
FEHB Program Carrier Letter

Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2018-05 (b)

Date: April 20, 2018

Fee-for-service [n/a] Experience-rated HMO [4] Community-rated HMO [4]

Subject: 2019 Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMOs

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2019 through December 31, 2019. The Federal Employees Health Benefits (FEHB) carrier guidance is issued in two documents:

1. The annual Call Letter (Carrier Letter 2018-01,) dated January 23, 2018, provides guidance on OPM's initiatives for the 2019 benefits negotiation cycle.
2. The Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMO's provides more technical requirements for the items listed in the Call Letter.

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: Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program
- Part Three: Benefits for Newly-Approved HMOs

This year's deadlines are as follows:

- **Due by May 7, 2018:** Please send your community benefit package and most commonly offered group benefit package.
- **Due by May 31, 2018:** Please send your complete proposal for benefit changes and clarifications to your Health Insurance Specialist by electronic means in addition to a hard copy. Your proposal should include language describing all proposed brochure changes. Your OPM Health Insurance 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 Health Insurance Specialist:** Please send him/her an electronic version of your fully revised 2019 brochure. See Attachment III - Preparing Your 2019 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 costs, and improve quality of care and the health of the enrolled population.

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

It is incumbent upon you to ensure that each of your benefit proposals is in accordance with all applicable Federal laws and regulations. Rate instructions for community-rated plans and experience-rated plans will be provided under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

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 recoup any improper payments.

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

Sincerely,

Alan P. Spielman
Director
Healthcare and Insurance

Attachments:

Attachment I – FEHB Carrier Contracting Official
Attachment II – FEHB Benefit Difference Comparison Chart in-Network Benefits Spreadsheet
Attachment III – Preparing Your 2019 Brochure and Benefits Plus Data Submission
Attachment IV – 2019 Organ/Tissue Transplants and Diagnoses
Attachment V – 2019 Technical Guidance Submission Checklist
Attachment VI – 2019 FEHB Drug Formulary Template

2019 FEHB Proposal Instructions

Part One: Preparing Your 2019 Benefit Proposal

I. All HMOs

A. 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:

1. Benefit package documentation.
2. A plain language description of each proposed benefit.
3. A signed contracting official's form (Attachment I).
4. In a cover letter accompanying your community package, 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 to 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, 2018**, and you obtain approval and submit approval documentation to us by **June 30, 2018**. Please let us know 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. The review period must have elapsed without objection by June 30, 2018.

Please include 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. If applicable, please include which state you have designated as the situs state. We will contact a state about benefits as necessary.

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 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.
 - a. 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.
 - b. Copays, coinsurance, benefits limitations, and exclusions must not vary by enrollment type.
 - c. FEHB Plans with High Deductible Health Plans must be cognizant of Treasury/IRS - 26 U.S. Code § 223; which requires twice the dollar amount for Self Plus One or Self Plus Family for deductibles, catastrophic maximums, and

premium pass-through contributions, that it does 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 type provides benefits for the enrollee and all eligible family members.

C. The Community Benefit Package (Certificate of coverage or Evidence of coverage) is the commercial health plan sold to the majority of non-Federal employees. Your proposal should reflect this package of benefits unless specific changes are approved in advance by your Health Insurance Specialist. A piece-meal collection of the most commonly purchased benefits taken from a number of different commercial health plan packages does not meet OPM's requirement.

D. Complete Attachment II - (Community Rated Plans Only) Benefit Difference Comparison Chart. Include on your chart:

1. Differences in copays, coinsurance, numbers of coverage days, and coverage levels in the three packages. In-network benefits are entered on a separate worksheet than out-of-network benefits.
2. Please highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 7, 2018, or if they were not specifically addressed in previous negotiations.
3. Please include whether riders are required within your *proposed 2019 FEHB benefit package*. For all community-rated plans, indicate the name of the community benefit package, including the entity noted as having the largest number of non-Federal employees number of subscribers/contract holders who purchased the 2018 package and who are expected to purchase the 2019 package.

E. 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. Please highlight and address any state mandated benefits. State-mandated benefits should be reported if finalized by May 7, 2018.

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. Please send the following by **May 7, 2018**:

1. A copy of a fully executed employer group contract (i.e., *Certificate of coverage or Evidence of coverage*) that non-Federal subscribers purchased in 2018.

B. Please send the following which must be received by **May 31, 2018**:

1. You must file your proposed benefit package (Certificate of coverage or Evidence of coverage) and the associated rate with your state, if required. If you have made changes since your application, submit a copy of the new benefits description and answer the questions below.
2. Attach a chart displaying the following information:
 - a. Benefits that are covered in one package, but not the other,
 - b. Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other.
 - c. The number of subscribers/contract holders who currently purchase each package.

