FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management
Insurance Services Programs

Letter No. 2010-06 **Date: April 7, 2010**

Fee-for-service [4] Experience-rated HMO [4] Community-rated HMO [3]

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 benefit and rate proposals for the contract term beginning January 1, 2011 should be submitted to us on or before **May 31, 2010**. Please send your proposals by **overnight mail, FAX, or email** to your contract specialist. We expect to complete benefit and rate negotiations by mid-August to ensure a timely Open Season. Our key initiatives this year are as follows:

1. We expect you to provide benefits for preventive care, immunizations, and screenings with no enrollee cost sharing.

2. We expect you to offer comprehensive smoking cessation benefits that include coverage for counseling, medications, multiple quit attempts, no annual or lifetime limitations and no enrollee cost sharing.

3. Plans are required to provide mental health and substance use parity benefits in accordance with interim final regulations issued on February 2, 2010.

4. 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 transplant donors.

5. We are again encouraging proposals from plans for Medicare coordination programs for annuitants within existing plan options. We are seeking pilot programs that coordinate FEHB benefits with those of Medicare Part B.

6. We again encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

7. We again encourage you to provide us with proposals for health promotion programs to educate enrollees about childhood obesity.

8. We expect you to enhance your efforts in promoting consumer awareness about healthy lifestyles and avoidance of the onset of chronic conditions and encourage you to provide proposals to expand incentives related to healthy lifestyles.

9. We expect you to continue to develop health care cost and quality initiatives and support the meaningful use of health information technology. We will be reviewing our current performance measurement process and existing measurement set with the goal of improving the use of measurement data in evaluating the FEHB program as well as developing a more rigorous set of measures addressing quality, resource use, and use of health information technology for dissemination to plans in 2011.

10. On March 23, 2010, the President signed into law the "Patient Protection and Affordable Care Act," Public Law 111-148. While many provisions of this law will not take effect until 2014, there are certain others that become effective before that time. Among those is the coverage of a dependent until age 26. The effective date of this provision is the first day of the plan year that is six months following enactment of the law. For the Federal Employees Health Benefits (FEHB) Program, that means January 1, 2011. The Office of Personnel Management (OPM) will take the necessary actions to comply with the new law by this effective date. We will provide you with additional information about the changes in the law in the near future. Information about health plan changes for the 2011 plan year will be available for employees and retirees on our website in time for the Open Season which begins in November.

I. Introduction

FEHB covers approximately 8 million lives: approximately 2.2 million active employees, 1.9 million annuitants, and the remainder spouses and other dependents. This program has withstood major changes in the health insurance market over the last fifty years. It has been able to keep premiums at or below industry averages and has retained choice of health plans in its diverse markets. The program is generally popular with federal employees. At the same time, there are some areas of concern. For example, prescription drug costs have risen sharply. Today, drug costs represent almost 30 percent of total FEHB costs.

The FEHB model is based largely on competition among plans as the driver of change with OPM encouraging plans to move in a certain direction consistent with government policy. However, many large employers demand the companies that insure their employees provide benefits through value-based purchasing, worksite wellness, and provider and employee incentive mechanism. Therefore, OPM is looking at ways in which the FEHB program can be enhanced through increasing effective competition among health plans; improving the efficiency of the program; addressing affordability issues; introducing more accountability; and, increasing the program's emphasis on wellness and prevention. We ask that you make innovative proposals for 2011 that will further increase consumer choice and improve the quality offered through their health care delivery systems.

We expect your benefit proposals to be consistent with the policies outlined in this letter. Proposals should be cost neutral by offsetting any proposed increases in benefits with the exception of changes necessary to meet the requirements for mental health parity, preventive services, smoking cessation, and value-based benefit designs that expand

consumer awareness about the importance of maintaining healthy lifestyles and receiving appropriate preventive care.

II. FEHB Program Benefits And Initiatives

A. Preventive Services

Our goal is to improve the health of federal employees, retirees and their dependents and potentially achieve medium to long term costs savings by incentivizing greater use of clinical preventive services. OPM is expecting proposals to cover preventive services, screenings, and immunizations with no cost sharing requirements (e.g. no copayments or coinsurance.).

Low utilization rates for cost-effective preventive services mean these services are not being used by the people who should be using them. Financial barriers are one of the leading factors why these services are not utilized. Enabling enrollees to obtain preventive services with no enrollee cost sharing should increase the number of enrollees who receive preventive services.

