
FEHB Program Carrier Letter

Health Maintenance Organizations

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2019-05 (a)

Date April 30, 2019

Fee-for-service [n/a] Experience-rated HMO [4] Community-rated HMO [5]

Subject: 2020 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, 2020 through December 31, 2020. The Federal Employees Health Benefits (FEHB) Carrier guidance for health benefit proposals is issued in three documents:

1. The annual Call Letter (Carrier Letter [2019-01](#)) dated March 14, 2019 outlines policy goals and initiatives for the 2020 plan year.
2. The Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals provides more technical requirements for the items listed in the Call Letter that must be addressed in your benefit proposals.
3. The 2020 Rate Instructions for Community-Rated Carriers are not included with these benefit instructions, but will be released shortly.

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, 2019:** Please send your community benefit package and non-Federal group benefit package we purchased.
- **Due by May 31, 2019 :** Please send your complete proposal for benefit changes and clarifications to your Health Insurance Specialist by email and overnight mail. Your proposal should include detailed draft language for all proposed brochure changes. Your Health Insurance Specialist will discuss your proposal with you and document accepted benefits and finalize negotiations in a close-out letter.
- **Please see Attachment IV - Preparing Your 2020 Brochure and Benefits Plus Data Submission** for additional deadlines.

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 evaluate their health plan options thoroughly 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 the 2020 Technical Guidance Submission checklist (Attachment VI) showing all the information to include with your benefit proposals. Please return the 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, identify, and recoup any improper payments.

We appreciate your efforts to submit benefit 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,

Alan P. Spielman
Director
Healthcare and Insurance

Attachments:

Attachment I – FEHB Carrier Contracting Official

Attachment II-a – (Community Rated Plans Only) FEHB Benefit Difference Comparison Chart Spreadsheet

Attachment II-b – Benefit Change Worksheet

Attachment III – Benefit Clarification Worksheet

Attachment IV – Preparing Your 2020 Brochure and Benefits Plus Data Submission

Attachment V – 2020 Organ/Tissue Transplants and Diagnoses

Attachment VI – 2020 Technical Guidance Submission Checklist

2020 FEHB Proposal Instructions

Part One: Preparing Your 2020 Benefit Proposal

I. All HMOs

- A. 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 piecemeal collection of the most commonly purchased benefits taken from a number of different commercial health plan packages does not meet OPM's requirements.
- B. **Complete Attachment II - a - (Community-Rated Plans Only)** Benefit Difference Comparison Chart that compares your current FEHB benefit package to your proposed 2020 FEHB benefit package and the 2019 community benefit package that we purchased. 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 31, 2019. Remember you must obtain approval and submit the documentation to us by June 28, 2019.
 3. Please include whether riders are required within your *proposed 2020 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 subscribers/contract holders who purchased the 2019 package and who are expected to purchase the 2020 package.
- C. 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 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, 2019**, and you obtain approval and submit approval documentation to us by **June 28, 2019**. 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 28, 2019.

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.

D. 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 our website: www.opm.gov/healthcare-insurance/healthcare/eligibility/ for eligibility criteria.
 - i. The 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.
 - ii. All other benefits, such as copays and coinsurance amounts, must be the same regardless of enrollment type.
 - iii. FEHB Plans with High Deductible Health Plans must be cognizant of 26 U.S. Code § 223, which requires that deductibles, catastrophic maximums, and premium pass-through contributions for Self Plus One or Self and Family coverage be twice the dollar amount of those 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.

E. Please send the following material by May 31, 2019:

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 2019 benefit package (adjusted for FEHB benefits) and your 2020 benefit package (Attachment II-a).
- c. Benefit package documentation (see [Benefit Changes](#) below).
- d. A plain language description of each proposed **benefit change** (Attachment II-b) and the revised language for your 2020 brochure.
- e. A plain language description of each proposed **benefit clarification** (Attachment III) and the revised language for your 2020 brochure.

Note: If you anticipate significant changes to your 2020 benefit package, please discuss them with your OPM Health Insurance 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 or Evidence of Coverage*) by May 6, 2019, that the majority of non-Federal subscribers purchased in 2019.
- 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 (Certificate of Coverage or Evidence of Coverage) 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 Health Insurance Specialist and your contact in the Office of the Actuaries regarding the alternate community package and refer to rate instructions. Submit a copy of a fully executed community-benefit package by May 6, 2019 (also known as a master group contract or subscriber certificate), including riders, copays, coinsurance, and deductible amounts that your non-Federal subscribers purchased in 2019. 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 intend 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 2020 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 2020.

