FEHB Program Carrier Letter

Health Maintenance Organizations (new)

U.S. Office of Personnel Management
Office of Insurance Programs

Letter No. 2000-21C **Date:** May 5, 2000

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

SUBJECT: Technical Guidance for Benefit and Service Area Proposals

This is additional guidance on benefit changes, instructions for submitting benefit proposals, and instructions for service area proposals for the upcoming contract term (January 1 through December 31, 2001). You must propose benefit changes according to carrier letter 2000-17, *Call Letter for Contract Year 2001 -- Policy Guidance*, dated April 11, 2000.

This letter has three parts:

Part One - Preparing Your Benefit Proposal
Part Two - Changes in Service Area Since You Applied to the FEHB Program
Part Three - Benefit Requirements for Newly-Approved HMOs

Remember that brochure language that accompanies and describes your benefit proposals must be in plain language and received by your OPM contract specialist by May 31, 2000. Non-benefit brochure language, using plain language throughout, is due to your contract specialist July 1, 2000.

We sent rate instructions in Carrier Letter 2000-18, dated April 19, 2000. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

Policies established in prior years remain in effect unless we say otherwise. See Part Three of this letter for details. We will not consider proposals that are contrary to these policies.

In keeping with the spirit of the call letter, we remain extremely price sensitive but do not limit HMOs to zero cost benefit tradeoffs. However, we prefer that benefits remain consistent with your community package.

Our experience is that a plan with less than four years experience in the FEHB Program is most at-risk for dropping out of the Program. Newer plans that drop out are more likely to cite insufficient FEHB enrollment as the reason for no longer wishing to participate. The FEHB

Program is a mature, managed care market. Your ability to differentiate yourself in terms of pricing, benefits, service, or provider panel will go a long way in determining your Program success. Keep your lines of communication open with your OPM contract specialist. Don't hesitate to call if you have any questions about the call letter or the material enclosed in this letter.

Sincerely,

(signed)

Frank D. Titus
Assistant Director
for Insurance Programs

Part One - Preparing Your Benefit Proposal

We expect every HMO to prepare a complete proposal according to these instructions and submit it by **May 31, 2000.**

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;

- Proposed 2001 benefit language (non-benefit brochure language in plain language format is due by July 1, 2000); and

- Signed contracting official form

If you foresee unusual or extensive changes to your community package, please discuss them with your OPM contract representative before you prepare your submission.

2001 FEHB Proposal Instructions

A. Provide the following material by **May 31, 2000:**

1. Experience-rated plans - Provide a copy of a fully executed employer group contract for 2000. If you have not made changes to this level of coverage since filing your application to participate in the FEHB Program, then submit a statement to this effect. If you have made changes, submit a copy of the new benefit description and answer the questions below (you must have filed this benefit package and the associated rate with your State if a filing is required by the State):

Attach a chart displaying the following information:

a. Benefits that are covered in one package but not the other;

b. Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other;

c. Whether you include the costs of the differences in a. and b. within or in addition to the community rate charged to other groups that purchase this community benefits package; and

d. The number of subscribers/contract holders who currently purchase each package.

2.Community-rated plans - We prefer to purchase the same community benefit package that covers the majority of your subscribers/contract holders, with adjustments for any benefit differences resulting from specific requirements of the FEHB Program. If you offer a variety of community packages, you should propose the core package of benefits that a majority (or the largest number) of plan subscribers or contract holders (not members or employer groups) purchase. If we later determine that the community benefits package we purchased is not the community benefits package purchased on behalf of the majority, we will adjust your 2001 FEHB rates.

Please append descriptions of community-based riders (e.g., prescription drugs, durable medical equipment) and other additions to the basic package that reflect changes, or mandated additions, to the community package. This material must show all benefits proposed for the FEHB Program for the 2001 contract term except those still under review by your State as described in Item B. below.

B. Describe the procedure in your State for filing and/or obtaining approval of community benefit packages and changes. If the State requires filing and/or approval, **provide a copy of the approval issued by the State applicable to the community package you submit in response to A1 or A2 above.** Please highlight and address any State mandated benefits that you have not specifically addressed in previous communications with us. Please note that we will accept proposed benefit changes only if: (1) you submitted the changes to your State prior to **May 31** and (2) you obtain approval and submit documentation of the approval to us by **June 30, 2000**. If the State grants approval by default, i.e., the State does not object to proposed changes within a certain period after they receive the proposal, please so note; the review period must have elapsed without objection by June 30.

