FEHB Program Carrier Letter
Health Maintenance Organizations

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2009-11(a) **Date: May 1, 2009**

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

SUBJECT: 2010 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals

Enclosed are the technical guidance and instructions for preparing your benefit and service area proposals for the contract term January 1, 2010, through December 31, 2010. The guidance and instructions are in four parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Preparing Service Area Changes or Re-designation as a Mixed Model Plan
- Part Three: Benefits for HMOs
- Part Four: Preparing Your 2010 Brochure

Please refer to our annual *Call Letter* (Carrier Letter 2009-08) dated April 20, 2009, for *policy guidance*. Benefit policies from prior years remain in effect.

Your community benefit package and non-Federal group benefit package that we purchased is due no later than May 12, 2009, and your complete proposal for benefits, clarifications, and service area changes is due no later than **May 31, 2009** (see Part One: Preparing Your Benefit Proposal). Please send a copy of your proposal to your contract specialist on a CD-ROM or other electronic means in addition to a hard copy. Your proposal should include the corresponding language that describes your proposed changes for Section 5 of the brochure. You do not need to send your fully revised 2010 brochure by May 31, 2009.

Your OPM contract specialist will negotiate your 2010 benefits with you and finalize the negotiations in a close-out letter. Please send an electronic version of your fully revised 2010 brochure to your contract specialist within five business days following the receipt of the close-out letter **or** by the date set by your contract specialist.

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

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

Sincerely,

Kay T. Ely
Associate Director
for Human Resources Products and Services

Enclosures

2010 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

- Submit a copy of a fully executed employer group contract (i.e., *certificate of coverage*) by May 12, 2009, that non-Federal subscribers purchased in 2009.

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

Community-rated Plans

We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions (as indicated in last year's *Call Letter*). If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB consumers. You should also identify each of the differences between your current benefit package and the proposed offering, and include the impact on your community-rated price proposal.

The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.

The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there is an impact on premiums.

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

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

- Submit a copy of a fully executed community-benefit package by May 12, 2009 (a.k.a. master group contract or subscriber certificate), including riders, co-pays, coinsurance, and deductible amounts that your non-Federal subscribers purchased in 2009. If the community benefit package is different from the FEHB's, also send a current copy of the benefit package that we purchased. Please highlight the difference(s) between the FEHB benefits and the package you based it upon. **Note:** If you offer a "national plan" then you need to send us your community benefit package for each state that you cover.

- Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering.

The material must show all proposed benefit changes for FEHB for the 2010 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 you to file this documentation, file the benefit package and the associated rate with the state first. We will accept the community-benefit package you project will be sold to the majority of your non-Federal subscribers in 2010.

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

All HMOs

1. Attach a chart that compares your proposed 2010 benefit package and the 2009 benefit package that we purchased. Include on your chart:

   A. Differences in co-pays, 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 within your community-rate or in addition to the community-rate you charge to the other groups that purchase this benefit package, and to the FEHB Program; and the number of subscribers/contract holders who purchased the 2009 package and who are expected to purchase the 2010 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 benefit package you sent us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to May 31, 2009, and you obtain approval and submit approval documentation to us by June 30, 2009. 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, 2009.

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. State-mandated benefits should be reported if finalized by May 1, 2009, or if they were not specifically addressed in previous negotiations.

Please send the following material by **May 31, 2009**:

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

- A comparison of your 2009 benefit package (adjusted for FEHB benefits) and your 2009 benefit package (see #1 above)

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

- A plain language description of each proposed **change** (in worksheet format) and the revised language for your 2010 brochure

- A plain language description of each proposed **clarification** (in worksheet format) and the revised language for your 2010 brochure

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

If there are, or if you anticipate significant changes to your 2010 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. Please use Attachment II as a template for submitting benefit changes. This template includes value-based benefit questions that must be answered for each benefit change. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if there is no rate change. Also, please answer the following questions in worksheet format for **each** proposed benefit change. Indicate if a particular question does not apply and use a separate page for **each** change you propose. We will return any incorrectly formatted submissions. ***We require the following format:***

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2010" 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 co-pay, indicate whether this change will also apply to in-patient hospitalizations under the emergency benefit. **If there are two or more changes to the same benefit, please show each change clearly.**

- Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefit package or if the change is one you submitted to the state for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2010.

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

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

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

- State the percentage of your subscribers/contract holders who now purchase this rider and the percentage you project it will cover by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to cover by this rider and when will that occur?

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

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

Benefit Clarifications

Clarifications are not benefit changes. Please use Attachment III as a template for submitting benefit clarifications**.** Clarifications help enrollees understand how a benefit is covered**.** For each clarification:

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

- Explain the reason for the benefit clarification.

