FEHB Program Carrier Letter
Health Maintenance Organizations

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2011-10(a) **Date: May 4, 2011**

Fee-for-service [n/a] Experience-rated HMO [8] Community-rated HMO [7]

SUBJECT: 2012 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals

Enclosed are the technical guidance and instructions for preparing your benefit and service area proposals for the contract term January 1, 2012, through December 31, 2012. The guidance and instructions are in four parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Preparing Service Area Changes
- Part Three: Benefits for HMOs
- Part Four: Preparing Your 2012 Brochure

Please refer to our annual *Call Letter* (Carrier Letter 2011-05) dated March 25, 2011 for *policy guidance*. Benefit policies from prior years remain in effect.

Your community benefit package and non-Federal group benefit package that we purchased is due no later than May 12, 2011, and your complete proposal for benefits, rates, clarifications, and service area changes is due no later than **May 31, 2011** (see Part One: Preparing Your Benefit Proposal). Please send a copy of your proposal to your contract specialist on a CD-ROM or other electronic means in addition to a hard copy. Your proposal should include the corresponding language that describes your proposed changes for Section 5 of the brochure. Your OPM contract specialist will negotiate your 2012 benefits with you and finalize the negotiations in a close-out letter.

Please send an electronic version of your fully revised 2012 brochure to your contract specialist within five business days following the receipt of the close-out letter **or** by the date set by your contract specialist.

As part of your proposal, please include your carrier's proposed plan for "Going Green." Attachment IX includes additional information on this initiative.

As a reminder, each year we assess carriers' overall performance. We consider your efforts to submit benefit and rate proposals timely as well as the accurate and timely production and distribution of brochures. Enclosed is a checklist (Attachment X) with the information you must provide. Please return the completed checklist along with your benefit and rate proposals.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

John O’Brien
Director
Healthcare and Insurance

2012 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

- Submit a copy of a fully executed employer group contract (i.e., *certificate of coverage*) by May 12, 2011, that non-Federal subscribers purchased in 2011.

- **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 and the associated rate with your state, if your state requires a filing.

Community-rated Plans

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 consumers. 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.

The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.

The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there is an impact on premiums.

Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your contact in the Office of the Actuaries regarding the alternate community package and requirements for the use of Similarly Sized Subscriber Groups (SSSGs) in the rating process.

- Submit a copy of a fully executed community-benefit package by May 12, 2011 (a.k.a. master group contract or subscriber certificate), including riders, co-pays, co-insurance, and deductible amounts that your non-Federal subscribers purchased in 2011. 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 "national plan" then you need to send us your community benefit package for each state that you cover.

- 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 2012 contract term, except for those still under review by your state.

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 2012.

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.

All HMOs

1. Attach a chart that compares your proposed 2012 benefit package and the 2011 benefit package that we purchased. Include on your chart:

   A. Differences in co-pays, co-insurance, numbers of coverage days, and coverage levels in the two packages.

   B. For community-rated plans only, indicate whether you include the costs of the differences within your community-rate or in addition to the community-rate you charge to the other groups that purchase this benefit package, and to the FEHB Program; and the number of subscribers/contract holders who purchased the 2011 package and who are expected to purchase the 2012 package.

   C. 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, 2011, and you obtain approval and submit approval documentation to us by June 30, 2011. 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, 2011.

2. 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.

3. Please highlight and address any state-mandated benefits that you have not specifically addressed in previous negotiations. State-mandated benefits should be reported if finalized by May 1, 2011, or if they were not specifically addressed in previous negotiations.

Please send the following material by **May 31, 2011**:

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 comparison of your 2011 benefit package (adjusted for FEHB benefits) and your 2012 benefit package (see #1 above)
- Benefit package documentation (see **Benefit Changes** below)
- A plain language description of each proposed **change** (in worksheet format) and the revised language for your 2012 brochure
- A plain language description of each proposed **clarification** (in worksheet format) and the revised language for your 2012 brochure
- A signed contracting official's form (see attached)

If there are, or if you anticipate significant changes to your 2012 benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Benefit Changes

Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II 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 answer the following questions in 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. ***We require the following format:***

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2012" section in "plain language" that is, in the active voice and from the enrollee'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.**
- 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 2012.
- 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.

