

**Attachment F: Federal Employees Health Benefits—Women & Family
Health Initiatives in Annual Call Letter Guidance**

4. FEHBP Call Letter 1997

FEHBP Letter

All Fee-for-Service Carriers

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

FEHBP Letter No. 97-7
Prepaid[] Fee for Service [7]

Date: March 31, 1997

Subject: Annual Call Letter for the 1998 Contract Year

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1998, will be considered through May 31, 1997.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 15, 1997.

Guidance on Benefits

Public Law 104-204, the Veterans Affairs - Housing and Urban Development Appropriations Act for Fiscal Year 1997, imposes a number of changes on all health insurance carriers. The guidance below on new benefit coverages includes the effect of this legislation on the FEHB Program.

A. Fee-for-Service Plans

We are committed to providing Federal employees, retirees and their families with high quality, comprehensive and affordable health care. Carriers are encouraged to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. We also expect carriers to put in place procedures to capture discounts from bills presented, where it is cost effective to do so. Likewise, we expect carriers to continue to encourage competition among subcontractors to reduce administrative costs.

As in past years, we will not accept proposals for second options. A proposal for a Point of Service product, discussed under "Common Coverage Issues," will be considered within an existing option only and may not be rated separately.

B. Prepaid Plans

We will accept carrier-initiated benefit changes only to the degree that they reflect changes in the carrier's community package that we purchase. All prepaid plans must meet our minimum benefit requirements provided in the enclosures.

Proposals for service area expansions and/or new rating areas for 1998 must be summarized in your cover letter. We will not consider any new rating areas or service area expansions not proposed in your May 31 submission. Proposals for additional rating areas must also be presented in your rate submission.

C. Common Coverage Issues

- **Mental Health and Substance Abuse Benefits.** Title VII of Public Law 104-204, the "Mental Health Parity Act of 1996," provides that health plans, including FEHB plans, may not impose annual or lifetime dollar limits on mental health benefits that are less generous than similar limits for other benefits. This change in the law signals an interest in adequate health care coverage for mental illness as a matter of public policy. We encourage all carriers to find ways to take significant steps toward improving access to appropriate health care for those suffering from mental illness.

In 1996, we required the elimination of lifetime dollar limits on mental health benefits. Beginning with the 1998 contract year, all plans must eliminate any annual dollar limits on benefits for the treatment of mental illness. In addition, while not required by law, we would like to see movement away from contractual day and visit limitations and high deductibles to improve access to appropriately managed care.

Although plans will be required to remove dollar limits, and we would hope day and visit limitations and high deductibles as well, we do not expect that plans will provide unlimited mental health benefits. Indeed, we expect that through judicious utilization management, plans can provide a higher level of care at no increase in cost.

Accordingly, we will expect these benefit adjustments to be cost neutral across all plan benefits, at no additional premium cost to the Program. Consideration should be given to accomplishing this goal through the development of preferred provider organizations of behavioral health care providers and innovative benefits design. The Mental Health Parity Act of 1996 does not apply to benefits for the treatment of alcoholism or substance abuse.

- **Maternity Length of Stay.** Beginning with the 1998 contract year, and in accordance with Title VI of Public Law 104-204, the "Newborns' and Mothers' Health Protection Act of 1996", the mother must have the option of remaining in the hospital for at least 48 hours after a regular delivery and 96 hours after a caesarean delivery. In addition, FEHB plans are expected to provide benefits for maternity admissions for as long beyond the 48 or 96 hours as the inpatient stay is medically necessary.

- **Mastectomy admission and length of stay.** Similarly, we want to prevent women who must undergo mastectomies from being required by their health plans to have this surgery on an outpatient basis or to leave the hospital prematurely. Beginning with the 1998 contract year, all FEHB plans must provide a mastectomy patient with the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
- **Mammography Screening.** Consistent with the President's announcement, the FEHBP will follow the recommendations of the National Cancer Advisory Board on mammography screening. Upon release of the specific recommendations, we will communicate them to you by separate letter.
- **Pre-existing conditions.** Most plans in the FEHB Program do not have any pre-existing condition limits in their benefit structures. A few plans have specific limitations that apply only to cosmetic surgery or dental benefits. Public Law 104-191, "the Health Insurance Portability and Accountability Act of 1996," amends the Public Health Service Act to limit waiting periods for coverage of pre-existing conditions. Therefore, beginning with the 1998 contract year, if your plan contains any pre-existing condition limitations, please submit a benefits proposal that eliminates them.

To the extent the FEHBP experience-rated carrier's actuarial projections demonstrate an increase in cost that would justify additional premium, we will entertain rate proposals related to any of the following: maternity length of stay, mastectomy admission and length of stay, and pre-existing conditions, as described above. To the extent that these benefits are not included in the Prepaid Plan's community package, we will entertain proposals for actuarially demonstrated loadings.

- **Point of Service (POS) Products.** Plans may again consider proposing a Point of Service (POS) product as an alternative choice within an existing option. We believe this is an effective way to encourage people to try managed care with the understanding that they can still exercise the choice to go outside the network for specific services if they decide to do so. Therefore, we will entertain proposals from both fee-for-service plans and prepaid plans for a POS product.

Fee-for-service plans may offer a POS product, and it may be offered on a pilot basis within a limited geographic area. Plans that offered a POS product on a pilot basis beginning in 1997 may propose an expansion of that product into additional geographic areas. Although plans may propose a POS product that requires a positive enrollee election, a rate differential will not be permitted for those electing the POS product.

Plans' POS offerings should specify network arrangements, including gatekeeper provisions, and benefit differentials for in- and out-of-network services. In-network

POS benefits may be more comprehensive than the standard benefit package, except for dental and vision care. Favorable consideration will be based on factors such as demonstrated experience with POS products by the sponsoring organization or network manager; presentation of an administrative/operational plan that addresses issues such as enrollee and provider education, the interrelationship between the POS product and the ongoing fee-for-service product; and presentation of a plan for evaluating pilot projects and expanding the POS product if it is successful. POS savings must accrue to the FEHB Program.

We will consider proposals from prepaid plans to offer a POS product only if the plan can demonstrate experience with a private sector employer who has purchased the product. As in past years, we will not accept proposals for second options. A POS product will be considered within an existing option only and may not be rated separately.

Prior Coverage Certificates

Beginning with the 1998 contract year, you will be required to provide certificates to individuals detailing prior coverage as required by the Health Insurance Portability and Accountability Act of 1996. As soon as the Department of Health and Human Services regulations are issued we will give you more information about this requirement.

Electronic Communication

In the past year, we have moved away from using the mail to communicate with plans to the extent feasible. We transmitted many All Carrier Letters by facsimile only and provided access to the FEHB Guide and plan brochures on the Internet. We wish to continue in this direction. Therefore, this year you will need to have internet capability prior to the beginning of the preparation of your brochure for this year's Open Season. This capability must include E-mail addresses for key personnel with whom we communicate regularly.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.
- ✓ Benefit changes and clarifications must be submitted in a specific format. This format is mandatory. Specific instructions for submitting your proposed changes and clarifications are included in the enclosures.

- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the enclosure. You must include language for a "How Benefits Change in 1998" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English and explain how the change will affect the customer from the customer's point of view.

Additional benefit proposal instructions appear in the enclosure.

Please note that we have temporarily relocated. Send your proposals to:

(Overnight delivery)
U.S. Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 4416
Washington, DC 20415

(Regular mail)
U.S. Office of Personnel Management
Office of Insurance Programs
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

You will continue to have the responsibility for producing the actual brochures from agreed-upon text provided to you on disk after the conclusion of benefits negotiations. Details of the process to be used in creating that disk are under consideration. We will give you more information about the process very soon.

Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting

We remain committed to the Government's policy of encouraging small, small-disadvantaged, and women-owned small business subcontracting in the performance of Federal agency contracts. Therefore, it is important for both OPM and FEHB Program carriers to continue to look for additional ways to expand relevant subcontracting opportunities.

Last year, we implemented a pilot project with the seven FEHB Program carriers that represent the greatest portion of total Program enrollment. The outcome of the project will determine the best way to integrate the small, small disadvantaged, and women-owned small business programs into the FEHB Program. For all other carriers, we want to emphasize your responsibility to look for ways to expand small, small disadvantaged, and women-owned small business subcontracting opportunities in accordance with FAR clause 52.219-8, "Utilization of Small, Small-Disadvantaged and Women-Owned Small Business Concerns."

Employing Welfare Recipients

Last summer, the President signed welfare reform legislation that imposed time limits, required work, and extended child and health care to enable people to move from welfare to work. At the same time, he called upon business to employ former welfare recipients in appropriate roles. This month, the President issued a complementary directive to Federal agencies to take steps to employ former welfare recipients. In order to further this objective, we expect that FEHB carriers will look for, and use, appropriate opportunities to support this initiative. Though no specific reporting mechanism is contemplated, FEHB carriers can reasonably be expected to outline steps they have taken and results achieved in this area.

Disclosure Policy Under The Freedom of Information Act

Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we intend to release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1998 Contracts

We will send 1998 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1998 contracts are expected to be signed before the 1998 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myers
Assistant Director
for Insurance Programs

Enclosures

Enclosure for Fee-for-Service Plans

This enclosure provides Fee-for-Service plans with additional guidance on benefit changes and instructions on the submission of benefit proposals for the contract term January 1 through December 31, 1998. You are expected to propose benefit changes in accordance with the "Guidance on Benefits" found in the call letter. **It is important that all Fee-for-Service plans review this entire enclosure.**

There are three main parts to this enclosure:

- Part One - Guidance on Benefit Changes
- Part Two - Preparing Your Benefit Proposal
- Part Three - Open Season Materials & Reimbursement of Printing Costs

Complete and return the enclosed Certificate of Program Integrity - Modification with your **May 31** submission.

If you have any questions about your benefits submission, please call your contract representative.

Any additional forms and materials needed to prepare your brochure and other open season documents will be sent to you by mid-April. These will include:

1. Revisions to mandated (i.e., non-negotiable) language and required changes for the 1998 brochure.
2. Printing specifications for the 1998 brochure and for the 1998 Rate Sheet.

Graphics and OPM authorization block for the cover of your 1998 brochure will be sent to you in June. Your brochure quantities form, shipping labels, and related open season instructions will be sent to you in August.

Part One - Guidance on Benefit Changes

In keeping with the spirit of the call letter, carrier-initiated benefit improvements will be accepted only to the degree that they are cost neutral. Savings from managed care initiatives must accrue to the FEHB Program. When you prepare your benefit proposal, review the effect of the proposed changes on language throughout the brochure, such as on the Cost Sharing and Catastrophic Protection and Lifetime Maximums sections of the brochure. We prefer that benefit enhancements for the next contract term be limited to those described in the call letter. With this in mind, we offer the following guidance for the 1998 contract term:

- A. **Mental Health and Substance Abuse Benefits.** As indicated in the call letter, beginning in 1998, all plans must eliminate any annual dollar limits they have on benefits for the treatment of mental illness. This does not apply to benefits for inpatient treatment of alcoholism and drug abuse. In addition, we encourage plans to move away from contractual day and visit limitations and high deductibles for treatment of mental conditions. All mental health benefit adjustments, however, must be cost neutral across all plan benefits. Plans are encouraged to accomplish this through the development of preferred provider organizations of behavioral health care providers and innovative benefits design.
- B. **Maternity and Mastectomy Length of Stay and Mastectomy Admissions.** All plans must provide for maternity admission lengths of stay of at least 48 hours after a regular delivery and 96 hours after a caesarian delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
- C. **Mammography Screening.** Consistent with the President's announcement, the FEHBP will follow the recommendations of the National Cancer Advisory Board on mammography screening. Upon release of the specific recommendations, we will communicate them to you by separate letter.
- D. **Pre-existing Conditions.** Beginning in 1998, plans will not be permitted to have pre-existing conditions limitations on any benefit, including cosmetic surgery and dental benefits.
- E. **Immunizations for Children.** All plans must provide coverage for childhood immunizations not subject to deductibles or coinsurance. This includes the cost of sera or inoculations. Benefits for associated office visits, diagnostic tests, etc., may be subject to applicable deductibles and/or coinsurance.

- F. **Prescription drugs.** All plans must provide at least a minimum level of coverage for all medically necessary prescription drugs that by Federal law require a prescription for their use, and insulin, when the drug (or insulin) is prescribed within accepted standards of medical care. Drug benefit deductibles cannot exceed \$600, member coinsurance cannot exceed 50%, and neither annual nor lifetime maximums are permitted on prescription drug benefits. Blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables" are not acceptable.
- G. **HDC/ABMT for Certain Cancers.** All non-experimental allogeneic and autologous bone marrow transplants (including autologous bone marrow transplants for acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors) must be covered. In addition, all plans must provide coverage for HDC/ABMT for breast cancer, multiple myeloma, and ovarian epithelial cell tumors. Coverage for these three conditions may be limited to services received in clinical trials, provided both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials).
- H. **Dental Care.** Consistent with our policy in recent years, we will not accept increases in dental benefits.
- I. **Managed Care Initiatives.** Fee-for-Service plans are encouraged to expand their existing Preferred Provider Organization (PPO) arrangements to increase both the availability of PPO providers and the services provided under such arrangements. Managed care savings must accrue to the FEHB Program.

We also expect carriers to have in place procedures to capture discounts from bills presented, and/or contract with vendors to do so, where cost-effective.

- J. **Flexible Services Option.** We continue to encourage carriers to utilize their authority under the "Flexible Services Option," to identify and offer medically appropriate, cost effective alternatives to traditional care as the most effective way to provide services to its enrollees and their covered family members, whenever appropriate (that is, not exclusively for "large case management"), when the provision of services not otherwise covered by the carrier's existing benefit structure (such as medical foods and nutrition therapies in the treatment of AIDS and other diseases) is medically appropriate, cost effective, and in the best interests of the patient. The decision to offer an alternative benefit, however, rests solely with the carrier and is not subject to OPM review under the disputed claims process.

Part Two - Preparing Your Benefit Proposal

Because we must conclude negotiations in a few weeks, we expect every Fee-for-Service Plan to prepare and submit a complete proposal in accordance with these instructions by May 31, 1997.

Your actual benefit proposal will consist of several parts:

- Narrative description of each proposed change (in worksheet format);
- Narrative description of each proposed clarification (in worksheet format); and,
- Proposed 1998 brochure language.

We are seeking stability in FEHB Program benefit packages and are not encouraging benefit changes beyond those noted in the call letter. If you foresee unusual or extensive changes, please discuss them with your OPM contract representative before you prepare your submission.

FEHB Proposal Instructions

You must include a narrative description of each proposed benefit change and clarification in your proposal. Answer the following questions in worksheet format for each proposed benefit change or clarification. If a particular question does not apply, please so indicate. Use a separate page for each change or clarification you propose. Incorrectly formatted submissions will be returned to you for correction. The following format is required:

Benefit Changes

1. Describe the existing benefit and your proposed change. State the proposed brochure language, including the "How the Plan Changes" section. The language for the "How the Plan Changes" section must be written from the enrollees' perspective and make clear to enrollees how the change will affect them. Be sure to show the complete range of the change. For example, if you are proposing to eliminate an inpatient deductible, indicate whether the change will also apply to hospitalizations under mental health benefits as well. If there is more than one change to the same benefit, present each change on a separate worksheet.
2. Describe the rationale or reasoning for the proposed benefit change.
3. State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If an increase, describe whether any other benefit is offset by your proposal. Include

the cost impact of this change as a biweekly amount for the Self Only and Self and Family rate. If there is no cost impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively.

