FEHB Program Carrier Letter
All Fee For Service Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

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

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

Subject: 2016 Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2016 through December 31, 2016. The Federal Employee Health Benefits (FEHB) carrier guidance is issued in two documents:

1. The annual Call Letter (Carrier Letter 2015- 02) dated March 16, 2015 provides guidance on OPM's initiatives for the 2016 benefits negotiation cycle.
2. The Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers provides more technical requirements for the items listed in the Call Letter.

The automated data collection tool (ADC) will be issued in two parts this year:

1. Part I will request current data and trend information; and
2. Part 2 will request information on your 2016 benefit proposal as compared with the 2016 Call Letter initiatives. You will receive Part II in late August after benefit negotiations have concluded. Part II will include questions on negotiated benefits and rates, tobacco cessation, and health information technology.

Please note: You will receive an email with unique link(s) from TG_ADC@opm.gov (TG_ADC) that will guide you to the online ADC tool. Each contract number will have an individualized link. We ask that you complete the ADC online by April 17, 2015.

Benefit policies from prior years remain in effect unless otherwise noted

The Guidance and instructions are in three parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Benefits for FFS Plans

This year's deadlines are as follows:

- **Due by April 17, 2015:** Please submit ADC responses online.

- **Due by May 31, 2015:** Please send your complete proposal for benefit changes and clarifications to your contract specialist on a CD-ROM (or other electronic means) in addition to a hard copy. Your proposal should include language describing all proposed brochure changes. Your OPM contract specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.

- **Within five business days following receipt of close-out letter or by date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2016 brochure. See Attachment IV: Preparing Your 2016 Brochure.

As stated in the Call Letter, we are encouraging all FEHB carriers to thoroughly evaluate their health plan options to find ways to improve affordability, reduce the cost and improve quality of care, and improve the health of the enrolled population. Benefit proposals must be cost neutral in that proposed benefit enhancements must be offset by proposed reductions so that premiums are not increased due to benefit changes. OPM will make exceptions to this requirement for proposed benefit changes in response to the Medicare and Applied Behavior Analysis (ABA) initiatives.
Enclosed is a checklist (Attachment VI) showing all the information to include with your benefit and rate proposals. Please return a completed checklist with your submission.

We appreciate your continued efforts to timely submit benefit and rate proposals and to produce and distribute brochures. We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2016 FEHB Proposal Instructions

Part One Preparing Your 2016 Benefit Proposal

A. Your benefit proposal must be complete. Timeframes to conclude benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

1. A signed contracting official's form (Attachment I);
2. A plain language description of each proposed benefit change (Attachment II) and revised language for your 2016 brochure; and
3. A plain language description of each proposed benefit clarification (Attachment III) and revised language for your 2016 brochure.

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

1. Self Only (codes ending in 1 and 4) - A Self Only enrollment type only provides benefits for the enrollee.

2. Self Plus One (codes ending in 3 and 6) – A Self Plus One enrollment type will be available for enrollment during the annual Open Season beginning November 9, 2015, effective in January 2016.

    a. Self Plus One enrollment type only provides benefits for the enrollee and one designated eligible family member. See website: http://www.opm.gov/healthcare-insurance/healthcare/eligibility/ for eligibility criteria.
    b. Catastrophic maximum, deductibles, and wellness incentives should be for dollar amounts that are less than or equal to corresponding benefits in Self and Family enrollment.
    c. All other benefits, such as copays and coinsurance amounts, must be the same regardless of enrollment type.
    d. FEHB plans with High Deductible Health Plans must be cognizant of Treasury/IRS - 26 U.S. Code § 223 which for deductibles, catastrophic maximums and premium pass-through contributions require twice the dollar amount for Self Plus One or Self Plus Family than for Self Only coverage. Note that family coverage is defined under 26 CFR 54.4980G-1 as including the Self Plus One coverage category.

3. Self and Family (codes ending in 2 and 5) - A Self and Family enrollment types provides benefits for the enrollee and all eligible family members.

4. If you anticipate significant changes to your benefit package, please discuss them with your OPM contract specialist before preparing your submission.

C. Benefit Changes

1. Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II as the template to submit benefit changes. You must show all changes, however small, that result in an increase or decrease in benefits, even if there is no rate change.

2. We expect you to answer each of 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.

3. Information Required for Proposal:

    a. Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2016" section in "plain language" using the active voice and written from the member's perspective. Show clearly how the change will affect members and the complete range of the change. For instance, if you propose to add inpatient hospital copays, indicate whether the change will also apply to inpatient hospitalizations under the emergency benefit. **If there are two or more changes to the same benefit, please show each change clearly.**

    b. Describe the rationale or reasoning for the proposed benefit change.

    c. State the actuarial value of the change and if the change represents an increase or decrease in (a) the existing benefit and (b) your overall benefit package. If an increase, describe whether any other benefit offsets your proposal. Include the cost impact of the change as a biweekly amount for the Self Only, Self Plus One, and Self and Family rates. If there is "no cost impact" or if the proposal involves a "cost trade-off" with another benefit, indicate which result is applicable, i.e. no cost or trade-off.

