FEHB Program Carrier Letter
Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2013-09(b) **Date: April 22, 2013**

Fee-for-service [n/a] Experience-rated HMO [8] Community-rated HMO [7]

Subject: 2014 Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMOs

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2013 through December 31, 2013. Please refer to our annual Call Letter (Carrier Letter 2013-04) dated March 21,2013 for policy guidance. Benefit policies from prior years remain in effect unless otherwise noted. The Guidance and instructions are in three parts:

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

Also, please note we have a new survey tool that asks for short responses on topics discussed in the Call Letter. OPM will use this new survey to gather information, along with the responses you provide in your proposal. A copy of the survey is included for informational purposes only as Attachment VI. **Please note:** You will receive an email from your contract specialist with a link(s) that will guide you to the online survey tool. Each contract number will have an individualized link. We ask that you complete the survey online by May 31, 2013.

This year's deadlines are as follows:

- **Due by May 3, 2013:** Please send your community benefit package and most commonly offered group benefit package.
- **Due by May 31, 2013:** Please send your complete proposal for benefit changes and clarifications to your contract specialist on a CD-ROM (or other electronic means) in addition to a hard copy. Your proposal should include language describing all proposed brochure changes. Your OPM contract specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.
- **Due by May 31, 2013:** Please submit survey information electronically.
- **Within five business days following receipt of close-out letter or by date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2014 brochure. See Attachment II -PreparingYour 2014 Brochure.

Carriers are strongly encouraged, as always, to follow our guiding principles of affordability and value-based benefit design when preparing proposals. This year you will see an increased focus on quantitative data, which we will use to measure plan performance. For some items, we are asking for historical data to establish a baseline.

Enclosed is a checklist (Attachment VII) showing all the information to include with your benefit and rate proposals. Please return a completed checklist with your submission.

Rate instructions for community-rated plans and experience-rated plans will be provided under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

In keeping with the spirit of the Call Letter, we remain extremely price sensitive. Although we do not limit HMOs to zero-cost benefit trade-offs, we prefer that benefits remain consistent with your benefit package purchased by the greatest number of your subscribers.

Our experience is that a plan with less than four years of experience in the FEHB Program is most at-risk for dropping out of the program. Plans that drop out are more likely to cite insufficient FEHB enrollment as the reason for no longer wishing to participate. The FEHB Program is a mature, managed-care market. Your ability to differentiate yourself in terms of pricing, benefits, service, or provider access will go a long way in determining your program success. Keep your lines of communication open with your OPM contract specialist. Please do not hesitate to call if you have any questions about the Call Letter or the material enclosed in this letter.

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

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2014 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

Please send the following by May 3, 2013:

- A copy of a fully executed employer group contract (i.e., *certificate of coverage*) that non-Federal subscribers purchased in 2013.

Please send the following by May 31, 2013:

- You must file your proposed benefit package and the associated rate with your state, if required. If you have made changes since your application, submit a copy of the new benefits description and answer the questions below.

- Attach a chart displaying the following information:

    - Benefits that are covered in one package but not the other

    - Differences in co-insurance, co-pays, numbers of days of coverage and other levels of coverage between one package and the other

    - The number of subscribers/contract holders who currently purchase each package.

Community-rated Plans

We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions. If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB enrollees.

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 refer to the rate instructions.

- Submit a copy of a fully executed community benefit package by May 3, 2013 (a.k.a. master group contract or subscriber certificate), including riders, co-pays, co-insurance, and

deductible amounts (e.g. prescription drugs and durable medical equipment) that non-Federal subscribers purchased in 2013. The material must show all proposed benefits for FEHB for the 2014 contract term, except for those still under review by your state. We will accept the community-benefit package that you *project* will be sold to the majority of your non-Federal subscribers in 2014. If you offer a "national plan" then you need to send us copies of your community-benefit package for each state you cover.

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

All HMOs

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:

- Benefit package documentation
- A plain language description of each proposed benefit
- A signed contracting official's form (see attached)
- Describe your state's filing process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent to us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to **May 31, 2013,** and you obtain approval and submit approval documentation to us by **June 30, 2013**. Please let us know if the state grants approval by default; i.e., it does not object to proposed changes within a certain period after it receives the proposal. The review period must have elapsed without objection by June 30, 2013.

We will contact the state about benefits as necessary. Please provide the name and phone number of the state official responsible for reviewing your plan's benefits. If your plan operates in more than one state, provide the information for each state.

- Please highlight and address any state mandated benefits. State-mandated benefits should be reported if finalized by May 1, 2013.

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

Part Two–Changes in Service Areas or Plan Designation Since You Applied to theFEHB Program

Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2014 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. This will allow greater choice for our customers. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose.**

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

- **Service Area Expansion**- You must propose any service area expansion by May 31, 2013. We may grant an extension for submitting supporting documentation to us until June 30, 2013.

- **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.

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.

Service Expansion 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 of 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, and hospitals in the proposed area with whom you have **executed** contracts. Also, please update this information on August 31, 2013. 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 our initial submission.

Service and Additional Geographic Areas:

Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an **additional** geographic area that surrounds, or is adjacent to, your service area, you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to enroll members who **work** but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy in your brochure.

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

Federal Employees Health Benefits Program Statement about Service Area Expansion

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

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2014 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 Newly-Approved 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 2014. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to *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 themunless they are specifically prohibited under FEHB.

As stated in the Call Letter, our four primary performance initiatives this year are:

- Improving the delivery of prescription drug benefits;
- Enhancing wellness programs;
- Advancing quality of care; and
- Encouraging Medicare population pilots.

I. CALL LETTER INITIATIVES

A. Improving the Delivery of Prescription Drug Benefits

1. Prescription Drugs

Our goal is to keep overall pharmacy trend at or below the industry growth rate, which we project to be approximately 8 percent for 2014. Your proposal should describe how your plan will achieve, maintain, and perhaps even exceed this goal. Your proposal should detail how you will accomplish this through pharmacy benefit structure changes, outreach and other strategies.

Information Required: Completed online survey questions. If your trend is expected to be above the 8 percent goal for 2014, complete Attachment III- Pharmacy,Table 1.

2. Generic Dispensing Rate

Our goal is to have a generic dispensing rate of at least 80 percent for the FEHB Program in 2014. Your proposal should describe how your plan will achieve, maintain, and perhaps even exceed this goal. Your proposal should detail how you will accomplish this throughthe benefits and administrative programs you will utilize to improve, or maintain, your generic dispensing rate.

Information Required: Completed online survey questions. If your generic dispensing rate is less than 80 percent for the FEHB Program as a whole in 2014, complete Attachment III - Pharmacy, Table 2.