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 2010 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 in other areas. Please consider expanding your FEHB service area to all areas in which you have authority to operate. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose**.

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

- **Service Area Expansion** - You must propose any service area expansion by May 31, 2009. We may grant an extension for submitting supporting documentation to us until June 30, 2009.

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

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

Important Notices

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

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

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

Criteria

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

- Your ability to provide contracted benefits

Please provide the following information:

- **A description 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.

- **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.

- **Access to providers:**

  Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have **executed** contracts. Also, please update this information on August 31, 2009. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of your initial submission.

Re-designation as a Mixed Model Plan

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

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

Include clear language in your brochure ("How we change for 2010" section plus "Facts about this HMO plan", if appropriate) to reflect the changes you propose.

Also answer the following questions:

- 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?

- 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?

- 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 2010 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. 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 2010. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to last year's *Call Letter* (Carrier Letter 2008-06) dated March 11, 2008. The FEHB policies include the following:

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

1. **Affordability** – As stated in our *Call Letter*, we will work closely with you to find ways to manage costs and utilization effectively.

2. **Value-Based Benefit Design** – As stated in our *Call Letter*, we expect proposals for value-based benefit designs. For each benefit change, please provide answers to the questions included in Attachment II.

   We will also consider separate proposals for health promotion or wellness incentives up to $250 per year per enrollee. Consumers can use these funds for health care costs not otherwise covered by the plan, but which provide an incentive to improve or maintain their health or to comply with care-coordination activities associated with diseases such as diabetes, high blood pressure, obesity, etc. We encourage you to establish accounts (these accounts are not HSA or HRA accounts) through which members can earn credits through reduced utilization and/or compliance with health care regimens as incentives to use their health care dollars wisely. This $250 health promotion or wellness incentive is separate from other benefits your plan offers. For example, if your plan is already waiving co-payments for members based on compliance with a drug regimen, then those waivers need not apply under this benefit.

   Please note: We will not accept proposals for separate wellness incentive accounts from HDHPs or CDHPs which already have savings accounts as part of their program structures.

   We have provided examples of health promotion and wellness incentives below.

   1. Karen decided she wants to stop smoking and signed up for a smoking cessation program. The program costs $250 for six weeks. Her health plan will provide benefits up to $100. She plans to use $150 from her health promotion account to pay the balance of the fee for the program.

   2. Mike has had diabetes for 10 years. While he has tried to maintain his weight and control his blood sugar levels, he has had mixed results and his family had to take him to the emergency room three times in January and February 2008. His health plan has a care-coordination program and a $250 incentive for patients who comply with the treatment protocol. Mike joined the program in March and worked closely with his care coordinator. He was able to better manage his sugar levels and did not need emergency care for the rest of the year. His health plan deposited $250 into his health promotion account in December which he can use during 2009 for medical expenses.

3. Harry is a healthy runner. He has not had an illness or injury for a number of years. He did not use his $250 promotion account in 2008, so he plans to roll it over to 2009.

3. **Mental Health Parity** – In accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, all carriers are required to offer parity benefits for medical and surgical benefits and mental health or substance use benefits, including out-of-network benefits. Please refer to Carrier Letter 2008-17 for guidance. As indicated in the past, mental health and substance abuse coverage must be identical to traditional medical care in terms of deductibles, coinsurance, co-pays. 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.

4. **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):
   1. Describe the expenses that fall under each of these categories: medical, surgical, mental health and prescription drug benefits.
   2. Please indicate completely what expenses are still the member's responsibilities after the member has reached the limit.
   3. 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.
   4. Given your catastrophic limits, what is the maximum out of pocket expense a member may pay for covered services?

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

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

7. **Coverage for Therapies.** We encourage you to examine and communicate your treatment modalities for conditions such as autism. See Attachment IV.

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

9. **Organ/Tissue Transplants** –We have updated the guidance on organ/tissue transplants which

we provided in last year's technical guidance.

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

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

10. **Prescription Drugs** – All plans must meet creditable coverage requirements. The prescription drug benefit must be at least as good as the standard Medicare Part D Benefit. All plans must provide at least a minimum coverage level for all medically necessary drugs that require a prescription, including insulin. Prescription drug deductibles may not exceed $600 and co-insurance 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; however, you may place dollar or dosage limits on these drugs. You may use a drug formulary or preferred list as long as the plan provides benefits for non-formulary or non-preferred drugs when prescribed by a Plan doctor. You cannot use the formulary or preferred list as a means to exclude benefits for drug coverage required through the FEHB Program. We do not allow exclusions of broad categories of drugs such as "non-generics" or "injectables".

