FEHB Program Carrier Letter

Health Maintenance Organizations

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2018-05 (a) **Date April 20, 2018**

Fee-for-service [n/a] Experience-rated HMO [4] Community-rated HMO [4]

Subject: 2019 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2019 through December 31, 2019. The Federal Employees Health Benefits (FEHB) Carrier guidance is issued in two documents:

1. The annual Call Letter (Carrier Letter 2018-01) dated, January 23, 2018 provides guidance on OPM's Initiatives for the 2019 benefits negotiation cycle.
2. The Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for HMO's provides more technical requirements for the items listed in the Call Letter.

A print version of the Automated Data Collection (ADC) was distributed by Listserv on March 2, 2018 in order to provide adequate time for question review prior to completion of the online tool. Submissions are due on April 30, 2018. We strongly recommend that you carefully read through the questions and gather all necessary information prior to inputting any data into the automated survey tool.

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: Preparing Service Area Changes
- Part Three: Benefits for HMOs

This year's deadlines are as follows:

- **Due by May 7, 2018:** Please send your community benefit package and non-Federal group benefit package we purchased.

- **Due by May 31, 2018:** 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 2019 brochure. See Attachment IV-Preparing Your 2019 Brochure.

It is incumbent upon you to ensure that each of your benefit proposals is in accordance with all applicable Federal laws and regulations. As stated in the Call Letter, we encourage all FEHB Carriers to thoroughly evaluate their Health Plan options to find ways to improve affordability and contain costs, as well as work to improve quality of care and the health of the enrolled population.

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

As a reminder, all carriers must adhere to the FEHB Guiding Principles available at 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 and to produce and distribute brochures in a timely manner. We look forward to working closely with you on these activities to ensure a successful Open Season again this year.

Sincerely,

Alan P. Spielman
Director
Healthcare and Insurance

Attachment I – FEHB Carrier Contracting Official
Attachment II-a – FEHB Benefit Difference Comparison Chart in-Network Benefits Spreadsheet
Attachment II-b – Benefit Change Worksheet
Attachment III – Benefit Clarification Worksheet
Attachment IV – Preparing Your 2019 Brochure and Benefits Plus Data Submission
Attachment V – 2019 Organ/Tissue Transplants and Diagnoses
Attachment VI – 2019 Technical Guidance Submission Checklist
Attachment VII – 2018 FEHB Drug Formulary Template

2019 FEHB Proposal Instructions

Part One: Preparing Your 2019 Benefit Proposal

I. All HMOs

A. The Community Benefit Package (Certificate of Coverage or Evidence of Coverage) is the commercial health plan sold to the majority 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 requirements.

B. Complete Attachment II-a – (Community Rated Plans Only) Benefit Difference Comparison Chart that compares your current FEHB benefit package to your proposed 2019 FEHB benefit package and the 2018 community benefit package that we purchased. Include on your chart:

1. Differences in copays, coinsurance, 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 31, 2018. Remember you must obtain approval and submit the documentation to us by June 30, 2018.

3. Please include whether riders are required within your *proposed 2019 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 2018 package and who are expected to purchase the 2019 package.

C. 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 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, 2018**, and you obtain approval and submit approval documentation to us by **June 30, 2018**. 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, 2018.

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.

D. The Federal Employees Health Benefits Program 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 only provides benefits for the enrollee and one designated eligible family member. See our website: 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 requires twice the dollar amount for Self Plus One or Self Plus Family for deductibles, catastrophic maximums, and premium pass-through contributions, that it does 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.

E. Please send the following material by May 31, 2018:

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:

a. A signed contracting official's form (Attachment I).

b. A comparison of your 2018 benefit package (adjusted for FEHB benefits) and your 2019 benefit package (Attachment II-a).

c. Benefit package documentation (see Benefit Changes below).

d. A plain language description of each proposed **benefit change** (Attachment II-b) and the revised language for your 2019 brochure.

e. A plain language description of each proposed **benefit clarification** (Attachment III) and the revised language for your 2019 brochure.

Note: If you anticipate significant changes to your 2019 benefit package, please discuss them with your OPM Health Insurance Specialist before you prepare your submission.