- 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)?

- 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 by this rider and when will that occur?

- Include the cost impact of this rider as a bi-weekly amount for Self Only and Self and Family on Attachment II of your rate calculation. If 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 to your rate calculation.

- If the change requires new providers, furnish an attachment that identifies the new providers.

Benefit Clarifications

Clarifications are not benefit changes. Please use Attachment III as a template for submitting benefit clarifications**.** Clarifications help enrollees understand how a benefit is covered**.** For each clarification:

- Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification. **Prepare a separate worksheet for each proposed clarification**. When you have more than one clarification to the same benefit you may combine them, but you must present the worksheet clearly. Remember to use plain language.

- Explain the reason for the benefit clarification.

Part Two - Service Area Changes

Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2012 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.

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**.

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.

- **Service Area Expansion** - You must propose any service area expansion by May 31, 2011. We may grant an extension for submitting supporting documentation to us until June 30, 2011.

- **Service Area Reduction** - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain.

Important Notices

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

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

- 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.

Service Area Expansion Criteria

We will evaluate your proposal to expand your service area according to these criteria:

- Legal authority to operate

- Reasonable access to providers

- Choice of quality primary and specialty medical care throughout the service area

- Your ability to provide contracted benefits

- Your proposed service area should be geographically contiguous

You must provide the following information:

- **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.

- **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.

- **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, 2011. 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.

Service Area Reduction Criteria

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

- We will accept the elimination of the corresponding service area, if you propose to eliminate an entire enrollment area
- Service area reductions should be associated with the following:

  - Significant loss of provider network
  - Poor market growth
  - Reduction applies to other employer groups
  - Reduction may apply to consolidation of two or more rating areas, or splitting rating areas

You must provide the following information:

- **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.

- **All state approvals that apply or 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 2012 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 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 2012. 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. The FEHB policies include the following:

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

1. **Programs to Manage Patient Care** – In February we issued Carrier Letter 2011-2 Demonstrating Value through Clinical and Financial Integration requesting plans to submit information on bundled payments, the Patient-Centered Medical Home, and Accountable Care Organizations. We encourage you to submit proposals for pilot programs that include detailed operational plans, including outreach and other communications to enrollees.

2. **Programs to Promote Health and Wellness** – As we indicated in last year's Call Letter, we expect you to offer health and wellness programs that have the potential to improve employee productivity by encouraging healthy lifestyles.

3. **Adult and Childhood Obesity** - We encourage you to provide us with proposals for health promotion programs to reduce the incidence of both adult and childhood obesity. Please describe in detail the programs you are offering to encourage healthy lifestyles and to reduce rates of obesity in children and in adults.

4. **Promoting Healthy Lifestyles** – We strongly encourage you to offer incentives such as reduced co-payments and deductibles to enrollees who complete a health risk assessment (HRA), are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Please complete Attachment IV: Current Baseline Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan and Attachment V: Projected 2012 Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan.

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. **Generic drugs** – We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically effective therapeutic alternatives. We encourage health plans which have not focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012.

7. **Pharmacy Spending** - We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic

drugs and clinically appropriate therapeutic alternatives. We encourage health plans which have not focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012. Additionally, we expect you to submit proposals that outline a savings plan to reduce your overall pharmacy spending for next year, without simply shifting costs to enrollees. We believe a four percent reduction in overall pharmacy spending should be achievable and each carrier will be required to do its part to help reach that goal. The savings plan should demonstrate how a reduction in pharmacy costs or overall costs is achievable. We will also require Plans to submit information on their current pharmacy costs and current drug benefits structure using standard formats which will be included with the rate instructions. This information will be used to compare pharmacy costs per enrollee, across plans, and for the FEHB Program as a whole.

