

Attachment A: Federal Employees Health Benefits--Patients' Bill of Rights

2. Agency Assessment Directive

THE WHITE HOUSE

WASHINGTON

November 20, 1997

MEMORANDUM FOR THE SECRETARY OF DEFENSE
THE SECRETARY OF LABOR
THE SECRETARY OF HEALTH AND HUMAN SERVICES
THE SECRETARY OF VETERANS AFFAIRS
THE DIRECTOR OF THE OFFICE OF PERSONNEL
MANAGEMENT

SUBJECT: The Health Care Consumer Bill of Rights and
Responsibilities

Last spring, when I appointed the members of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, I specifically charged them to develop a consumer bill of rights. This period of rapid change and experimentation in the way Americans receive and pay for their medical care holds the promise for improved quality, greater choice, and lower expense. At the same time, we must identify and protect certain fundamental rights of patients and their families so that, whatever health care delivery system they choose, they can obtain the information and care they need when necessary. Health care consumers also need to understand their responsibilities in a changing health care environment to ensure that they get the best possible care. Confirming such rights and responsibilities is critical to ensuring that the quality of medical care does not suffer as we seek to expand access and improve efficiency of delivery.

The Consumer Bill of Rights and Responsibilities in Health Care, issued today by the Commission, fully lives up to my high expectations. The members of the Commission have brought to bear their own considerable abilities and have obtained information from a wide range of sources. This Bill of Rights and Responsibilities is a comprehensive and thoughtful document that will be an excellent guide as we move through this transition in health care delivery. We must take steps to see that the rights contained in this document become a reality for all Americans.

Therefore, I hereby direct you to take the following actions consistent with the mission of your agency.

First, I direct you to determine the extent of your current compliance with the recommendations of the Commission.

Second, I direct you to use your administrative authorities, including existing regulations, advisories, and other guidance regarding health plans under their respective jurisdictions to initiate appropriate administrative actions consistent with the recommendations of the Commission.

Third, I direct you to identify the statutory impediments to compliance with the recommendations of the Commission.

Finally, I direct you to report back to me, through the Vice President, by February 19, 1998, with your findings and the administrative actions you have already undertaken and will undertake to effect the Commission's recommendations.

William J. Clinton

Attachment A: Federal Employees Health Benefits--Patients' Bill of Rights

3. Agency Compliance Directive

THE WHITE HOUSE
WASHINGTON

February 20, 1998

MEMORANDUM FOR THE SECRETARY OF DEFENSE
THE SECRETARY OF LABOR
THE SECRETARY OF HEALTH AND HUMAN SERVICES
THE SECRETARY OF VETERANS AFFAIRS
THE DIRECTOR OF THE OFFICE OF PERSONNEL
MANAGEMENT

SUBJECT: Federal Agency Compliance with the Patient Bill
of Rights

Last November, I directed you to review the health care programs you administer and/or oversee and report to me on the level and adequacy of the patient protections they provide. Specifically, I asked you to advise me on the extent to which those programs are in compliance with the Health Care Consumer Bill of Rights (the "Patient Bill of Rights") recommended by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry ("the Quality Commission").

Yesterday, you formally conveyed your reports to me through Vice President Gore. He advises me that each of your agencies is well on its way toward full compliance with the patient protections recommended by the Quality Commission. By doing so, your agencies will serve as strong models for health plans in the private sector.

Under your leadership, we are showing that it is possible and desirable to ensure that patients have the tools they need to navigate through an increasingly complex health care delivery system. We are showing that common sense solutions for all too common problems in our health systems are the right prescription not only for beneficiaries of Federally administered programs, but for our private sector colleagues as well. Your efforts illustrate that patient protections can be accomplished without excessive costs or regulations.

While the news is encouraging, your reports also indicate that we have not completed the job. Although Federal health programs are taking a leading role in providing protections to patients, your report indicates we have the regulatory and administrative authority to come into substantial compliance with the Patient Bill of Rights, and I believe that this should be one of my Administration's highest priorities.

Therefore, I hereby direct you to take the following actions consistent with the missions of your agencies to come into compliance with the Patient Bill of Rights.

The Secretary of Health and Human Services shall:

- take all appropriate administrative actions to ensure that the Medicare and Medicaid programs come into substantial compliance with the Patient Bill of Rights, including access to specialists and improved participation in treatment decisions, by no later than December 1999; and
- notify all State Medicaid directors that emergency room care protections should be consistent with the Patient Bill of Rights.

The Director of the Office of Personnel Management shall:

- ensure that all 350 Federal Employees Health Benefits Plan (FEHBP) participating carriers come into contractual compliance with the Patient Bill of Rights, particularly with regard to access to specialists, continuity of care, and access to emergency room services by no later than December 31, 1999; and
- with respect to participating carriers, propose regulations to prohibit, within 90 days, practices that restrict physician-patient communications about medically necessary treatment options.

The Secretary of Veterans Affairs shall:

- take the necessary administrative action to ensure that a sufficient appeals process is in place throughout the Veteran's Health System by September 30, 1998; and
- issue a policy directive to ensure that beneficiaries in the Veteran's Health System are provided information consistent with the Patient Bill of Rights by September 30, 1998.

The Secretary of Defense shall:

- establish a strong grievance and appeals process consistent with the Patient Bill of Rights throughout the military health system by September 30, 1998;
- issue a policy directive to promote greater use, within the military health system, of providers who have specialized training in women's health issues to serve as primary care managers for female beneficiaries and to ensure access to specialists for beneficiaries with chronic medical conditions by September 30, 1998; and
- issue a policy directive to ensure that all patients in the military health system can fully discuss all treatment options. This includes requiring disclosure of financial incentives to physicians and prohibiting "gag clauses" by September 30, 1998.

The Secretary of Labor shall:

- propose regulations to strengthen the internal appeals process for all Employee Retirement Income Security Act (ERISA) health plans to ensure that decisions regarding urgent care are resolved within 72 hours and generally resolved within 15 days for non-urgent care; and
- propose regulations that require ERISA health plans to ensure the information they provide to plan participants is consistent with the Patient Bill of Rights.

William J. Clinton



Attachment A: Federal Employees Health Benefits--Patients' Bill of Rights

4. Office of Personnel Management Reports



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

FEB 19 1998

The President
The White House
Washington, DC 20500

The Vice President
The White House
Washington, DC 20500

Dear Mr. President and Mr. Vice President:

When you endorsed the Health Care Consumer Bill of Rights and Responsibilities, you instructed the Office of Personnel Management (OPM), together with four other agencies, to report on their current and future compliance with its provisions. OPM's report accompanies this letter.

As you know, OPM administers the largest employer-sponsored health benefits program in the nation, the Federal Employees Health Benefits (FEHB) Program. Given a total membership of 9 million Americans and with 350 participating health benefits carriers, the FEHB Program is well positioned to influence the health care marketplace for the benefit of all consumers.

We are pleased to point out that the accompanying report reveals that the FEHB Program is currently in substantial compliance with the rights enumerated for health care consumers and that complete compliance is within reach with no legislative impediments. The Program is frequently cited as a model in which managed competition has produced both quality and cost effective health benefits. Unparalleled consumer choice is a hallmark of this Program, which rests on comprehensive consumer information and equitable treatment across participating plans. The Program has incorporated an independent third party review of grievances and appeals for over 20 years. All of these features are fundamental to the rights you have endorsed for all consumers.

In order to achieve full compliance with the Health Care Consumer Bill of Rights and Responsibilities, several actions are needed. First, we should communicate our expectations that FEHB carriers will work with us to become fully compliant with the consumer rights. Second, regulations will be necessary in order to prohibit "gag orders" and similar mechanisms from inhibiting a provider's ability to advise patients. Third, OPM should undertake a communications campaign to assure that FEHB enrollees become aware of their rights and responsibilities, and what they can expect from OPM and their FEHB carriers in the future. Finally, the FEHB Program could be strengthened by adopting a more broadly accepted survey instrument--the Consumer Assessment of Health Plans Survey. Use of this survey can

Mr. President and Mr. Vice President

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give Federal participants a better set of comparative data about health plan performance.

We look forward to completing the implementation of the Health Care Consumer Bill of Rights throughout the FEHB Program and hope that our leadership serves all our nation's health care consumers.

Sincerely,



Janice R. Lachance
Director

Enclosure

Implementing the Health Care Consumer Bill of Rights and Responsibilities in the Federal Employees Health Benefits Program

Executive Summary

Introduction

The Federal Employees Health Benefits (FEHB) Program is, by far, the largest employer sponsored health benefits program in the United States with 4.1 million enrollees and 9 million covered lives. The FEHB Program encompasses 350 carriers and is cited as a model health care program where managed competition has produced cost effective results. Consumer choice is the hallmark of the Program. The typical FEHB enrollee has a dozen plans from which to choose including Managed Fee-for-Service Plans, Preferred Provider Organizations (PPO), Point of Service (POS) products, and Health Maintenance Organizations (HMO).

The FEHB Program is currently in substantial compliance with the eight broad principles of the Consumer Bill of Rights. Comprehensive consumer information and equitable treatment across participating plans are fundamental to the Program's hallmark, consumer choice. Current adherence to the Consumer Bill of Rights is a matter of consistency and degree, with all, or a majority of plans meeting some provisions.

The Office of Personnel Management (OPM) will communicate its policy and benefit expectations for the 1999 contract year in a letter sent to carriers in March. This letter will include our expectation that carriers work with OPM to achieve contractual compliance with the Consumer Bill of Rights by the end of 1999, with full implementation projected for the year 2000. The letter will ask carriers to assess their current compliance with the Consumer Bill of Rights and how they propose to achieve full compliance within our required timeframes. Actions required on the part of carriers will vary, as will the timeframes necessary to achieve full compliance. For example, some carriers already have much of the required information about plan characteristics and performance while others will need to collect and summarize information. OPM will facilitate and encourage the process by providing leadership, identifying and publicizing best practices, and developing frameworks and standards.

To kick the process off, OPM will feature information about the Consumer Bill of Rights on our Web page with a link to its full text and background information. This will quickly communicate the Consumer Bill of Rights to FEHB participants so that they become aware of their responsibilities and the information they can expect in the future. Literature provided to consumers in the 1999 and 2000 contract years will clearly delineate what consumers can expect from individual plans.

I. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

OPM and its carriers currently publish health benefit brochures, provider directories, and comparison charts in multi-media formats that contain information on available plan types, benefits, limitations, maximums, exclusions, referral procedures, provider types and geographic location, quality assurance indicators, customer satisfaction survey results, and internal and external dispute resolution procedures.

Other information required by the Consumer Bill of Rights will be relatively easy to collect from health plans and providers such as license, certification, disenrollment rates, accreditation status, corporate form, years in existence, and compliance with state and federal requirements. Aggregate provider (physician and facility) network information will be more difficult for PPO plans to develop than for HMO and POS plans due to the size of their networks, limited contractual control of providers, and the fact that this level of network detail has not previously been required.

The technical information contained in the Consumer Bill of Rights will require development, compilation and refinement into consumer friendly formats. This information includes formulary development and experimental/investigational determination procedures, potential conflicts of interest, provider experience with and volume of procedures, provider compliant procedures, care management protocols, provider service and clinical quality indicators, and provider and health plan compensation arrangements.

OPM's letter to carriers in March will set forth our expectation that carriers began collecting and summarizing information not yet available, and propose formats for presentation of currently available information to consumers in 1999.

II. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

OPM currently offers consumers a wide choice of health care deliver systems that can provide coverage for, and access to, any licensed or certified provider. OPM's 350 carriers provide a choice of approximately one dozen health plans in any one geographic location. Continuity of coverage is assured through temporary continuation of coverage and conversion opportunities when enrollments terminate, and hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option. Network adequacy is assured during the FEHB Program carrier application process.

OPM will work with carriers to assure that there is reasonable access to specialty care, for the purpose of care continuity, where it makes sense taking into consideration clinical efficacy, plan design characteristics, and cost. OPM will establish guidelines to create consistency within the program in its letter to carriers in March.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

All health plans under the FEHB Program cover members for emergency services whenever and wherever needed. The Emergency Benefits section of plan brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing.

Our March letter will provide direction to carriers to utilize the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility. We will also express our expectation that carriers fully educate consumers regarding the availability, location, and use of emergency care facilities, as well as our expectation that contracting emergency room personnel contact health plans as quickly as possible in order to coordinate follow-up-care.

IV. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

OPM encourages consumers to take an active role in the decisions that affect their health and welfare. To aid in the decision making process, OPM provides multi-media detailed information on individual plan provisions, customer satisfaction, NCQA accreditation, benefit and rate comparisons, and resolves claims disputes between carriers and consumers.

OPM's March letter will communicate to carriers our expectation that contracting providers fully discuss treatment options, consequences of non-treatment, ensure adequate communication with disabled and non-English speaking persons, discuss advanced directives, and abide by patients or designated representatives decisions consistent with the informed consent process. We also will inform carriers that we will eliminate "gag" clauses under the FEHB Program by working with them to publish an FEHB Regulation effectuating this change.

V. Respect and Nondiscrimination

- Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.
- Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

The FEHB Program has a longstanding tradition of respect for its customers and prohibits discriminatory practices through a variety of legal provisions throughout its authorizing legislation.

Our March letter will require carriers and contracting providers to assure that FEHB participants:

- receive respectful treatment
- have access to copies of laws prohibiting disrespectful or discriminatory treatment when requested
- are assured appropriate time during visits to address concerns
- are provided with timely notice of changes in billing practices
- are helped to overcome cultural, physical, or language barriers
- are not unnecessarily delayed and apologized to when delays are unavoidable

VI Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

FEHB Program benefit brochures currently guarantee confidentiality of health care information for Federal members.

OPM's March letter will not address the confidentiality issue since the FEHB Program is currently fully in compliance.

VII. Complaints and Appeals

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

In accordance with longstanding legislation, all health plans in the FEHB Program have internal appeal processes and OPM provides the extra protection of an external appeal process. OPM's external appeal process begins after a consumer requests their carrier to reconsider a benefit denial and the carrier affirms the denial. Consumers then have up to 90 days to appeal the denial to OPM from the date the carrier affirmed its original denial or 30 days after the consumer requested the carrier to reconsider a denial, and the carrier has not responded. By virtue of OPM's contract with carriers as well as FEHB law, OPM has final decision making authority to settle an appeal.

OPM's March letter will request that carriers review their internal procedures to assure that they are in compliance with the detailed requirements of the Consumer Bill of Rights.

VIII. Consumer Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment.

In the FEHB Program, our benefit brochures emphasize the member's responsibility to be informed about health benefits and indicate where information can be accessed regarding enrollment procedures, eligibility, and benefits.

OPM will immediately initiate the necessary communication plan to assure that consumers are advised of their responsibilities. We have a number of communication vehicles available such as plan brochures, comparison charts and an Internet Website.

Implementation Action Plan

I. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities.

OPM currently publishes health benefit brochures that contain information on benefits, limitations, exclusions, referral procedures, and dispute resolution procedures. Our Guide to Employee Health Benefit Plans contains information on available plan types, quality assurance indicators, and customer satisfaction survey results. Plan provider directories contain information on various provider types and geographic location. Most of this information is presented in multi-media formats, which include Internet access.

The Bill indicates that Consumer Assistance Programs should be created to inspire consumer confidence, provide a safety valve, and foster collaboration between the different players of the health care system. OPM serves this function for Federal employees.

Information Disclosure	Implementation Strategy
Benefits, Cost Sharing, and Dispute Resolution (Prior to Enrollment)	
<ul style="list-style-type: none"> • Benefits, premiums, dispute resolution, and general limits on coverage e.g., lifetime or annual max, cost sharing, exclusions, or preventive care. 	Currently in compliance. Plan brochures and Web site contain the required information.
<ul style="list-style-type: none"> • Formulary drug inclusion and exception process. • Experimental/investigational determination process. 	Call Letter will require that necessary information is in plan brochures.
Health Plan Characteristics and Performance Information (Prior to Enrollment)	
<ul style="list-style-type: none"> • License, certification, disenrollment rates and accreditation status. 	OPM currently requires most of this information in the carrier application process. We will work with carriers to make it available to consumers in 1999.
<ul style="list-style-type: none"> • Service, clinical quality, and customer satisfaction performance measures. 	<ul style="list-style-type: none"> • Customer satisfaction data currently in place • Service measures will be perfected in 1999 for implementation in year 2000 • OPM is actively encouraging testing of clinical quality measures and will implement as they become available and are validated
Health Plan Characteristics and Performance Information (Upon Request)	
<ul style="list-style-type: none"> • Number of years existence and corporate form. • Meets State, Federal, and accreditation requirements for fiscal solvency, confidentiality, and transfer of medical records. 	OPM currently requires most of this information in the carrier application process. We will work with carriers to make it available to consumers in 1999.