F. **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. Submit a copy of a fully executed employer group contract (i.e., *Certificate of Coverage or Evidence of Coverage*) by May 7, 2018, that the majority of non-Federal subscribers purchased in 2018.

B. **If you have not made changes to the level of coverage we already purchase,** then submit a statement to that effect. **If you have made changes,** submit a copy of the new benefit description as explained in **Benefit Changes** below. You must file your proposed benefit package (Certificate of Coverage or Evidence of Coverage) and the associated rate with your state, if your state requires a filing.

III. Community-rated Plans

A. We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions (as indicated in the Call Letter for the 2009 contract year). 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. You should also identify each of the differences between your current benefit package and the proposed offering, and include the impact on your community-rated price proposal.

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 rate instructions B. Submit a copy of a fully executed community-benefit package by May 7, 2018 (also known as a master group contract or subscriber certificate), including riders, copays, coinsurance, and deductible amounts that your non-Federal subscribers purchased in 2018. If the community benefit package is different from the FEHB's, also send a current copy of the benefit package that we purchased. Please highlight the difference(s) between the FEHB benefits and the package you based it upon. Note: If you offer a plan in multiple states please send us your community benefit package for each state that you intend to cover.

C. Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2019 contract term, except for those still under review by your state.

D. If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. If you have made changes, submit a copy of the new benefits description. If your state requires you to file this documentation, file the benefit package and the associated rate with the state first. We will accept the community-benefit package you project will be sold to the majority of your non-Federal subscribers in 2019.

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

IV. Benefit Changes

A. Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II-b as a template for submitting benefit changes. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if there is no rate change. Also, please respond to each of the items below in Section B, Information Required for Proposal in a worksheet format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incorrectly formatted submissions.

B. Information Required for Proposal:

1. Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2019 " section in plain language that is, in the active voice and from the member’s perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital co-pay, indicate whether this change will also apply to in-patient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, please show each change clearly.

2. Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefit package or if the change is one you submitted to the state for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2019.

3. State the actuarial value of the change and whether it represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If it is an increase, describe whether any other benefit offsets your proposal.

4. If the change is not part of the proposed benefit package, is the change a rider? If yes, is it a community rider (offered to all employer groups at the same rate)?

   a. State the percentage of your subscribers/contract holders who now purchase this rider and the percentage you project it will cover by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to cover under this rider and when will this occur?

   b. Include the cost impact of this rider as a bi-weekly amount for Self Only, Self Plus One, and Self and Family on Attachment II-b of your rate calculation. There is no cost impact, or, if the rider involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively, on Attachment II-b to your rate calculation.

   c. If the change requires new specialties of providers, furnish an attachment that identifies the new providers and network coverage.

V. Benefit Clarifications

A. <u>Clarifications are not benefit changes</u>. Please use Attachment III as a template for submitting benefit clarifications**.** Clarifications help members understand how a benefit is covered. If a benefit is a clarification, there should not be a change in premium.

B. <u>Information Required for Proposal</u>:

1. Show the current and proposed language for each proposed clarification and reference all portions of the brochure it affects. **Prepare a separate benefits clarification worksheet for each proposed clarification**. You may combine more than one clarification to the same benefit, but you must present each one clearly on the worksheet. Remember to use plain language.

2. Explain the reason for the proposed clarification.

Part Two: Preparing Service Area Changes

I. Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2019 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. **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 files 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, 2018. We may grant an extension for submitting supporting documentation to us until June 30, 2018.

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.

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.

C. We will assign new codes as necessary. In some cases, rating area or service area changes require a re-enrollment by your FEHB members. We will advise you if this is necessary.

V. Service Area Expansion Criteria

A. We will evaluate your proposal to expand your service area 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. <u>You must provide the following information:</u>

1. A description of the proposed expansion area in which you are approved to operate.

2. Provide the proposed service area expansion by ZIP Code, county, city or town (whichever applies) and 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.

3. 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.

4. Access to providers.

   Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have **executed** contracts. You must update this information by August 31, 2018. 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.

V. New Rating Area

A. We will evaluate your proposal for a new rating area (or splits a current service area) according to these criteria:

1. Why the area has been added;
2. How it relates to the previous service area (for example, the new rating area is a portion of an existing area that has been split into two or more sections); and
3. How the carrier's current enrollment will be affected by the addition of this new rating area.