    Plans that use levels or tiers to denote different prescription drug co-pays must clearly describe the coverage and difference between each level or tier in the 2010 brochure. The *2010 Guide to Federal Benefits* will illustrate the prescription drug co-pays at the following levels.

    - Level I – generally includes generic drugs but may include some brand formulary or preferred brands. Usually represents the lowest co-pays.
    - Level II – generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range co-pays.
    - Level III – may include all other covered drugs not on Levels I and II, i.e. non-formulary, or non-preferred, and some specialty drugs.

    If your plan has more than three co-pay levels for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2010 Guide to Federal Benefits.*

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

12. **Maternity and Mastectomy Admissions** – All plans must provide for maternity benefits. Benefits must be for coverage of admissions 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 in-patient basis and remaining in the hospital for at least 48 hours after the procedure.

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

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

15. **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.

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

17. **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 2010 brochure language clearly describes your coverage.

18. **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 co-insurance of up to 50 percent if that is your community benefit. All plans must provide **speech** therapy when medically necessary. If your community package limits speech therapy coverage to rehabilitation only, you must remove that limit for the FEHB Program.

Federal Preemption Authority

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not pre-empt 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:

- Non-experimental bone marrow, cornea, kidney, and liver transplants

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

- Family planning services include all necessary non-experimental infertility services such as artificial insemination with either the husband's or donor sperm. You do not have to cover the cost of donor sperm if it is not in your community package. You may exclude benefits for conception by artificial means or assisted reproductive technology to the extent permitted by applicable state law and excluded in your community package

- Pediatric and adult immunizations, in accordance with accepted medical practice

- Allergy testing, treatment and allergy serum

- Well-child care from birth

- Periodic health evaluations for adults

- Home health services

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

- Surgical treatment of morbid obesity, when medically necessary

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

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

Part Four – Preparing Your 2010 Brochure

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

The *2010 FEHB Program Application User Manual* will be available June 1. In June, we will provide in-house training for all plans that did not use the tool exclusively for both printing purposes as well as for use on the FEHB website. There will be 10 separate training sessions held at OPM. We will send an email via the FEHB Carriers listserv as to the dates and times of these trainings. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at angelo.cueto@opm.gov.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 15, 2009. Plans will be unable to make any changes on September 16, 2009, as we will lock-down the tool to enable contract specialists to review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.

The *2010 FEHB Brochure Handbook* will be ready by June 1. Plans can download the *Handbook* from the file manager at www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal. In August, we will also send you a brochure quantity form and other related Open Season instructions.

By August 11, 2009, we will issue a second version of the *2010 FEHB Brochure Handbook* with final language changes and shipping labels. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

Attachment I: Carrier Contracting Officials

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

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

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

for _____(Plan).

Enrollment code(s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX number)

_____
(E-mail address)

Attachment #II

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

Please complete a separate worksheet for each proposed benefit change.

Section 1: Benefit Change Description

Applicable options	☐ High Option ☐ Standard Option ☐ HDHP
Proposed description of change for "Section 2. How we change for 2010"	**Changes to the High Option** • **Changes to the Standard Option** •
The reason for proposed change (brief description, see Section 5 for supporting detail)	

Section 2: Reason for change (Supporting detail)

Reason for change (supporting detail)	

Section 3: For each proposed benefit change, answer the following questions to show how your proposal is value based:

What change in utilization do you anticipate based on the benefit change?	
How do you anticipate that this may affect health outcomes?	
Did you do an analysis of the comparative effectiveness of medical treatments that are covered under the affected benefit category?	
What evidence did you evaluate with respect to question 3? What other evidence did you evaluate?	
How do you propose to analyze the resulting impact of the benefit change?	

Section 4: Current language (Section x, page x):

[Insert Section Name]	You Pay	
	High Option	**Standard Option**
Benefit description language • Benefit description bullet	$x per office visit	$x per office visit
Benefit exclusion language • *Benefit exclusion bullet*	*All charges*	*All charges*

Section 5: Proposed language:

[Insert Section Name]	You Pay	
	High Option	**Standard Option**
Benefit description language • Benefit description bullet	$x per office visit	$x per office visit
Benefit exclusion language • *Benefit exclusion bullet*	*All charges*	*All charges*

Section 6: Type and implementation of benefit change

Is the change part of the proposed benefit package or a rider?	☐ Proposed benefit package ☐ Community rider ☐ Rider, but not a community rider
Is submission to a state entity required?	☐ Yes (documentation attached) ☐ No Explain:
Is this benefit change linked to other changes?	☐ Yes Explain: ☐ No
Percent of subscribers that have this benefit currently	x% as of [insert date]
Percent of subscribers expected to have this benefit on 1/1/2010	x%
Effective date of change for other employers	☐ 1/1/2010 ☐ 1/1/2010 or upon group renewal, whichever is later ☐ Other: _____