Information Disclosure	Implementation Strategy
<p>Network Characteristics</p> <ul style="list-style-type: none"> ✓ • Aggregate information on the numbers, types, board certification status, and geographic distribution of primary care providers and specialists. ✓ • Names, board certification status, and geographic location of PCPs; whether accepting new patients; language(s) spoken, availability of interpreter, and whether facilities are accessible to disabled people. ✓ • Provider compensation methods and additional financial incentives (bonus, withhold ect). 	<ul style="list-style-type: none"> • OPM currently requires most of this information in the carrier application process for HMO and POS plans. We will work with carriers to make it available to consumers. PPOs will need more time to compile and disseminating this type of information. Work with the carriers to achieve compliance will begin immediately • Directories for HMO and POS products already communicate provider geographic distribution, specialty, and panel availability.
<ul style="list-style-type: none"> ✓ • Rules regarding coverage of out-of-network services, and applicable rates of cost sharing. ✓ • Information about circumstances under which primary care referral is required to access specialty care. ✓ • Information about what options exist for 24-hour coverage and whether enrollees have access to urgent care centers. 	<p>Currently in compliance. Plan brochures and Web site currently communicate this information.</p>
<p>Network Characteristics (Upon Request)</p>	
<ul style="list-style-type: none"> ✓ • Names, board certification status, and geographic location of specialists and specialty care centers; whether accepting new patients; language(s) spoken, availability of interpreter, and whether facilities are accessible to disabled people. ✓ • Names, accreditation status, and geographic location of hospitals, home health agencies, rehabilitation and long-term care facilities; whether accepting new patients; language(s) spoken, availability of interpreter services; and whether accessible to disabled people. 	<p>OPM currently requires most of this information in the carrier application process for HMO and POS plans. We will work with carriers to make it available to consumers in 1999. PPOs will need more time to compile and disseminate this type of information. Action will be initiated immediately to achieve compliance in 2000.</p>

Information Disclosure	Implementation Strategy
<p>Care Management Information (Upon Request)</p> <ul style="list-style-type: none"> • ✓ Preauthorization and utilization review procedures followed. • ✓ Use of clinical protocols, practice guidelines, and utilization review standards pertinent to patient's clinical circumstances. • ✓ Whether plan has special disease management programs or programs for persons with disabilities. • ✓ Whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers. • ✓ Qualifications of reviewers at the primary and appeals levels. 	<p>Call Letter will initiate process of compiling and summarizing technical information in consumer friendly formats and making it available to enrollees.</p>
<p>Health Professional Information</p> <ul style="list-style-type: none"> • ✓ Whether ownership or affiliation arrangement with provider group or institution would make it likely that a consumer would be referred to particular specialists or facility or receive service. • How the provider is compensated, including base payment method and additional financial incentives. 	<p>OPM currently requires most of this information in the carrier application process for HMO and POS products. We will work with carriers to make it available to consumers.</p>
<p>Health Professional Information (Upon Request)</p> <ul style="list-style-type: none"> • ✓ Education, board certification, and recertification status. • ✓ Names of hospitals where physicians have admitting privileges. • ✓ Years of practice as a physician or specialist. • ✓ Accreditation status. • ✓ Corporate form of the practice. • ✓ Availability of translation or interpretation services for non-English speakers and people with communication disabilities. • ✓ Cancellation, suspension, sanctions or exclusion from participation in Federal programs. • ✓ Suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges. 	<p>For information already available through the POS and HMO application process, OPM will work with carriers to compile, summarize, and disseminate it in 1999. We will require carriers to collect the remaining information and make it available in 2000.</p>
<ul style="list-style-type: none"> • ✓ Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity. • ✓ Consumer satisfaction, clinical quality and service performance measures. 	<p>OPM will encourage carriers to make this provider level information available to consumers when comparative criteria are defined and data collection becomes feasible.</p>

Information Disclosure	Implementation Strategy
<p>Health Care Facility Information</p> <ul style="list-style-type: none"> ✓ Corporate form of the facility. ✓ Accreditation status. • Whether specialty programs meet guidelines established by specialty societies or other bodies. • Complaint procedures. ✓ Availability of translation or interpretation services for non-English speakers and people with communication disabilities. • Whether facility has been excluded from any Federal health programs (i.e., Medicare or Medicaid). • Volume of certain procedures performed at facility. • Consumer satisfaction, clinical quality and service performance measures. • Numbers and credentials of providers of direct patient care (e.g., registered nurses, other licensed providers) • Whether the facility's affiliation with a provider network would make it more likely that consumer would be referred to health professionals or other organizations in network. 	<p>Call Letter will initiate action by carriers to identify data currently available and data not historically required of facilities. Available data will be formatted for consumers in 1999. Carriers will be required to begin collection of data not currently available, with 2000 target compliance projected.</p>
<p>Consumer Assistance Program</p> <p>OPM serves this function.</p>	<p>Currently in compliance.</p>

II. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

OPM currently offers a choice of Managed Fee-for-Service, PPO, HMO, and POS delivery systems that can provide coverage for, and access to, any licensed or certified provider across the nation to over 9 million people. OPM contracts with over 350 health plans and the FEHB Program offers a choice of approximately one dozen health plans in any one geographic location.

The FEHB Program provides continuity through temporary continuation of coverage and conversion opportunities when enrollments terminate. In addition, hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option.

Carriers' networks are reviewed for adequacy when they apply to participate in the FEHB Program.

<i>Choice of Providers and Plans</i>	<i>Implementation Strategy</i>
<ul style="list-style-type: none"> • Offer consumers a choice of high-quality health insurance products. • All health plan networks should provide access to sufficient numbers and types of providers to assure covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day and seven days a week. • Plans also should establish and maintain adequate arrangements to ensure reasonable proximity of providers to the business or personal residence of their members. 	Currently in compliance. These are minimum requirements of the FEHB Program that are verified in the carrier application process.
<ul style="list-style-type: none"> • Women should have access to plan gynecologists, certified nurse midwives, and other qualified providers for routine and preventative women's health care services. • If health plan has insufficient number or type of providers to provide covered benefits with the appropriate degree of specialization, plan should ensure consumer obtains benefit outside network at no greater cost than if obtained from in-network providers. • Authorizations when required should be for an adequate number of direct access visits under approved treatment plan. 	OPM will work with carriers to assure reasonable access to specialty care. We will establish guidelines in the Call Letter to create consistency within the Program.
<ul style="list-style-type: none"> • Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to qualified specialist of choice within plan's network of providers. 	OPM will work with carriers to assure that there is reasonable access to specialty care, for the purpose of care continuity, where it makes sense taking into consideration clinical efficacy, plan design characteristics, and cost.
<ul style="list-style-type: none"> • Consumers, undergoing treatment for chronic or disabling conditions (or in second or third trimester of pregnancy) at time they involuntarily change health plans or at time when provider is terminated by plan for other than cause, should continue seeing specialty providers for up to 90 days (or through completion of postpartum care) to allow transition of care. During transition period, patients will continue to have information and medical records available and will not incur greater costs for services. 	OPM will work with carriers to achieve full compliance in the year 2000.

III. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

All health plans under the FEHB Program cover members for emergency services whenever, and wherever, they are needed. The Emergency Benefits section of plan brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing.

<i>Access To Emergency Services</i>	<i>Implementation Strategy</i>
<ul style="list-style-type: none"> • Plans should educate members about availability, location, and appropriate use of emergency and other medical services; cost sharing for emergency services; and availability of care outside emergency department. • Plans using defined networks should cover emergency department screening and stabilization services both in-network and out-of-network without prior authorization consistent with the "prudent layperson" standard. Patients should not be charged in excess of plan's routine payment arrangements. • Emergency department personnel should contact patient's primary care provider or plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care. 	<p>OPM is in substantial compliance. However, to ensure consistency through out the program we will direct carriers to use the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility and reflect the benefit in the 1999 brochures.</p>

IV. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

OPM encourages members to take an active roll in the decisions that affect their health and wellbeing. To aid in the decision making process, OPM provides multi-media detailed information on individual plan provisions, customer satisfaction, NCQA accreditation, and benefit and rate comparison charts, and resolves claims disputes between carriers and members.

Participation In Treatment Decisions	Implementation Strategy
<p>Health care professionals should:</p> <ul style="list-style-type: none"> • Provide patients with easily understood information and opportunity to decide among treatment options consistent with informed consent process. Specifically: <ul style="list-style-type: none"> • Discuss all treatment options with patient in culturally competent manner, including option of no treatment • Ensure persons with disabilities and non-English speaking persons have effective communications with members of health system in making decisions • Discuss current treatments, including self-administered alternative treatments • Discuss risks, benefits, and consequences to treatment or non-treatment. • Give patients opportunity to refuse treatment and to express preferences about future treatment. • Discuss use of advance directives—both living wills and durable powers of attorney for health care. • Abide by decisions made by patients and/or designated representatives consistent with informed consent process. 	<p>We believe that FEHB plan participating providers are in substantial compliance. We will work with carriers to standardize practices throughout the Program by 2000.</p>
<p>Health plans should:</p> <ul style="list-style-type: none"> • Disclose to consumers methods of compensation, ownership of or interest in health care facilities, or matters of conscience that could influence advice or treatment decisions. 	<p>Call Letter will require carriers to develop ways to make this information available to consumers.</p>
<p>Health plans should:</p> <ul style="list-style-type: none"> • Ensure that provider contracts do not contain any "gag clauses" or other contractual mechanisms that restrict providers' ability to communicate with and advise patients about medically necessary treatment options. • Be prohibited from penalizing or seeking retribution against health care professionals or workers for advocating on behalf of patients. 	<p>Most carriers already comply. OPM will publish a Notice of Proposed Rule Making prohibiting carriers from having "gag clauses" in their contracts with providers serving FEHB enrollees. The NPRM will invite comments from the carriers and the public on how best to effectuate any necessary changes.</p>

V. Respect and Nondiscrimination

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

The FEHB Program has a longstanding tradition of respect for its customers and prohibits discriminatory practices through a variety of legal provisions throughout its authorizing legislation.

<i>Respect and Nondiscrimination</i>	<i>Implementation Strategy</i>
<p>Consumers should be assured:</p> <ul style="list-style-type: none"> • Considerate, respectful care from the health care system at all times and under all circumstances. • Delivery of health care services consistent with benefits policy or as required by law regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. • Nondiscriminatory plan marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. 	<p>Currently in compliance with Federal law.</p>
<p>Members of the health care industry should strive to:</p> <ul style="list-style-type: none"> • Provide consumers with assurances that disrespect or discrimination is intolerable. • Provide consumers with information regarding existing laws prohibiting disrespectful or discriminatory treatment. • Provide consumers with an appropriate amount of time to fully discuss their concerns and questions. • Provide consumers with reasonable assistance to overcome language (including limited English proficiency), cultural, physical or communication barriers. • Provide consumers with timely notice and explanation of changes in fees or billing practices. • Avoid lengthy delays in seeing a patient; when delays occur, explain why they occurred and, if appropriate, apologize for such delays. 	<p>We believe that FEHB participating plans and providers are in substantial compliance. We will work with carriers to achieve program wide compliance by 2000.</p>

VI. Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

FEHB Program benefit brochures currently guarantee confidentiality of health care information for Federal members.

<i>Confidentiality of Health Information</i>	<i>Implementation Strategy</i>
<ul style="list-style-type: none"> • Consumers have right to communicate with providers in confidence and to have confidentiality of individually identifiable information protected. • Consumers also have right to review and copy own medical records and request amendments. • Disclosure of individually identifiable health care information without written consent should be permitted for: <ul style="list-style-type: none"> • Provision of healthcare • Payment for services • Peer review • Health promotion • Disease management • Quality assurance or only when there is a clear legal basis for doing so, such as: <ul style="list-style-type: none"> • Medical or health care research for which an Institutional review board has determined anonymous records will not suffice • Investigation of health care fraud • Public health reporting • Non-identifiable health care information should be used unless the individual has consented to disclosure of individually identifiable information. • When disclosure required, no greater information should be disclosed than necessary to achieve specific purpose of disclosure. 	<p>Currently in compliance. The confidentiality provisions contained in our plan brochures and on our Web site are even more stringent than the Bill requires.</p>

VII. Complaints and Appeals

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

All health plans in the FEHB Program have internal appeal processes and OPM provides the extra protection of an external appeal process.

Complaints and Appeals	Implementation Strategy
<p>Internal appeals systems should include:</p> <ul style="list-style-type: none"> • Timely written notification of decision to deny, reduce, terminate services or deny payment for services. Notification include explanation for decisions and procedures for appeal. • Resolve appeals in timely manner with expedited consideration for emergency or urgent care decisions consistent with time frames required by Medicare (i.e., 72 hours). • Claim review process by health care professionals credentialed with respect to treatment involved. • Reviews conducted by individuals not involved in initial decision. • Written notification of final determination by plan that includes: <ul style="list-style-type: none"> • Reason for determination and how to appeal decision to external entity • Reasonable processes for resolving consumer complaints about issues e.g., waiting times, operating hours, demeanor of health care personnel, and adequacy of facilities 	<p>Substantially in compliance. OPM currently requires carriers to maintain an appeal process. Call Letter will require that carriers review their internal procedures to assure full compliance by all plans in 1999.</p>
<p>External appeals systems should:</p> <ul style="list-style-type: none"> • Be available only after consumers have exhausted internal processes (except in cases of urgently needed care). • Apply to any decision by health plan to deny, reduce, or terminate coverage or deny payment for services based on determination that treatment is <ul style="list-style-type: none"> • Experimental or investigational in nature • Not medically necessary and amount exceeds threshold • Patient's life or health is jeopardized • Be conducted by health care professionals who are appropriately credentialed with respect to treatment involved and subject to conflict-of-interest prohibitions. • Be conducted by individuals who were not involved in initial decision. • Follow standard of review that promotes evidence-based decision making and relies on objective evidence. • Resolve appeals in timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames required by Medicare (i.e., 72 hours). 	<p>Currently in compliance. Our third party appeal process is in place and available to consumers through our brochures and Web site. OPM's external appeal process begins after a consumer requests their carrier to reconsider a benefit denial and the carrier affirms the denial. Consumers then have up to 90 days to appeal the denial to OPM from the date the carrier affirmed its original denial or 30 days after the consumer requested the carrier to reconsider a denial, and the carrier has not responded. By virtue of OPM's contract with carriers as well as FEHB law, OPM has final decision making authority to settle an appeal.</p>

VIII. Consumer Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment.

In the FEHB Program, our benefit brochures emphasize the member's responsibility to be informed about health benefits and indicate where information can be accessed regarding enrollment procedures, eligibility, and benefits.

<i>Consumer Responsibilities</i>	<i>Implementation Strategy</i>
<p>Greater individual involvement by consumers in care increases likelihood of achieving best outcomes and helps support a quality improvement, cost-conscious environment. Therefore members should be informed of their responsibility to:</p> <ul style="list-style-type: none"> • Maximize healthy habits e.g., exercising, not smoking, and eating healthy diet. • Become involved in care decisions. • Work collaboratively with providers in developing and carrying out agreed-upon treatment plans. • Disclose relevant information and clearly communicate wants and needs. • Use health plan's internal complaint and appeal processes to address concerns that may arise. • Avoid knowingly spreading disease. • Recognize reality of risks and limits of the science of medical care and human fallibility of health care professionals. • Be aware of health care provider's obligation to be efficient and equitable in providing care to others • Become knowledgeable about coverage and health plan options (when available) including covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and process to appeal coverage decisions. • Show respect for other patients and health workers. • Make a good-faith effort to meet financial obligations. • Abide by administrative and operational procedures of health plans, providers, and Government health programs. • Report wrongdoing and fraud to appropriate resources or legal authorities. 	<p>OPM will initiate the necessary communication plan to assure that consumers are advised of their responsibilities. We will use communication vehicles such as plan brochures and enrollment guides and our Web page.</p>

<i>Consumer Responsibilities</i>	<i>Implementation Strategy</i>
<p>Consumers should educate themselves with respect to specifics of benefit coverage and to learn how to access health care and services by:</p> <ul style="list-style-type: none"> • Reading and understanding written information that explains benefit coverage, health plan processes, and procedures to follow when seeking care from physician, hospital, or other providers. • Seeking information or clarification of information from health plan as necessary. • Using health plan's processes for addressing complaints or grievances when disputes with providers or health plan procedures arise. 	<p>OPM will use communication vehicles such as plan brochures and enrollment guides and provide extensive information on our Web page.</p>



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

OCT 29 1998

The Vice President
The White House
Washington, DC 20500

Dear Mr. Vice President:

I am pleased to submit the Office of Personnel Management's (OPM) report on implementation of the Patients' Bill of Rights within the Federal Employees Health Benefits (FEHB) Program. As you know, with almost 9 million covered individuals, the FEHB Program is the largest employer-sponsored health insurance program in the nation. The Program is frequently cited as a model for others to emulate; indeed, it will soon be duplicated in a pilot program for meeting the health care needs of selected military retirees. Given the attention paid to the FEHB Program by others, we believed that a real success in implementing the Patients' Bill of Rights would have an impact well beyond the FEHB Program.

I was directed by the President in February to ensure that all health plans participating in the FEHB Program would be in full contractual compliance with the Patients' Bill of Rights by the end of 1999. I immediately took steps to tell our 350 health plans about these new requirements, and the actions necessary to guarantee they would be met. I also proposed a regulation to prohibit practices that restrict physician-patient communications about medically necessary treatment options. That regulation took effect September 9, 1998.