VII. Service Area Reduction Criteria

A. We will evaluate your proposal to reduce your service area or enrollment area according to the following criteria:

1. We will accept the elimination of the corresponding service area, if you propose to eliminate an entire enrollment area.

2. Service area reductions should be associated with the following:

a. Significant loss of provider network
b. Poor market growth
c. Reduction applies to other employer groups
d. Reduction may apply to consolidation of two or more rating areas
e. Splitting rating areas.

B. <u>You must provide the following information:</u>

1. A description of the proposed reduced service and enrollment area:

   Provide the proposed service area reduction by zip code, county, city or town (whichever applies) and provide a map of the old and new services areas. Provide the exact wording of how you will describe the service area change in the brochure.

2. All state approvals that apply or are associated with the revised service area.

We will not accept service area proposals that result in service areas that are not contiguous or consistent with the residency of the Federal population or proposals that seek to provide services only to lower cost enrollees.

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 2019 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.

____

Signature of Plan Contracting Official

____

Title

____

Plan Name

____

Date

Part Three: Benefits for 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 2019. 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 policy goals and initiatives this year are:

A. Addressing the Opioid Epidemic
B. Prescription Drugs
C. Additional Plan Design and Benefit Management Initiatives
   1) Excise Tax
   2) High Deductible Health Plans
   3) Genetic Testing
D. Continuing Emphasis on Population Health

I. 2019 INITIATIVES

A. <u>Addressing the Opioid Epidemic</u>

Section II of Carrier Letter 2018-01 highlights OPM's expectation that all FEHB Carriers will strengthen their efforts to prevent opioid misuse and provides a listing of requirements that must be included in 2019 proposals. Additional information is provided below:

1. Provide a description of provider outreach regarding opioid risks, including efforts made to reach out to dental providers and other specialists such as obstetricians. Effective outreach should cover screening of patients for opioid use history, pathways for referral to treatment, as well as recommendations for Prescription Drug Monitoring System use.

2. Please provide the methods used for ensuring that enrollees are aware of opioid risks and other modalities for the treatment of pain. Include proposed plans to enhance the program.

3. Please use the chart below to describe any proposed quantity and prior approval limits on opioid medications, along with summary of safety edits for initial opioid prescription fills and high morphine milligram equivalent doses in the table below:

Proposed initiative start date	**Name of Opioid Preparation**	**Quantity Limit**	**Prior Approval**	**Safety Edit (incl. MME dose if applicable)**

4. Provide a summary of proposed efforts to promote safe disposal of prescription medications in the table below:

Type of program to promote safe disposal	Proposed program start date	Proposed # of prescriptions impacted	Cost to be incurred

5. Include proposed initiatives to further improve access to medication assisted treatment (MAT) in the table below:

Proposed initiatives to further improve access to MAT	Proposed initiative start date	# of products/providers affected/added
Adding qualified network providers		
Removing prior approval requirements		
Removing quantity limits		
Adjusting formulary placement		
Other proposed initiatives -		

6. Naloxone-based rescue agents are essential for the prevention of opioid overdose related deaths. OPM recognizes these rescue agents as preventive care. This will allow a corresponding copay waiver and remove any financial barriers that would prevent members from obtaining a naloxone-based product. This also allows high deductible health plans (HDHPs) to provide some naloxone-based rescue agents without a deductible under the preventive care safe harbor of Section 223(c)(2)(C) of the Internal Revenue Code. Use the chart below to describe any initiatives in place (or proposed) to facilitate access to naloxone-based rescue agents.

Proposed initiatives to facilitate access to naloxone based rescue agents	Proposed initiative start date	# of Naloxone - based products impacted
Reducing cost sharing - deductibles still apply		
Reducing cost sharing - deductibles do not apply		
Eliminating cost sharing - deductibles still apply		
Eliminating cost sharing - deductibles do not apply		
Removing prior approval requirements		
Other proposed initiatives -		

7. Please describe how you ensure the availability of addiction treatment programs for special populations such as pregnant women and youth.