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

1. Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II-b as the template to submit benefit changes. You must show all changes, however small, that result in an increase or decrease in benefits, even if there is no rate change.
2. We expect you to respond to each of the items in Information Required for Proposal in the worksheet format provided in Attachment II-b for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incorrectly formatted submissions.
3. As indicated in Carrier Letter [2019-01](#), in general, OPM continues to require that when proposing an increase in benefits, Carriers must propose corresponding benefit reductions within the same plan option to offset any potential increase in premium, with limited exceptions directed by OPM. However, for the 2020 plan year, under certain circumstances, OPM will consider Carrier-generated proposals for exceptions to this cost neutrality requirement, as follows:

Exception 1: A Carrier may include benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

- i. Ensure that a meaningful difference between plan options will continue to exist if the change is approved, and describe the difference;
- ii. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
- iii. Provide evidence to support that cost neutrality will be achieved in plan year 2020.

Exception 2: A Carrier may propose benefit enhancements that are not cost-neutral in the current year within a single plan option, if the Carrier can show a strategy to achieve cost

neutrality within that option, and eventual savings, in the near-term future (i.e., within three years).

Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.

4. Information Required for Proposal:

- a. Describe the benefit change completely. Show the proposed brochure language, including the “Changes for 2020” section in plain language using the active voice and written from the member’s perspective. Show clearly how the change will affect members and the complete range of the change. For instance, if you propose to add inpatient hospital copays, indicate whether the change will also apply to inpatient hospitalizations under the emergency benefit. **If there are two or more changes to the same benefit, show each change clearly.**
 - b. Describe the rationale for the proposed benefit change.
 - c. State the actuarial value of the change and if the change represents an increase or decrease in (a) the existing benefit and (b) your overall benefit package. If an increase, describe whether any other benefit change within that plan option offsets the increase. Include the cost impact of the change as a biweekly amount for the Self Only, Self Plus One, and Self and Family rates. Indicate whether there is no cost impact, or if the proposal involves a cost trade-off with another benefit and what benefit is being used as the offset. If you are proposing an exception to the cost-neutrality requirement, note the exception category (1, 2, or 3) and provide the information necessary to support that exception as described above.
5. If you anticipate significant changes to your benefit package, please discuss them with your OPM Health Insurance Specialist before preparing your submission.

V. Benefit Clarifications

A. Clarifications are not benefit changes. Clarifications have no premium impact. Please use Attachment III as a template for submitting all benefit clarifications. Clarifications help members understand how a benefit is covered. If a benefit is a clarification, there should not be a change in premium.

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 2020 contract term. We are committed to providing as much choice to our enrollees as possible. Given consolidations in the managed-care industry, there are geographic areas where our enrollees 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, 2019. We may grant an extension for submitting supporting documentation to us until June 30, 2019.
 - 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 plan/enrollment codes as necessary. In some cases, rating area or service area changes require 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; and
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. 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, 2019. 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. New Rating Area

- A.** We will evaluate your proposal to add a new rating area (or split a current service area) according to these criteria:

1. Why the area has been added;
2. How it relates to the previous service area (for example, the new rating area is a portion of an existing area that has been split into two or more sections); and
3. How the Carrier's current enrollment will be affected by the addition of this new rating area.

VII. 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; and
- e. 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 2020 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 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 2020. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to the 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 2020 plan year Call Letter, our policy goals and initiatives this year are:

A. Quality

1. Mental Health and Substance Use Disorder Services
 - a. Access to Care
 - b. Addressing the Opioid Epidemic
 1. Opioid Use in Pregnancy
 - c. Tobacco Cessation/E-cigarettes
2. Patient Safety
 - a. Maternal Health
3. Preventive Services

B. Affordability

1. Transparency
 - a. Drug Transparency Tools
 - b. Medical Services Transparency Tools
2. Prescription Drugs
 - a. Specialty Drug Management
 - b. Point-of-Sale Rebates
 - c. Incentivizing Generic Drugs
3. Controlling Fraud, Waste and Abuse (FWA)

I. 2020 INITIATIVES

A. Quality

1. Mental Health and Substance Use Disorder Services

Access to Care

OPM strongly encourages Carriers to remain focused on the provision of mental health benefits by improving access to and availability of treatment. Efforts to remove barriers to care are focused on both provider availability and access, as well as accessible and timely benefits within the plan.