Another way to improve the overall health of the federal population is to remove restrictions to smoking cessation benefit programs. Stopping smoking has the single most beneficial effect on health because of its association with many cancers, heart disease, high blood pressure and other chronic diseases. Many plans currently include treatment programs; however, these programs include annual or lifetime coverage limits. These restrictions serve as a barrier to those who are current smokers and would like to stop. Research shows most smokers require multiple quit attempts to be successful. Therefore, we believe annual or lifetime limits for smoking cessation programs should be eliminated. Benefits for smoking cessation should be available with no copayments/coinsurance and not subject to deductibles, annual or life time dollar limits. Beginning in 2011, carriers shall offer standalone smoking cessation programs that cover up to four smoking cessation counseling sessions per quit attempt and two quit attempts per year. These programs shall also include coverage for appropriate prescription and over-the-counter drugs approved by the FDA to treat tobacco dependence without copayments and not subject to annual deductibles or annual or life time dollar limits.

New evidence shows children and adolescents can be effectively treated for obesity. Obesity continues to be a serious health concern for both children and adolescents and increases the onset of diabetes and other chronic diseases as adults. Approximately 32% of 2 to19 year old children and adolescents are overweight or obese. The USPSTF recommends clinicians screen children ages 6 to 18 years for obesity and refer them to programs to improve their weight status. We are encouraging proposals for programs that address weight control through healthy food choices, physical activity, and behavioral skill building, i.e., goal setting and self monitoring. Best practice guidelines for physical activity and nutrition may be found on the Centers for Disease Control and Prevention's website at www.cdc.gov/HealthyYouth.

We are also expecting carriers to enhance their efforts in promoting healthy lifestyles and providing tools enrollees can use to track their own health. We are encouraging

proposals for incentive programs that encourage enrollees to complete Health Risk Assessments (HRA) tools and to follow treatment plans designed to manage or improve their health. HRAs provide a unique emphasis on health education and behavior change and can lead to health risk reduction. Motivating and sustaining health behavior change is the key to improving population health, productivity and controlling health care costs. Please describe in detail the efforts you are making to encourage prevention and healthy lifestyles.

B. Bone Marrow/Stem Cell Transplant Donors

We are encouraging plans to increase their benefits on bone marrow/stem cell transplant to include benefits coverage for testing of up to four donors. Seventy percent of people do not have a donor in their family. There is no way to predict who will be a suitable match for a patient in need of a transplant without confirmatory testing and locating a donor is an essential part of the process. The average number of donors tested in a treatment case is 3.58. Currently, the patient has to pay for lab testing/DNA matching for their donors in order to obtain the best match for the optimal outcome. This cost is billed by the transplant center to the patient or insurance company. Many plans pay for these costs related to the actual donor; however, the costs incurred for the donors that do not match may or may not be covered by their health insurance.

The average donor related cost for the actual donor is less than $1,000; however, the average cost for donors not used for the transplant is approximately $2,200. Patients are usually required to pay the costs of a donor search upfront which causes a significant financial burden and potential time lag. At times, this barrier prevents a patient from proceeding or delays in transplant timing can lead to poor outcomes, increased complications and additional hospital stays which all result in increased costs. Therefore, we believe covering these additional donor costs will result in long-term savings to the program.

C. Medicare Pilots

We are encouraging the development of pilot programs that improve the value of coverage for annuitants through improved benefits coordination between FEHB and Medicare Part B. At present, plans effectively waive their cost sharing requirements for enrollees with Medicare Part B, which means Medicare/FEHB members typically receive first dollar (100%) coverage for many services. We do not support splitting risk pools for annuitants and active employees and believe that these pilots can demonstrate ways of stemming cost growth through strengthened benefits coordination.

OPM is encouraging proposals for pilot programs wherein participating carriers offer a sub-option for Medicare eligible annuitants as an alternate choice within their existing option(s). The sub-option may include premium pass-through accounts to be used solely for plans paying some or all of Medicare Part B premiums. The uniform contribution amount should provide an adequate incentive for eligible members to participate, but need not represent the full amount of Medicare Part B premiums. Individual Medicare premium amounts may vary based on consumer choice, penalties for failure to enroll in Medicare at the first opportunity, or increased premiums based on means testing.

Selected plans would offer a pilot for annuitants with Medicare B. Annuitants would be able to elect whether or not to participate. The health plan would pay for the Medicare Part B premiums and provide Medicare gap benefits. The Medicare/FEHB enrollee would not bear the cost of the Medicare Part B premiums but would continue to pay the health plan's normal out-of-pocket cost sharing. That means benefits would be essentially the same as those for non-Medicare enrollees. The intent of this demonstration is that, on average, this group of enrollees would pay less out-of-pocket because the plan's cost sharing requirements would be less than the Medicare Part B premiums. Plans may also consider proposing lower out-of-pocket cost sharing limits for Medicare/FEHB enrollees to encourage broader participation.