III. Community-rated Plans

A. We will allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions. 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.

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 Health Insurance Specialist and your contact in the Office of the Actuaries regarding the alternate community package and refer to the rate instructions.

1. Submit a copy of a fully executed community benefit package by May 7, 2018 (also known as a master group contract or subscriber certificate), including riders, copays, coinsurance, and deductible amounts (e.g. prescription drugs and durable medical equipment) that non-Federal subscribers purchased in 2018. The material must show all proposed benefits for FEHB for the 2019 contract term, except for those still under review by your state. We will accept the community benefit package that you *project* will be sold to the majority of your non-Federal subscribers in 2019. If you offer a plan in multiple states please send us your community benefit

- package for each state that you intend to cover.
2. Your FEHB rate must be consistent with the community-benefit package on which it is based. Benefit differences must be accounted for in your proposal or you may end up with a defective community rate.

Part Two: Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program

- I. Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2019 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. This will allow greater choice for our customers. **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 file 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.
- 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.

V. Service Area Expansion Criteria

A. We will evaluate your service area proposal 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:

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.

2. 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.

3. Access to providers:

Provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have **executed** contracts. Also, please update this information by August 31, 2018. 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 and Additional Geographic Areas:

1. Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an **additional** geographic area that surrounds, or is adjacent to, your service area, you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to enroll members who **work** but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy in your brochure.
2. Benefits may be restricted for non-emergency care received outside the service area. Your proposal must include language to clearly describe any additional geographic area as well as your service area.

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 2019 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. 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 Newly-Approved HMOs

The policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your Health Insurance Specialist to develop a complete benefit package for 2019. 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 policy goals and initiatives this year are:

- A. Addressing the Opioid Epidemic
- B. Prescription Drugs
- C. Additional Plan Design and Benefit Management Initiatives
 - 1) Excise Tax
 - 2) High Deductible Health Plans
 - 3) Genetic Testing
- D. Continuing Emphasis on Population Health

I. 2019 INITIATIVES

A. Addressing the Opioid Epidemic

Section II of Carrier Letter 2018-01 highlights OPM's expectation that all FEHB Carriers will strengthen their efforts to prevent opioid misuse and provides a listing of requirements that must be included in 2019 proposals. Additional information is provided below:

1. Provide a description of provider outreach regarding opioid risks, including efforts made to reach out to dental providers and other specialists such as obstetricians. Effective outreach should cover screening of patients for opioid use history, pathways for referral to treatment, as well as recommendations for Prescription Drug Monitoring System use.
2. Please provide the methods used for ensuring that enrollees are aware of opioid risks and other modalities for the treatment of pain. Include proposed plans to enhance the program.
3. Please use the chart below to describe any proposed quantity and prior approval limits on opioid medications, along with summary of safety edits for initial opioid prescription fills and high morphine milligram equivalent doses in the table below:

Proposed initiative start date	Name of Opioid Preparation	Quantity Limit	Prior Approval	Safety Edit (incl. MME dose if applicable)

4. Provide a summary of proposed efforts to promote safe disposal of prescription medications in the table below:

Type of program to promote safe disposal	Proposed program start date	Proposed # of prescriptions impacted	Cost to be incurred

5. Include proposed initiatives to further improve access to medication assisted treatment (MAT) in the table below:

Proposed initiatives to further improve access to MAT	Proposed initiative start date	# of products/providers affected/added
Adding qualified network providers		
Removing prior approval requirements		
Removing quantity limits		
Adjusting formulary placement		
Other proposed initiatives -		

6. Naloxone-based rescue agents are essential for the prevention of opioid overdose related deaths. OPM recognizes these rescue agents as preventive care. This will allow a corresponding copay waiver and remove any financial barriers that would prevent members from obtaining a naloxone-based product. This also allows high deductible health plans (HDHPs) to provide some naloxone-based rescue agents without a deductible under the preventive care safe harbor of Section 223(c)(2)(C) of the Internal Revenue Code. Use the chart below to describe any initiatives in place (or proposed) to facilitate access to naloxone-based rescue agents.

