

Part One - Preparing Your Benefit Proposal

2005 FEHB Proposal Instructions

Please send the following material by **May 14, 2004**:

Experience-rated Plans

- A copy of a fully executed employer group contract (i.e., *certificate of coverage*) that the greatest number of your non-Federal subscribers purchased in 2004.
- **If you have not made changes to the level of coverage we already purchase**, then submit a statement to that effect. **If you have made changes**, submit a copy of the new benefit description as explained in **Benefit Changes** below. You must file your proposed benefit package and the associated rate with your State, if a filing is required by the State.

Community-rated Plans

- A copy of a fully executed community benefits package (a.k.a. master group contract or subscriber certificate) including riders as well as copays, coinsurance, and deductible amounts, purchased by the greatest number of your non-Federal subscribers in 2004. If the community benefits package is different from FEHB's, send a current copy of the benefits package that we purchased also. Please highlight the difference(s) between the FEHB benefits and the package it is based upon.
- Attach all community-based riders (e.g. prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2005 contract term, except for those still under review by your State.

If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. **If you have made changes**, submit a copy of the new benefits description. If your State requires that you file this documentation, file the benefit package and the associated rate with the State first. We will accept the community benefits package that you *project* will be sold to the majority of your non-Federal subscribers in 2005.

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

All HMOs

1. Attach a chart that compares your proposed 2005 benefits package and the 2004 benefits package that we purchased. Include on your chart:

- A. Differences in copays, coinsurance, numbers of coverage days, and coverage levels in the two packages;
 - B. For community-rated plans only, indicate whether you include the costs of the differences at (A) above within your community rate or in addition to the community rate you charge to the other groups that purchase this benefits package, and to the FEHB Program; and the number of subscribers/contract holders who purchase the 2004 package and who are expected to purchase the 2005 package;
 - C. 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 benefits package you sent us and a copy of the State's approval document. We usually will accept proposed benefit changes if you submitted the changes to your State prior to **May 31**, and you obtain approval and submit documentation of the approval to us by **June 30, 2004**. If the State grants approval by default, i.e., it does not object to proposed changes within a certain period after it receives the proposal, please so note. The review period must have elapsed without objection by June 30.
2. We will contact the State about benefits as necessary. Please provide the name and phone number of the State official responsible for reviewing your plan's benefits. If your plan operates in more than one State, provide the information for each State.
 3. Please highlight and address any State mandated benefits that you have not specifically addressed in previous negotiations.

Please send the following material by **June 1, 2004**:

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

- A comparison of your 2004 benefits package (adjusted for FEHB benefits) and your 2005 benefits package (see #1 above);
- Benefit package documentation (See **Benefit Changes** below);
- A plain language description of each proposed change (in worksheet format) and the revised language for your 2005 brochure;
- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2005 brochure; and
- A signed contracting officials' form.

If there are, or you anticipate significant changes to your 2005 benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Benefit Changes

Your proposal must include a narrative description of each proposed benefit change. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if there is no rate change. 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 2005" section in "plain language" that is, in the active voice and from the enrollee's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital copay, indicate whether this change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, please show each change clearly.
- Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefits package or if the change is one you submitted to the State for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2005.
- State the actuarial value of the change and whether it represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If it is an increase, describe whether any other benefit offsets your proposal.
- If the change is not part of the proposed benefits package, is the change a rider? If yes,
 1. Is it a community rider (offered to all employer groups at the same rate)?
 2. State the percentage of your subscribers/contract holders who now purchase this package and the percentage you project it will cover by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to cover by this rider and when will that occur?
 3. Include the cost impact of this rider as a biweekly amount for Self Only and Self and Family on Attachment 2 of your rate calculation. If there is no cost impact or if the rider involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively, on Attachment 2 to your rate calculation.
- If the change requires new providers, furnish an attachment that identifies the new providers.

Benefit Clarifications

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

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

Carrier Contracting Officials

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

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

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

for _____ (Plan)

Enrollment code(s): _____

Typed name	Title	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

(Typed name and title)

(Phone number) _____
(FAX Number)

(E-mail address)

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

Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2005 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed care industry, there are geographic areas where our customers have more limited choices than other areas. Please consider expanding your FEHB service area to all areas in which you have authority to operate. This will allow greater choice for our customers.

- **Service Area Expansion** - You must propose any service area expansion by **June 1**. We will grant an extension for submitting supporting documentation to us until June 30.
- **Service Area Reduction** - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain.