3. Specialty Drug Trend

Given the expansion in the specialty drug market, we are setting an FEHB Program goal of maintaining specialty drug trend costs at 22 percent or less. Your proposal should state what you expect your plan's trend to be in 2014. If your cost trend is expected to exceed 22 percent you must submit a proposal to address how you will control rising specialty drug costs that considers both benefit and administrative changes, while remaining respectful of member needs. For reference, OPM's list of specialty drugs can be found in Attachment V. This specialty drug list is for the calculation of trend only and should not be used for the administration of benefits. We are also interested in proposals that include specialty pharmacies, prior approval, and programs that limit the quantity dispensed on new prescriptions to assess side effects that may impact a patient's ability to continue therapy.

Information Required: Completed online survey questions. If your specialty drug cost trend is above the 22 percent industry specialty drug trend, complete Attachment III - Pharmacy, Table 3.

4. Prescription Drug Benefit Administration

We encourage efforts to engage enrollees and their providers in meaningful discussions about clinically effective medications that may be offered at relatively low costs. In addition to maximizing the use of generics, there are many drug classes for which therapeutic equivalents or alternatives can be prescribed. Examples include drugs for insomnia, acid reflux, high blood pressure, high cholesterol, and osteoporosis. Your proposal should address benefit designs, utilization management edits, and other implementation strategies that focus on this area. It shouldalso include information on transition of enrollees from one drug to another, utilization management policies and procedures, customer service,education and grandfathering policies.

Carriers should begin adopting a common pharmacy benefit structure utilizing a minimum of four tiers and propose nomenclature to help members understand pharmacy benefits, including key elements such as cost sharing arrangements. Plans must migrate to the following minimum four-tier prescription drug benefit with common definitions no later than 2016: (1) Tier One: Generics; (2) Tier Two: Preferred Brands; (3) Tier Three: Non-preferred Brands; and (4) Tier Four: Specialty Drugs.

Member cost share should increase from Tier One toTier Three, with special consideration given to the affordability of specialty drugs. A copayment structure that is easy for members to understand serves as an effective incentive to utilize generics and preferred brands. We would like to know if you currently have or are moving to a four-tier benefit structure in your community package or drug rider.We also strongly encourage use of cost effective medication distribution channels, specifically mail order or retail programs that offer 90 day supplies of maintenance medications.

We understand that members can achieve even greater savings on prescription drugs with minimal member disruption through either a narrower pharmacy network or a preferred pharmacy network, and welcome proposals for narrower or preferred pharmacy networks. If you propose such networks, you must include information about how such changes will impact member access to medications and the proposed exception process for consumers.

Information Required: Completed online survey questions.

B. Wellness

1. Comprehensive Wellness Programs

We strongly encourage carriers to re-examine the scope of their wellness programs, outreach efforts, and the level of incentives as detailed below. At a minimum, all FEHB Program carriers must offer a Health Risk Assessment (HRA). Also, carriers must include a plan to offer biometric screening (as a component of preventive care) to covered adults, describing the projected population and the costs for implementation**.** Biometric screening programs are designed to collect specific metrics on the health status of an individual to assist them in achieving or maintaining better health. Carriers should indicate which of the following elements will be included in their FEHB biometric screening benefits:

- Body mass index (BMI);
- Waist circumference;
- Lipid or cholesterol levels;
- Blood pressure;
- Tobacco use testing (cotinine, etc.); and
- Glucose or Hemoglobin A1c measurement

For both HRAs and biometric screenings, carriers must set participation goals and propose relevant incentives. Proposals should also include a process to communicate results to members' primary care physicians, when applicable. We recommend considering specific outreach to senior populations. If you have a biometric screening program that uses other indicators than those listed above, please describe those indicators in your proposal as well.

We continue to encourage you to offer financial incentives to enrollees who (a) complete anHRA or biometric assessment or (b) participate in wellness activities or treatment plans to improve their health status.

Information Required: Completed online survey questions.

2. Preventive Care

In accordance with the latest United States Preventive Services Task Force (USPSTF) recommendations, available at http://www.uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.pdf, all FEHB Program carriers must cover screening for all adults for obesity and referrals for behavior change interventions for adults with a Body Mass Index (BMI) over 30kg/m^2 with no cost sharing. Interventions are still subject to applicable member cost sharing. The USPSTF preventive care list is an ongoing requirement.For additional information on the coverage of preventive services, please view the recently published Centers for Medicare and Medicaid Services FAQs available at http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs12.html.

Information Required: Completed online survey questions.

3. Condition Management

In addition to implementing USPSTF guidance on adult obesity prevention, carriers should review and update their criteria for bariatric surgery coverage. A recent review of FEHB carriers reveals that some have very high BMI thresholds or impose waiting periods that are no longer clinically appropriate. Carriers should describe any revised eligibility criteria for bariatric surgery identified in their review. For further guidance, please see the subsequent Carrier Letter that will be released shortly.

Information Required: Completed online survey questions.

C. Advancing Quality of Care

We request that carriers consider hospital performance on CMS measures of hospital acquired conditions (available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html) and early elective delivery as important factors in the choice of network facilities. We also encourage carriers to review the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely Campaign (available at http://choosingwisely.org/),which highlights commonly overused tests and procedures. Carriers must select at least three tests or procedures that they will evaluate this year as part of their utilization management programs.In your proposal, identify the tests or procedures that you will focus on, 2012 annual cost and utilization data, and describe your plan for intervention, including projected reductions in cost and utilization data as a result. The list of tests and procedures identified in the Choosing Wisely Campaign that should be used when completing the online survey is available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/reference/principles/choosing-wisely-campaign.pdf.

Finally, we encourage carriers to advance the Meaningful Use (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html) of health information technology by network providers. We are requesting statistics on the percentage of network providers who have achieved Meaningful Use compliance (Stage 1 or beyond).

Information Required: Completed online survey questions. In addition, please address in your proposal the three tests or procedures you will focus on and describe your plan for intervention.

D. Medicare Population Pilots

We are encouraging proposals for pilot programs where participating carriers offer a sub-option for Medicare eligible annuitants as an alternate choice. The sub-option may include premium pass-through accounts for plans to use solely to pay some or all of Medicare Part B premiums. Carriers may propose cost sharing for members with Medicare Part B that is sufficient to encourage them to participate in the pilot program. Increased communication and education to enrollees will be important for the success of the pilot programs.

Information Required: Completed online survey.

II. BENEFITS & SERVICES

A. New Guidance: Out-of-Pocket Maximums

The U.S. Department of Health and Human Services issued a final rule regarding out-of-pocket (OOP) maximums that applies to all FEHB plans and becomes effective April 26, 2013. The final rule provided that OOP limits up to the health savings account (HSA) OOP limit apply to all FEHB Program plans. The final rule also sets forth the methods for determining whether health plans provide minimum value (MV).The 2013OOP maximumsare $6,250 for self only and $12,500 for self and family.For additional information on OOP maximums, please view the recently published Centers for Medicare and Medicaid Services FAQs available at http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs12.html.

