FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management
Federal Employee Insurance Operations

Letter No. 2012-09 **Date: March 29, 2012**

Fee-for-service [8] Experience-rated HMO [8] Community-rated HMO [9]

SUBJECT: Federal Employees Health Benefits Program Call Letter

SUBMISSION OF PROPOSALS

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. Your benefit and rate proposals for the contract term beginning January 1, 2013 should be submitted to us on or before **May 31, 2012**. Please send your proposals by **overnight mail, FAX, or email** to your contract specialist. We expect to complete benefit and rate negotiations by mid-August to ensure a timely Open Season.

FEHB PROGRAM BENEFITS AND INITIATIVES

I. Introduction

This year we have three primary initiatives: 1) implementation of additional requirements under the Affordable Care Act; 2) improvement in the delivery and cost efficiency of prescription drugs; and 3) advancing quality of care principles. These initiatives are discussed below.

Proposed benefit changes must be value-based. That means, you should demonstrate in your proposals that you evaluated proposed changes in light of their influence on promoting the most effective care (i.e., that generally produces the best health outcomes), not just with respect to cost. We encourage innovative proposals aimed at controlling long-term costs by promoting evidence-based services and behaviors that improve enrollees' health. This includes providing additional incentives to enrollees with chronic disease conditions to encourage adherence with prevention and care management strategies.

II. Affordable Care Act

We appreciate your continued cooperation incorporating Affordable Care Act provisions in FEHB benefits. This year we are taking additional steps to expand coverage in advance of the effective date for such coverage in the Affordable Care Act, regardless of grandfather plan status.

A. Annual and Lifetime Limits

The Affordable Care Act requires a gradual phase-out of annual limits on the dollar amount of benefits by 2014. There are few annual limits on essential benefits in the FEHB program today. Therefore, we expect all FEHB plans to eliminate annual limits on essential health benefits for the 2013 contract year, regardless of grandfathered plan status. Categories of essential health benefits are described in section 1302 of the Affordable Care Act. The Secretary of Health and

Human Services has issued preliminary guidance on essential benefits and has asked issuers to make a good faith effort to comply with a reasonable interpretation of the term "essential health benefits." We will work closely with all FEHB plans on eliminating annual limits during our contract negotiations this summer.

The Affordable Care Act requires group health plans to eliminate lifetime limits on the dollar value of essential health benefits for plan years beginning after the enactment date. FEHB plans have historically not imposed lifetime limits, and we will continue to enforce this requirement.

B. Clinical Trial Coverage Requirement

Section 2709 of the Public Health Service Act, as amended by the Affordable Care Act, requires group health plans to provide coverage for approved clinical trials. Specifically, health plans may not deny the individual participation in certain clinical trials; may not deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and may not discriminate against an individual on the basis of that individual's participation in such trial.

Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

FEHB plans are expected to comply with these coverage requirements for clinical trials next year, in advance of required implementation for 2014, and regardless of grandfathered status.

C. Preventive Care

You have helped expand the accessibility of preventive services within the FEHB Program by providing full coverage for the recommendations of the United States Preventive Services Task Force (USPSTF) as well as for tobacco cessation services and medication.

For 2013, in addition to evidence-based items or services that have a rating of A or B in the USPSTF's recommendations, the Affordable Care Act requires coverage for additional preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Services Administration (HRSA). On July 19, 2011, the Institute of Medicine released a report that recommended women's preventive services that should be included in health plans with no cost-sharing, which were adopted by HRSA. Based on this report, HHS issued final regulations on preventive services, including requirements that insurers cover contraceptive services with no cost-sharing effective for plan year 2013. Plans must submit proposals that include coverage for these services with no cost sharing. The list of services is available here: http://www.hrsa.gov/womensguidelines/.

D. Summary of Benefits

The Affordable Care Act requires group health plans to provide a summary of plan benefits and coverage based on standards developed by the Secretary of the Department of Labor. We intend to start the process of implementing these summary requirements for the 2013 contract year.

III. Prescription Medications

OPM is continuing to explore innovative methods to reduce pharmacy spending. In last year's Call Letter we asked that you focus on programs that promote member use of generic drugs. In the next few years, we will see significant changes in the prescription drug industry as more brand name drugs have generic substitutes. The current generic dispensing rate for the FEHB Program is less than 70 percent (percentage of all prescriptions dispensed as generics). Our goal is to have a generic dispensing rate of at least 75 percent for the FEHB Program as a whole in 2013**.** We are interested in working with plans to improve generic dispensing rates through benefit changes as well as through other programs that you may propose which increase consumer awareness and acceptance of new generic drugs. Your proposal should include your current (historic) generic dispensing rate and your projected rate for 2013.

We are also interested in proposals that demonstrate effective prescription drug management without cost shifting or burdening patients; examples are prior approval and utilization management techniques, such as step therapy.

We continue to be concerned about the increased cost and utilization associated with the growth of specialty drugs in the program. These expensive drugs account for approximately 10 percent of total prescription costs. Large PBMs have reported that annual specialty drug trend is from 14 percent to 20 percent, which is significantly higher than overall drug trend. Last year we encouraged you, if you had not already done so, to offer proposals to implement specialty drug programs. In your response to the Call Letter this year, please provide information on your current growth of specialty drugs in your plan, cost trends, and proposals for managing this portion of your prescription drug benefits. Our objective is to keep the growth of specialty drugs and their cost trend below industry averages.