Benefit Clarifications

1. Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification. Prepare a separate worksheet for each proposed clarification.

2. Describe the rationale and need for the language change.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g.,

changing the number of days for a prescription drug supply from 31 to 30 days.

Clarifications, on the other hand, comprise changes in wording that do not affect the level of benefits provided. A proposed change that results in an increase or decrease in benefits must be shown as a benefit change, even if there is no change in rates.

Part Three - Open Season Material & Reimbursement of Printing Costs

A. Your FEHB Brochure - As in past years, we expect you to typeset and print your brochures for the FEHB Program. The brochure production schedule and the distribution deadlines that must be met remain unchanged. Carriers will again bear full responsibility for the accuracy and timeliness of their FEHB brochures, and will be held accountable for any brochure errors.

The Office of Insurance Programs will concentrate our attention on the benefit proposals, obtaining agreement with the Plans on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Plans will have sole responsibility for preparing the camera ready proof and printing the brochure.

We will advise plans about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General Advisory on Fraud section, etc.). Additional information about the brochure production process will be forthcoming.

Once the benefit negotiation process is complete, we will provide you with a disk containing the agreed-upon brochure text language that is to be printed in your 1998 brochure, along with two paper copies of the information. The paper copies will be accompanied by a cover sheet (2 copies) that indicates that the attached document is the Appendix A to the contract between OPM and the carrier and reflects the agreed-upon brochure text that is to be the language used in the brochure. The Appendix A will be signed by OPM and by an authorized contracting official for your plan, and will be inserted in your 1998 contract as the contractual statement of benefits and related conditions for your plan for 1998.

After the Appendix A is signed, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that the brochure is correct. You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure. You will be held accountable for any errors in the final printed brochure. After printing the brochure, please send 25 copies to your OPM contract representative.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will be required to reprint and redistribute corrected brochures at your expense. In addition, you will be required to notify all enrollees of the error and of the correct available benefit, and to absorb the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing corrected brochure language, rather than reprinting the brochure. Your OPM Contracting Officer will advise you what corrective action will be required. It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure the accuracy of your brochures.

B. Rates - We will provide you with a rate sheet similar to the one we provided last year. You will need to insert copies in the brochures you send to your members and to all distribution points, including the annuitant shipping point in Iowa. The rate sheet will be available when rates are released, after the enrollee and Government shares have been calculated, in early September. Paper specifications will be forwarded with the printing specifications for your brochure.

C. Reimbursement of Printing Costs - As in previous years, we will reimburse you for costs associated with printing the quantity of brochures that we authorize the plan to print. We will not reimburse the costs of printing other open season materials such as preferred provider lists or pamphlets, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Plans that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our brochure production process provides them. However, plans that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect participating FEHB plans to devote the resources necessary to assume responsibility throughout the brochure production process for the accuracy and content of their brochures.

Penalties will be assessed for errors based on the significance of the error. Plans will also be required to take appropriate corrective action (at plan expense) to assure that FEHB members receive the correct information. Penalties and the cost of corrective action are not chargeable to the FEHB Program. Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than \$500, but if more, not more than 50 percent of your brochure printing allowance.

The cost of reprinting and redistribution of corrected brochures, addendum sheets, or other corrective action will not be reimbursed or chargeable to the FEHB contract. In addition, failure to efficiently produce accurate FEHB brochures will be taken into consideration in determining your service charge.

E. Penalties for Late Brochure Distribution - In the past, we've experienced problems with plans failing to ship requested brochure quantities to OPM's delivery point in Iowa City in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures are delivered on time. However, if your plan does not ship timely, you may be subject to the penalties in Item D above against your brochure printing allowance (The penalty will be increased as warranted by the delay.). In addition, your failure to ship timely will be taken into consideration in determining your service charge. To avoid such actions, please make timely shipping to Iowa City and Federal agencies a priority when you distribute Plan brochures this Fall.

Plan _____

Carrier _____
(Enter only if carrier is different from Plan)

Enrollment Code(s) _____

CERTIFICATE OF PROCUREMENT INTEGRITY--
MODIFICATION (NOV 1990)

(1) I, _____ *[Name of certifier]* am the officer or employee responsible for the preparation of this modification proposal and hereby certify that, to the best of my knowledge and belief, with the exception of any information described in this certification, I have no information concerning a violation or possible violation of subsection 27(a), (b), (d), or (f) of the Office of Federal Procurement Policy Act, as amended (41 U.S.C. 423), (hereinafter referred to as "the Act"), as implemented in the FAR, occurring during the conduct of this procurement CS _____
[contract number and year]

(2) As required by subsection 27(e)(1)(B) of the Act, I further certify that, to the best of my knowledge and belief, each officer, employee, agent, representative, and consultant of _____ *[Name of Offeror, i.e., Plan]* who has participated personally and substantially in the preparation or submission of this proposal has certified that he or she is familiar with, and will comply with, the requirements of subsection 27(a) of the Act, as implemented in the FAR, and will report immediately to me any information concerning a violation or possible violation of subsections 27(a), (b), (d), or (f) of the Act, as implemented in the FAR, pertaining to this procurement.

(3) Violations or possible violations: *(Continue on plain bond paper if necessary and label Certificate of Procurement Integrity--Modification (Continuation Sheet), Enter "NONE" if none exists)*

[Signature of the officer or employee responsible for the offeror/Plan]

[date]

[Typed name of the responsible officer or employee]

THIS CERTIFICATION CONCERNS A MATTER WITHIN THE JURISDICTION OF AN AGENCY OF THE UNITED STATES AND THE MAKING OF A FALSE, FICTITIOUS, OR FRAUDULENT CERTIFICATION MAY RENDER THE MAKER SUBJECT TO PROSECUTION UNDER TITLE 18, UNITED STATES CODE, SECTION 1001.

FEHBP Letter

All Prepaid Carriers

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

FEHBP Letter No. 97-9
Prepaid[9] Fee for Service[]

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- **Mastectomy admission and length of stay.** Similarly, we want to prevent women who must undergo mastectomies from being required by their health plans to have this surgery on an outpatient basis or to leave the hospital prematurely. Beginning with the 1998 contract year, all FEHB plans must provide a mastectomy patient with the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
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To the extent the FEHBP experience-rated carrier's actuarial projections demonstrate an increase in cost that would justify additional premium, we will entertain rate proposals related to any of the following: maternity length of stay, mastectomy admission and length of stay, and pre-existing conditions, as described above. To the extent that these benefits are not included in the Prepaid Plan's community package, we will entertain proposals for actuarially demonstrated loadings.

- **Point of Service Product.** Plans may again consider proposing a Point of Service (POS) product as an alternative choice within an existing option. We believe this is an effective way to encourage people to try managed care with the understanding that they can still exercise the choice to go outside the network for specific services if they decide to do so. Therefore, we will entertain proposals from both fee-for-service plans and prepaid plans for a POS product.

Fee-for-service plans may offer a POS product, and it may be offered on a pilot basis within a limited geographic area. Plans that offered a POS product on a pilot basis beginning in 1997 may propose an expansion of that product into additional geographic areas. Although plans may propose a POS product that requires a positive enrollee election, a rate differential will not be permitted for those electing the POS product.

Plans' POS offerings should specify network arrangements, including gatekeeper provisions, and benefit differentials for in- and out-of-network services. In-network POS benefits may be more comprehensive than the standard benefit package, except

for dental and vision care. Favorable consideration will be based on factors such as demonstrated experience with POS products by the sponsoring organization or network manager; presentation of an administrative/operational plan that addresses issues such as enrollee and provider education, the interrelationship between the POS product and the ongoing fee-for-service product; and presentation of a plan for evaluating pilot projects and expanding the POS product if it is successful. POS savings must accrue to the FEHB Program.

We will consider proposals from prepaid plans to offer a POS product only if the plan can demonstrate experience with a private sector employer who has purchased the product. As in past years, we will not accept proposals for second options. A POS product will be considered within an existing option only and may not be rated separately.

Prior Coverage Certificates

Beginning with the 1998 contract year, you will be required to provide certificates to individuals detailing prior coverage as required by the Health Insurance Portability and Accountability Act of 1996. As soon as the Department of Health and Human Services' regulations are issued we will give you more information about this requirement.

Electronic Communication

In the past year, we have moved away from using the mail to communicate with plans to the extent feasible. We transmitted many All Carrier Letters by facsimile only and provided access to the FEHB Guide and plan brochures on the Internet. We wish to continue in this direction. Therefore, this year you will need to have internet capability prior to the beginning of the preparation of your brochure for this year's Open Season. This capability must include E-mail addresses for key personnel with whom we communicate regularly.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.
- ✓ Benefit changes and clarifications must be submitted in a specific format. **This format is mandatory.** Specific instructions for submitting your proposed changes and clarifications are included in the enclosures.

- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the enclosure. You must include language for a "How Benefits Change in 1998" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English and explain how the change will affect the customer from the customer's point of view.

Additional benefit proposal instructions appear in the enclosure.

Please note that we have temporarily relocated. Send your proposals to:

(Overnight delivery)
 U.S. Office of Personnel Management
 Office of Insurance Programs
 1900 E Street, NW., Room 4416
 Washington, DC 20415

(Regular mail)
 U.S. Office of Personnel Management
 Office of Insurance Programs
 P.O. Box 707
 Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

You will continue to have the responsibility for producing the actual brochures from agreed-upon text provided to you on disk after the conclusion of benefits negotiations. Details of the process to be used in creating that disk are under consideration. We will give you more information about the process very soon.

Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting

We remain committed to the Government's policy of encouraging small, small-disadvantaged, and women-owned small business subcontracting in the performance of Federal agency contracts. Therefore, it is important for both OPM and FEHB Program carriers to continue to look for additional ways to expand relevant subcontracting opportunities.

Last year, we implemented a pilot project with the seven FEHB Program carriers that represent the greatest portion of total Program enrollment. The outcome of the project will determine the best way to integrate the small, small disadvantaged, and women-owned small business programs into the FEHB Program. For all other carriers, we want to emphasize

your responsibility to look for ways to expand small, small disadvantaged, and women-owned small business subcontracting opportunities in accordance with FAR clause 52.219-8, "Utilization of Small, Small-Disadvantaged and Women-Owned Small Business Concerns."

Employing Welfare Recipients

Last summer, the President signed welfare reform legislation that imposed time limits, required work, and extended child and health care to enable people to move from welfare to work. At the same time, he called upon business to employ former welfare recipients in appropriate roles. This month, the President issued a complementary directive to Federal agencies to take steps to employ former welfare recipients. In order to further this objective, we expect that FEHB carriers will look for, and use, appropriate opportunities to support this initiative. Though no specific reporting mechanism is contemplated, FEHB carriers can reasonably be expected to outline steps they have taken and results achieved in this area.

Disclosure Policy Under The Freedom of Information Act

Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we intend to release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1998 Contracts

We will send 1998 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1998 contracts are expected to be signed before the 1998 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myers
Assistant Director
for Insurance Programs

Enclosures

Enclosure for Prepaid Plans

This enclosure provides prepaid plans with additional guidance on benefit changes and instructions on the submission of benefit and service area proposals for the upcoming contract term (January 1 through December 31, 1998). You are expected to propose benefit changes in accordance with the "Guidance on Benefits" found in the call letter. It is important that all prepaid plans review this entire enclosure; certain information is required of all plans.

There are four main parts to this enclosure:

- Part One - Guidance on Benefit Changes
- Part Two - Preparing Your Benefit Proposal
- Part Three - Changes in Service Area
- Part Four - Open Season Materials and Reimbursement of Printing Costs

Complete and return the enclosed Certificate of Program Integrity - Modification with your May 31 submission.

If you have any questions about your benefits submission, please call your contract representative.

Any additional forms and materials needed to prepare your brochure and other open season documents will be sent to you by mid-April. These will include:

1. Revisions to mandated (i.e., non-negotiable) language and required changes for the 1998 brochure.
2. Printing specifications for the 1998 brochure and for the 1998 Rate Sheet.

Graphics and OPM authorization block for the cover of your 1998 brochure will be sent to you in June. Your brochure quantities form, shipping labels, and related open season instructions will be sent to you in August.

Rate instructions will be sent under separate cover. It should be remembered at all times that FEHB rate submissions are the cornerstone of our financial relationship with prepaid plans. The FEHB rates and their supporting documentation are subject to audit to ensure their accuracy and reasonableness. Misrepresentation of your FEHB Program rates can result in criminal or civil legal actions against the Plan or its officials. We, with the support of the Inspector General's Office and the Justice Department, intend to aggressively pursue health plans that attempt to cheat the FEHB Program.

Part One - Guidance on Benefit Changes

In keeping with the spirit of the call letter, carrier-initiated benefit improvements will be accepted when they are part of the community package. However, we do prefer that benefits remain stable. With this in mind, we offer the following guidance for the 1998 contract term:

- A. **Mental Health and Substance Abuse** - As indicated in the call letter, beginning in 1998, all plans must eliminate any annual dollar limits they have on benefits for the treatment of mental illness. This does not apply to benefits for inpatient treatment of alcoholism and drug abuse. Lifetime benefit maximums for treatment of mental conditions have not been permitted. In addition, we encourage plans to move away from contractual day and visit limitations and high deductibles for treatment of mental conditions. All mental health benefit adjustments, however, must be cost neutral across all plan benefits. Plans are encouraged to accomplish this through their managed care networks of behavioral health care providers and innovative benefits design.
- B. **Maternity and Mastectomy Length of Stay and Mastectomy Admissions** - All plans must provide for maternity admission lengths of stay of at least 48 hours after a regular delivery and 96 hours after a caesarean delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an inpatient basis and remaining in the hospital for at least 48 hours after the procedure.
- C. **Mammography Screening**. Consistent with the President's announcement, the FEHBP will follow the recommendations of the National Cancer Advisory Board on mammography screening. Upon release of the specific recommendations, we will communicate them to you by separate letter.
- D. **Pre-existing Conditions** - Beginning in 1998, plans will not be permitted to have pre-existing conditions limitations on any benefit, including cosmetic surgery and dental benefits.
- E. **Point of Service Product** - We will consider proposals from prepaid plans to offer a Point of Service product (providing reimbursement for plan members who elect to receive non-emergency care from non-plan providers at reduced indemnity rates) under the FEHB Program only if the Plan can demonstrate experience with a private sector employer who has purchased this benefit.
- F. **Waiver of Office Visit Copayments for Prenatal and Postnatal Care** - A number of plans currently waive these copayments as a means of helping assure that pregnant members obtain adequate pre- and post-natal care, and thereby increase the likelihood that their babies will be born without complications. We encourage other prepaid plans to do the same.

