on a separate worksheet than out-of-network benefits.
2. Please highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 6, 2019, or if they were not specifically addressed in previous negotiations.
3. Please include whether riders are required within your *proposed 2020 FEHB benefit package*. For all community-rated plans, indicate the name of the community benefit package, including the entity noted as having the largest number of non-Federal employees number of subscribers/contract holders who purchased the 2019 package and who are expected to purchase the 2020 package.

E. 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. Please highlight and address any state mandated benefits. State-mandated benefits should be reported if finalized by May 6, 2019.

F. Federal Preemption Authority

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. OPM no longer requires plans to comply with benefit requirements for Federally Qualified Health Maintenance Organizations.

II. Experience-rated Plans

A. Please send the following by **May 6, 2019**:

1. A copy of a fully executed employer group contract (i.e., *Certificate of coverage or Evidence of coverage*) that non-Federal subscribers purchased in 2019.

B. Please send the following which must be received by **May 31, 2019**:

1. You must file your proposed benefit package (Certificate of coverage or Evidence of coverage) and the associated rate with your state, if required. If you have made changes since your application, submit a copy of the new benefits description and answer the questions below.
2. 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; and
 - c. The number of subscribers/contract holders who currently purchase each package.

III. Community-Rated Plans

A. We will allow 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 enrollees.

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.
3. Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

B. Please consult with your Health Insurance Specialist and your contact in the Office of the Actuaries regarding the alternate community package and refer to the rate instructions.

1. Submit a copy of a fully executed community benefit package by May 6, 2019 (also known as a master group contract or subscriber certificate), including riders, copays, coinsurance, and deductible amounts (e.g. prescription drugs and durable medical equipment) that non-Federal subscribers purchased in 2019. The material must show all proposed benefits for FEHB for the 2020 contract term, except for those still under review by your state. We will accept the community benefit package that you *project* will be sold to the majority of your non-Federal subscribers in 2020. If you offer a plan in multiple states please send us your community benefit

- package for each state that you intend to cover.
2. Your FEHB rate must be consistent with the community-benefit package on which it is based. Benefit differences must be accounted for in your proposal or you may end up with a defective community rate.

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

- I. Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2020 contract term. We are committed to providing as much choice to our enrollees as possible. Given consolidations in the managed-care industry, there are geographic areas where our enrollees have more limited choices than in other areas.
- II. Please consider expanding your FEHB service area to all areas in which you have authority to operate. This will allow greater choice for our customers. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose.**
- III. We will provide detailed instructions for submitting your ZIP Code file 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.

IV. Important Notices

- A. The information you provide about your delivery system must be based on **executed** contracts. We will not accept letters of intent.
- B. All provider contracts must have “hold harmless” clauses.

V. Service Area Expansion Criteria

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

1. Legal authority to operate;
2. Reasonable access to providers;
3. Choice of quality primary and specialty medical care throughout the service area;
4. Your ability to provide contracted benefits; and
5. Your proposed service area must be geographically contiguous.

B. You must provide the following information:

1. A description of the proposed expansion area in which you are approved to operate.

2. The proposed service area expansion by ZIP Code, county, city or town (whichever applies) and 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.
3. The 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.

4. 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. You must update this information by August 31, 2019. 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.

Service and Additional Geographic Areas:

1. 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.
2. Benefits may be restricted for non-emergency care received outside the service area. Your proposal must include language to clearly describe any additional geographic area as well as your service area.

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 2020 Benefits and Service Area Proposals. Specifically,

1. All provider contracts include “hold harmless” provisions.
2. All provider contracts are fully executed at the time of this submission. 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 Newly-Approved HMOs

The policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your Health Insurance Specialist to develop a complete benefit package for 2020. For guidance in preparing your proposal for High Deductible Health Plans (HDHPs), Health Savings Accounts (HSAs), and Health Reimbursement Arrangements (HRAs), please refer to Carrier Letter [2008-06](#) dated March 11, 2008.

If you propose to eliminate any state mandated benefits normally included in your community package, specify them in your benefit proposal and provide a rationale.