Please provide a map and precise language to amend the service area description for both expansions and reductions.

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

Important Notices

- The information you provide about your delivery system must be based on executed contracts. We will not accept letters of intent.
- All provider contracts must have "hold harmless" clauses.
- We will assign new codes as necessary. In some cases, rating area or service area changes require a re-enrollment by your FEHB members. We will advise you if this is necessary.

Instructions

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

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

Please provide the following information:

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

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

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

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

- **Access to providers:**

Provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have executed contracts.

Re-designation as a Mixed Model Plan:

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

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

Include clear language in your brochure ("How we change for 2005" section plus "Facts about this HMO plan", if appropriate) to reflect the changes you propose.

Also answer the following questions:

1. Do you require all members of a family to use the same delivery system, or may some members of a family use GPP doctors while others use IPP doctors?
2. If you restrict members to one type of delivery system, what must a member do to change from one delivery system to the other during a contract term? How soon after it is requested would such a change be effective?
3. If a member wants to change primary care doctors (centers for GPPs), what must the member do? Is there a limit on the number of times that a member may change primary care doctors (centers)? If yes, will you waive the limit for FEHB members? How soon is a requested change effective?

Federal Employees Health Benefits Program Statement about Service Area Expansion

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

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2005 Benefits and Service Area Proposals. Specifically,

1. All provider contracts have hold harmless provisions in them.
2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.
3. All of the information provided is accurate as of the date of this statement.

Signature of Plan Contracting Official

Title

Plan Name

Date

Part Three – Benefits for HMOs

The policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your contract specialist to develop a complete benefit package for 2005. The policies include the following:

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

1. **Mental Health and Substance Abuse** - Mental health and substance abuse coverage must be identical to traditional medical care in terms of deductibles, coinsurance, copays, and day and visit limitations. We expect plans to make patient access to adequate mental health services available through managed care networks of behavioral health care providers and innovative benefits design.
2. **Maternity and Mastectomy Admissions** - All plans must provide for maternity admission lengths of stay of at least 48 hours after a regular delivery and 96 hours after a cesarean delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
3. **Pre-existing Conditions** - Pre-existing condition limitations are not permitted for any required benefits.
4. **Point of Service Product** - We will consider proposals to offer a Point of Service product under the FEHB Program. Your plan's proposal must demonstrate experience with a private sector employer who has already purchased the POS product.
5. **Infertility treatment** - We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. This requirement does not include related prescription drugs. Your brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.
6. **Immunizations for Children** - All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums.
7. **Transplants** - All plans must provide coverage for all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney transplants. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. You may limit coverage for these three conditions to services provided at a recognized Center of Excellence and received in clinical trials, as long as both randomized and nonrandomized trials are included (the benefit may not be

- limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but you must provide necessary follow-up care to the experimental procedure. All plans must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors, benefits must be coordinated according to NAIC guidelines, the same as for any other benefit. You may exclude from your FEHB benefits other transplants if they are not part of the community benefit package we purchase, and as State law permits.
8. **Dental and Vision Benefits** - We will consider dental or vision care benefits from community-rated plans when these benefits are a part of the core community benefits package that we purchase.
 9. **Prescription Drugs** - All plans must provide at least a minimum coverage level for all medically necessary drugs that require a prescription, including insulin. Prescription drug deductibles may not exceed \$600 and coinsurance may not exceed 50 percent. We don't allow lifetime or annual benefit maximums on prescription drugs. You must cover disposable needles and syringes used to administer covered injectables, IV fluids, and medications for home use, growth hormones, and allergy serum. You must also provide benefits for "off-label" use of covered medications when prescribed in accordance with generally accepted medical practice by a plan doctor. You may not exclude drugs for sexual dysfunction. You may place dollar or dosage limits on drugs for sexual dysfunction. You may use a drug formulary as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. You cannot have a closed formulary. You cannot use the formulary as a means to exclude benefits for the types of drugs required for the FEHB Program. We don't allow blanket exclusions of broad categories of drugs such as "non-generics," or "injectables".
 10. **Speech therapy** - All plans must provide speech therapy when medically necessary. If your community package limits coverage to rehabilitation only, you must remove that limit for the FEHB Program. You must provide coverage for no less than two consecutive months per condition. You may provide a richer benefit, such as 60 visits per condition, if that is your community benefit. You may apply copays or coinsurance of up to 50 percent.

