FEHB Program Carrier Letter
All Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2009-08 **Date:** April 20, 2009

Fee-for-service [5] Experience-rated HMO [5] Community-rated HMO [6]

Subject: Federal Employees Health Benefits Program Call Letter

EXECUTIVE SUMMARY

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. Your proposal for the contract term beginning January 1, 2010 is due on or before **May 31, 2009**. Please send your proposal by **overnight mail, FAX, or e-mail** to your contract specialist. We expect to complete benefit and rate negotiations by **August 14, 2009** to ensure a timely Open Season.

Our key initiatives and policies this year are as follows:

1. We need your help to keep the FEHB Program affordable. During the upcoming negotiations, we will work closely with you to find ways to manage cost and utilization effectively.

2. We expect carriers to provide value-based benefits proposals. You must demonstrate that you have evaluated each proposed benefit change with respect to its effect on encouraging the most appropriate care.

3. In accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, all carriers are required to offer parity benefits for medical and surgical benefits and mental health or substance use benefits, including out-of-network benefits.

4. We expect carriers to review 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.

5. We expect carriers to continue health care cost and quality transparency initiatives, to broaden the use of health information technology (HIT), and to educate consumers on the value of HIT and transparency.

6. We encourage you to review your coverage guidelines with respect to preventable medical errors and to revise your policies so that you have arrangements in place to protect your members from balance billing.

I. INTRODUCTION

The hallmark of the FEHB Program is consumer choice and competition. We ask you to make innovative proposals for containing costs and keeping health care affordable for employees. We would like you to explore all reasonable options to constrain premium increases while maintaining a high quality benefits program.

We encourage you to submit innovative proposals that expand choice and promote better health through appropriate screenings and care management. Your benefit structure and delivery system should encourage members to receive appropriate care and reward the most effective physicians and hospitals. We expect FEHB plans to compete on the value and effectiveness of the benefits provided and the quality of delivery systems.

Your proposed benefit changes must be value-based. You must demonstrate that you have evaluated your proposed benefit changes with regard to their influence on promoting the most effective care (i.e., the care that generally produces the best health outcomes), not just with respect to cost.

We encourage you to continue your efforts to expand the use of health information technology (HIT) and decision support tools, and to make personal health records available to patients. We encourage you to analyze the comparative effectiveness of treatments for your members, provided the analysis is done in a manner that complies with HIPAA and HITECH privacy laws and regulations.

Your overall proposal should be cost neutral by offsetting any proposed benefit increases with corresponding medical savings or benefit reductions, with the exception of benefit changes necessary to meet the requirements for mental health parity discussed below. Your benefit proposal must be consistent with the policies outlined in this letter.

II. PROGRAM INTEGRITY

We list the FEHB Program Carrier Guiding Principles on our website at http://www.opm.gov/carrier. All FEHB carriers must adhere to these principles. We expect timely and accurate processing of claims, including coordination of benefits; prompt and accurate submission of actuarial and financial data, including accounting statements; and, we expect all plans to be well managed and financially secure.

III. FEHB PROGRAM POLICIES AND OBJECTIVES

A. Cost Effectiveness

We are asking for your best ideas to help contain premiums and promote quality. However, we will closely review proposals that merely provide for cost shifting without adding quality and value to your benefit design.

We also are asking you to remain committed to managing prescription drug costs by ensuring your benefit structure encourages sound decision-making. You should consider further strengthening proposals that encourage members to use generic drugs through reduced copays or coinsurance.

Coordination of benefits (COB) with Medicare is an important health plan responsibility and is an important part of your contract requirements. It helps you control health care expenditures and ensures accountability throughout the health care system. In order to keep enrollees' premiums as low as possible, you must make sure your Medicare billing practices support correct COB administration. We expect you to report on changes or improvements to your coordination of benefits activities with Medicare.

B. Quality and Value in Benefit Design

We expect you to make value-based benefit proposals. By that, we mean evidence-based proposals that use incentives to encourage members to adhere to benefit management guidelines while addressing the potential for reducing cost and utilization. We believe you can reduce medical costs and achieve better health outcomes by encouraging appropriate care and encouraging compliance with medically effective treatment plans and medication regimens. We encourage you to incentivize quality and better health outcomes through a variety of initiatives, including ways to reduce preventable hospital readmissions within a certain time period. We are encouraging proposals with incentives for patients to maintain compliance with drug and/or treatment regimens for chronic conditions such as high cholesterol, high blood pressure, asthma, and diabetes.