B. Continued Focus from Previous Years

1. Coverage of Applied Behavior Analysis (ABA)

We encourage plans to offer Applied Behavior Analysis (ABA) for children with autism.

Information Required: Completed online survey.

2. Affinity Products

We encourage you to add products on the "non-FEHB" page of your plan brochure that may be of interest to members, especially individual policies for domestic partners, as well as for members who may seek additional insurance products, such as short-term disability.

Information Required: Completed online survey questions.

3. Organ/Tissue Transplants

We have updated the guidance on organ/tissue transplants. When you determine that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following table in Attachment IV:

Table 1– OPM's required list of covered organ/tissue transplants. We have added autologous transplants for aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms to Section IV Table 1 Required Coverage).

Information Required: Completed Attachment IV - 2014 Organ/Tissue Transplants and Diagnoses.

4. 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.

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. Reduce Health Disparities

We encourage you to submit proposals that aim to reduce disparities, such as racial and ethnic disparities, in both health status and healthcare. Please provide us with a description of the specific goals and processes you are undertaking or plan to implement in order to reduce health disparities.

7. Actuarial Value

We are requesting additional information on the medical loss ratio for FEHB plans. Please refer to the medical loss ratio defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options.

8. Facility Fee for an Office Visit

We would like to clarify that if an enrollee visits a doctor whose office is located in a facility (such as a hospital), the enrollee should only be charged the doctor's co-payment. We have been informed that some enrollees are charged the hospital co-payment in addition to the doctor's copayment. Please ensure that this does not occur.

9. Smoking Cessation

Carriers must offer smoking cessation programs without co-payments or co-insurance and which are not subject to deductibles, annual or lifetime dollar limits. The programs must include at least two quit attempts per year with up to four smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling and individual counseling. In addition to the smoking cessation programs, drugs (over-the-counter (OTC) and prescribed) approved by the FDA to treat tobacco dependence for smoking cessation should be available with no co-payments or co-insurance and not subject to deductibles, annual or life time dollar limits (a list of covered OTC drugs is attached). Plans should include OTC drugs in their smoking cessation programs.

Plans must follow the FDA guidelines for all approved drugs. Enrollees who use drugs with multiple purposes, such as Zyban which may be used to treat smoking cessation or depression, must be carefully monitored by a health care professional.

For further information regarding tobacco cessation treatment, please reference the Clinical Practice Guideline, Treating Tobacco Use and Dependence 2008 Update, U.S. Department of Health and Human Services Public Health Service, May 2008. Here is a link to the Guideline: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

10. Donor Testing Services

We are enhancing benefits related to donor testing services for bone marrow and stem cell transplants and encourage proposals that include testing for up to four bone marrow transplant donors per year. We encourage proposals that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.

11. Assistive Technologies

We encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. We also encourage you to offer auditory osseointegrated implants / bone anchored hearing aid (BAHA). Please note that the BAHA benefit should be listed under orthopedic/prosthetic devices in your plan brochure. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

12. Coordination of Benefits

When FEHB Program plans pay secondary COB claims, including those with **Medicare**, they pay the lesser of their allowance or the difference between their allowance and what is paid by the primary plan. You may continue to charge the member co-payments or co-insurance on secondary COB claims. If your benefit design includes co-insurance, it should be based on the remaining charge, not on your allowance. In the following example Medicare is primary and your health plan is secondary. The plan design requires the member to pay 10% co-insurance.

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

If your brochure language does not currently describe this process correctly, please work with your contract specialist to ensure that your 2014 Federal brochure correctly describes this process.

13. 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?

14. <u>Preventable Medical Errors</u>

We encourage you to explore proven strategies to reduce preventable medical errors and to consider proposals for nonpayment of claims for services related to "never events" if you can demonstrate you have consumer protections against balance billing by providers. Never events cause serious injury or death to patients and result in unnecessary costs due to the need to treat the consequences of the errors. The following never events are not reimbursable under Medicare: wrong surgical or other invasive procedures performed on a patient; surgical or other invasive procedures performed on the wrong body part; and surgical or other invasive procedures performed on the wrong patient. We would not expect plans to receive billings from hospitals for these types of events.

FEHB carriers may deny payment for provider claims for the following HospitalAcquired Conditions (HAC) so long as their policies and procedures ensure members are held harmless:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcer stages III & IV
5. Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
6. Catheter-associated urinary tract infection (UTI)
7. Vascular catheter-associated infection
8. Manifestations of poor glycemic control
9. Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)
10. Surgical site infection following certain orthopedic surgeries
11. Surgical site infection following bariatric surgery for obesity
12. Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

We are also asking Carriers to consider coverage for durable medical equipment, including assistive devices for individuals with special needs, such as audible prescription reading devices to prevent the improper use of medications. As an example, some audible prescription-reading devices rely on bar-code scanners while others are devices that fit on the bottom of prescription bottles and allow people with vision challenges to identify their medications and dosage.

In addition, we are requesting that Carriers ensure their benefits include medically necessary laboratory tests, as recommended by the Food and Drug Administration, for the effectiveness of medications including those prescribed to treat breast cancer and the tolerance of anticoagulant medications. We are also requesting carriers ensure they provide coverage for medically necessary speech, physical, and occupational therapies for the treatment of conditions related to certain diagnoses, such as autism, to the extent benefits are provided for other illnesses and

conditions.

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. For information on reducing prematurity and readmissions, please see Carrier Letter 2012-17, available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-17.pdf.

15. Mental Health Parity

The Department of Health and Human Services, Department of Labor, and Department of Treasury released interim final regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Under these rules, health plans cannot have separate deductible and out-of-pocket maximum requirements that are applicable only with respect to mental health or substance use disorders. This means plans must accrue member expenses toward the same deductibles and out-of-pocket maximums for both medical and surgical benefits and mental health and substance use disorder benefits. In addition, if a health plan has a lower copayment for Primary Care Physician visits, the Plan must use the same copayment level for outpatient visits to providers of mental health or substance use disorder services.

These regulations require parity between medical/surgical and mental health/substance use disorder benefits with respect to financial requirements (copayment, co-insurance, deductibles, and out-of-pocket maximums) or treatment limitations (visit or treatment limit) in the following six classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drug benefits. A financial requirement or treatment limitation must be compared only to a financial requirement or treatment limitation of the same type (co-payments, co-insurance, etc.). For instance, co-payments are compared only to other co-payments; co-payments cannot be compared to co-insurance and vice versa.