As outlined in the Call Letter, Carriers must address how they are focusing on issues relating to provider access and availability:

- Provide information on how you monitor and address known Mental Health Care Health Professional Shortage Areas (HPSAs)¹.
- If your plan provides a telehealth benefit, provide information regarding how telehealth is being used in these shortage areas and in mental health coverage in general.
- Provide information on any specific initiatives to promote integrated mental health care or reimbursement models that promote this integration.
- Describe how you calculate payment for services provided by out-of-network providers at in-network rates when needed to provide timely access to specialized care for mental health.

OPM remains focused on mental health parity and the efforts to assure this parity exists in our member experiences. Carriers are reminded that parity requirements in the Mental Health Parity and Addiction Equity Act² (MHPAEA) apply to both Quantifiable Treatment Limits (QTLs) such as cost sharing, visit limits, or deductibles, and to Non-Quantifiable Treatment Limits (NQTLs), such as medical necessity criteria. OPM previously reviewed FEHB Plan compliance with non-quantitative parity requirements for mental health in Carrier Letter [2017-01](#). OPM is continuing our focus on assuring these barriers do not exist in the FEHB Program. Carriers should review their current benefits to ensure full compliance with MHPAEA and at a minimum plan proposals should:

- Indicate that the appropriate quantitative and non-quantitative testing has been completed.
- Describe in detail any limits you have for mental health and substance use disorder services. Include all information on treatment limits (such as limits on the number of days or visits covered) and on other limits such as limits on scope or duration of treatment.
- Identify the factors used in the development of the limitations (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment).

¹ See <https://data.hrsa.gov/tools/shortage-area>

² Mental Health Parity and Addiction Equity Act of 2008. <https://www.congress.gov/bill/110th-congress/house-bill/6983>

Addressing the Opioid Epidemic

Reducing opioid misuse continues to be a critical priority, as evidenced by enactment of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*,³ which was signed into law by President Donald J. Trump on October 24, 2018. We applaud the efforts that FEHB Carriers have made to mitigate the opioid epidemic, including putting in place requirements outlined in Carrier Letter [2018-01](#).⁴ The number of opioid prescriptions dispensed to FEHB Program members and the number of unique members receiving opioid prescriptions have fallen consistently over the past three years. FEHB Carriers have also implemented programs for providers and members to improve safe dispensing, utilization, and disposal of opioids, as well as increased access to naloxone-based rescue agents. However, continued emphasis on prevention and treatment of opioid misuse is needed to foster further progress.

Opioid use in pregnancy

According to the CDC's Morbidity and Mortality Weekly Report, the number of women with opioid use disorder (OUD) giving birth more than quadrupled from 1999 to 2014.⁵ OUD in pregnancy has been associated with numerous adverse outcomes ranging from neonatal abstinence syndrome (NAS) to stillbirth and maternal mortality.⁶ The complexity and coordination of care required to care for mother and child during the prenatal, perinatal and postnatal stages can result in gaps in care if adequate resources and policies are not in place.⁷ FEHB Carriers are strongly encouraged to implement or review processes in place for the early detection, access to treatment, and coordination of care for pregnant women with OUD and the affected babies.

A comprehensive, multi-pronged strategy will continue to be necessary to overcome the opioid epidemic. OPM will be reviewing FEHB Carriers' 2020 proposals for the following:

1. Enhanced programs in place for providers and members to improve safe dispensing, utilization, and disposal of opioids, as well as increased access to naloxone-based rescue agents.
2. Access to programs that identify and refer members at risk for opioid use disorder such as point-of-sale edits, retrospective data review and outreach referral programs. Describe how the plan identifies and refers members at risk for opioid use disorder.
3. Promote evidence-based pain management through coverage of and access to non-pharmacological therapies and non-opioid medications or devices used to treat pain.
4. If your plan provides telehealth services, assess them for OUD and other substance use disorder treatments. Include summary results of the assessment.
5. Improved access to opioid addiction treatment programs, family-focused residential treatment and comprehensive opioid recovery centers; review the adequacy of access

³ <https://www.congress.gov/bill/115th-congress/house-bill/6/all-actions?overview=closed#tabs>

⁴ <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2018/2018-01.pdf>

⁵ Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. *MMWR Morb Mortal Wkly Rep* 2018; 67:845–849. DOI: <http://dx.doi.org/10.15585/mmwr.mm6731a1>.

