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# FEHB Program Carrier Letter

## Health Maintenance Organizations (New)

U.S. Office of Personnel Management  
Healthcare and Insurance

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Letter No. 2017-04 (b)

Date: April 18, 2017

Fee-for-service [2] Experience-rated HMO [2] Community-rated HMO [4]

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### Subject: 2018 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, 2018 through December 31, 2018. The Federal Employees Health Benefits (FEHB) carrier guidance is issued in two documents:

1. The annual Call Letter Carrier Letter 2017-01 dated January 11, 2017 provides guidance on OPM's initiatives for the 2018 benefits negotiation cycle.
2. The Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMO's provides more technical requirements for the items listed in the Call Letter.

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

This year's deadlines are as follows:

- **Due by May 8, 2017:** Please send your community benefit package and most commonly offered group benefit package.
- **Due by May 31, 2017:** Please send your complete proposal for benefit changes and clarifications to your Health Insurance Specialist by electronic means in addition to a hard copy. Your proposal should include language describing all proposed brochure changes. Your OPM Health Insurance Specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.
- **Within five business days, following receipt of the close-out letter or by the date set by your Health insurance Specialist:** Please send him/her an electronic version of your fully revised 2018 brochure. See Attachment III - Preparing Your 2018 Brochure.

As stated in the Call Letter, we are encouraging all FEHB carriers to thoroughly evaluate their health plan options to find ways to improve affordability reduce costs and improve quality of care, and the health of the enrolled population.

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

It is incumbent upon you to ensure that each of your benefit proposals is in accordance with all applicable Federal laws and regulations. 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.

As a reminder, all carriers must adhere to the FEHB Guiding Principles available at [www.opm.gov/healthcare-insurance/healthcare/carriers/reference/principles/](http://www.opm.gov/healthcare-insurance/healthcare/carriers/reference/principles/). In addition, all carriers must have a vigorous and effective fraud detection and prevention program along with programs to prevent and recoup any improper payments.

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

Sincerely,

Alan P. Spielman  
Director  
Healthcare and Insurance

Attachments:

Attachment I – FEHB Carrier Contracting Official  
Attachment II – FEHB Benefit Difference Comparison Chart in-Network Benefits Spreadsheet  
Attachment III – Preparing Your 2018 Brochure and Benefits Plus Data Submission  
Attachment IV – 2018 Organ/Tissue Transplants and Diagnoses  
Attachment V – 2018 Technical Guidance Submission Checklist  
Attachment VI – 2018 FEHB Drug Formulary Template

## 2018 FEHB Proposal Instructions

### Part One - Preparing Your Benefit Proposal

#### I. All HMOs

A. 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:

1. Benefit package documentation.
2. A plain language description of each proposed benefit.
3. A signed contracting official's form (Attachment I).
4. In a cover letter accompanying your community package, 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, 2017**, and you obtain approval and submit approval documentation to us by **June 30, 2017**. 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, 2017. Please include 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. If applicable, please include which state you have designated as the situs state. We will contact a state about benefits as necessary.

B. The Federal Employees Health Benefits Program has three enrollment types:

Self Only (codes ending in 1 and 4) - A Self Only enrollment type only provides benefits for the enrollee

Self Plus One (codes ending in 3 and 6) - A Self Plus One enrollment only provides benefits for the enrollee and one designated eligible family member. See website: [www.opm.gov/healthcare-insurance/healthcare/eligibility/](http://www.opm.gov/healthcare-insurance/healthcare/eligibility/) for eligibility criteria.

- a. Catastrophic maximum, deductibles, and wellness incentives should be for dollar amounts that are less than or equal to corresponding benefits in the Self and Family enrollment.
- b. Copays, coinsurance, and benefits, limitations, and exclusions must not vary by enrollment type.
- c. FEHB Plans with High Deductible Health Plans must be cognizant of Treasury/IRS - 26 U.S. Code § 223 which for deductibles, catastrophic maximums and premium pass-through contributions require twice the dollar amount for Self Plus One or Self Plus Family than for Self Only coverage. Note that family coverage is defined under 26 CFR 54.4980G-1 as including the Self Plus One coverage category.