As stated in the 2020 plan year Call Letter, our policy goals and initiatives this year are:

- A. Quality
 - 1. Mental Health and Substance Use Disorder Services
 - a. Access to Care
 - b. Addressing the Opioid Epidemic
 - 1. Opioid Use in Pregnancy
 - c. Tobacco Cessation/E-cigarettes
 - 2. Patient Safety
 - a. Maternal Health
 - 3. Preventive Services
- B. Affordability
 - 1. Transparency
 - a. Drug Transparency Tools
 - b. Medical Services Transparency Tools
 - 2. Prescription Drugs
 - a. Specialty Drug Management
 - b. Point-of-Sale Rebates
 - c. Incentivizing Generic Drugs
 - 3. Controlling Fraud, Waste and Abuse

I. 2020 INITIATIVES

A. Quality

1. Mental Health and Substance Use Disorder Services

Access to Care

OPM strongly encourages Carriers to remain focused on the provision of mental health benefits by improving access to and availability of treatment. Efforts to remove barriers to care are focused on both provider availability and access, as well as accessible and timely benefits within the plan.

As outlined in the Call Letter, Carriers must address how they are focusing on issues relating to provider access and availability:

- Provide information on how you monitor and address known Mental Health Care Health Professional Shortage Areas (HPSAs)¹.
- If your plan provides a telehealth benefit, provide information regarding how telehealth is being used in these shortage areas and in mental health coverage in general.
- Provide information on any specific initiatives to promote integrated mental health care or reimbursement models that promote this integration.
- Describe how you calculate payment for services provided by out-of-network providers at in-network rates when needed to provide timely access to specialized care for mental health.

OPM remains focused on mental health parity and the efforts to assure this parity exists in our member experiences. Carriers are reminded that parity requirements in the Mental Health Parity and Addiction Equity Act² (MHPAEA) apply to both Quantifiable Treatment Limits (QTLs) such as cost sharing, visit limits, or deductibles, and to Non-Quantifiable Treatment Limits (NQTLs), such as medical necessity criteria. OPM previously reviewed FEHB Plan compliance with non-quantitative parity requirements for mental health in Carrier Letter [2017-01](#). OPM is continuing our focus on assuring these barriers do not exist in the FEHB Program. Carriers should review their current benefits to ensure full compliance with MHPAEA and at a minimum plan proposals should:

- Indicate that the appropriate quantitative and non-quantitative testing has been completed.
- Describe in detail any limits you have for mental health and substance use disorder abuse services. Include all information on treatment limits (such as limits on the number of days or visits covered) and on other limits such as limits on scope or duration of treatment.

¹ See <https://data.hrsa.gov/tools/shortage-area>

² Mental Health Parity and Addiction Equity Act of 2008. <https://www.congress.gov/bill/110th-congress/house-bill/6983>

- Identify the factors used in the development of the limitations (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment).

Addressing the Opioid Epidemic

Reducing opioid misuse continues to be a critical priority, as evidenced by enactment of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*,³ which was signed into law by President Donald J. Trump on October 24, 2018. We applaud the efforts that FEHB Carriers have made to mitigate the opioid epidemic, including putting in place requirements outlined in Carrier Letter [2018-01](#).⁴ The number of opioid prescriptions dispensed to FEHB Program members and the number of unique members receiving opioid prescriptions have fallen consistently over the past three years. FEHB Carriers have also implemented programs for providers and members to improve safe dispensing, utilization, and disposal of opioids, as well as increased access to naloxone-based rescue agents. However, continued emphasis on prevention and treatment of opioid misuse is needed to foster further progress.

Opioid use in pregnancy

According to the CDC's Morbidity and Mortality Weekly Report, the number of women with opioid use disorder (OUD) giving birth more than quadrupled from 1999 to 2014.⁵ OUD in pregnancy has been associated with numerous adverse outcomes ranging from neonatal abstinence syndrome (NAS) to stillbirth and maternal mortality.⁶ The complexity and coordination of care required to care for mother and child during the prenatal, perinatal and postnatal stages can result in gaps in care if adequate resources and policies are not in place.⁷ FEHB Carriers are strongly encouraged to implement or review processes in place for the early detection, access to treatment, and coordination of care for pregnant women with OUD and the affected babies.

A comprehensive, multi-pronged strategy will continue to be necessary to overcome the opioid epidemic. OPM will be reviewing FEHB Carriers' 2020 proposals for the following:

1. Enhanced programs in place for providers and members to improve safe dispensing, utilization, and disposal of opioids, as well as increased access to naloxone-based rescue agents.
2. Access to programs that identify and refer members at risk for opioid use disorder such as point-of-sale edits, retrospective data review and outreach

³ <https://www.congress.gov/bill/115th-congress/house-bill/6/all-actions?overview=closed#tabs>

⁴ <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2018/2018-01.pdf>

⁵ Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. *MMWR Morb Mortal Wkly Rep* 2018; 67:845–849. DOI: <http://dx.doi.org/10.15585/mmwr.mm6731a1>.