Federal Preemption Authority

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

Department of Health and Human Services (HHS) Benefits

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

1. Non-experimental bone marrow, cornea, kidney, and liver transplants;
2. Short-term rehabilitative therapy (physical, occupational, and speech therapy), if significant improvement in the patient's condition can be expected within two months;
3. Family planning services, including all necessary non-experimental infertility services, to include artificial insemination with either the husband's or donor sperm. You don't have to cover the cost of donor sperm. You may exclude other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) to the extent permitted by applicable State law;
4. Pediatric and adult immunizations, in accordance with accepted medical practice;
5. Allergy testing and treatment and allergy serum;
6. Well child care from birth;
7. Periodic health evaluations for adults;
8. Home health services;
9. In-hospital administration of blood and blood products (including "blood processing");
10. Surgical treatment of morbid obesity, when medically necessary; and
11. Implants – you must cover the surgical procedure, but you may exclude the cost of the device.

Federally qualified community-rated plans offer these benefits at no additional cost, since the cost is covered by the community rate. Community-rated plans that are not Federally-qualified should reflect the cost of any non-community benefits on Attachment 2 of their rate calculation. If there is no additional cost, the cost entry should be zero.

Part Four - High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA)

High Deductible Health Plans (HDHP)

The Internal Revenue Service (IRS) requires that an HDHP have an annual deductible of at least \$1,000 for self only coverage and annual out-of-pocket expenses (deductibles, co-payments, etc.) that do not exceed \$5,000. For family coverage, an HDHP must have an annual deductible of at least \$2,000 and annual out-of-pocket expenses that do not exceed \$10,000. **Both the deductible minimum and out-of-pocket expense maximums are indexed for inflation.** An HDHP may not provide benefits for any year until the deductible for that year is met. However, a plan may offer first-dollar coverage for preventive care (or have only a small deductible) and still be defined as an HDHP. The following guidance applies for health plans proposing to offer an HDHP for 2005:

- High Deductible Health Plans (HDHP) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
- HDHP proposals should reflect that these choices will be open to everyone within the defined service area eligible to enroll in the FEHB Program.
- HDHP proposals will be evaluated in accordance with OPM premium rating guidelines.
- HDHP proposals must include both Health Savings Account (HSA) and Health Reimbursement Account (HRA) components. The HRA component is available only to enrollees who are ineligible for an HSA.
- Proposals should reflect costs only, including the amounts to be deposited/credited to the enrollee's HSA or HRA.
- Proposals should specify the annual dollar amounts of the deposits from premium, not to exceed the maximum Government contribution in 2004, for the enrollee's HSA or HRA.
- Proposals should clearly describe the health benefits to be offered, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.
- Proposals should include a description of all preventive care benefits and any applicable out-of-pocket amounts.
- Proposals should include a description of catastrophic limitations and how they will be administered for self only and for family enrollments.
- The HDHP provider network to be used should be described and evidence provided that there will be sufficient access to in-network primary, specialty and tertiary providers.
- Proposals should include a description of the HDHP health education program components to be offered.
- Proposals should also include a description of the consumer education program the health plan intends to provide including appropriate use of HSA/HRA funds for necessary medical expenses.
- Proposals should include a complete description of the geographic service area.

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

Tax-favored HSAs are available to those who have an HDHP and who are not eligible for Medicare. However, HSAs are not open to people eligible for Medicare (generally age 65 and over) or to those enrolled in another medical benefit health plan.. Therefore, health plans that are proposing HDHP/HSAs should also propose an HRA of equivalent value or other alternative benefits for enrollees who are ineligible for an HSA. The HRA would be used for medical expenses, which may include Medicare premiums. The following guidance applies for health plans proposing to offer an HDHP and HSA/HRA for 2005

- Health Savings Accounts (HSA) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Internal Revenue Service (IRS) Guidance.
- Health Reimbursement Arrangements (HRA) must meet applicable IRS requirements.
- Fiduciary institutions for HSAs and HRAs must be banks or other non-bank trustees or custodians approved by the IRS.
- Health plan proposals should clearly state how they intend to meet IRS requirements pertaining to HSA and HRA fiduciary responsibilities.
- Health plan proposals must include assurances their fiduciary is financially stable. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level.
- Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.
- Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.
- Health plans that intend to provide a mechanism for payment of Medicare premiums (e.g. allotment) should provide a description from the fiduciary on the proposed authorization and transaction processes to be administered.
- HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how these would be managed and monitored, including accounting for earned interest.

NOTE: Final brochure language is not required with your June 1 submission. OPM will work with you to jointly develop brochure language.