FEHB Program Carrier Letter

All Fee-For-Service Carriers and Health Maintenance Organizations (HMOs)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2020-03 **Date: March 24, 2020**

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

Subject: Technical Guidance and Instructions for 2021 Benefit Proposals

Enclosed are the Technical Guidance and instructions for preparing your benefit proposals for the contract term January 1, 2021 through December 31, 2021. **Please note that this year's Technical Guidance is being released as a single document for all Carriers. Guidance applicable to the different Carrier types [Fee-For-Service (FFS), Health Maintenance Organizations (HMO) – Community-Rated (CR) or Experience-Rated (ER), Returning HMOs, and New HMOs] will be noted throughout the document. Similarly, guidance that is applicable to all Carriers will be noted as such. Please read through the Technical Guidance carefully and contact your Health Insurance Specialist with questions.**

OPM's annual policy and proposal guidance for Federal Employees Health Benefits (FEHB) Program health benefit proposals is issued in two documents:

1. The Call Letter (Carrier Letter 2020-01) dated February 10, 2020 outlines policy goals and initiatives for the 2021 contract year, and

2. The Technical Guidance and Instructions for Preparing Proposals for the 2021 Plan Year provides detailed technical requirements for the items listed in the Call Letter that must be addressed in your benefit proposals.

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

The 2021 Rate Instructions for **Community-Rated HMO** Carriers are not included with these benefit instructions but will be released in an upcoming Carrier Letter. The 2021 Rate Instructions for **Experience-Rated HMO** and **Fee-For-Service** Carriers will be sent directly from OPM's Office of the Actuaries to the Carriers.

We continue to encourage 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.

It is incumbent on all Carriers to ensure that each benefit proposal complies with all applicable Federal laws and regulations. As a reminder, all Carriers must adhere to the FEHB Program Guiding 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 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 again this year.

Sincerely,

Laurie Bodenheimer
Acting Director
Healthcare and Insurance

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Schedule

We have prepared the following chart with deadlines that are part of the benefit and rate proposal negotiation process. Benefit proposals must be complete upon submission. The deadlines for concluding benefit negotiations are firm and we cannot consider late proposals. This year's deadlines are as follows:

DATES	ACTIVITY
May 8	**Community Benefit Package (Certificate of Coverage, Evidence of Coverage, Master Group Contract or Agreement) for New** and **Returning HMOs** Send the community benefit package by email to your Health Insurance Specialist. The Community Benefit Package is the commercial health insurance coverage sold to the majority of non-Federal employees.
May 31	**Benefit Proposal and Rate Proposal** As required by 5 CFR § 890.203, **all Carriers** must send a complete proposal for benefit changes and clarifications to your Health Insurance Specialist by email in addition to a hard copy. Proposals must include language describing all proposed brochure changes. Your OPM Health Insurance Specialist will discuss the benefit proposal with you.
May 31	**Drug Formularies** All 2020 FEHB Carriers must submit their 2020 drug formularies. **FFS and Returning HMOs** changing formularies or moving to new formularies in 2021 must submit a 2021 FEHB Drug Formulary Template. **New HMOs** must submit a 2021 FEHB Drug Formulary Template to OPM.
June 29	OPM will send the *2021 FEHB Brochure Handbook* via Listserv.
July 1	OPM will provide the *2021 Brochure Creation Tool (BCT) User Manual* and make the BCT available to all Carriers for updates.

DATES	ACTIVITY
July 13 - 24	**Benefits Plus and BCT Training** OPM hosts training on the use of these tools. Carriers should plan to attend. Please contact BPBCT@opm.gov for password resets, technical questions or if you have suggestions on changes to Benefits Plus or the BCT.
August 17	**Brochure Creation Tool** Plans must submit initial draft of brochure language.
August 19	**Benefits Plus Updates** Plans must complete draft of all data and plan-specific updates within Benefits Plus.
September 9	**Brochure Creation Tool** Plans must complete import of rate information into BCT.
September 25	All Carriers must finalize brochures by this date. OPM sends brochure quantity forms, as well as other related Open Season instructions, to Carriers after Health Insurance Specialist approves the brochure for printing.
October 12	**Brochure Shipment** Plan Brochures are due to the Retirement Services vendor.

Part I: 2021 FEHB Benefit Proposal Instructions for All Carriers

Enrollment Types

- Self Only (codes ending in 1 and 4) – Self Only enrollment provides benefits for only the enrollee.
- Self Plus One (codes ending in 3 and 6) – Self Plus One enrollment provides benefits for the enrollee and one designated eligible family member.
  - The catastrophic maximum, deductibles, and wellness incentives must be for dollar amounts that are less than or equal to corresponding benefits in the Self and Family enrollment.
  - All other benefits, such as copays and coinsurance amounts, must be the same regardless of enrollment type.
  - FEHB Carriers with High Deductible Health Plans (HDHPs) must be cognizant of 26 U.S.C. § 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.

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

Please visit OPM's website for eligibility criteria.

Federal Preemption Authority

The law[1] governing the FEHB Program gives OPM the authority to preempt 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.