⁶ *Ibid* Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. *MMWR Morb Mortal Wkly Rep* 2018; 67:845–849. DOI: <http://dx.doi.org/10.15585/mmwr.mm6731a1>

⁷ Substance Abuse and Mental Health Services Administration. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: <http://store.samhsa.gov/>.

referral programs. Describe how the plan identifies and refers members at risk for opioid use disorder.

3. Promote evidence-based pain management through coverage of and access to non-pharmacological therapies and non-opioid medications or devices used to treat pain.
4. If your plan provides telehealth services, assess them for OUD and other substance use disorder treatments. Include summary results of the assessment.
5. Improved access to opioid addiction treatment programs, family-focused residential treatment and comprehensive opioid recovery centers; review the adequacy of access to care for high-risk populations such as pregnant women and youth. Include summary results of the adequacy of access reviews.
6. Review and/or develop policies to extend the duration of addiction treatment or length of stays as medically appropriate.
7. Implement or review processes in place for the early detection, access to treatment, and coordination of care for pregnant women with OUD and the affected babies. Attach summary results of the review or a description of the new process.
8. Complete the table below.

| | Improvements made to care management of pregnant women with OUD | Summary of results from retrospective review of care management for pregnant women with OUD |
|----|--|--|
| 1. | <i>(please list)</i> | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

9. Describe how the carrier promotes a comprehensive, coordinated care approach that includes medical, pharmacy, behavioral and mental health to provide care coordination and recovery support to members with OUD.

Tobacco Cessation/E-cigarettes

Tobacco dependence is a chronic, relapsing condition that requires repeated intervention. Carriers must offer tobacco cessation programs to all covered individuals without copayments or coinsurance and which are not subject to deductibles, or to annual or lifetime dollar limits. Programs must follow the most current United States Preventive Services Task Force USPSTF recommendations by covering at least two quit attempts per year with each attempt allowing a minimum of four tobacco cessation counseling sessions, including individual counseling, group counseling, and proactive telephone counseling. Carriers are advised that the FEHB tobacco cessation benefit includes coverage of cessation treatment for users of all tobacco products, including e-cigarettes.

In addition to the tobacco cessation counseling programs, cessation medications (over-the-counter (OTC) and prescribed) approved by the FDA to treat tobacco dependence should be available with no copayments or coinsurance and not subject to deductibles or to annual or life time dollar limits. While all seven FDA-approved cessation medications are effective in helping smokers quit, varenicline and combination nicotine replacement (NRT) therapy, which consists of a combination of the nicotine patch with a fast-acting form of NRT, are currently the two most effective medication approaches available. The combination of counseling plus medication is the optimal approach that gives adult tobacco users the best chance of quitting. Therefore, it is important for adult tobacco users to have access to both cessation counseling and cessation medications for use as approved by the FDA.

As outlined in the Call Letter, benefit proposals must include your plan to re-invigorate messaging about the tobacco cessation benefit. Studies show that barrier-free tobacco cessation benefits are most effective when actively communicated to members and providers. This includes repeatedly educating members and providers using a variety of communication methods. The 2017 Federal Employee Benefits Survey (FEBS) results showed awareness of the FEHB Tobacco Cessation Benefit remains low, with only 16.7 percent of current tobacco users reporting knowledge of the benefit prior to participating in the survey. Earlier FEBS results indicated that over half of current tobacco users at the time were either “extremely likely” or “likely” to try to quit once they were made aware of the FEHB benefit. We also know that a considerable number of survey participants who do not use tobacco themselves have a household member who does use tobacco. Since many employees have Self and Family coverage under FEHB, this should be taken into consideration when promoting awareness of the tobacco cessation benefit.

We will be reviewing your plan proposal for:

- Barrier-free coverage of and access to the tobacco cessation benefit, including individual, group, and telephone counseling, as well as coverage of and access to all FDA-approved cessation medications, including varenicline and combination NRT therapy.
- Proactive communication of the benefit, including cessation treatments covered and the process for accessing them, to all members and providers via multiple channels and methods.
- Targeted communication of benefit to members with conditions particularly impacted by tobacco use, including individuals with diabetes, cancer, heart disease, Chronic Obstructive Pulmonary Disease (COPD), and pregnant women.
- Education for members and providers on appropriate and effective use of cessation medications, including partnering with pharmacists to provide education and decision support on cessation medications.
- Education for members and providers regarding prevention and cessation of youth use of all tobacco products, including e-cigarettes; this would include education to parents and providers about the dangers of youth tobacco use and approaches for preventing youth initiation of tobacco use, including e-cigarette use, and helping youth tobacco users, including e-cigarette users, quit.