In addition, the regulations state a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (level of type of financial requirement applied to more than one half) financial requirement or treatment limitation of that type that is applied to substantially all (at least two-thirds) medical/surgical benefits in the same classification. In other words, if co-payments are identified as the financial requirement applied to substantially all medical/surgical benefits (measured by plan costs) in that classification and there are multiple levels of co-payments, the level that applies to more than one half would be considered the "predominant" financial requirement for that classification. Similarly, if a single level applies to at least two-thirds of medical/surgical benefits in a classification, then that level is considered the predominant level that applies to mental health/substance use benefits in that classification. Example: Plan A co-payments apply to at least two-thirds of inpatient/in-network classification and there are two levels of co-payments ($20 & $30); however, the $30 copayment applies to more than one-half of the benefits in that classification, in this case the $30 copayment would be the predominant level.

The regulations prohibit discrimination in the application of non-quantitative treatment limitations, such as medical management standards, prescription drug formulary design, determinations of usual, reasonable and customary amounts, step therapy, and requiring benefits be subjected to a condition such as completing a course of treatment. Any elements used in non-quantitative treatment limitations for mental health benefits must be comparable to those used for medical and surgical benefits. The regulations allow variations to this rule to the extent that recognized clinically appropriate standards of care permit a difference; therefore, concurrent review of mental health care can be required even if the same is not required for medical surgical care.

For further guidance refer to Carrier Letter No. 2008-17 and Letter No. 2009-08 as well as the Interim Final Rules implementing the Act: http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf

16. 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.

17. Immunizations for Children

All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums.

18. 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 2014 brochure language clearly describes your coverage.

19. 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) Essential Health Benefits

All plans*must* offer certain essential health benefits (EHB) required by the Department of Health and Human Services (HHS), **without limits on time and cost,** except as prescribed in the Public Health Service Act and HHS regulations. Plans must review HHS guidance on EHB and update benefits accordingly. Under the Affordable Care Act (ACA), EHB must include items and services within at least the following ten categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Attachment I
FEHB Carrier Contracting Official

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

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

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

for _____ (Plan).

Enrollment code (s):_____

Typed name	Title	Signature	Date

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

_____
(Typed name and title)

_____ _____
(Telephone) (FAX)

_____
(Email)

Attachment II
Preparing Your 2014 Brochure

Summary of Plan Benefits

FEHB plans will continue to provide a summary of plan benefits and coverage (SBC) based on standards developed by the Secretary of the Department of Labor. You will receive additional information regarding the SBC in a subsequent carrier letter.

Going Green

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

Please provide responses to the online survey questions that address your paper reduction inititivesavings.

Timeline: 2014 Brochure Process

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software to generate a Section 508-compliant PDF. This year's deadlines and significant dates are:

DEADLINES	ACTIVITY
May 31	Plans submit Section 5 Benefits information with proposal if suggesting new option
July 2	Plans receive *2014 FEHBBrochure Handbook* via listserv
July 2	OPM will provide *2014 Brochure Creation Tool (BCT) User Manual*
July 10-12 & 15-19	OPM in-house training on the use of the Brochure Creation Tool
July 2-August 31	OPM circulates updated FEHB Brochure Handbook pages by listserv
September 4	Plans must enter all data into Section 5 Benefits and update all plan specific information in the brochure tool. Plans will be unable to make changes after this date so that Contract Specialists can review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.
September 10	OPM sends brochure quantity form to plan after Contract Specialist approves brochure for printing as well as other related Open Season instructions
August 24	OPM's deadline to finalize all language and shipping labels

In mid-July, we will provide in-house training to refresh plans on the use of the Brochure Creation Tool with 8 individual sessions held at OPM. We will notify plans via the FEHB Carriers listserv about the training dates and times. Please send any comments or questions pertaining to the Brochure Creation Tool to Lionell Jones at lionell.jones@opm.gov or Angelo Cueto at angelo.cueto@opm.gov.

Attachment III
Pharmacy

Table 1: Pharmacy Drug Trend

Remember to prepare your data worksheet to return to the OPM actuaries.

Our target pharmacy drug trend for 2014 is 8% or below. Is your current pharmacy drug trend at 8% or below? Yes __No__.

If yes, you may skip the rest of this worksheet. If no, please describe what activities, beyond those currently in place, that you will implement to reach this target for 2014? Please describe the three activities that are most likely to help you reach this goal.

Pharmacy Drug Trend Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Pharmacy Drug Trend Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	
Pharmacy Drug Trend Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Attachment III
Pharmacy

Table 2: Generic Dispensing Rate (GDR)

Remember to prepare your data worksheet to return to the OPM actuaries.

We have a target GDR for 2014 of at least 80%. Is your current GDR at least 80%? Yes __No__.

If yes, you may skip the rest of this worksheet. If no, please describe what activities, beyond those currently in place that you will implement to reach this target for 2014? Please describe the three activities that are most likely to help you reach this goal.

Generic Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Generic Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	
Generic Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Attachment III
Pharmacy

Table 3: Specialty

Remember to prepare your data worksheet to return to the OPM actuaries.

We have a specialty pharmacy trend target for 2014 of keeping cost trends at or below 22 percent. Is your current cost trend at or below 22 percent?Yes__No__.

If yes, you may skip the rest of this worksheet. If no, please describe what activities, beyond those currently in place, that you will implement to reach this target for 2014? Please describe the three activities that are most likely to help you reach this goal.

Specialty Initiative	
Target beneficiary population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Specialty Initiative	
Target beneficiary population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	
Specialty Initiative	
Target beneficiary population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

AttachmentIV
2014Organ/Tissue Transplants and Diagnoses

Table 1: Required Coverage

NOTE**: *** indicates an addition to the chart for 2014.

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 cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis.	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Hemoglobinopathy	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)	
Myelodysplasia/Myelodysplastic Syndromes	
Paroxysmal Nocturnal Hemoglobinuria	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B

Amyloidosis	
Neuroblastoma	Call Letter 96-08B
III.Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
Childhood rhabdomyosarcoma	
Advanced Ewing sarcoma	
*****Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)	Carrier Letter 2013-12a
Advanced Childhood kidney cancers	
Mantle Cell (Non-Hodgkin lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage; Transplants under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services recommended under Clinical Trials. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2013?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		

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

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

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

	Does your plan cover this transplant for 2013?	
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'smacroglobulinemia		