Community Benefit Package (**All HMOs**)

Submit a copy of a fully executed community benefit package (e.g., *Certificate of Coverage* or *Evidence of Coverage*) by May 8, 2020, including riders, copays, coinsurance, and deductible amounts (e.g., prescription drugs, durable medical equipment) that your plan with the largest number of non-Federal subscribers purchased in 2020. If you offer a plan in multiple states, please send us your community benefit package for each state that you intend to cover.

Community-Rated HMOs

In a cover letter accompanying your community benefit 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. If necessary, please ensure these documents have been translated to English. We usually accept proposed benefit changes if you submitted the changes to your state prior to May 31, 2020 and you obtain approval and submit approval documentation to us by June 30, 2020. 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, 2020.

Please include the name and contact information (phone number, email) 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 states about benefits as necessary.

*Note for **Returning HMOs***

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.

[1] Current law governing the Program is chapter 89 of title 5, United States Code.

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 2021 contract term, including those still under review by your state.

If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. If you have made changes, submit a copy of the new benefits description. If your state requires you to file this documentation, file the benefit package you project will be sold to the majority of your non-Federal subscribers in 2021.

Note for ***New HMOs***

Your material must show all proposed benefits for FEHB for the 2021 contract term, including 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 2021.

Experience-Rated HMOs

You must file your proposed benefit package (e.g., *Certificate of Coverage* or *Evidence of Coverage*) and the associated rate with your state, if the state requires it.

Note for ***Returning HMOs***

Carriers that have made changes to the level of coverage purchased by OPM, must submit a copy of the new benefit description as explained in the Benefit Changes section. If no changes have been made, a statement to that effect must be submitted.

Note for ***New HMOs***

Carriers that have made changes since their application must submit a copy of the new benefits description and attach a chart with the following information:

- Benefits that are covered in one package, but not the other;
- Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other; and
- The number of subscribers/contract holders who currently purchase each package.

Benefit Proposal Information for **All Carriers**

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

Benefit Proposal Information from **Returning HMOs**

- A signed Contracting Official's Form.
- A comparison of your 2020 benefit package (adjusted for FEHB benefits) and your 2021 benefit package.
- Benefit package documentation (See Benefit Changes below).
- A plain language description of each proposed Benefit Change and the revised language for your 2021 brochure.
- A plain language description of each proposed Benefit Clarification and the revised language for your 2021 brochure.

- Benefit Difference Comparison Chart In-Network Benefits Spreadsheet.
- Drug Formulary (See Attachment IV for instructions. The FEHB Drug Formulary Template is a separate Excel document sent out with this Technical Guidance).

Benefit Proposal Information from **New HMOs**

- A signed Contracting Official's Form.
- Benefits package documentation (e.g., complete proposed brochure template with all benefit information).
- Benefit Difference Comparison Chart In-Network Benefits Spreadsheet.
- Drug Formulary (See Attachment IV for instructions. The FEHB Drug Formulary Template is a separate Excel document sent out with this Technical Guidance).

Benefit Proposal Information from **Fee-For-Service** Carriers

- A signed Contracting Official's Form.
- Benefit package documentation (See Benefit Changes below).
- A plain language description of each proposed Benefit Change and the revised language for your 2021 brochure.
- A plain language description of each proposed Benefit Clarification and the revised language for your 2021 brochure.
- Drug Formulary (See Attachment IV for instructions. The FEHB Drug Formulary Template is a separate Excel document sent out with this Technical Guidance).

Benefit Changes (**Fee-For-Service** Carriers and **Returning HMOs**)

Your proposal must include a narrative description of each proposed benefit change. Please use the Benefit Change Worksheet 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. **This must be inclusive of process changes that would impact a member's benefits (e.g., state mandate imposing a limit on opioids due to regulation).**

You must respond to each of the items in Information Required for Proposal in the *Benefit Change Worksheet* format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incorrectly formatted submissions.

Cost Neutrality

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 2021 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 2021.

- 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.

Information Required for Proposal

If you anticipate significant changes to your benefit package, please discuss them with your OPM Health Insurance Specialist before preparing your submission.

- Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2021" 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.
- Describe the rationale for the proposed benefit change.
- 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 bi-weekly 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.

Benefit Clarifications (**Fee-For-Service** Carriers and **Returning HMOs**)

Clarifications help members understand how a benefit is covered. Clarifications are not benefit changes and therefore have no premium impact. Please use the Benefit Clarification Worksheet as a template for submitting all benefit clarifications.

Information required for proposal

- 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 using plain language.

- Explain the reason for the proposed clarification.

Alternate Benefit Package **(Community-Rated HMOs)**

OPM will allow HMOs the opportunity to adjust benefit payment levels in response to local market conditions. If you choose to offer an alternate benefit package, you must clearly state your business case for the offering. We will only accept an alternate benefit package if it is in the best interest of the Government and FEHB enrollees.

- The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.
- The alternate benefit package may not exclude benefits that are required of all FEHB plans.
- Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your Health Insurance Specialist and your contact in the Office of the Actuaries regarding the alternate benefit package and refer to the rate instructions.

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.