2. Patient Safety

Maternal Health

Many maternal deaths are attributable to preventable or detectable causes, including postpartum hemorrhage, cardiomyopathy, severe hypertension, infection/sepsis, and thrombotic pulmonary embolism. Timely prenatal care may help identify or prevent risk factors, as well as provide ample opportunity for member education about delivery options that may improve maternal outcomes. (Timeliness of Prenatal Care is a high-priority measure under FEHB Plan Performance Assessment.) FEHB Carriers can support maternal health when designing networks and engaging in hospital contracting through:

- Use of Alliance for Innovation on Maternal Health (AIM) patient safety bundles;
- Use of standard communication processes for identifying patient risk for labor complications;
- Use of the Maternal Health Compact, which formalizes connections between facilities to establish consultation or transfer resources during unexpected maternal emergencies;
- Use of or particular performance on the Joint Commission's PC-02 measure (the Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean delivery rate);
- Coverage of and/or incentives for childbirth education classes for women and their partners so they can make better decisions during the birth process;
- Coverage of continuous one-on-one support during labor and delivery, including services provided by midwives, doulas and/or other trained birth assistants; and
- Use of payment practices that are designed to remove unintended financial incentives that favor surgical deliveries, while not adding penalties that can discourage appropriate Cesarean sections and thereby raise safety concerns.

3. Preventive Services

Carriers are reminded to review the guidance on preventive services in Carrier Letter [2019-01](#), and adjust benefits and services accordingly. These services must be covered with no cost sharing. Plans may elect to provide coverage for additional preventive services with or without cost sharing.

B. Affordability

1. Transparency

a. Drug Transparency Tools

Enhancing the availability and accessibility of price and quality information to Federal employees, annuitants and family members is an important strategy for

fostering the continued quality and affordability of FEHB plans, aiding in personal healthcare decision making, and taking an active role in one's health.

Prescription Drug Transparency Tools- In Carrier Letter [2014-03](#), FEHB Carriers were required to provide a prescription drug cost transparency tool to current and prospective members by plan year 2016. In Carrier Letters [2016-03](#), [2017-01](#), and [2019-01](#), OPM continued to prescribe required improvements to ensure access to this important information, and expanded the requirement even further. Plan proposals will be reviewed to determine the extent of these tools and their planned enhancements.

Please complete the table below and include it with your proposal.

| Prescription Drug Transparency Tools Existing and Planned Features | | | | |
|---|-----------------------|-------------------------------------|---|---------------------------------|
| The tool provides: | Existing (Y/N) | New or Planned Feature (Y/N) | Date of (planned) Implementation | If N/A, please describe. |
| Member cost-share information specific to the member | | | | |
| Information on Utilization management requirements | | | | |
| Access to information about the formulary tier | | | | |
| Access to information about formulary alternatives | | | | |
| Estimated cost of the drug through retail (30 days) as well as mail-order (90 days) or other delivery channels (e.g. specialty drugs). | | | | |
| Real time benefit accumulator information such as deductibles etc. | | | | |
| Incentives to encourage the use of the tool | | | | |
| Tracking to capture usage of drug transparency tool | | | | |
| Other features not listed (please list by additional rows) | | | | |

Proposals must describe how the Carrier meets the requirements for prescription drug transparency tools and include a link(s) to both the pre-enrollment and member specific pharmacy price transparency tool.

FEHB Carriers are also encouraged to promote the use of tools for providers, when available, such as electronic prior authorization and benefit check tools that display drug formulary and pricing information at the point of prescribing. These provider-level tools can reduce prescription abandonment and result in quicker turnaround times.