D. Benefit Clarifications

1. Clarifications are not benefit changes. Please use Attachment III as the template to submit all clarifications that better explain to members how a benefit is covered.

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

3. Explain the reason for the proposed clarification.

E. Information Required for Proposal:

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

2. Explain the reason for the proposed clarification.

Part Two: Benefits for Fee For Service Plans

As stated in the Call Letter, our primary performance initiatives this year are:

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

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

I. CALL LETTER INITIATIVES

A. Self Plus One Enrollment Type:

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

B. Encouraging Participation in Medicare Part B:

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

We want to see that there is a clear incentive for members to enroll in Medicare Part B. If incentives may not currently be adequate in your plan, we are seeking enhancements that provide value to dually enrolled Medicare and FEHB Program members. These may include waivers or reductions of cost sharing. We are not encouraging plans to pay Medicare premiums directly on behalf of members; however, FEHB Program members may use Health Reimbursement Arrangement (HRA) funds to pay some or all of their individual Medicare Part B premiums. If this applies to your plan, it should be made clear to the Plan's Medicare population. We are aware that some carriers offer Medicare Part C (Medicare Advantage) Plans. If you offer a Medicare Advantage product, you should explore how it may better coordinate with your FEHB Program coverage to incentivize Medicare Part B enrollment. Your proposal should be included in your response to the Call Letter.

C. Expanding Access to Care:

1. Applied Behavior Analysis (ABA): OPM is strongly committed to expanding access to ABA services for children with autism. Our goal is to ensure that family members

needing this care have the option to select a plan offering it. We recognize that provider supply, licensure requirements, and state insurance mandates for ABA vary, but note that the number of certified professionals available to deliver this benefit has expanded significantly since 2012. Additionally, over three-quarters of the states have approved private insurance mandates to provide ABA. This section provides further program management details for carriers to consider when developing benefit proposals designed to achieve OPM's policy goal at an affordable cost.

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

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

a. Promote early, accurate diagnosis,
b. Intervene as early as possible in the child's life,
c. Develop treatment plans with clear therapeutic milestones and measurable objectives,
d. Establish tiered specialty networks of licensed providers and supervised direct service professionals; ideally overseen by a specialized care management team[1] ,
e. Train families/caregivers to sustain improvement beyond scheduled sessions,
f. Coordinate care so that covered benefits are not utilized in lieu of educational services provided by community agencies, residential facilities, or schools , and
g. Schedule frequent re-evaluation to assess progress, evolving needs, or failure to improve.

Families may also benefit from transition plans to facilitate access to an appropriate continuum of services once active ABA treatment ends. Additionally, carriers may need to update their utilization review and disputed claims processes to ensure that fully qualified professionals are available to perform reviews when indicated.

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

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

terminology as appropriate, consistent with FEHB coverage of same sex spouses outlined in Carrier Letter 2013-20.

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

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

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

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

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

D. Preventive Care and Wellness:

1. Wellness and Preventive Screening: OPM strongly encourages Plans to explore innovative approaches to communicate wellness and preventive services, to engage members to participate, and to incentivize steps to adopt and maintain healthy behaviors. Success may require multiple strategies aimed at both providers and enrollees. To improve participation, we invite Plans to consider promoting an annual visit which includes wellness and preventive services, if not doing so already. Depending on plan benefits, these services may be incorporated into the Annual Physical Exam or organized separately as an annual wellness visit. Recent reports indicate these visits are gaining

acceptance among providers and consumers as a means to update health status, provide tailored health advice, schedule preventive services, and initiate behavior modification referrals. We further note that this approach could also improve Plan performance on relevant HEDIS measures. Another popular option involves offering wearable activity trackers as member incentives with the added benefit of reinforcing healthy lifestyle choices.

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

3. Cardiovascular Risk Reduction: To reduce cardiovascular risk, we continue to stress attention to blood pressure control and promotion of FEHB benefits for tobacco cessation. Helping members understand the risk of heart attack and stroke associated with high blood pressure, encouraging providers to use evidence based treatment protocols, and emphasizing adherence to prescribed medications will enhance our collective progress toward this important health outcome. Key insights from OPM's collaboration with the Million Hearts[4] initiative include:

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

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

F. Preparing for the Excise Tax in 2018:

Title IX, Subtitle A, section 9001 of the Affordable Care Act (ACA), establishes an excise tax on high cost employer-sponsored health coverage. Beginning Plan year 2018, a forty (40) percent

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

excise tax will be assessed to health plans as described below. The excise tax applies to the overall aggregate plan cost/premium and contributions to flexible spending accounts, health savings accounts, and health reimbursement accounts. The Internal Revenue Service is expected to issue guidance for the administration of this excise tax including the method and timing for payment.