FEHB Benefit Difference Comparison Chart **(All HMOs)**

You must complete the FEHB Benefit Difference Comparison Chart (in Excel, electronic template sent out with Technical Guidance) with the following information:

- Differences in copays, coinsurance, coverage levels in the packages. In-network benefits are entered on a separate tab than out-of-network benefits.
- Please highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 31, 2020, or if they were not specifically addressed in previous negotiations. Remember, you must obtain state approval and submit the documentation to us by June 30, 2020.
- Please include whether riders are required within your proposed 2021 FEHB benefit package. Indicate the name of the community benefit package, including the entity noted as having the largest number of non-Federal employee subscribers/contract holders who purchased the 2020 package and who are expected to purchase the 2021 package.

Part II: 2021 Service Area Proposal Instructions for **All HMOs**

Service Area Eligibility

Federal employees and annuitants who live or work within the approved service area 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. OPM will provide model language for stating your policy in your brochure.

Service Area Changes

Returning HMOs proposing service area changes and **New HMOs** proposing changes in their service area or plan designation since applying to the FEHB Program should refer to the guidance in this section.

All HMOs must inform OPM of service area changes. Service areas and provider networks must be available for the 2021 contract term. OPM is committed to providing as much choice to our enrollees as possible. Given consolidations in the healthcare industry, there are geographic areas where our members have more limited choices than in other areas.

Please consider expanding your FEHB service area to all areas in which you have authority to operate. This will allow greater choice for our customers. You must upload a .CSV file to Benefits Plus of covered ZIP Codes for your existing service area and any new service area expansion that you propose. ZIP Codes should be listed in a single column, one row per ZIP Code.

Delivery System

The information you provide about your delivery system must be based on executed contracts. We will not accept letters of intent. All provider contracts must have “hold harmless” clauses that preclude the provider from pursuing or “back billing” a member for fees in excess of the allowed amount under the plan.

New Enrollment Codes (**Community-Rated HMOs**)

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

Service Area Expansion Criteria

You must propose any service area expansion by May 31, 2020. OPM grants an extension for submitting state approval supporting documentation until June 30, 2020.

OPM will evaluate your proposal to expand your service area according to the following criteria:

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

You must provide the following information:

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

- 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.
- The authority to operate in the proposed area. Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.
- Access to providers. Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts. You must update this information by August 31, 2020. The update must 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.

New Rating Area (**Returning Community-Rated HMOs only**)

OPM will evaluate your proposal to add a new rating area (or split a current service area) according to these criteria:

- Why the area has been added;
- 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
- How your current enrollment will be affected by the addition of this new rating area.

Service Area Reduction Criteria (**Returning HMOs only**)

Please explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain.

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

- We will accept the elimination of the corresponding service area only if you propose to eliminate an entire enrollment area.
- Service area reductions should be associated with the following:
    - Significant loss of provider network;
    - Poor market growth;
    - Reduction applies to other employer groups;
    - Reduction may apply to consolidation of two or more rating areas **(Returning Community-Rated HMOs only**); and
    - Splitting rating areas **(Returning Community-Rated HMOs only)**

You must provide the following information:

- A description of the proposed reduced service area or 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 service areas. Provide the exact wording of how you will describe the service area change in the brochure, if you are a returning HMO.

- 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.

Part III: 2021 Call Letter Initiatives for All Carriers

As stated in the Call Letter, our primary performance initiatives for the 2021 plan year are:

- Opioids
- Addressing Low-Value Care such as Unnecessary Diagnostic Testing and Clinical Procedures
- Tobacco Cessation
- Provider Contracting Status and Surprise Billing
- Patient Responsibility for Observation Care
- Pharmacy Benefit Transparency Tools
- Medical and Real Time Benefit Transparency Tools
- Genetic Therapies
- Biosimilars
- High Deductible Health Plans and Preventive Care Benefits
- Wellness Incentives
- Coinsurance Maximum for Prescription Drugs
- Controlling Fraud, Waste, and Abuse

Opioids

In order to mitigate the effects of the opioid epidemic, FEHB Carriers must continue ongoing efforts to minimize the overutilization and misuse of opioids, ensure access to non-opioids, non-pharmacological treatments and drugs for medication assisted treatment (MAT) and expand access to behavioral health services.

For 2021, each FEHB Carrier is required to demonstrate a multi-faceted approach to addressing the opioid crisis including ensuring safe opioid utilization, access to naloxone, non-opioid based pain treatments and treatments for opioid use disorder. In your proposal, please describe:

- Outreach and educational programs for providers and members regarding opioid risks;
- Strategies in place to address initial opioid prescriptions in opioid naïve members;
- Strategies in place to monitor subsequent fills of opioids including care coordination, referral programs and actions taken as a result of retrospective opioid safety edit reviews;
- Programs in place to ensure safe disposal of opioids;
- Efforts taken to promote evidence-based pain management through coverage of, or access to non-pharmacological therapies, and non-opioid medications or devices used to treat pain;
- Results of efforts taken to ensure broad access to naloxone and drugs used in medication assisted treatment;
- Efforts taken to improve access to behavioral health services including telehealth services for Opioid Use Disorder (OUD) and other substance use disorder treatments;

- Efforts taken to improve access to opioid addiction treatment programs, family-focused residential treatment and comprehensive opioid recovery centers including the results of the review of adequacy of access to care for high risk populations such as pregnant women and youth;
- Processes in place to evaluate the effectiveness of opioid programs and improvements made as a result;
- Efforts taken to promote a comprehensive, coordinated care approach that includes medical, pharmacy, behavioral and mental health to provide care coordination and recovery support to members with OUD; and
- Processes in place to identify potential opioid overutilization, fraud and abuse and actions taken or improvements made based on findings.