Please complete the table below and include it with your proposal:

| Provider Tools | | | | |
|--------------------------------------|-----------------------|-------------------------------------|---|---------------------------------|
| Existing and Planned Features | | | | |
| The tool provides: | Existing (Y/N) | New or Planned Feature (Y/N) | Date of (planned) Implementation | If N/A, please describe. |
| Electronic Prior authorization | | | | |
| Real time benefit check capabilities | | | | |

Please describe in detail the type of prescription drug tools available to providers. In addition, please provide information to support the following:

1. Please describe in detail the strategy for promoting and measuring the use of prescription drug transparency tools; be sure to address how the tools encourage members to research and choose lower-cost, higher quality options for their prescription drugs.
2. OPM encourages Carriers to propose creative methods for incentivizing or rewarding members' use of transparency tools. Please provide in detail the current or planned incentive strategy to encourage use of prescription transparency tools.

b. Medical Services Transparency Tools

OPM first called on Carriers to provide cost and quality transparency tools for medical procedures in Carrier Letter [2006-09](#) and is focusing on improving these tools for the 2020 plan year and beyond. In order to allow individuals to take a more active role in selecting quality, affordable healthcare, OPM calls on Carriers to intensify their efforts in improving transparency tools.

Specifically, OPM asks Carriers to describe in their proposals how they would, by 2021, provide robust online search tools with the following features.

| The tool: | Existing (Y/N) | New or Planned Feature (Y/N) | Date of (planned) Implementation | If N/A, please describe. |
|--|----------------|------------------------------|----------------------------------|--------------------------|
| Provides an estimate of the dollar amount a member should expect to pay for a defined set of common outpatient and elective in-patient health care procedures and services <u>pre-login</u> | | | | |
| Provides an estimate of the dollar amount a member should expect to pay for a defined set of common outpatient and elective in-patient health care procedures and services <u>post-login</u> | | | | |
| Provides estimates that are personalized based on the member's plan option and deductible status | | | | |
| Includes information tailored to geographical areas | | | | |
| Is accessible via prominent links on the Carrier's website | | | | |
| Presents network, quality, and cost information together | | | | |
| Is easy to use and provides complete, accurate, up-to-date information | | | | |
| Incentives to encourage the use of the tool | | | | |
| Tracking to capture usage of the tool | | | | |

In addition, please describe in detail the strategy for promoting and measuring the use of medical transparency tools; be sure to address how the tools encourage members to research and choose lower-cost, higher quality options for their health care.

OPM encourages Carriers to propose creative methods for incentivizing or rewarding members’ use of medical transparency tools. Please provide in detail the current or planned incentive strategy to encourage use of these transparency tools.

2. Prescription Drugs

In 2017 approximately 27 percent of the total FEHB premium was attributed to prescription medications. The cost of prescription drugs remains a top concern for the FEHB Program, especially as more expensive drugs are expected to come to market over the next several years.

a. Specialty Drug Management

Specialty drugs may involve the pharmacy and/or medical benefit and are projected to account for a larger amount of total drug spending over the next several years.⁸ Specialty medications under the pharmacy benefit can be managed using several strategies, including benefit design, utilization management tools and specialty pharmacy networks. While slightly more complex, strategies to manage drugs billed under the medical benefit may include site of care management, utilization management programs and network reimbursement strategies. Specialty medications billed under the medical benefit can be administered in various settings, such as physician’s office, hospital outpatient facility, or a home health setting. Costs vary by site of care. Site-of-care programs can redirect patients and medications to the most clinically appropriate and lowest-cost channel without compromising patient outcomes. As in previous years, FEHB Carriers are expected to have a robust specialty management program in place that manages and coordinates drugs under the medical and pharmacy benefit. In addition to outlining how they are meeting the strategies above, carriers are required to include their site of care management program as part of their proposal.

| Specialty Management Strategies utilized under the pharmacy benefit | New or Existing Program? |
|--|---------------------------------|
| <i>(please list)</i> | |
| | |
| | |
| | |

⁸ Carrier Letter 2017-01: <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2017/2017-01.pdf>

| Specialty Management Strategies utilized under the medical benefit | New or Existing Program? |
|--|--------------------------|
| <i>(please list)</i> | |
| | |
| | |
| | |
| | |

b. Point-of-Sale Rebates

Health plans or their pharmacy benefit managers (PBMs) are typically able to negotiate with pharmaceutical manufacturers to obtain rebates on branded drugs based on formulary placement and other considerations. FEHB experience-rated and fee-for-service contracts require PBMs to credit rebates to Carriers and require Carriers to include these in their net benefit costs. FEHB Carriers are allowed to reflect some or all of the rebate value at the time the claim is adjudicated through point-of-sale rebates. A number of Carriers have implemented such programs, which can lower out-of-pocket drug costs for members whose plan design includes deductibles and/or coinsurance. OPM encourages Carriers to submit innovative proposals to deliver rebate value at the point of sale while keeping premiums affordable. The value of the rebate applied at the point of sale should be identifiable, as should all the components of the drug price.