I am pleased to forward the accompanying report which highlights our initiatives and accomplishments. It demonstrates that a collaborative and flexible approach to implementing an important set of patient protections can produce outstanding results. The FEHB Program encompasses most of the nation's health benefits plans and the three major types of health care delivery systems: fee-for-service with preferred provider organizations, health maintenance organizations, and point-of-service plans.

We worked together and focused on ultimate outcomes not process. The result, reflected in the accompanying report, demonstrates that the Patients' Bill of Rights can be implemented in the world of commercial health care for less than 25 cents per subscriber per year. Truly, we have demonstrated that there is no reason why all Americans should not benefit from the protections that President Clinton provided to the almost 9 million people covered under the FEHB Program.

Sincerely,

Janice R. Lachance
Director

Enclosure

REPORT TO THE VICE PRESIDENT OF THE UNITED STATES

**Progress Report in Implementing the Patients' Bill of Rights at the
U.S. Office of Personnel Management**

November 2, 1998

Patients' Bill of Rights Report

I. Introduction

The Federal Employees Health Benefits (FEHB) Program is in compliance with the eight broad principles of President Clinton's Patients' Bill of Rights.

Last November the President asked the Director of the Office of Personnel Management (OPM) to assess the adequacy of the patient protections OPM provides under the Federal Employees Health Benefits (FEHB) Program. On February 19, 1998, the Director submitted, through the Vice President, OPM's compliance assessment. That assessment indicated that while most FEHB participating carriers were in substantial compliance with the eight broad principles of the Patients' Bill of Rights (PBR), not all provided full protection in all areas. On February 20, 1998, the President signed an Executive Memorandum directing OPM to ensure that all FEHB participating carriers come into compliance with regard to access to specialists, continuity of care, and access to emergency room services by no later than December 31, 1999. He also directed OPM to propose regulations within 90 days to prohibit practices that restrict physician-patient communications about medically necessary treatment options.

Comprehensive and clear consumer information, and equitable treatment across participating plans, are fundamental to the FEHB Program. Nonetheless, to meet the President's directive, enrollees needed better information about the organizational structure and operating procedures of health plans. While Federal employees enjoy choice and fundamental protections in regard to their health care providers, some additional information was needed about the characteristics of providers.

Each plan's adherence to the Patients' Bill of Rights varies only slightly at this point. By the end of 1999, all plans will have completed contractual agreements ensuring full adherence to all of the Patients' Bill of Rights provisions. There are no statutory barriers to full implementation of the President's Patients' Bill of Rights. The protections it provides apply to all 8.7 million people covered by the FEHB Program. The protections added for 1999 will cost less than 25 cents of the annual premium.

The Office of Personnel Management (OPM) has completed the following actions to bring carriers into compliance with the Patients' Bill of Rights by the end of 1999:

Policy Direction to Health Carriers

On April 3, 1998, OPM sent its annual "call letter" to prospective health care carriers desiring to participate in the FEHB Program in 1999. The call letter provided policy guidance for the 1999 contract year. We informed carriers that we expected implementation of the Patients' Bill of Rights to be a collaborative process among OPM, the carriers, other federal agencies, and private-sector

organizations. We told them that we would work together to comply fully with the Patients' Bill of Rights by the end of 1999.

Our call letter requested that carriers discuss how their plans now comply with access to specialists, access to women's health services, and emergency care requirements of the Patients' Bill of Rights. The letter asked those carriers not yet in compliance to share their strategy to attain compliance. Working with the carriers, we were able to assure that they all submitted acceptable proposals.

Recognizing that some Patients' Bill of Rights changes require a certain amount of advance notice, OPM allowed carriers until the end of 1999 to achieve compliance with the network and provider level disclosure requirements and compliance strategies that require changes to provider contracts (for example; continuity of care, access to medical records, and certain network adequacy requirements).

Standardized Brochure Language

On May 1, 1998, OPM sent standardized brochure language to the plans on topics such as information disclosure, access to specialists, direct access to Obstetrician/Gynecologists (OB/GYN), and emergency services. This ensures these protections are described clearly and understandably for all FEHB participants.

Notification to All Federal Agencies

OPM communicates regularly with Federal agency benefits administrators, our primary link with Federal employees, through Benefits Administration Letters (BAL). On June 2, 1998, we sent a BAL to the agencies notifying them of the President's directive to implement the Patients' Bill of Rights, and providing them with our implementation strategy.

FEHBP Guide and Web Page Revisions

In its Open Season enrollment guide, OPM highlighted Patients' Bill of Rights features which federal employees, retirees and their covered family members can expect from their health plans in 1999. In June, we also created a separate section on our web site devoted to information on the Patients' Bill of Rights. This site includes links to full Patients' Bill of Rights information, including summaries on objectives, rights, and responsibilities. We updated this site in September to advise the federal community about what additional information they can expect to receive through the year 2000. This is to ensure that all FEHB participants know about their rights and protections. The site address is: www.opm.gov/insure.

OPM "Gag Clause" Regulation Published on August 10

As the President directed, OPM published a final regulation which prohibited health plans from restricting patient information on all medically necessary and appropriate treatment options. The regulation was effective September 9, 1998.

Contract Compliance

At the conclusion of the negotiations cycle, OPM revised the 1999 health plan contracts and amendments to require implementation of Patients' Bill of Rights provisions. These new contracts and amendments, which are effective on January 1, 1999, also require carriers to modify, where necessary, their provider contracts to comply with the Patients' Bill of Rights by the year 2000.

Service, Clinical Quality, and Customer Satisfaction Measurement Standardization

OPM is working with other federal agencies and accrediting organizations to create standard performance measures. The implementation of performance measures will enable us to make carriers increasingly accountable for the quality of health care services they deliver. This year we will use the Consumer Assessment of Health Plans Survey (CAHPS) instrument, which has become the industry standard. Widespread use of CAHPS will give consumers uniform health plan satisfaction ratings.

II. Provision-by-Provision Summary of the Extent to Which the Federal Employees Health Benefits Program Complies With the Patients' Bill of Rights.

Information Disclosure

OPM and its carriers currently publish health benefit brochures, provider directories, and guides in multi-media formats that contain information on available plan types, premiums, benefits, limitations, maximums, exclusions, referral procedures, emergency and urgent care procedures, provider types and geographic location, quality assurance indicators, customer satisfaction survey results, and internal and external dispute resolution procedures.

To fully implement the remaining requirements of the Patients' Bill of Rights, OPM's call letter requested the following information during the upcoming Open Season for the 1999 contract period:

- How the plan administers its formulary drug inclusion/exception and experimental/investigational determination processes;
- Disenrollment rates for the year ending 1997;
- Compliance with state and federal licensing or certification requirements,

if applicable, including the date the requirements were met. We also asked carriers to note where they do not comply with a requirement and the reason for non-compliance, and to indicate all accreditations and dates those accreditations were received;

- Carrier's corporate form, and the years it has been in existence; and
- Whether the plan meets state, federal, and accreditation requirements for fiscal solvency, confidentiality, and transfer of medical records.

Our call letter asked carriers to propose a format and process for providing the following information to members upon their request, beginning in 1999:

- Plan preauthorization and utilization review procedures;
- Use of clinical protocols, practice guidelines, and utilization review standards pertinent to a patient's clinical circumstances;
- Whether the plan has special disease management programs or programs for persons with disabilities;
- Whether a specific prescription drug is included in a formulary and procedures for considering requests for patient-specific waivers; and
- Qualifications of reviewers at the initial decision and reconsideration level under the FEHB disputed claims process.

Choice of Providers and Plans

Provider Network Adequacy

OPM currently offers consumers a wide choice of health care delivery systems including Preferred Provider Organizations (PPO), Point-of-Service (POS) plans, Health Maintenance Organizations (HMO), and Fee-for-Service (FFS) plans. Within the FEHB Program, coverage and access are available to a broad range of services and providers. OPM's 300 carriers provide a choice of approximately one dozen health plans in any single geographic location. OPM reviews HMO provider networks for adequacy during the carrier application process.

Access to Qualified Specialists For Women's Health Services

Our call letter asked that carriers provide narrative descriptions of how they currently comply with this provision; and, if they did not comply, to propose benefit or process changes to bring their plan into compliance. We informed carriers that -- to the extent certified nurse midwives are eligible to practice under existing state laws and meet credentialing requirements -- we expected plans to contract with and provide access to them for covered services. We also required that plans either allow members to select an Obstetrician/Gynecologist (OB/GYN) as their primary care provider, or allow members direct access for routine gynecological examinations.

Access to Specialists

For 1999, OPM's call letter directed plans to create procedures to assure that members who require frequent or prolonged specialty care can obtain

authorization for direct access to a qualified specialist of their choice within their network of providers. We also directed plans to review their provider referral practices and revise them as appropriate to ensure that members receive approval for an adequate number of visits to specialty providers under an approved treatment plan, so as not to unduly burden members with further approvals.

Continuity of Care

Continuity of care is currently assured in the FEHB Program through temporary continuation of coverage and conversion opportunities when enrollments terminate. Hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option. OPM's call letter asked each carrier to provide their strategy to implement the Patients' Bill of Rights continuity requirements by year end 1999.

Access To Emergency Services

All health plans under the FEHB Program currently cover members for emergency services whenever and wherever needed, 24 hours a day, seven days a week. The Emergency Benefits section of plan benefit brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing. Many of OPM's health plans already used the "prudent layperson" standard when reviewing emergency care visits for coverage eligibility. Our call letter required all carriers to use the "prudent layperson" standard when making coverage eligibility decisions in 1999.

Participation in Treatment Decisions

OPM encourages consumers to take an active role in the decisions that affect their health and welfare. To aid in the decision-making process, OPM provides detailed multi-media information on individual plan provisions, consumer satisfaction, National Committee for Quality Assurance (NCQA) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, and benefit and rate comparisons. We also resolve claims disputes between carriers and consumers. OPM's carrier contracts and amendments for 1999 require carriers to modify, where necessary, provider contracts to comply with Patients' Bill of Rights provisions.

On August 10, 1998, OPM published a regulation prohibiting "gag clauses" in provider contracts serving federal members to ensure unimpeded communication between health care providers and their patients.

Respect and Non-Discrimination

The FEHB Program has a long tradition of respect for its customers and prohibits illegal discriminatory practices.

Confidentiality of Health Information

The FEHB Program currently guarantees confidentiality of health care information for federal members. OPM's carrier contracts and amendments for 1999 require carriers

to modify, where necessary, provider contracts to comply with Patients' Bill of Rights provisions regarding patient access to medical records.

Complaints and Appeals

All health plans in the FEHB Program have both internal and external appeal processes.

Internal Appeals

The internal reconsideration process, including timeframes for response to participants, is specified in both regulation and carrier contracts. Carriers must give participants a complete explanation for why a claim or service has been denied.

External Appeals

OPM's external appeal process begins after a consumer asks the carrier to reconsider a benefit denial and the carrier affirms the denial. Consumers then have up to 90 days from the date the carrier affirmed its original denial, or 30 days after the consumer requested the carrier to reconsider the denial and the carrier has not responded, to appeal the denial to OPM. OPM has an in-house staff that reviews disputed claims. It also uses outside medical consultants for cases requiring a special level of expertise. OPM makes the final decision. The agency has both statutory and contractual authority to direct a plan to pay for or provide a service.

III. Number of People in Health Plans

The FEHB Program currently covers 4.1 million enrollees and approximately 8.7 million people, including dependents. Coverage is provided to enrollees and dependents through four types of health care delivery systems, Preferred Provider Organizations (PPO), Point-of-Service (POS) plans, Health Maintenance Organizations (HMO), and Fee-for-Service (FFS) plans. The program has approximately 2.6 million members enrolled in HMOs (including HMO based POS plans) and approximately 6.1 million members enrolled in FFS/PPO plans (including indemnity-based POS plans).

All patient protections under the Patients' Bill of Rights apply to all types of plans under the FEHB Program. Before providing guidance to carriers in its annual call letter that was issued on April 3, 1998, OPM determined that network and provider level information disclosure requirements were required of all plans that maintain contracted provider networks (e.g., HMO, PPO, POS delivery systems). Since most of the plans in the FEHB Program maintain networks, the network and provider level disclosure requirements were applied to the majority of plans in the program. Plan level information disclosure requirements were applied to all plans regardless of network arrangement. OPM provided guidance to the participating carriers in the April call letter. The call letter guidance established the basis for the carrier proposals that were due to OPM on May 31, 1998, and negotiated during the summer. OPM worked with carriers to ensure that their in-network benefit structures, referral procedures and prior

authorization requirements did not unduly restrict access to specialists, women's health services, and emergency care.

VI. Implications of These New Protections

For existing contracts, the average per member per year premium increase to pay for the patient protections provided by the Patients' Bill of Rights for 1999 will be less than 25 cents.

In general, carriers were receptive to our request to implement the Patients' Bill of Rights requirements and appreciated our efforts to work with them to design implementation strategies that were reasonable and achievable. Some of the PPO carriers expressed concern with compiling certain provider-level information because of the size of their networks and their limited contractual control over providers. OPM was able to work out a mechanism that was acceptable to everyone. It places primary reliance on providers in PPO networks, but holds carriers responsible for ensuring that consumers get the information they need. OPM will monitor the reaction of its customers as these provisions go into effect at the end of 1998 and the beginning of 1999.

OPM is committed to bring carriers into contractual compliance with all of the Patients' Bill of Rights recommendations by the end of 1999. Contract clauses requiring Patients' Bill of Rights compliance do not go into effect until January 1, 1999, and much of the new information that will be available to consumers in both print and electronic format is disseminated early in November in conjunction with the annual health benefits Open Season. However, we began to receive feedback on the President's initiative last June when we conducted a half-day session for over 400 agency benefits officers on the Patients' Bill of Rights. The session included workshops to educate these key agency personnel about the protections that would be provided to all FEHB participants, the information that would be available, and the improvements in health care related services we anticipated from this effort. Their response was overwhelmingly favorable.

When we published our proposed regulation prohibiting "gag clauses" under the FEHB Program, we received many positive comments. The American Academy of Ophthalmology said that since the FEHB Program is the benchmark for measuring and providing premier health care, by setting the example of banning all gag clauses it stands to provide all Americans with a key protection outlined in the Consumer (Patients') Bill of Rights and Responsibilities. The American Society of Internal Medicine indicated support for the rule because it assures that physicians and other providers participating in the FEHB Program will not be prevented from providing information on all medically appropriate treatment options. Individual employees and retirees also applauded OPM for its work on improving patient care under the FEHB Program, and supported OPM's efforts to prohibit contractual clauses or incentives that prevent open and candid communication between physicians and patients concerning appropriate treatment options. One person praised our efforts to eliminate health plan restrictions that violate the most basic rights in a free society.

This kind of support and the high level of existing compliance among FEHB Program plans lead us to expect that full compliance by our plans will continue to be a collaborative and cooperative process. In the unlikely event that a plan is unwilling to comply with the Patients' Bill of Rights, our contracting procedures provide a mechanism by which OPM may terminate that plan's participation in the FEHB Program for failure to meet its contractual obligations. Our plan participants can be assured that at the end of the day all health plans in the Program will be in full compliance with the Patients' Bill of Rights, because OPM has the tools it needs, as well as the will, to ensure this result.

Based on our experience with implementing the Patients' Bill of Rights requirements for the FEHB Program, we believe that the private sector should have no significant problems with implementing the protections. Once the protections are in place for the FEHB Program and other federal health programs, they can easily be extended elsewhere since it is neither cost effective nor, in some cases, operationally possible for carriers to extend the protections to FEHB Program enrollees without making them available to others.

V. Conclusion

Implementing the Patients' Bill of Rights has been an extremely positive experience for OPM.

Assuring consumer protections, as well as providing consumers with the information they need to make informed health care decisions, drives our carriers to compete on the basis of quality as well as cost. As we enhance the information we give consumers about carrier performance, and they become increasingly aware of differences and make plan choices accordingly, we expect that carriers will strive to provide higher quality care for our members in order to compete effectively for market share in the FEHB Program. As our implementation effort is phased in over the next two contract periods – beginning January 1, 1999, and January 1, 2000 – we will assess the impact the protections have on our members' confidence in the quality of their health plans.

We at OPM continually seek to have the FEHB Program -- as an exemplary quality-driven employer-sponsored health benefits program -- set the standard for the private sector. We are pleased to have been able to implement Patients' Bill of Rights requirements in the FEHB Program in 1999 for less than 25 cents per enrollee. We believe providing quality care at minimal cost should be the highest priority of a model health benefit program.



OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20416-0001

JAN 12 2000

The Vice President
The White House
Washington, DC 20500

Dear Mr. Vice President:

In February of 1998, I was directed by the President to ensure that all health plans participating in the Federal Employees Health Benefits Program come into compliance with the President's Patients' Bill of Rights, particularly in regard to access to specialists, continuity of care, and access to emergency room services by no later than December 31, 1999. The President also directed me to propose regulations to prohibit practices that restrict physician-patient communications about medically necessary treatment options.