Addressing Low-Value Care such as Unnecessary Diagnostic Testing and Clinical Procedures

OPM's goal is for FEHB members to receive high-quality, high-value care. FEHB Carriers must provide the following information:

- Identify at least three (3) areas of low-value care not previously addressed by your plan where internal controls (e.g. non-payment, requirement for prior authorization) will be put in place to address the provision of low-value care;
- Cite evidence supporting the rationale for these new areas of increased scrutiny;
- Detail plan policies and procedures that are intended to identify new areas of low-value care.

Tobacco Cessation

Tobacco dependence is a chronic, relapsing condition driven by addiction to nicotine. Treatment of tobacco dependence may require repeated intervention and long-term support. The FEHB Program remains committed to offering a robust, comprehensive tobacco cessation benefit and supports interventions to prevent initiation of tobacco use among school-aged children and adolescents.

Opportunities for improvement were identified in the 2019 ADC, with 55% of our top 20 plans reporting they are not promoting the tobacco cessation benefit to providers and no plans reporting they are using their affiliated pharmacies or laboratories to assist in communication efforts. While the combination of counseling and medication is the best practice, it is the least reported method of tobacco cessation. Variance in how members were asked about tobacco use and how they interpret the term "tobacco product" contributed to a low confidence in the reported numbers of tobacco users in the FEHB population. One of the major conclusions of the Surgeon General's report on smoking cessation released January 23, 2020 states: *Insurance coverage for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted increases the use of these treatment services, leads to higher rates of successful quitting, and is cost-effective.*

The Fact Sheet for Payers derived from the Surgeon General's Report reinforces the important role Carriers have in smoking cessation efforts and provides reason to focus on improving promotion of our comprehensive tobacco cessation benefit and incentivizing the use of evidence-

based cessation treatments, including the combination of counseling and medications and the combination of the nicotine patch with another form of nicotine replacement therapy (NRT). We encourage you to use elements from or the full Fact Sheet for Healthcare Professionals and Health Systems to promote the FEHB tobacco cessation benefit to healthcare providers and to partner with providers to improve tobacco cessation rates among our beneficiaries. Consider leveraging significant medical events experienced by members, such as hospitalization, surgery, or lung cancer screening, that may motivate them to try to quit by offering them cessation support.

In addition to the 2020 Surgeon General's Report, several other resources containing practical information on approaches to promoting a comprehensive tobacco cessation benefit and integrating tobacco screening and tobacco cessation treatment into routine clinical care have become available since the release of the 2019 Call Letter and Technical Guidance. We direct your attention to the Million Hearts Tobacco Cessation Change Package and in particular to the recommended actions and resources on Change Concepts and Ideas that this resource provides on billing practice optimization (Table 2, page 12), performance and quality goals (Table 2, page 12 and Appendix A, page 23), universal screening protocols (including electronic health records and other patient record keeping systems), and standard orders sets and referral services. For example, to promote consistent screening for tobacco use, consider using the template recommendations for tobacco screening from the Association of American Family Physicians included in Table 3 on page 15 of the Million Hearts Tobacco Cessation Change Package. Assistance is also available through the CDC's 6|18 Initiative that recommends Carriers use multiple avenues to identify and connect with members who use tobacco products.

We also understand from the 2019 ADC results that three of the top 20 plans report having a youth education program in place to address tobacco use and emerging tobacco products. A December 2019 Morbidity and Mortality Weekly Report (*MMWR*) from the CDC based on data from the 2019 National Youth Tobacco Survey (NYTS) found that many young people continue to have misperceptions about the harms of tobacco product use. Substantial proportions of middle and high school students (28.2% for e-cigarettes, 16.4% for hookahs, 11.5% for smokeless tobacco products, and 9.5% for cigarettes) perceived no harm or little harm from intermittent tobacco product use (use on some days but not every day). This study found that e-cigarettes are the most commonly used tobacco product, with 27.5% of high school students and 10.5% of middle school students reporting current e-cigarette use. The study also found that 57.8% of current youth tobacco product users reported that they were seriously thinking about quitting the use of all tobacco products, with 57.5% of current youth tobacco product users reporting making a quit attempt in the past year. Preventing initiation of tobacco use in the youth population is key because of the limited cessation treatment options for this population, the likelihood that many adolescents and teens who begin using tobacco products will continue using tobacco into adulthood, and the short- and long-term health consequences of tobacco and nicotine use. Exposure to nicotine during adolescence and young adulthood can harm the developing brain, leading to potentially detrimental effects on brain function and cognition, attention, and mood. Information for members and providers on the prevention and cessation of youth use of all tobacco products, including e-cigarettes, is found on the CDC's Smoking &

Tobacco Use webpage for adults and CDC's Youth Tobacco Prevention webpage. These sites provide additional resources, depending on your needs.