Finally, OPM expects that the pharmacy benefit managers (PBMs) used by FEHB plans are providing the highest levels of customer service to federal employees, retirees and their families. To that end, please explain how your PBM is accredited, and if it is not, describe your plans for accreditation requirements in future PBM contracts and/or contract options.

IV. Advancing Quality of Care

A. Quality

For the past several years we have sought measures aimed at enhancing quality of care under the FEHB Program. These include initiatives to increase patient safety such as stemming hospital-acquired conditions and reducing avoidable readmission rates. In addition, we have collected, analyzed and made available quality metrics, including Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems

(CAHPS). As noted in our Carrier Letter 2012-02, we will be comparing health plan performance to NCQA benchmarks, and we expect to see measurable improvement.

Aligned with our efforts to reliably deliver preventive care, effectively coordinate care to stabilize chronic disease, and reduce Emergency Room use, we are reinforcing our support for patient centered medical homes (PCMH) and similar advanced primary care models. Last year we encouraged plans to submit proposals for pilot programs for integrated healthcare systems, including those which strengthened relationships between patients and primary care providers. We are again calling for your proposals to increase FEHBP members' access to primary care providers who have adopted the principles of the medical home. All plans should submit data on the percentage of the plan's in-network primary care practitioners who are recognized as medical homes at the start of the plan year. Proposals should include your criteria for recognition of a practice as meeting the definition of advanced primary care along with any provider payment incentives that have been evaluated. Plans for implementation and expansion should explain details of how patients will be made aware of quality outcomes associated with these practices and how they will be invited to participate.

Additionally, OPM supports the goals of HHS' *Partnership for Patients, Better Care, Lower Costs* to reduce hospital readmissions by 20% and decrease preventable hospital acquired conditions by 40% when compared with 2010 (for more information, please see http://www.healthcare.gov/compare/partnership-for-patients/). We will issue separate guidance outlining the measurement of baseline rates for FEHB populations, but expect that you will make a concerted effort to help meet these goals through improvements in the quality and safety of health care. We appreciate the leadership shown by FEHB plans on care coordination and we will continue to focus on care management and other relevant programs and results, such as case management, disease management, affiliation with hospitals or networks participating in the *Partnership*, medication management, and use of Centers of Excellence for complex procedures beyond transplantation.

Finally, we are beginning a focus on maternity and neonatal care. Each week, over 2800 patients covered under the FEHB Program give birth. The American College of Obstetricians and Gynecologists and American Academy of Pediatrics have developed guidelines which seek to eliminate elective delivery before 39 weeks' gestation to reduce adverse neonatal outcomes and give these infants the best possible start in life. We encourage you to share any programs or initiatives you are using to ensure quality in this important area. To develop a relevant baseline, we will issue separate guidance on measurement of the percentage of live births requiring a Neonatal ICU stay.

B. Wellness

The health and wellness of FEHB Program members continues to be one of our most important priorities. Overweight and obesity continue to be widespread problems with strong implications for health care costs, chronic illness and disease management. It is well-established that people who are obese contract chronic diseases at a higher rate than others, and will consequently pay more for medical care. The lifetime medical costs related to diabetes, heart disease, high cholesterol, hypertension, and stroke among people who are obese are $10,000 higher than among people who are not obese. It has been reported that among people who are overweight, lifetime medical costs can be reduced by $2,200 to $5,300 following a 10 percent reduction in

body weight. A number of plans included obesity-reducing programs in response to last year's Call Letter. Please provide a status update for these programs and your assessment of program effectiveness, including changes in your HEDIS measures. Those plans that do not have overweight and obesity reduction programs in place today are expected to submit proposals for our review. Finally, we strongly encourage plans to review specific weight-loss related coverage exclusions to ensure that enrollees receive the appropriate care to achieve and sustain a healthier weight.

We expect you to offer programs that promote health and wellness and which are aimed at improving employee productivity, enhancing healthy lifestyles, and lowering long-term healthcare costs. This includes incentives for enrollees who complete health risk assessments, who adhere to disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Programs should provide support in a continuous manner in an effort to create sustained lifestyle changes. In addition, incentives should be utilized in a manner that encourages members to take positive action and achieve *sustained* success.

V. Technical Guidance for Proposals

Specific requirements for submitting your benefit and rate proposals and information on how to prepare your 2013 brochures will be provided at a later date.

As a reminder, all FEHB carriers must adhere to the Guiding Principles available at: http://www.opm.gov/carrier. We expect timely and accurate processing of claims, including coordination of benefits; prompt and accurate submission of actuarial and financial data, including accounting statements; and we expect all plans to be well managed and financially secure.

CONCLUSION

Please discuss your benefit changes with your contract specialist before you submit your proposals. Proposed benefit changes must be cost-neutral, with the exception of value-based and required benefits, and all savings from managed care initiatives must accrue to the FEHB Program. We will begin negotiations when we receive your proposals.

We look forward to the negotiations for the upcoming contract year. Thank you for your commitment to the FEHB Program.

Sincerely,

John O'Brien, Director
Healthcare and Insurance