8. **Prescription Drugs** – All plans must meet creditable coverage requirements. The prescription drug benefit must be at least as good as the standard Medicare Part D Benefit. All plans must provide at least a minimum coverage level for all medically necessary drugs that require a prescription, including insulin. Prescription drug deductibles may not exceed $600 and co-insurance may not exceed 50 percent. We don't allow lifetime or annual benefit maximums on prescription drugs. You must cover disposable needles and syringes used to administer covered injectables, IV fluids, and medications for home use, growth hormones, and allergy serum. You must also provide benefits for "off-label" use of covered medications when prescribed in accordance with generally accepted medical practice by a plan doctor. You may not exclude drugs for sexual dysfunction; however, you may place dollar or dosage limits on these drugs. You may use a drug formulary or preferred list as long as the plan provides benefits for non-formulary or non-preferred drugs when prescribed by a Plan doctor. You cannot use the formulary or preferred list as a means to exclude benefits for drug coverage required through the FEHB Program. We do not allow exclusions of broad categories of drugs such as "non-generics" or "injectables".

   Plans that use levels or tiers to denote different prescription drug co-pays must clearly describe the coverage and difference between each level or tier in the 2012 brochure. The *2012 Guide to Federal Benefits* will illustrate the prescription drug co-pays at the following levels.

   - Level I – generally includes generic drugs but may include some brand formulary or preferred brands. Usually represents the lowest co-pays.
   - Level II – generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range co-pays.
   - Level III – may include all other covered drugs not on Levels I and II, i.e. non-formulary, or non-preferred, and some specialty drugs.

   If your plan has more than three co-pay levels for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2012 Guide to Federal Benefits.*

9. **Increase FEHB providers** – We strongly encourage you to increase the number of health care providers in FEHB plan networks who are board certified, or have training in, geriatrics. We will allow you to use incentives to encourage geriatric doctors to participate in your network; however, please provide a cost benefit analysis. Please provide data on the number and

percentage of providers with this training in your current networks, including particular focus on those geographic areas with a large older population, and your plan to reach out to providers and expand your networks with this additional expertise.

10. **Affinity products** - We have encouraged you to add products on the "non-FEHB" page of your plan brochure that would be attractive to Federal members. We especially encourage plans to acknowledge individual policies for extended family members, such as dependents beyond age 26 and domestic partners.

11. **Actuarial Value** – We are requesting additional information on the medical loss ratio for FEHB plans. Please refer to the medical loss ratio defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options.

12. **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 copayment. 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.

13. **Grandfathered Plans** – If one or more of your plan's options was grandfathered in 2011, and any of those options are anticipated to continue to meet requirements to remain grandfathered for plan year 2012 (based only on benefit changes), please complete Attachment VI: Grandfathered Status Certification. The certification lists the regulatory requirements to be considered grandfathered under the Act. Final grandfathered status will only be confirmed once final benefits and rates are negotiated. Plans only need to complete the certification for those options that are anticipated to be grandfathered.

    Please note, if one or more of your plan options was grandfathered in 2011 but will no longer meet regulatory requirements for 2012, the option must meet all requirements for non-grandfathered plans under the Affordable Care Act.

14. **Eliminate Cost-Sharing** - As stated in last year's Call Letter, benefits for coverage of all recommended in-network preventive care, immunizations, and screenings will be provided with no cost-sharing. A list of recommended preventive services (including immunizations) by the Advisory Committee on Immunizations Practices (ACIP) in conjunction with the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), and Health Resources and Services Administration (HRSA) is included in Carrier Letter 2010- 11(a) 2011 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals for HMO Carriers.

15. **Assistive Technologies** - We again encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. We also encourage you to offer auditory osseointegrated implants / bone anchored hearing aid (BAHA). Please note that the BAHA benefit should be listed under orthopedic/prosthetic devices in your plan brochure. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

16. **Coordination of Benefits (COB)** –
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 correctly describe this process currently, please work with your contract specialist to clarify your language for 2012.

17. **Affordability** – We will again work closely with you to find ways to manage costs and utilization effectively.

18. **Value-Based Benefit Design** – Please establish how your complete benefit package is value based.

19. **Catastrophic Limitations** – Please address any changes to the catastrophic limitations.

20. **Health Care Cost and Quality Transparency Initiatives** – We continue to encourage you to expand your 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.

21. **Preventable Medical Errors** - We continue to encourage you to review your coverage guidelines with respect to preventable medical errors and to revise your policies as long as you have arrangements in place to protect your members from balance billing

22. **Preventive Care** – As stated in our *Call Letter*, we encourage your review of your current preventive benefits for adults and compare them to the United States Preventive Services Task Force (USPSTF) recommendations and propose benefit changes to address any gaps between the two. The USPSTF guidelines are at http://www.ahrq.gov/clinic/uspstfix.htm.