Self and Family (codes ending in 2 and 5) - A Self and Family enrollment type provides benefits for the enrollee and all eligible family members.

- C. The Community Benefit Package is the commercial health plan sold to the largest number of non-Federal employees. Your proposal should reflect this package of benefits unless specific changes are approved in advance by your Health Insurance Specialist. A piece-meal collection of the most commonly purchased benefits taken from a number of different commercial health plan packages does not meet OPM's requirement.
- D. Complete Attachment II - (Community Rated Plans Only) Benefit Difference Comparison Chart. Include on your chart:
  - 1. Differences in co-pays, co-insurance, numbers of coverage days, and coverage levels in the three packages. In-network benefits are entered on a separate worksheet than out-of-network benefits.
  - 2. Please highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 8, 2017, or if they were not specifically addressed in previous negotiations.
  - 3. Please include whether riders are required within your *proposed 2018 FEHB benefit package*. For all community-rated plans, indicate the name of the community benefit package, including the entity noted as having the largest number of non-Federal employees number of subscribers/contract holders who purchased the 2017 package and who are expected to purchase the 2018 package.

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 8, 2017.

#### E. 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. OPM no longer requires plans to comply with benefit requirements for Federally qualified Health Maintenance Organizations.

## II. Experience-rated Plans

### A. Please send the following by May 8, 2017:

- 1. A copy of a fully executed employer group contract (i.e., *certificate of coverage*) that non-Federal subscribers purchased in 2017.

### B. Please send the following which must be received by **May 31, 2017**:

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.

### III. Community-rated Plans

A. We will 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.

1. The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.
2. The alternate benefit package may not exclude benefits that are required of all FEHB plans.
3. Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

B. Please consult with your Health Insurance Specialist and your contact in the Office of the Actuaries regarding the alternate community package and refer to the rate instructions.

1. Submit a copy of a fully executed community benefit package by May 8, 2017 (also known as 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 2017. The material must show all proposed benefits for FEHB for the 2018 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 2018. If you offer a plan in multiple states please send us your community benefit package for each state that you intend to cover.

Your FEHB rate must be consistent with the community-benefit 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.

## **Part Two – Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program**

- I. Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2018 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.
- II. 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.**
- III. 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.

### Important Notices

- A. The information you provide about your delivery system must be based on **executed** contracts. We will not accept letters of intent.
- B. All provider contracts must have “hold harmless” clauses.

### IV. Service Expansion Criteria

- A. We will evaluate your service area proposal according to these criteria:
  1. Legal authority to operate.
  2. Reasonable access to providers.
  3. Choice of quality primary and specialty medical care throughout the service area.
  4. Your ability to provide contracted benefits.
  5. Your proposed service area must be geographically contiguous.
- B. You must provide the following information:
  1. 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.
  2. 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.

### 3. 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 by August 31, 2017. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of your initial submission.

### Service and Additional Geographic Areas:

1. 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.
2. 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 2018 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. 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.

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Signature of Plan Contracting Official

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Title

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Plan Name

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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 Health Insurance Specialist to develop a complete benefit package for 2018. 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.

If you propose to eliminate any state mandated benefits normally included in your community package, specify them in your benefit proposal and provide a rationale.

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

1. Managing Prescription Drugs
2. Ensuring Access to Care
3. Population Health
4. Alternative Payment Models
5. Plan Performance Assessment

Please address all of the Call Letter initiatives in your proposal. Please refer any questions to your Health Insurance Specialist.

### **I. 2018 INITIATIVES**

#### **A. Managing Prescription Drugs**

OPM continues to emphasize the effective use of prescription medications while managing drug costs. Your proposal should highlight how you will achieve these goals through benefit structure and program initiatives. At a minimum, all 2018 proposals must describe the strategies you have in place, or propose specific strategies, to manage prescription drugs within the following categories:

- Biosimilar medications
- Lipid lowering drugs
- Drugs for hepatitis
- Oncology drugs
- Diabetes drugs

#### **Formularies**

Carriers must address how their formulary design prevents selection bias or discrimination and facilitates appropriate access to drug therapy for members with chronic conditions, such as mental health conditions, substance use disorders, immunosuppression, diabetes, HIV, seizure disorders, and cancer.