We recognize that FEHB carriers have been leaders in promoting preventive care and targeted disease management and care management programs. However, we ask that you expand your focus so that you examine your benefits from an evidence-based perspective. For instance, if one drug is equally as effective as another drug, but costs less, your benefit design could encourage your members to obtain the lower cost but equally effective drug. Many health plans have already utilized this concept by designing tiered medication copayment arrangements. Likewise, if one treatment or medication has been demonstrated to produce better health outcomes, your benefit design could encourage the use of that treatment or medication. Keep in mind that treatments that produce better health outcomes may reduce future healthcare costs.

We are again seeking proposals to expand consumer awareness of the importance of healthy lifestyles to avoid the onset of chronic conditions. In particular, we encourage you to provide us with proposals for health promotion actions to educate parents about childhood obesity. Obesity is a serious health concern for both children and adolescents and its prevalence has increased significantly in recent years. The American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care* includes measurements of body mass index beginning at 24 months and continuing to age 21. We urge you to work with your preferred providers and your members to bring greater awareness to this serious health

problem and help prevent childhood obesity and improve the health status of children who are already overweight and obese. We also encourage you to make health risk assessment (HRA) tools available to enrollees on your web site if you do not already provide this service. Please describe in detail the efforts you are making to encourage prevention and healthy lifestyles.

For benefit changes, other than those that represent adjustments due to inflation, describe how they will promote the most effective use of healthcare dollars to achieve the best possible medical outcome. Include in your description: changes in utilization you expect to achieve; how the change will affect health outcomes; your analysis of the comparative effectiveness of medical treatments covered under the affected benefit category; medical evidence evaluated as part of your proposal; and how you plan to analyze the resulting impact of the benefit change.

We will also consider separate proposals for health promotion or wellness incentives up to $250.00 per year per enrollee. Consumers can use these funds for health care costs not otherwise covered by the health plan, but which provide an incentive to improve or maintain their health or to comply with care coordination activities associated with controlling diseases such as diabetes, high blood pressure, obesity, etc. We encourage you to establish accounts through which members can earn credits through reduced utilization of services and/or increased compliance with healthcare regimens as incentives to use their healthcare dollars wisely.

C. Mental Health Parity

The requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 will take effect on January 1, 2010. If a plan provides both medical and surgical benefits and mental health or substance abuse benefits, and it provides coverage for out-of-network providers for medical or surgical benefits, the plan must also provide mental health or substance abuse benefits for out-of-network providers at a parity level.

We released Carrier Letter 2008-17 to provide guidance regarding the law and its effect on FEHB plans. FEHB plans now will be required to apply equivalent (or no more restrictive) financial requirements (coinsurance, co-payments, deductibles and out-of-pocket maximums) and treatment limitations (visit and day limits) to both out-of-network medical and surgical benefits and out-of-network mental health or substance use disorder benefits. When assigning financial requirements and treatment limits:

- In-network financial requirements and treatment limits for medical and surgical services should be the same as those applied to in-network mental health or substance use disorder benefits.
- Out-of-network financial requirements and treatment limits for medical and surgical services should be the same as those applied to out-of-network mental health or substance use disorder benefits.

- Plans may not apply separate cost sharing requirements (e.g. dollar limits) or treatment limitations (e.g. day limits) only to mental health or substance use disorder benefits in-network or out-of-network.
- Benefits for mental health or substance use disorders may not be equated with benefit limitations for other therapies, such as physical, speech or occupational therapy.
- Expenses incurred for mental health or substance use disorders may be applied to the same medical and surgical deductibles and catastrophic limits or to separate deductibles and catastrophic limits so long as they are for the equivalent amounts.
- We strongly encourage FEHB plans to offer combined deductibles and catastrophic limits which include expenses for both medical and surgical and mental health and substance use disorder services and you should provide a reasonable explanation and justification for not doing so.
- Plans must make information available to current or potential enrollees or contracting providers upon request, regarding the criteria used for making medical necessity determinations related to mental health or substance use disorder benefits.
- The reason for any denial of benefits, reimbursement, or payment for services must be made available to enrollees upon request.