23. **Organ/Tissue Transplants** –We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance. When a carrier determines 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. We have updated the following tables in Attachment VII:

    - Table 1– OPM's required list of covered organ/tissue transplants
    - Table 2 – Recommended organ/tissue transplants when received as part of a clinical trial

24. **Durable Medical Equipment.** Please indicate which items you cover by completing the checklist in Attachment VIII.

25. **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.

26. **Pre-existing Conditions** – Pre-existing condition limitations are not permitted for any required benefits.

27. **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.

28. **Infertility Treatment** – We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. **This requirement does not include related prescription drugs.** Your brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.

29. **Immunizations for Children** – All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums.

30. **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 2012 brochure language clearly describes your coverage.

31. **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.

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. We do not pre-empt state laws that increase our enrollees' benefits unless the state mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

Department of Health and Human Services (HHS) Benefits

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

- Non-experimental bone marrow, cornea, kidney, and liver transplants
- Short-term rehabilitative therapy (physical, occupational, and speech), if significant improvement in the patient's condition can be expected within two months
- Family planning services include all necessary non-experimental infertility services such as artificial insemination with either the husband's or donor sperm. You do not have to cover the cost of donor sperm if it is not in your community package. You may exclude benefits for conception by artificial means or assisted reproductive technology to the extent permitted by applicable state law and excluded in your community package
- Pediatric and adult immunizations, in accordance with accepted medical practice
- Allergy testing, treatment and allergy serum
- Well-child care from birth
- Periodic health evaluations for adults
- Home health services
- In-hospital administration of blood and blood products (including "blood processing")
- Surgical treatment of morbid obesity, when medically necessary
- Implants – you must cover the surgical procedure, but you may exclude the cost of the device if the device is excluded in your community package

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

Part Four – Preparing Your 2012 Brochure

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software. The web application will generate a 508-compliant PDF.

The *2012 FEHB Brochure Handbook* will be ready by June 13. Plans can download the *Handbook* from the file manager at www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal. In August, we will also send you a brochure quantity form and other related Open Season instructions.

We will provide updates to the FEHB Brochure Templates between June 6 and August 11, 2011. We will not issue a second version of the *2012 FEHB Brochure Handbook*; however, we will post the revised FEHB Handbook pages and a revised Brochure Template to the File Manager. We should have all language and shipping labels finalized no later then August 11, 2011. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

The *2012 Brochure Creation Tool (BCT) User Manual* will be available July 1. Also in July, we will provide in-house training to refresh plans on the use of the BCT. There will be 10 separate training sessions held at OPM. We will send an email via the FEHB Carriers listserv as to the dates and times of these trainings. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at angelo.cueto@opm.gov.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 19, 2011. Plans will be unable to make any changes after this date, as we will lock the tool to enable contract specialists to review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.

Attachment I: Carrier Contracting Officials

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

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

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

for _____(Plan).

Enrollment code(s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX number)

_____
(E-mail address)

Attachment II

[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 5-6 to complete the worksheet.

Benefit Change Description

Applicable options:

High	☐	CDHP	☐
Standard	☐	HDHP	☐
Basic	☐		

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?
- (b) If approved, when? (attach supporting documentation)
- (c) How will the change be introduced to other employers?
- (d) What percentage of the plan subscribers now have this benefit?
- (e) What percentage of plan subscribers do you project will have this benefit by January 2012?

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 2012?
- (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
[Insert Subsection Name]

Please refer to Benefit Clarifications on page 6 to complete the worksheet.

