FEHB Program Carrier Letter
Health Maintenance Organizations

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2016-07 **Date: April 20, 2016**

Fee-for-service [2] Experience-rated HMO [2] Community-rated HMO [1]

Subject: 2017 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2017 through December 31, 2017. The Federal Employees Health Benefits (FEHB) Carrier guidance is issued in two documents:

1. The annual Call Letter (Carrier Letter 2016-03) dated February 26, 2016 provides guidance on OPM's Initiatives for the 2017 benefits negotiation cycle.
2. The Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for HMO's provides more technical requirements for the items listed in the Call Letter.

A print version of the Automated Data Collection (ADC) was provided to you prior to the distribution of the online tool in order to provide adequate time for question review. We strongly recommend that you carefully read through the questions and gather the information prior to completing the online tool.

Benefit policies from prior years remain in effect unless otherwise noted.

The Guidance and instructions are in three parts:

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

This year's deadlines are as follows:

- **Due by May 6, 2016:** Please send your community benefit package and non-Federal group benefit package we purchased.

- **Due by May 31, 2016:** 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 the close-out letter or by the date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2017 brochure. See Attachment IV- Preparing Your 2017 Brochure.

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

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

As a reminder, all Carriers must adhere to the FEHB Guiding Principles available at www.opm.gov/healthcare-insurance/healthcare/carriers/reference/principles/. In addition, all Carriers must have a vigorous and effective fraud detection and prevention program along with programs to prevent and collect any improper payments.

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

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2016 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

I. All HMOs

A. Complete Attachment II - Benefit Change Worksheet that compares your proposed 2017 benefit package and the 2016 benefit package that we purchased. Include on your chart:

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

2. 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 2016 package and who are expected to purchase the 2017 package.

3. 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, 2016**, and you obtain approval and submit approval documentation to us by **June 30, 2016**. 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, 2016.

B. The Federal Employees Health Benefits Program has three enrollment types:

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

2. Self Plus One (codes ending in 3 and 6) - A Self Plus One enrollment only provides benefits for the enrollee and one designated eligible family member.

    a. Self Plus One enrollment type only provides benefits for the enrollee and one designated eligible family member. See website: 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 the Self and Family enrollment.

    c. Copays, coinsurance, and benefits, limitations, and exclusions must not vary by 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.

C. 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.

D. 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 8, 2016, or if they were not specifically addressed in previous negotiations.

E. Please send the following material by **May 31, 2016**:

1. Your benefit proposal must be complete. The timeframes for concluding benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

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

   b. A comparison of your 2016 benefit package (adjusted for FEHB benefits) and your 2017 benefit package.

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

   d. A plain language description of each proposed **benefit change** (Attachment II) and the revised language for your 2017 brochure.

   e. A plain language description of each proposed **benefit clarification** (Attachment III) and the revised language for your 2017 brochure.

   Note: If you anticipate significant changes to your 2017 benefit package, please discuss them with your OPM Contract Specialist before you prepare your submission.

F. Federal Preemption Authority

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. OPM no longer requires plans to comply with benefit requirements for federally qualified Health Maintenance Organizations.

II. Experience-rated Plans

A. Submit a copy of a fully executed employer group contract (i.e., *certificate of coverage*) by May 8, 2016, that non-Federal subscribers purchased in 2016.

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

III. Community-rated Plans

A. We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions (as indicated in the Call Letter for the 2009 contract year). If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB enrollees. You should also identify each of the differences between your current benefit package and the proposed offering, and include the impact on your community-rated price proposal.

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

2. The alternate benefit package may not exclude benefits that are required of all FEHB plans.

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

B. Please consult with your contract specialist and your contact in the Office of the Actuaries regarding the alternate community package and refer to the rate instructions B. Submit a copy of a fully executed community-benefit package by May 8, 2016 (also known as a master group contract or subscriber certificate), including riders, co-pays, co-insurance, and deductible amounts that your non-Federal subscribers purchased in 2016. If the community benefit package is different from the FEHB's, also send a current copy of the benefit package that we purchased. Please highlight the difference(s) between the FEHB benefits and the package you based it upon. Note: If you offer a plan in multiple states please send us your community benefit package for each state that you plan to cover.

C. Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2017 contract term, except for those still under review by your state.

D. If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. If you have made changes, submit a copy of the new benefits description. If your state requires you to file this documentation, file the benefit package and the associated rate with the state first. We will accept the community-benefit package you project will be sold to the majority of your non-Federal subscribers in 2017.

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

IV. Benefit Changes

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

B. Information Required for Proposal:

1. Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2017" section in “plain language” that is, in the active voice and from the member’s perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital co-pay, indicate whether this change will also apply to in-patient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, please show each change clearly.

2. Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefit package or if the change is one you submitted to the state for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2017.

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

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

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

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

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

V. Benefit Clarifications

A. **Clarifications are not benefit changes.** Please use Attachment III as a template for submitting benefit clarifications**.** Clarifications help members understand how a benefit is covered**.**

B. 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 benefits clarification worksheet for each proposed clarification**. You may combine more than one clarification to the same benefit, but you must present each one clearly on the worksheet. Remember to use plain language.

2. Explain the reason for the proposed clarification.

Part Two – Preparing Service Area Changes

I. Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2017 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed-care industry, there are geographic areas where our customers have more limited choices than in other areas.

II. Please consider expanding your FEHB service area to all areas in which you have authority to operate. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose.**

III. We will provide detailed instructions for submitting your ZIP Code files in September. However, please note that we will ask you to provide your ZIP Codes in a comma delimited text file format and we will provide instructions for uploading your files to our secure web portal.

A. **Service Area Expansion** - You must propose any service area expansion by May 31, 2016. We may grant an extension for submitting supporting documentation to us until June 30, 2016.

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

IV. Important Notices

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

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

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

V. Service Area Expansion Criteria

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

1. Legal authority to operate.
2. Reasonable access to providers.
3. Choice of quality primary and specialty medical care throughout the service area.
4. Your ability to provide contracted benefits.
5. Your proposed service area must be geographically contiguous.

B. You must provide the following information:

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

2. Provide the proposed service area expansion by ZIP Code, county, city or town (whichever applies) and a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure.

3. The authority to operate in proposed area.

   Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.

4. Access to providers.

   Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have **executed** contracts. You must update this information by August 31, 2016. 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.

VI. Service Area Reduction Criteria

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

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

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

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

B. You must provide the following information:

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

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

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

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

Federal Employees Health Benefits Program statement about Service Area Expansion

(COMPLETE THIS FORM ONLY IF YOU ARE PROPOSING A SERVICE AREA EXPANSION)

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2017 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 2017. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to Call Letter (Carrier Letter 2008-06) dated March 11, 2008.

If you propose to eliminate any state mandated benefits normally included in your community package, specify them in your benefit proposal and provide a rationale.

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

1. Limiting cost growth;
2. Managing prescription drugs;
3. Ensuring access to care;
4. Coordinating benefits for the Medicare population;
5. Implementing plan performance assessment; and
6. Continuing to implement Self Plus One coverage.

I. 2017 INITIATIVES

A**.** Limiting cost growth:

Limiting plan cost growth will allow Plans to remain competitive, attract and retain members. OPM continues to encourage all Carriers to address rising healthcare costs through a review of plan design, provider networks, pharmacy programs and benefit management initiatives. The review should also include member education on how to use their benefits and services in a cost-effective manner. For the 2017 plan year, OPM is urging Carriers to evaluate drivers of health care costs and offer solutions to achieve both short and long-term savings for the FEHB Program. Controlling costs and increasing member health remains a priority for OPM. We want Carriers to provide cost-effective quality care. Carriers are expected to explore innovative models of health care delivery that can help manage and control costs as well as producing better health outcomes. In line with this expectation, Carriers are encouraged to offer proposals that address ways in which to limit cost growth.

Title IX, Subtitle A, section 9001 of the Affordable Care Act (ACA), which established an excise tax on high cost employer-sponsored health coverage has been delayed until 2020. To remain competitive, it is extremely important for Plans to avoid this additional cost.