Since the President's directive, our work with health plans throughout 1998 and 1999 has enabled us to achieve full compliance with the Patients' Bill of Rights. In working with health plans, we focused on results and collaborated on meeting them. We were flexible on process, but determined on outcomes. We are proud to report complete implementation of the Patients' Bill of Rights at a total annual cost of under \$10 a member - less than \$1 a month.

Over the past 2 years, we worked with health plans to implement these important consumer protections. More information is now available to consumers regarding their health plans, networks, providers and facilities. It is now easier for consumers to access specialty care and women's health services. Consumers can get emergency care without fear of financial consequences. They can be assured that there are no incentives in place that could dissuade their doctor from telling them of all appropriate treatment options.

As part of our implementation process, we developed standardized benefit brochure language to assure consistency in benefits administration and communication to consumers. To aid consumers in the health care decision-making process, we developed educational information highlighting our protections and published this information in our Open Season Guides and on our Web page. To measure customer satisfaction and clinical quality, we adopted the standard Consumer Assessment of Health Plans core and child survey instruments, and we are beginning to collect Healthplan and Employer Data and Information Set type data.

Mr. Vice President

2

Our success resulted from our strategy of focusing on outcomes, not process. This allowed our health plans the flexibility to implement the protections in ways best suited to the capabilities of their business settings. Through our example, we have demonstrated that important consumer protections can be implemented cost effectively across all health care delivery systems on a national basis. We are proud that our successful experience influenced Congress to act on similar consumer protections for the nation's private health care system and offer our assistance in any way we can to help facilitate this process.

Sincerely,

A handwritten signature in cursive script that reads "Janice R. Lachance". The signature is written in dark ink and is positioned above the printed name and title.

Janice R. Lachance
Director

Enclosure

REPORT TO THE VICE PRESIDENT OF THE UNITED STATES

December 31, 1999

Status of Implementation of the Consumer Bill of Rights and Responsibilities (Patients' Bill of Rights) in the Federal Employees Health Benefits Program

Third Status Report, Describing Progress through December 31, 1999

I. Introduction

In November of 1997, the President asked the Office of Personnel Management (OPM), the Department of Labor, the Department of Health and Human Services, the Department of Veterans Affairs, and the Department of Defense to assess the level to which their health care programs were in compliance with the Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities (Patients' Bill of Rights). The President also asked the agencies to identify any statutory impediments to implementing the Patients' Bill of Rights recommendations. In February of 1998, OPM reported through the Vice President its compliance assessment. OPM's assessment indicated there were no statutory impediments to full implementation of the Patients' Bill of Rights in the Federal Employees Health Benefits (FEHB) Program. Indeed, we found that many health plans participating in the program were already providing most of the protections. Health plan compliance was a matter of consistency or degree, so we still had work to do to achieve full compliance.

The President then directed the affected agencies by Executive Memorandum to use their regulatory and administrative authority to bring their health programs into full compliance with the Patients' Bill of Rights. Specifically, the Executive Memorandum required OPM to ensure that all FEHB participating health plans complied with regard to access to specialists, continuity of care, and access to emergency room services by no later than December 31, 1999. He also directed OPM to propose regulations within 90 days to prohibit practices that restrict physician-patient communications about medically necessary treatment options.

Since the President's directive, our work with health plans throughout 1998 and 1999 has enabled us to achieve full compliance with the Patients' Bill of Rights. In working with health plans, we focused on results and collaborated on meeting them. We were flexible on process, but determined on outcomes. We are proud to report complete implementation of the Patients' Bill of Rights at a total annual cost of under \$10 a member – less than \$1 a month.

Over the past 2 years, we developed standardized benefit brochure language to assure consistency in benefits administration and communication to consumers. We published regulations prohibiting "gag" clauses in provider contracts so that Federal enrollees can be assured that there are no incentives in place that could dissuade their doctors from telling them of all appropriate treatment options.

We worked, and are continuing to work, with industry stakeholders to help consumers make quality comparisons. We adopted the standard Consumer Assessment of Health Plans (CAHPS) core and child survey instruments to measure customer satisfaction in health plans as part of the standardization process. We are currently assessing health plan capabilities to provide Healthplan and Employer Data and Information Set (HEDIS) type data to measure clinical quality across all health care delivery systems. We have developed educational consumer information highlighting Patients' Bill of Rights protections and published this information in our Open Season Guides and on our Web page to aid consumers in making health care decisions.

OPM's 1998 policy guidance "call letter" required that all health plans in the FEHB Program achieve compliance with the health plan and care management information disclosure requirements of the Patients' Bill of Rights. It also required compliance with the access to specialists, access to women's health services, network adequacy, and emergency care requirements. Our 1999 "call letter" completed the implementation process by requiring compliance with the network and provider level information disclosure requirements as well as the transitional care and access to medical records protections.

II. Specific Rights

A. Information Disclosure

Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals, and facilities.

OPM and its health plans publish health benefit brochures, provider directories, and guides in multi-media formats that contain information on available plan types, premiums, benefits, emergency and urgent care procedures, limitations, maximums, exclusions, referral procedures, provider types and geographic location, quality assurance indicators, customer satisfaction survey results, and internal and external dispute resolution procedures.

In addition to the information that we made available prior to the President's directive, we worked with health plans throughout 1998 and 1999 to provide consumers with even more health plan, care management, network, provider, and facility information. Health plans provide this information through benefit brochures, on web sites, in guides, in fact sheets, in provider directories, by telephone, or through other means of communication. Since much of the network and provider information required by the Patients' Bill of Rights is maintained by providers, health plans in some cases direct consumers to their providers for certain specific information, but inform consumers that they are prepared to assist them in obtaining the information if necessary.

B. Choice of Providers and Plans

Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.

The FEHB program offers consumers a wide choice of health care delivery systems including Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Point of Service (POS), and Fee-for-Service (FFS) plans. Within the FEHB Program, coverage and access is available to a broad range of services and providers. OPM's over 290 health plan options provide a choice of approximately one dozen health plan options in a typical geographic location. Network adequacy is assured for HMOs during the health plan application process. Continuity of care is assured in the FEHB Program through temporary continuation of coverage and conversion opportunities when enrollments terminate. Hospitalized members have up to 92 days, or until discharge, to continue coverage under their current plan or option in the event of a change in plan or option.

After the President's directive, OPM directed health plans to increase access to women's health services, access to specialists, and to provide for greater continuity of care when a member loses access to his or her specialist.

Access to Women's Health Services

Health plans now contract with, or provide access to, certified nurse midwives where they are eligible to practice under existing state laws and meet credentialing requirements. Women also have the right to select OB/GYNs as their primary care providers or to access them directly for routine gynecological examinations.

Access to Specialists

Patients who require frequent or prolonged specialty care can now obtain a treatment plan which provides direct access to a qualified specialist within a health plan's network of providers.

Continuity of Care/Transitional Care

If a health plan terminates a provider from its network for reasons other than cause, or when a health plan leaves the FEHB Program, patients can now continue to see their specialty provider for up to 90 days, or through the completion of postpartum care. Patients undergoing this transitional care can be assured that they will not pay any more out-of-pocket than they would have previously, and that their medical records will be expeditiously transferred to their new provider.

C. Access to Emergency Services

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—that a “prudent layperson” could reasonably expect the absence of medical attention to result in placing that consumer’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Health plans under the FEHB Program have always covered members for emergency services whenever and wherever needed, 24 hours a day, 7 days a week. The Emergency Benefits section of plan benefit brochures explains procedures for accessing services, the availability of urgent care centers, and lists applicable cost sharing. All health plans now use the “prudent layperson” standard when making coverage eligibility decisions.

D. Participation in Treatment Decisions

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

OPM encourages consumers to take an active role in the decisions that affect their health and welfare. To aid in the decision-making process, OPM provides detailed multi-media information on individual plan provisions, consumer satisfaction, National Committee for Quality Assurance and Joint Commission on Accreditation of Healthcare Organizations accreditation, and benefit and rate comparisons. We also resolve claims disputes between health plans, providers, and consumers.

On August 10, 1998, OPM published a regulation prohibiting “gag clauses” in provider contracts serving Federal consumers to ensure unimpeded communication between health care providers and their patients.

E. Respect and Nondiscrimination

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances.

Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and

enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

The legislation authorizing the FEHB Program prohibited discriminatory practices. Observance of these legislative provisions has developed into a longstanding tradition of respect for FEHB customers.

F. Confidentiality of Health Information

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

Our contracts with health plans have always guaranteed the confidentiality of health care information for Federal consumers. Consumers have the right to review and obtain copies of their medical records promptly. They also have the right to request that their physician amend their record if it is not accurate, relevant, or complete. If the physician does not amend the record in accordance with the consumer's request, the consumer may add a brief statement to the record. This statement will be sent along with the medical record when it is disclosed or transferred.

G. Complaints and Appeals

Consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

All health plans in the FEHB Program have internal reconsideration processes. OPM provides the extra protection of an external appeal.

Internal Reconsideration

The internal reconsideration process, including timelines for response to members, is specified in both regulation and health plan contracts. Health plans must give members a complete written explanation for why a claim or service has been denied, or ask the member to provide additional information necessary to review the complaint, within 30 days of the member's appeal. The health plan then has 30 days from the date it receives the additional information to make its determination.

External Appeals

If a health plan's reconsideration decision is unfavorable, or not forthcoming within 30 days, members may request an OPM review. OPM has an in-house staff that reviews such disputed claims. It also uses outside medical consultants for cases requiring a special level of expertise. OPM makes the final decision. The agency has both statutory and contractual authority to direct a plan to pay for or provide a service.

III. Assuring Implementation of the Consumer Bill of Rights Protections

We have the tools we need to measure and reward compliance with Patients' Bill of Rights protections as well as the means with which to penalize non-compliance. Our health plan contracts contain financial mechanisms to either reward positive performance under the contract or penalize negative performance. We can use data from CAHPS surveys, HEDIS indicators, disputed claims experience, and overall health plan responsiveness to OPM instructions and directives to measure compliance with the protections. In extreme cases of non-compliance, we have the statutory and contractual authority to terminate a health plan's contract for non-compliance with the FEHB contract or OPM's instructions and directives.

IV. Numbers of People in Health Plans Who have been Affected to date

The FEHB Program currently covers 4.1 million enrollees and approximately 9 million people, including dependents. Coverage is provided to enrollees and dependents through HMO, PPO, POS, and FFS plans. The FEHB Program enrolls approximately 2.7 million members in HMOs (including HMO based POS plans) and approximately 6.3 million people in FFS/PPO plans (including indemnity based POS plans).

All patient protections under the Patients' Bill of Rights apply to all 9 million people enrolled in the FEHB Program.

V. Conclusion

We at the Office of Personnel Management are proud to have worked collaboratively and successfully with many of the nation's health plans to implement the important protections of the President's Patients' Bill of Rights. The total cost for these important protections amounts to less than \$1 a month. We have provided FEHB enrollees and their family members with an excellent set of consumer protections as well as the information they need to make informed, value-based health care decisions. Informed decision making by consumers creates a healthy competitive environment that drives our health plans to compete on quality - not just price.

Our focus on outcomes over process was the cornerstone of our implementation approach because it allowed our health plans the flexibility to implement the Patients' Bill of Rights protections in ways best suited to the capabilities of their unique business settings. Through our example, we demonstrated that valuable consumer protections can be implemented cost effectively across all health care delivery systems on a national basis. We take pride in the fact that our successful experience influenced Congress to act on similar consumer protections for the nation's private health care system.

**Attachment B: Federal Employees Health Benefits—Mental Health
and Substance Abuse Parity**

- 1. Press Release**
- 2. FEHBP Carriers Letter**
- 3. Federal Agency Notice**

**Attachment B: Federal Employees Health Benefits—Mental Health
and Substance Abuse Parity**

1. Press Release



FOR IMMEDIATE
RELEASE
June 7, 1999

CONTACT: Edmund
Byrnes
(202) 606-2402
edbyrnes@opm.gov

WHITE HOUSE DIRECTS OPM TO ACHIEVE MENTAL HEALTH AND SUBSTANCE ABUSE HEALTH COVERAGE PARITY

Washington, DC -- President Clinton, in his address today at the White House Conference on Mental Health, directed the U.S. Office of Personnel Management (OPM) to achieve parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program (FEHBP) by 2001.

"I believe that OPM, in cooperation with these health plans, can demonstrate that mental health and substance abuse parity can be achieved at an affordable price," said Clinton. "The goal is to make plan coverage for mental health and substance abuse care identical to traditional medical care with regard to deductibles, coinsurance, copayments, and day and visit limitations."

In response, OPM Director Janice R. Lachance issued a letter to over 285 participating health plans enlisting their support. The FEHBP is by far the largest employer-sponsored health insurance program in the country, covering about 9 million people including federal employees, retirees and their families.

"Affordable and fair health care coverage is vital for those suffering physically or mentally," said Lachance. "OPM will work with the health plans to introduce managed behavioral health care components that incorporate proven techniques such as case management, authorized treatment plans, provider networks using

effective screening and referral procedures, pre-certification and disease management.”

Because of its size and the large number of participating health plans, the President noted that the FEHBP is in a unique position to serve as a model for other employers and for the insurance industry.

Over the past several years, the FEHBP has been moving toward mental health and substance abuse parity.

OPM has eliminated lifetime and annual maximums in the Program, and negotiated with plans to move away from contractual day and visit limitations and high deductibles, copayments, and coinsurance for mental health coverage. For 1999, pharmacotherapy, medical visits and testing to monitor drug treatment for mental conditions were covered as pharmaceutical disease management.

Given recent advances in treatment and related factors, the President is confident that parity in the Government’s health insurance program for federal employees, retirees and their families can be achieved affordably through appropriate care management.

-END-

United States Office of Personnel Management	Office of Communications Building	Theodore Roosevelt Building 1900 E Street, NW Room 5F12 Washington, DC 20415-0001	(202) 606-2402 FAX: (202) 606-2264
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Web page updated 15 June 1999

**Attachment B: Federal Employees Health Benefits—Mental Health
and Substance Abuse Parity**

2. FEHBP Carriers Letter

FEHB Program Carrier Letter

All Carriers

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

Letter No. 1999-027

Date: June 7, 1999

Fee-for-service [23] Experience-rated HMO [24] Community-rated HMO [25]

SUBJECT: Mental Health and Substance Abuse Parity

Introduction

At today's White House Conference on Mental Health Parity, the President directed the Office of Personnel Management to achieve mental health and substance abuse parity in the Federal Employees Health Benefits (FEHB) Program. Our work with health plans and others has demonstrated conclusively that this goal can be reached effectively. In its simplest form, we want to enlist your support to make plan coverage for mental health and substance abuse identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. We recognize that there are a variety of benefit design approaches that can achieve this goal. We are excited about this initiative and look forward to a cooperative introduction in the 2001 contract year.

Background

Over the past several years, the FEHB Program has been moving toward mental health and substance abuse parity. We eliminated lifetime and annual maximums in the FEHB Program. We negotiated with health plans to move away from contractual day and visit limitations and high deductibles, copayments, and coinsurance for mental health coverage. For 1999, pharmacotherapy, medical visits and testing to monitor drug treatment for mental conditions were covered as pharmaceutical disease management. We encouraged the use of Preferred Provider Organizations and utilization management to improve mental health benefits, and we allowed some mental health improvements as an exception to our normal policy of only accepting cost-neutral benefit changes. Finally, we have not accepted proposed reductions in the value of mental health benefits. While we had good success, more work is needed.

We reviewed research by the National Advisory Mental Health Council, the National Alliance for the Mentally Ill, the Substance Abuse and Mental Health Services Administration, and others. We also considered recommendations of the National Institutes of Mental Health. These sources indicated a growing consensus on key issues of the effectiveness of treatment and the efficiency of managed delivery systems in providing care.

At our 1998 carrier conference, we hosted a panel of experts on mental health and substance abuse services. Their presentations stimulated a lively discussion on how managing behavioral health care can affect the cost, comprehensiveness, and quality of mental health and substance

abuse services in an employer-sponsored health benefits program. Many of you expressed an interest in using the information provided to enhance programs within your plans. These activities coincided with other factors such as legislative action at the State level, insurance industry trends, recent advances in treatment, and the proven ability of managed behavioral health care organizations to control costs.

Action

We are convinced that mental health and substance abuse parity can be introduced, using appropriate care management, in a way that expands the range of benefits offered and holds costs to a minimum. We believe that parity can be delivered in a fully coordinated managed behavioral health environment that incorporates techniques such as case management, authorized treatment plans, gatekeepers and referral mechanisms, contracted networks, pre-certification of inpatient services, concurrent review, discharge planning, retrospective review, and disease management. We hope to partner with you in creating options that will work best for your plan.

We encourage you to start planning your implementation strategy now, since contractual arrangements take time to put into place. By working together, we can ensure a smooth transition to parity in 2001.

If you have any questions regarding this letter, please contact your contract representative.