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

Benefit Clarification Description

Applicable options:

High	☐	CDHP	☐
Standard	☐	HDHP	☐
Basic	☐		

Item	Narrative Description
Current Benefit Language	
Proposed Benefit Change	
Reason For Benefit Clarification	

Attachment IV: Current Baseline Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan

INITIATIVE	PROGRAMS & INCENTIVES NOW OFFERED – DESCRIBE HERE	CURRENT ENROLLEES: TOTAL NUMBER & PERCENTAGE OF PLAN
Promote health & wellness		
e.g. comprehensive diabetes care		
e.g. cholesterol management for enrollees with cardiovascular conditions		
e.g. controlling high blood pressure		
Reduce adult & childhood obesity		
Promote healthy lifestyles		
e.g. reduced co-payments & deductibles for enrollees completing health risk assessment (HRA)		
e.g. compliant with disease management programs		
e.g. participate in wellness activities		

Attachment V: Projected 2012 Data: Health & Wellness Programs or Incentives by Enrollee Total Numbers & Percentage of Plan

INITIATIVE	PROPOSED PROGRAMS & INCENTIVES - DESCRIBE HERE	TARGET ENROLLEES: TOTAL NUMBER & PERCENTAGE OF PLAN
Promote health & wellness		
e.g. comprehensive diabetes care		
e.g. cholesterol management for enrollees with cardiovascular conditions		
e.g. controlling high blood pressure		
Reduce adult & childhood obesity		
Promote healthy lifestyles		
e.g. reduced co-payments & deductibles for enrollees completing health risk assessment (HRA)		
e.g. compliant with disease management programs		
e.g. participate in wellness activities		

Attachment VI: Grandfathered Status Certification

The Patient Protection and Affordable Care Act, as amended ("the Act"), imposes coverage, premium and notification requirements for group health plans. Certain existing group health plans, referred to as "grandfathered plans," are exempt from some of those requirements.
According to regulations published jointly by the Departments of Treasury, Labor and Health and Human Services (http://cciio.cms.gov/programs/marketreforms/grandfathered/index.html), health plans existing on March 23, 2010 may meet the definition of a grandfathered health plan by making only certain limited changes to benefits and rates each year and by complying with certain notification and records retention requirements.

For plan year 2011, we asked FEHB carriers to certify whether each plan option offered was grandfathered under the Act. For plan year 2012, we are asking plans to complete the certification below for options that continue to meet the requirements to remain grandfathered.

The checklist below lists the requirements in the regulations. If an FEHB plan chooses to assert grandfathered status for plan year 2012, the plan must certify that the applicable plan option, based on the benefit changes from **2010 to 2012**, meets the definition of a grandfathered plan for plan year 2012. (Be aware that a group health plan ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010. You are not certifying to this requirement.) If the plan option meets all the requirements listed below, plans should certify that this option is considered grandfathered under the Act (pending final rate determinations.)

You only need to submit this certification if you are choosing to assert that a particular plan option is grandfathered for 2012. Please do not complete a certification for plan options that do not meet the requirements below.

Plans should also be aware of record keeping and notification requirements if the plan is to remain grandfathered for 2012. In addition, grandfathered plans must:

- Include a statement in plan materials describing benefits (plan brochure) that the plan believes it is a grandfathered health plan and include contact information for enrollee complaints. OPM will provide standard plan language for FEHB brochures disclosing a plan's grandfathered status.

- Maintain records documenting the terms of the plan that were in effect on the date of enactment.

Grandfathered Status Certification

Plan Name and Option:

Carrier Codes:

Category	Requirement (Change from 2010)	Met by 2012 Benefit Package- (Yes or No)
Benefits	Benefit option has not eliminated all or substantially all benefits to diagnose or treat a particular condition. Plan has not eliminated benefits considered necessary to treat a particular condition.	
Cost Sharing (coinsurance)	Benefit option has not made any increase in percentage cost sharing amount.	
Fixed Cost Sharing (Deductible or Out-of-Pocket Limit)	Benefit option has not increased deductibles or out-of-pocket- limits more than medical inflation* plus 15 percentage points.	
Fixed- Amount Copayment	Benefit option has not increased copayments more than the greater of: 1) $5 increased by medical inflation* ($5 plus medical inflation times $5) or 2) medical inflation plus 15 percentage points (by expressing copayment as a percentage).	
Changes in annual limits	Benefit option has not imposed an overall annual limit on the dollar value of all benefits.	

* Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted). Increase is computed by subtracting 387.142 (CPI-U for March 2010) from the indexed amount for any months before the new change is to take effect.

I certify that this plan option meets the requirements of the Patient Protection and Affordable Care Act as a Grandfathered plan (pending final rate determinations.)

Signature of authorized contracting official:

Name **Date**

Title

Please return this page to your OPM contract specialist for each grandfathered plan option under the FEHB Program. Your contract specialist will advise you of the deadline for returning the certification.