8. List proposed changes to non-opioid pharmacy benefits for pain management in the table below:

Non-opioid prescription product	**Proposed initiative start date**	**Change to formulary tier**	**Removal of prior authorization**	**Removal of step therapy**	**Removal of quantity limit**	**Other changes**

9. Proposals must also include an assessment of the adequacy of current non-pharmacologic benefits for pain management, including physical therapy, chiropractic or other manipulative therapy, acupuncture, injection therapies, and cognitive therapies. Describe your proposed changes to non-pharmacologic benefits for pain.

10. Fraud and abuse in drug testing is a growing concern for FEHB health plans and the FEHB Program. Your proposal must include the following with your submission:
    a. Description of your concurrent utilization review process to pend suspicious claims for investigation;
    b. Description of your retrospective utilization review process to assess the effectiveness of your overall program to combat drug testing abuses; and
    c. Your maximum plan allowance for out-of-network drug testing and how it meets mental health parity.
    d. Your drug testing medical policy as of 2018 that is based on relevant clinical guidelines from organizations such as the American Society of Addiction Medicine (ASAM) or the Substance Abuse and Mental Health Services Administration (SAMHSA); Within the scope of evaluating your current policy, you may wish to review items including:
       - Appropriate medical necessity criteria for definitive (quantitative) and presumptive (qualitative) urine drug testing, including frequency limitations.
       - CPT and HCPCS codes that are covered for drug testing. For example, many plans are limiting drug testing coverage for presumptive drug testing to CPT codes 80305, 80306 and 80307 along with a limitation that the screen may only be performed once per date of service. Definitive drug testing is frequently limited to HCPCS codes to G0480, G0481, G0482, and G0483.
       - Medicare's strategy to zero-price CPT drug testing codes 80300-80377 (except 80305, 80306 and 80307).

B. <u>Prescription Drugs</u>

OPM expects carriers to have effective management programs in place for formulary, utilization, pharmacy network, medication therapy and chronic disease management to support the delivery of quality and affordable healthcare to members. Proposals should address the following:

- How medication management, pharmacy network and utilization management (UM) programs are coordinated to support chronic disease management.

- How the formulary is structured to support the various pharmacy programs. Include an updated copy of the pharmacy policy that guides formulary decision making.
- In addition, carriers must complete one of the two tables below:

For FEHB plans implementing a new medication management program:

Proposed Medication management program name	Projected # of members to be enrolled	Inclusion criteria	Exclusion criteria (if any)

For FEHB plans making enhancements to an existing medication management program:

List enhancements made to existing medication management program	Projected impact to existing program	Projected # of members to be enrolled	Inclusion criteria

C. Additional Plan Design and Benefit Management Initiatives

Excise Tax

Title IX, Subtitle A, section 9001 of the Affordable Care Act (ACA), which established an excise tax on high cost employer-sponsored health coverage, has been delayed until 2022.

To remain competitive, it is imperative for Plans to avoid this additional cost. Carrier Letter 2016-07 directed carriers who projected they would be subject to the tax in 2020 to submit a multi-year assessment of any changes needed to avoid the excise tax.

In an effort to avoid incurring an excise tax penalty in 2022, carriers should communicate the following with their proposal:

- All measures that have been undertaken as detailed in the response to Carrier Letter 2016-07
- Any new measures that have been implemented subsequent to the response to Carrier Letter 2016-07
- How the carrier anticipates the measures above will assist in addressing the potential impact of the excise tax.

High-Deductible Health Plans (HDHPs)

Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied. However, Section 223(c)(2)(C) (of the Internal Revenue Code) provides a safe harbor for the absence of a preventive care deductible. That section states, a "plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care." Certain maintenance medications may be beneficial to the health of the members and should be included as preventive. However, the IRS does not list what drugs are considered preventive. Please identify maintenance medications that you propose be included under the safe harbor to deductibles in HSA-qualified HDHPs.

Genetic Testing

Carriers should describe their approach to a comprehensive genetic testing strategy and outline covered benefits. Proposals must include:

- A copy of any relevant corporate policy framework or medical policy that guides genetics benefit management
- Specifics of covered testing
- A list of vendors (as applicable) used by the plan to provide market intelligence and/or genetics decision support, with a short description of the scope of each contract
- Any covered genetic counseling for members or test interpretation services for ordering providers

All new features being proposed for 2019 contracts should include estimated costs and offsets. (For example: cost of genetic decision support contract may be offset by more precise application of testing, or cost of cancer genetic testing may be offset by more informed drug treatment decisions.) Continuing benefit features should be so annotated whenever possible.