Proposed initiatives to facilitate access to naloxone based rescue agents	Proposed initiative start date	# of Naloxone-based products impacted
Reducing cost sharing - deductibles still apply		
Reducing cost sharing - deductibles do not apply		

Eliminating cost sharing - deductibles still apply		
Eliminating cost sharing - deductibles do not apply		
Removing prior approval requirements		
Other proposed initiatives -		

7. Please describe how you ensure the availability of addiction treatment programs for special populations such as pregnant women and youth.
8. List proposed changes to non-opioid pharmacy benefits for pain management in the table below:

Non-opioid prescription product	Proposed initiative start date	Change to formulary tier	Removal of prior authorization	Removal of step therapy	Removal of quantity limit	Other changes

9. Proposals must also include an assessment of the adequacy of current non-pharmacologic benefits for pain management, including physical therapy, chiropractic or other manipulative therapy, acupuncture, injection therapies, and cognitive therapies. Describe your proposed changes to non-pharmacologic benefits for pain.
10. Fraud and abuse in drug testing is a growing concern for FEHB health plans and the FEHB Program. Your proposal must include the following with your submission:
 - a. Description of your concurrent utilization review process to pend suspicious claims for investigation;
 - b. Description of your retrospective utilization review process to assess the effectiveness of your overall program to combat drug testing abuses; and
 - c. Your maximum plan allowance for out-of-network drug testing and how it meets mental health parity.
 - d. Your drug testing medical policy as of 2018 that is based on relevant clinical guidelines from organizations such as the American Society of Addiction Medicine (ASAM) or the Substance Abuse and Mental Health Services Administration (SAMHSA); Within the scope of evaluating your current policy, you may wish to review items including:
 - Appropriate medical necessity criteria for definitive (quantitative) and presumptive (qualitative) urine drug testing, including frequency limitations.
 - CPT and HCPCS codes that are covered for drug testing. For example, many plans are limiting drug testing coverage for presumptive drug testing

to CPT codes 80305, 80306 and 80307 along with a limitation that the screen may only be performed once per date of service. Definitive drug testing is frequently limited to HCPCS codes to G0480, G0481, G0482, and G0483.

- Medicare’s strategy to zero-price CPT drug testing codes 80300-80377 (except 80305, 80306 and 80307).

B. Prescription Drugs

OPM expects carriers to have effective management programs in place for formulary, utilization, pharmacy network, medication therapy and chronic disease management to support the delivery of quality and affordable healthcare to members. Proposals should address the following:

- How medication management, pharmacy network and utilization management (UM) programs are coordinated to support chronic disease management.
- How the formulary is structured to support the various pharmacy programs. Include an updated copy of the pharmacy policy that guides formulary decision making.
- In addition, carriers must complete one of the two tables below:

For FEHB plans implementing a new medication management program:

Proposed Medication management program name	Projected # of members to be enrolled	Inclusion criteria	Exclusion criteria (if any)

For FEHB plans making enhancements to an existing medication management program:

List enhancements made to existing medication management program	Projected impact to existing program	Projected # of members to be enrolled	Inclusion criteria

C. Additional Plan Design and Benefit Management Initiatives

Excise Tax

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 2022.

To remain competitive, it is imperative for Plans to avoid this additional cost. Carrier Letter 2016-07 directed carriers who projected they would be subject to the tax in 2020 to submit a multi-year assessment of any changes needed to avoid the excise tax.

In an effort to avoid incurring an excise tax penalty in 2022, carriers should communicate the following with their proposal:

- Any measures that have been implemented to avoid an excise tax penalty in 2022.
- How the carrier anticipates the measures above will assist in addressing the potential impact of the excise tax.

High-Deductible Health Plans (HDHPs)

Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied. However, section 223(c)(2)(C) of the Internal Revenue Code provides a safe harbor for the absence of a preventive care deductible. That section states, a “plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care.” Certain maintenance medications may be beneficial to the health of the members and should be included as preventive. However, the IRS does not list what drugs are considered preventive. Please identify maintenance medications that you propose be included under the safe harbor to deductibles in HSA-qualified HDHPs.

Genetic Testing

Carriers should describe their approach to a comprehensive genetic testing strategy and outline covered benefits. Proposals must include:

- A copy of any relevant corporate policy framework or medical policy that guides genetics benefit management
- Specifics of covered testing
- A list of vendors (as applicable) used by the plan to provide market intelligence and/or genetics decision support, with a short description of the scope of each contract
- Any covered genetic counseling for members or test interpretation services for ordering providers

All new features being proposed for 2019 contracts should include estimated costs and offsets. (For example: cost of genetic decision support contract may be offset by more precise application of testing, or cost of cancer genetic testing may be offset by more informed drug treatment decisions.) Continuing benefit features should be so annotated whenever possible.

