2006 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Please send the following material by **May 31, 2005:**

Experience-rated Plans

- A copy of a fully executed employer group contract (i.e., *certificate of coverage)* that the greatest number of your subscribers purchased in 2005.
- You must file your proposed benefit package and the associated rate with your State, if a filing is required by the State. 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:

1. Benefits that are covered in one package but not the other;
2. Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other; and
3. The number of subscribers/contract holders who currently purchase each package.

Community-rated Plans

- A copy of a fully executed community benefits package (a.k.a. master group contract or subscriber certificate) including riders, as well as copays, coinsurance, and deductible amounts (e.g. prescription drugs and durable medical equipment) purchased by the greatest number of your subscribers in 2005. The material must show all proposed benefits for FEHB for the 2006 contract term, except for those still under review by your State. We will accept the community benefits package that you *project* will be sold to the majority of your non-Federal subscribers in 2006. If you offer a "national plan" then you need to send us copies of your community benefits package for each State that you cover.

  Note: Your FEHB rate must be consistent with the community package it is based on. 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 benefit proposals. Your benefit proposal should include:

- Benefit package documentation;
- A plain language description of each proposed benefit; and
- A signed contracting officials' form.
  - 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 benefits 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**, and you obtain approval and submit approval documentation to us by **June 30, 2005**. If the State grants approval by default; i.e., it does not object to proposed changes within a certain period after it receives the proposal, please so note. The review period must have elapsed without objection by June 30.

    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.

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

Carrier Contracting Officials

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

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

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

for ____(Plan)

Enrollment code(s):____

Typed name	Title	Signature	Date

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

____
(Typed name and title)

____________________ ____________________
(Phone number) (FAX Number)

____
(Email address)

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

Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2006 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 other areas. Please consider expanding your service area for FEHB to all areas in which you have authority to operate. This will allow greater choice for our customers. **You must submit in an 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 at a later date. 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. We may grant an extension for submitting supporting documentation to us until June 30.

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

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

Important Notices

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

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

Instructions

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; and
- Your ability to provide contracted benefits.

Please provide the following information:

- **Describe 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.

- **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, 2005. 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 Area 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.

Since benefits may be restricted for non-emergency care received outside the service area where plan providers are generally located, your proposal must include language to clearly describe this additional geographic area as well as your service area.

Re-designation as a Mixed Model Plan:

This section applies only if you applied as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) and, since the application approval, you now offer both types of providers. Please explain whether you are adding a GPP or IPP provider system.

If you are adding a GPP component to an existing IPP delivery system, you will need to demonstrate that the group includes "at least three physicians who receive all or a substantial part of their professional income from the HMO funds and who represent one

or more medical specialties appropriate and necessary for the population proposed to be served by the plan." (5 USC 8903(4)(A))

Also answer the following questions:

1. Do you require all members of a family to use the same delivery system, or may some members of a family use GPP doctors while others use IPP doctors?

2. If you restrict members to one type of delivery system, what must a member do to change from one delivery system to the other during a contract term? How soon after it is requested would such a change be effective?

3. If a member wants to change primary care doctors (centers for GPPs), what must the member do? Is there a limit on the number of times that a member may change primary care doctors (centers)? If yes, will you waive the limit for FEHB members? How soon is a requested change effective?

Federal Employees Health Benefits Program Statement About Service Area Expansion

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

We have prepared the attached service area expansion proposal in accordance with the requirements found in Part Two, Changes in Service Area, of the Technical Guidance for 2006 Benefit and Service Area Proposals. Specifically,

1. All provider contracts have hold harmless provisions in them.

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

<u>Part Three</u> – Benefits for Newly-Approved HMOs

The FEHB 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 2006. The policies include the following:

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

1. **<u>Mental Health and Substance Abuse</u>** - Mental health and substance abuse coverage must be identical to traditional medical care in terms of deductibles, coinsurance, copays, and day and visit limitations. We expect plans to make patient access to adequate mental health services available through managed care networks of behavioral health care providers and innovative benefits design.

2. **<u>Maternity and Mastectomy Admissions</u>** - All plans must provide for maternity admission lengths of stay 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 inpatient basis and remaining in the hospital for at least 48 hours after the procedure.

3. **<u>Pre-existing Conditions</u>** - Pre-existing condition limitations are not permitted for any required benefits.

4. **<u>Point of Service Product</u>** - 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. **<u>Infertility treatment</u>** - We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. <u>This requirement does not include related prescription drugs.</u> 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. **<u>Immunizations for Children</u>** - All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums.

7. **<u>Transplants</u>** - All plans must provide coverage for all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney

transplants. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. You may limit coverage for these three conditions to services provided at a recognized Center of Excellence and received in clinical trials, as long as both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but you must provide necessary follow-up care to the experimental procedure.

All plans must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors, benefits must be coordinated according to NAIC guidelines, the same as for any other benefit. You may exclude from your FEHB benefits other transplants if they are not part of the community benefit package we purchase, and as State law permits.

8. **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.) or vision care (refractions, lenses, frames, etc.) from community-rated plans when these benefits are a part of the core community benefits package that we purchase. Additionally, we will consider hearing care benefits (testing for and provision of hearing aids). It is important that your 2006 brochure language clearly describes your coverage.