Sincerely,

(signed)

Frank D. Titus
Assistant Director
for Insurance Programs

**Attachment B: Federal Employees Health Benefits—Mental Health
and Substance Abuse Parity**

3. Federal Agency Notice

July 13, 2000

**MEMORANDUM FOR PERSONNEL DIRECTORS OF EXECUTIVE
DEPARTMENTS AND AGENCIES**

**FROM: JANICE R. LACHANCE
DIRECTOR**

**SUBJECT: Mental Health and Substance Abuse Parity
Implementation in the Federal Employees Health
Benefits
(FEHB) Program**

In 2001, we will introduce an important enhancement to the FEHB Program – parity benefits for mental health and substance abuse treatment. We want to ensure that this contributes to healthy outcomes for Federal employees and their families. Federal agency personnel, particularly Employee Assistance Program (EAP) staff, represent an important front line in our effort to do this. In this memo, we want to offer information and assistance to you and your EAPs, enlist your support, and encourage your suggestions. We need your help.

At the White House Conference on Mental Health held on June 7, 1999, President Clinton directed the Office of Personnel Management (OPM) to achieve mental health and substance abuse parity in the (FEHB) Program for contract year 2001. Subsequent to the President's directive, OPM issued its annual policy guidance letter for the year 2001 to all FEHB health plans on April 11, 2000 (relevant section attached). Our letter directed health plans to provide network parity coverage for all diagnostic categories of mental health and substance abuse conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*. We encouraged health plans to manage mental health and substance abuse care in order to expand coverage cost effectively. We required that coverage be made available for services to treat all DSM IV diagnoses to the extent that the services:

- are included in authorized treatment plans;
- delivered in accordance with standard protocols; and
- meet medical necessity determination criteria

Parity in the FEHB Program means that coverage for mental health, substance abuse, medical, surgical, and hospital services will be identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. Historically, health plans have applied higher patient cost sharing and shorter day and visit limitations to mental health and substance abuse services than they did to services for physical illness or injury. Beginning January 1, 2001, this practice will stop when patients use network providers and comply with authorized treatment plans.

We anticipate that FEHB health plans will implement these benefit enhancements in a variety of ways. Some health plans will use the services of managed behavioral health care organizations (MBHO) and their networks of providers, while others will manage their own provider networks.

Since your front line EAP personnel are involved in the initial assessment of conditions and treatment referrals, they play a vital role in achieving healthy outcomes for Federal employees and their families. Your EAP personnel, who already have relationships with FEHB health plans and their MBHOs, need to work closely with those organizations so that they can effectively coordinate the changes that will occur at the beginning of the 2001 contract year. They need to be certain that they are up to date on their local health plans' benefits, network entry procedures, authorization processes, care transition procedures, and telephone systems to facilitate appropriate referrals.

OPM's Office of Insurance Programs will work with FEHB health plans to educate Federal enrollees and their families on this parity initiative through a multi-faceted approach using enrollment guides, brochures, and web sites. Your EAP personnel will be able to access health plan brochures that contain plan benefits, procedures and phone numbers on the FEHB web site at www.opm.gov/insure by mid-November. The web site also will have other information on parity including a set of questions and answers that will explain our approach.

Smooth coordination between your EAPs and FEHB health plans will enable Federal enrollees and their families to get the care they need when they need it. This will benefit our workforce by improving health outcomes, providing financial protection, and reducing employee absences and disabilities.

Please share this memorandum with your EAP personnel and encourage them to participate fully in our upcoming communication and education efforts. Their participation is vital to our success. They may contact Mike Kaszynski, Policy Analyst, Insurance Policy and Information Division, through email at mwkaszyn@opm.gov with any suggestions on implementation or any problems they become aware of when implementing this initiative. The point of contact for EAP matters is Frank Cavanaugh, EAP Program Manager, Office of Workforce Relations, at fcavana@opm.gov.

We would like to thank you for your help in implementing this important initiative.

Attachment

Attachment

Mental Health and Substance Abuse Parity

Introduction. At the White House Conference on Mental Health held on June 7, 1999, President Clinton directed OPM to achieve mental health and

substance abuse parity in the FEHB Program by contract year 2001. Achieving parity means that your Plan's 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 recognize that there are a variety of benefit design approaches that can meet this standard. This letter sets out the elements that we anticipate will be present in your proposal for introduction of parity in the 2001 contract year. We look forward to working cooperatively with you to implement this initiative.

Background. For the past several years, we have negotiated changes to improve mental health and substance abuse benefits in the FEHB Program. At our 1998 and 1999 carrier conferences, we featured presentations by panels of experts who discussed the desirability and feasibility of achieving mental health and substance abuse treatment parity at an affordable cost. We stated then and in subsequent discussions that we expect your proposals for 2001 to eliminate differences in benefit levels and limitations between coverage for mental health and substance abuse services and medical, surgical, and hospital services. We also provided you with extensive information about this initiative at our carrier conference in October 1999.

To help us develop more specific guidance for implementing parity in the FEHB Program, we contracted with the Washington Business Group on Health (WBGH) for a report on the practices of other large employers. WBGH assembled a group of eight employers who provide parity or near parity benefits in their health plans and collected information from them on best practices and potential pitfalls. They analyzed and synthesized the approaches of the participants and provided recommendations to OPM in a report published March 10, 2000. We sent you a copy by email. The text also is available on both the OPM and WBGH web sites. The OPM web site is www.opm.gov/insure. The WBGH web site is www.wbgh.com/html/new_at_wbgh.html. The report helped us immeasurably to clarify issues and refine our approach.

Delivery Systems. The overriding goal of parity is to expand the range of benefits offered while managing costs effectively. Based on studies by the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and others, we believe that you can deliver parity coverage cost effectively in a fully coordinated managed behavioral health environment. We anticipate that your parity benefit proposals will likely encompass an appropriate care-management structure. For Plans that currently provide unmanaged fee-for-service or point of service mental health and substance abuse benefits levels that are below those for medical benefits, you may continue to offer these benefits, but you must also provide in-network benefits that meet the parity standards. However you choose to provide parity benefits, access to providers of care should be consistent with the intent of the "Access to Network Providers" discussion below.

Managed behavioral healthcare organizations (MBHO) can provide a range of services to fully implement or supplement your program. They can establish networks of providers for you and manage network services using treatment plans and care coordinators. Alternatively, they can manage the care delivered by your existing network providers. If you decide to contract with a MBHO, please include in your selection criteria such factors as accreditation by an independent organization.

If you do not choose to use an MBHO, we still encourage you to consider approaches such as gatekeeper referrals to network providers, authorized treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs. We will be looking for proposed strategies that will expand access to services and mitigate the cost impact of doing so.

We also expect you to develop benefit packages that will make effective use of available treatment methods. Since much successful treatment for mental health and substance abuse conditions is now being delivered through alternative modalities such as partial hospitalization and intensive outpatient care, we encourage a flexible approach to covering a continuum of care from a comprehensive group of facilities and providers.

The experience of other purchasers has shown that in order to manage care effectively, access should be available 24 hours a day 7 days a week to facilitate immediate referral to appropriate treatment. While the prudent layperson standard will continue to apply to mental health and substance abuse as well as medical emergencies, this level of access can ensure that care is rendered in settings that are most appropriate and cost effective.

Full coordination of care between primary care physicians and behavioral health providers and networks can also improve both outcomes and cost effectiveness. Discharge planning should assure that inpatient treatment is followed by appropriate outpatient care. Coordination of care is especially important for patients with multiple diagnoses.

Covered Services. You must provide coverage for clinically proven treatment for mental illness and substance abuse. We expect that will include all categories of mental health and substance abuse conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)* to the extent that the services for these conditions are included in authorized treatment plans. Treatment plans should be in accordance with standard protocols, and meet medical necessity determination criteria. You may limit parity benefits when patients do not substantially follow their treatment plans. However, you must continue to provide medically necessary services to stabilize the patient during acute episodes. As before, you are not required to cover services that are currently covered and paid for by public entities, such as state or local government or schools.

Network Cost-Sharing and Day/Visit Limitations. You must provide network or similar medical, hospital, pharmaceutical, outpatient facility, and professional services for the treatment of mental and substance abuse conditions at the same benefit levels as for any other illness or disease. Cost-sharing, including deductibles, coinsurance, copays and catastrophic maximums must be the same. Day and visit limits must also be the same.

Mental health and substance abuse benefit levels should be based on the benefit category for comparable medical treatment, such as, inpatient hospital, professional office visits for specialists, diagnostic tests, and pharmacy benefits. The copayment, coinsurance, or deductible that applies to a specialist office visit for a physical illness will apply to an office visit for therapy from a mental health provider. The same cost sharing that applies to a test to diagnose a physical illness, such as diabetes, must be applied to a test to diagnose depression. The same inpatient deductible, copayment, or coinsurance that applies to an acute inpatient hospital admission for a physical illness or disease should apply to an inpatient hospital admission for a substance abuse or mental health condition.

Where there are no coverage limits for other diagnoses, there should be none for DSM-IV diagnoses. If there are coverage limits or other conditions under your medical benefits for certain services, you may apply the same limits for analogous services under your mental health and substance abuse benefits. For example, the allowable number of visits for speech, occupational, or physical therapy may be no fewer for an autistic child who requires those services than for a person recovering from a stroke who needs the same services.

Out-of-Network Cost-Sharing and Day/Visit Limitations. HMOs may continue to limit services to network providers only, unless your Plan has a point-of-service option. All other delivery systems must give members the option to use non-network providers. However, we do not expect parity for out-of-network coverage so long as you meet reasonable standards for access to network providers and facilities. You may keep cost sharing, day/visit limits, and catastrophic maximums for out-of-network services for mental health and substance abuse at or near year 2000 levels.

Catastrophic Maximums, Deductibles and other Plan Provisions. We will leave to your judgment how you decide to handle deductibles and catastrophic limits, and we will entertain all reasonable proposals. In keeping with the goal of parity, you may propose either to combine or separate deductibles and catastrophic limits for medical services and mental health and substance abuse services. You may also propose other changes to your basic Plan structure such as copayment, coinsurance or deductible levels. We will consider your proposals in the context of your entire benefits package. Proposals from HMOs must be consistent with their community practices.

Access to Network Providers. We have encouraged you to contract with a broad range of providers and facilities to ensure adequate access to care. In addition, we learned from the WBGH report that patients often get better

results with providers with whom they feel comfortable because they share common characteristics such as race, sex, or ethnicity. This finding parallels experience in other areas of our increasingly diverse world. You should consider the advantages associated with providing access to a diverse group of practitioners.

We understand that enabling access to providers can be more difficult in some geographic areas. Nevertheless, we expect you to explore every possible option, including contracting with existing community mental health and substance abuse providers and facilities, and incorporating into your networks providers who are already treating some of your members. It is important to provide significant levels of in-network services in 2001 and beyond. We expect you to work continually toward increasing access to network providers, particularly in areas where there may be initial shortages.

Coverage provided outside the United States for mental health and substance abuse services must be handled in the same manner as you provide benefits for treatment of a physical illness for members residing or traveling outside the United States.

Minimum Access Standards. As you know, there are no universally accepted standards for access to network providers. As with preferred provider standards in general, access is typically measured by waiting times for various categories of appointments, such as emergency/critical, or routine, and by distance or travel time to the nearest available provider or facility. We will apply a reasonableness test to your proposals, with the clear understanding that an improvement effort will be ongoing.

Transitional Care. Your current members undergoing services for mental health and substance abuse conditions at the beginning of the new contract year will be eligible for transitional care coverage under specified conditions. Transitional care must be provided if a patient can no longer receive any benefits for services from a specialty provider with whom the patient is already in treatment in January 2001, or if the reimbursement for that provider will be less than it was in contract year 2000. Under either of these circumstances, you must allow members reasonable time to transfer care to a network specialty provider. Note that the transition period may begin with notice given before January 1, 2001. We believe that 90 days will be sufficient except under extraordinary circumstances.

Claims and Coverage Disputes. As you know, all FEHB members have the right to a fair and efficient process for resolving disputes with their Plans. This dispute resolution process will continue under parity. You must continue to review all disputed claims before they are referred to OPM, including those involving your MBHO, if you use one. We expect that you will review all disputed claims involving mental health or substance abuse treatment. We will not accept a dispute for review that has been considered only by your MBHO.

Employee Education and Communication. Where there are significant changes, we must ensure that all FEHB members are thoroughly informed

about benefits, network restrictions, network entry procedures, telephone numbers, authorization processes, and referral procedures before January 2001. We will use enrollment guides, communication with Federal agencies, and the OPM website to provide general information to the Federal population. We will not specify a particular strategy, but will ask you to provide a description of how you intend to educate your members. Plan brochures, Plan websites, fact sheets, newsletters, frequently asked question and answer sheets, provider directories, explanation of benefits documents (EOBs) over the remainder of this year, or other patient mailings, telephone calls, and health fairs are all acceptable means of communication. Acceptable strategies will require multi-faceted efforts.

Plan personnel who will have contact with members and potential members should be knowledgeable about your network entry procedures, point of entry telephone numbers, authorization processes, transfer of care procedures, and referral procedures. It is especially important that your nurse advice telephone staff or customer service staff and your representatives at health fairs be prepared to discuss all aspects of your mental health and substance abuse parity program. If you decide to use a vendor, you may want to bring their representative to health fairs with you.

Provider Network Education. All of your medical providers and facilities should be thoroughly informed about mental health and substance abuse network entry procedures, telephone numbers, authorization process, care transition procedures, and referral processes. If you are introducing a vendor into the process for the first time, it is critical to define lines of communication and acceptable methods for sharing information while preserving patient privacy. You also will need to establish and communicate a clear line of responsibility between you and your vendor.

The American Psychiatric Association can provide guidelines to help primary care providers to identify mental health problems early so that appropriate treatment can be initiated or referrals made.

Interface with EAP Programs. We will provide information to Federal Employee Assistance Programs (EAP) about our new mental health and substance abuse parity benefits. To ensure continuity of care, you should use existing EAP contacts or develop contacts where they do not already exist to facilitate appropriate member referrals. EAP personnel will need to understand your network entry procedures, authorization processes, care transition procedures, and telephone systems. We will facilitate the exchange of information between health Plans and EAP Programs.

Program Evaluation. We are working with the Department of Health and Human Services (HHS) to evaluate the implementation and operation of our mental health and substance abuse parity initiative. We look forward to your cooperation as we undertake this effort to understand more systematically the implications of parity for employers, health plans and participants.

Quality Assessment and Performance Management. This year our focus is

on meeting the requirements for implementing mental health and substance abuse parity in 2001. but we look forward to the time when we work with you to institute performance measurement and quality assessment activities. We will continue to work with accrediting organizations and others toward the goal of identifying a set of standards and measures that are generally accepted by the industry and by both public and private purchasers. We will keep you informed and seek your collaboration and cooperation in this process.

Attachment C: Federal Employees Health Benefits—Government
Contribution Formula

1. Public Law 105-33
2. Regulations

Attachment C: Federal Employees Health Benefits—Government
Contribution Formula

1. Public Law 105-33

Pub. L. 105-33, BALANCED BUDGET ACT OF 1997, approved 8/5/97.
111 Stat. 662

H. R. 2015—412

*3.25	January 1, 1999, to December 31, 1999.
3.4	January 1, 2000, to December 31, 2000.
3.5	January 1, 2001, to December 31, 2002.

"(2) The amount of such payments shall be determined in accordance with regulations of the Secretary of State consistent with regulations for making corresponding determinations under chapter 83, title 5, United States Code, together with interest determined under regulations issued by the Secretary of State."

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Agency contributions under section 857 of the Foreign Service Act of 1980 (22 U.S.C. 4071f) shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—This section shall take effect on—

(A) October 1, 1997; or

(B) if later, the date of enactment of this Act.

(2) SPECIAL RULE.—If the date of enactment of this Act is later than October 1, 1997, then any reference to October 1, 1997, in subsection (a)(1), (c)(1), or (d)(1) shall be treated as a reference to the date of enactment of this Act.

SEC. 7002. GOVERNMENT CONTRIBUTIONS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

(a) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by striking subsection (a) and all that follows through the end of paragraph (1) of subsection (b) and inserting the following:

"(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

"(A) enrollments under this chapter for self alone; and

"(B) enrollments under this chapter for self and family.

"(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

"(3) For purposes of paragraph (2), the term 'enrollee' means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

"(b)(1) Except as provided in paragraphs (2) and (3), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1) (A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made."

(b) EFFECTIVE DATE.—This section shall take effect on the first day of the contract year that begins in 1999. Nothing in this subsection shall prevent the Office of Personnel Management

H. R. 2015—413

from taking any action, before such first day, which it considers necessary in order to ensure the timely implementation of this section.

SEC. 7003. REPEAL OF AUTHORIZATION OF TRANSITIONAL APPROPRIATIONS FOR THE UNITED STATES POSTAL SERVICE.

(a) REPEAL.—

(1) **IN GENERAL.**—Section 2004 of title 39, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 20 of such title is amended by repealing the item relating to section 2004.

(B) Section 2003(e)(2) of such title is amended by striking “sections 2401 and 2004” each place it appears and inserting “section 2401”.

(b) CLARIFICATION THAT LIABILITIES FORMERLY PAID PURSUANT TO SECTION 2004 REMAIN LIABILITIES PAYABLE BY THE POSTAL SERVICE.—Section 2003 of title 39, United States Code, is amended by adding at the end the following:

“(h) Liabilities of the former Post Office Department to the Employees’ Compensation Fund (appropriations for which were authorized by former section 2004, as in effect before the effective date of this subsection) shall be liabilities of the Postal Service payable out of the Fund.”