Please answer the following questions:

Do you currently reduce the allowed charge for any branded drugs at the point of sale by crediting some or all of the rebate received from the pharmaceutical manufacturer to the allowed charge? Y/N

If not, are you proposing to do so for the 2020 plan year? Y/N

If you answer “Yes” to either question above, please describe the point-of-sale rebate program offered or proposed. Please note that cost neutrality requirements apply to point-of-sale rebate proposals. That is, if the point-of-sale rebate benefit would add to premium, you must explain how and make additional proposals to offset the increase in premium.

c. Incentivizing Generic Drugs

OPM appreciates the efforts Carriers have made in the past to incentivize the use of generic drugs when available. Still, according to the 2018 ADC, the non-weighted average Generic Dispensing Rate (GDR) in the FEHB Program was 92 percent compared to a 98 percent GDR for commercial plans as reported by URAC.

FEHB Carriers must describe any policies and programs they are proposing or already have in place to encourage the use of generic drugs when available.

Please provide the following information:

| Programs/Policies to incentivize the use of generics | New or Existing Program? | Program Description |
|---|---------------------------------|----------------------------|
| <i>(please list)</i> | | |
| | | |
| | | |
| | | |
| | | |

| Programs/Policies to mitigate the effect of multi-source brand couponing | New or Existing Program? | Program Description |
|---|---------------------------------|----------------------------|
| <i>(please list)</i> | | |
| | | |
| | | |
| | | |
| | | |

3. Controlling Fraud, Waste and Abuse (FWA)

In addition to routine audits of FEHB Carrier operations, OPM’s Office of Inspector General (OIG) examines potential healthcare fraud against the FEHB Program by conducting criminal investigations that are coordinated with the Department of Justice and other law enforcement agencies. In the course of its investigations, the OIG has recommended several areas where we believe Carriers should adjust benefit designs to better control fraudulent payments. FEHB Carriers should implement processes that monitor pharmacy claims in order to identify outliers that may be evidence of fraud, waste, and abuse. For example, the OIG has investigated several schemes related to compounding pharmacies billing for unnecessary and high-cost creams, and most recently found multiple cases in which providers overcharged or otherwise submitted fraudulent billing for lidocaine creams. These same schemes involved high dollar coinsurance payments which were found to be waived or significantly reduced for the member, which as a result increases the program costs. In addition, the OIG has been investigating sober homes, laboratories, hospitals, and providers who have been billing for multiple Urine Drug Test screens

(UDT), both qualitative and quantitative, that are not medically necessary, as well as fraudulent screens for individuals not undergoing substance use disorder treatment. Appropriate monitoring processes can identify these types of payments to prevent larger schemes from taking hold.

Accordingly, OPM is requesting that Carriers adjust plan benefits to discourage these schemes and to continue reporting waivers of co-payments related to high dollar compounded medications to the OIG. For further information on industry best practices to control FWA for these and other payment practices, please see Carrier Letter [2017-13](#).

Describe the monitoring process you have in place for compounded drugs and Urine Drug Test Screens as shown by example in the tables below:

| Monitoring processes for compounded drugs | New or Existing Program? |
|--|---------------------------------|
| <i>E.g. XX Dollar limits on compounds</i> | <i>Existing</i> |
| <i>E.g. Quarterly retrospective reviews of all compounds</i> | <i>New in 2020</i> |
| | |
| <i>Others (please list)</i> | |

| Monitoring processes for Urine Drug Test Screens | New or Existing Program? |
|---|---------------------------------|
| <i>E.g. Pre-payment claim edit process in place</i> | <i>Existing</i> |
| <i>E.g. Quarterly retrospective reviews</i> | <i>New in 2020</i> |
| | |
| <i>Others (please list)</i> | |

II. BENEFITS & SERVICES

Continued Focus from Previous Years

1. Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2020. When you determine that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits.

The following tables are in Attachment IV:

Table 1 – OPM’s required list of covered organ/tissue transplants.

Table 2 – OPM’s recommended coverage of transplants under Clinical Trials.

Table 3 – OPM’s recommended list of covered rare organ/tissue transplants.

Information Required: Completed Attachment IV - 2020 Organ/Tissue Transplants and Diagnoses.