- G. Coverage for Fertility Drugs** - All prepaid plans are required to cover treatment of infertility, but many do not cover related prescription drugs. To better inform FEHB members, if they have not already done so, plans should clarify their brochure language to indicate whether fertility drugs are covered or not covered, in both their infertility benefit description and their prescription drug benefit description.
- H. Immunizations for Children** - All FEHB plans must provide coverage (including the cost of inoculations or sera) for childhood immunizations.
- I. Transplants** - We require that all non-experimental bone marrow transplants (including non-experimental allogeneic bone marrow transplants, and autologous bone marrow transplants for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors), cornea, heart, liver, and kidney transplants be covered. In addition, all FEHB plans must provide coverage for HDC/ABMT for the treatment of breast cancer, multiple myeloma, and epithelial ovarian cancer. Coverage for these three conditions may be limited to services received in clinical trials, provided both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials). Otherwise, experimental transplant procedures need not be covered, but the Plan must provide necessary follow-up care to the experimental procedure. All prepaid plans must cover related medical and hospital expenses of the donor (when the recipient is covered by the Plan). If the donor has primary coverage that provides benefits for organ transplant donors, the Plan will coordinate benefits according to NAIC guidelines, as with any other benefit.

To the extent permitted by applicable State law, other transplants not mandated by OPM may be excluded from the FEHB benefits if they are not in the community benefit package which we purchase.

- J. Dental and Vision Benefits** - We will consider new dental or vision care benefits only from community-rated plans and only when they are an integral part of the community benefits package we purchase.
- K. Prescription Drugs** - All plans must provide at least a minimum level of coverage for all medically necessary drugs that require a prescription for their use, and insulin. Drug benefit deductibles may not exceed \$600 and member coinsurance may not exceed 50%. Lifetime or annual benefit maximums on prescription drugs are not permitted.

Coverage must be provided for disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. In addition, benefits must be provided for "off-label" use of covered medication if prescribed for such use by a Plan doctor.

A drug formulary may be used as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. The formulary cannot be

used as a means to exclude benefits for the types of drugs mandated for the FEHB. Blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables" are not acceptable.

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

- ✓ Nonexperimental bone marrow, cornea, kidney, and liver transplants (see H. above for other FEHB requirements in this area);
- ✓ Short-term rehabilitative therapy (physical, speech, and occupational) the provision of which can be expected to result in significant improvement in the patient's condition within two months;
- ✓ Family planning services, including all necessary nonexperimental infertility services, to include artificial insemination with either the husband's or donor sperm. The cost of donor sperm need not be covered. Other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) may be excluded to the extent permitted by applicable State law.
- ✓ Home health services;
- ✓ Inhospital administration of blood and blood products (including "blood processing");
- ✓ Surgical treatment of morbid obesity, when medically necessary;
- ✓ Implants - the procedure must be covered, although the cost of the device may be excluded;

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

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

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

Part Two - Preparing Your Benefit Proposal

Because we must conclude negotiations in a few weeks, we expect every prepaid plan to prepare and submit a complete proposal in accordance with these instructions by **May 31, 1997**.

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;
- Comparison of 1997 community package (adjusted for special FEHBP benefits) and the proposed 1998 community package;
- Narrative description of each proposed change (in worksheet format);
- Narrative description of each proposed clarification (in worksheet format); and,
- Proposed 1998 brochure language

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

As a reminder, in calculating your rate, you should adjust your community rate for the package you propose to reflect the additional cost - or savings - of increased, reduced, or excluded benefits resulting from OPM benefit requirements that are specific to the FEHB group, such as improved mental conditions benefits. If there is no change to the rate because of such requirements, each benefit difference should be identified nonetheless, by a zero on Attachment 2 (line 2) of your rate calculation.

1998 FEHB Proposal Instructions

A. Provide the following material by **May 2, 1997**:

1. Experience-rated Plans - Provide a copy of a fully executed employer group contract evidencing the highest level of coverage offered for 1997.
2. Community-rated Plans - Provide a fully executed copy of the community benefits package (aka master group contract or subscriber certificate) that describes the community benefits package, and riders, purchased by the greatest number of the plan's non-Federal subscribers in 1997. If the community benefits package we currently purchase is not the same one, please also send us a copy of the package we do purchase.

B. Provide the following by May 31, 1997, to document your proposal:

1. Experience-rated Plans - It is OPM's intention to continue to purchase the highest level of coverage offered to employer groups by your Plan (or current FEHB benefits, whichever is higher). If you have not made changes to the highest level of coverage submitted in response to A(1) above, then submit a statement to this effect, along with an additional copy of the benefit description. If you have made changes, submit a copy of the new benefit description and answer the questions in Section C below. This benefit package and the associated rate must have been filed with your State if a filing is required by the State.

2. Community-rated Plans - It is OPM's intention to purchase the same community benefit package that covers the majority of your plan's subscribers/contract holders, with adjustments for any benefit differences resulting from specific requirements of the FEHB Program. If you offer a variety of community packages, you must propose the core package of benefits purchased by a majority (or the largest number) of plan subscribers or contract holders (not members or employer groups.) Also note that if we later determine that the community benefits package you submit is not the community benefits package purchased on behalf of the majority, your 1998 FEHB rates will be subject to adjustment in accordance with the Federal Employees Health Benefits Acquisition Regulations (FEHBAR).

Descriptions of community-based riders and other additions to the basic package that reflect previously agreed-upon modifications or mandated additions to the community package, must be appended. Riders (optional benefits not sold to all plan groups) that are incorporated in the community package must be identified. This material must evidence all benefit changes proposed for the FEHB Program for the 1998 contract term except those still under review by your State as described in Item D below.

C. To simplify our comparison of your 1998 community benefits package proposal and the benefits package currently purchased for the 1997 contract term, please attach a chart displaying the following information:

1. Benefits that are covered in one package but not the other;
2. Differences in copays, coinsurance, numbers of days of coverage and other levels of coverage between one package and the other;
3. Whether the costs of the differences at (1) and (2) are included within or are in addition to the community rate charged to the other groups that purchase this community benefits package, and to the FEHB Program;
4. The number of subscribers/contract holders who currently purchase each package.

- D. Describe the procedure in your State for filing and/or obtaining approval of community benefit packages and changes. If filing and/or approval is required, provide a copy of the plan's most recent submission applicable to the community benefits package you submit in response to B(2) and provide a copy of the approval issued by the State. Please highlight and address any State mandated benefits that have not been specifically addressed in previous negotiations with OPM. Please note that we will accept proposed benefit changes only if: (1) the changes were submitted to your State prior to May 31 and (2) approval is obtained and documentation of the approval is submitted to OPM by June 30, 1997. If State approval is granted by default, i.e., the State does not object to proposed changes within a certain period after receipt of the proposal, please so note; the review period must have elapsed without objection by June 30.

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

- E. You must provide a narrative description of each proposed benefit change and clarification in your proposal. Answer the following questions in worksheet format for each proposed benefit change or clarification. Use a separate page for each change or clarification you propose. Incorrectly formatted submissions will be returned to you for correction. The following format is required:

Benefit Changes

1. Describe the existing benefit and how you propose to change it. State the proposed brochure language, including the "How the Plan Changes" section. The language for the "How the Plan Changes" section must be written from the enrollees' perspective and make clear to enrollees how the change will affect them. Be sure to show the complete range of the change. For instance, if the Plan is proposing elimination of its hospitalization copay, indicate whether this change will also apply to hospitalizations under the emergency and mental health benefits. If there is more than one change to the same benefit, present each change on a separate worksheet.
2. Describe the rationale or reasoning for the proposed benefit change.
3. State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If an increase, describe whether any other benefit is offset by your proposal.

4. State whether this change is part of the plan's proposed community benefits package (see Item B.2.) or a change that has been submitted to the State for approval. State how the change will be introduced to other employers (e.g., group renewal date). State what percentage of Plan contract holders/subscribers now have this benefit and the percentage you project will be covered by January 1998.

5. Has the change been submitted to and approved by the appropriate State authorities? If so, when? Supporting documentation must be submitted (see Item D above).

6. If not part of the proposed community benefits package, is the change a rider? If yes,

a. Is it a community rider (offered to all employer groups at the same rate)?

b. State the percentage of the Plan's subscribers/contract holders who purchase this now and the percentage you project will be covered by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to be covered by this rider and when will that occur?

c. Include the cost impact of this rider as a biweekly amount for Self Only and Self and Family on Attachment 2 of your rate calculation. If there is no cost impact or if the rider involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively, on Attachment 2 to your rate calculation.

7. Will the change require new providers (e.g., dental, vision)? Furnish an updated provider directory that includes these new providers.

Benefit Clarifications

1. Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification. Prepare a separate worksheet for each proposed clarification.

2. Describe the rationale and need for the language change.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g., changing the number of days for a prescription drug supply from 31 to 30 days. Clarifications, on the other hand, comprise changes in wording which do not affect the level of benefits provided. **A proposed change that results in an increase or decrease in benefits must be shown as a benefit change, even if there is no change in rates.**

Part Three - Changes in Service Areas or Redesignation as a Mixed Model Plan

We expect that your plan's present service area and the individual doctors or medical groups with whom you contract to offer services to the FEHB will remain available to our members for the 1998 contract term. You must inform us of any expected changes. See Part One if you are proposing separate service areas for 1998.

Service Area Reductions - Explain the reason for and provide supporting documentation (e.g., withdrawal notice from medical group) regarding any proposed reduction to the plan's service area. Does this reduction apply only to the Federal group? Describe precisely, and provide a map of, the area to be eliminated.

Service Area Expansions - The Plan must propose any service area expansion by May 31. We will grant an extension for submitting to OPM any supporting documentation described below, including all necessary State authorizations, until no later than June 30. We cannot grant exceptions to this date because of printing deadlines we must meet in order to include approved expansions in the FEHB Guide.

Redesignation as a Mixed Model Plan - If your Plan formerly operated as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) and now offers both types of providers, redesignation as a Mixed Model Plan (MMP) may be appropriate. You must request redesignation and describe the delivery system that has been added.

Please note: You must indicate to us that the information you provide us concerning your delivery system is based on providers with whom you have executed contracts; letters of intent are not acceptable in lieu of executed contracts. We also require that you state that all contracts with providers contain a "hold harmless" clause. Use the statement form at III-5.

Important Notice: If your Plan has a service area reduction or a new rating area is established that requires current Plan members to change enrollment codes, new codes will be assigned and there will be a total positive re-enrollment of all of the Plan's FEHB members during the 1997 Open Season.

OPM will evaluate your proposal in accordance with these criteria: legal authority to operate, adequate access to plan doctors and hospitals, and plan ability to provide contracted benefits. Accordingly, please provide the following information:

Instructions

A. Provide a description of the proposed expansion:

1. Describe the proposed service area expansion by zip code, county, city or town.
2. Provide a map of the old and new service areas.
3. In addition to the access to providers within the proposed expansion you describe in C. below, be sure to describe access to care in contiguous areas within your existing service area. Show the distance in miles/minutes from the furthest point of the proposed expansion to current locations of Plan primary care doctors and to contracting hospitals in your existing service area. (If your plan is a GPP, show the distance to a current center (not satellite) in the existing service area.)
4. Include proposed language for this expansion in your brochure language submission (see Part IV), in the Service Area description.

B. Authority to operate in proposed area:

1. If the new service area is not contiguous to your current service area, indicate whether or not the Plan operates in the proposed area with the same articles of incorporation, license, management, benefits and rate as in your current service area. If not, explain in detail.
2. Please provide a copy of the State approval document authorizing you to both market and provide services in the proposed expansion area, and the name and telephone number of the person at the state agency who worked on the authorization. If State approval has not been obtained, note the June 30 deadline for our receipt of this documentation.

C. Access to Providers - Please submit statements (signed by an authorized contracting official) of the following information concerning the availability of services in your proposed expansion, for each zip code, county, city or town, as described in your proposed expansion. Please note that a provider directory is not sufficient.

- 1a. The number of primary care physicians in the proposed area with whom you have executed contracts.
- 1b. The total number of primary care physicians in the proposed area.
- 2a. The number of specialists in the proposed area with whom you have executed contracts.
- 2b. The total number of specialists in the area.

- 3a. The number of hospitals in the proposed area with whom you have executed contracts. List them.
- 3b. The total number of hospitals in the area.
4. The average drive time to a primary care doctor.
5. The average drive time to a specialist.
6. The average drive time to a hospital.
7. The approximate size of the proposed area at its longest (north to south) and widest (east to west) points.
8. Description of the general area (e.g., rural vs. urban, population, geographic boundaries to access, etc.).
9. Description of other services and their locations (e.g., pharmacies, DME, etc.).

D. Redesignation as a Mixed Model Plan - This section applies only if your Plan formerly operated as a GPP or IPP and now offers both types of providers, and you are requesting redesignation as a Mixed Model Plan. Please indicate the provider system being added.

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

Include clear brochure language in your brochure ("How the Plan Changes" section plus "Information About This Plan", if appropriate) to reflect the proposed changes.

Remember, if the proposal is approved, you will need to provide the following information:

1. Do you require all members of a family to use the same delivery system, or may some members of a family use GPP doctors while others use IPP doctors?
2. If members are restricted to one type of delivery system, what must a member do to change from one delivery system to the other during a contract term? How soon after it is requested would such a change be effective?
3. If a member wants to change primary care doctors (centers for GPPs), what must the member do? Is there a limit on the number of times a member may change primary care doctors (centers)? If yes, will you waive the limit for FEHB members? How soon is a requested change effective?

Federal Employees Health Benefits Program
Statement About Service Area Expansion

I hereby state that the attached service area expansion proposal has been prepared in accordance with the requirements found in Part III, Changes in Service Areas, located in the Annual Call Letter for the 1998 Contract Year. Specifically,

1. All provider contracts have hold harmless provisions in them.
2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.
3. All of the information provided in response to Part III, Paragraph C (Access to Providers) is accurate as of the date of this statement.

Signature of Plan Contracting Official

Title

Plan Name

Date

Part Four - Open Season Material & Reimbursement of Printing Costs

A. Your FEHB Brochure - As in past years, we expect you to typeset and print your brochures for the FEHB Program. The brochure production schedule and the distribution deadlines that must be met remain unchanged. Carriers will again bear full responsibility for the accuracy and timeliness of their FEHB brochures, and will be held accountable for any brochure errors.

The Office of Insurance Programs will concentrate our attention on the benefit proposals, obtaining agreement with the Plans on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Plans will have sole responsibility for preparing the camera ready proof and printing the brochure.

We will advise plans about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General Advisory on Fraud section, etc.). Additional information about the brochure production process will be forthcoming.

Once the benefit negotiation process is complete, we will provide you with a disk containing the agreed-upon brochure text language that is to be printed in your 1998 brochure, along with two paper copies of the information. The paper copies will be accompanied by a cover sheet (2 copies) that indicates that the attached document is the Appendix A to the contract between OPM and the carrier and reflects the agreed-upon brochure text that is to be the language used in the brochure. The Appendix A will be signed by OPM and by an authorized contracting official for your plan, and will be inserted in your 1998 contract as the contractual statement of benefits and related conditions for your plan for 1998.