Attachment V
Specialty Drug List

Chemical Name or Proper Name for Vaccines, Blood & Biologics	**Examples of Brand Rx**
Note: This list is for calculation of trend ONLY, not for benefits administration	
ABACAVIR	Ziagen
ABACAVIR; LAMIVUDINE	Epzicom
ABACAVIR; LAMIVUDINE; ZIDOVUDINE	Trizivir
ABATACEPT	Orencia
ABIRATERONE ACETATE	Zytiga
ADALIMUMAB	Humira
ADEFOVIR DIPIVOXIL	Hepsera
AFLIBERCEPT	Eylea
AGALSIDASE BETA	Fabrazyme
ALEFACEPT	Amevive
ALGLUCOSIDASE ALFA	Lumizyme, Myozyme
ALPHA1-PROTEINASE INHIBITOR (HUMAN)	Aralast, Glassia
AMBRISENTAN	Letairis
ANAKINRA	Kineret
ANTIHEMOPHILIC FACTOR (HUMAN)	Koate-DVI, Monoclate-P
ANTIHEMOPHILIC FACTOR (RECOMBINANT)	Hemofil M, Kogenate FS, Recombinatef, HelixateFS
ANTIHEMOPHILIC FACTOR (RECOMBINANT), PLASMA/ALBUMIN FREE	Xyntha, Advate, XynthaSolofuse
ANTIHEMOPHILIC FACTOR / VON WILLEBRAND FACTOR COMPLEX (HUMAN)	Humate-P, Alphanate
APOMORPHINE	Apokyn
ATAZANAVIR	Reyataz
AXITINIB	Inlyta
BELATACEPT	Nulojix
BELIMUMAB	Benlysta
BEXAROTENE	Targretin
BOCEPREVIR	Victrelis
BOSENTAN	Tracleer
BOTULINUM TOXIN TYPE A	Dysport, Botox
BOTULINUM TOXIN TYPE B	Myobloc
C1 ESTERASE INHIBITOR (HUMAN)	Berinert, Cinryze
CANAKINUMAB	Ilaris
CAPECITABINE	Xeloda
CAPSAICIN	Qutenza
CERTOLIZUMAB PEGOL	Cimzia
CETRORELIX	Cetrotide
CHORIOGONADOTROPIN ALFA	Ovidrel
CHORIONIC GONADOTROPIN	Novarel, Pregnyl

COAGULATION FACTOR IX	AlphaNine SD
COAGULATION FACTOR IX (HUMAN)	Mononine
COAGULATION FACTOR IX (RECOMBINANT)	BeneFIX
COAGULATION FACTOR VIIa (RECOMBINANT)	NovoSeven
COBICISTAT; ELVITEGRAVIR; TENOFOVIR; EMTRICITABINE	Stribild
COLLAGENASE CLOSTRIDIUM HISTOLYTICUM	Xiaflex
CRIZOTINIB	Xalkori
CYCLOSPORINE	Gengraf, Sandimmune, Neoral
CYSTEAMINE	Cystagon
CYTOMEGALOVIRUS IMMUNE GLOBULIN INTRAVENOUS (HUMAN)	CytoGam
DALFAMPRIDINE	Ampyra
DARBEPOETIN ALFA	Aranesp
DARUNAVIR	Prezista
DASATINIB	Sprycel
DEFERASIROX	Exjade
DEGARELIX	Firmagon
DELAVIRDINE	Rescriptor
DENOSUMAB	Prolia, Xgeva
DESFEROXAMINE	Desferal
DEXAMETHASONE	Ozurdex
DEXTRANOMER AND SODIUM HYALURONATE	Solesta
DIDANOSINE	Videx, *Videx EC*
DORNASE ALFA	Pulmozyme
ECULIZUMAB	Soliris
EFAVIRENZ	Sustiva
EFAVIRENZ; TENOFOVIR; EMTRICITABINE	Atripla
ELTROMBOPAG	Promacta
EMTRICITABINE	Emtriva
EMTRICITABINE; TENOFOVIR	Truvada
EMTRICITABINE; TENOFOVIR; RILPIVIRINE	Complera
ENFUVIRTIDE	Fuzeon
ENTECAVIR	Baraclude
ENZALUTAMIDE	Xtandi
EPOETIN ALFA	Procrit, Epogen
EPOPROSTENOL	Flolan, Veletri
ERLOTINIB	Tarceva
ETANERCEPT	Enbrel
ETONOGESTREL	Implanon, Nexplanon
ETRAVIRINE	Intelence
EVEROLIMUS	Afinitor, Zortress
FACTOR IX COMPLEX	Bebulin, Bebulin VH
FACTOR XIII CONCENTRATE (HUMAN)	Corifact
FILGRASTIM	Neupogen

FINGOLIMOD	Gilenya
FLUOCINOLONE	Retisert
FOLLITROPIN ALFA/BETA	Follistim AQ, Gonal-F
FOSAMPRENAVIR	Lexiva
GALSULFASE	Naglazyme
GLATIRAMER ACETATE	Copaxone
GOLIMUMAB	Simponi
GOSERELIN	Zoladex
HEPATITIS B IMMUNE GLOBULIN (HUMAN)	Nabi-HB
HEPATITIS B IMMUNE GLOBULIN INTRAVENOUS(HUMAN)	HepaGam B
HEPATITIS IMMUNE GLOBULIN	HyperHEP B
HISTRELIN	Vantas, Supprelin LA
HYALURONATE	Hyalgan, Supartz, Euflexxa, Orthovisc
HYDROXYPROGESTERONE CAPROATE	Makena
HYLANG-f20	Synvisc, Synvisc One
ICATIBANT	Firazyr
IDURSULFASE	Elaprase
ILOPROST	Ventavis
IMATINIB	Gleevec
IMIGLUCERASE	Cerezyme
IMMUNE GLOBULIN (HUMAN)	GamaSTAN S/D, HyperRHO S/D, MICRhoGAM, RhoGam
IMMUNE GLOBULIN INFUSION (HUMAN)	Gammagard
IMMUNE GLOBULIN INJECTION (HUMAN), 10% CAPRYLATE/CHROMATOGRAPHY PURIFIED	Gamunex-C
IMMUNE GLOBULIN INTRAVENOUS (HUMAN)	Flebogamma, Carimune NF, Gammagard SD, Gammaplex
IMMUNE GLOBULIN INTRAVENOUS (HUMAN), 10% LIQUID	Privigen
IMMUNE GLOBULIN INTRAVENOUS, HUMAN 5%	Octagam
IMMUNE GLOBULIN SUBCUTANEOUS (HUMAN), 20% LIQUID	Hizentra
INCOBOTULINUMTOXIN A	Xeomin
INDINAVIR	Crixivan
INFLIXIMAB	Remicade
INTERFERON BETA-1A/*B*	Avonex, Rebif, Betaseron, Extavia
INTERFERON GAMMA-1B	Actimmune
IVACAFTOR	Kalydeco
LAMIVUDINE	Epivir, Epivir-HBV
LAMIVUDINE; ZIDOVUDINE	Combivir
LAPATINIB	Tykerb
LARONIADASE	Aldurazyme
LENALIDOMIDE	Revlimid
LEUPROLIDE	Eligard, Lupron
LEVONORGESTREL	Mirena, Skyla