D. <u>Continuing Emphasis on Population Health</u>

In 2017, the U.S. Preventive Services Task Force (USPSTF) reviewed and updated 4 recommendations that already carried an A or B rating. In addition to addressing the USPSTF recommendations to refer qualifying adults to intensive behavioral counseling interventions for cardiovascular disease and diabetes prevention in their 2019 proposals, Carriers are reminded to review programs and benefits pertaining to:

- folic acid for the prevention of neural tube defects
- screening for preeclampsia
- screening for vision in children ages 6 months to 5 years, and
- screening and referral to comprehensive, intensive behavioral interventions to treat obesity in children and adolescents.

Carrier proposals should describe any benefit changes needed to align with these USPSTF updates. Useful references are included in Carrier Letter 2018-01.

FEHB carriers are required to follow CDC's Advisory Committee on Immunization Practices (ACIP) recommendations on immunizations. Carrier Letter 2018-01 reminds Carriers that ACIP recommends a dose of Tetanus, Diphtheria, and Pertussis (Tdap) vaccine during each pregnancy and highlights recent changes to the human papillomavirus (HPV) vaccination schedule. As applicable, proposals should also address any benefit or cost changes related to the new vaccine for the prevention of herpes zoster in adults aged >50 years and the requirement for many older adults to receive 2 types of pneumococcal vaccines. Additionally, changes in recommended age ranges for certain vaccines may have a cost impact and reduced schedules for other vaccines may provide a cost offset. Please complete the following table with your proposal. The vaccines listed are examples only. Your submission should include only your plan's specific changes.

Product	**Change**	**Effective date**	**Number of members impacted**	**Cost impact (+ or -)**	**Proposed outreach strategy**
Tdap	One dose during pregnancy	ongoing			
HPV	Two dose schedule for some recipients	ongoing			
Shingrix	Wider age range	Jan 1, 2019 or actual available date			
Zostavax	lower use as Shingrix becomes more widely utilized				
PPSV23/Pneumovax23	Adults 65+, order and timing interval	ongoing			
PCV13/Prevnar 13	Adults 65+, order and timing interval	ongoing			
MenB	2 dose schedule for Trumenba in young adults	ongoing			

Plan proposals should also describe communication pathways to ensure providers and members receive updated information about covered vaccinations. The most reliable method for tracking current and accurate immunization schedules on your intranet or consumer portal/website is through the use of content syndication from the CDC. Use of content syndication requires a one-time step that ensures an organization's website displays current schedules as soon as they are published or revised; instructions for the syndication code are available on CDC's website at (https://www.cdc.gov/vaccines/schedules/syndicate.html). CDC also offers technical assistance for implementing this form of content syndication (e-mail request to ncirdwebteam@cdc.gov.)

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 2019. 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 V:

Table 1 – OPM's required list of covered organ/tissue transplants. We have removed Autologous transplants for acute lymphocytic leukemia, since this diagnosis is not treated with autologous transplant.

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 V - 2019 Organ/Tissue Transplants and Diagnoses.

2. Healthy Maternity Outcomes

Carrier Letter 2017-04 strongly encouraged all plans to review their coverage of specialized medical foods for children and pregnant women with Phenylketonuria (PKU) to align with current clinical guidelines and help ensure optimal pregnancy outcomes. Given the rarity of this condition, OPM estimated the cost impact of adding coverage for medical foods for all PKU affected children and pregnant women across the FEHB program as minimal. Carriers proposing to update coverage for 2019 should include details with their proposals, along with justification for any proposed age limits.

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

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

Attachment II-b
[Insert Health Plan Name]: Benefit Change Worksheet #1
[Insert Subsection Name]

Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes on pages 6-7 to complete the worksheet.

Benefit Change Description

Applicable options:

High Option	☐	CDHP	☐
Standard Option	☐	HDHP	☐
Basic Option	☐		

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	
Reason	
Cost Impact / Actuarial Value	

Additional Questions:

I. Actuarial Value:
- (a) Is the change an increase or decrease in existing benefit package?
- (b) If an increase, describe whether any other benefit is off-set by your proposal.