The pilot must offer a Medicare wrap-around benefit design with the same premium as the high, standard, or basic option for which it would be a sub-option. FEHB requirements that apply to all plans, such as mental health parity, also apply to the benefits offered in the sub-option. In exchange for paying all or part of Medicare Part B premiums, annuitants in the sub-option would have the same cost sharing requirement as all other enrollees without Medicare; that is, their benefit structure would mirror their active duty coverage. Participation in the program is voluntary; individual annuitants enrolled in plans offering a sub-option pilot must actively choose to participate in the pilot program.

We will be assessing each pilot's performance on a continuous basis and will make a decision after the second contract year whether to continue each pilot.

D. Assistive Technologies

We are again encouraging plans to consider proposals for enhanced 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, speech generating devices, and hearing aids, and to increase the dollar amounts for these benefits so that consumers have greater protection against these costs.

E. Health Care Quality

In previous years, we have asked carriers to develop health care cost and quality transparency initiatives, including supporting the use of health information technology (HIT) and educating consumers on the value of HIT. On January 20, 2010, we sent our annual carrier letters on HEDIS measurements for all HMO and Fee-For-Service (FFS) carriers. Since the FEHB program began collecting data on performance measurement roughly 10 years ago, carriers have demonstrated their ability and commitment to measuring the quality of care provided to their members each year. While we expect plans to continue these efforts, this year we plan to review our current system for assessing the quality of care our members receive with the goal of developing a more robust set of performance measures that will make your efforts to improve quality more transparent to OPM and FEHB enrollees.

Currently, FEHB HMO carriers and FFS carriers collect and report data on a subset of HEDIS measures used by the National Committee for Quality Assurance (NCQA) to measure health plan quality. OPM contracts with NCQA to collect this data from plans and submit the data to OPM for posting on the FEHB website. Using this process, FEHB plans could meet their

requirements for NCQA accreditation and for FEHB performance measurement. Historically, the subset of HEDIS measures selected by OPM was restricted only to those measures used by NCQA for accreditation scoring. These measures primarily fall under NCQA's "Effectiveness of Care" measures and are basic, validated measures of health care quality.

While our current quality measures have been extremely valuable to OPM and enrollees, we want to ensure that our measurement process keeps pace with the evolving science of performance measurement. In addition to the HEDIS measures currently used in the FEHB program, there are additional HEDIS measures developed by NCQA that focus on access, resource use, and cost of care. Additionally, other organizations have developed and tested similarly innovative measures, including measurement of plan efforts to promote the use of HIT among their providers. Plans will be expected to provide information on the utilization of HIT such as the proportion of providers with electronic medical records. OPM plans to work with experts in the field to develop a refined set of performance measures that provide additional insights into plan quality. We will continue to endeavor to align our quality measurement requirements with existing NCQA processes wherever possible to reduce the burden on plans. Other large employers and purchasing coalitions have continually evolved their performance measurement requirements and the FEHB Program needs to do the same.

III. Mental Health Parity

In last year's Call Letter, we discussed the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The Department of Health and Human Services, Department of Labor, and Department of Treasury released interim final regulations on February 2, 2010 that implement the Act. Under these rules, health plans cannot have separate deductible and out-of-pocket maximum requirements that are applicable only with respect to mental health or substance use disorders. This means plans must accrue member expenses toward the same deductibles and out-of-pocket maximums for both medical and surgical benefits and mental health and substance use disorder benefits. In addition, if a health plan has a lower copayment for Primary Care Physician visits, the Plan must use the same copayment level for outpatient visits to providers of mental health or substance use disorder services.

The regulations also prohibit discrimination in the application of non-quantitative treatment limitations, such as medical management standards, prescription drug formulary design, determinations of usual, reasonable and customary amounts, step therapy, and requiring benefits be subjected to a condition such as completing a course of treatment. Any elements used in non-quantitative treatment limitations for mental health benefits must be comparable to those used for medical and surgical benefits. For example, health plans would not be permitted to require concurrent review of mental health care but not medical surgical care. However, exceptions may apply to the extent that clinically appropriate standards of care permit a difference.

IV. Program Integrity

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 account statements; and, we expect all plans to be well managed and financially secure.

V. Technical Guidance for Proposals

Specific requirements for submitting your benefit and rate proposals and information on how to prepare your 2011 brochures will be provided at a later date.

CONCLUSION

Please discuss your benefit changes with your contract specialist before you submit your proposals. Proposed benefit changes must be cost-neutral, with the exceptions previously noted, and any savings from managed care initiatives must accrue to the FEHB Program. We will begin negotiations when we receive your proposals.

We look forward to the negotiations for the upcoming contract year. Thank you for your commitment to the FEHB Program.

Sincerely,

John O'Brien
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Program Planning and Policy Analysis

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