Plans that exceed specified annual limits must pay the tax of forty (40) percent of any dollar amount beyond the cap that is considered excess health spending. As an example, the 2018 limits would be as follows:

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

In order to prepare for this tax, Plans must assess each of their Plan options and include a multi-year assessment of any changes needed if they will believe they may be subject to the excise tax

in 2020. Plans are strongly encouraged to review all aspects of cost control and develop innovative cost-reduction strategies with limited member impact. The multi-year assessment should be provided by year.
Examples of areas for review include:

- Wellness programs – See Carrier Letter 2016-04;
- Dental and vision coverage;
- Deductibles, catastrophic limits and copays;
- Provider Networks/Access to care;
- Pharmacy management cost strategies such as utilization management/formulary management;
- Disease management programs that target and manage chronic conditions;
- Care coordination and long-term care management; and
- Coverage for health-related travel costs to hospitals and other providers recognized for quality care and health outcomes.

B. Managing prescription drugs:

OPM continues to emphasize the effective use of prescription medications while managing drug costs. Your proposals should highlight how you will achieve these goals through benefit structure and program initiatives. At a minimum, 2017 proposals must describe the strategies you have in place, or propose specific strategies, to manage high cost prescription drugs within the following categories:

- Compound pharmaceuticals
- Biosimilar medications
- Dermatological preparations
- Lipid lowering drugs
- Drugs for hepatitis
- Oncology drugs
- Diabetes drugs

Formularies

To prevent selection bias or discrimination, all Carriers must address how their formulary design facilitates appropriate access to drug therapy for members with chronic conditions, such as rheumatoid arthritis, HIV, and serious mental illness.

Carriers proposing or revising managed formularies must complete the spreadsheet included as Attachment VII, Drug Formulary Worksheet.xlsx. Please include the name of the Carrier in the file name before the suffix (xlsx). This will allow OPM to evaluate the range and adequacy of coverage in key therapeutic classes, along with any potential barriers to access. The sample spreadsheet includes two therapeutic classes for purposes of illustration. You must complete the spreadsheet for **all** of the following therapeutic classes:

- Inhalers for control of asthma and COPD (exclude immediate acting rescue inhalers)
- Cholesterol lowering drugs
- Growth hormone preparations
- Second generation antipsychotics
- Tumor Necrosis Factor blockers

- Testosterone preparations
- Long acting insulin preparations
- Drugs for narcotic addiction (specifically naltrexone, naloxone, buprenorphine, methadone)
- Antiviral drugs for HIV infection
- Antiviral drugs for Hepatitis C
- Topical pain preparations
- Aromatase inhibitors

Please use either the National Drug Code (NDC) or RxNorm Concept Unique Identifier (RxCUI) for each drug in each therapeutic class. Include the brand name, dose form, ingredient name, and assigned formulary tier. If you submit RxCUI, it must be accompanied by the Semantic Clinical Drug Component (SCDC). Those submitting NDC may omit the SCDC.

In a separate Word document, all Carriers using more than the four tiers outlined in Carrier Letter 2015-02 should document the relevant tier definitions.

Proposals must also include a communication plan for physicians, pharmacies and members. Carriers making changes to their formulary should highlight those changes and how they will inform members. Carriers must also have a formulary exception process that permits reimbursement of non-covered drugs when justified by members' medical needs. Descriptions of these processes should include relevant timelines.

Transparency

Beginning in 2006, OPM began an emphasis on fostering pharmacy price transparency. In Call Letters 2014-03 and 2015-02, plans were asked to provide easy and convenient access to information about the formulary tier and member cost-share for prescription drugs. Plans are expected to have a user-friendly, easy-to-locate interactive tool on their website available to current and prospective enrollees without a log on requirement. A formulary list with tier information is insufficient to meet this objective.

Proposals must describe how the carrier meets this requirement and include a link to the pharmacy price transparency tool. The pharmacy tool should display the following information: name of drug, dosage/strength, indicator of brand or generic, an estimated cost of the drug through retail (30 days) as well as mail-order (90 days) or other delivery channels, and utilization management requirements (step-therapy, pre-authorization, etc.).

Patient Safety

Over 80% of FEHB Carriers have quantity limits for narcotics, as well as for stimulants and sleep medications. Any Carrier that does not have these limits in place should describe how they ensure safe utilization of these drugs with misuse and diversion potential.