After the Appendix A is signed, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that the brochure is correct. You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure. You will be held accountable for any errors in the final printed brochure. After printing the brochure, please send 25 copies to your OPM contract representative.

Many FEHB plans are affiliated with other FEHB plans, or are members of a group of several subsidiary plans in the FEHB Program under a larger parent organization. We urge you to discuss your brochure production process with related plans and find ways to coordinate your efforts, increase efficiency, and eliminate duplication of effort. Newly-approved FEHB plans producing FEHB brochures for the first time can benefit from the guidance and experience of related affiliate plans who have produced FEHB brochures previously.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will be required to reprint and redistribute corrected brochures at your expense. In addition, you will be required to notify all enrollees of the error and of the correct available benefit, and to absorb the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing corrected brochure language, rather than reprinting the brochure. Your OPM Contracting Officer will advise you what corrective action will be required. **It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure the accuracy of your brochures.**

B. Rates - We will provide you with a rate sheet similar to the one we provided last year. You will need to insert copies in the brochures you send to your members and to all distribution points, including the annuitant shipping point in Iowa. The rate sheet will be available when rates are released, after the enrollee and Government shares have been calculated, in early September. Paper specifications will be forwarded with the printing specifications for your brochure.

C. Reimbursement of Printing Costs - As in previous years, we will reimburse community-rated plans for costs associated with printing the quantity of brochures that we authorize the plan to print. These charges to the FEHB Program will be accounted for as part of the rate reconciliation process. We will not reimburse the costs of printing other open season materials such as provider lists or pamphlets, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Plans that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our brochure production process provides them. However, plans that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect participating FEHB plans to devote the resources necessary to assume responsibility throughout the brochure production process for the accuracy and content of their brochures.

Penalties will be assessed for errors based on the significance of the error. Plans will also be required to take appropriate corrective action (at plan expense) to assure that FEHB members receive the correct information. Penalties and the cost of corrective action are not chargeable to the FEHB Program. Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than \$500, but if more, not more than 50 percent of your brochure printing allowance.

The cost of reprinting and distribution of corrected brochures, addendum sheets, or other required corrective action will not be reimbursed or chargeable to the FEHB contract. In addition, if your plan is experience-rated, failure to efficiently produce accurate FEHB brochures will be taken into consideration in determining your service charge.

E. Penalties for Late Brochure Distribution - In the past, we've experienced problems with plans failing to ship requested brochure quantities to OPM's delivery point in Iowa City in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures are delivered on time. However, if your plan does not ship timely, you may be subject to the penalties cited in Item D above (The penalty will be increased as warranted by the delay.). If your plan is community-rated, the penalty will be deducted as a part of the rate reconciliation. If your plan is experience-rated, your failure to ship timely will be taken into consideration in determining your service charge. To avoid such actions, please make timely shipping to Iowa City and Federal agencies a priority when you distribute Plan brochures this Fall.

Plan _____

Carrier _____
[Enter only if carrier is different from Plan]

Enrollment Code(s) _____

**CERTIFICATE OF PROCUREMENT INTEGRITY--
MODIFICATION (Nov 1990)**

(1) I, _____ *[Name of certifier]* am the officer or employee responsible for the preparation of this modification proposal and hereby certify that, to the best of my knowledge and belief, with the exception of any information described in this certification, I have no information concerning a violation or possible violation of subsection 27(a), (b), (d), or (f) of the Office of Federal Procurement Policy Act, as amended (41 U.S.C. 423), (hereinafter referred to as "the Act"), as implemented in the FAR, occurring during the conduct of this procurement CS _____
[contract number and year]

(2) As required by subsection 27(e)(1)(B) of the Act, I further certify that, to the best of my knowledge and belief, each officer, employee, agent, representative, and consultant of _____ *[Name of Offeror, i.e., Plan]* who has participated personally and substantially in the preparation or submission of this proposal has certified that he or she is familiar with, and will comply with, the requirements of subsection 27(a) of the Act, as implemented in the FAR, and will report immediately to me any information concerning a violation or possible violation of subsections 27(e), (b), (d), or (f) of the Act, as implemented in the FAR, pertaining to this procurement.

(3) Violations or possible violations: *[Continue on plain bond paper if necessary and label Certificate of Procurement Integrity-Modification (Continuation Sheet), Enter "NONE" if none exists]*

[Signature of the officer or employee responsible for the offeror/Plan] *[date]*

[Typed name of the responsible officer or employee]

THIS CERTIFICATION CONCERNS A MATTER WITHIN THE JURISDICTION OF AN AGENCY OF THE UNITED STATES AND THE MAKING OF A FALSE, FICTITIOUS, OR FRAUDULENT CERTIFICATION MAY RENDER THE MAKER SUBJECT TO PROSECUTION UNDER TITLE 18, UNITED STATES CODE, SECTION 1001.

Attachment F: Federal Employees Health Benefits—Women & Family
Health Initiatives in Annual Call Letter Guidance

5. FEHBP Call Letter 1996-

FEHBP Letter

All Fee-for-Service Carriers

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

FEHBP Letter No. 96-08A

Date March 4, 1996

Subject: Annual Call Letter for the 1997 Contract Year

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1997, will be considered through May 31, 1996.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 16, 1996.

Guidance on Benefits

We are not proposing any new benefit initiatives for 1997.

Fee-for-Service Plans

As indicated above, we are not seeking any Program-wide benefit changes. Proposals for benefit improvements will be considered only to the degree that they are cost neutral.

We again encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. We also expect carriers to put in place procedures to capture discounts from bills presented, where it is cost effective to do so.

As in past years, we will not accept proposals for second options. A proposal for a Point of Service product, discussed under "Common Coverage Issues," will be considered within an existing option only and may not be rated separately.

Prepaid Plans

As indicated above, we are not seeking any Program-wide benefit changes. We will accept carrier-initiated benefit changes only to the degree that they reflect changes in the carrier's community package that we purchase. All prepaid plans must meet our minimum benefit requirements provided in the enclosures.

Proposals for service area expansions and/or new rating areas for 1997 must be summarized in your cover letter. We will not consider any new rating areas or service area expansions not proposed in your May 31 submission. Proposals for additional rating areas must also be presented in your rate submission.

Common Coverage Issues

Plans may consider proposing a Point of Service (POS) product as an alternative choice within an existing option. Several prepaid plans in the FEHB Program have provided this alternative for a number of years, and both the industry and other large employer purchasers have begun to adopt POS alternatives as a means to introduce individuals to managed care who would otherwise be reluctant to commit to this kind of delivery system. We believe this is an effective way to encourage people to try managed care with the understanding that they can still exercise the choice to go outside the network for specific services if they decide to do so. Therefore, we will entertain proposals from both fee-for-service plans and prepaid plans for a POS product.

Fee-for-service plans may offer a POS product, and it may be offered on a pilot basis within a limited geographic area. Although plans may propose a POS product that requires a positive enrollee election, a rate differential for those electing the POS product would not be acceptable. Plans should specify network arrangements, including gatekeeper provisions, and benefit differentials for in and out of network services. In-network POS benefits may be more comprehensive than the standard benefit package, except for dental and vision care. Favorable consideration will be based on factors such as demonstrated experience with POS products by the sponsoring organization or network manager; presentation of an administrative/operational plan that addresses issues such as enrollee and provider education, the interrelationship between the POS product and the ongoing fee-for-service product; and presentation of a plan for evaluating pilot projects and expanding the POS product if it is successful. POS savings must accrue to the FEHB Program.

We will consider proposals from prepaid plans to offer POS or Opt-Out benefits only if the plan can demonstrate experience with a private sector employer who has purchased the benefit. As in past years, we will not accept proposals for second options. A POS or Opt-Out product will be considered within an existing option only and may not be rated separately.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.

- ✓ Benefit changes and clarifications submissions must be submitted in a specific format. This format is mandatory. Specific instructions for submitting your proposed changes and clarifications are included in the enclosures.
- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the attached enclosure. You must include language for a "How Benefits Change in 1997" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English and explain how the change will affect the customer from the customer's point of view.

Additional benefit proposal instructions appear in the enclosure.

Send your proposals to:

(Overnight delivery)

U.S. Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 3439
Washington, DC 20415

(Regular mail)

U.S. Office of Personnel Management
Office of Insurance Programs
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

Last year, we took the major steps of computerizing the brochure text and giving carriers more responsibility for producing the actual brochures from that text. This was a major task, and we greatly appreciate the hard work that everyone put into this effort. Now that the brochure text is on file, we are concentrating on refining the process for producing the 1997 brochures. We will give you more information about the process very soon.

Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting

We are committed to the Government's policy of encouraging small, small-disadvantaged, and women-owned small business subcontracting in the performance of Federal agency contracts. Therefore, it is important for both OPM and FEHB Program carriers to look for additional ways to expand relevant subcontracting opportunities.

Last year, we conducted a survey of all participating carriers to learn more about their subcontracting activities. We also have been working actively with the Small Business Administration to determine how best to implement subcontracting initiatives that are appropriate to our Program structure and which will produce desirable results. For contract year 1997, we will implement a pilot project with the seven FEHB Program carriers that represent the greatest portion of total Program enrollment. We will be consulting separately with the selected carriers and will incorporate the pilot project into the negotiations process. For all other carriers, we will place renewed emphasis on your responsibility to look for ways to expand small, small disadvantaged, and women-owned small business subcontracting opportunities in accordance with FAR clause 52.219-8, "Utilization of Small, Small-Disadvantaged and Women-Owned Small Business Concerns."

Disclosure Policy Under The Freedom of Information Act

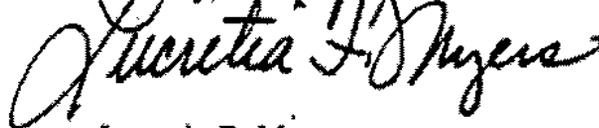
Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we intend to release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1997 Contracts

We will send 1997 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1997 contracts are expected to be signed before the 1997 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myers
Assistant Director
for Insurance Programs

FEHBP Letter

All Fee-for-Service Carriers

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

FEHBP Letter No. 96-08A

Date March 4, 1996

Subject: Annual Call Letter for the 1997 Contract Year

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1997, will be considered through May 31, 1996.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 16, 1996.

Guidance on Benefits

We are not proposing any new benefit initiatives for 1997.

Fee-for-Service Plans

As indicated above, we are not seeking any Program-wide benefit changes. Proposals for benefit improvements will be considered only to the degree that they are cost neutral.

We again encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. We also expect carriers to put in place procedures to capture discounts from bills presented, where it is cost effective to do so.

As in past years, we will not accept proposals for second options. A proposal for a Point of Service product, discussed under "Common Coverage Issues," will be considered within an existing option only and may not be rated separately.

Prepaid Plans

As indicated above, we are not seeking any Program-wide benefit changes. We will accept carrier-initiated benefit changes only to the degree that they reflect changes in the carrier's

community package that we purchase. All prepaid plans must meet our minimum benefit requirements provided in the enclosures.

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Plans may consider proposing a Point of Service (POS) product as an alternative choice within an existing option. Several prepaid plans in the FEHB Program have provided this alternative for a number of years, and both the industry and other large employer purchasers have begun to adopt POS alternatives as a means to introduce individuals to managed care who would otherwise be reluctant to commit to this kind of delivery system. We believe this is an effective way to encourage people to try managed care with the understanding that they can still exercise the choice to go outside the network for specific services if they decide to do so. Therefore, we will entertain proposals from both fee-for-service plans and prepaid plans for a POS product.

Fee-for-service plans may offer a POS product, and it may be offered on a pilot basis within a limited geographic area. Although plans may propose a POS product that requires a positive enrollee election, a rate differential for those electing the POS product would not be acceptable. Plans should specify network arrangements, including gatekeeper provisions, and benefit differentials for in and out of network services. In-network POS benefits may be more comprehensive than the standard benefit package, except for dental and vision care. Favorable consideration will be based on factors such as demonstrated experience with POS products by the sponsoring organization or network manager; presentation of an administrative/operational plan that addresses issues such as enrollee and provider education, the interrelationship between the POS product and the ongoing fee-for-service product; and presentation of a plan for evaluating pilot projects and expanding the POS product if it is successful. POS savings must accrue to the FEHB Program.

We will consider proposals from prepaid plans to offer POS or Opt-Out benefits only if the plan can demonstrate experience with a private sector employer who has purchased the benefit. As in past years, we will not accept proposals for second options. A POS or Opt-Out product will be considered within an existing option only and may not be rated separately.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.

- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.
- ✓ Benefit changes and clarifications submissions must be submitted in a specific format. **This format is mandatory.** Specific instructions for submitting your proposed changes and clarifications are included in the enclosures.
- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the attached enclosure. You must include language for a "How Benefits Change in 1997" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English and explain how the change will affect the customer from the customer's point of view.

Additional benefit proposal instructions appear in the enclosure.

Send your proposals to:

(Overnight delivery)

U.S. Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 3439
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(Regular mail)

U.S. Office of Personnel Management
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Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

Last year, we took the major steps of computerizing the brochure text and giving carriers more responsibility for producing the actual brochures from that text. This was a major task, and we greatly appreciate the hard work that everyone put into this effort. Now that the brochure text is on file, we are concentrating on refining the process for producing the 1997 brochures. We will give you more information about the process very soon.

Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting

We are committed to the Government's policy of encouraging small, small-disadvantaged, and women-owned small business subcontracting in the performance of Federal agency

contracts. Therefore, it is important for both OPM and FEHB Program carriers to look for additional ways to expand relevant subcontracting opportunities.

Last year, we conducted a survey of all participating carriers to learn more about their subcontracting activities. We also have been working actively with the Small Business Administration to determine how best to implement subcontracting initiatives that are appropriate to our Program structure and which will produce desirable results. For contract year 1997, we will implement a pilot project with the seven FEHB Program carriers that represent the greatest portion of total Program enrollment. We will be consulting separately with the selected carriers and will incorporate the pilot project into the negotiations process. For all other carriers, we will place renewed emphasis on your responsibility to look for ways to expand small, small disadvantaged, and women-owned small business subcontracting opportunities in accordance with FAR clause 52.219-8, "Utilization of Small, Small-Disadvantaged and Women-Owned Small Business Concerns."

Disclosure Policy Under Freedom of Information Act

Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we intend to release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1997 Contracts

We will send 1997 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1997 contracts are expected to be signed before the 1997 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myers
Assistant Director
for Insurance Programs

Enclosures

Enclosure for Fee-for-Service Plans

This enclosure provides FFS Plans with additional guidance on the submission of benefit proposals for the contract term January 1 through December 31, 1997. As stated in the call letter, we are not seeking benefit changes for 1997. It is important that all FFS Plans review this entire enclosure.

