FEHB Program Carrier Letter
Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2015-03 (b) **Date: March 17, 2015**

Fee-for-service [3] Experience-rated HMO [3] Community-rated HMO [2]

Subject: 2016 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, 2016 through December 31, 2016. The Federal Employees Health Benefits (FEHB) carrier guidance is issued in two documents:

1. The annual Call Letter Carrier Letter 2015-02 dated March 16, 2015 provides guidance on OPM's initiatives for the 2016 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, 2015:** Please send your community benefit package and most commonly offered group benefit package.
- **Due by May 31, 2015:** 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.
- **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 2016 brochure. See Attachment II - Preparing Your 2016 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 the cost and improve quality of care, and improve the health of the enrolled population. Benefit proposals must be cost neutral in that proposed benefit enhancements must be offset by proposed reductions so that premiums are not increased due to

benefit changes. OPM will make exceptions to this requirement for proposed benefit changes in response to the Medicare and Applied Behavior Analysis (ABA) initiatives.

Enclosed is a checklist (Attachment IV) 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.

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 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.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2016 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. 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, 2015,** and you obtain approval and submit approval documentation to us by **June 30, 2015**. 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, 2015.

B. The Federal Employee Health Benefit Plan has three enrollment types:

1. Self Only (codes ending in 1 and 4) - A Self Only enrollment type only provides benefits for the enrollee.
2. Self Plus One (codes ending in 3 and 6) - A Self Plus One enrollment type will be available for enrollment during the annual Open Season beginning November 9, 2015, with enrollments effective in January 2016.
    a. Self Plus One enrollment type only provides benefits for the enrollee and one designated eligible family member. See website: http://www.opm.gov/healthcare-insurance/healthcare/eligibility/ for eligibility criteria.
    b. Catastrophic maximum, deductibles, and wellness incentives should be for dollar amounts that are less than or equal to corresponding benefits in Self and Family enrollment.
    c. Copays, coinsurance, and benefits, limitations, and exclusions must not vary by enrollment type.
    d. 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.
3. Self and Family (codes ending in 2 and 5) - A Self and Family enrollment types provides benefits for the enrollee and all eligible family members.

C. 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, 2015.

D. 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[1] .

II. Experience-rated Plans

A. Please send the following by May 8, 2015:

1. A copy of a fully executed employer group contract (i.e., *certificate of coverage*) that on-Federal subscribers purchased in 2015.

B. Please send the following by May 31, 2015:

1. 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.

2. Attach a chart displaying the following information:

a. Benefits that are covered in one package, but not the other,
b. Differences in co-insurance, co-pays, numbers of days of coverage and other levels of coverage between one package and the other.
c. 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. However, other benefits may be reduced or not covered if there is an impact on premiums.

[1] HMO Act of 1973, 42 U.S. Code Section 300e.

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 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, 2015 (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 2015. The material must show all proposed benefits for FEHB for the 2016 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 2016. If you offer a plan in multiple states please send us your community benefit package for each state that you plan to cover.

2. 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 2016 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.

A. Service Area Expansion - You must propose any service area expansion by May 31, 2015. We may grant an extension for submitting supporting documentation to us until June 30, 2015.

B. 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.

IV. 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.

V. 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 should 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 on August 31, 2015. 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.

C. 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 2016 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 2016. 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. Implementing Self Plus One coverage;
2. Encouraging participation in Medicare Part B;
3. Expanding access to care;
4. Optimizing delivery of prescription drug benefits;
5. Promoting preventive care and wellness;
6. Advancing quality and value of care; and
7. Preparing for the Excise Tax in 2018.

However, we are not issuing further guidance for the Call Letter initiatives on optimizing delivery of prescription drug benefits and advancing quality and value of care, as we feel the instructions in the Call Letter are sufficient. Please address all of the Call Letter initiatives in your proposal. Please refer any questions to your contract specialist.

I. CALL LETTER INITIATIVES

A. Self Plus One Enrollment Type:

Beginning with Open Season on (November 9, 2015, federal employees, annuitants, and tribal employees will be able to enroll in Self Plus One enrollment type, which will be effective in January 2016. See *Part One: Preparing Your Benefit Proposal of this Technical Guidance* for additional instructions for the three enrollment types available in 2016.