We strongly encourage Carriers to review and improve access to drugs used to manage addiction, including reversal agents and Medication Assisted Treatment. Questions in the Automated Data Collection (ADC) tool address specifics of access to this important care.

Please submit a copy of your medical policy pertaining to buprenorphine use along with your proposal. Also, any Carrier excluding methadone maintenance must provide justification of the basis for this exclusion to OPM for review.

Adherence

Proposals should also include details of programs that help to identify patients at risk and increase their adherence to prescribed medications. Please describe how you use pharmacy claims data to identify and intervene with members who have abandoned/failed to refill maintenance medications.

Medication reconciliation is an established technique to reduce drug interactions and adverse drug events that may lead to hospital readmission, as well as to enhance patient adherence. Your responses to ADC questions will help evaluate adoption of this practice among FEHB plans as well as opportunities to improve.

C. Ensuring access to care:

1. Applied Behavior Analysis (ABA): Beginning in 2017, FEHB Carriers may no longer exclude ABA for the treatment of Autism Spectrum Disorder. This section provides further program management details for Carriers to consider when developing proposals to offer this benefit at an affordable cost.

   Carriers that offer ABA as a habilitative service may propose a fully case-managed benefit with prior authorization, and describe their coverage in brochure section 5(a) under Treatment Therapies**.**

   If a Carrier instead 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. Under this circumstance, coverage should be described in brochure Section 5(e) Mental health and substance abuse benefits. The brochure should also include a reference under section 5(a) that ABA Therapy can be found in Section 5(e). The brochure should also include a reference under section 5(a) that ABA Therapy can be found in Section 5(e).

   For service characterization, coding, and billing, Carriers may wish to consult CPT Category III codes for reporting adaptive behavior assessment and treatment. These codes (0359T through 0374T) were initially published by the AMA in July 2014.

   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. Telehealth: Many Carriers now offer telehealth options for urgent care, along with various options for urgent care centers or retail health clinics. These types of visits can be more convenient than office visits and much more cost effective than emergency services. We urge Carriers to make a special effort to educate members about the availability of these services. To facilitate clear communications, we have added a new heading for Urgent Care in brochure Section 5(a). Please see the brochure template for details.

3. Population Health and Wellness: Carriers not meeting the goals for Health Risk Assessment and biometric screening outlined in Carrier Letter 2016-04 must include a description of new or improved efforts to target outreach and enhance participation. Incentives must be evidence based and available to all enrollees. Any tax implications must also be addressed.

4. In-Network Benefits: All proposals should include a description of your efforts to minimize member exposure to out-of-network services at in-network facilities. Please detail your procedures for notifying members who may be subject to out-of-network cost sharing before elective services are delivered. ADC questions will ask about professional services claims that were processed as out-of-network services for key specialists.

5. Transgender Services: Plans proposing to include surgical benefits for gender transition should submit the relevant medical policy describing covered procedures, applicable pre-authorization requirements, and a list of network providers qualified to perform these procedures. If network providers are not available, plans should describe how members are directed to qualified providers with experience delivering this specialized care.

6. End of Life Care: All proposals should clarify services available for advance care planning and hospice along with applicable duration (days, periods of service) and payment arrangements. OPM strongly encourages Carriers to offer these services to all members in need, regardless of age or Medicare status. Any Carriers proposing age, Medicare status, or dollar limits must submit detailed justification for OPM review.

D. Coordinating benefits for the Medicare population:

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

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. Plans should not reimburse Medicare premiums directly on behalf of members, except as allowed under a Health Reimbursement Arrangement (HRA). If this applies to your plan, it should be made clear to the Plan's Medicare population.

Payment of Medicare premiums through an HRA is one method by which plans can offer a clear incentive for members and prospective members to enroll in Medicare Part B. Under Section 213 of the Internal Revenue Code, HRAs may be used to pay Medicare Part B insurance premiums. Additionally, employers have complete flexibility to offer various combinations of benefits in designing their plan. Because of this flexibility, we encourage plans that choose to use this method to encourage Part B participation to restrict the HRA's covered benefits to a combination of benefits that would appeal to dually enrolled Medicare and FEHB Program members. We encourage plans to fully review legal requirements to ensure that any proposal complies with applicable statutes and regulations.