⁶ *Ibid* Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. *MMWR Morb Mortal Wkly Rep* 2018; 67:845–849. DOI: <http://dx.doi.org/10.15585/mmwr.mm6731a1>

⁷ S Substance Abuse and Mental Health Services Administration. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: <http://store.samhsa.gov/>.

to care for high-risk populations such as pregnant women and youth; i Include summary results of the adequacy of access reviews.

6. Review and/or develop policies to extend the duration of addiction treatment or length of stays as medically appropriate.
7. Implement or review processes in place for the early detection, access to treatment, and coordination of care for pregnant women with OUD and the affected babies. Attach summary results of the review or a description of the new process.
8. Complete the table below.

	Improvements made to care management of pregnant women with OUD	Summary of results from retrospective review of care management for pregnant women with OUD
1.	<i>(please list)</i>	
2.		
3.		
4.		
5.		

9. Describe how the carrier promotes a comprehensive, coordinated care approach that includes medical, pharmacy, behavioral and mental health to provide care coordination and recovery support to members with OUD.

Tobacco Cessation/E-cigarettes

Tobacco dependence is a chronic, relapsing condition that requires repeated intervention. Carriers must offer tobacco cessation programs to all covered individuals without copayments or coinsurance and which are not subject to deductibles, or to annual or lifetime dollar limits. Programs must follow the most current United States Preventive Services Task Force (USPSTF) recommendations by covering at least two quit attempts per year with each attempt allowing a minimum of four tobacco cessation counseling sessions, including individual counseling, group counseling, and proactive telephone counseling. Carriers are advised that the FEHB tobacco cessation benefit includes coverage of cessation treatment for users of all tobacco products, including e-cigarettes.

In addition to the tobacco cessation counseling programs, cessation medications (over-the-counter (OTC) and prescribed) approved by the FDA to treat tobacco dependence should be available with no copayments or coinsurance and not subject to deductibles or to annual or life time dollar limits. While all seven FDA-approved cessation medications are effective in helping smokers quit, varenicline and combination nicotine replacement (NRT) therapy, which consists of a combination of the nicotine patch with a fast-acting form of NRT, are currently the two most effective medication approaches available. The combination of counseling plus medication is the optimal approach that gives adult tobacco users the best chance of quitting. Therefore, it is important for adult tobacco users to have access to both cessation counseling and cessation medications for use as approved by the FDA.

As outlined in the Call Letter, benefit proposals must include your plan to re-invigorate messaging about the tobacco cessation benefit. Studies show that barrier-free tobacco cessation benefits are most effective when actively communicated to members and providers. This

includes repeatedly educating members and providers using a variety of communication methods. The 2017 Federal Employee Benefits Survey (FEBS) results showed awareness of the FEHB Tobacco Cessation Benefit remains low, with only 16.7 percent of current tobacco users reporting knowledge of the benefit prior to participating in the survey. Earlier FEBS results indicated that over half of current tobacco users at the time were either “extremely likely” or “likely” to try to quit once they were made aware of the FEHB benefit. We also know that a considerable number of survey participants who do not use tobacco themselves have a household member who does use tobacco. Since many employees have Self and Family coverage under FEHB, this should be taken into consideration when promoting awareness of the tobacco cessation benefit.

We will be reviewing your plan proposal for:

- Barrier-free coverage of and access to the tobacco cessation benefit, including individual, group, and telephone counseling, as well as coverage of and access to all FDA-approved cessation medications, including varenicline and combination NRT therapy.
- Proactive communication of the benefit, including cessation treatments covered and the process for accessing them, to all members and providers via multiple channels and methods.
- Targeted communication of benefit to members with conditions particularly impacted by tobacco use, including individuals with diabetes, cancer, heart disease, Chronic Obstructive Pulmonary Disease (COPD), and pregnant women.
- Education for members and providers on appropriate and effective use of cessation medications, including partnering with pharmacists to provide education and decision support on cessation medications.
- Education for members and providers regarding prevention and cessation of youth use of all tobacco products, including e-cigarettes; this would include education to parents and providers about the dangers of youth tobacco use and approaches for preventing youth initiation of tobacco use, including e-cigarette use, and helping youth tobacco users, including e-cigarette users, quit.