In your plan proposals, you must describe your use of evidence-based strategies to promote the FEHB tobacco cessation benefit to members who use tobacco products and their providers, how you will encourage the use of combination therapies (including combining counseling and medication and combining a fast-acting and short-acting form of NRT), and support efforts to prevent use of tobacco products by youths and adolescents.

Provider Contracting Status and Surprise Billing

No later than calendar year 2022, Carriers will be expected to display the network contracting status of selected specialties of physicians, physician groups, or categories of services that provide emergent or urgent care services in a hospital (e.g., pathology, radiology, anesthesia). This may be directly shown on the hospital webpage as a categorical statement (e.g., all radiologists are contracted with the plan, no anesthesiologists are contracted with the plan) or it may take the form of a hyperlink from the provider directory listing for the hospital to a webpage showing physicians practicing at that hospital organized by specialty, name and network contracting status. OPM will give latitude in webpage design to plans, but the expectation is that members will be able to rapidly and easily identify network-contracted physicians practicing at a specific hospital.

The physician specialties or categories of services that must be included are:

- Anesthesiology
- Emergency Department medicine
- Neonatology
- Pathology
- Radiology
- All Surgical Specialties

Patient Responsibility for Observation Care

Carriers should update plan benefits so that the member share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. For example, if an enrollee is responsible for a copayment of $150 for an inpatient hospitalization, a member would be responsible for a $150 copayment for hospital observation care that has lasted 24 hours or more. The equalization of member cost sharing between hospital observation care that exceeds 24 hours and inpatient hospital care should be cost neutral. If the adjustment will not be cost neutral, carriers must describe in detail in their proposals why a higher cost to members for observation care is required to maintain cost neutrality. In addition, the plan must ensure that there is a clear definition in the plan brochure of observation care and that members receive separate notification of any disparity in benefits.

Pharmacy Benefit Transparency Tools

Real-time benefit tools (RTBT) inform prescribers when lower-cost alternative drug therapies are available. This can improve medication adherence, lower prescription drug costs, and reduce

member out-of-pocket costs. For 2021, FEHB Carriers must adopt one or more RTBT that can integrate with at least one prescriber's ePrescribing system or electronic health record.

Tool	In place for PY2021 Y/N	Tool Capabilities
Real-Time Benefit Tool		

Provide a justification, if unable to implement a RTBT by plan year 2021.

Medical Benefit Transparency Tools

In Carrier Letter 2019-01, OPM requested Carriers to enhance their medical services transparency tools by 2021. Please describe in detail the progress in meeting the objectives set forth in Carrier Letter 2019-01. If there are any impediments in meeting the 2021 timeline, please elaborate.

Genetic Therapies

OPM is interested to know what implementation and financial strategies FEHB Carriers have outlined to cover new and often expensive genetic therapies, many expected to exceed $1 million. For instance, in order to afford these new therapies, some insurance carriers set aside increased reserves or obtain reinsurance. Carriers should indicate whether their reinsurance companies are planning to cover genetic therapies or if they have excluded them from coverage (i.e., carved them out).

Some Carriers have set up (or are planning to set up) value-based payment arrangements with manufacturers that limit payment if the therapy is not effective or long-lasting. Some Carriers will prefer to pay for treatment in one lump sum or on an amortized basis. If the latter, we wish to know what Carriers anticipate will occur if a member changes Carriers prior to the completion of payments. Finally, we are interested to know what processes Carriers have established for the review and approval of these new treatments for affected members, as well as any coordination of care or wraparound services that will be provided with the provision of these genetic therapies.

Biosimilars

FEHB Carriers are expected to align reimbursement and formularies to encourage appropriate biosimilar adoption and educate providers and members about biosimilars. For 2021, each FEHB Carrier is required to promote the use of biosimilars under the pharmacy and the medical benefit, demonstrated by:

- Outreach and educational programs for providers and members regarding biosimilars;
- Strategies in place to encourage biosimilar utilization under the pharmacy benefit such as formulary and benefit design strategies;
- Strategies in place to encourage biosimilar adoption under the medical benefit such as reimbursement and fee-schedule strategies.

High Deductible Health Plans and Preventive Care Benefits

High Deductible Health Plans (HDHPs) require that the combined medical and pharmacy deductible be met before traditional coverage begins, with the exception of certain preventive care benefits. Per IRS Notice 2019-45, [2] coverage of additional preventive care benefits for certain chronic conditions is permitted before the deductible is met or at a lower deductible than the HDHP statutory minimum. Please indicate below what specific preventive care drugs or products will be covered before the deductible is met or at a lower deductible than the HDHP statutory minimum.