9. **Prescription Drugs** - All plans must provide at least a minimum coverage level for all medically necessary drugs that require a prescription, including insulin. Prescription drug deductibles may not exceed $600 and coinsurance may not exceed 50 percent. We don’t allow lifetime or annual benefit maximums on prescription drugs. You must cover disposable needles and syringes used to administer covered injectables, IV fluids, and medications for home use, growth hormones, and allergy serum. You must also provide benefits for "off-label" use of covered medications when prescribed in accordance with generally accepted medical practice by a Plan doctor. You may not exclude drugs for sexual dysfunction. You may place dollar or dosage limits on drugs for sexual dysfunction. You may use a drug formulary as long as the Plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. You cannot have a closed formulary. You cannot use the formulary as a means to exclude benefits for drug coverage required through the FEHB Program. We don’t allow blanket exclusions of broad categories of drugs such as "non-generics," or "injectables".

10. **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 copays or coinsurance of up to 50 percent. 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 the Office of Personnel Management the authority to preempt State laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not preempt State laws that increase our enrollee's benefits unless the State mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

Department of Health and Human Services (HHS) Benefits

All HMOs *must* offer certain benefits that the Department of Health and Human Services (HHS) requires for Federally qualified plans, *without limits on time and cost*, except as prescribed in the Public Health Service Act and HHS regulations. These required benefits include:

1. Non-experimental bone marrow, cornea, kidney, and liver transplants;

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

3. Family planning services, including all necessary non-experimental infertility services, to include artificial insemination with either the husband's or donor sperm. You don't have to cover the cost of donor sperm. You may exclude other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) to the extent permitted by applicable State law;

4. Pediatric and adult immunizations, in accordance with accepted medical practice;

5. Allergy testing and treatment and allergy serum;

6. Well child care from birth;

7. Periodic health evaluations for adults;

8. Home health services;

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

10. Surgical treatment of morbid obesity, when medically necessary; and
11. Implants – you must cover the surgical procedure, but you may exclude the cost of the device.

Federally qualified community-rated plans offer these benefits at no additional cost, since the cost is covered by the community rate. Community-rated plans that are not Federally-qualified should reflect the cost of any non-community benefits on Attachment 2 of their rate calculation. If there is no additional cost, the cost entry should be zero.

Part Four - Preparing Your Proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA)

High Deductible Health Plans (HDHP)

The U.S. Department of The Treasury (Treasury) requires that an HDHP have an annual deductible of at least $1,000 for self only coverage and annual out-of-pocket expenses (deductibles, co-payments, etc.) that do not exceed $5,100. For family coverage, an HDHP must have an annual deductible of at least $2,000 and annual out-of-pocket expenses that do not exceed $10,200. **Both the deductible minimum and out-of-pocket expense maximums are indexed for inflation**. Because we anticipate an increase in the minimum annual deductible amount, we will not accept proposals with deductibles less than $1,100 for self only and $2,200 for self and family coverage.

An HDHP may not provide benefits for any year until the member meets the annual deductible. However, a plan may offer first-dollar coverage for preventive care (or have only a small deductible) and still be defined as an HDHP. Additional Treasury guidance may be found at: http:/www.treas.gov/offices/public-affairs/hsa/. The following guidance applies for health plans proposing to offer an HDHP for 2006:

- High Deductible Health Plans (HDHP) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
- HDHP proposals should reflect that these choices will be open to everyone within the defined service area eligible to enroll in the FEHB Program.
- We will evaluate HDHP proposals in accordance with OPM premium rating guidelines.
- Your HDHP proposal must include a Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) component. The HRA component is available only to enrollees who are ineligible for an HSA.
- Proposals should reflect costs only, including the amounts the Plan will deposit/credit to the enrollee's HSA or HRA.
- Proposals should clearly describe the health benefits that the Plan offers, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.
- Proposals should include a description of all preventive care benefits and any applicable out-of-pocket amounts.

- Proposals should include a description of catastrophic limitations and how they apply to self only and family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).

- You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.

- Proposals should include a description of the HDHP health education program components that the Plan offers.

- Proposals should also include a description of the consumer education program the health plan intends to provide including appropriate use of HSA/HRA funds for necessary medical expenses.

- Proposals should include a complete description of the geographic service area.

- Proposals should include a certification that the State in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.

Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA)

Tax-favored HSAs are available to those who have an HDHP. However, HSAs are not open to people enrolled in Medicare or another medical benefit health plan (with certain exceptions as provided in Treasury's guidance). Therefore, health plans that are proposing HDHP/HSAs should also propose an HRA of equivalent value for enrollees who are ineligible for an HSA. The HRA could be used for medical expenses, including Medicare premiums. The following guidance applies for health plans proposing to offer an HDHP and HSA/HRA for 2006:

- Health Savings Accounts (HSA) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury Guidance.

- Health Reimbursement Arrangements (HRA) must meet applicable Treasury requirements.

- Fiduciary institutions for HSAs and HRAs must be banks or other non-bank trustees or custodians approved by Treasury. However, the health plan may choose to manage the HRA component in-house.

- Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities.

- Health plan proposals must include assurances that its fiduciary is financially stable. At a minimum, a major financial rating service must rate the trustee/custodian in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level.

- Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.

- Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRA financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.

- HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how the Plan will manage and monitor them, including accounting for earned interest.

- Proposals should state how fees and ancillary charges to individual accounts will be paid for.

NOTE: Final brochure language is not required with your May 31 submission. OPM will work with you to jointly develop brochure language.