II. Is the benefit change a part of the plan's proposed community benefits package?
- (a) If yes, when?
- (a) If approved, when? (attach supporting documentation)
- (b) How will the change be introduced to other employers?
- (c) What percentage of the plan subscribers now have this benefit?
- (d) What percentage of plan subscribers do you project will have this benefit by January 2019?

III. If change is not part of proposed community benefits package, is the change a rider?
- (a) If yes, is it a community rider (offered to all employers at the same rate)?
- (b) What percentage of plan subscribers now have this benefit?
- (c) What percentage of plan subscribers do you project will have this benefit by January 2019?
- (d) What is the maximum percentage of all subscribers you expect to be covered by this rider?
- (e) When will that occur?

IV. Will this change require new providers?
- (a) If yes, provide a copy of the directory which includes new providers.

Attachment III
[Insert Health Plan Name]: Benefit Clarification Worksheet #1
B. [Insert Subsection Name]

Please refer to Benefit Clarifications on page 7 to complete the worksheet.

Please Note: If the benefit clarification equates to a benefit change, you must indicate it as a benefit change on the Benefit Change Worksheet.

Benefit Clarification Description

Applicable options:

High Option ☐
Standard Option ☐
Basic Option ☐
CDHP ☐
HDHP ☐

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Attachment IV
Preparing Your 2019 Brochure and Benefits Plus Data Submission

I. Preparing Your 2019 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: 2019 Brochure Process
We will continue to use the brochure process we used 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 proposing new option.
July 2	Plans receive: *2019 FEHB Brochure Handbook.* Updated FEHB Brochure Handbook pages by Listserv.
July 13	OPM will provide *2019 Brochure Creation Tool (BCT) User Manual* in the BCT.
July 16 – 20	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 31	Plans must complete entering all data into Section 5 Benefits and update all plan specific information in the Brochure Creation Tool. Plans will be unable to make changes after this date so that Health Insurance Specialists can review PDF versions of plan brochures.
September 11	OPM sends brochure quantity form to plan 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 five 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 Kaisha Elphick at kaisha.elphick@opm.gov.

II. Benefits Plus Data Submission

Timeline: 2019 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:

DEADLINES	ACTIVITY
March 23	Section I of ADC due. Please note that Section I in the online questionnaire consists of two brief items. Section numbers will differ slightly from the PDF in the online tool.
April 1 - 15	Plans enter Table 1 Enrollment Data
April 30	Section II (Prescription Drugs), Section IV (Plan Design & Benefit Management), Section V (Population Health and Wellness), and Section VI (Plan Performance Assessment) of the ADC due.
May 31	Section III (Formulary Template) of the ADC due.
July 16-20	OPM in-house training on the use of Benefits Plus: 10 in-house individual sessions, 2 Webcast sessions.
August 31	Deadline for the plans to complete all data and plan specific updates within Benefits Plus. Plans will be unable to make changes after this date unless directed or approved by their Health Insurance Specialist.

OPM determines and communicates any additions to the required Benefits Plus data input that may be required for Plan Comparison Tool (www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/) enhancements via listserv by mid-July.

For Password resets please contact 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 and Maria.Bianchini@opm.gov.

Attachment V
2019 Organ/Tissue Transplants and Diagnoses
Table 1: Required Coverage

I. Solid Organ and Tissues 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
Kidney - Pancreas	Call Letter 2017-04
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 indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, or 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:	
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’s lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for 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.

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2019?	
	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) 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		
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 2019?	
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 VI
2019 Technical Guidance Submission Checklist

Topic/Attachment Number	In Proposal Yes/No/NA	Worksheet Completed Yes/No/NA
FEHB Carrier Contracting Official (Attachment I)		
Benefit Change Worksheet: worksheet for each change (Attachment II-b)		
Benefit Clarification Worksheet: worksheet for each clarification (Attachment III)		
Preparing Your 2019 Brochure (Attachment IV)		
2019 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 (Attachment V)		
Technical Guidance Submission Checklist (Attachment VI)	N/A	
2018 FEHB Drug Formulary Template	N/A	

Please return this checklist with your CY 2019 benefit and rate proposal

Attachment VII
2019 FEHB Drug Formulary Template

See *Drug Formulary Template* attached with listserv