B. Encouraging Participation in Medicare Part B:

Your benefit design should encourage individuals for whom Medicare is primary to participate in both Medicare Part B and the FEHB Program. You should provide a plan to OPM that focuses on educating your members and prospective members on the additional benefits you offer to those that are enrolled in Medicare Part B.

We want to see that there is a clear incentive for members to enroll in Medicare Part B. If incentives may not currently be adequate in your plan, we are seeking enhancements that provide value to dually enrolled Medicare and FEHB Program members. These may include waivers or reductions of cost sharing. We are not encouraging plans to pay Medicare premiums directly on behalf of members; however, FEHB Program members may use Health

Reimbursement Arrangement (HRA) funds to pay some or all of their individual Medicare Part B premiums. If this applies to your plan, it should be made clear to the Plan's Medicare population. We are aware that some carriers offer Medicare Part C (Medicare Advantage) Plans. If you offer a Medicare Advantage product, you should explore how it may better coordinate with your FEHB Program coverage to incentivize Medicare Part B enrollment. Your proposal should be included in your response to the Call Letter.

C. Expanding Access to Care:

1. Applied Behavior Analysis (ABA) - OPM is strongly committed to expanding access to ABA services for children with autism. Our goal is to ensure that family members needing this care have the option to select a plan offering it. We recognize that provider supply, licensure requirements, and state insurance mandates for ABA vary, but note that the number of certified professionals available to deliver this benefit has expanded significantly since 2012. Additionally, over three-quarters of the states have approved private insurance mandates to provide ABA. This section provides further program management details for carriers to consider when developing benefit proposals designed to achieve OPM's policy goal at an affordable cost.

   Carriers adding ABA coverage may do so as either a habilitative service or mental health benefit. Carriers that offer ABA as a habilitative service may propose a fully case-managed benefit with prior authorization, and/or an in-network benefit only. If a Carrier classifies ABA as mental health, then it must ensure that parity rules are respected in terms of pre-authorization, case management requirements, visit or age limits, and the availability of out of network benefits. National carriers electing to phase in benefits should include a phasing plan with their proposal.

   Our market research also indicates that common benefit management strategies can help ensure qualified providers, define service intensity, and contain costs. Health plans and behavioral health vendors successfully delivering this benefit describe key components of effective care as follows:

   a. Promote early, accurate diagnosis,
   b. Intervene as early as possible in the child's life,
   c. Develop treatment plans with clear therapeutic milestones and measurable objectives,
   d. Establish tiered specialty networks of licensed providers and supervised direct service professionals; ideally overseen by a specialized care management team [2],
   e. Train families/caregivers to sustain improvement beyond scheduled sessions,
   f. Coordinate care so that covered benefits are not utilized in lieu of educational services provided by community agencies, residential facilities, or schools, and
   g. Schedule frequent re-evaluation to assess progress, evolving needs, or failure to improve.

   Families may also benefit from transition plans to facilitate access to an appropriate continuum of services once active ABA treatment ends. Additionally, carriers may need

[2] http://www.bacb.com/index.php?page=100772

to update their utilization review and disputed claims processes to ensure that fully qualified professionals are available to perform reviews when indicated.

2. Infertility Benefits: FEHB carriers offer a range of diagnostic and therapeutic benefits for infertility. OPM welcomes this diversity in coverage as an important distinguishing feature that allows members to choose a plan that best meets their medical needs. However, many carriers have not updated their coverage language to ensure that all FEHB members with a qualifying condition can understand how the benefit applies to them. In particular, several carriers reference heterosexual spousal relationships in brochures, or omit information on male infertility. We ask that you review and refresh terminology as appropriate, consistent with FEHB coverage of same sex spouses outlined in Carrier Letter 2013-20.

   Brochures should include a definition of infertility, age limits if medically indicated, relationship or gender specifics as appropriate, prior-authorization or medical necessity criteria as applicable, a list of covered infertility services (including drugs, diagnostic testing, cycle limits), plus exclusions. For purposes of illustration, we call your attention to selected excerpts from contemporary language used by commercial and/or government plans:

   > *Infertility is the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the female is over the age of 35. … For women without male partners or exposure to sperm, infertility is the inability to conceive after six cycles of Artificial Insemination or Intrauterine Insemination performed by a qualified specialist using normal quality donor sperm. These 6 cycles (including donor sperm) are not covered by the plan as a diagnosis of infertility is not established until the cycles have been completed.*
   >
   > *Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.*
   >
   > *Procedure is covered if the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other.*

   Examples of covered infertility services for men may include, but are not limited to, medically necessary hormone testing, semen analysis, sperm function testing, chromosomal analysis, medical imaging, surgical correction of genitourinary tract abnormalities, and sperm extraction.