(c) EFFECTIVE DATE.—

(1) **IN GENERAL.**—This section and the amendments made by this section shall take effect on the date of the enactment of this Act or October 1, 1997, whichever is later.

(2) **PROVISIONS RELATING TO PAYMENTS FOR FISCAL YEAR 1998.—**

(A) **AMOUNTS NOT YET PAID.**—No payment may be made to the Postal Service Fund, on or after the date of the enactment of this Act, pursuant to any appropriation for fiscal year 1998 authorized by section 2004 of title 39, United States Code (as in effect before the effective date of this section).

(B) **AMOUNTS PAID.**—If any payment to the Postal Service Fund is or has been made pursuant to an appropriation for fiscal year 1998 authorized by such section 2004, then, an amount equal to the amount of such payment shall be paid from such Fund into the Treasury as miscellaneous receipts before October 1, 1998.

TITLE VIII—VETERANS AND RELATED MATTERS

SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This title may be cited as the “Veterans Reconciliation Act of 1997”.

(b) **TABLE OF CONTENTS.**—The table of contents for this title is as follows:

Sec. 8001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Sec. 8011. Enhanced loan asset sale authority.

Sec. 8012. Home loan fees.

**Attachment C: Federal Employees Health Benefits—Government
Contribution Formula**

2. Regulations

NOTICE AND POSTING SYSTEM

Notice No. 98-40

Washington, DC 20415

Date: September 2, 1998

Notice of OPM Regulatory Change

AGENCIES: POST THIS NOTICE IN A PROMINENT PLACE. The attached regulations must be made available for employees to review in accordance with 5 U.S.C. 1103(b)(2)(A) and 5 CFR Part 110. Insert the location where the regulations can be reviewed in the box below. This notice should be posted for a minimum of 10 workdays.

EMPLOYEES: The OPM regulations summarized in this Notice were recently published in the Federal Register. The complete text of the regulations, including relevant dates and addresses, is available for review in the location listed below. This Notice is for informational purposes only. Publication in the Federal Register provides official notice to the public of OPM regulatory changes.

REGULATION STAGE:	<input type="checkbox"/> Proposed	<input checked="" type="checkbox"/> Interim	<input type="checkbox"/> Final
SUBJECT:	Implementation of New Government Contribution Formula Under the Federal Employees Health Benefits (FEHB) Program.		
SUMMARY:	<p>We are amending 5 CFR 890.501(a) and (b) concerning Government contributions toward FEHB enrollment costs. Amendments to the FEHB law under the Balanced Budget Act of 1997 (Public Law 105-33, approved August 5, 1997), provide a new method for calculating the Government contribution effective with the 1999 contract year. The new Government contribution equals 72 percent of the program-wide weighted average of subscription charges in effect each year, for self only enrollments and for self and family enrollments, subject to a maximum of 75 percent of the charges for any particular plan or option.</p> <p>The law directs OPM to determine the weighted average of subscription charges which will be in effect for each upcoming contract year by October 1 of the preceding year. The interim regulations explain this calculation.</p>		
LOCATION OF COMPLETE TEXT:			



Janice R. Lachance
Director

Attachment

Inquiries: Government personnel should contact their installation specialist; others may call OPM's Office of Insurance Programs, Insurance Policy and Information Division, at 202-606-0191.



Federal Recycling Program
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OPM Form 1824-R 12/93

Rules and Regulations

Federal Register

Vol. 63, No. 167

Friday, August 28, 1998

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206-A033

Federal Employees Health Benefits Program: Contributions and Withholdings

AGENCY: Office of Personnel
Management.

ACTION: Interim regulations with request
for comments.

SUMMARY: The Office of Personnel Management (OPM) is issuing interim regulations to describe procedures for OPM's annual determination of the weighted average of subscription charges in effect for self only and for self and family enrollments under the Federal Employees Health Benefits (FEHB) Program. The determinations are a requirement under recent amendments to the FEHB law which authorize a new Government contribution toward FEHB enrollment charges effective with the contract year beginning in January 1999, which generally pays 72 percent of the weighted average of subscription charges.

DATES: Interim regulations are effective August 28, 1998. We must receive comments on or before September 28, 1998.

ADDRESSES: Send written comments to Abby L. Block, Chief, Insurance Policy and Information Division, Retirement and Insurance Group, Office of Personnel Management, P.O. Box 57, Washington, DC 20044; or hand deliver to OPM, Room 3425, 1900 E Street NW., Washington, DC; or FAX to (202) 696-0833.

FOR FURTHER INFORMATION CONTACT:
Bonnie R. Rose (202) 696-0004.

SUPPLEMENTARY INFORMATION: The Balanced Budget Act of 1997, approved on August 5, 1997 (Public Law 105-33,

sec. 7002, 111 Stat. 662), amended the Federal Employees Health Benefits (FEHB) law to authorize a new Government contribution formula effective on the first day of the contract year that begins in January 1999. In place of the "Big-6" formula, which evolved under FEHB law during the early 1970's, the new formula bases Government contributions on the program-wide weighted average costs, for self only and for self and family enrollments, respectively.

The Big-6 formula provided a Government contribution for eligible enrollees in any FEHB plan or option equal to the lesser of: (1) 60 percent of the simple average of self only or self and family enrollment charges for the highest level of benefits offered under six large plans described in law, or (2) 75 percent of charges for the particular plan an individual elects to enroll in. Initially, the Big-6 formula effectively linked Government contributions to health plan preferences of a majority of FEHB enrollees.

Over time, though, FEHB enrollees increasingly left high option health plans which were the basis of the Big-6 formula and dispersed themselves among other plans. During the 1970's and 1980's, the FEHB Program expanded from several dozen to several hundred health plans and health care inflation and rapid health plan premium increases during this period encouraged enrollees to more carefully evaluate all options. One distinct component of the Big-6 formula, the Governmentwide Indemnity Benefit Plan, decided to terminate FEHB participation at the end of 1999 due to escalating premiums and declining enrollment. Because the average of premiums under the five remaining Big-6 plans would have resulted in lower Government contributions, Congress enacted temporary legislation to continue the Big-6 calculation by using premiums for the five remaining formula plans and a so-called phantom premium in place of the lapsed plan. The phantom formula effectively held the Government contributions near 72 percent of total program costs and was due to expire at the end of 1998 in the absence of further action by Congress.

The 1997 amendments to the FEHB law require a determination by the Office of Personnel Management (OPM) in advance of each contract year of the

weighted average of subscription charges that will be in effect during the year under all FEHB plans, for self only and for self and family types of enrollment, respectively. For employees and annuitants generally, the law provides a Government contribution equal to the lesser of: (1) 72 percent of the amount OPM determines is the program-wide weighted average of subscription charges for the type of enrollment the individual selects, or (2) 75 percent of the subscription charge for a particular plan (5 U.S.C. § 8906 (a) and (b)). The intent of the new FEHB contribution formula, which is referred to as the "Fair Share" formula, is to maintain a consistent level of Government contributions, as a percent of the total program costs, regardless of the configuration of participating health plans or FEHB enrollment patterns.

The law requires OPM's determination of the amounts of the weighted average of subscription charges for each FEHB contract year, for self only and for self and family enrollments, not later than October 1 immediately preceding the beginning of the contract year in January. By expressed provision of law, the weight given to each subscription charge that will be in effect for the following FEHB contract year must be commensurate with the number of enrollees eligible for a Government contribution and enrolled for the same plan or option as of March 31 of the year in which the determination is being made. Thus, OPM will multiply each subscription charge that will be in effect for the next contract year by the number of eligible enrollees who are in the plan and option to which the charge applies as of March 31 immediately preceding the contract year. We will then compute the total-dollar subscription charge amounts for all self only enrollments and for all self and family enrollments respectively. Finally, we will divide each dollar total by the corresponding total numbers under each enrollment type to achieve the program-wide weighted average costs.

The FEHB law is very clear regarding the methodology for determining the program-wide weighted average of subscription charges in cases where health plans continue participation substantially unchanged from year to year. OPM is issuing regulations to explain how we intend to treat plans for

purposes of determining the program-wide weighted average of subscription charges when conditions of a plan's FEHB participation change from one year to the next, including cases in which plans enter the FEHB Program, cease participation, or merge with another FEHB plan, and cases in which a health maintenance organization alters its previous rating structure.

The regulations provide that OPM will proceed with our determination of the program-wide weighted average of subscription charges for the following contract year on September 1. If OPM and the carrier of any health plan which has applied to continue FEHB participation have not closed rate negotiations for the following contract year by September 1, the regulations state that OPM will apply deemed adjustments to such plan's current-year self only and self and family subscription charges for purposes of including enrollees of the plan in the determination of the coming year's program-wide weighted average of subscription charges. The deemed adjustments will be equal to any increase or decrease that OPM finds to exist in a calculation of the weighted-average of subscription charges using only those plans with which OPM has closed rate negotiations for the following contract year by September 1. There will be no readjustment in the program-wide weighted average charges based on rate negotiations closed after September 1.

We expect deemed adjustments to be infrequent because provisions in 5 CFR 890.203 require all FEHB plans to submit benefit and rate proposals to OPM not less than 7 months before a new contract year. However, the regulations will ensure that OPM can complete determination of program-wide weighted average charge amounts for each contract year by October 1 of the preceding year, as the law requires, and that complete information to assist enrollees in comparing health plan features is available at the start of the annual open enrollment period in November.

Since newly participating or terminating FEHB plans inherently lack one of two requisite data needed for determining the program-wide weighted average of subscription charges, namely, previous enrollment or subscription charges for the following contract year, the regulations exclude data associated with these plans from these determinations. If two or more existing FEHB plans merge, or if a two-option plan ceases to offer one of the options, the regulations state that OPM will use the combined enrollments from the

merging plans, or the two plan options, for purposes of weighting the subscription charges for the successor entity.

Contracts with comprehensive medical plans (CMPs) may include different rates for specified portions of the plan's service area and will assign a distinct enrollment code for each rating area. Such plans occasionally decide to split the existing rating area(s) into two or more new areas or to reconfigure geographic areas covered by existing rating codes. When this occurs, there may not be a direct correlation between the plan's current-year enrollment and rating codes for the following contract year for purposes of determining the weight to be given to each new subscription charge. So, where a participating CMP plan is altering its FEHB rating structure for the following contract year, the regulations provide that OPM will estimate what portion of the total enrollments under all rating codes for the same plan on March 31 of the determination year correlates to each of the plan's rating codes for the following contract year.

Finally, we are removing existing provisions in paragraph 5 CFR 890.501(b), and the reference to paragraph (b) in 5 CFR 890.501(e), which reflect FEHB law in effect prior to 1974 amendments to the Government contribution formula (Public Law 93-248, section 1, 88 Stat. 3).

Waiver of Notice of Proposed Rulemaking and Delay in Effective Date

Pursuant to section 553(b)(3)(B) and (d)(3) of title 5, United States Code, I find that good cause exists for waiving the general notice of proposed rulemaking and for making these rules effective in less than 30 days. These regulations essentially expound on a requirement in the FEHB law, which includes a prescribed methodology, for OPM to make a determination of the weighted average of subscription charges in effect under all FEHB plans in each contract year after 1996. Accordingly, notice of proposed rulemaking and public procedure thereon are unnecessary. Also, good cause exists for making these rules effective in less than 30 days. The law gives OPM some discretion regarding the time frame for making the required determination. For purposes of including information on Government contributions in materials for the annual FEHB open enrollment period in November, OPM concludes that determination of the weighted average of subscription charges must proceed on September 1 each year, beginning with 1998.

Regulatory Flexibility Act

I certify that these regulations will not have a significant economic impact on a substantial number of small entities because the regulations only affect Federal Government contributions toward enrollment costs under the Federal Employee Health Benefits Program.

Executive Order 12888, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Order 12888.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Reporting and record keeping requirements, Retirement.

U.S. Office of Personnel Management.

Janice R. Lachance,

Director.

Accordingly, OPM is amending Title 5 of the Code of Federal Regulations as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; § 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c-1; subpart L also issued under sec. 599C of Pub. L. 101-513, 104 Stat. 2064, as amended; § 890.302 also issued under sections 11292(f), 11292(e), and 11246 (b) and (c) of Pub. L. 105-33, 111 Stat. 251.

Subpart E—Contributions and Withholdings

2. Amend § 890.501 by revising paragraphs (a) and (b) to read as follows:

§ 890.501 Government contributions.

(a) The Government contribution toward subscription charges under all health benefits plans, for each enrolled employee who is paid biweekly, is the amount provided in section 8906 of title 5, United States Code, plus 4 percent of that amount.

(b) In accordance with the provisions of 5 U.S.C. 8906(a) which take effect with the contract year that begins in January 1999, OPM will determine the amounts representing the weighted average of subscription charges in effect for each contract year, for self only enrollments and for self and family enrollments, as follows:

(1) The determination of the weighted average of subscription charges will only include those health benefits plans

which are continuing FEHB Program participation from one contract year to the next.

(i) If OPM and the carrier for a plan that will continue participation have closed negotiations on rates for the upcoming contract year by September 1 of the current contract year, i.e., the determination year, OPM will use the plan's negotiated subscription charges for the upcoming contract year in the determination of the weighted average of subscription charges.

(ii) If OPM and the carrier for a plan that applied to continue participation have not closed rate negotiations for the upcoming contract year by September 1 of the determination year, OPM will make a deemed adjustment to such plan's subscription charges for the current contract year for purposes of counting eligible enrollees of the plan in the determination of weighted average charges for the upcoming contract year. The deemed adjustment will equal any increase or decrease OPM finds in its determination of the weighted average of subscription charges for the upcoming contract year for all plans with which OPM has closed rates on September 1 of the determination year.

(iii) There will be no subsequent adjustment in the weighted average charges applicable to the upcoming contract year to reflect rate negotiations closed after September 1 of the determination year.

(2) Except as otherwise specified in paragraphs (b)(2)(i) and (b)(2)(ii) of this section, the weight OPM gives to each subscription charge for purposes of determining the weighted average of subscription charges for the upcoming contract year will be proportionate to the number of individuals who, as of March 31 of the determination year, are enrolled in the plan or benefits option to which such charge applies and are eligible for a Government health benefits contribution in the upcoming contract year.

(i) When a subscription charge for an upcoming contract year applies to a plan that is the result of a merger of two or more plans which contract separately with OPM during the determination year, or applies to a plan which will cease to offer two benefits options, OPM will combine the self only enrollments and the self and family enrollments from the merging plans, or from a plan's two benefits options, for purposes of weighting subscription charges in effect for the successor plan for the upcoming contract year.

(ii) When a comprehensive medical plan (CMP) varies subscription charges for different portions of the plan's service area and the plan's contract for

the upcoming contract year will reconfigure geographic areas associated with subscription charges, so that there will not be a direct correlation between enrollment in the determination year and rating areas for the upcoming contract year, OPM will estimate what portion of the plan's enrollees on March 31 of the determination year will be subject to each of the plan's subscription rates for the upcoming contract year.

(3) After OPM weights each subscription charge as provided in paragraphs (b)(2), (b)(2)(i), and (b)(2)(ii) of this section, OPM will compute the total of subscription charges associated with self only enrollments, and the total of subscription charges associated with self and family enrollments. OPM will divide each subscription charge total by the total number of enrollments such amount represents to obtain the program-wide weighted average subscription charges for self only and for self and family enrollments, respectively.

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[FR Doc. 98-33149 Filed 8-27-98; 8:45 am]
BILLING CODE 5225-01-P

**Attachment D: Federal Employees Health Benefits—Premium Conversion
Regulations**

Rules and Regulations

Federal Register

Vol. 65, No. 139

Wednesday, July 19, 2000

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 550

RIN 3206-AJ16

Pretax Allotments for Health Insurance Premiums

AGENCY: Office of Personnel
Management.

ACTION: Interim rule with request for
comments.

SUMMARY: The Office of Personnel Management (OPM) is issuing interim regulations to enable employees to pay Federal Employees Health Benefits (FEHB) premiums through an allotment from the employee's pay to the employing agency. Use of this allotment mechanism allows FEHB premiums to be paid with pre-tax dollars, as provided under section 125 of the Internal Revenue Code. These allotment regulations are connected to a separate interim rule, published in this issue of the Federal Register, which will amend the FEHB regulations to establish the premium conversion program.

DATES: This interim rule is effective September 18, 2000. Comments must be received on or before September 18, 2000.

ADDRESSES: Comments may be sent or delivered to Donald J. Winstead, Assistant Director for Compensation Administration, Workforce Compensation and Performance Service, Office of Personnel Management, Room 7H31, 1900 E Street NW., Washington, DC 20415-8200 (FAX: (202) 606-0824 or EMAIL: payleave@opm.gov).

FOR FURTHER INFORMATION CONTACT: Bryce Baker, (202) 606-2858 or FAX: (202) 606-0824 or EMAIL: payleave@opm.gov.