Carriers must provide a copy of the full 2017 formulary as well as document the relevant formulary tier definitions and proposed cost share assigned using the formulary template

included as Attachment VI, Drug Formulary Template. The completed template is expected to be uploaded to the FEHB Formulary group within Filemanager by May 31, 2017. (This group will be available to carriers starting April 15, 2017.)

To grant the appropriate access to the FEHB Formulary group in Filemanager, we will need the following information for your plan representative who will be responsible for the upload. This information should be sent to your Health Insurance Specialist by COB May 31, 2017.

- First name
- Last name
- Email address
- Plan name
- Plan code(s)

Once this information is received and the plan user has added to Filemanager, the user will receive an email with their login ID and temporary password. The user will need to log into Filemanager (using the credentials supplied) and will need to update their password. Users are encouraged on an annual basis to change their password.

In Filemanger, please use the following file naming convention for the file name:

**Formulary2017\_***zzz*. “*zzz*” represents the 1st three characters FEHB Plan code and option that utilizes the formulary (that appears in cell B7 of the Formulary Tiers tab of the excel template). For questions or concerns, please contact your Health Insurance Specialist.

OPM will evaluate the range and adequacy of coverage in key therapeutic classes, along with any potential barriers to access.

## **Transparency**

Beginning in 2006, OPM began an emphasis on fostering pharmacy price transparency. In Call Letters 2014-03 and 2015-02, plans were asked to provide easy and convenient access to information about the formulary tier and member cost-share for prescription drugs. OPM appreciates efforts carriers have made to provide drug cost calculators that display up-to-date information about the formulary tier, member cost-share and utilization management requirements for covered prescription drugs.

The prescription drug calculator tool should display at least the following information:

- Name of drug
- Dosage/strength
- Indicator of brand or generic
- Formulary tier
- Estimated cost of the drug through retail (30 days) as well as mail-order (90 days) or other delivery channels
- Utilization management requirements (step-therapy, pre-authorization, etc.)

Effective drug use calculators should be accurate, intuitive, easy to navigate, clear to understand and member-friendly. The drug cost calculator must be interactive, static formulary lists do not meet this requirement.

Proposals must describe how the carrier meets this requirement and include a link to the pre-enrollment pharmacy price transparency tool. Carriers that do not meet the requirements above should indicate enhancements that they plan to make to their drug calculator tools.

### **Patient Safety**

Over 80% of FEHB carriers have quantity limits for narcotics, as well as for stimulants and sleep medications. Any carrier that does not have these limits in place should describe how they ensure safe utilization of these drugs with misuse and diversion potential.

We strongly encourage carriers to review and improve access to drugs used to manage addiction, including reversal agents and Medication Assisted Treatment. Questions in the Automated Data Collection (ADC) tool address specifics of access to this important care.

In your 2018 proposal, indicate any opioid overutilization programs in place or proposed and outline your process once members that fit the defined parameters are identified.

Please submit a copy of your medical policy pertaining to buprenorphine use along with your proposal. Also, any carrier excluding methadone maintenance must provide justification of the basis for this exclusion to OPM for review.

### **Adherence**

Proposals should also include details of programs that help to identify patients at risk and increase their adherence to prescribed medications. Please describe how you use pharmacy claims data to identify and intervene with members who have abandoned/failed to refill maintenance medications.

Medication reconciliation is an established technique to reduce drug interactions and adverse drug events that may lead to hospital readmission, as well as to enhance patient adherence. Your responses to ADC questions will help evaluate adoption of this practice among FEHB plans as well as opportunities to improve.

## **B. Ensuring Access to Care**

### **Unexpected Bills from Out-of-Network Providers**

FEHB members continue to encounter unexpected charges from out-of-network providers who render services within in-network facilities. OPM remains focused on minimizing unnecessary cost to members. OPM strongly encourages carriers to be attentive to this concern and strive to eliminate balance billing to our members in these types of situations.