D. Continuing Emphasis on Population Health

In 2017, the U.S. Preventive Services Task Force (USPSTF) reviewed and updated 4 recommendations that already carried an A or B rating. In addition to addressing the USPSTF recommendations to refer qualifying adults to intensive behavioral counseling interventions for

cardiovascular disease and diabetes prevention in their 2019 proposals, Carriers are reminded to review programs and benefits pertaining to:

- folic acid for the prevention of neural tube defects
- screening for preeclampsia
- screening for vision in children ages 6 months to 5 years, and
- screening and referral to comprehensive, intensive behavioral interventions to treat obesity in children and adolescents.

Carrier proposals should describe any benefit changes needed to align with these USPSTF updates. Useful references are included in Carrier Letter 2018-01.

FEHB carriers are required to follow CDC’s Advisory Committee on Immunization Practices (ACIP) recommendations on immunizations. Carrier Letter 2018-01 reminds Carriers that ACIP recommends a dose of Tetanus, Diphtheria, and Pertussis (Tdap) vaccine during each pregnancy and highlights recent changes to the human papillomavirus (HPV) vaccination schedule. As applicable, proposals should also address any benefit or cost changes related to the new vaccine for the prevention of herpes zoster in adults aged >50 years and the requirement for many older adults to receive 2 types of pneumococcal vaccines. Additionally, changes in recommended age ranges for certain vaccines may have a cost impact and reduced schedules for other vaccines may provide a cost offset. Please complete the following table with your proposal. The vaccines listed are examples only. Your submission should include only your plan’s specific changes.

Product	Change	Effective date	Number of members impacted	Cost impact (+ or -)	Proposed outreach strategy
Tdap	One dose during pregnancy	ongoing			
HPV	Two dose schedule for some recipients	ongoing			
Shingrix	Wider age range	Jan 1, 2019 or actual available date			
Zostavax	lower use as Shingrix becomes more widely utilized				

PPSV23/Pneumovax23	Adults 65+, order and timing interval	ongoing			
PCV13/Prevnar 13	Adults 65+, order and timing interval	ongoing			
MenB	2 dose schedule for Trumenba in young adults	ongoing			

Plan proposals should also describe communication pathways to ensure providers and members receive updated information about covered vaccinations. The most reliable method for tracking current and accurate immunization schedules on your intranet or consumer portal/website is through the use of content syndication from the CDC. Use of content syndication requires a one-time step that ensures an organization’s website displays current schedules as soon as they are published or revised; instructions for the syndication code are available on CDC’s website at (<https://www.cdc.gov/vaccines/schedules/syndicate.html>). CDC also offers technical assistance for implementing this form of content syndication (e-mail request to ncirdwebteam@cdc.gov.)

II. BENEFITS & SERVICES

Continued Focus from Previous Years

1. Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2019. 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 IV:

Table 1 – OPM’s required list of covered organ/tissue transplants. We have removed Autologous transplants for acute lymphocytic leukemia, since this diagnosis is not treated with autologous transplant.

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 IV - 2019 Organ/Tissue Transplants and Diagnoses.

2. Healthy Maternity Outcomes

Carrier Letter 2017-04 strongly encouraged all plans to review their coverage of specialized medical foods for children and pregnant women with Phenylketonuria (PKU) to align with current clinical guidelines and help ensure optimal pregnancy outcomes. Given the rarity of this condition, OPM estimated the cost impact of adding coverage for medical foods for all PKU affected children and pregnant women across the FEHB program as minimal. Carriers proposing to update coverage for 2019 should include details with their proposals, along with justification for any proposed age limits.

3. 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 co-payment. 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.

4. Coordination of Benefits

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 coinsurance on secondary COB claims. If your benefit design includes coinsurance, 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% coinsurance.

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 \times 10\% = \180
Plan pays:	$\$1,800 \times 90\% = \$1,620$

If your brochure language does not currently describe this process correctly, please work with your Health Insurance Specialist to ensure that your 2018 Federal brochure correctly describes this process.

5. Catastrophic Limitations

We expect carriers to fully describe their catastrophic limitations for all benefits as well as balance billing for the services of out-of-network providers to ensure FEHB enrollees receive appropriate coverage for medically necessary services. We encourage proposals to mitigate any gaps you may have in the catastrophic coverage that you offer.