What Must Be Covered?

- Plans must cover all categories of mental health or substance use disorders to the extent that the services are included in authorized treatment plans.
- Plans may manage care through referrals, prior authorization, treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs.
- Treatment plans should be developed in accordance with evidence-based clinical guidelines, and meet medical necessity criteria.
- Plans may continue to use managed behavioral healthcare organizations (MBHO) to implement or supplement their programs.
- MBHOs may maintain networks of providers for the plans and manage in-network and out-of-network services using prior authorization, treatment plans, and care coordinators. Alternatively, MBHOs may manage the care delivered by the plan's existing network providers and authorize appropriate out-of-network care.

Please consult with your contract specialist as you prepare your proposal. Your 2010 benefits must be in line with the requirements of the law.

D. Catastrophic Protection and Cost Transparency

The fundamental purpose of insurance is to protect against catastrophe. Health benefits also promote better health and provide reimbursement for preventive care and routine services, but we must ensure that enrollees receive sufficient coverage for medically necessary services and adequate protection against catastrophe. 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) describing the expenses that fall under it in all areas including medical, surgical, mental health and prescription drug benefits. In addition, please indicate completely what expenses are still the member's responsibilities after the member has reached the limit. If you have an out-of-network benefit, 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.

For 2010, we will clarify the FEHB brochure to make it easier for prospective enrollees to make comparisons regarding the catastrophic coverage offered by FEHB plans. Plans will be required to describe benefits that are not included in catastrophic limits. Also, if an enrollee has a choice of using an in-network benefit or out-of-network benefit, the brochure description should clearly describe the out-of-network benefit and the out of pocket cost associated with this benefit to allow enrollees to make an informed choice of provider.

E. Health Information Technology (HIT) and Transparency

We continue to support this healthcare initiative. It is important that FEHB Program carriers continue to be proactive in developing and implementing healthcare systems that use recognized interoperability standards including personal health records so that patient safety can be maximized and evidence based medicine can be administered.

We will continue to recognize and reward carriers that demonstrate their commitment to making the best use of HIT and fostering the greatest transparency regarding cost and quality. Please consult Carrier Letter 2009-04 for more information.

F. Preventable Medical Errors

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

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

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

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

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

G. Preventive Care Guidelines

The FEHB Program follows the guidelines on preventive care for children recommended by the American Academy of Pediatrics and the guidelines for adults recommended by the United States Preventive Services Task Force (USPSTF). Please review these guidelines to ensure your policies comply with the most recent updates. The guidelines may be found at the following web sites:
http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf
http://www.ahrq.gov/clinic/uspstfix.htm.

H. Technical Guidance for Proposals

By April 30, we will send specific requirements for submitting your benefit and rate proposals. By May 30, we will provide you with information on how to prepare

your brochures for 2010. As you prepare your benefit proposal, please review the effect of any proposed benefit changes on language throughout your brochure (e.g., cost sharing, catastrophic protection and lifetime maximums), and include your proposals for appropriate language changes in your May 31 submission.
As a reminder, you may only distribute brochures, provider directories or lists, and marketing materials or other supplemental literature that are prepared in accordance with FEHBAR 1652.203-70.

IV. OTHER ISSUES

We allow each FEHB Program plan to describe affinity products on the "non-FEHB" page of its brochure. Traditionally plans have used this page to describe supplemental dental and vision programs or other benefits that complemented the FEHB Program benefits. Since supplemental dental and vision benefits are now available to members through the Federal Employees Dental and Vision Insurance Program (FEDVIP), we encourage you to analyze the benefits that you are offering on this page. There may be other products that would be attractive to Federal members, such as short-term disability insurance coverage, health insurance coverage for dependents up to age 25, and health insurance coverage for domestic partners. If you have these types of other products to offer to your FEHB Program members, we encourage you to include them on the non-FEHB Program page of your brochure.

CONCLUSION

Discuss your benefit changes with your contract specialist before you submit your proposals. Proposed benefit changes must be cost-neutral, and any savings from managed care initiatives must accrue to the FEHB Program. You must indicate that you have evaluated each proposed benefit change from a value-based perspective. We will begin negotiations when we receive your proposals.

We look forward to receiving your timely benefit and rate proposals for the 2010 contract term. Thank you for your commitment to the FEHB Program.

Sincerely,

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