Please include in your proposal a specific description of the new strategies you will leverage to address this issue in 2018. In addition, your proposal should address negotiating one-time contracts with out-of-network providers to protect members from balance billing.

### **Telehealth Services**

Telehealth includes virtual visits for primary care, urgent care, behavioral health, in-home monitoring of chronic illnesses, and dermatology. This modality can also be a viable alternative to expand network boundaries, and address privacy concerns. Industry data show that telehealth can reduce avoidable hospital visits as well as provide regular access to care in remote and rural areas. Our Automated Data Collection data showed that 56% of our plans offer primary care video, telephonic, or e-visits. OPM continues to encourage carriers to leverage these tools. In your proposal, please describe any areas in which you intend to implement or to expand these services for the 2018 Plan year. We are especially interested in proposals that demonstrate increased value or projected savings to healthcare costs.

## **C. Population Health**

### **Comprehensive Diabetes Management**

Carrier Letters 2015-14 and 2016-04 reinforce OPM's expectation that all FEHB health plans sponsor programs that promote healthy lifestyles and help members modify health risks. The CDC reports eighty-six million Americans now have prediabetes and 9 out of 10 of them don't know they have it. Without intervention, 15% to 30% of people with prediabetes will develop Type 2 diabetes within 5 years<sup>1</sup>.

Diabetes increases the risk for heart attack and stroke. In the Framingham Heart Study, diabetes doubled the age adjusted risk for cardiovascular disease in men and tripled it in women. Patients with prediabetes and diabetes also tend to have more health risk factors than non-diabetics, including hypertension, lipid abnormalities and obesity. To address the rising prevalence of diabetes and the associated long term cost implications, FEHB plans must employ interventions to change both trajectories.

In October 2015, the United States Preventive Services Task Force (USPSTF) endorsed blood glucose testing as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Those with abnormal blood glucose should be referred to intensive behavioral counseling interventions to promote a healthful diet and physical activity. This aligns with the 2014 USPSTF recommendation to refer overweight or obese adults with additional cardiovascular risk factors to intensive behavioral counseling. Please describe how your plan ensures eligible patients are referred to appropriate programs.

In addition to prevention, successful management for those with established diabetes includes an ongoing care relationship with a treating provider, routine monitoring of HgbA1c and glucose levels, medication adherence, and access to support services that promote lifestyle change. We congratulate the FEHB carriers who are already reporting HgbA1c measure results at or above national commercial averages. Others have room for improvement. Please describe your Plan's efforts to:

- Reinforce continuity of care for members with diabetes
- Facilitate access to regular laboratory testing and supplies for home monitoring
- Align formulary placement and/or adjust medication copays/coinsurance to increase adherence

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<sup>1</sup> <https://www.cdc.gov/diabetes/prevention/prediabetes-type2/index.html>

- Promote access to lifestyle change, diabetes education, peer support, or coaching programs

Nationally recognized programs that direct efforts towards diabetes prevention, obesity management, and reduction of cardiovascular disease risk are listed at [https://nccd.cdc.gov/DDT\\_DPRP/Registry.aspx](https://nccd.cdc.gov/DDT_DPRP/Registry.aspx). Prevent Diabetes STAT (Screen/Test/Act Today) offers health professionals and insurers additional information and resources on the prevention of diabetes at <http://www.ama-assn.org/sub/prevent-diabetes-stat>. Resources for Type 2 diabetes management include the Together 2 Goal campaign at <http://www.together2goal.org/>, and the National Diabetes Education Program at <https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/Pages/index.aspx>.

## **Healthy Maternity Outcomes**

OPM's Plan Performance Assessment reinforces healthy pregnancy outcomes and healthy children as clear FEHB goals. To date, FEHB carriers have taken important steps to ensure timely prenatal care and to reduce early elective deliveries. This section calls attention to the maternity outcomes of pregnant women with Phenylketonuria (PKU), an inborn error of metabolism.