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

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

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

Examples of areas for review include:

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

II. Benefits For FFS Plans

A. Continued Focus from Previous Years

1. Organ/Tissue Transplants

There are no changes to the guidance on organ/tissue transplants for 2016. When you determine that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. The following tables are in Attachment V:

Table 1 – OPM's required list of covered organ/tissue transplants.
Table 2 – OPM's recommended coverage of transplants under Clinical Trials.

Table 3 – OPM's recommended list of covered rare organ/tissue transplants.

Information Required: Completed Attachment V - 2016 Organ/Tissue Transplants and Diagnoses.

2. Point of Service Product

We will consider proposals to offer a Point of Service (POS) product under the FEHB Program. Your plan's proposal must demonstrate experience with a private sector employer who has already purchased the POS product.

3. Health Plan Accreditation

Updated accreditation requirements were published in carrier Letter 2014-10. Carriers are reminded that all FEHB health plans are expected to meet OPM's accreditation requirement no later than April 2017.

4. Mental Health Parity

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

Attachment I FEHB Carrier Contracting Official

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

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

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

for _____ (Plan).

Enrollment code (s):_____

Typed name	Title	Signature	Date

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

_____
(Typed name and title)

_____ _____
(Telephone) (FAX)

_____
(Email)

Attachment II

[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 page 3-4 to complete the worksheet.

Benefit Change Description

Applicable options:

High Option	☐	CDHP	☐
Standard Option	☐	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. What is the cost impact of this change as a bi-weekly amount for Self Only and Self and Family rate?
   (a) If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, as appropriate.

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

Please refer to Benefit Clarifications on pages 4 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 Option	☐	CDHP	☐
Standard Option	☐	HDHP	☐
Basic	☐		

Current Benefit Language	Proposed Clarification	Reason For Benefit Clarification

Attachment IV
Preparing Your 2016 Brochure

Summary of Plan Benefits

FEHB plans will continue to provide a summary of plan benefits and coverage (SBC) based on standards developed by the Secretary of the Department of Labor. You will receive additional information regarding the SBC in a subsequent carrier guidance.

Going Green

We appreciate your efforts to support our "Going Green" goals to help reduce FEHB administrative costs. Once again, you must provide paper copies of plan brochures to new members or only upon request to current members and may send Explanations of Benefits, newsletters and other plan materials electronically.

Timeline: 2016 Brochure Process

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software to generate a Section 508-compliant PDF. This year's deadlines and significant dates are:

DEADLINES	ACTIVITY
May 31	Plans submit Section 5 Benefits information with proposal if suggesting new option.
July 2	Plans receive *2016 FEHB Brochure Handbook* via listserv
July 2	OPM will provide *2016 Brochure Creation Tool (BCT) User Manual.*
July 9-11 & 14-18	OPM in-house training on the use of the Brochure Creation Tool
July 2-August 28	OPM circulates updated FEHB Brochure Handbook pages by listserv.
September 4	Plans must enter all data into Section 5 Benefits and update all plan specific information in the brochure tool. Plans will be unable to make changes after this date so that Contract Specialists can review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.
September 10	OPM sends brochure quantity form to plan after Contract Specialist approves brochure for printing as well as other related Open Season instructions.
August 22	OPM's deadline to finalize all language and shipping labels.

In mid-July, we will provide in-house training to refresh plans on the use of the Brochure Creation Tool with 8 individual sessions held at OPM. We will notify plans via the FEHB Carriers listserv about the training dates and times. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at Angelo.Cueto@opm.gov or Andrew Chu at Andrew.Chu@opm.gov.

Attachment V
2016 Organ/Tissue Transplants and Diagnoses

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	**Reference**
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Call Letter 2014-03
Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs such as the liver, stomach, and pancreas) or isolated small intestine	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not subject to medical necessity. Plan's denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, advanced, or chronic) as appropriate for the diagnosis.	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Hemoglobinopathy	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)	
Myelodysplasia/Myelodysplastic Syndromes	
Paroxysmal Nocturnal Hemoglobinuria	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	

Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B
Amyloidosis	
Neuroblastoma	Call Letter 96-08B
III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
Childhood rhabdomyosarcoma	
Advanced Ewing sarcoma	
Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)	Carrier Letter 2013-12a
Advanced Childhood kidney cancers	
Mantle Cell (Non-Hodgkin lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage: Transplants under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services recommended under Clinical Trials. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2016?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		

Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Small cell lung cancer		
Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		
Scleroderma		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage: Rare Organ/Tissue Transplants

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/ investigational. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2016?	
Solid Organ Transplants	**Yes**	**No**
Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment VI
2016 Technical Guidance Submission Checklist

Topic/Attachment Number	In Proposal Yes/No/NA	Worksheet Completed Yes/No/NA
FEHB Carrier Contracting Official (Attachment I)		
Benefit Change Worksheet: worksheet for each change (Attachment II)		
Benefit Clarification Worksheet: worksheet for each clarification (Attachment III)		
Preparing Your 2016 Brochure (Attachment IV)		
2016 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 (Attachment V)		
2016 Technical Guidance Submission Checklist (Attachment VI)	N/A	

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