SUPPLEMENTARY INFORMATION: At the President's direction, OPM will implement a health insurance premium

conversion plan for employees participating in the FEHB Program. The premium conversion plan is part of a "cafeteria plan" under Section 125 of the Internal Revenue Code.

The premium conversion plan will take effect on October 1, 2000. Under the plan, employees' FEHB premium withholdings are treated as a pre-tax salary reduction. Because premium conversion lowers employees' taxable income, it reduces their tax burden. The reduction in taxable income reduces the base for Federal income tax, Social Security and Medicare taxes, and, in most States and localities, State and local taxes based on income.

Employees in the Executive Branch of the Federal Government who are participating in the Program and whose pay is issued by an Executive Branch agency, will automatically have their salaries reduced and their health benefit premiums paid under the premium conversion plan. Also, individuals enrolled in the FEHB Program who are employed outside the Executive Branch, or whose pay is not issued by an agency of the Executive Branch, will have their salaries reduced and their FEHB premiums paid under our premium conversion plan if their employer, in coordination with their payroll office, agrees to offer participation in the plan. However, any individual enrolled in the FEHB Program who does not want to participate in premium conversion may waive participation, subject to certain limitations.

Premium conversion has no effect on: statutory pay provisions or the General Schedule; the amount of any employee's health insurance premium; or on the amount of the Government share towards the FEHB Program premium on behalf of any employee. Base pay for retirement, life insurance and Thrift Savings Plan purposes is unaffected.

To ensure that the premium conversion plan qualifies for pre-tax treatment of health insurance premiums, OPM is amending its allotment regulations at 5 CFR part 550, subpart C. Each employee participating in premium conversion will make an allotment to his or her employing agency in the amount of the employee share of the FEHB premium. The agency will then use that amount to pay the employee's FEHB premium. The allotment will be automatic unless the

employee elects to waive premium conversion.

We are also amending the allotment regulations to make clear that except where there is an authority specific to Federal employees (i.e., a statute, Executive order, Presidential directive, or OPM regulation) agencies may not authorize allotments for the purpose of reducing taxable income. For example, a salary reduction for a transportation fringe benefit under 26 U.S.C. 132(f)(4) is another type of pre-tax allotment that is permitted by 5 U.S.C. 7905(b) and Executive Order 13150.

OPM is issuing a separate interim rule amending its FEHB regulations to establish the premium conversion program effective in October 2000. No FEHB premium may be allotted except as allowed under the premium conversion program. Therefore, no allotment of FEHB premiums is permitted until the first day of the first pay period beginning on or after October 1, 2000.

Waiver of Notice of Proposed Rulemaking

In accordance with section 553(b)(3)(B) of title 5 of the U.S. Code, I find that good cause exists for waiving the general notice of proposed rulemaking. An opportunity for public comment prior to issuing this rule is unnecessary and contrary to the public interest. In developing this regulation, OPM worked extensively with affected stakeholders. OPM followed the Internal Revenue Code to develop a plan document and regulations that comply with tax law and parallel the practices of private sector employers. It is necessary that payroll offices begin work on systems changes so that this benefit will be available at the start of Fiscal Year 2001—a logical time in terms of Federal agency budget and payroll administration.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation will only affect tax withholdings for Federal employees.

Executive Order 12866, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Order 12866.

List of Subjects in 5 CFR Part 550

Administrative practice and procedure, Claims, Government employees, Wages.

U.S. Office of Personnel Management,
Janica R. Lachance,
Director.

Accordingly, OPM is amending 5 CFR part 550 as follows:

PART 550—PAY ADMINISTRATION (GENERAL)**Subpart C—Allotments and Assignments From Federal Employees**

1. The authority citation for subpart C of part 550 continues to read as follows:

Authority: 5 U.S.C. 5527; E.O. 10982, 3 CFR 1059-1063 Comp., p. 502.

§ 550.301 [Amended]

2. Section 550.301 is amended by removing the definition of pay.

3. In § 550.311:

A. Paragraph (a) is amended by removing the period at the end of paragraph (a)(7) and adding a semicolon in its place:

H. A new paragraph (a)(8) is added: and

C. Paragraph (b) is revised.

The addition and revision read as follows:

§ 550.311 Authority of agency.

(a) * * *

(8) An allotment to the employing Federal agency to pay an employee's share of Federal Employees Health Benefits premiums, consistent with part 892 of this chapter.

(b) In addition to those allotments provided for in paragraph (a) of this section, an agency may permit an employee to make an allotment for any legal purpose deemed appropriate by the head of the agency. This authority does not extend to allotments to the paying agency for the purpose of reducing taxable income, except where there is an authority specific to Federal employees (statute, Executive order, Presidential directive, or OPM regulations) permitting agencies to provide the pretax benefit in question.

4. In § 550.312, paragraph (f) is added to read as follows:

§ 550.312 General limitations.

(f) Notwithstanding the requirements in paragraphs (a) and (c) of this section, an agency may make an allotment for an employee's share of health benefits premiums under § 550.311(a)(8) without specific authorization from the

employee, unless the employee specifically waives such allotment. Agency procedures for processing employee waivers must be consistent with procedures established by the Office of Personnel Management. (See part 892 of this chapter.)

5. Section 550.313 is added to read as follows:

§ 550.313 Order of precedence when there is insufficient pay to cover all deductions.

(a) Except as provided in paragraph (b) of this section, an agency must deduct allotments from any net pay remaining after applying all deductions authorized by law, including any deductions for retirement and other benefits, Social Security and income tax withholdings, collection of a debt to the Government via levy or salary offset, and garnishment. If there is insufficient net pay to cover all of the employee's allotments, the agency must deduct allotments in the order specified under its established rules of precedence.

(b) An agency must deduct an allotment for an employee's share of health benefits premiums under § 550.311(a)(8) before deducting any type of tax withholding.

[FR Doc. 00-18232 Filed 7-14-00; 3:10 pm]

BILLING CODE 5325-01-P

OFFICE OF PERSONNEL MANAGEMENT**5 CFR Parts 890 and 892**

RIN 3205-AJ17

Health Insurance Premium Conversion

AGENCY: Office of Personnel Management.

ACTION: Interim rule with request for comments.

SUMMARY: The Office of Personnel Management (OPM) is issuing interim regulations to enable employees to pay Federal Employees Health Benefits (FEHB) premiums with pre-tax dollars, as provided under section 125 of the Internal Revenue Code. These regulations establish the basic rules under which this premium conversion plan will operate, beginning October 2000.

DATES: This interim rule is effective September 18, 2000. Comments must be received on or before September 18, 2000.

ADDRESSES: Send written comments to Abby L. Block, Chief, Insurance Policy and Information Division, Office of Insurance Programs, Retirement and Insurance Service, Office of Personnel

Management, 1900 E Street NW., Washington, DC 20415-3666; or deliver to OPM, Room 3425, 1900 E Street NW., Washington, DC; or FAX to (202) 606-0633.

FOR FURTHER INFORMATION CONTACT: Laurie Bodenheimer, (202) 606-0004, or email to lrbodenh@opm.gov.

SUPPLEMENTARY INFORMATION:**Background**

At the President's direction, OPM will implement a health insurance premium conversion plan for employees participating in the FEHB Program. The premium conversion plan is part of a "cafeteria plan" under Section 125 of the Internal Revenue Code. OPM will execute a separate plan document to comply with Section 125 requirements and will make that document available on OPM's website: www.opm.gov. OPM is also issuing separate instructions to personnel and payroll offices.

The premium conversion plan will take effect on October 1, 2000. Under the plan, employees' health benefit premium withholdings are treated as a pre-tax salary deduction. Because premium conversion lowers employees' taxable income, it reduces their tax burden. The reduction in taxable income reduces the base for Federal income tax, Social Security and Medicare taxes, and, in most States and localities, State and local taxes based on income.

While most Federal employees are currently not covered by a premium conversion plan, the Federal Judiciary, the United States Postal Service, and some smaller Executive Branch agencies with independent compensation-setting authority have already implemented their own premium conversion plans. Employees of those entities will not be covered by the premium conversion plan described here.

All other employees in the Executive Branch of the Federal Government who are participating in the FEHB Program, and whose pay is issued by an Executive Branch agency, will automatically have their salary reduced (through a Federal allotment) and their FEHB premiums paid under the premium conversion plan. Also, individuals enrolled in the FEHB Program who are employed outside the Executive Branch, or whose pay is not issued by an agency of the Executive Branch, will have their salaries reduced and their FEHB premiums paid under our premium conversion plan if their employer, in coordination with their payroll office, agrees to offer participation in the plan. However, any individual enrolled in the FEHB

Program who does not want to participate in premium conversion may waive participation, subject to the limitations in these regulations.

Premium conversion has no effect on: statutory pay provisions or the General Schedule; the amount of any employee's health insurance premium; or the amount of the Government share towards the FEHB premium on behalf of any employee. Base pay for retirement, life insurance and Thrift Savings Plan purposes is unaffected.

To ensure that the premium conversion plan qualifies for pre-tax treatment of health insurance premiums, OPM is also amending its allotment regulations at 5 CFR part 550, subpart C in a separate interim rule issued simultaneously with this rule. Each employee participating in premium conversion will make an allotment to his or her employing agency in the amount of the employee share of the FEHB insurance premium. The agency will then use that amount to pay the employee's premium. The allotment will be automatic unless the employee elects to waive premium conversion.

Waiver of Notice of Proposed Rulemaking

In accordance with section 553(b)(3)(B) of title 5 of the U.S. Code, I find that good cause exists for waiving the general notice of proposed rulemaking. An opportunity for public comment prior to issuing this rule is unnecessary and contrary to the public interest. In developing this regulation, OPM worked extensively with affected stakeholders. OPM followed the Internal Revenue Code to develop a plan document and regulations that comply with tax law and parallel the practices of private sector employers. It is necessary that payroll offices begin work on systems changes so that this benefit will be available at the start of Fiscal Year 2001—a logical time in terms of Federal agency budget and payroll administration.

Regulatory Planning and Review

This regulation has been reviewed by the Office of Management and Budget in accordance with Executive Order 12866, "Regulatory Planning and Review." Because this regulation has an economic impact exceeding \$100 million annually it is defined by that Executive Order as being "economically significant." It is classified as a major regulation in accordance with the Congressional Review Act because of its economic impact.

Analysis of Costs and Benefits

In OPM's view, the benefits of this regulation substantially outweigh the costs. Under this regulation, Federal employees with health insurance through the FEHB Program will begin paying their insurance premiums with pre-tax dollars, similar to how millions of private sector employees currently pay their health insurance premiums. The benefits of this change in tax status are significant: the Federal Government will become a more competitive employer and the tax liability of Federal employees will decrease.

Costs of this regulation include a start-up cost in the first year to implement the program; a decrease in Medicare, Social Security and income taxes paid by Federal employees; and a decrease in Federal employer payments to the Medicare and Social Security Trust Funds. The benefits and costs of this regulation are described in more detail in the following sections.

Statement of Need for Proposed Action

In his 2001 Budget, the President directed OPM to implement health insurance premium conversion. Premium conversion will bring the Federal Government in line with private sector practices regarding employee payments of health insurance premiums. Over 60 million private sector employees with employment based health insurance pay their premiums with pre-tax dollars. This regulation will take advantage of current law to allow over 1.5 million Federal employees, representing more than 3 million lives including dependents, to have the same benefit as private sector workers. As a result, the Federal Government will become a more competitive employer and health insurance will become more affordable for Federal employees.

Examination of Alternative Approaches

In order to implement the President's premium conversion directive, regulatory action is necessary. In developing this regulation, OPM considered various ways to put premium conversion into operation. OPM also hired a contractor with substantial experience in employee benefits tax compliance to write a plan document that conforms to IRS Section 125 rules.

OPM met with those Federal agencies that have already implemented a premium conversion plan: the U.S. Postal Service, the Federal Judiciary, and some small Executive Branch agencies with independent compensation-setting authority. It

studied the range of implementation issues that these organizations encountered, from payroll system changes and educational outreach to complying with the tax code, and identified the key issues that OPM would need to address. OPM has developed these regulations by using the "best practices" of other employers in terms of premium conversion program development and implementation.

Benefits Analysis

Over the last few decades, the U.S. labor market has become increasingly competitive. Unemployment rates have hovered at about 4 percent, the lowest rates since 1970. Labor force participation rates are at all time highs—67 percent in recent months, up from around 60 percent in 1970. Given these tight labor market conditions, the Federal Government, like all employers, must use every means possible to attract and retain high quality employees. Currently, the Federal Government is at a competitive disadvantage in the labor market because its employees pay their health insurance premiums with after-tax dollars. In the private sector, many employees pay their health insurance premiums with pre-tax dollars, resulting in reduced tax liabilities and greater take-home pay. This regulation will eliminate the Federal Government's competitive disadvantage in this area, giving it an additional tool to attract and retain high quality workers and increase employee satisfaction.

Another advantage of this regulation is that it lowers the tax liability of Federal employees. Under this regulation, Federal employees will enjoy the same benefit as private sector employees and no longer will pay income tax, Social Security tax or Medicare tax on their health insurance premium dollars. This tax cut increases the take-home pay of Federal workers: Federal workers enrolled in the FEHB Program can save over \$430 per year on average.

Cost Analysis

The costs associated with this regulation are the start-up costs to implement the premium conversion program: the decrease in Medicare, Social Security, and income taxes paid by Federal employees; and the decrease in Federal employer payments to the Medicare and Social Security Trust Funds.

The start-up costs of this regulation will be incurred in the first year of the program as individual Federal Government Agencies update their payroll systems to accommodate

premium conversion and as OPM and individual Agencies educate the Federal employee population, including benefits officers, about the new program. OPM estimates the start-up cost to be \$3 million in 2001, with \$2.5 million coming from Agency implementation costs and the remaining \$.5 million from educational outreach programs such as information pamphlets for employees and benefits officers. The cost estimate is based on an assumption that each of the 164 discrete non-Postal payroll systems would incur \$15,000 in spending on systems analysis, programming, testing, and overhead.

In Fiscal Year 2001, the tax benefit to Federal employees caused by premium conversion is estimated to be about \$670 million; \$550 million in Federal income taxes, \$85 million in Social Security taxes, and \$35 million in Medicare taxes. The decrease in Federal employer payments to the Medicare and Social Security Trust Funds is estimated to be \$85 million and \$35 million dollars respectively. Assuming that health insurance premiums will continue to increase at recent rates, the change in tax benefits and Federal employer payments from premium conversion is expected to grow at roughly a proportional rate in each subsequent year.

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency determines that a rule is not likely to have a significant economic impact on a substantial number of small entities, the RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

OPM has determined that this rule will not have a significant economic impact on a substantial number of small entities. The regulation does not impact small entities.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), as well as Executive Order 12875, this interim-final rule does not

include any Federal mandate that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million or more.

Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this final rule will not have any negative impact on the rights, roles, and responsibilities of State, local or Tribal governments.

List of Subjects

5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Reporting and recordkeeping requirements, Retirement.

5 CFR Part 892

Administrative practice and procedure, Government employees, Health insurance, Wages, Taxes.

U.S. Office of Personnel Management.

Janice R. Lachance,

Director.

Accordingly, OPM is amending 5 CFR part 890 and adding part 892 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; § 890.303 also issued under 50 U.S.C. 403 p, 22 U.S.C. 4069c and 4069c-1; subpart L also issued under sec. 599C of Pub. L. 101-513, 104 Stat. 2064, as amended; § 890.102 also issued under sections 11202(f), 11232(a), and 11246(b) and (c) of Pub. L. 105-33, 111 Stat. 251; and section 721 of Pub. L. 105-26, 112 Stat. 2061.

2. Amend § 890.301 to revise the heading and paragraph (e)(1) to read as follows:

§ 890.301 Opportunities for employees who are not participants in premium conversion to enroll or change enrollment effective dates.

(e)(1) *Change to self only.* (1) An employee may change the enrollment from self and family to self only at any time, except that an employee participating in health insurance premium conversion as provided in part 892 of this chapter may make this change only during an open season or on account of and consistent with a qualifying life event as defined in

§ 892.101 of this chapter that affects eligibility for coverage.

3. Amend § 890.304 to revise paragraph (d)(1) to read as follows:

§ 890.304 Termination of enrollment.

(d)(1) An enrollee may cancel his or her enrollment at any time by filing an appropriate request with the employing office except that an employee participating in health insurance premium conversion as provided in part 892 of this chapter may make this change only during an open season or on account of and consistent with a qualifying life event defined in § 892.101 of this chapter that affects eligibility for coverage. The cancellation takes effect on the last day of the pay period in which the appropriate request canceling the enrollment is received by the employing office.

4. Add part 892 to read as follows:

PART 892—FEDERAL FLEXIBLE BENEFITS PLAN: PRE-TAX PAYMENT OF HEALTH BENEFITS PREMIUMS

Subpart A—Administration and General Provisions

Sec.

- 892.101 Definitions
892.102 What is premium conversion and how does it work?
892.103 What can I do if I disagree with my agency's decision about my pre- or post-tax election?