Preventive Care for Specified Conditions	**For Individuals Diagnosed with**	**List Drugs/Products Covered before the deductible is met**	**List Drugs/Products Covered at a lower deductible than the HDHP statutory minimum**
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease		
Anti-resorptive therapy	Osteoporosis and/or osteopenia		
Beta-blockers	Congestive heart failure and/or coronary artery disease		
Blood pressure monitor	Hypertension		
Inhaled corticosteroids	Asthma		
Insulin and other glucose lowering agents	Diabetes		
Peak flow meter	Asthma		
Glucometer	Diabetes		
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression		
Statins	Heart disease and/or diabetes		

Please indicate below if the following preventive care tests will be covered before the deductible is met or at a lower deductible than the HDHP statutory minimum.

[2] Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223 https://www.irs.gov/pub/irs-drop/n-19-45.pdf

Preventive Care for Specified Conditions	**For Individuals Diagnosed with**	**Test Covered before the deductible is met Y/N**	**Test Covered at a lower deductible than the HDHP statutory minimum Y/N**
Retinopathy screening	Diabetes		
Hemoglobin A1c testing	Diabetes		
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders		
Low-density Lipoprotein (LDL) testing	Heart disease		

Wellness Incentives

For the upcoming 2021 plan year, OPM will eliminate the specific dollar limits set forth in Carrier Letter 2014-03 on non-taxable wellness incentives.

As stated in Carrier Letter 2016-04, OPM maintains that well-crafted incentives can promote participation in screening activities and reinforce the adoption of health behaviors. FEHB plans must limit cash or cash equivalent wellness incentive benefits to medical care that falls within the exclusion in Section 213 of the Internal Revenue Code, or that is not considered income under IRS rules and guidance. There are no dollar limits as to the value plans may offer in terms of wellness incentives; however, any value provided to enrollees must be limited to qualified medical expenses and *de minimis* incentives. Examples of permissible wellness incentives, if allowed by your plan type (HSA-qualified HDHPs cannot provide coverage below the deductible), include automatically loaded debit cards limited to purchases for qualified medical expenses and reduced copayments for covered benefits.

Coinsurance Maximum for Prescription Drugs

As the cost of prescription drugs continues to rise there is concern that some FEHB members may not be able to afford their medication costs. This is especially true for FEHB members in plans that do not have a maximum on coinsurance for prescription drugs.

OPM encourages FEHB Carriers to place a maximum on prescription drug coinsurance for non-HDHP or CDHP plans to reduce the financial burden on members while keeping premiums neutral.

Plan Option	Prescription Co-insurance value without a max (Y/N)	Changes being made for plan year 2021 (please describe)

If no changes are being made, please provide a justification for not placing a maximum on the prescription coinsurance.

Controlling Fraud, Waste, and Abuse

In addition to routine audits of FEHB Carrier operations, OPM's Office of the Inspector General (OIG) examines potential healthcare fraud against the FEHB Program by conducting criminal investigations 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.

Accordingly, OPM is requesting that Carriers adjust plan benefits to discourage these schemes and to continue reporting waivers of copayments related to high dollar compounded medications to the OIG. For further information on industry best practices to control Fraud, Waste, and Abuse (FWA) for these and other payment practices, please see Carrier Letter 2017-13.

Healthcare fraud costs the federal government and taxpayers billions of dollars each year. New technologies like telemedicine may be contributing to the problem. Report out any telemedicine fraud schemes your organization is tracking along with the action plans to combat.

Telemedicine fraud schemes your organization is tracking	**Action plans to combat future occurrences**

Describe the proactive monitoring processes or strategies you have in place for telemedicine fraud as shown by example in the table below:

Monitoring processes for Telemedicine Fraud	**Existing Program? Y/N**	**New Program for 2021? Y/N**
E.g. Pre-payment claim edit process for telemedicine claims in place	Y	
E.g. Quarterly retrospective reviews of all telemedicine claims		Y
Others (please list)		

Continued Focus from Previous Years for **All Carriers**

Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2021. 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 included in the Organ/Tissue Transplants and Diagnoses worksheet:

- Table 1 – OPM's required list of covered organ/tissue transplants.
- Table 2 – OPM's recommended coverage of transplants under Clinical Trials. All Carriers are to complete and return this table.
- Table 3 – OPM's recommended list of covered rare organ/tissue transplants. All Carriers are to complete and return this table.

Preventive Services

The United States Preventive Services Task Force (USPSTF) recently recommended that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. For 2021, please indicate how the following drugs for PrEP are covered.

Drug	**Available at zero cost share Y/N**	**Subject to utilization management (UM) edits Y/N (Indicate type of edit if applicable)**	**Subject to deductibles Y/N**	**Subject to annual limits Y/N**
Truvada				
Descovy				

As a reminder, please review updates to preventive services endorsed by the below listed entities:

- All services recommended by the United States Preventive Services Task Force (USPSTF) with an "A" or "B" rating.[3] These include, but are not limited to, screenings, testing, preventive care, and certain medications.
- Adult and child immunizations approved by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).[4]
- Pediatric screenings and preventive care endorsed by the American Academy of Pediatrics Bright Futures Guidelines.[5]
- Women's Preventive Services recommended in guidelines issued by the Health Resources and Services Administration (HRSA)[6], along with contraceptive coverage mandated by section 726 of the Consolidated Appropriations Act, 2018 (P.L. 115-141) or later renewals.