All newborns in the US are tested for PKU within a few days of birth, and started on a special formula if the diagnosis is confirmed. The formula restricts intake of the amino acid phenylalanine, which otherwise accumulates to toxic levels in the developing brains of children with PKU. All naturally occurring proteins contain this amino acid, and no drugs address the developmental consequences as well as this dietary intervention. Many FEHB plans already cover low phenylalanine formulas for children with PKU under the category of "medical foods". In the past, few women with PKU were healthy enough to successfully complete pregnancy. Now that more affected women reach reproductive age, research documents significant health risks to their offspring. Some infants may inherit the PKU gene, but even those who do not face substantial health consequences from high phenylalanine levels in their mother's blood during pregnancy. Strict maternal adherence to a "PKU diet" during pregnancy, including special formulas to replace normal dietary sources of protein, reduces the risk of serious developmental abnormalities in newborns.

To maximize the opportunity for healthy newborns and normal early childhood development, we strongly encourage all plans to review their coverage of specialized medical foods for children and pregnant women with PKU. Current clinical guidance, especially the Practice Guidelines of the American College of Medical Genetics and Genomics (Feb 2014) and the Committee Opinion, Management of Women with Phenylketonuria of the American College of Obstetricians and Gynecologists (June 2015), is available to help plans craft medical and coverage policies that are supported by strong scientific evidence. Plans proposing or updating coverage may also wish to consult the definition of medical foods established by the Food and Drug Administration (FDA) in the Orphan Drug Act.

Using population estimates of prevalence and rates of existing coverage within FEHB, OPM estimated the cost impact of adding coverage for medical foods for all children and pregnant women across the program as minimal.

## **D. Alternative Payment Models**

OPM continues to encourage all carriers to address rising healthcare costs through a review of plan design, provider networks, pharmacy programs and benefit management initiatives. The review should also include member education on how to use their benefits and services in a cost-effective manner. For the 2018 plan year, OPM is urging carriers to evaluate drivers of health care costs and offer solutions to achieve both short and long-term savings for the FEHB Program. Carriers are expected to explore innovative models of health care delivery that can help manage and control costs as well as producing better health outcomes. In line with this expectation, carriers are encouraged to offer proposals that address ways in which to limit cost growth.

Recent industry communications report that major carriers are moving quickly toward value based care models, with over 40% of medical spending tied to quality, efficiency, and health outcomes (<http://www.forbes.com/sites/brucejapsen/2017/02/02/unitedhealth-aetna-anthem-near-50-value-based-care-spending/#37abf3844722>). OPM welcomes carriers to propose these alternative payment models for inclusion in FEHB lines of business. Details regarding the clinical area (global payment, primary care, maternity, orthopedics, oncology, etc.), facility/provider type, nature of the payment, risk arrangement if any, transparency provisions, and projected outcome/cost impact should be described in detail.

Along these lines, Centers for Medicare and Medicaid Services (CMS) is now allowing certain carriers to include non-Medicare lines of business in the Comprehensive Primary Care Plus (CPC+) demonstration in order to help determine whether the model is effective for patients of varying age and health status. Carriers that enter participation agreements with CMS are encouraged to include their FEHB lives in this regionally-based multi-payer payment reform initiative. Carriers who anticipate including FEHB lives should so indicate in their proposals. OPM will follow up to understand how you plan to evaluate your overall experience in the CPC+, and how you expect to approach coordination of benefits for members who carry both FEHB and Medicare Part B. For more information on the CPC+ please visit:

<https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus>. For a list of participating health insurance carriers please visit: <https://innovation.cms.gov/Files/x/cpcplus-payerregionlist.pdf>.

## **E. Plan Performance Assessment**

We strongly encourage all carriers to engage in process improvement throughout the year in order to maximize their Plan Performance Assessment results. Many carriers need to focus their improvement efforts on reducing hospital readmissions. OPM's upcoming Best Practices sessions will highlight successful strategies from high performing plans. Proposals should include details of new or enhanced initiatives you are undertaking in order to impact results, especially predictive modeling, care coordination, advanced primary care implementation, pharmacy based strategies, robust aftercare, or alternative payment arrangements. We also call your attention to ADC questions on this topic that are designed to seek input on specific measures as well as future directions for the Plan Performance Assessment. The most recent information regarding the Plan Performance Assessment can be found in the following letters: Carrier Letter 2016-11 outlining the methodology for the Improvement Increment, Carrier Letter 2016-14 includes the current version of the Plan Performance Assessment Carrier Manual, and Carrier Letter 2017-02 includes an update to the calculation of the Performance Adjustment for Community-Rated Plans.