2. Patient Safety

Maternal Health

Many maternal deaths are attributable to preventable or detectable causes, including postpartum hemorrhage, cardiomyopathy, severe hypertension, infection/sepsis, and thrombotic pulmonary embolism. Timely prenatal care may help identify or prevent risk factors, as well as provide ample opportunity for member education about delivery options that may improve maternal outcomes. (Timeliness of Prenatal Care is a high-priority measure under FEHB Plan Performance Assessment.) FEHB Carriers can support maternal health when designing networks and engaging in hospital contracting through:

- Use of Alliance for Innovation on Maternal Health (AIM) patient safety bundles;
- Use of standard communication processes for identifying patient risk for labor complications;

- Use of the Maternal Health Compact, which formalizes connections between facilities to establish consultation or transfer resources during unexpected maternal emergencies;
- Use of or particular performance on the Joint Commission’s PC-02 measure (the Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean delivery rate);
- Coverage of and/or incentives for childbirth education classes for women and their partners so they can make better decisions during the birth process;
- Coverage of continuous one-on-one support during labor and delivery, including services provide by midwives, doulas, and/or other trained birth assistants; and Use of payment practices that are designed to remove unintended financial incentives that favor surgical deliveries, while not adding penalties that can discourage appropriate Cesarean sections and thereby raise safety concerns.

3. Preventive Services

Carriers are reminded to review the guidance on preventive services in Carrier Letter [2019-01](#), and adjust benefits and services accordingly. These services must be covered with no cost sharing. Plans may elect to provide coverage for additional preventive services with or without cost sharing.

B. Affordability

1. Transparency

a. Drug Transparency Tools

Enhancing the availability and accessibility of price and quality information to Federal employees, annuitants and family members is an important strategy for fostering the continued quality and affordability of FEHB plans, aiding in personal healthcare decision making, and taking an active role in one’s health.

Prescription Drug Transparency Tools- In Carrier Letter [2014-03](#), FEHB Carriers were required to provide a prescription drug cost transparency tool to current and prospective members by plan year 2016. In Carrier Letters [2016-03](#), [2017-01](#), and [2019-01](#), OPM continued to prescribe required improvements to ensure access to this important information, and expanded the requirement even further. Plan proposals will be reviewed to determine the extent of these tools and their planned enhancements.

Please complete the table below and include it with your proposal.

Prescription Drug Transparency Tools Existing and Planned Features				
The tool provides:	Existing (Y/N)	New or Planned Feature (Y/N)	Date of (planned) Implementation	If N/A, please describe.
Member cost-share information specific to the member				
Information on Utilization management requirements				
Access to information about the formulary tier				
Access to information about formulary alternatives				
Estimated cost of the drug through retail (30 days) as well as mail-order (90 days) or other delivery channels (e.g. specialty drugs).				
Real time benefit accumulator information such as deductibles etc.				
Incentives to encourage the use of the tool				
Tracking to capture usage of drug transparency tool				
Other features not listed (please list by additional rows)				

Proposals must describe how the Carrier meets the requirements for prescription drug transparency tools and include a link(s) to both the pre-enrollment and member specific pharmacy price transparency tool.

FEHB Carriers are also encouraged to promote the use of tools for providers, when available, such as electronic prior authorization and benefit check tools that display drug formulary and pricing information at the point of prescribing. These provider-level tools can reduce prescription abandonment and result in quicker turnaround times.

Please complete the table below and include it with your proposal:

Provider Tools				
Existing and Planned Features				
The tool provides:	Existing (Y/N)	New or Planned Feature (Y/N)	Date of (planned) Implementation	If N/A, please describe.
Electronic Prior authorization				
Real time benefit check capabilities				

Please describe in detail the type of prescription drug tools available to providers. In addition, please provide information to support the following:

1. Please describe in detail the strategy for promoting and measuring the use of prescription drug transparency tools; be sure to address how the tools encourage members to research and choose lower-cost, higher quality options for their prescription drugs.
2. OPM encourages Carriers to propose creative methods for incentivizing or rewarding members' use of transparency tools. Please provide in detail the current or planned incentive strategy to encourage use of prescription transparency tools.

b. Medical Services Transparency Tools

OPM first called on Carriers to provide cost and quality transparency tools for medical procedures in Carrier Letter [2006-09](#) and is focusing on improving these tools for the 2020 plan year and beyond. In order to allow individuals to take a more active role in selecting quality, affordable healthcare, OPM calls on Carriers to intensify their efforts in improving transparency tools.