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[3] USPSTF Recommendations: https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
[4] ACIP Recommendations: https://www.cdc.gov/vaccines/acip/
[5] AAP/Bright Futures Guidelines: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf and https://brightfutures.aap.org/Pages/default.aspx
[6] HRSA Guidelines: https://www.hrsa.gov/womens-guidelines-2016/index.html

OPM expects FEHB Carriers to cover these endorsed preventive services with no cost sharing when received from an in-network provider. "No cost sharing" means that services are not subject to copayments, coinsurance, deductibles, or annual limits.

Coordination of Benefits for **All HMOs**

When FEHB plans pay secondary Coordination of Benefits (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 copayments or coinsurance on secondary COB claims. If your benefit design includes coinsurance, it must be based on the remaining charge, not on your allowance.

In the following example Medicare is primary and the FEHB plan is secondary. The plan design requires the member to pay 10% coinsurance.

DOS 02/10/20 billed	$10,000
Medicare allowance	$9,000
Medicare payment	$7,200 (80% of allowance)
Balance after Medicare payment	$1,800
Member responsibility	$1,800 x 10% = $180
Plan pays	$1,800 x 90% = $1,620

If your brochure language does not currently describe this process correctly, please work with your Health Insurance Specialist to ensure that your 2021 brochure does so.

Attachments

The following attachments must be completed and returned to OPM as part of your Plan Year 2021 proposal. Not all attachments are applicable to each Carrier. The list and table below organize the attachments by their applicability to particular Carrier types. If you have questions, please contact your Health Insurance Specialist.

Worksheet attachment	Applicable to FFS?	Applicable to Returning HMOs (ER & CR)?	Applicable to New HMO?
Attachment I: Technical Guidance Submission Checklist	Yes	Yes	Yes
Attachment II: FEHB Carrier Contracting Official	Yes	Yes	Yes
Attachment III: Organ/Tissue Transplants and Diagnoses	Yes	Yes	Yes
Attachment IV: FEHB Drug Formulary Template (in Excel, separate document sent out with this Technical Guidance)	Yes	Yes	Yes

Worksheet attachment	Applicable to FFS?	Applicable to Returning HMOs (ER & CR)?	Applicable to New HMO?
Attachment V-a: Benefit Change Worksheet for Community-Rated HMOs	No	Yes, only CR	No
Attachment V-b: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	Yes	Yes, only ER	No
Attachment V-c: Benefit Clarification Worksheet	Yes	Yes	No
Attachment VI: FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet (in Excel, separate document sent out with Technical Guidance)	No	Yes	Yes
Attachment VII: Federal Employees Health Benefits Program Statement About Service Area Expansion	No	Yes, if proposing expansion	Yes, if proposing expansion

Attachment I: Technical Guidance Submission Checklist

Please return this checklist with your 2021 benefit and rate proposal.

Not all attachments are applicable to each Carrier. Please refer to the Attachments section of the 2021 Technical Guidance and, if you have further questions, please contact your Health Insurance Specialist.

Attachment	Attachment completed and in proposal? Yes/No/NA
Attachment II: FEHB Carrier Contracting Official	
Attachment III: Organ/Tissue Transplants and Diagnoses	
Attachment IV: FEHB Drug Formulary Template*	
Attachment V-a: Benefit Change Worksheet for Community-Rated HMOs	
Attachment V-b: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	
Attachment V-c: Benefit Clarification Worksheet	
Attachment VI: FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet (HMOs only)*	
Attachment VII: Federal Employees Health Benefits Program Statement About Service Area Expansion	

* *Please note that the* Attachment IV: FEHB Drug Formulary Template *and* Attachment VI: FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet *are Excel documents sent out with the 2021 Technical Guidance.*

Attachment II: 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. An updated worksheet should be submitted any time revisions are made. Please submit the worksheet containing the **original signature** of the contracting official; photocopies are not acceptable.

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 III: 2021 Organ/Tissue Transplants and Diagnoses

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services recommended under clinical trials and transplants 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. If you have further questions, please contact your Health Insurance Specialist.

Table 1: Required Coverage

I. Solid Organ and Tissues Transplants: Subject to Medical Necessity
Cornea
Heart
Heart-Lung
Kidney
Kidney-Pancreas
Liver
Pancreas
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs, such as the liver, stomach, and pancreas) or isolated small intestine
Lung: single/bilateral/lobar
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
Hodgkin's lymphoma – relapsed
Non-Hodgkin's lymphoma – relapsed
Acute myeloid leukemia
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
Hodgkin's lymphoma – relapsed
Non-Hodgkin's lymphoma – relapsed

Amyloidosis
Neuroblastoma
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
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.
Autologous transplants for:
Breast cancer
Epithelial ovarian cancer
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)
Advanced Childhood kidney cancers
V. Mini-transplants performed in a Clinical Trial Setting (nonmyeloablative, reduced intensity conditioning for with a diagnosis listed under Section II): Subject to Medical Necessity. There is no defined age limit for the use of reduced intensity conditioning for an allogeneic stem cell transplant.
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)

Table 2: Recommended for Coverage – Transplants Under Clinical Trials

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2021?	
	Yes	No
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Hodgkin's lymphoma		

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2021?	
	Yes	No
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 Transplant

Solid Organ Transplants	Does your plan cover this transplant for 2021?	
	Yes	No
Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment IV: FEHB Drug Formularies

2020 Formularies

FFS and Returning HMOs must provide a copy of the full 2020 FEHB drug formulary as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as an attachment "2020 FEHB Drug Formulary Template" with this Technical Guidance Document. Include a Formulary Tier sheet and Drug List for **each** plan option. Please follow the more detailed instructions in the formulary template. Please note that the formulary template has not changed from 2019. The completed templates should be uploaded to Section II of the ADC tool in Benefits Plus by May 31, 2020.