Please provide a full description of your catastrophic limit(s):

- a. Describe the expenses that fall under each of these categories: medical, surgical, mental health and prescription drug benefits.
- b. Please indicate completely what expenses are still the member's responsibilities after the member has reached the limit.
- c. If you have an out-of-network benefit, please include any payments that members could be responsible for after they have met the catastrophic limit, including provider balance billing. We will consider cost neutral proposals that mitigate the potential for high cost sharing.
- d. Given your catastrophic limits, what is the maximum out of pocket expense a member may pay for covered services?

6. 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 2019 brochure language clearly describes your coverage.

7. 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 coinsurance 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 or provide habilitative services consistent with the state benchmark.

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 (Community Rated Plans Only)
FEHB Benefit Difference Comparison Chart
In-Network Benefits Spreadsheet

See *FEHB Benefit Difference Comparisons Chart In-Network Benefits Spreadsheet*
attached with listserv

Attachment III
Preparing Your 2019 Brochure and Benefits Plus Data Submission

I. Preparing Your 2019 Brochure

Summary of Plan Benefits

FEHB Plans will 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 subsequent carrier guidance.

Going Green

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

Timeline: 2019 Brochure Process

You will use a web application called the Brochure Creation Tool that uses database software to generate a Section 508-compliant PDF of your FEHB brochure. This year’s deadlines and significant dates are:

DEADLINES	ACTIVITY
May 31	Plans submit <u>Section 5 Benefits</u> information with proposal if proposing new option.
July 2	Plans receive: <i>2019 FEHB Brochure Handbook.</i> Updated FEHB Brochure Handbook pages by Listserv.
July 13	OPM will provide <i>2019 Brochure Creation Tool (BCT) User Manual</i> in the BCT.
July 16 – 20	OPM in-house training on the use of the Brochure Creation Tool.
August 15	OPM’s deadline to finalize all language and shipping labels.
August 31	Plans must complete entering all data into <u>Section 5 Benefits</u> and update all plan specific information in the Brochure Creation Tool. Plans will be unable to make changes after this date so that Health Insurance Specialists can review PDF versions of plan brochures.
September 11	OPM sends brochure quantity form to plan after Health Insurance Specialist approves brochure for printing as well as other related Open Season instructions.

In mid-July, we will provide in-house training on the use of the Brochure Creation Tool with five 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 Kaisha Elphick at kaisha.elphick@opm.gov.

II. Benefits Plus Data Submission

Timeline: 2019 Benefits Plus Process

We use the Benefits Plus system to collect some data from carriers. This year's deadlines and significant dates are:

DEADLINES	ACTIVITY
April 1 - 15	Plans enter Table 1 Enrollment Data
July 16-20	OPM in-house training on the use of Benefits Plus: 10 in-house individual sessions, 2 Webcast sessions.
August 31	Deadline for the plans to complete all data and plan specific updates within Benefits Plus. Plans will be unable to make changes after this date unless directed or approved by their Health Insurance Specialist.

OPM determines and communicates any additions to the required Benefits Plus data input that may be required for Plan Comparison Tool (www.opm.gov/healthcare-insurance/healthcare/plan-information/compare-plans/) enhancements via listserv by mid-July.

For Password resets please contact Kaisha.Elphick@opm.gov.

For technical questions or if you have suggestions on changes to Benefits Plus, please send them to Stephen.Rappaport@opm.gov and Maria.Bianchini@opm.gov.

Attachment IV
2019 Organ/Tissue Transplants and Diagnoses
Table 1: Required Coverage

I. Solid Organ and Tissues 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
Kidney - Pancreas	Call Letter 2017-04
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 indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, or 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:	
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's lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for 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 2019?	
	Yes	No
Blood or Marrow Stem Cell Transplants		
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) relapsed/refractory disease		
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 2019?	
	Yes	No
Solid Organ Transplants		
Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann’s syndrome		
Leukocyte adhesion deficiencies		
Mucopolysaccharidosis (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:		
Ependyoblastoma		
Ewing’s sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom’s macroglobulinemia		

**Attachment V
2019 Technical Guidance Submission Checklist**

Topic/Attachment Number	In Proposal Yes/No/NA	Worksheet Completed Yes/No/NA
Attachment I FEHB Carrier Contracting Official		
Attachment II (Community Rated Plans Only) FEHB Benefit Difference Comparison Chart		
Attachment III Preparing Your 2019 Brochure and Benefits Plus Data Submission		
Attachment IV 2019 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3		
Attachment V Technical Guidance Submission Checklist	N/A	
Attachment VI 2018 FEHB Drug Formulary Template	N/A	

Please return this checklist with your CY 2019 benefit and rate proposal

Attachment VI
2019 FEHB Drug Formulary Template

See Drug Formulary Template attached with listserv