Section 7: Cost Impact

Approximate actuarial value/cost impact of change	☐ Less than $0.01 per member per month (pmpm) ☐ Subscriber Only: $x Subscriber and Family: $x (bi-weekly)
Affect on the existing benefit	☐ Increase ☐ Decrease ☐ Other (explain):
Affect on overall benefit package	☐ Increase ☐ Decrease ☐ Other (explain):

Section 8: Provider Impact

Additional providers needed	☐ Yes ☐ No (end)
Provider recruitment plan (if applicable)	

Attachment III

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

Applicable options	☐ Standard Option ☐ High Option ☐ HDHP
Reason for the benefit clarification	

Current language (Section x, page x):

[Insert Section Name]	**You Pay**	
	High Option	**Standard Option**
Benefit description language • Benefit description bullet	$x per office visit	$x per office visit
Benefit exclusion language • *Benefit exclusion bullet*	*All charges*	*All charges*

Proposed language change:

[Insert Section Name]	**You Pay**	
	High Option	**Standard Option**
Benefit description language • Benefit description bullet	$x per office visit	$x per office visit
Benefit exclusion language • *Benefit exclusion bullet*	*All charges*	*All charges*

Attachment IV: Coverage for Therapies

Please indicate which therapies you provide for treatment of conditions related to certain diagnoses, such as autism, to the extent benefits are provided for other illnesses and conditions.

Therapy	**Yes**	**No**
•Speech therapy		
•Physical therapy		
•Occupational therapy		
•Other therapy (please describe)		

Attachment V 2010 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	Reference
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the Staging of the Diagnosis (e.g. acute, chronic).	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Advanced Hodgkin's lymphoma	
Advanced non-Hodgkin's lymphoma	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, pure red cell aplasia)	
Hemoglobinopathy	
Myelodysplasia/Myelodysplastic syndromes	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Amyloidosis	
Paroxysmal Nocturnal Hemoglobinuria	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma	Call Letter 96-08B
Neuroblastoma	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma	Call Letter 96-08B
Amyloidosis	
Autologous tandem transplants for:	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14
Multiple myeloma	

De novo myeloma	
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
V. Mini-transplants (non-myeloablative, reduced intensity conditioning): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

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

	Does your plan cover this transplant for 2009?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)		
Hemoglobinopathies		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Myelodysplasia/Myelodysplastic syndromes		
Multiple myeloma		
Multiple sclerosis		
Nonmyeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Myelodysplasia/Myelodysplastic syndromes		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Myeloproliferative disorders		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
	Yes	**No**

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

Table 3: Recommended For Coverage

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

	Does your plan cover this transplant for 2010?	
Solid Organ Transplants	**Yes**	**No**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment VI: Durable Medical Equipment

Please indicate which items you cover.

Item	Yes	No
Durable Medical Equipment		
•Air fluidized beds		
•Blood glucose monitors		
•Bone growth (or osteogenesis) stimulators		
•Canes (except white canes for the blind)		
•Commode chairs		
•Crutches		
•Home oxygen equipment and supplies		
•Hospital beds		
•Infusion pumps and somemedicines used in them		
•Lymphedema pumps/pneumatic compression devices		
•Nebulizers and medicines used in them		
•Patient lifts		
•Scooters		
•Suction pumps		
•Traction equipment		
•Transcutaneous electronic nerve stimulators (TENS)		
•Ventilators or respiratory assist devices		
•Walkers		
•Wheelchairs (manual and power)		
Prosthetics and Orthotics		
•Arm, leg, back, and neck braces		
•Artificial limbs and eyes		
•Breast prostheses after a mastectomy		
•Ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy		
•Prosthetic devices needed to replace an internal body part or function		
•Therapeutic shoes or inserts for people with diabetes with severe diabetic foot disease		

Attachment VII: Checklist

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

Topic	Included in Proposal
1. Quality and Value in Benefit Design – Including a description of current consumer outreach activities and how you proposed to enhance them	
2. Benefit Change Worksheets for each proposed benefit change (include answers to the value based benefits questions for each benefit change)	
3. Benefit Clarification Worksheet for each proposed benefit clarification	
4. HMO Community Package Requirements – You may propose an alternative benefits package	
5. Mental Health Parity benefits in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008	
6. Full description of your catastrophic limit(s)	
7. Revised policies regarding preventable medical errors to protect members from balanced billing	
8. Completed Coverage for Therapies Checklist	
9. Organ/Tissue Transplants	
10. Completed Durable Medical Equipment Checklist	

Please return this checklist with your CY 2010 benefit and rate proposal