   Finally, we emphasize that OPM's interest is only to make certain that members understand available infertility coverage, not to establish any coverage requirement.

3. Transgender Services: Beginning with 2016 brochures, Plans should describe their covered benefits for gender transition along with any excluded services, and list any applicable prior authorization requirements or age limits.

D. Preventive Care and Wellness:

1. Wellness and Preventive Screening: OPM strongly encourages Plans to explore innovative approaches to communicate wellness and preventive services, to engage members to participate, and to incentivize steps to adopt and maintain healthy behaviors. Success may require multiple strategies aimed at both providers and enrollees. To improve participation, we invite Plans to consider promoting an annual visit which includes wellness and preventive services, if not doing so already. Depending on plan benefits, these services may be incorporated into the Annual Physical Exam or organized separately as an annual wellness visit. Recent reports indicate these visits are gaining acceptance among providers and consumers as a means to update health status, provide tailored health advice, schedule preventive services, and initiate behavior modification referrals. We further note that this approach could also improve Plan performance on relevant HEDIS measures. Another popular option involves offering wearable activity trackers as member incentives with the added benefit of reinforcing healthy lifestyle choices.

2. Immunizations: As a reminder, the Affordable Care Act also requires coverage of immunizations recommended by the Advisory Committee on Immunization Practices[3],[4] of the Centers for Disease Control. Plans should review these requirements at least annually for changes.

3. Cardiovascular Risk Reduction: To reduce cardiovascular risk, we continue to stress attention to blood pressure control and promotion of FEHB benefits for tobacco cessation. Helping members understand the risk of heart attack and stroke associated with high blood pressure, encouraging providers to use evidence based treatment protocols, and emphasizing adherence to prescribed medications will enhance our collective progress toward this important health outcome. Key insights from OPM's collaboration with the Million Hearts[5] initiative include:

    a. Every 20/10 mm Hg increase in blood pressure doubles the risk of dying from ischemic heart disease and stroke,
    b. Managing blood pressure can reduce the incidence of heart attacks by 20-25%, strokes by 35-40%, and heart failure by more than 50%,
    c. Effective medications are available as generics, and protocols for dosing adjustment and follow up can be readily incorporated into clinical practice workflow. (See Million Hearts protocols: http://millionhearts.hhs.gov/resources/protocols.html),
    d. Lifestyle modifications are essential to prevent and manage hypertension. These include losing weight, increasing physical activity, and adopting the Dietary Approaches to Stop Hypertension (DASH) eating plan, and
    e. Managing hypertension requires medication adherence, yet a significant percentage of those on medication don't take it as prescribed.

[3] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
[4] http://www.cdc.gov/vaccines/hcp/acip-recs/index.html
[5] http://millionhearts.hhs.gov/index.html

Consistent reinforcement of these messages in member and provider communications through targeted plan or Pharmacy Benefit Manager (PBM) outreach will improve population health, reduce long term complications, and assist plans with HEDIS performance.

E. Preparing for the Excise Tax in 2018:

Title IX, Subtitle A, section 9001 of the Affordable Care Act (ACA), establishes an excise tax on high cost employer-sponsored health coverage. Beginning Plan year 2018, a forty (40) percent excise tax will be assessed to health plans as described below. The excise tax applies to the overall aggregate plan cost/premium and contributions to flexible spending accounts, health savings accounts, and health reimbursement accounts. The Internal Revenue Service is expected to issue guidance for the administration of this excise tax including the method and timing for payment.

Plans that exceed the following annual limits must pay the tax of forty (40) percent of any dollar amount beyond the caps that is considered excess health spending:

- $10,200 for individual coverage
- $27,500 for self and spouse or family coverage

Plans must assess each of their Plan options to provide Contracting Officers with an initial three-year assessment of any changes needed if they will be subject to the excise tax 2018. Plans are strongly encouraged to review all aspects of cost control and develop innovative cost-reduction strategies with limited member impact. The three year strategic plan should be provided by year and include the current benefit costs and projected costs for the next three years based on changes they may be making to their FEHB plan offerings in advance of the 2018 plan year.