## **II. BENEFITS & SERVICES**

## Continued Focus from Previous Years

### 1. Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2018. 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. The following tables are in Attachment IV:

Table 1 – OPM’s required list of covered organ/tissue transplants. We have added Kidney-Pancreas to the list of required organ/tissue transplants. If your plan does not currently cover this transplant, you must submit a benefit change worksheet.

Table 2 – OPM’s recommended coverage of transplants under Clinical Trials.

Table 3 – OPM’s recommended list of covered rare organ/tissue transplants.

Information Required: Completed Attachment IV - 2018 Organ/Tissue Transplants and Diagnoses.

### 2. Health Plan Accreditation

Updated accreditation requirements were published in Carrier Letter 2014-10. Carriers are reminded that all FEHB health plans are expected to meet OPM’s accreditation requirement no later than April 2017.

### 3. Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between a group health plan’s medical/surgical (MED) benefits and mental health or substance use disorder (MHSUD) benefits. Final implementing regulations were published in late 2013. OPM has previously reviewed FEHB Plan compliance with quantitative parity requirements. Carrier Letter 2017-01 describes this year’s focus on whether Non-Quantitative Treatment Limitations (NQTLs) imposed by FEHB carriers respect parity rules. To facilitate this review, carriers should complete Automated Data Collection (ADC) items 29 – 38 and include supplemental material with your proposal as described below. For clarity and continuity, the relevant ADC items are reproduced here.

As a reminder, in circumstances where NQTLs are applied to mental health and substance use disorder benefits, they must be comparable to and applied no more stringently than NQTLs applied to the same classification of medical-surgical benefits. Benefit classifications defined in the Final Rule are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs.

1. (ADC item 29) does your plan use a vendor or subcontractor for any aspect of MHSUD benefits or care?  
 No  
 Yes (*your proposal must include an explanation of how parity is assured between MHSUD benefits provided by a vendor and plan provided MED benefits*)
2. (ADC item 30) How does your plan ensure parity in processes used to develop medical

necessity criteria/medical policy documents? *(select all that apply)*

- Plan convenes the same committee (or evidence review body) for both MED and MHSUD
- Committee(s) involved includes both MHSUD and MED subject matter experts
- Plan relies on an external entity that incorporates both MHSUD and MED expertise
- Plan uses separate processes to develop medical policy for MHSUD and MED. *Please include information in their proposals describing how parity is assured when processes are different.*

3. (ADC item 31) How does your plan evaluate medications for formulary inclusion, tier placement, step therapy, and prior-authorization?
- Plan convenes or relies on the same Pharmacy and Therapeutics (P&T) committee for both MED and MHSUD medications for all processes
  - Plan uses the same P&T committee for formulary inclusion and tier placement, but relies on different processes for step therapy and prior authorization criteria *(Proposals should explain how comparability is assured)*
  - Plan uses separate processes for MED and MHSUD *(your proposals should explain how comparability is assured)*
4. (ADC item 32) Do plan benefits include any circumstances under which members who fail to complete a recommended treatment cannot access additional benefits for the same or a related diagnosis?
- Yes, for MHSUD only
  - Yes, for MED only
  - Yes, for both MHSUD and MED
  - No
5. (ADC item 33) Does your plan require 100% or “blanket” preauthorization for in-network non-emergency care in any of the following classification categories or subsets of those categories? *(select all that apply)*
- Inpatient MED
  - Inpatient MHSUD
  - Outpatient MED
  - Outpatient MHSUD
  - Other: \_\_\_\_\_
6. (ADC item 34) Does your plan require 100% preauthorization for non-emergency care out-of-network (OON) in any of the following classifications? *(select all that apply)*
- No
  - Yes for inpatient MHSUD
  - Yes for outpatient MHSUD
  - Yes for inpatient MED
  - Yes for outpatient MED
  - Plan does not offer OON benefits
7. (ADC item 35) Does your plan require 100% case management for non-emergency care in-network? *(select all that apply)*