2. Healthy Maternity Outcomes

[Carrier Letter 2017-04](#) strongly encouraged all plans to review their coverage of specialized medical foods for children and pregnant women with Phenylketonuria (PKU) to align with current clinical guidelines and help ensure optimal pregnancy outcomes. Given the rarity of this condition, OPM estimated the cost impact of adding coverage for medical foods for all PKU affected children and pregnant women across the FEHB program as minimal. Carriers proposing to update coverage for 2020 should include details with their proposals, along with justification for any proposed age limits.

3. 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 co-payment. We have been informed that some enrollees are charged the hospital co-payment in addition to the doctor’s copayment. Please ensure that this does not occur.

4. Coordination of Benefits

When FEHB Program Plans pay secondary COB claims, including those with **Medicare**, they pay the lesser of their allowance or the difference between their allowance and what is paid by the primary Plan. You may continue to charge the member co-payments or coinsurance on secondary COB claims. If your benefit

design includes coinsurance, it should be based on the remaining charge, not on your allowance. In the following example Medicare is primary and your health plan is secondary. The plan design requires the member to pay 10% coinsurance.

| | |
|---------------------------------|---------------------------------|
| DOS 02/01/20 billed: | \$10,000 |
| Medicare allowance: | \$9,000 |
| Medicare payment: | \$7,200 (80% of allowance) |
| Balance after Medicare payment: | \$1,800 |
| Member responsibility: | $\$1,800 \times 10\% = \180 |
| Plan pays: | $\$1,800 \times 90\% = \$1,620$ |

If your brochure language does not currently describe this process correctly, please work with your Health Insurance Specialist to ensure that your 2020 Federal brochure correctly describes this process.

5. Catastrophic Limitations

We expect carriers to fully describe their catastrophic limitations for all benefits as well as balance billing for the services of out-of-network providers to ensure FEHB enrollees receive appropriate coverage for medically necessary services. We encourage proposals to mitigate any gaps you may have in the catastrophic coverage that you offer.

Please provide a full description of your catastrophic limit(s):

- a. Describe the expenses that fall under each of these categories: medical, surgical, mental health and prescription drug benefits.
- b. Please indicate completely what expenses are still the member's responsibilities after the member has reached the limit.
- c. If you have an out-of-network benefit, please include any payments that members could be responsible for after they have met the catastrophic limit, including provider balance billing. We will consider cost neutral proposals that mitigate the potential for high cost sharing.
- d. Given your catastrophic limits, what is the maximum out of pocket expense a member may pay for covered services?

6. 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 2020 brochure language clearly describes

your coverage.

7. 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 co-pays 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 or provide habilitative services consistent with the state benchmark.

8. Antibiotic Resistance

Antibiotic Resistance is a significant threat to population health, and OPM strongly encourages FEHB Carriers to approach this critical issue through two channels: encouraging appropriate antibiotic prescribing and supporting effective hospital infection control. Specifically, FEHB Carriers are strongly encouraged to:

- Use data on the Medicare Hospital Compare⁹ and Leapfrog Hospital Safety Grade¹⁰ websites to inform hospital network decisions and contract terms.
- Monitor antibiotic prescribing rates across care settings, including urgent care networks and services.
- Discourage antibiotic prescribing for conditions where they are not indicated, including viral upper respiratory infections and bronchitis¹¹, through the use of provider reports showing provider antibiotic prescribing patterns compared to peers to reduce unnecessary prescribing (i.e., post-prescription audit and feedback)¹².
- Support patient education efforts. Choosing Wisely's patient resources may help increase patient literacy and knowledge about the risks of inappropriate antibiotic use¹³.
- Examine provider incentives and consider aligning payment models accordingly.

⁹ <https://www.medicare.gov/hospitalcompare/search.html>

¹⁰ <http://www.hospitalsafetygrade.org/>

¹¹ <http://www.choosingwisely.org/clinician-lists/infectious-diseases-society-antibiotics-for-upper-respiratory-infections/>

¹² Linder, J.A. et al. (2017). Effects of behavioral interventions on inappropriate antibiotic prescribing in primary care 12 months after stopping interventions. *JAMA*, doi:10.1001/jama.2017.11152.

¹³ <http://www.choosingwisely.org/patient-resources/colds-flu-and-other-respiratory-illnesses-in-adults/>

Attachment I
FEHB Carrier Contracting Official

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)

(Telephone) (FAX)

(Email)

Attachment II (Community Rated Plans Only)
FEHB Benefit Difference Comparison Chart

See *FEHB Benefit Difference Comparisons Chart Spreadsheet* attached with listserv

Attachment III
Preparing Your 2020 Brochure and Benefits Plus Data Submission

Benefits Plus Process

We will continue to use the Benefits Plus system to collect data from carriers. We have expanded the data collected this year, and made changes to Benefits Plus to improve functionality, usability and performance. OPM determines and communicates any additions to the required Benefits Plus data input that may be required for Plan Comparison Tool enhancements via listserv.