There are three main parts to this enclosure:

- Part One - Guidance on Benefit Changes**
- Part Two - Preparing Your Benefit Proposal**
- Part Three - Open Season Materials & Printing**

You will be provided with several forms currently under revision to conform to Postal Addressing Standards. Complete and return the following to OPM by May 3, 1996, along with the material described in Part Two of this enclosure:

- Designated Plan Contact**
- Plan Contracting Officials**
- Plan Contact for Brochures**
- Plan Contact for Enrollment**

Complete and return the following with your May 31 submission:

- Certificate of Program Integrity - Modification**
- FEHB Guide Strip**

If you have any questions about your benefits submission, please call your contract representative.

The above forms and additional materials needed to prepare your brochure and other open season documents will be sent to you by mid-April. These will include:

1. A copy of each of your plan's entries in the 1996 FEHB Guide for you to mark-up with any changes (e.g., in the catastrophic limit, deductibles, etc.) you propose for 1997. Return the strip with your May 31 submission. We will send you a final version for a plan contracting official to certify in mid-July.
2. Revisions to mandated (i.e., non-negotiable) language and required changes for the 1997 brochure.
3. Printing specifications for the 1997 brochure and for the 1997 Rate Sheet.

4. Logo and OPM authorization block for the cover of your 1997 brochure. Your brochure quantities form, shipping labels, and related open season instructions will be sent to you in August.

Rate instructions will be sent under separate cover. The FEHB rates and their supporting documentation are subject to audit. Misrepresentation of your FEHB Program rates can result in criminal or civil legal actions against the Plan or its officials. We, with the support of the Inspector General's Office and the Justice Department, intend to aggressively pursue health plans that attempt to cheat the FEHB Program.

Part One - Guidance on Benefit Changes

In keeping with the spirit of the call letter, we remain extremely price sensitive. Benefit improvements will be accepted only to the degree that they are cost neutral. Savings from managed care initiatives must accrue to the FEHB Program. When you prepare your benefit proposal, review the effect of the proposed changes on language throughout the brochure, such as on the Cost Sharing and Catastrophic Protection and Lifetime Maximums sections of the brochure. We prefer no changes in benefits for the next contract term. With this in mind, we offer the following guidance for the 1997 contract term:

- A. **Mental Health and Substance Abuse Benefits.** Consistent with our policy in recent years, current Mental Health and Substance Abuse benefit levels may not be reduced.
- B. **Immunizations for Children.** All plans must provide coverage for childhood immunizations not subject to deductibles or coinsurance. This includes the cost of sera or inoculations. Benefits for associated office visits, diagnostic tests, etc., may be subject to applicable deductibles and/or coinsurance.
- C. **Prescription drugs.** All plans must provide at least a minimum level of coverage for all medically necessary prescription drugs that by Federal law require a prescription for their use, and insulin, when the drug (or insulin) is prescribed within accepted standards of medical care. Drug benefit deductibles cannot exceed \$600, member coinsurance cannot exceed 50%, and neither annual nor lifetime maximums are permitted on prescription drug benefits. Blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables" are not acceptable.
- D. **HDC/ABMT for Certain Cancers.** All non-experimental allogeneic and autologous bone marrow transplants (including autologous bone marrow transplants for acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors) must be covered. In addition, all plans must provide coverage for HDC/ABMT for breast cancer, multiple myeloma, and ovarian epithelial cell tumors. Coverage for these three conditions may be limited to services received in clinical trials, provided both randomized and nonrandomized trials are included (the benefit may not be limited to randomized trials).
- E. **Dental Care.** Consistent with our policy in recent years, we will not accept increases in dental benefits.

- F. **Managed Care Initiatives.** FFS plans are encouraged to expand their existing PPO arrangements to increase both the availability of PPO providers and the services provided under such arrangements. Managed care savings must accrue to the FEHB Program.

We also expect carriers to have in place procedures to capture discounts from bills presented, and/or contract with vendors to do so, where cost-effective.

- G. **Flexible Services Option.** We continue to encourage carriers to utilize their authority under the "Flexible Services Option", to identify and offer medically appropriate, cost effective alternatives to traditional care as the most effective way to provide services to its enrollees and their covered family members, whenever appropriate (that is, not exclusively for "large case management"), when the provision of services not otherwise covered by the carrier's existing benefit structure (such as medical foods and nutrition therapies in the treatment of AIDS and other diseases) is medically appropriate, cost effective, and in the best interests of the patient. The decision to offer an alternative benefit, however, rests solely with the carrier and is not subject to OPM review under the disputed claims process.

Part Two - Preparing Your Benefit Proposal

Because we must conclude negotiations in a few weeks, we expect every FFS Plan to prepare and submit a complete proposal in accordance with these instructions by May 31, 1996.

Your actual benefit proposal will consist of several parts:

- Narrative description of each proposed change (in worksheet format);
- Narrative description of each proposed clarification (in worksheet format); and,
- Proposed 1997 brochure language.

We are seeking stability in FEHB Program benefit packages and are not encouraging benefit changes. If you foresee unusual or extensive changes, please discuss them with your OPM contract representative before you prepare your submission. If you are not proposing any benefit changes for 1997, provide a statement to that effect in your May 31 response.

FEHB Proposal Instructions

You must include a narrative description of each proposed benefit change and clarification in your proposal. Answer the following questions in worksheet format for each proposed benefit change or clarification. If a particular question does not apply, please so indicate. Use a separate page for each change or clarification you propose. Incorrectly formatted submissions will be returned to you for correction. The following format is required:

Benefit Changes

1. Describe the existing benefit and your proposed change. State the proposed brochure language, including the "How the Plan Changes" section. Be sure to show the complete range of the change. For example, if you are proposing to eliminate an inpatient deductible, indicate whether the change will apply to hospitalizations under mental health benefits as well. If there is more than one change to the same benefit, present each change on a separate worksheet.
2. Describe the rationale or reasoning for the proposed benefit change.
3. State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If an increase, describe whether any other benefit is offset by your proposal. Include the cost impact of this change as a biweekly amount for the Self Only and Self and

Family rate. If there is no cost impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively.

Benefit Clarifications

1. Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification, including the "How the Plan Changes" section. Prepare a separate worksheet for each proposed clarification.

2. Describe the rationale and need for the language change.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g., changing the number of days for a prescription drug supply from 31 to 30 days. Clarifications, on the other hand, comprise changes in wording that do not affect the level of benefits provided. **A proposed change that results in an increase or decrease in benefits must be shown as a benefit change, even if there is no change in rates.**

Part Three - Open Season Material & Printing

A. **Your FEHB Brochure** - As in past years, we expect you to typeset and print your brochures for the FEHB Program. The brochure production schedule and the distribution deadlines that must be met remain unchanged. Last year, we automated the process and no longer exchange typeset brochure proofs. Carriers will again bear full responsibility for the accuracy and timeliness of their FEHB brochures, and will be held accountable for any brochure errors.

The Office of Insurance Programs will again this year concentrate our attention on the benefit proposals, obtaining agreement with the Plans on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Plans will have sole responsibility for preparing the camera ready proof and printing the brochure.

As was indicated in the call letter, we are refining the process for producing the 1997 brochure. We will advise plans about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General Advisory on Fraud section, etc.). Additional information about the refined process will be forthcoming.

Once the benefit negotiation process is complete, we will provide you with a disk containing the language that is to be printed in your 1997 brochure, along with two paper copies of the information. The paper copies will be accompanied by a certification (2 copies) that indicates that the attached document reflects our agreement and is to be the language used in the brochure. The certification will be signed by OPM and by an authorized contracting official for your plan, and will be inserted in your 1997 contract as the contractual statement of benefits and related conditions for your plan for 1997.

After the certificate is signed, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that the brochure is correct. **You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure. You will be held accountable for any errors in the final printed brochure.** After printing the brochure, please send 25 copies to your OPM contract specialist.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will be required to reprint and redistribute corrected brochures at your expense. In addition, you will be required to notify all enrollees of the error and of the correct available benefit, and to absorb the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing

corrected brochure language, rather than reprinting the brochure. Your OPM Contracting Officer will advise you what corrective action will be required. It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure the accuracy of your brochures.

B. Rates - We will provide you with a rate sheet similar to the one we provided last year. You will need to insert copies in the brochures you send to your members and to all distribution points, including the annuitant shipping point in Iowa. The rate sheet will be available when rates are released, after the enrollee and Government shares have been calculated, after September 8. Paper specifications will be forwarded with the printing specifications for your brochure.

C. Reimbursement of Printing Costs - As in previous years, we will reimburse you for costs associated with printing the quantity of brochures that we authorize the plan to print. We will not reimburse the costs of printing other open season materials such as preferred provider lists or pamphlets, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Plans that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our new brochure production process provides. However, plans that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect participating FEHB plans to devote the resources necessary to assume responsibility throughout the brochure production process for the accuracy and content of their brochures.

Penalties will be assessed for errors based on the significance of the error. Plans will also be required to take appropriate corrective action (at plan expense) to assure that FEHB members receive the correct information. Penalties and the cost of corrective action are not chargeable to the FEHB Program. Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than \$500, but if more, not more than 50 percent of your brochure printing allowance.

The cost of reprinting and redistribution of corrected brochures, addendum sheets, or other corrective action will not be reimbursed or chargeable to the FEHB contract. In addition, failure to efficiently produce accurate FEHB brochures will be taken into consideration in determining your service charge.

E. Penalties for Late Brochure Distribution - in the past we've experienced problems with plans failing to ship requested brochure quantities to OPM's delivery point in Iowa City in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures were delivered on time. **If your Plan does not ship timely, you may be subject to the penalties in Item D above against your brochure printing allowance** (The penalty will be increased

as warranted by the delay.). In addition, your failure to ship timely will be taken into consideration in determining your service charge. To avoid such actions, please make timely shipping to Iowa City and Federal agencies a priority when you distribute Plan brochures this Fall.

Be conscientious and avoid these penalties!

FEHBP Letter

All Prepaid Carriers

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

FEHBP Letter No. 96-08B

Date March 4, 1996

Subject: Annual Call Letter for the 1997 Contract Year

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1997, will be considered through May 31, 1996.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 16, 1996.

Guidance on Benefits

We are not proposing any new benefit initiatives for 1997.

Fee-for-Service Plans

As indicated above, we are not seeking any Program-wide benefit changes. Proposals for benefit improvements will be considered only to the degree that they are cost neutral.

We again encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. We also expect carriers to put in place procedures to capture discounts from bills presented, where it is cost effective to do so.

As in past years, we will not accept proposals for second options. A proposal for a Point of Service product, discussed under "Common Coverage Issues," will be considered within an existing option only and may not be rated separately.

Prepaid Plans

As indicated above, we are not seeking any Program-wide benefit changes. We will accept carrier-initiated benefit changes only to the degree that they reflect changes in the carrier's community package that we purchase. All prepaid plans must meet our minimum benefit requirements provided in the enclosures.

Proposals for service area expansions and/or new rating areas for 1997 must be summarized in your cover letter. We will not consider any new rating areas or service area expansions not proposed in your May 31 submission. Proposals for additional rating areas must also be presented in your rate submission.

Common Coverage Issues

Plans may consider proposing a Point of Service (POS) product as an alternative choice within an existing option. Several prepaid plans in the FEHB Program have provided this alternative for a number of years, and both the industry and other large employer purchasers have begun to adopt POS alternatives as a means to introduce individuals to managed care who would otherwise be reluctant to commit to this kind of delivery system. We believe this is an effective way to encourage people to try managed care with the understanding that they can still exercise the choice to go outside the network for specific services if they decide to do so. Therefore, we will entertain proposals from both fee-for-service plans and prepaid plans for a POS product.

Fee-for-service plans may offer a POS product, and it may be offered on a pilot basis within a limited geographic area. Although plans may propose a POS product that requires a positive enrollee election, a rate differential for those electing the POS product would not be acceptable. Plans should specify network arrangements, including gatekeeper provisions, and benefit differentials for in and out of network services. In-network POS benefits may be more comprehensive than the standard benefit package, except for dental and vision care. Favorable consideration will be based on factors such as demonstrated experience with POS products by the sponsoring organization or network manager; presentation of an administrative/operational plan that addresses issues such as enrollee and provider education, the interrelationship between the POS product and the ongoing fee-for-service product; and presentation of a plan for evaluating pilot projects and expanding the POS product if it is successful. POS savings must accrue to the FEHB Program.

We will consider proposals from prepaid plans to offer POS or Opt-Out benefits only if the plan can demonstrate experience with a private sector employer who has purchased the benefit. As in past years, we will not accept proposals for second options. A POS or Opt-Out product will be considered within an existing option only and may not be rated separately.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.

- ✓ Benefit changes and clarifications submissions must be submitted in a specific format. **This format is mandatory.** Specific instructions for submitting your proposed changes and clarifications are included in the enclosures.
- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the attached enclosure. You must include language for a "How Benefits Change in 1997" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English and explain how the change will affect the customer from the customer's point of view.

Additional benefit proposal instructions appear in the enclosure.

Send your proposals to:

(Overnight delivery)
U.S. Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 3439
Washington, DC 20415

(Regular mail)
U.S. Office of Personnel Management
Office of Insurance Programs
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

Last year, we took the major steps of computerizing the brochure text and giving carriers more responsibility for producing the actual brochures from that text. This was a major task, and we greatly appreciate the hard work that everyone put into this effort. Now that the brochure text is on file, we are concentrating on refining the process for producing the 1997 brochures. We will give you more information about the process very soon.

Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting

We are committed to the Government's policy of encouraging small, small-disadvantaged, and women-owned small business subcontracting in the performance of Federal agency contracts. Therefore, it is important for both OPM and FEHB Program carriers to look for additional ways to expand relevant subcontracting opportunities.

Last year, we conducted a survey of all participating carriers to learn more about their subcontracting activities. We also have been working actively with the Small Business Administration to determine how best to implement subcontracting initiatives that are appropriate to our Program structure and which will produce desirable results. For contract year 1997, we will implement a pilot project with the seven FEHB Program carriers that represent the greatest portion of total Program enrollment. We will be consulting separately with the selected carriers and will incorporate the pilot project into the negotiations process. For all other carriers, we will place renewed emphasis on your responsibility to look for ways to expand small, small disadvantaged, and women-owned small business subcontracting opportunities in accordance with FAR clause 52.219-8, "Utilization of Small, Small-Disadvantaged and Women-Owned Small Business Concerns."

Disclosure Policy Under The Freedom of Information Act

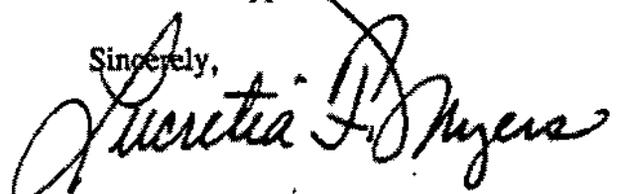
Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we intend to release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1997 Contracts

We will send 1997 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1997 contracts are expected to be signed before the 1997 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myers
Assistant Director
for Insurance Programs

Enclosure for Prepaid Plans

This enclosure provides prepaid plans with additional guidance on benefit changes and instructions on the submission of benefit and service area proposals for the upcoming contract term (January 1 through December 31, 1997). We prefer no changes in benefits for the next contract term. It is important that all prepaid plans review this entire enclosure, even if the plan does not intend to propose any changes for 1997; certain information is required of all plans, whether or not they propose changes.