Specifically, OPM asks Carriers to describe in their proposals how they would, by 2021, provide robust online search tools with the following features.

The tool:	Existing (Y/N)	New or Planned Feature (Y/N)	Date of (planned) Implementation	If N/A, please describe.
Provides an estimate of the dollar amount a member should expect to pay for a defined set of common outpatient and elective in-patient health care procedures and services <u>pre-login</u>				
Provides an estimate of the dollar amount a member should expect to pay for a defined set of common outpatient and elective in-patient health care procedures and services <u>post-login</u>				
Provides estimates that are personalized based on the member's plan option and deductible status				
Includes information tailored to geographical areas				
Is accessible via prominent links on the Carrier's website				
Presents network, quality, and cost information together				
Is easy to use and provides complete, accurate, up-to-date information				
Incentives to encourage the use of the tool				
Tracking to capture usage of the tool				

In addition, please describe in detail the strategy for promoting and measuring the use of medical transparency tools; be sure to address how the tools encourage members to research and choose lower-cost, higher quality options for their health care.

OPM encourages Carriers to propose creative methods for incentivizing or rewarding members’ use of medical transparency tools. Please provide in detail the current or planned incentive strategy to encourage use of these transparency tools.

2. Prescription Drugs

In 2017 approximately 27 percent of the total FEHB premium was attributed to prescription medications. The cost of prescription drugs remains a top concern for the FEHB Program, especially as more expensive drugs are expected to come to market over the next several years.

a. Specialty Drug Management

Specialty drugs may involve the pharmacy and/or medical benefit and are projected to account for a larger amount of total drug spending over the next several years.⁸ Specialty medications under the pharmacy benefit can be managed using several strategies, including benefit design, utilization management tools and specialty pharmacy networks. While slightly more complex, strategies to manage drugs billed under the medical benefit may include site of care management, utilization management programs and network reimbursement strategies. Specialty medications billed under the medical benefit can be administered in various settings, such as physician’s office, hospital outpatient facility, or a home health setting. Costs vary by site of care. Site-of-care programs can redirect patients and medications to the most clinically appropriate and lowest-cost channel without compromising patient outcomes. As in previous years, FEHB Carriers are expected to have a robust specialty management program in place that manages and coordinates drugs under the medical and pharmacy benefit. In addition to outlining how they are meeting the strategies above, carriers are required to include their site of care management program as part of their proposal.

Specialty Management Strategies utilized under the pharmacy benefit	New or Existing Program?
<i>(please list)</i>	

⁸ Carrier Letter 2017-01: <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2017/2017-01.pdf>

Specialty Management Strategies utilized under the medical benefit	New or Existing Program?
<i>(please list)</i>	

b. Point-of-Sale Rebates

Health plans or their pharmacy benefit managers (PBMs) are typically able to negotiate with pharmaceutical manufacturers to obtain rebates on branded drugs based on formulary placement and other considerations. FEHB experience-rated and fee-for-service contracts require PBMs to credit rebates to Carriers and require Carriers to include these in their net benefit costs. FEHB Carriers are allowed to reflect some or all of the rebate value at the time the claim is adjudicated through point-of-sale rebates. A number of Carriers have implemented such programs, which can lower out-of-pocket drug costs for members whose plan design includes deductibles and/or coinsurance. OPM encourages Carriers to submit innovative proposals to deliver rebate value at the point of sale while keeping premiums affordable. The value of the rebate applied at the point of sale should be identifiable, as should all the components of the drug price.

Please answer the following questions:

Do you currently reduce the allowed charge for any branded drugs at the point of sale by crediting some or all of the rebate received from the pharmaceutical manufacturer to the allowed charge? Y/N

If not, are you proposing to do so for the 2020 plan year? Y/N

If you answer “Yes” to either question above, please describe the point-of-sale rebate program offered or proposed. Please note that cost neutrality requirements apply to point-of-sale rebate proposals. That is, if the point-of-sale rebate benefit would add to premium, you must explain how and make additional proposals to offset the increase in premium.

c. Incentivizing Generic Drugs

OPM appreciates the efforts Carriers have made in the past to incentivize the use of generic drugs when available. Still, according to the 2018 ADC, the non-weighted average Generic Dispensing Rate (GDR) in the FEHB Program was 92 percent compared to a 98 percent GDR for commercial plans as reported by URAC.