LOPINAVIR; RITONAVIR	Kaletra
LUTROPIN ALFA	Luveris
MARAVIROC	Selzentry
MECASERMIN RECOMBINANT	Increlex
MENOTROPINS (FSH;LH)	Menopur, Repronex
MYCOPHENOLATE MOFETIL	CellCept, Myfortic
NALTREXONE	Vivitrol
NATALIZUMAB	Tysabri
NELFINAVIR	Viracept
NEVIRAPINE	Viramune
NILOTINIB	Tasigna
OCTREOTIDE	Sandostatin, Sandostatin LAR
OMACETAXINE	Synribo
OMALIZUMAB	Xolair
OPRELVEKIN	Neumega
PALIVIZUMAB	Synagis
PAZOPANIB	Votrient
PEGAPTANIB	Macugen
PEGFILGRASTIM	Neulasta
PEGINTERFERON ALFA-2A	Pegasys, PegasysProclick
PEGINTERFERON ALFA-2B	Pegintron, PegintronRedipen, Sylantron
PEGLOTICASE	Krystexxa
PEGVISOMANT	Somavert
PLERIXAFOR	Mozobil
RALTEGRAVIR	Isentress
RANIBIZUMAB	Lucentis
REGORAFENIB	Stivarga
Rho(D) Immune Globulin Intravenous (Human)	WinRho SDF
RIBAVIRIN	Copegus, Ribasphere, Rebetol, Ribatab, Ribapak
RILONACEPT	Arcalyst
RILPIVIRINE	Edurant
RITONAVIR	Norvir
ROMIPLOSTIM	Nplate
RUXOLITINIB	Jakafi
SAPROPTERIN	Kuvan
SAQUINAVIR	Invirase
SARGRAMOSTIM	Leukine
SILDENAFIL	Revatio
SIROLIMUS	Rapamune
SOMATROPIN RECOMBINANT	Humatrope, Nutropin, Omnitrope, Saizen, Tev-Tropin, Genotropin, Serostim

SORAFENIB	Nexavar
STAVUDINE	Zerit
SUNITINIB	Sutent
TACROLIMUS	Prograf
TADALAFIL	Adcirca
TELBIVUDINE	T yzeka
TEMOZOLOMIDE	Temodar
TENOFOVIR	Viread
TERIFLUNOMIDE	Aubagio
TERIPARATIDE RECOMBINANT HUMAN	Forteo
TESAMORELIN	Egrifta
TETRABENAZINE	Xenazine
THALIDOMIDE	Thalomid
THYROTROPIN ALFA	Thyrogen
TIPRANAVIR	Aptivus
TOBRAMYCIN	Tobi
TOCILIZUMAB	Actemra
TOFACITINIB	Xeljanz
TOPOTECAN	Hycamtin
TREPROSTINIL	Remodulin, Tyvaso
TRIPTORELIN	Trelstar, Trelstar Depot
UROFOLLITROPIN	Bravelle
USTEKINUMAB	Stelara
VELAGLUCERASE ALFA	VPRIV
VEMURAFENIB	Zelboraf
VERTEPORFIN	Visudyne
VIGABATRIN	Sabril
VISMODEGIB	Erivedge
VORINOSTAT	Zolinza
ZIDOVUDINE	Retrovir
ZOLEDRONIC ACID	Reclast, Zometa

THESE QUESTIONS ARE ATTACHED FOR YOUR INFORMATION ONLY. RESPONSES TO THESE QUESTIONS SHOULD BE PROVIDED THROUGH THE ONLINE SURVEY.

Attachment VI
Online Survey Questions

U.S. Office of Personnel Management
2013 Technical Guidance

As the 2013 Technical Guidance mentioned, OPM is implementing a new survey tool as part of this year's data collection for topics outlined in the Call Letter. The survey you are about to complete will allow you to enter and submit your answers electronically. You will have the opportunity to provide more detailed information and explanations in your proposal. If you have any questions while you are completing the survey, please contact your contract specialist.

Please note: You should have received an email from your contract specialist with a link(s) for each unique contract. If applicable, please make sure you complete a separate survey for every contract. We appreciate your effort and cooperation and look forward to working with you throughout the next plan year.

(End of Page 1)

Please fill in the blank for each line below:

Contract Number: _____

Plan Name: _____

Two Digit Carrier Code(s): _____

Contract Holders in the Plan as of March 31, 2013: _____

Covered Lives in the Plan as of March 31, 2013: _____

(End of Page 2)

Section I: Prescription Drugs

A pharmacy growth rate trend includes: >Inflation – cost of drugs per member per year >Utilization – number of drugs used per member per year >Mix – market basket of drugs dispensed and reimbursed

Based on the above definition of pharmacy growth rate trend, please provide your overall drug trend for:

2012 (actual) please respond N/A if you were not in FEHB in 2012: _____

2013 (projected): _____

2014 (projected): _____

If your pharmacy growth rate trend is projected to be higher than 8% for 2014, what actions will you take to lower it? (*Please select all that apply)*

□ NA, Growth rate is lower than 8%

□ Add/modify tiers

□ Change cost sharing structure

□ Add specialty pharmacy

□ Add or expand step therapy

□ Add or expand prior authorization

□ Add or expand quantity limits for new specialty drug prescriptions

□ Offer member educational campaign

□ Offer 90-day retail program

□ Change or add mail order benefits

□ Offer incentive programs

□ Offer Medication Therapy Management programs

□ Narrow pharmacy networks or add preferred pharmacy network

□ Develop an EGWP strategy

□ Integrate specialty drugs dispensed in physician offices with PBM

□ Other (please explain in your proposal)

(End of Page 3)

Section I: Prescription Drugs- *continued*

Generic Dispensing Rate (GDR) is defined as the percentage of total prescriptions filled with generic drugs. The denominator is the total number of prescriptions dispensed during the period and the numerator is the total number of prescriptions in the denominator that are dispensed as generics.

Based on the above definition of GDR, please provide your GDR for:

2012 (actual) please respond N/A if you were not in FEHB in 2012: _____

2013 (projected): _____

2014 (projected): _____

If your projected GDR for 2014 is below the goal of 80%, what actions will you take to reach it? (*Please select all that apply)*

□NA, GDR for 2014 is below 80%

□Add/modify tiers

□Change cost sharing structure

□Add or expand step therapy

□Add or expand prior authorization

□Offer member educational campaign

□Offer incentive programs

□Narrow or add preferred pharmacy networks

□Offer 90-day retail program

□Change or add mail order benefits

□Other (please explain in your proposal)

(End of Page 4)

Section I: Prescription Drugs- *continued*

OPM has developed a list (www.opm.gov) of specialty drugs to use in your calculation of specialty drug trend. Using the list provided, what is your specialty drug trend for:

2012 (actual) please respond N/A if you were not in FEHB in 2012:_____

2013 (projected): _____

2014 (projected): _____

If your projected specialty drug trend for 2014 is above OPM's goal of 22%, what actions will you take to reduce it? (*Please select all that apply)*

□NA, projected specialty trend is less than 22%

☐Add/modify tiers

☐Change cost sharing structure

☐Add specialty pharmacy

☐Add or expand step therapy

☐Add or expand prior authorization

☐Add or expand quantity limits for new specialty drug prescriptions

☐Offer member educational campaign

☐Offer 90-day retail program

☐Change or add mail order benefits

☐Offer Medication Therapy Management programs

☐Integrate specialty drugs dispensed in physician offices with PBM

☐Other (please explain in your proposal)