Subpart B—Eligibility and Participation

- 892.201 Who is covered by the premium conversion plan?
892.202 Are retirees eligible for the premium conversion plan?
892.203 When will my premium conversion begin?
892.204 How do I waive participation in premium conversion before the benefit first becomes effective?
892.205 May I waive participation in premium conversion after the initial implementation?
892.206 Can I cancel my waiver and participate in premium conversion?
892.207 Can I make changes to my FEHB enrollment while I am participating in premium conversion?
892.208 Can I change from self-and-family enrollment in FEHB to self-only enrollment at any time?
892.209 Can I cancel FEHB coverage at any time?
892.210 Does premium conversion change the effective date of an FEHB enrollment, change in enrollment, or cancellation of enrollment?
892.211 What happens if I go on leave without pay (LWOP)?

Subpart C—Contributions and Withholdings

§ 892.301 How do I pay my premium?

§ 892.302 Will the Government contribution continue?

§ 892.303 Can I pay my premiums directly by check under the premium conversion plan?

Subpart D—Reemployed Annuitants

§ 892.401 Am I eligible for premium conversion if I retire and then come back to work for the Federal Government?

Authority: 5 U.S.C. 8913; 26 U.S.C. 125.

Subpart A—Administration and General Provisions**§ 892.101 Definitions.**

Days mean calendar days.

Dependent means a family member who is both eligible for coverage under the FEHB Program and a dependent as defined in section 152 of the Internal Revenue Code.

FEHB Program means the Federal Employees Health Benefits Program described in 5 U.S.C. 8901.

Open Season means the period of time each year as described in § 890.301(f) of this chapter when all individuals eligible for FEHB coverage have the opportunity to enroll or change their enrollment. These changes become effective with the first pay period that begins in the following year. For additional open seasons authorized by OPM, the effective date is specified.

OPM means the Office of Personnel Management.

Qualifying life event means events that may permit election changes as described in Treasury regulations at 26 CFR 1.125-4 and includes the following:

- (1) Addition of a dependent;
- (2) Birth or adoption of a child;
- (3) Changes in entitlement to Medicare or Medicaid for you, your spouse or dependent;
- (4) Change in work site;
- (5) Change in your employment status or that of your spouse or dependent from either full-time to part-time, or the reverse;
- (6) Death of your spouse or dependent;
- (7) Divorce or annulment;
- (8) Loss of a dependent;
- (9) Marriage;
- (10) Significant change in the health coverage of you or your spouse related to your spouse's employment;
- (11) Start or end of an unpaid leave of absence by you or your spouse; or
- (12) Start or end of your spouse's employment.

§ 892.102 What is premium conversion and how does it work?

Premium conversion is a method of reducing your taxable income by the

amount of your contribution to your FEHB insurance premium. If you are a participant in the premium conversion plan, Section 125 of the Internal Revenue Code allows you to reduce your salary (through an employer allotment) and provide that portion of your salary back to your employer. Instead of being paid to you as taxable income, this allotted amount is used to purchase your FEHB insurance for you. The effect is that your taxable income is reduced. Because taxable income is reduced, the amount of tax you pay is reduced. You save on Federal income tax, Social Security and Medicare tax and in most States and localities, State and local income taxes.

§ 892.103 What can I do if I disagree with my agency's decision about my pre- or post-tax election?

You may use the reconsideration procedure set out at § 890.104 of this chapter to request an agency to reconsider its initial decision affecting your participation in the premium conversion plan.

Subpart B—Eligibility and Participation**§ 892.201 Who is covered by the premium conversion plan?**

(a) All employees in the Executive Branch of the Federal Government who are participating in the FEHB Program (as described in 5 U.S.C. 8901), and whose pay is issued by an agency of the Executive Branch of the Federal Government, are automatically covered by the premium conversion plan. Certain reemployed annuitants may be considered employees for purposes of premium conversion, as described in subpart D of this part.

(b) Employees of organizations that have established a premium conversion plan under separate authority prior to October 2000 may not participate in the premium conversion plan described here because they are already covered by their employing agency's plan.

(c) Individuals enrolled in FEHB who are not employees of the Executive Branch of the Federal Government or are not employees of the Federal government, will be covered by the premium conversion plan if their employer signs an adoption agreement that is accepted by OPM.

(d) Individuals enrolled in FEHB who are appointed by an agency in the Executive Branch, but whose pay is not issued by that agency, will be covered by the premium conversion plan if the entity that makes their FEHB contribution signs an adoption agreement that is accepted by OPM.

(e) Individuals may waive premium conversion by filing a waiver form with

their employer in accordance with this part.

§ 892.202 Are retirees eligible for the premium conversion plan?

No, only current employees who are enrolled in the FEHB Program are covered by the premium conversion plan. Former employees are not eligible. If you are a reemployed annuitant, see subpart D of this part.

§ 892.203 When will my premium conversion begin?

Your salary reduction (through a Federal allotment) and pre-tax benefit become effective with the first day of the first pay period beginning on or after October 1, 2000, if you are employed in a covered Executive Branch agency as described in § 892.201(a). Otherwise, your salary reduction (through a Federal allotment) and pre-tax benefit will be effective on the first day of the first pay period beginning on or after the date that your employer officially adopts the premium conversion plan (see § 892.201(c), (d)).

§ 892.204 How do I waive participation in premium conversion before the benefit first becomes effective?

You must file a waiver form by the date set by your employing office, but not later than the day before the effective date of coverage. The waiver form is available from your employing office.

§ 892.205 May I waive participation in premium conversion after the initial implementation?

Yes, but the opportunity to waive premium conversion is limited. You may waive premium conversion:

(a) During the annual FEHB open season. The effective date of the waiver will be the first day of the first pay period that begins in the following calendar year;

(b) At the same time as you sign up for FEHB when first hired or hired as a reemployed annuitant. Employees who leave Federal service and are rehired after a three-day break in service or in a different calendar year also may waive;

(c) In conjunction with a change in FEHB enrollment, on account of and consistent with a qualifying life event (see § 892.101); or

(d) When you have a qualifying life event and the waiver is on account of and consistent with that qualifying life event (even if you do not change your FEHB enrollment). You have 60 days after the qualifying life event to file a waiver with your employer. The waiver is effective on the first day of the pay

period following the date your employer receives the waiver.

§ 892.206 Can I cancel my waiver and participate in premium conversion?

Yes, you may cancel a waiver and participate in premium conversion if:

(a) You have a qualifying life event; the change in FEHB coverage is consistent with the qualifying life event; and you complete an election form to participate in premium conversion within 60 days after the qualifying life event; or

(b) You cancel your waiver during an open season, including an extended open season authorized by DPM.

§ 892.207 Can I make changes to my FEHB enrollment while I am participating in premium conversion?

Generally, you can make changes to your FEHB enrollment for the same reasons and with the same effective dates listed in § 890.301 of this chapter. However, if you are participating in premium conversion there are two exceptions: you must have a qualifying life event to change from self-and-family enrollment to self-only enrollment or to drop FEHB coverage entirely. (See § 892.209 and § 892.210.) Your change in enrollment must be consistent with and correspond to your qualifying life event as described in § 892.101. These limitations only apply to changes you may wish to make outside open season.

§ 892.208 Can I change from self-and-family enrollment in FEHB to self-only enrollment at any time?

If you are participating in premium conversion you may change your FEHB enrollment from self-and-family to self-only:

(a) During the annual open season; or
(b) Within 60 days after you have a qualifying life event. Your change in enrollment must be consistent with and correspond to your qualifying life event. For example, if you get divorced, changing to self-only would be consistent with that qualifying life event. If you adopt a child, a change from self-only to self-and-family coverage would also be consistent with that qualifying life event.

§ 892.209 Can I cancel FEHB coverage at any time?

If you are participating in premium conversion you may cancel your FEHB coverage:

(a) During the annual open season; or
(b) Within 60 days after you have a qualifying life event. Your cancellation of coverage must be consistent with and correspond to your qualifying life event. For example, if you get married and your spouse is employed by a company

that provides health insurance for you, then canceling FEHB coverage would be consistent with that qualifying life event. If you adopt a child, canceling coverage would not be consistent with that qualifying life event.

§ 892.210 Does premium conversion change the effective date of an FEHB enrollment, change in enrollment, or cancellation of enrollment?

No. If you are participating in premium conversion, the effective date of an FEHB enrollment, change in enrollment, or cancellation of enrollment is the same effective date as provided in § 890.301 of this chapter.

§ 892.211 What happens if I go on leave without pay (LWOP)?

(a) Your commencement of LWOP is a qualifying life event as described in § 892.101. You may change your premium conversion election (waive if you now participate, or participate if you now waive).

(b)(1) You may continue your FEHB coverage by agreeing in advance of LWOP to one of the payment options described in paragraphs (b)(2), (b)(3), or (b)(4) of this section.

(2) *Pre-pay.* Prior to commencement of your LWOP you may pay the amount due for your share of your FEHB premium during your LWOP period, if your employing agency, at its discretion, allows you to do so. Contributions under the pre-pay option may be made through premium conversion on a pre-tax basis. Alternatively, you may pre-pay premiums for the LWOP period on an after-tax basis.

(3) *Direct pay.* Under the direct pay option, you may pay your share of your FEHB premium on the same schedule as payments would be made if you were not on LWOP, as described in § 890.502(b) of this chapter. You must make the premium payments directly to your employing agency. The payments you make under the direct pay option are not subject to premium conversion, and are made on an after-tax basis.

(4) *Catch-up.* Under the catch-up option, you must agree in advance of the LWOP period that: you will continue FEHB coverage while on LWOP; your employer will advance your share of your FEHB premium during your LWOP period; and you will repay the advanced amounts when you return from LWOP. (Described in § 890.502(b) of this chapter.) Your catch-up contributions may be made through premium conversion.

(5) If you remain in FEHB upon your return from LWOP, your catch-up premiums and current premiums will be paid at the same time.

(c) Your return from LWOP constitutes a qualifying life event as described in § 892.101. You may change your premium conversion election (waive if you now participate, or participate if you now waive). The election you choose upon return from LWOP will apply to your current as well as your catch-up premiums.

Subpart C—Contributions and Withholdings

§ 892.301 How do I pay my premium?

As a participant in premium conversion, instead of having your premium withheld from after-tax salary, your salary will be reduced (through a Federal allotment) by the amount equal to your FEHB premium, which you will allot to your agency. The allotment from salary satisfies the FEHB premium payment requirement of 5 U.S.C. 8906. Your employer is authorized to accept this allotment under § 550.311(a)(8) and § 550.312 of this chapter or, for employers not subject to those regulations, a similar mechanism. Your agency will use the allotment to pay your share of your FEHB premium. This will reduce your taxable income as described in § 892.102.

§ 892.302 Will the Government contribution continue?

Yes, your employer will still pay the same share of your premium as provided in the Federal Employees Health Benefits Act, and § 890.501 of this chapter. Employee allotments do not count toward the Government's statutory maximum contribution.

§ 892.303 Can I pay my premium directly by check under the premium conversion plan?

No, your employer must take your contribution to your FEHB premium from your salary to qualify for pre-tax treatment.

Subpart D—Reemployed Annuitants

§ 892.401 Am I eligible for premium conversion if I retire and then come back to work for the Federal Government?

(a) If you are a retired individual enrolled in FEHB who is receiving an annuity and you are reemployed in a position that conveys FEHB eligibility and is covered by the premium conversion plan, you are automatically covered by premium conversion, unless you waive participation as described in § 892.205.

(b)(1) If you do not waive premium conversion, your FEHB coverage will be transferred to your employing agency, and your employing agency will assume responsibility for contributing the

government share of your FEHB coverage. Your coverage will be based on your status as an active employee and your employing agency will deduct your premiums from your salary.

(2) If you elect to waive participation in premium conversion, you will keep your FEHB coverage as an annuitant, but your contributions towards your FEHB premiums will be made on an after-tax basis. Your employing agency must receive your waiver no later than 60 days after the date you return to Federal employment. A waiver will be effective at the beginning of the first pay period after your employer receives it.

(c) If you did not carry FEHB into retirement and you are reemployed as an employee in a position covered by the premium conversion plan, you may enroll in the FEHB Program as a new employee as described in § 890.301 of this chapter. Upon enrolling in FEHB, you are automatically covered by the premium conversion plan, unless you waive participation as described in § 892.205.

(d) Your status as an annuitant under the retirement regulations and your right to continue FEHB as an annuitant following your period of reemployment is unaffected.

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NUCLEAR REGULATORY COMMISSION

10 CFR Parts 2 and 50

RIN 3150 AG38

Antitrust Review Authority: Clarification

AGENCY: U.S. Nuclear Regulatory Commission.

ACTION: Final rule.

SUMMARY: The Nuclear Regulatory Commission is clarifying its regulations to reflect more clearly its limited antitrust review authority by explicitly limiting the types of applications that must include antitrust information. Specifically, because the Commission is not authorized to conduct antitrust reviews of post-operating license transfer applications, or at least is not required to conduct this type of review and has decided that it no longer will conduct them, no antitrust information is required as part of a post-operating license transfer application. Because the current regulations do not clearly specify which types of applications are not subject to antitrust review, these

clarifying amendments will bring the regulations into conformance with the Commission's limited statutory authority to conduct antitrust reviews. **EFFECTIVE DATE:** This final rule is effective August 18, 2000.

FOR FURTHER INFORMATION CONTACT: Jack R. Goldberg, Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; telephone 301-415-1881; e-mail JRG1@nrc.gov.

SUPPLEMENTARY INFORMATION:

I. Background

In a license transfer application filed on October 27, 1998, by Kansas Gas and Electric Company (KGE) and Kansas City Power and Light Company (KCP&L) (Applicants), Commission approval pursuant to 10 CFR 50.80 was sought of a transfer of the Applicants' possession-only interests in the operating license for the Wolf Creek Generating Station, Unit 1, to a new company, Westar Energy, Inc. Wolf Creek is jointly owned by the Applicants, each of which owns an undivided 47 percent interest. The remaining 6 percent interest is owned by Kansas Electric Power Cooperative, Inc. (KEPCo). The Applicants requested that the Commission amend the operating license for Wolf Creek pursuant to 10 CFR 50.90 by deleting KGE and KCPL as licensees and adding Westar Energy in their place. KEPCo opposed the transfer on antitrust grounds, claiming that the transfer would have anticompetitive effects and would result in "significant changes" in the competitive market. KEPCo petitioned the Commission to intervene in the transfer proceeding and requested a hearing, arguing that the Commission should conduct an antitrust review of the proposed transfer under section 105c of the Atomic Energy Act, 42 U.S.C. 2135(c). Applicants opposed the petition and request for a hearing.

By Memorandum and Order dated March 2, 1999, CLI-99-05, 49 NRC 199 (1999), the Commission indicated that although its staff historically has performed a "significant changes" review in connection with certain kinds of license transfers, it intended to consider in the Wolf Creek case whether to depart from that practice and "direct the NRC staff no longer to conduct significant changes reviews in license transfer cases, including the current case." In deciding this matter, the Commission stated that it expected to consider a number of factors, including its statutory mandate, its expertise, and its resources. Accordingly, the Commission directed the Applicants and KEPCo to file briefs on the single

question: "whether as a matter of law or policy the Commission may and should eliminate all antitrust reviews in connection with license transfers and therefore terminate this adjudicatory proceeding forthwith." *Id.* at 200.

Because the issue of the Commission's authority to conduct antitrust reviews of license transfers is of interest to, and affects, more than only the parties directly involved in, or affected by, the proposed Wolf Creek transfer, the Commission in that case invited *amicus curiae* briefs from "any interested person or entity." CLI-99-05, 49 NRC at 200, n.1. (Briefs on the issue subsequently were received from a number of nonparties.) In addition, widespread notice of the Commission's intent to decide this matter in the Wolf Creek proceeding was provided by publishing that order on the NRC's web site and in the Federal Register (64 FR 11069; March 8, 1999), and also by sending copies to organizations known to be active in or interested in the Commission's antitrust activities. *Id.*

After considering the arguments presented in the briefs, and based on a thorough *de novo* review of the scope of the Commission's antitrust authority, the Commission concluded that the structure, language, and history of the Atomic Energy Act do not support its prior practice of conducting antitrust reviews of post-operating license transfers. The Commission stated:

It now seems clear to us that Congress never contemplated such reviews. On the contrary, Congress carefully set out exactly when and how the Commission should exercise its antitrust authority, and limited the Commission's review responsibilities to the anticipatory, precensing stage, prior to the commitment of substantial licensee resources and at a time when the Commission's opportunity to fashion effective antitrust relief was at its maximum. The Act's antitrust provisions nowhere even mention post-operating license transfers.

The statutory scheme is best understood, in our view, as an implied prohibition against additional Commission antitrust reviews beyond those Congress specified. At the least, the statute cannot be viewed as a requirement of such reviews. In these circumstances, and given what we view as strong policy reasons against a continued expansive view of our antitrust authority, we have decided to abandon our prior practice of conducting antitrust reviews of post-operating license transfers. * * *

Kansas Gas and Electric Co. (Wolf Creek Generating Station, Unit 1), CLI-99-19, 49 NRC 441, 446 (1999) (Wolf Creek).

II. Discussion

The Commission's decision in Wolf Creek was based on a thorough consideration of the documented