We will contact the State about benefits as necessary; please provide the name and phone number of the State official responsible for reviewing your plan's benefits. If your plan operates in more than one State, provide this information for each State.

Carrier Contracting Officials

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 persons 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)

_____ _____
(Phone number) (FAX Number)

(New HMOs)

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

We expect that your present service area and the individual doctors or medical groups with whom you contract to offer services to the FEHB will be available to our members for the 2001 contract term. You must inform us of any changes.

Service Area Reduction - Explain the reason for and provide supporting documentation (e.g., withdrawal notice from medical group) for any proposed reduction to your service area. Does this reduction apply only to the Federal group?

Service Area Expansion - You must propose any service area expansion by **May 31**. We will grant an extension no later than June 30 for submitting supporting documentation described below, including all necessary State authorizations. We cannot grant exceptions to this date.

Redesignation as a Mixed Model Plan - If you applied as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) during the application process and you now offer both types of providers, redesignation as a Mixed Model Plan (MMP) may be appropriate. You must request redesignation and describe the delivery system that you added.

Please note: You must indicate to us that the information you provide concerning your delivery system is based on providers with whom you have executed contracts; letters of intent are not acceptable in lieu of executed contracts. We also require that you state that all contracts with providers contain a "hold harmless" clause. Use the statement form included in this mailing.

OPM will evaluate your proposal according to these criteria: legal authority to operate, reasonable access to and choice of quality primary and specialty medical care throughout the service area, and your ability to provide contracted benefits. Please provide the following information:

A. Provide a description of the proposed expansion area in which you are approved to operate (if different from what you proposed and what we accepted in your application):

1. Describe the proposed service area expansion by zip code, county, city or town, and provide a map of the old and new service areas.

B. Authority to operate in proposed area:

1. Please provide a copy of the State approval document authorizing you to both market and provide services in the proposed expansion area, and the name and telephone number of the person at the state agency who worked on the authorization. The document must include a description of the approved area.

C. Access to Providers

1. Please provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have executed contracts.

Service Area and Additional Geographic Areas - Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an additional geographic area that surrounds, or is adjacent to, your service area you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the State where you have legal authority to operate permits you to enroll members who work but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy in your brochure.

Since benefits may be restricted for nonemergency care received outside the service area where plan providers are generally located, your proposal must include language to clearly describe this additional geographic area as well as your service area.

D. Redesignation as a Mixed Model Plan - This section applies only if you applied as a GPP or IPP and, since the application approval, now offer both types of providers. Please indicate the provider system you are adding.

If you are adding a GPP component to an existing IPP delivery system, please note that in order to meet FEHB requirements you must demonstrate that the group includes "at least three physicians who receive all or a substantial part of their professional income from the HMO funds and who represent one or more medical specialties appropriate and necessary for the population proposed to be served by the plan." (5 USC 8903(4)(A))

If we approve your proposal, you will need to provide the following information:

1. Do you require all members of a family to use the same delivery system, or may some members of a family use GPP doctors while others use IPP doctors?

2. If you restrict members to one type of delivery system, what must a member do to change from one delivery system to the other during a contract term? How soon after it is requested would such a change be effective?

3. If a member wants to change primary care doctors (centers for GPPs), what must the member do? Is there a limit on the number of times a member may change primary care doctors (centers)? If yes, will you waive the limit for FEHB members? How soon is a requested change effective?

Federal Employees Health Benefits Program
Statement About Service Area Expansion

We have prepared the attached service area expansion proposal in accordance with the requirements found in Part Two, Changes in Service Area, of Carrier Letter 2000-21C. Specifically,

1. All provider contracts have hold harmless provisions in them.

2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.