FEHB Carriers must describe any policies and programs they are proposing or already have in place to encourage the use of generic drugs when available.

Please provide the following information:

Programs/Policies to incentivize the use of generics	New or Existing Program?	Program Description
<i>(please list)</i>		

Programs/Policies to mitigate the effect of multi-source brand couponing	New or Existing Program?	Program Description
<i>(please list)</i>		

3. Controlling Fraud, Waste and Abuse (FWA)

In addition to routine audits of FEHB Carrier operations, OPM’s Office of Inspector General (OIG) examines potential healthcare fraud against the FEHB Program by conducting criminal investigations that are coordinated with the Department of Justice and other law enforcement agencies. In the course of its investigations, the OIG has recommended several areas where we believe Carriers should adjust benefit designs to better control fraudulent payments. FEHB Carriers should implement processes that monitor pharmacy claims in order to identify outliers that may be evidence of fraud, waste, and abuse. For example, the OIG has investigated several schemes related to compounding pharmacies billing for unnecessary and high-cost creams, and most recently found multiple cases in which providers overcharged or otherwise submitted fraudulent billing for lidocaine creams. These same schemes involved high dollar coinsurance payments which were found to be waived or significantly reduced for the member, which as a result increases the program costs. In addition, the OIG has been investigating sober homes, laboratories, hospitals, and providers who have been billing for multiple Urine Drug Test screens (UDT), both qualitative and quantitative, that are not medically necessary, as well as fraudulent screens for individuals not undergoing substance use disorder treatment. Appropriate monitoring processes can identify these types of payments to prevent larger schemes from taking hold.

Accordingly, OPM is requesting that Carriers adjust plan benefits to discourage these schemes and to continue reporting waivers of co-payments related to high dollar

compounded medications to the OIG. For further information on industry best practices to control FWA for these and other payment practices, please see Carrier Letter [2017-13](#).

Describe the monitoring process you have in place for compounded drugs and Urine Drug Test Screens as shown by example in the tables below:

Monitoring processes for compounded drugs	New or Existing Program?
<i>E.g. XX Dollar limits on compounds</i>	<i>Existing</i>
<i>E.g. Quarterly retrospective reviews of all compounds</i>	<i>New in 2020</i>
<i>Others (please list)</i>	

Monitoring processes for Urine Drug Test Screens	New or Existing Program?
<i>E.g. Pre-payment claim edit process in place</i>	<i>Existing</i>
<i>E.g. Quarterly retrospective reviews</i>	<i>New in 2020</i>
<i>Others (please list)</i>	

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 2020. When you determine that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. The following tables are in Attachment V:

Table 1 – OPM’s required list of covered organ/tissue transplants.

Table 2 – OPM’s recommended coverage of transplants under Clinical Trials.

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

Information Required: Completed Attachment V - 2020 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 2020 should include details with their proposals, along with justification for any proposed age limits.

3. Antibiotic Resistance

Antibiotic Resistance is a significant threat to population health, and OPM strongly encourages FEHB Carriers to approach this critical issue through two channels: encouraging appropriate antibiotic prescribing and supporting effective hospital infection control. Specifically, FEHB Carriers are strongly encouraged to:

- Use data on the Medicare Hospital Compare⁹ and Leapfrog Hospital Safety Grade¹⁰ websites to inform hospital network decisions and contract terms.
- Monitor antibiotic prescribing rates across care settings, including urgent care networks and services.
- Discourage antibiotic prescribing for conditions where they are not indicated, including viral upper respiratory infections and bronchitis¹¹, through the use of provider reports showing provider antibiotic prescribing patterns compared to

⁹ <https://www.medicare.gov/hospitalcompare/search.html>

¹⁰ <http://www.hospitalsafetygrade.org/>

¹¹ <http://www.choosingwisely.org/clinician-lists/infectious-diseases-society-antibiotics-for-upper-respiratory-infections/>

peers to reduce unnecessary prescribing (i.e., post-prescription audit and feedback)¹².

- Support patient education efforts. Choosing Wisely’s patient resources may help increase patient literacy and knowledge about the risks of inappropriate antibiotic use¹³.
- Examine provider incentives and consider aligning payment models accordingly.