Oncology drugs and therapeutics are commonly reimbursed on the medical side of the benefit and may not be included in your specialty drug program.
You may, however, have special approaches to assess the appropriate use of these drugs. (*Please select all that apply)*

☐Clinical pathway or guideline program

☐Decision support tools

☐Outlier analysis

☐Expert review

☐Pre-authorization

☐Other (please explain in your proposal)

(End of Page 5)

Section I: Prescription Drugs- *continued*

What drug utilization management edits or programs do you currently have to incentivize the use of clinically effective medications at low costs?*(Please select all that apply)*

☐Step therapy

☐Prior authorization

☐Quantity Limits

☐Adherence Programs

☐Medication Management Programs

☐Other (please specify in your proposal)

☐None

In 2014, which areas will you use to increase incentives to use clinically effective, safe and low cost medications?*(Please select all that apply)*

☐Step therapy

☐Prior authorization

☐Quantity Limits

☐Adherence Programs

☐Medication Management Programs

☐Other (please specify in your proposal)

☐None

(End of Page 6)

Section I: Prescription Drugs- *continued*

For 2013, what percentage of maintenance medications are provided through:

Retail pharmacy: _____

Mail service pharmacy: _____

Specialty pharmacy: _____

Please check the items below that your 2013 prescription drug benefit design contains.(*Please select all that apply)*

☐Three tier benefit design

☐Four tier benefit design

☐More than four tier benefit design

☐Copay cost sharing

☐Coinsurance cost sharing

□Combination of copay and coinsurance

□Designated specialty drug tier

□Designated generic drug tier

□Designated preferred brand drug tier

□Designated non-preferred brand drug tier

Please check the items below that your proposed 2014 prescription drug benefit design will contain.*(Please select all that apply)*

□Three tier benefit design

□Four tier benefit design

□More than four tier benefit design

□Copay cost sharing

□Coinsurance cost sharing

□Combination of copay and coinsurance

□Designated specialty drug tier

□Designated generic drug tier

□Designated preferred brand drug tier

(End of Page 7)

Section II: Wellness and Preventive Care

All FEHB Program carriers must offer a health risk assessment (HRA). Our goal is to increase member participation significantly in 2014.

Participation rate is defined as the percentage of covered adults (members age 18 or above) completing the health risk assessment.

Estimate your plan's HRA participation rate for 2013: _____

Project your FEHB participation rate goal for 2014: _____

What is the reference standard for your plan's HRA? *(Please select all that apply)*

□National Committee on Quality Assurance

□Utilization Review and Accreditation Commission

☐HERO Best Practice Scorecard

☐Centers for Disease Control and Prevention

☐Other (Please specify in your proposal)

(End of Page 8)

Section II: Wellness and Preventive Care- *continued*

Which incentives do you currently use to encourage HRA completion? *(Please select all that apply)*

☐Member incentive

☐Provider incentive

☐Other (please specify in your proposal)

☐None

Which additional incentives are you proposing for 2014 to increase HRA completion rates?*(Please select all that apply)*

☐Member incentive

☐Provider incentive

☐Other (please specify in your proposal)

☐None

Note: Please specify the details of your plan to achieve your HRA participation goal in your rate/benefit proposal, including member outreach and incentives.

(End of Page 9)

Section II: Wellness and Preventive Care- *continued*

Carriers must begin offering biometric screening benefits for FEHB covered adults in 2014.

Please indicate which of the following elements will be included in your FEHB biometric screening benefits.*(Please select all that apply)*

☐Body mass index (BMI)

☐Waist circumference

☐Lipid or cholesterol levels

□Blood pressure

□Tobacco use testing (cotinine, etc)

□Glucose or Hemoglobin A1c measurement

□Other (please specify in your proposal)

What is your participation goal for completion of biometric screenings (as a percent of FEHB covered adults):

For 2014: _____

Please indicate the venues in which you propose to provide biometric screening benefits:*(Please select all that apply)*

□Provider Office

□Retail clinic/urgent care

□Pharmacy

□Laboratory

□Workplace

□Fitness Center/Health Club

□Health Fair

□Other (please specify in your proposal)

Do you plan to contract with a vendor to provide biometric screenings?

□ Yes (please describe the arrangement in your proposal)

□ No

Do you have a process in place to communicate biometric screening results to members' primary care physicians?

□ Yes

□ No

Note: Plans for biometric screening must be submitted with your rate/benefit proposal and describe the projected population and implementation costs, along with relevant incentives to achieve your participation goals.

(End of Page 10)

Section III: Advancing Quality of Care

When your plan assesses network hospitals, which of the following performance measures do you evaluate?*(Please select all that apply)*

Facility specific readmission rates

CMS measures of hospital acquired conditions (www.medicare.gov/hospitalcompare)

Joint Commission Core Measures (http://www.jointcommission.org/core_measure_sets.aspx)

Leapfrog measures of hospital quality and safety (www.leapfroggroup.org)

Any measure of early elective obstetric delivery

Other patient safety measures

Other surgical checklists

Other medication reconciliation

Other fall prevention protocols

Other, unspecified (please specify in your proposal)

(End of Page 11)

Section III: Advancing Quality of Care - *continued*

OPM requires FEHB plans that offer PCMH to utilize criteria that document enhanced access, management of patient populations, care management and planning, provision of self-care support, care coordination, and performance measurement.

Which of the following programs do you use to certify or recognize PCMH?*(Please select all that apply)*

NCQA Patient Centered Medical Home Recognition—Levels 2 and 3

The Joint Commission Primary Care Medical Home Certification

URAC Patient Centered Health Care Home Certification

AAAHC Medical Home Certification

Alternative method (contract specialist will provide supplemental worksheet for submission of details)

How many FEHB covered lives are currently enrolled in a PCMH practice affiliated with your plan:

As of April 1, 2013: _____

How many FEHB covered lives are currently enrolled in a practice participating in the CMS Comprehensive Primary Care Initiative:

As of April 1, 2013: _____

What percentage of your plan's primary care providers serving FEHB members are certified or recognized as PCMH according to the criteria listed above:

As of April 1, 2013: _____

What is your goal for 2014: _____

(End of Page 12)

Section III: Advancing Quality of Care - *continued*

After considering the commonly overused tests and procedures highlighted in the Choosing Wisely Campaign, (the numbered elements are available for review and selection at www.opm.gov) please identify 3 tests or procedures by the coordinating number that your plan will focus on this year as part of your utilization management program. OPM will use this information to inform the selection of HEDIS measures reported by all plans in 2014.