- No
- Yes for inpatient MHSUD
- Yes for outpatient MHSUD
- Yes for inpatient MED
- Yes for outpatient MED

8. (ADC item 36) Does your plan require written treatment plans for non-emergency care in-network? *(select all that apply)*

- No
- Yes for inpatient MHSUD
- Yes for outpatient MHSUD
- Yes for inpatient MED
- Yes for outpatient MED

9. (ADC item 37) How does your plan determine appropriate MHSUD care for purposes of prior authorization, utilization management, or reimbursement? *(select all that apply)*

- Plan accepts treating provider recommendation
- Plan relies on medical policy or clinical guidelines
- Plan relies on third party utilization management criteria
- Plan relies on tools available through a state regulatory body (such as the Department of Mental Health) or professional society (such as American Society of Addiction Medicine)
- Other *(Please include an explanation in your proposal)*

10. (ADC item 38) How does your plan ensure parity in medical necessity appeals/disputed claims/requests for reconsideration? *(select all that apply)*

- Plan uses same review body for all MED and MHSUD medical necessity reconsiderations
- Process(es) involved incorporates both MED and MHSUD subject matter experts
- Denial letters include rationale and criteria for decisions in MHSUD cases
- Denial letters include rationale and criteria for decisions in MED cases
- Plan periodically compares percentage of MHSUD appeals overturned in favor of the member to the percentage of MED appeals overturned in favor of the member
- Other process or method *(Please include an explanation in their proposal)*
- None of the above

11. If the plan is proposing changes to their 2018 benefit package that would alter any of the parameters described in 1-10 above, please provide details.

#### 4. 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.

#### 5. 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 Health Insurance Specialist to ensure that your 2018 Federal brochure correctly describes this process.

#### *6. 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):

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

#### *7. 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 2018 brochure language clearly describes your coverage.

#### *8. 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 or provide habilitative services consistent with the state benchmark.

**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 (Community Rated Plans Only)**  
**FEHB Benefit Difference Comparison Chart**  
**In-Network Benefits Spreadsheet**

See *FEHB Benefit Difference Comparisons Chart In-Network Benefits Spreadsheet* attached with listserv

**Attachment III**  
**Preparing Your 2018 Brochure and Benefits Plus Data Submission**

**I. Preparing Your 2018 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 subsequent carrier guidance.

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 and only upon request to current members. You may send Explanations of Benefits, newsletters and other plan materials electronically.

Timeline: 2018 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 5	Plans receive: <i>2018 FEHB Brochure Handbook</i> Updated FEHB Brochure Handbook pages by Listserv.
July 5	OPM will provide <i>2018 Brochure Creation Tool (BCT) User Manual</i> .
July 11 –17 & July 18 – 24	OPM in-house training on the use of the Brochure Creation Tool.
August 15	OPM’s deadline to finalize all language and shipping labels.
August 25	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 Health Insurance 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 11	OPM sends brochure quantity form to plans after Health Insurance Specialist approves brochure for printing as well as other related Open Season instructions.

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 Angelo Cueto at [Angelo.Cueto@opm.gov](mailto:Angelo.Cueto@opm.gov) or Kaisha Elphick at [kaisha.elphick@opm.gov](mailto:kaisha.elphick@opm.gov).

**II. Benefits Plus Data Submission**

Timeline: 2018 Benefits Plus Process

We will continue to use the Benefits Plus system to collect data from carriers. We have expanded the data collected this year, and made changes to Benefits Plus to improve functionality, usability and performance. This year's deadlines and significant dates are:

<b>DEADLINES</b>	<b>ACTIVITY</b>
July 5	Plans receive Benefits Plus change information via listserv.
July 11- 17 & 18-24	OPM in-house training on the use of Benefits Plus: 10 in- house individual sessions, 2 Webcast sessions.
August 25	Plans must enter all Plan specific information in Benefits Plus. Plans will be unable to make changes after this date so that Health Insurance Specialists can review the information. If changes need to be made, we will unlock Plan access on a case-by-case basis.