There are four main parts to this enclosure:

- Part One - Guidance on Benefit Changes
- Part Two - Preparing Your Benefit Proposal
- Part Three - Changes in Service and Enrollment Areas
- Part Four - Open Season Materials and Reimbursement of Printing Costs

You will be provided with several forms currently under revision to conform to Postal Addressing Standards. Complete and return the following to OPM by May 3, 1996, along with the material described in Part Two of this enclosure:

- Designated Plan Contact
- Plan Contracting Officials
- Plan Contact for Brochures
- Plan Contact for Enrollment

Complete and return the following with your May 31 submission:

- Certificate of Program Integrity - Modification
- FEHB Guide Strip

If you have any questions about your benefits submission, please call your contract representative.

The above forms and additional materials needed to prepare your brochure and other open season documents will be sent to you by mid-April. These will include:

1. A copy of each of your plan's entries in the 1996 FEHB Guide for you to mark-up with any changes (e.g., new plan name, expanded service area, etc.) you propose for 1997. If you propose additional rating areas (i.e., enrollment codes) or to operate in new states, prepare additional entries. **Return the strip, or strips, with your May 31 submission.** We will send you a final version for a plan contracting official to certify in mid-July.
2. Revisions to mandated (i.e., non-negotiable) language and required changes for the 1997 brochure.

3. Printing specifications for the 1997 brochure and for the 1997 Rate Sheet.
4. Logo and OPM authorization block for the cover of your 1997 brochure. Your brochure quantities form, shipping labels, and related open season instructions will be sent to you in August.

Rate instructions will be sent under separate cover. It should be remembered at all times that FEHB rate submissions are the cornerstone of our financial relationship with prepaid plans. The FEHB rates and their supporting documentation are subject to audit to ensure their accuracy and reasonableness. Misrepresentation of your FEHB Program rates can result in criminal or civil legal actions against the Plan or its officials. We, with the support of the Inspector General's Office and the Justice Department, intend to aggressively pursue health plans that attempt to cheat the FEHB Program.

Part One - Guidance on Benefit Changes

In keeping with the spirit of the call letter, we remain extremely price sensitive, but do not limit prepaid plans to zero cost benefit tradeoffs. However, we do prefer that benefits remain stable. With this in mind, we offer the following guidance for the 1997 contract term:

- A. **"Opt-Out" Benefits** - We will consider proposals from prepaid plans to offer Point of Service or "Opt-Out" benefits (providing reimbursement for plan members who elect to receive non-emergency care from non-plan providers at reduced indemnity rates) under the FEHB Program only if the Plan can demonstrate experience with a private sector employer who has purchased this benefit.
- B. **Waiver of Office Visit Copayments for Prenatal and Postnatal Care** - A number of plans currently waive these copayments as a means of helping assure that pregnant members obtain adequate pre- and post-natal care, and thereby increase the likelihood that their babies will be born without complications. We encourage other prepaid plans to do the same.
- C. **Coverage for Fertility Drugs** - All prepaid plans are required to cover treatment of infertility, but many do not cover related prescription drugs. To better inform FEHB members, if they have not already done so, plans should clarify their brochure language to indicate whether fertility drugs are covered or not covered, in both their infertility benefit description and their prescription drug benefit description.
- D. **Mental Health and Substance Abuse** - Consistent with our policy in recent years, Mental Health and Substance Abuse benefits may not be decreased. All prepaid plans must offer, at a minimum, either combined Mental Health and Substance Abuse benefits of at least 30 inpatient days and 40 outpatient visits or "stand alone" benefit configurations, providing benefits for mental conditions separately from those for substance abuse, that provide total benefits at least equal to this combined benefit. Any adjustments to "stand alone" benefits to meet the minimum may not result in an overall decrease in benefits from those previously available.

Covered Mental Health/Substance Abuse inpatient days may be exchanged for outpatient day treatment or outpatient visits at the rate of one inpatient day for two outpatient treatments/visits, but the minimum benefit levels must still be available. Plans may meet the outpatient limits if they trade off inpatient days set above the 30 day inpatient minimum. Trade off rules must be shown in the brochure. Copayments may not exceed 50% of the cost of the service. Increased copayments or coinsurance may be allowed for additional outpatient visits needed to meet the 40 visit requirement, but may not exceed 50%. Any benefits that are expressed in terms of a

specific dollar figure must be accompanied by documentation (updated each year) demonstrating that the dollar cap is sufficient to cover 50% of the cost of the covered days/visits. Lifetime benefit maximums for treatment of mental conditions are not permitted.

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

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

To the extent permitted by applicable State law, other transplants not mandated by OPM may be excluded from the FEHB benefits if they are not in the community benefit package which we purchase.

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

- H. **Prescription Drugs** - All plans must provide at least a minimum level of coverage for all medically necessary drugs that require a prescription for their use, and insulin. Drug benefit deductibles may not exceed \$600 and member coinsurance may not exceed 50%. Lifetime or annual benefit maximums on prescription drugs are not permitted.

Coverage must be provided for disposable needles and syringes to administer covered injectables, IV fluids and medications for home use, growth hormones, and allergy serum. In addition, benefits must be provided for "off-label" use of covered medication if prescribed for such use by a Plan doctor.

A drug formulary may be used as long as the plan provides benefits for non-formulary drugs when prescribed by a Plan doctor. The formulary cannot be used as a means to exclude benefits for the types of drugs mandated for the FEHB. Blanket exclusions of broad categories of drugs such as "non-generics," "psychotropic drugs," or "injectables" are not acceptable.

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

- ✓ Nonexperimental bone marrow, cornea, kidney, and liver transplants (see F. above for other FEHB requirements in this area);
- ✓ Short-term rehabilitative therapy (physical, speech, and occupational) the provision of which can be expected to result in significant improvement in the patient's condition within two months;
- ✓ Family planning services, including all necessary nonexperimental infertility services, to include artificial insemination with either the husband's or donor sperm. The cost of donor sperm need not be covered. Other costs of conception by artificial means or assisted reproductive technology (such as in vitro fertilization or embryo transplants) may be excluded to the extent permitted by applicable State law.
- ✓ Home health services;
- ✓ Inhospital administration of blood and blood products (including "blood processing");
- ✓ Surgical treatment of morbid obesity, when medically necessary;
- ✓ Implants - the procedure must be covered, although the cost of the device may be excluded;

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

J. **Separate Service and Enrollment Areas** - You may propose a separate enrollment area for Federal members that is equivalent to the enrollment area offered to your commercial, non-Federal members. In addition, if the State(s) where you have legal authority to operate permit you to enroll members who work (rather than live) within

your commercial service/enrollment areas, you may propose an equivalent enrollment policy with respect to FEHB Program enrollees. Since benefits may be restricted for care received outside the service area (the area in which plan providers of medical services are generally located), your proposal must also include brochure language to clearly describe each area separately. Your brochure will be the primary source of information available to Federal employees, and must therefore accurately describe your proposed enrollment area policy. See Part Three for instructions concerning proposed expansion or reduction of your current service area.

Part Two - Preparing Your Benefit Proposal

Because we must conclude negotiations in a few weeks, we expect every prepaid plan to prepare and submit a complete proposal in accordance with these instructions by May 31, 1996.

Your actual benefit proposal will consist of several parts:

- Benefit package documentation;
- Comparison of 1996 community package (adjusted for special FEHBP benefits) and the 1997 proposed community package;
- Narrative description of each proposed change (in worksheet format);
- Narrative description of each proposed clarification (in worksheet format); and,
- Proposed 1997 brochure language

If you foresee unusual or extensive changes to your community package, please discuss them with your OPM contract representative before you prepare your submission. **If you are not proposing any benefit changes for 1997, provide a statement to that effect in your May 31 response.**

As a reminder, in calculating your rate, you should adjust your community rate for the package you propose to reflect the additional cost - or savings - of increased, reduced, or excluded benefits resulting from OPM benefit requirements that are specific to the FEHB group, such as improved mental conditions benefits. If there is no change to the rate because of such requirements, each benefit difference should be identified nonetheless, by a zero on Attachment 2 (line 2) of your rate calculation.

1997 FEHB Proposal Instructions

A. Provide the following material by May 3, 1996:

1. Experience-rated Plans - Provide a copy of a fully executed employer group contract evidencing the highest level of coverage offered for 1996.
2. Community-rated Plans - Provide a fully executed copy of the community benefits package (aka master group contract or subscriber certificate) that describes the community benefits package, and riders, purchased by the greatest number of the plan's non-Federal subscribers in 1996. If the community benefits package we currently purchase is not the same one, please also send us a copy of the package we do purchase.

B. Provide the following by May 31, 1996, to document your proposal:

1. Experience-rated Plans - It is OPM's intention to continue to purchase the highest level of coverage offered to employer groups by your Plan (or current FEHB benefits, whichever is higher). If you have not made changes to the highest level of coverage submitted in response to A(1) above, then submit a statement to this effect, along with an additional copy of the benefit description. If you have made changes, submit a copy of the new benefit description and answer the questions in Section C below. This benefit package and the associated rate must have been filed with your State if a filing is required by the State.

2. Community-rated Plans - It is OPM's intention to purchase the same community benefit package that covers the majority of your plan's subscribers/contract holders, with adjustments for any benefit differences resulting from specific requirements of the FEHB Program. If you offer a variety of community packages, you must propose the core package of benefits purchased by a majority (or the largest number) of plan subscribers or contract holders (not members or employer groups.) Also note that if we later determine that the community benefits package you submit is not the community benefits package purchased on behalf of the majority, your 1997 FEHB rates will be subject to adjustment in accordance with the Federal Employees Health Benefits Acquisition Regulations (FEHBAR).

Descriptions of community-based riders and other additions to the basic package that reflect previously agreed-upon modifications or mandated additions to the community package, must be appended. Riders (optional benefits not sold to all plan groups) that are incorporated in the community package must be identified. This material must evidence all benefit changes proposed for the FEHB Program for the 1997 contract term except those still under review by your State as described in Item D below.

C. To simplify our comparison of your 1997 community benefits package proposal and the benefits package currently purchased for the 1996 contract term, please attach a chart displaying the following information:

1. Benefits that are covered in one package but not the other;
2. Differences in copays, coinsurance, numbers of days of coverage and other levels of coverage between one package and the other;
3. Whether the costs of the differences at (1) and (2) are included within or are in addition to the community rate charged to the other groups that purchase this community benefits package, and to the FEHB Program;
4. The number of subscribers/contract holders who currently purchase each package.

- D. Describe the procedure in your State for filing and/or obtaining approval of community benefit packages and changes. If filing and/or approval is required, provide a copy of the plan's most recent submission applicable to the community benefits package you submit in response to B(2) and provide a copy of the approval issued by the State. Please highlight and address any State mandated benefits that have not been specifically addressed in previous negotiations with OPM. Please note that we will accept proposed benefit changes only if: (1) the changes were submitted to your State prior to May 31 and (2) approval is obtained and documentation of the approval is submitted to OPM by June 30, 1996. If State approval is granted by default, i.e., the State does not object to proposed changes within a certain period after receipt of the proposal, please so note; the review period must have elapsed without objection by June 30.

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

- E. You must provide a narrative description of each proposed benefit change and clarification in your proposal. Answer the following questions in worksheet format for each proposed benefit change or clarification. Use a separate page for each change or clarification you propose. Incorrectly formatted submissions will be returned to you for correction. The following format is required:

Benefit Changes

1. Describe the existing benefit and how you propose to change it. State the proposed brochure language, including the "How the Plan Changes" section. Be sure to show the complete range of the change. For instance, if the Plan is proposing elimination of its hospitalization copay, indicate whether this change will apply to hospitalizations under the emergency and mental health benefits. If there is more than one change to the same benefit, present each change on a separate worksheet.
2. Describe the rationale or reasoning for the proposed benefit change.
3. State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If an increase, describe whether any other benefit is offset by your proposal.
4. State whether this change is part of the plan's proposed community benefits package (see Item B.2.) or a change that has been submitted to the State for approval. State how the change will be introduced to other employers (e.g., group renewal date). State what percentage of Plan contract holders/subscribers now have this benefit and the percentage you project will be covered by January 1997.

5. Has the change been submitted to and approved by the appropriate State authorities? If so, when? Supporting documentation must be submitted (see Item D above).
6. If not part of the proposed community benefits package, is the change a rider? If yes,
- a. Is it a community rider (offered to all employer groups at the same rate)?
 - b. State the percentage of the Plan's subscribers/contract holders who purchase this now and the percentage you project will be covered by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to be covered by this rider and when will that occur?
 - c. Include the cost impact of this rider as a biweekly amount for Self Only and Self and Family on Attachment 2 of your rate calculation. If there is no cost impact or if the rider involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, respectively, on Attachment 2 to your rate calculation.
6. Will the change require new providers (e.g., dental, vision)? Furnish an updated provider directory that includes these new providers.

Benefit Clarifications

1. Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification, including the "How the Plan Changes" section. Prepare a separate worksheet for each proposed clarification.
2. Describe the rationale and need for the language change.

Please note that we consider a benefit change to be an increase or reduction, however slight, in the level of coverage of a benefit shown in the plan's current FEHB brochure, e.g., changing the number of days for a prescription drug supply from 31 to 30 days. Clarifications, on the other hand, comprise changes in wording which do not affect the level of benefits provided. A proposed change that results in an increase or decrease in benefits must be shown as a benefit change, even if there is no change in rates.

Part Three - Changes in Service/Enrollment Areas or Redesignation as a Mixed Model Plan

We expect that your plan's present service area and the individual doctors or medical groups with whom you contract to offer services to the FEHB will remain available to our members for the 1997 contract term. You must inform us of any expected changes. See Part One if you are proposing separate service and enrollment areas for 1997.

Service/Enrollment Area Reductions - Explain the reason for and provide supporting documentation (e.g., withdrawal notice from medical group) regarding any proposed reduction to the plan's service/enrollment area. Does this reduction apply only to the Federal group? Describe precisely, and provide a map of, the area to be eliminated.

Service/Enrollment Area Expansions - The Plan must propose any service/enrollment area expansion by May 31. We will grant an extension for submitting to OPM any supporting documentation described below, including all necessary State authorizations, until no later than June 30. We cannot extend further because of printing deadlines we must meet in order to include approved expansions in the FEHB Guide.

Redesignation as a Mixed Model Plan - If your Plan formerly operated as a Group Practice Plan (GPP) or Individual Practice Plan (IPP) and now offers both types of providers, redesignation as a Mixed Model Plan (MMP) may be appropriate. You must request redesignation and describe the delivery system that has been added.

Please note: We require that you certify that the information you provide us concerning your delivery system is based on providers with whom you have executed contracts; letters of intent are not acceptable in lieu of executed contracts. We also require that you certify that all contracts with providers contain a "hold harmless" clause. Use the certification form at III-5.

Important Notice: If your Plan has an enrollment area reduction or a new rating area is established that requires current Plan members to change enrollment codes, new codes will be assigned and there will be a total positive re-enrollment of all of the Plan's FEHB members during the 1996 Open Season.