¹² Linder, J.A. et al. (2017). Effects of behavioral interventions on inappropriate antibiotic prescribing in primary care 12 months after stopping interventions. *JAMA*, doi:10.1001/jama.2017.11152.

¹³ <http://www.choosingwisely.org/patient-resources/colds-flu-and-other-respiratory-illnesses-in-adults/>

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-a (Community Rated Plans Only)
FEHB Benefit Difference Comparison Chart

See *FEHB Benefit Difference Comparison Chart Spreadsheet* attached with listserv

Attachment II-b
[Insert Health Plan Name]: Benefit Change Worksheet [Insert Worksheet Number]
[Insert Subsection Name]

Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes on pages 6-7 to complete the worksheet.

I. Benefit Change Description

Applicable options:

High Option	<input type="checkbox"/>	CDHP	<input type="checkbox"/>
Standard Option	<input type="checkbox"/>	HDHP	<input type="checkbox"/>
Basic Option	<input type="checkbox"/>		

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	
Reason	
Cost Impact/Actuarial Value (See Note 1)	
Exception to Cost Neutrality Requested (if applicable; See Note 2)	

Notes:

1. 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.

Cost impact of this change as a bi-weekly amount for the Self Only, Self Plus One, and Self and Family rate

- (a) If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, as appropriate.

2. Exception to Cost Neutrality:

Indicate which exception applies, and provide the information as indicated:

Exception 1: A Carrier may include benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

- i. Ensure that a meaningful difference between plan options will continue to exist if the change is approved, and describe the difference;

- ii. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
- iii. Provide evidence to support that cost neutrality will be achieved in plan year 2020.

Exception 2: A Carrier may propose benefit enhancements that are not cost-neutral in the current year within a single plan option, if the Carrier can show a strategy to achieve cost neutrality within that option, and eventual savings, in the near-term future (i.e., within three years).

Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.

II. Is the benefit change a part of the plan's proposed community benefits package?

(b) 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 2020?

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 2020?

(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 [Insert Worksheet Number]
[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
Standard Option
Basic Option

CDHP
HDHP

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Attachment IV
Preparing Your 2020 Brochure and Benefits Plus Data Submission

Benefits Plus Process

We will continue to use the Benefits Plus system to collect data from carriers. We have expanded the data collected this year, and made changes to Benefits Plus to improve functionality, usability and performance. OPM determines and communicates any additions to the required Benefits Plus data input that may be required for Plan Comparison Tool enhancements via listserv.

Timeline: 2020 Brochure and Benefits Plus Process

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.
May 31	Sections II and III of the ADC (Formulary and Cost/Utilization Templates) due.
June 28	Plans receive: <i>2020 FEHB Brochure Handbook</i> (to include shipping label and brochure printing instructions).
July 1	Brochure Creation Tool (BCT) opens to Carriers. OPM will provide the 2019 Brochure Creation Tool (BCT) User Manual in the BCT.
July 15 - 26	OPM hosts training on the use of Benefits Plus and the BCT.
August 15	Plans must finalize all language and shipping labels.
August 19	Plans must complete all data and plan-specific updates within Benefits Plus. Plans must complete entry of data into BCT except for rate information.
September 9	Plans must complete entry of rate information into BCT.
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.

Please contact bbpct@opm.gov for Benefits Plus password resets, Benefits Plus technical questions or suggestions on changes, and comments or questions pertaining to the Brochure Creation Tool.

Summary of Benefits and Coverage

FEHB plans will continue to provide a Summary of Benefits and Coverage (SBC) based on standards developed by the Secretary of the Department of Labor.

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 but only upon request to current members. You may send Explanations of Benefits, newsletters and other plan materials electronically.

Attachment V
2020 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:	
Acute lymphocytic or non-lymphocytic (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'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 2020?	
	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 2020?	
	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 VI
2020 Technical Guidance Submission Checklist

Topic/Attachment Number	In Proposal Yes/No/N/A	Worksheet Completed Yes/No/N/A
FEHB Carrier Contracting Official (Attachment I)		
Benefit Difference Comparison Chart (Attachment II-a; Community-Rated Plans Only)		
Benefit Change Worksheet: worksheet for each change (Attachment II-b)		
Benefit Clarification Worksheet: worksheet for each clarification (Attachment III)		
Preparing Your 2020 Brochure and Benefits Plus Data Submission (Attachment IV)	N/A	N/A
2020 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 2020 benefit and rate proposal