Additions to Benefits Plus data input will include those necessary for the updated presentation of information within the OPM Plan comparison tool located at [www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/](http://www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/).

For Password resets please contact [Kaisha.Elphick@opm.gov](mailto:Kaisha.Elphick@opm.gov).

For technical questions or if you have suggestions on changes to Benefits Plus, please send them to [Stephen.Rappaport@opm.gov](mailto:Stephen.Rappaport@opm.gov) and [Maria.Bianchini@opm.gov](mailto:Maria.Bianchini@opm.gov).

**Attachment IV**  
**2018 Organ/Tissue Transplants and Diagnoses**

**Table 1: Required Coverage**

<b>I. Solid Organ and Tissues Transplants: Subject to Medical Necessity</b>
Cornea
Heart
Heart-lung
Kidney
Kidney - Pancreas
Liver
Pancreas
Autologous pancreas islet cell transplant ( as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs such as the liver, stomach, and pancreas) or isolated small intestine
Lung: Single/bilateral/lobar
<b>II. Blood or Marrow Stem Cell Transplants: Plan’s denial is limited to indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, staging or the diagnosis.</b>
<b>Allogeneic transplants for:</b>
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
Severe combined immunodeficiency
Severe or very severe aplastic anemia
<b>Autologous transplants for:</b>
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia
Hodgkin's lymphoma – relapsed or refractory



Non-Hodgkin's lymphoma – relapsed or refractory
Amyloidosis
Neuroblastoma
<b>III. Blood or Marrow Stem Cell Transplants:</b>
<b>Allogeneic transplants for:</b>
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)
<b>Autologous transplants for:</b>
Multiple myeloma
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors
<b>IV. Blood or Marrow Stem Cell Transplants: Subject to Medical Necessity.</b>
<b>Autologous transplants for:</b>
Breast cancer
Epithelial ovarian cancer
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)
Advanced Childhood kidney cancers
<b>V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning with a diagnosis listed under Section II): Subject to Medical Necessity.</b>
<b>VI. Tandem transplants: Subject to medical necessity</b>
<b>Autologous tandem transplants for:</b>
AL Amyloidosis
Multiple myeloma (de novo and treated)
Recurrent germ cell tumors (including testicular cancer)

**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 2017?	
	Yes	No
<b>Blood or Marrow Stem Cell Transplants</b>		
<b>Allogeneic transplants for:</b>		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
<b>Non-myeloablative allogeneic transplants for:</b>		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin’s lymphoma		
Non-Hodgkin's lymphoma – relapsed or refractory		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease		
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		

<b>Blood or Marrow Stem Cell Transplants</b>	<b>Does your plan cover this transplant for 2017?</b>	
	<b>Yes</b>	<b>No</b>
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
<b>Autologous transplants for:</b>		
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		

**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.

	<b>Does your plan cover this transplant for 2017?</b>	
	<b>Yes</b>	<b>No</b>
<b>Solid Organ Transplants</b>		
Allogeneic islet transplantation		
<b>Blood or Marrow Stem Cell Transplants</b>		
<b>Allogeneic transplants for:</b>		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucopolysaccharidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
X-linked lymphoproliferative syndrome		
<b>Autologous transplants for:</b>		
Ependyoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

**Attachment V**  
**2018 Technical Guidance Submission Checklist**

Topic/Attachment Number	In Proposal Yes/No/NA	Worksheet Completed Yes/No/NA
FEHB Carrier Contracting Official (Attachment I)		
Preparing Your 2018 Brochure (Attachment III)		
2018 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 (Attachment III)		
Technical Guidance Submission Checklist (Attachment V)	N/A	

*Please return this checklist with your CY 2018 benefit and rate proposal*

**Attachment VI**  
**2018 FEHB Drug Formulary Template**

See *Drug Formulary Template* attached with listserv