OPM will evaluate your proposal in accordance with these criteria: legal authority to operate, adequate access to plan doctors and hospitals, and plan ability to provide contracted benefits. Accordingly, please provide the following information:

Instructions

A. Provide a description of the proposed expansion:

1. Describe the proposed service area expansion by zip code, county, city or town. Please note that in general, FEHB service and enrollment areas must be the same (except as noted in Part One, J. of this enclosure).
2. Provide a map of the old and new service areas.
3. In addition to the access to providers within the proposed expansion you describe in C. below, be sure to describe access to care in contiguous areas within your existing service area. Show the distance in miles/minutes from the furthest point of the new service area to current locations of Plan primary care doctors and to contracting hospitals in your existing service area. (If your plan is a GPP, show the distance to a current center (not satellite) in the existing service area.)
4. Include proposed language for this expansion in your brochure language submission (see Part IV), in both the Service/Enrollment Area description and "How the Plan Changes" section.

B. Authority to operate in proposed area:

1. If the new area is not contiguous to your current service area, indicate whether or not the Plan operates in the proposed area with the same articles of incorporation, license, management, benefits and rate as in your current service area. If not, explain in detail.
2. Please provide a copy of the State approval document authorizing you to both market and provide services in the proposed expansion area, and the name and telephone number of the person at the state agency who worked on the authorization. If State approval has not been obtained, note the June 30 deadline for our receipt of this documentation.

C. Access to Providers - Please submit certified statements (signed by an authorized contracting official) of the following information concerning the availability of services in your proposed expansion, for each zip code, county, city or town, as described in your proposed service area expansion. Please note that a provider directory is not sufficient.

- 1a. The number of primary care physicians in the proposed area with whom you have executed contracts.
- 1b. The total number of primary care physicians in the proposed area.

- 2a. The number of specialists in the proposed area with whom you have executed contracts.
- 2b. The total number of specialists in the area.
- 3a. The number of hospitals in the proposed area with whom you have executed contracts. List them.
- 3b. The total number of hospitals in the area.
4. The average drive time to a primary care doctor.
5. The average drive time to a specialist.
6. The average drive time to a hospital.
7. The approximate size of the proposed area at its longest (north to south) and widest (east to west) points.
8. Description of the general area (e.g., rural vs. urban, population, geographic boundaries to access, etc.).
9. Description of other services and their locations (e.g., pharmacies, DME, etc.).

D. Redesignation as a Mixed Model Plan - This section applies only if your Plan formerly operated as a GPP or IPP and now offers both types of providers, and you are requesting redesignation as a Mixed Model Plan. Please indicate the provider system being added.

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

Include clear brochure language in your brochure ("How the Plan Changes" section plus "Information About This Plan", if appropriate) to reflect the proposed changes.

Remember, if the proposal is approved, you will need to provide the following information:

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

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

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

Federal Employees Health Benefits Program
Service Area Expansion Certification

I hereby certify that the attached service area expansion proposal has been prepared in accordance with the requirements found in Part III, Changes in Service/Enrollment Areas, located in the FEHBP Letter 96-08B. Specifically,

1. All provider contracts have hold harmless provisions in them.
2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.
3. All of the information provided in response to Part III, Paragraph C (Access to Providers) is accurate as of the date of this certification.

Signature of Plan Contracting Official

Title

Plan Name

Date

Part Four- Open Season Material & Reimbursement of Printing Costs

A. Your FEHB Brochure - As in past years, we expect you to typeset and print your brochures for the FEHB Program. The brochure production schedule and the distribution deadlines that must be met remain unchanged. Last year, we automated the process and no longer exchange typeset brochure proofs. Carriers will again bear full responsibility for the accuracy and timeliness of their FEHB brochures, and will be held accountable for any brochure errors.

The Office of Insurance Programs will again this year concentrate our attention on the benefit proposals, obtaining agreement with the Plans on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Plans will have sole responsibility for preparing the camera ready proof and printing the brochure.

As was indicated in the call letter, we are refining the process for producing the 1997 brochure. We will advise plans about any revisions to the mandatory language that must appear in all FEHB brochures (such as the Disputed Claims page, Inspector General, Advisory on Fraud section, etc.). Additional information about the refined process will be forthcoming.

Once the benefit negotiation process is complete, we will provide you with a disk containing the language that is to be printed in your 1997 brochure, along with two paper copies of the information. The paper copies will be accompanied by a certification (2 copies) that indicates that the attached document reflects our agreement and is to be the language used in the brochure. The certification will be signed by OPM and by an authorized contracting official for your plan, and will be inserted in your 1997 contract as the contractual statement of benefits and related conditions for your plan for 1997.

After the certificate is signed, you are free to proceed with the layout and printing of your brochures. You may print the brochure when you are confident that the brochure is correct. You are responsible for assuring that the brochure is accurately typeset and conforms to the agreements reached on benefits and the instructions for printing the brochure. You will be held accountable for any errors in the final printed brochure. After printing the brochure, please send 25 copies to your OPM contract specialist.

If we discover unauthorized material changes to benefits or language in your printed brochure, you will be required to reprint and redistribute corrected brochures at your expense. In addition, you will be required to notify all enrollees of the error and of the correct available benefit, and to absorb the penalties described below. It may be possible to correct some less serious errors through printing and distributing addendum sheets containing corrected brochure language, rather than reprinting the brochure. Your OPM Contracting

Officer will advise you what corrective action will be required. It is in the best interests of you, your FEHB members, and the FEHB Program to produce accurate FEHB brochures. Please take appropriate steps during brochure production to assure the accuracy of your brochures.

B. Rates - We will provide you with a rate sheet similar to the one we provided last year. You will need to insert copies in the brochures you send to your members and to all distribution points, including the annuitant shipping point in Iowa. The rate sheet will be available when rates are released, after the enrollee and Government shares have been calculated, after September 8. Paper specifications will be forwarded with the printing specifications for your brochure.

C. Reimbursement of Printing Costs - As in previous years, we will reimburse community-rated plans for costs associated with printing the quantity of brochures that we authorize the plan to print. These charges to the FEHBP will be accounted for as part of the rate reconciliation process. We will not reimburse the costs of printing other open season materials such as provider lists or pamphlets, or of brochures, addenda, or other informational materials required to correct brochure printing errors.

D. Penalties for Brochure Production Errors - Plans that efficiently produce accurate FEHB brochures will benefit from the additional time and increased freedom our new brochure production process provides. However, plans that are unable to produce accurate brochure proofs will face additional work as printing deadlines approach. We expect participating FEHB plans to devote the resources necessary to assume responsibility throughout the brochure production process for the accuracy and content of their brochures.

Penalties will be assessed for errors based on the significance of the error. Plans will also be required to take appropriate corrective action (at plan expense) to assure that FEHB members receive the correct information. Penalties and the cost of corrective action are not chargeable to the FEHB Program. Possible penalties (in addition to appropriate corrective action) would be a disallowance of not less than \$500, but if more, not more than 50 percent of your brochure printing allowance.

The cost of reprinting and distribution of corrected brochures, addendum sheets, or other required corrective action will not be reimbursed or chargeable to the FEHB contract. In addition, if your plan is experience-rated, failure to efficiently produce accurate FEHB brochures will be taken into consideration in determining your service charge.

E. Penalties for Late Brochure Distribution - In the past we've experienced problems with plans failing to ship requested brochure quantities to OPM's delivery point in Iowa City in a timely manner and, less frequently, to Federal agencies. Most FEHB brochures were delivered on time. If your Plan does not ship timely, you may be subject to the penalties cited in Item D above (The penalty will be increased as warranted by the delay.). If your plan is community-rated, the penalty will be deducted as a part of the rate reconciliation. In

addition, if your plan is experience-rated, your failure to ship timely will be taken into consideration in determining your service charge. To avoid such actions, please make timely shipping to Iowa City and Federal agencies a priority when you distribute Plan brochures this Fall.

Be conscientious and avoid these penalties!

Many FEHB plans are affiliated with other FEHB plans, or members of a group of several subsidiary plans in the FEHB Program under a larger parent organization. We urge you to discuss your brochure production process with related plans in order to find ways to coordinate your efforts, increase efficiency, and eliminate duplication of effort.

Newly-approved FEHB plans producing FEHB brochures for the first time can benefit from the guidance and experience of related affiliate plans who have produced FEHB brochures previously.

**Attachment F: Federal Employees Health Benefits—Women & Family
Health Initiatives in Annual Call Letter Guidance**

6. FEHBP Call Letter 1995

FEHBP Letter
All Carriers

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

FEHBP Letter No. 95-7

Date March 13, 1995

SUBJECT: Annual Call Letter for the 1996 Contract Year

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1996, will be considered through May 31, 1995. We will not consider supplemental requests for changes submitted after May 31, unless they pertain to proposed rates and based on data unavailable at the time of submission.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 15, 1995.

Guidance on Benefits

We are proposing no new benefit initiatives for 1996.

Fee-for-Service Plans

We are not seeking Program-wide benefit changes. Benefit improvements will be accepted only to the degree that they are cost neutral. Savings from managed care initiatives must accrue to the FEHB Program.

Fee-for-Service plans are encouraged to expand their existing PPO arrangements and the services provided under such arrangements. We also expect carriers to put in place procedures to capture discounts from bills presented, where cost effective to do so.

We are changing Fee-for-Service prototype language to substitute the term "Flexible Services Option" for "Large Case Management." This term more aptly describes the actual benefit, and Fee-for-Service plans are encouraged to utilize this provision to cover cost effective, medically necessary services (such as medical foods and nutrition therapy) they do not otherwise cover.

Prepaid Plans

We are not seeking Program-wide benefit changes. We will accept carrier-initiated benefit changes only to the degree that they reflect changes in the carrier's community package which we purchase. All prepaid plans must meet our minimum benefit requirements provided in the attached enclosure.

Proposals for service area expansions and/or new rating areas for 1996 must be summarized in your cover letter. We will not consider any new rating areas or service area expansions not proposed in your May 31 submission. Proposals for additional rating areas must also be presented in your rate submission.

Common Coverage Issues

We will not accept any proposals for second options.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by actuarial justification.
- ✓ We have in the past requested that your benefit changes and clarifications submissions be submitted in a specific format. This format is now mandatory. Specific instructions for submitting your proposed changes and clarifications are included in the attached enclosure.
- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Instructions for submitting your proposed brochure language are included in the attached enclosure. You must include language for a "How Benefits Change in 1996" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be clear and in plain English.

Additional benefit proposal instructions appear in the enclosure.

Send your proposals to:

(Overnight delivery)
Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 3439
Washington, DC 20415

(Regular mail)
Office of Personnel Management
Office of Insurance Programs
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

We will evaluate your benefit proposal according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Brochures

We have reengineered the process by which we produce the brochures. In the past, the Office of Insurance Programs has worked very closely with the carriers in the actual production of the brochure, including giving the "ok to print" at the end of the process. This year we will concentrate our attention on the benefit proposals, obtaining agreement with the Plans on those proposals, and perfecting language so that we clearly communicate the coverage in a manner that is easily understood by our customers. Plans will have sole responsibility for preparing the camera ready proof and printing the brochure.

We will provide plans with the 1996 mandatory language that must appear in all FEHB brochures. The information will be in an automated form, on a computer disk. Any changes from the 1995 mandatory language will be in bold for easy recognition of the changes. Plans are not permitted to modify the mandatory language.

Plans will add the exact text of their 1995 brochure to the 1996 mandatory language they receive from OPM. This information will form the platform on which the Plans will reflect their desired changes for 1996. (Plans cannot change the mandatory language provided by OPM.)

Plans will reflect their proposed benefit changes or clarifications by adding new text, proposing revised text, and flagging sections to be deleted. New text is to be added in boldface. When existing text is clarified it will appear twice. The old text, now proposed for revision will appear with underlining. The new, revised, text proposed as the replacement will appear in boldface. When Plans propose to delete text, the language to be deleted should appear in underline. In summary, all language that you propose to delete or change must be shown in underline (do not delete any existing brochure language). All new language (or changed language) that you are proposing to add for 1996 must be shown in boldface. Boldface and underlining are not to be used in your submission except as specified here.

This information will be submitted to OPM on disk. We will then revise it as necessary to reflect the result of our negotiations with you. When the benefit negotiation process is complete, we will return on disk an updated version that contains the language that is to be printed in your 1996 brochure.

We will return the disk along with two paper copies of the information. The paper copies will be accompanied by a certification (2 copies) that indicates that the attached document reflects our agreement and is to be the language used in the brochure. The certification will be signed by OPM and by an authorized contracting official for your plan, and will be inserted in your 1996 contract as the contractual statement of benefits and related conditions for your plan for 1996.

After the certificate is signed, you are free to proceed with the layout and printing of your brochures. Rates will not be included in the brochure, but as in 1995 are to be printed on a separate sheet to accompany your brochure at the time of distribution. Plans will be responsible for ensuring that the brochures conform to the agreements reached on benefits and the instructions for printing the brochure. As in the past several years, OPM will levy penalties on plans that deliver their brochures late to Iowa City.

Material errors in brochure benefit descriptions will require prompt corrective action as soon as the error is discovered, even if this occurs after the brochure is printed. It is in the best interests of FEHB carriers, FEHB enrollees, and the FEHB Program to detect and correct all such errors before the brochure is printed, and carriers will now bear sole responsibility for doing so. We appreciate past efforts and support you gave us to assure brochure accuracy and timely distribution.

Disclosure Policy Under Freedom of Information

Any information included in your proposal will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your proposal that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will base our decision on the justification for nondisclosure you submitted with your letter. If we release any information that you believe is exempt from disclosure, we will inform you before it is disclosed.

Execution of 1996 Contracts

We will send 1996 FEHB contracts to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. All 1996 contracts, and contracts and amendments for prior years, are expected to be signed before the 1996 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,

A handwritten signature in cursive script that reads "Lucretia F. Myers". The signature is written in dark ink and is positioned above the printed name.

Lucretia F. Myers
Assistant Director
for Insurance Programs

Enclosures

**Attachment F: Federal Employees Health Benefits—Women & Family
Health Initiatives in Annual Call Letter Guidance**

7. FEHBP Call Letter 1994

FEHBP Letter
All Carriers

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

FEHBP Letter No. 94-04

Date March 24, 1994

SUBJECT: Annual Call Letter for the 1995 Contract Year

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1995, will be considered through May 31, 1994. We will not consider any supplemental requests for changes submitted after May 31, except those pertaining to proposed rates and based on data not available at the time of submission.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 15, 1994.

Guidance on Benefits

In light of the President's proposal to completely reform the national health system and the ensuing debate we want to maintain the current stability of the FEHB Program. We are not encouraging major changes to the FEHB Program or to the benefit packages offered by participating FEHB plans. It is our intent that the benefits we negotiate this year will remain in place for the 1996 contract term as well, and that we will not accept any benefit changes for 1996, although rate negotiations will take place next year as usual.

This year, we hope to put our efforts into brochure improvements for ease of use and clarity. We have therefore limited our benefit initiatives to those designed to correct certain operational discrepancies noted in the past and minimize adverse selection factors where possible.

The details for OPM's benefit initiatives for the 1995 contract follow.