Procedure #1 _____

Procedure #2 _____

Procedure #3 _____

What percent of your plan's network providers have achieved Stage 1 or Stage 2 of the Meaningful Use of health information technology? _____

(End of Page 13)

Section IV: Coverage and Benefits: Applied Behavioral Analysis (ABA)

Does your service area include one or more states with an insurance mandate to cover ABA for children with autism?

□Yes >>>> Skip to Page 15: In states with a mandate to cover ABA services, do you offer ABA services in any of your non-FEHB health insurance products?

□No >>>> Skip to Page 17: Our research shows that CO, CT, NJ, SC, and VA have mandated ABA coverage; large populations of federal workers; and significant numbers of ABA providers. Do you operate in one of these states?

(End of Page 14)

Section IV: Coverage and Benefits: Applied Behavioral Analysis (ABA)- *continued*

In states with a mandate to cover ABA services, do you offer ABA services in any of your non-FEHB health insurance products?

□Yes >>>> Skip to Page 16: OPM encourages your plan to propose ABA coverage for FEHB members.

□No >>>> Skip to Page 17: Our research shows that CO, CT, NJ, SC, and VA have mandated ABA coverage; large populations of federal workers; and significant numbers of ABA providers. Do you operate in one of these states?

(End of Page 15)

Section IV: Coverage and Benefits: Applied Behavioral Analysis (ABA)- *continued*

OPM encourages your plan to propose ABA coverage for FEHB members.

□Plan already covers ABA for FEHB members

□Plan is proposing coverage for 2014 benefit year for FEHB members

□Plan projects an ability to propose coverage for FEHB members in (fill in the benefit year) _____

(End of Page 16)

Section IV: Coverage and Benefits: Applied Behavioral Analysis (ABA)- *continued*

Our research shows that CO, CT, NJ, SC, and VA have mandated ABA coverage; large populations of federal workers; and significant numbers of ABA providers.
Do you operate in one of these states?

□Yes >>>> Skip to Page 18: Are you able to include ABA coverage for FEHB members in these states as part of your 2014 rate/benefit proposal?

□No >>>> Skip to Page 19: For FEHB members who have obesity uncomplicated by other medical conditions, what is your plan's BMI threshold for bariatric surgery?

(End of Page 17)

Section IV: Coverage and Benefits: Applied Behavioral Analysis (ABA)- *continued*

Are you able to include ABA coverage for FEHB members in these states as part of your 2014 rate/benefit proposal?

□Yes

□No(please explain the primary reason in your rate/benefit proposal)

(End of Page 18)

Section V: Coverage and Benefits: Bariatric Surgery

For FEHB members who have obesity uncomplicated by other medical conditions, what is your plan's BMI threshold for bariatric surgery?

Please specify as kg/m2: _____

For FEHB members whose obesity is complicated by diabetes, what is your plan's BMI threshold for bariatric surgery?

Please specify as kg/m2: _____

What is your required pre-surgical waiting period for bariatric surgical procedures?

□<6 months

□6-12 months

□12-24 months

□Longer than 24 months

Do you direct FEHB members to bariatric surgical centers of excellence?

□Yes

□No

Which bariatric surgical procedures are covered? *(Please select all that apply)*

□Roux-en-Y gastric bypass

□Adjustable gastric banding

□Sleeve gastrectomy

□Duodenal switch procedure

□Other malabsorptive procedure(s)

□Other restrictive procedure(s)

□Other combination procedure(s)

(End of Page 19)

Section VI: Medicare Population Pilots

Have you submitted a proposal for a pilot program to offer a sub-option for Medicare eligible annuitants as an alternate choice?

□ Yes

□ No

Note: Please provide detailed responses in your proposals.

(End of Page 20)

Section VII: Affordable Care Act (ACA) Compliance

In 2014, will you comply with the Affordable Care Act requirementsfor preventive services at no cost (65 total preventive services)?

□Yes

□No

In 2014, will you comply with the Affordable Care Act's limits for out-of-pocket maximums for non-grandfathered large group health plans in 2014?

□Yes

□No

(End of Page 21)

Section VIII: Geriatric Providers

Do you have a mechanism to identify providers with geriatric training or certification (including those PCPs with these qualifications) in your FEHBP directory?

□Yes

□No

As of April 1, 2013, how many FEHB members over the age of 65 do you have?

_____

Note: Please describe your mechanism in your proposal.

(End of Page 22)

Section IX: Affinity Products

Do you offer individual policies for FEHB domestic partners?

□Yes

□No

Do you offer short-term disability coverage for FEHB members?

□Yes

□No

Do you list individual policies for domestic partners on your non-FEHB page?

□Yes

□No

Do you list short-term disability coverage on your non-FEHB page?

□Yes

□No

(End of Page 23)

Section X: Brochure Cost Savings from Going Green Initiative

Was 2013 your first year in FEHB?

□ Yes >>>> Skip to Page 25: **Please estimate your brochure cost savings in 2012:**

□ No >>>> Skip to Page 26:

(End of Page 24)

Section X: Brochure Cost Savings from Going Green Initiative- *continued*

Please estimate your brochure cost savings in 2012:

Printing Savings (**in U.S. dollars**): _____

Shipping Savings (**in U.S. dollars**): _____

Postage Savings (**in U.S. dollars**): _____

Other savings (please specify the type in your proposal): _____

Total Savings (**in U.S. dollars**): _____

Please estimate your total brochure cost savings since the beginning of the Going Green Initiative in 2011*:*

Printing Savings (**in U.S. dollars**): _____

Shipping Savings (**in U.S. dollars**): _____

Postage Savings (**in U.S. dollars**): _____

Other savings (please specify the type in your proposal): _____

Total Savings in 2011 and 2012 (**in U.S. dollars**): _____

(End of Page 25)

You have reached the end of the electronic portion of the 2013 Technical Guidance. We recommend reviewing all of your answers before submitting the form. Once you click submit, you will not be able to go back and edit any answers. Please keep in mind, however, that you will have the opportunity to provide more details and information in your benefit proposal. Thank you for your time. The information you have provided will strongly contribute to the success of FEHB.

(End of Page 26)

Attachment VII
2014 Technical Guidance Submission Checklist

Topic/Attachment Number	In Proposal Yes/No/NA	Worksheet Completed Yes/No/NA	Online Survey Completed Yes/No/NA
FEHB Carrier Contracting Official (Attachment I)			N/A
Preparing Your 2014 Brochure (Attachment II)			
Pharmacy - Pharmacy Drug Trend (Attachment III)			
Pharmacy - Dispensing Rate (Attachment III)			
Pharmacy - Specialty (Attachment III)			
Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 (Attachment IV)			N/A
Specialty Drug List (Attachment V)	N/A	N/A	N/A
Online Survey Questions (Attachment VI)	N/A	N/A	
Technical Guidance Submission Checklist (Attachment VII)	N/A		N/A

Please return this checklist with your CY 2014 benefit and rate proposal