2021 Formularies

New HMOs must submit a 2021 FEHB Drug Formulary Template to OPM. **FFS and Returning HMOs** changing formularies or moving to new formularies in 2021 must submit a 2021 FEHB Drug Formulary Template. Include a Formulary Tier sheet and Drug List for **each** plan option. Please follow the more detailed instructions in the formulary template. The completed templates should be emailed to your Health Insurance Specialist, by May 31, 2020.

File Naming Convention

Please upload your FEHB Drug Formulary Template. Use the following file naming convention for the formulary file(s) you submit: **Formulary2020_zzz**, (or **Formulary 2021_zzz**, if applicable) where "zzz" represents the 1st three characters of the FEHB Plan code and option that utilizes the formulary. For Carriers that have multiple plan options that share the same formulary, please include only one enrollment code in the file name and include all Self Only enrollment codes in cell B7 of the Formulary Tiers sheet of the Excel template).

File Resubmission

If you are resubmitting a file, please add a letter in alphabetical order at the end of the file name for each subsequent resubmission: (e.g., **Formulary2020_zzz_a, Formulary2020_zzz_b**, etc.).

Attachment V-a: Benefit Change Worksheet for **Community-Rated HMOs**

[Insert Health Plan Name] [Insert Subsection Name]

Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes section to complete the worksheet.

Benefit Change Description

List option(s) Benefit Change applies to (for example, High or HDHP): ____________________

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 it is an increase, describe whether any other benefit is off-set by your proposal.

   ____

   c. What is the cost impact of this change as a bi-weekly amount for Self Only, Self Plus One, and Self and Family rate?

   ____

i. 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:

<u>Exception 1</u>: 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 2021.

<u>Exception 2</u>: A Carrier may propose benefit enhancements that are not cost neutral in the current year within a single plan options, 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).

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

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

a. If yes, when?

____

b. If approved, when? (attach supporting documentation)

____

c. How will the change be introduced to other employers?

____

d. What percentage of the plan subscribers now have this benefit?

____

e. What percentage of plan subscribers do you project will have this benefit by January 2021?____

4. 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 2021?

____

d. What is the maximum percentage of all subscribers you expect to be covered by this rider?

____

e. When will that occur?

____

5. Will this change require new providers? ____

a. If yes, provide a copy of the directory which includes new providers.

____

Attachment V-b: Benefit Change Worksheet for **Fee-For-Service** and **Experience-Rated HMOs**

[Insert Health Plan Name] [Insert Subsection Name]

Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes section to complete the worksheet.

Benefit Change Description

List option(s) Benefit Change applies to (for example, High or HDHP): ____________________

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:

b. Actuarial Value:
   a. Is the change an increase or decrease in existing benefit package?
      ____

   b. If it is an increase, describe whether any other benefit is off-set by your proposal.

____

c. What is the cost impact of this change as a bi-weekly amount for Self Only, Self Plus One, and Self and Family rate?

---

i. 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.

---

c. 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 2021.

Exception 2: A Carrier may propose benefit enhancements that are not cost neutral in the current year within a single plan options, 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.

Attachment V-c: Benefit Clarification Worksheet

[Insert Health Plan Name] [Insert Subsection Name]

Please refer to Benefit Clarifications section to complete the worksheet.

Please note: Clarifications help members understand how a benefit is covered, it is not a benefit change. If a benefit is a clarification, there should not be a change in premium.

Benefit Clarification Description

List option(s) Benefit Clarification applies to (for example, High or HDHP): ________________

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Attachment VI: FEHB Benefit Difference Comparison Chart

The FEHB Benefit Difference Comparison Chart is an Excel Spreadsheet sent out with the Technical Guidance. Please refer to the FEHB Benefit Difference Comparison Chart section and follow the Excel Spreadsheet Template for instructions.

If you have questions, please contact your Health Insurance Specialist.

Attachment VII: Federal Employees Health Benefits Program Statement About Service Area Expansion

New HMOs and Returning HMOs complete this form only if you are proposing a service area expansion. Please refer to the Service Area Expansion section of the 2021 Technical Guidance. If you have additional questions, please contact your Health Insurance Specialist.

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2021 Benefits and Service Area Proposals. Specifically,

1. All provider contracts include "hold harmless" provisions that preclude the provider from pursuing or "back billing" a member for fees in excess of the allowed amount under the plan
2. All provider contracts are fully executed at the time of this submission. We 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

____

Name and Title

____

Plan Name

____

Date