FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2013-04 **Date: March 21, 2013**

Fee-for-service [4] Experience-rated HMO [4] Community-rated HMO [3]

SUBJECT: Federal Employees Health Benefits Program Call Letter

SUBMISSION OF PROPOSALS

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. Your benefit and rate proposals for the contract term beginning January 1, 2014 should be submitted to us on or before **May 31, 2013**. Please send your proposals by **overnight mail, FAX, or email** to your contract specialist. We expect to complete benefit and rate negotiations by mid-August to ensure a timely Open Season.

FEHB PROGRAM BENEFITS AND INITIATIVES

I. Introduction

We appreciate all of the efforts you have made in helping to achieve the goals of the FEHB Program. With your help, we have made substantial progress in improving the health care available to Federal employees, retirees and their families.

This year we emphasize performance in four key areas: 1) improving the delivery of prescription drug benefits; 2) enhancing wellness programs; 3) advancing quality of care; and 4) encouraging Medicare population pilots. Specific initiatives are discussed below.

Proposed benefit changes must be value-based. That means all FEHB Program carriers should demonstrate that they evaluated proposed changes in light of their impact on delivering the most effective care (i.e., that generally produces the best health outcomes), not just with respect to cost. We encourage innovative proposals aimed at controlling long-term costs by promoting services and behaviors that improve enrollees' health.

II. Prescription Drugs

OPM continues to focus on ways to further reduce pharmacy spending through ensuring the safe and clinically effective use of prescription medications. Your proposals should highlight how you will achieve these goals through benefit structure changes and outreach.

Pharmacy claims account for approximately 30 percent of FEHB Program premiums, so maximizing the effective use of medications and controlling pharmacy costs should be a central theme of 2014 benefit proposals. Additionally, we seek to synchronize pharmacy benefit designs so that enrollees may make meaningful comparisons between plans. In addition, our goal is to

keep overall pharmacy trend at or below the industry growth rate which we project to be approximately 8 percent for 2014.

Generic Dispensing Rate. We are pleased to see your greater emphasis and focus on the generic dispensing rate. As more generic equivalents become available, our goal is to have a generic dispensing rate of at least 80 percent for the FEHB Program as a whole in 2014. We are interested in your proposals for benefits and administrative programs to improve your rate, help us achieve our goal and support the use of generic drugs.

Preferred Brands. We encourage efforts to engage enrollees and their providers in meaningful discussions about clinically effective medications which may be offered at a lower cost. In addition to maximizing the use of generics, there are many drug classes for which therapeutic equivalents or alternatives can be prescribed through the use of step therapy. Examples include drugs for insomnia, acid reflux, high blood pressure, high cholesterol, and osteoporosis. Proposals should address implementation strategies that also include information on transition, prior authorization, customer service and grandfathering policies.

Specialty Drug Trend. Although specialty drugs make up less than one percent of total prescriptions, they can account for a significant amount of total drug spend. Given the expansion of drugs in this market segment, we are reinforcing our goal of maintaining specialty drug trend at 22 percent or less, which is in line with the industry specialty drug trend. Proposals to address rising specialty drug costs should consider both benefit and administrative changes, while remaining respectful of member needs. Examples include specialty pharmacies, prior approval and programs that limit the quantity dispensed on new prescriptions to assess side effects which may impact a patient's ability to continue therapy. We welcome your recommendations for innovation in this area.

Drug Tiers. This year, OPM recommends that carriers begin adopting a common pharmacy benefit- structure, and propose nomenclature, to help members understand pharmacy benefits, including key elements such as cost sharing arrangements. Plans should migrate to a minimum four-tier prescription drug benefit with common definitions no later than 2016 as follows:

- Tier one: Generics
- Tier two: Preferred brands
- Tier three: Non-preferred brands
- Tier four: Specialty drugs

We will work with you throughout the implementation of these changes. Member cost share should increase from Tier one – Tier three, with special consideration given to the affordability of specialty drugs. A copayment structure that is easy for members to understand serves as an effective incentive to utilize generics and preferred brands. For HMOs, we would like to know if you are moving to a four-tier benefit structure in your community package. We also strongly encourage use of cost effective medication distribution channels, specifically mail order or retail programs that offer 90 day supplies of maintenance medications.

We understand that members can achieve even greater savings on prescription drugs with minimal member disruption, through either a narrower pharmacy network or a preferred pharmacy network. We welcome proposals for narrower or preferred pharmacy networks. In

your proposals, please include information about how such a change will continue to ensure member access to medications and the proposed exception process in your submission.

III. Wellness

To enhance the overall health of our population, we call your attention to specific aspects of wellness, preventive care, and condition management:

Comprehensive Wellness Programs

Although FEHB carriers already offer a variety of wellness programs, our most recent data reveals low levels of member participation. To have a greater impact on enrollee health, we strongly encourage carriers to re-examine the scope of their programs, outreach efforts, and the level of incentives as detailed below.

The essential elements of a comprehensive wellness program[1] include:

- **Assessment and screening**. A voluntary tool or process, such as a healthrisk assessment, used to assess health status at the individual level and, when aggregated, can provide health status information on the enrolled population.
- **Behavior change interventions**. Evidence based programs, activities, and information designed to improve individual lifestyle habits and health status.