3. All of the information provided in response to Part Two, Paragraph C (Access to Providers) is accurate as of the date of this statement.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

(New HMOs)

Part Three - Benefit Requirements for Newly-Approved HMOs

Policies established in prior years remain in effect unless we say otherwise. We have highlighted some here as an aid to you in preparing your proposal. We will not consider proposed benefits that are contrary to policy. You should work closely with your contract specialist to develop a complete benefit package for 2001.

A. **Mental Health and Substance Abuse** - Under mental health and substance abuse parity, your coverage for mental health and substance abuse must be identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. We would like to see you make patient access to adequate mental health services happen through managed care networks of behavioral health care providers and innovative benefits design.

B. **Maternity and Mastectomy Admissions** - All plans must provide for maternity admission lengths of stay of at least 48 hours after a regular delivery and 96 hours after a caesarian delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.

C. **Pre-existing Conditions** - We do not allow pre-existing condition limitations on any benefit, including cosmetic surgery and dental benefits.

D. **Point of Service Product** - We will consider proposals to offer a Point of Service product under the FEHB Program only if you can demonstrate experience with a private sector employer who has purchased this product.

E. **Waiver of Office Visit Copayments for Prenatal and Postnatal Care** - A number of plans waive these copayments to help assure that pregnant members obtain adequate pre- and post-natal care, and thereby increase the likelihood that their babies will be born without complications. We encourage other HMOs to do the same.

F. **Coverage for Fertility Drugs** - We require you to cover treatment of infertility, but this requirement does not include related prescription drugs. Brochure language should clearly indicate whether you cover fertility drugs or not, in both the infertility benefit description and the prescription drug benefit description. You may not exclude drugs for sexual dysfunction (impotence), but you may place limits on the benefit.

G. **Immunizations for Children** - All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or sera.

H. **Transplants** -All plans must provide coverage for all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney transplants. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. You may limit coverage for these three conditions to services provided at a recognized Center of Excellence and received in clinical trials, as long as both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but you must provide necessary follow-up care to the experimental procedure. All HMOs must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors,you will coordinate benefits according to NAIC guidelines, as with any other benefit.

You may exclude from your FEHB benefits other transplants not mandated by us if they are not in the community benefit package we purchase, and as permitted by applicable State law.

I. **Dental and Vision Benefits** - We will consider dental or vision care benefits only from community-rated plans and only when they are a part of the core community benefits package we purchase.

J. **Prescription Drugs** - All plans must provide at least a minimum level of coverage for all medically necessary drugs that require a prescription for their use, and insulin.

Drug benefit deductibles may not exceed $600 and member coinsurance may not exceed 50%. We don’t allow lifetime or annual benefit maximums on prescription drugs.

You must cover disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. In addition, you must provide benefits for "off-label" use of covered medications if prescribed for such use by a plan doctor in accordance with generally accepted medical practice.

You may use a drug formulary as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. You cannot use the formulary as a means to exclude benefits for the types of drugs mandated for the FEHB. We don’t allow blanket

exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables".

K. **Coverage for Contraceptives** -You must provide coverage for all FDA-approved prescriptions and devices for contraception.

L. **DHHS-Mandated Benefits** - All HMOs **must** offer certain benefits that are mandated for Federally qualified plans by the Department of Health and Human Services (DHHS), **without limitation as to time and cost,** other than as prescribed in the Public Health Service Act and DHHS regulations. These required benefits include:

- Nonexperimental bone marrow, cornea, kidney, and liver transplants (see H. above for other FEHB requirements in this area);

- Short-term rehabilitative therapy (physical, speech, and occupational), if significant improvement in the patient's condition can be expected within two months;

- Family planning services, including all necessary nonexperimental infertility services, to include artificial insemination with either the husband's or donor sperm. You don't have to cover the cost of donor sperm. You may exlude other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) to the extent permitted by applicable State law;

- Home health services;

- Inhospital administration of blood and blood products (including "blood processing");

- Surgical treatment of morbid obesity, when medically necessary;

- Implants - the surgical procedure must be covered, although the cost of the device may be excluded.

Federally qualified community-rated plans offer these benefits at no additional cost, i.e., the cost is covered by the community rate. Community-rated plans that are not Federally-qualified should reflect the cost of any non-community benefits on Attachment 2 of their rate calculation (if there is no additional cost, the cost entry should be zero).