

Preparing Your Benefit Proposal

2005 FEHB Proposal Instructions

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 actual benefit proposal should include:

- 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 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 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 biweekly amount for the Self Only and Self and Family rate. If there is no cost impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, as appropriate.

Benefit Clarifications

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.

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.

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)