Attachment: VII 2012 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
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	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, 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	
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 that transition from experimental/investigational to being 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 2012?	
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		
Sclerodema		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage

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 to being 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 2012?	
Solid Organ Transplants	**Yes**	**No**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
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 VIII: Durable Medical Equipment

Plan Name: _____

Plan Code(s): _____

Please indicate which items you cover and describe the type of coverage you provide.

Item	Yes	No
•Hearing Aids Description:		
•Prescription Drug Readers Description:		
•Scooters Description:		
•Speech Generating Devices Description:		
•Story Boards (graphic organizers such as a series of illustrations or images displayed in sequence) Description:		
•Talkers Description:		

Attachment IX: Going Green Initiative

We encourage plans to "go green" where possible. Examples of "going green" are as follows:

- **Delivering Plan Brochures -** If you have not responded to our FEHB carrier listserv of March 30, please provide us with a plan of action detailing how you will promote the use of electronic copies of your brochures.
- **Sending Explanation of Benefits electronically (EOB)**
- **Using summary EOBs**
- **Distributing health plan newsletters**

Please provide us with how your plan will "go green" for the items indicated below as well as any other areas your plan has undertaken. Please include a cost benefit analysis for the items your plan has addressed.

Delivering Plan Brochures	**Plan Response**
A timeframe for the process carriers will use for gathering information, processing requests, the cut-off point for determining the number of hard copy and electronic copy requests, etc.	
How carriers will determine if enrollees want an electronic brochure (via postcard, phone call, etc.)	
If enrollees will be able to request both an electronic and hard copy of the brochure.	
If enrollees request an electronic brochure and then decide to change to a hard copy, will this request be honored.	
How carriers will collect and maintain current email addresses.	
How carriers will ensure enrollees have received the brochure.	
A cost/benefit analysis	
Sending Explanation of Benefits (EOB) electronically	
Using Summary EOBs	
Distributing health plan newsletters	
Other areas	

Attachment X: Checklist

Federal Employees Health Benefits Program Annual Call Letter --- Checklist

Topic	Included in Proposal
1. Programs to manage patient care – Pilot programs that include detailed operational plans, including outreach and other communication to enrollees.	
2. Programs to promote health and wellness aimed at improving employee productivity, enhancing healthy lifestyles and lowering long-term healthcare costs.	
3. Programs to reduce adult and childhood obesity described in detail.	
4. Incentives to promote healthy lifestyles such as reduced co-payments and deductibles for enrollees who complete a health risk assessment (HRA), are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status. Completed Attachments IV and V.	
5. Proposal to reduce disparities that includes a description of specific goals and processes your plan is undertaking or plan to implement to reduce health disparities.	
6. Expanded program to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no co-payments for generic drugs and clinically effective therapeutic alternatives.	
7. Plan to reduce overall pharmacy spending.	
8. Increase FEHB providers and include data on the number and percentage of providers with geriatric training in your current network, including particular focus on those geographic areas with a large older population. In addition, include your plan to reach out to providers and expand your networks with this expertise.	
9. Describe affinity products on the "non-FEHB" page of your brochure that are attractive to FEHB enrollees.	
10. Actuarial value – include information on medical loss ratio.	
11. Eliminate cost-sharing for all recommended in-network preventive care, immunizations, and screenings.	
12. Assistive Technologies – Increased dollar amounts on assisted	

technologies such as hearing aids, speech generating devices, and prescription drug readers, if applicable.	
13. Coordination of Benefits - Benefit designs that include co-insurance should be based on the remaining charge, not the plan's allowance.	
14. Value-Based Benefit Design –Establish how your benefit package is value based.	
15. Changes to your catastrophic limit(s), if applicable.	
16. Completed Organ/Tissue Transplants tables.	
17. Grandfathered Status Certification, if applicable.	
18. Benefit Change Worksheet for each proposed benefit change.	
19. Benefit Clarification Worksheet for each proposed benefit clarification.	
20. HMO Community Package Requirements – You may propose an alternative benefits package.	
21. Completed Durable Medical Equipment Checklist.	
22. "Going Green" initiative.	

Please return this checklist with your CY 2012 benefit and rate proposal