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.

E. Implementing Plan Performance Assessment:

We strongly encourage Carriers to monitor their progress on Plan Performance Assessment measures throughout the plan year. In addition to offering an OPM forum for Carriers to discuss best practices, several ADC questions are designed to seek Carrier input on specific measures.

F. Continuing to implement Self Plus One Coverage:

We expect proposals for Self Plus One rates to be lower than Self and Family rates. In no event can Self Plus One rates be higher than Self and Family rates. Carriers should refer to the rate instructions for their plans for further guidance.

II. BENEFITS & SERVICES

A. Continued Focus from Previous Years

1. Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2017. When you determine that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not

obligated to wait for the next contract year before they begin providing such benefits. The following tables are in Attachment V:

Table 1 – OPM's required list of covered organ/tissue transplants. We have added Kidney-Pancreas to the list of required organ/tissue transplants. If your Plan does not currently cover this transplant, you must submit a benefit change worksheet.
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 - 2017 Organ/Tissue Transplants and Diagnoses.

2. 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.

3. 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. The Mental Health Parity final regulations provide express disclosure requirements. Specifically, the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. In addition, the reason for any denial of reimbursement or payment for mental health or substance use disorder services must be made available to beneficiaries. In your proposals, please describe your procedures for disclosure of this information to members.

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 6-7 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. Is the benefit change a part of the plan's proposed community benefits package?
- (a) If yes, when?
- (a) If approved, when? (attach supporting documentation)
- (b) How will the change be introduced to other employers?
- (c) What percentage of the plan subscribers now have this benefit?
- (d) What percentage of plan subscribers do you project will have this benefit by January 2017?

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 2017?
- (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
A. [Insert Subsection Name]

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

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

Benefit Clarification Description

Applicable options:

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

Current Benefit Language	Proposed Clarification	Reason For Benefit Clarification

Attachment IV
Preparing Your 2017 Brochure and Benefits Plus Data Submission

I. Preparing Your 2017 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: 2017 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 1	Plans receive *2017 FEHB Brochure Handbook* via listserv
July 5	OPM will provide *2017 Brochure Creation Tool (BCT) User Manual*
July 11 – 15 & 18 - 22	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 Kaisha Elphick at Kaisha.Elphick@opm.gov

II. Benefits Plus Data Submission

Timeline: 2017 Benefits Plus Process
We will continue to use the Benefits Plus system we implemented last year to collect some data from Carriers. We have expanded the data collected this year, and made changes to Benefits Plus to improve functionality and performance. This year's deadlines and significant dates are:

DEADLINES	ACTIVITY
July 1	Plans receive Benefits Plus change information via listserv
July 11- 15 & 18-22	OPM in-house training on the use of Benefits Plus: 10 in- house individual sessions, 2 Webcast sessions
September 2	Plans must enter all plan specific information in Benefits Plus. Plans will be unable to make changes after this date so that Contract Specialists can review the information. If changes need to be made, we will unlock plan access on a case-by-case basis.

Additions to Benefits Plus data input will include those necessary for the updated presentation of information within the OPM plan comparison tool located at www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/.

For Password resets and technical questions, please contact Kaisha.Elphick@opm.gov.

If you have suggestions on changes to Benefits Plus, please send them to Stephen.Rappaport@opm.gov and Nicole.Nelson@opm.gov.

Attachment V
2017 Organ/Tissue Transplants and Diagnoses
Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	**Reference**
Cornea	Carrier Letter 92-09
Heart	Carrier Letter 92-09
Heart-lung	Carrier Letter 92-09
Kidney	Carrier Letter 92-09
Kidney - Pancreas	
Liver	Carrier Letter 92-09
Pancreas	Carrier Letter 92-09
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Carrier 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. The Plan extends coverage for the diagnoses as indicated below**.**	
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 2017?	
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
2017 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		
Technical Guidance Submission Checklist (Attachment VI)	N/A	

Please return this checklist with your CY 2017 benefit and rate proposal

Attachment VII
2017 Technical Guidance Managed Formularies Spreadsheet

See file *Drug Formulary Worksheet Analysis* attached with listserv