Wellness programs must be designed to comply with the Health Insurance Portability and Accountability Act (HIPAA), Affordable Care Act and implementing regulations, and should include an evaluation strategy. For more specific guidance on comprehensive wellness programs, carriers should consult accreditation standards published by the National Committee for Quality Assurance (NCQA) and the Utilization Review and Accreditation Commission (URAC), the HERO Best Practice Scorecard[2], and the Center for Disease Control (CDC) Interim Guidance for Health Risk Assessments[3].

At a minimum, all FEHB Program carriers must offer a health risk assessment. Carriers must also include in their proposals a plan for offering biometric screening (as a component of preventive care) to covered adults, describing the projected population and the costs for implementation. For both health risk assessments and biometric screening, carriers must set participation goals and propose relevant incentives. Proposals should also include a process to communicate results to members' primary care physicians, when applicable and carriers should consider specific outreach to senior populations.

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[1] Joint Consensus Statement."Guidance for a Reasonable Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives".http://www.acoem.org/uploadedFiles/Public_Affairs/Policies_And_Position_Statements/JOEM%20Joint%20Consensus%20Statement.pdf

[2] "The HERO Best Practice Scorecard in Collaboration with Mercer"
http://the-hero.org/scorecard_folder/HEROScorecardV3%201.pdf

[3] "Interim Guidance for Health Risk Assessments and their Modes of Provision for Medicare Beneficiaries."
http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/downloads/healthriskassessmentsCDCfinal.pdf

Preventive Care

In accordance with the latest United States Preventive Services Task Force (USPSTF) recommendations[4], all FEHB Program carriers must cover screening for all adults for obesity and referrals for behavior change interventions for adults with a Body Mass Index (BMI) over 30kg/m2 with no cost sharing.

Condition Management

In addition to implementing USPSTF guidance on adult obesity prevention, carriers should review and update their criteria for bariatric surgery coverage. A recent review of FEHB carriers reveals that some have very high BMI thresholds or impose waiting periods that are no longer clinically appropriate. Carriers should describe any revised eligibility criteria for bariatric surgery identified in their review.

IV. Advancing Quality of Care

We appreciate each carrier's ongoing efforts to ensure the delivery of high quality care, as evidenced by performance on HEDIS metrics, and to augment care coordination through the implementation of Patient Centered Medical Homes. To sharpen our focus on delivering the right care in the right setting, we added measures of readmission rates and emergency care to the FEHB 2013 HEDIS request. We plan to recognize quality leaders on our website in the fall.

Additionally, OPM Carrier Letter 2012-17 outlined initiatives to reduce preventable complications of healthcare and prematurity. To continue our emphasis on patient safety and neonatal health, we ask carriers to consider hospital performance on CMS measures of hospital acquired conditions[5] and early elective delivery[6] as important factors in the choice of network facilities. We also encourage carriers to review the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely Campaign[7] which highlights commonly overused tests and procedures. When one of these interventions is being considered, physician specialty societies recommend careful discussion between physician and patient to review potential benefits and risks before proceeding. Limiting overuse of care may avoid morbidity, risk of harm, and unnecessary spending for our members.

Finally, we encourage carriers to advance the Meaningful Use[8] of health information technology by network providers. Electronic health data will allow us to more effectively close gaps in care and design benefits to improve the health of Federal families. We will request statistics on the percentage of network providers who have achieved Stage 1 or Stage 2 of Meaningful Use.

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[4] http://www.uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.pdf

[5] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

[6] Federal Register Vol 77, No 170, August 31, 2012, pages 53528-31

[7] http://choosingwisely.org/

[8] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

V. Medicare Population Pilots

OPM is encouraging proposals for pilot programs where participating carriers offer a sub-option for Medicare eligible annuitants as an alternate choice. The sub-option may include premium pass-through accounts for plans to use solely to pay some or all of Medicare Part B premiums. Carriers may propose cost sharing reductions for members with Medicare Part B that are sufficient to encourage them to participate in the pilot program. Increased communication and education to enrollees will be important for the success of the pilot programs.

VI. Technical Guidance for Proposals

We will provide specific requirements for submitting benefit and rate proposals and information for preparing the 2014 brochures at a later date.

As a reminder, all FEHB carriers must adhere to the Guiding Principles available at: http://www.opm.gov/carrier. We expect timely and accurate processing of claims, including coordination of benefits; prompt and accurate submission of actuarial and financial data, including accounting statements; and we expect all plans are well managed and financially secure. In addition, all carriers are expected to have a vigorous and effective fraud detection and prevention program. Carriers must ensure that they have programs in place for prevention and prompt collection of improper payments.

CONCLUSION

Please discuss benefit changes with your contract specialist before submitting your proposals. Proposed benefit changes must be cost-neutral and all savings from managed care initiatives must accrue to the FEHB Program. We will begin negotiations when we receive your proposals.

We look forward to the negotiations for the upcoming contract year. Thank you for your commitment to the FEHB Program.

Sincerely,

John O'Brien
Director
Healthcare and Insurance