Timeline: 2020 Brochure and Benefits Plus Process

This year's deadlines and significant dates are:

| DEADLINES | ACTIVITY |
|------------------|--|
| May 31 | Plans submit <u>Section 5 Benefits</u> information with proposal if proposing new option. |
| May 31 | Sections II and III of the ADC (Formulary and Cost/Utilization Templates) due. |
| June 28 | Plans receive: <i>2020 FEHB Brochure Handbook</i> (to include shipping label and brochure printing instructions). |
| July 1 | Brochure Creation Tool (BCT) opens to Carriers. OPM will provide 2019 Brochure Creation Tool (BCT) User Manual in the BCT. |
| July 15 - 26 | OPM hosts training on the use of Benefits Plus and the BCT. |
| August 15 | Plans must finalize all language and shipping labels. |
| August 19 | Plans must complete all data and plan-specific updates within Benefits Plus. Plans must complete entry of data into BCT except for rate information. |
| September 9 | Plans must complete entry of rate information into BCT. |
| September 11 | OPM sends brochure quantity form to plan after Health Insurance Specialist approves brochure for printing as well as other related Open Season instructions. |

Please contact bbpct@opm.gov for Benefits Plus password resets, Benefits Plus technical questions or suggestions on changes, and comments or questions pertaining to the Brochure Creation Tool.

Summary of Benefits and Coverage

FEHB plans will continue to provide a Summary of Benefits and Coverage (SBC) based on standards developed by the Secretary of the Department of Labor.

Going Green

We appreciate your efforts to support our “Going Green” goals to help reduce FEHB administrative costs. You must provide paper copies of plan brochures to new members. You may send Explanations of Benefits, newsletters and other plan materials electronically.

**Attachment IV: 2020 Organ/Tissue Transplants and Diagnoses
Table 1: Required Coverage**

| I. Solid Organ and Tissues 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 |
| Kidney - Pancreas | Call Letter 2017-04 |
| Liver | Call Letter 92-09 |
| Pancreas | Call Letter 92-09 |
| Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis | Call Letter 2014-03 |
| Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs, such as the liver, stomach, and pancreas) or isolated small intestine | Call Letter 2014-03 |
| 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 indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, or 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 lymphocytic (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 | |
| Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) | Carrier Letter 2013-12a |
| Advanced Childhood kidney cancers | |
| Mantle Cell (non-Hodgkin's lymphoma) | |
| V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for 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 recommended under Clinical Trials. These types of transplants may transition from experimental/investigational and become 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 2020? | |
|---|--|----|
| | Yes | No |
| Blood or Marrow Stem Cell Transplants | | |
| 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) relapsed/refractory disease | | |
| 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 | | |
| Scleroderma | | |
| Scleroderma-SSc (severe, progressive) | | |

Table 3: Recommended For Coverage: Rare Organ/Tissue Transplants

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. These types of transplants may transition from experimental/investigational and become 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 2020? | |
|---|--|----|
| | Yes | No |
| Solid Organ Transplants | | |
| Allogeneic islet transplantation | | |
| Blood or Marrow Stem Cell Transplants | | |
| Allogeneic transplants for: | | |
| Advanced neuroblastoma | | |
| Infantile malignant osteopetrosis | | |
| Kostmann's syndrome | | |
| Leukocyte adhesion deficiencies | | |
| Mucopolidosis (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: | | |
| Ependyoblastoma | | |
| Ewing's sarcoma | | |
| Medulloblastoma | | |
| Pineoblastoma | | |
| Waldenstrom's macroglobulinemia | | |

**Attachment V
2020 Technical Guidance Submission Checklist**

| Topic/Attachment Number | In Proposal Yes/No/N/A | Worksheet Completed Yes/No/N/A |
|--|-----------------------------------|---|
| Attachment I FEHB Carrier Contracting Official | | |
| Attachment II (Community Rated Plans Only) FEHB Benefit Difference Comparison Chart | | |
| Attachment III Preparing Your 2020 Brochure and Benefits Plus Data Submission | N/A | N/A |
| Attachment IV 2020 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 | | |
| Attachment V Technical Guidance Submission Checklist | N/A | |

Please return this checklist with your CY 2020 benefit and rate proposal