Examples of areas for review include:

a. Wellness incentives,
b. Dental and vision coverage,
c. Deductibles, catastrophic limits and copays,
d. Provider Networks,
e. Pharmacy management cost strategies such as a utilization management/formulary management,
f. Expansion of disease management programs to target and reduce chronic conditions,
g. Care coordination and long-term care management, and
h. Coverage for health-related travel costs to hospitals and other providers with better track records for quality care and health outcomes.

II. BENEFITS & SERVICES

A. Continued Focus from Previous Years

1. Organ/Tissue Transplants

There are no changes to the guidance on organ/tissue transplants for 2016. 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 III:

Table 1 – OPM's required list of covered organ/tissue transplants.
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 III - 2016 Organ/Tissue Transplants and Diagnoses.

2. 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.

3. 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.

4. Mental Health Parity

Carriers are required to comply with the provisions of the final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

5. 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.

6. 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.

7. Tobacco 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 lifetime dollar limits. Plans should include OTC drugs in their smoking cessation programs.

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

8. 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.

9. 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 2016 Federal brochure correctly describes this process.

10. 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?

11. 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.

12. Immunizations for Children

All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums. Preventive coverage such as immunizations should be covered without a copay.

13. 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 2016 brochure language clearly describes your coverage.

14. 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.

15. Advancing Quality and Value of Care

The Office of Personnel Management's (OPM) goal is to improve the health of the populations we serve, ensure the delivery of high quality consumer focused health care, and provide Federal employees and retirees with affordable insurance benefits. We evaluate FEHB plans on key parameters of clinical quality, customer service, resource use, and contract oversight. Many aspects of our performance assessment framework rely on measures from the Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Scoring measures against national benchmarks helps OPM recognize top plans in the program, inform enrollee choice, and link objective performance to profit factors. The first year of data collection using OPM's new measures hierarchy and pay for performance methodology will be in 2016.

We encourage carriers to become active in the Health Care Payment Learning and Action Network[6], which HHS has recently established as a means for promoting proven payment-for-value models among private payers.New plans should carefully review the below listed carrier letters for details. Plans may submit comments and questions to fehbperformance@opm.gov with a copy to their contract specialist.

- Carrier Letter 2013-01 Patient Centered Medical Homes within the FEHB
- Carrier Letter 2014-10 Updated FEHB Accreditation Requirements
- Carrier Letter 2014-15 ACA Medical Loss Ratio in the FEHB
- Carrier Letter 2014-19 Initial Guidance on FEHB Plan Performance Assessment
- Carrier Letter 2014-20 2015 CAHPS Program Requirements
- Carrier Letter 2014-24 Measuring Healthcare Quality in the FEHB
- Carrier Letter 2014-28 Additional Information on the Performance Areas for the FEHB Plan Performance Assessment
- Carrier Letter 2014-04 Methodology for the FEHB Plan Performance Assessment

[6] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

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 2016 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 or only upon request to current members and may send Explanations of Benefits, newsletters and other plan materials electronically.

Timeline: 2016 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 *2016 FEHB Brochure Handbook* via listserv
July 2	OPM will provide *2016 Brochure Creation Tool (BCT) User Manual*
July 9-11 & 14-18	OPM in-house training on the use of the Brochure Creation Tool
July 2 – August 28	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 22	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 Angelo Cueto at Angelo.Cueto@opm.gov or Andrew Chu at Andrew.Chu@opm.gov.

Attachment III
2016 Organ/Tissue Transplants and Diagnoses

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	**Reference**
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Call letter 2014-03
Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs such as the liver, stomach, and pancreas) or isolated small intestine	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, advanced, or 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:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
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 2016?	
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		
Scleroderma		
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 2016?	
Solid Organ Transplants	**Yes**	**No**
Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment IV
2016 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 2016 Brochure (Attachment II)		
2016 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 (Attachment III)		
Technical Guidance Submission Checklist (Attachment IV)	N/A	

Please return this checklist with your CY 2016 benefit and rate proposal