Fee-For-Service Plan Issues

A. COST SENSITIVITY--Containing price increases is one of the paramount issues facing the FEHB Program as well as the country. Consistent with our policy in recent years, we expect cost increases related to benefit adjustments as a result of OPM initiatives will be kept at zero or the lowest level possible. Benefit improvements initiated by the carriers, including managed care initiatives, will be accepted only to the degree that they are matched by reductions.

We continue to encourage expansion of PPO arrangements, in terms of availability of PPO providers to enrollees and coverage provided. In addition, carriers are expected to obtain the lowest price available for all goods and services, including those of non-PPO providers. All carriers must put in place procedures to capture discounts from all bills presented and/or contract with vendors to do this. You must describe these procedures in your benefit submission to us.

B. BENEFIT INITIATIVES

1. Medicare Part B Limiting Charge--The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) applies the Medicare Part B limiting charges for physicians' services to retirees enrolled in the FEHB Program who are 65 years of age and older and who do not participate in Medicare Part B. OBRA 90 amended the FEHB law effective January 1, 1992, to require fee-for-service FEHB plans to apply the Medicare Part A limitations on payments for hospital charges when FEHB benefits for the same service are provided to retired FEHB enrollees who are age 65 and older and are ineligible for Medicare. OBRA 93 applies the Part B schedule limits for physician services in the same manner, effective January 1, 1995. We will write to you separately with additional details.

2. Mental Health--Fee-for-service plans that have lifetime maximums for the treatment of mental conditions must eliminate them for 1995.

Prepaid Plan Issues

A. Opt-Out Benefits--We believe that out-of-plan Point of Service or "Opt-Out" benefits offered by prepaid plans help introduce the concept of managed care to persons who would not generally consider prepaid alternatives. Consequently, if you already offer an approved opt-out package to your non-Federal enrollees and wish to offer it under the FEHB Program as well, we will be happy to consider such a proposal.

B. Stability of Benefit Packages--As previously indicated, we anticipate allowing no benefit changes for 1996. We therefore expect all prepaid plans to maintain a stable benefit package for their Federal members. Any prepaid plan that anticipates changing its basic community package, the number of rating areas, plan type (GPP, IPP, MMP), or a merger/consolidation with another entity during this timeframe

should indicate the change in its proposal and describe it in as much detail as possible, so that its anticipated effect can be taken into account in negotiations.

C. Separate Service and Enrollment Areas--Up to now we have required Federal enrollees to live within a prepaid plan's OPM-approved service area in order to enroll in that plan. We are changing our policy in this area. For 1995, we will accept proposals from prepaid plans to set their enrollment area for Federal members equivalent to the plan's enrollment area for its commercial members. For example, if your commercial enrollment policy is to permit the enrollment of persons who either live or work in your service area, you may do the same for FEHB enrollees. Additional guidance is provided in the attached enclosure.

Common Coverage Issues

A. Immunizations for Children--All FEHB plans will provide coverage for childhood immunizations. These benefits may not be made subject to deductibles or coinsurance/copayments. Benefits for associated office visits may, however, be subject to such cost sharing.

B. Mental Health and Substance Abuse Benefits--Consistent with our policy in recent years, current levels of benefits will not be reduced. In addition, all lifetime benefit maximums for treatment of mental conditions must be eliminated. All plans must provide mental health benefits at least covering the equivalent of 50% of the cost of 30 inpatient days and 20 outpatient visits per calendar year. Inpatient days can be exchanged for outpatient day treatment at the rate of two day treatments for each inpatient day. Prepaid plans that currently have combined mental health and substance abuse benefits must offer benefits that cover 30 inpatient days and 20 outpatient visits for each category.

C. Dental Benefits--Consistent with our policy in recent years, we will not accept any increases in dental benefits for 1995 by fee-for-service plans. We will not consider new dental benefits or enhancements to current dental benefits by prepaid plans unless they are an integral part of the community package and offered at the community rate.

D. ABMT for Breast Cancer--We do not feel we can require all FEHB plans to provide coverage for high dose chemotherapy with autologous bone marrow transplant (HDC/ABMT) for the treatment of breast cancer at this time. However, in light of the ongoing controversy over this treatment modality and our desire to be responsive to the needs of our enrollees and their family members, we want to discuss the issue with all of you and reach a consensus on what to do FEHB-wide.

Please be advised that we will not hesitate to make changes in our requirements in this area once clinical evidence establishes the efficacy of this procedure. We will expect all FEHB plans to immediately comply with those requirements, including changing coverage in mid-year.

Brochures

All plans will typeset their FEHB brochures again this year. The typesetting schedule for 1995 brochures is similar to last year. We will provide you with additional instructions concerning production and distribution of brochures under separate cover. When you receive the manuscript of your 1995 Plan brochure, please typeset it as soon as possible and forward the first proof to OPM not later than May 2, 1994.

We appreciate the support we received from FEHB plans last year. Because of the efforts put forth, most brochures were distributed timely. Last year only a few plans failed to timely deliver requested brochures to NCS, our distribution center in Iowa City, Iowa.

We remind you that OPM levels a penalty on plans that are late in delivering their brochures. We will also assess additional penalties of at least \$500 for failure to comply with our required brochure production procedures, such as when a plan certifies an erroneous brochure proof, or when unauthorized alterations (intentional or unintentional) appear in production brochures. Additional guidance is provided in the attached enclosure.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Proposed benefit changes must be precisely described and supported by your best estimate of their impact on premium rates. Only changes supported by actuarial justification will be considered.
- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. Specific instructions for submitting your proposed brochure language are included in the attached enclosure. Be sure to include language for a "How Benefits Change in 1995" page, as well as language describing how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be set forth in plain English and reflect the proposal accurately and clearly.

Additional benefit proposal instructions appear in the enclosure.

Proposals submitted by overnight delivery should be sent to:

Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 3415
Washington, DC 20415

Proposals submitted by regular mail should be sent to:

Office of Personnel Management
Office of Insurance Programs
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

Your benefit proposal will be evaluated according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Disclosure Policy Under Freedom of Information

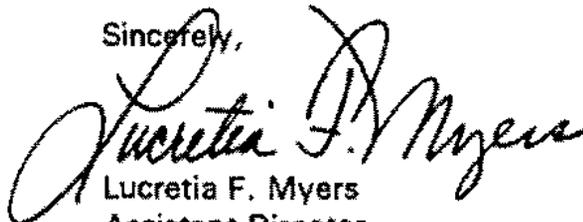
Any information included in your letter will be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your letter that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will make our decision based on your justification for nondisclosure submitted with your letter. If we decide that any item of information that you believe is exempt from disclosure is not exempt, we will so inform you before it is disclosed.

Execution of 1995 Contracts

1995 FEHB contracts will be sent to each FEHB carrier in time for the contract to be fully executed prior to the beginning of the contract year. Additional information and requirements will be sent to you shortly. 1995 contracts, and all contracts and amendments for prior years, are expected to be signed before the 1995 contract year begins. Your assistance in this effort will be appreciated.

Sincerely,



Lucretia F. Myers
Assistant Director
for Insurance Programs

Enclosures

**Attachment F: Federal Employees Health Benefits—Women & Family
Health Initiatives in Annual Call Letter Guidance**

8. FEHBP Call Letter 1993



United States
**Office of
Personnel Management**

Washington, D.C. 20415-0001

In Reply Refer To

Your Reference

CARRIER LETTER 93-16

MAR 31 1993

Dear Carrier:

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits (FEHB) Program. As in the past, this year's call letter states our goals and procedures for the upcoming negotiations.

Under 5 CFR 890.203(b), requests for the contract term beginning January 1, 1994, will be considered through May 31, 1993. We will not consider any supplemental requests for changes submitted after May 31, except those pertaining to proposed rates and based on data not available at the time of submission.

To assure a timely Open Season, we will begin negotiations upon receipt of requests for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will follow shortly. We will operate under a schedule that will ensure completion of all negotiations (benefits and rates) by August 13, 1993.

Guidance on Benefits

All FEHB members should be assured of a reasonable level of benefits. Our goal is to rationalize the benefit packages in the FEHB Program so that very small benefit differences do not influence behavior. In addition, we hope to minimize adverse selection factors and where possible improve the alignment of coverage so that consumers can make decisions based on facts without the fear that subtle benefit language will cause big surprises.

The details for OPM's benefit initiatives for the 1994 contract follow.

Guidance for Fee-For-Service Plans

A. **MANAGEMENT INITIATIVES**---Health care costs are driven by both benefit and administrative costs. Carriers must encourage good management practices wherever possible.

1. We encourage the use of paperless transactions and innovative benefit designs that would be cost effective and deliver better customer services.

2. We will allow enhanced service charges for carrier initiated cost reductions. Within the confines of the structured approach to profit, we will share savings generated by contractor proposed administrative expense reductions not previously negotiated. The savings will be formula driven with up to 10% of the documented first year savings and up to 5% of the continuing savings for up to two additional years.

3. Carriers are directed to review major vendor costs for possible reductions.

B. **COST SENSITIVITY**---Containing health care price increases is one of the paramount issues facing the FEHB Program as well as the country.

1. Cost increases related to benefit adjustments as a result of OPM initiatives will be kept at zero or the lowest level possible.

2. Benefit improvements initiated by the carriers will be accepted only to the degree that they are matched by reductions. However, since we are encouraging managed care initiatives, we will consider Plan initiated benefit improvements up to 25% of the savings resulting from new managed care initiatives. (OPM will not consider enhancements to dental benefits.)

3. Carriers are to actively establish or promote the expansion of existing PPO arrangements in terms of availability to enrollees as well as coverage provided. In addition, OPM is aware that price concessions are available from non-network providers, e.g. hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO providers. If you currently have such price concessions in place, please indicate their extent in your rate proposal.

C. **BENEFIT INITIATIVES**---OPM is not proposing, nor will we accept, any major benefit initiatives for 1994 in view of the current debate on health care reform and our desire to assure the continued stability of the FEHB Program.

1. Combine Inpatient Doctor (Surgical and Other)

Reimbursement Levels--FFS plans must equalize levels of benefits for all inpatient doctor care. Unequal benefit levels do not seem logical and may encourage surgical care.

2. Combine Outpatient Doctor Reimbursement Levels--The same rationale as indicated above for inpatient doctor care holds for the outpatient side. In view of this, all FFS plans must equalize levels of benefits for all outpatient doctor care.

3. Diagnosis and Treatment of Infertility--All FFS plans are to provide benefits for the diagnosis and treatment of infertility problems. This does not mandate coverage for ART procedures (artificial reproductive technology - such as artificial insemination, in vitro fertilization, and embryo transfer).

4. Preventive Care in FFS Plans--Over the last several years OPM has mandated certain benefits to expand the coverage of cost-effective preventive care. Within the cost restraints outlined earlier, we encourage plans to add new preventive benefits. We recommend FFS plan preventive care packages include the following:

- Well child care (visits, tests, immunizations)
- Blood lead level screening for children
- Pregnancy Risk Management Programs with incentives for participation
- Group B streptococcus infection screening of pregnant women
- Coverage of smoking cessation drugs and medications
- Cancer screening (breast, cervical, colorectal & prostate)

Guidance for Prepaid Plans

A. Transplant Benefits--All Prepaid plans will cover non-experimental liver transplants. Additionally, all Prepaid plans will provide benefits for donor expenses (medical and surgical) associated with any covered transplant, subject to coordination of benefits with any coverage the donor may have.

B. **Drug Formularies**--OPM will permit prescription drug formularies (a set list of drugs) to be used to harness the cost of drug benefits. Many Prepaid plans have evaluated value-based purchasing and have developed a formulary to maximize their findings. This has not led to buying the cheapest drugs based on wholesale cost, but on buying the best drug, looking at cost as well as other attributes (dosage, how it affects the total cost of an episode of care, and quality of life perspectives).

Prepays may propose to use the Plan formulary for filling prescriptions, but OPM will require the Plan to honor prescriptions written by Plan providers for drugs not on the formulary. (Permitting the use of a formulary does not reduce the range of drugs that OPM requires to be covered, affect drugs prescribed out-of-Plan under Emergency Care benefits, or permit annual or lifetime maximum benefits to be imposed under the FEHB.)

C. **Dental Care**--OPM will not consider new dental benefits or enhancements to current dental benefits unless the benefit is an integral part of the community package.

Common Coverage Issues

A. **Mental Health and Substance Abuse Benefits**--Current levels of benefits will not be reduced. All plans must provide mental health benefits at least covering the equivalent of 50% of the cost of 30 inpatient days and 20 outpatient visits per calendar year. Inpatient days can be exchanged for outpatient day treatment at the rate of two day treatments for each inpatient day. Prepaid plans that currently have combined mental health and substance abuse benefits must offer benefits that cover 30 inpatient days and 20 outpatient visits for each category.

B. **Extended Care**--Current levels of benefits will not be reduced. All plans must provide a minimum of 30 days extended care coverage when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. This is critical for those patients who no longer need the level of care available in a hospital, but for whom it is medically inappropriate to discharge to a home setting.

C. **Disposable Needles and Syringes**--All plans currently cover injectable prescription drugs. For 1994, all plans must also cover the needles and syringes needed to administer covered prescription drugs and medication.

D. **Home IV Therapy**--All plans must cover intravenous fluids and medications for home use. Medical technology now makes it possible for certain IV therapy to be safely performed at home (such as antibiotic and chemotherapy). Home administration is cheaper than administration at a hospital, but an expensive alternative for an enrollee in a Plan that does not cover it out of the hospital setting. Benefits will be provided when the IV therapy is part of a covered home health care program or when the fluids and medication are obtained through the prescription drug benefit.

E. **Growth Hormone Therapy**--All plans are to cover growth hormone therapy, including the cost of the growth hormones. The cost of growth hormones will be covered under the prescription drug benefit.

F. **Allergy Serum**--All plans must cover the cost of allergy serum. Benefits will be provided for allergy serum obtained through the prescription drug benefit or for the serum when it is provided by the allergist treating the member.

Brochures

All plans will typeset their FEHB brochures again this year. We have accelerated the typesetting schedule for 1994 brochures. We have enclosed the manuscript of your 1994 Plan brochure. Please typeset it as soon as possible and forward the first proof to OPM not later than May 1, 1993. We have also enclosed a copy of the 1994 Brochure Production Schedule.

We appreciate the support we received from FEHB plans last year. Because of the efforts put forth, most brochures were distributed timely. Last year only a few plans failed to timely deliver requested brochures to NCS (our distribution center in Iowa City, Iowa). We remind you that OPM levels a penalty on plans that are late in delivering their brochures.

Non-FEHB Benefit Offerings

We encourage plans to take advantage of the opportunity to offer benefits not available through your FEHB plan, but that meet the needs of certain individuals at preferred rates. Prepaid plans that offer enrollment to Medicare recipients through a Medicare risk contract should add information to the Non-FEHB Benefit section in their Plan brochure to let current FEHB members know that they can enroll through Medicare and drop their FEHB coverage until a later time.

Submission of Proposals

- ✓ Requests for benefit changes and clarifications must be in writing and signed by an authorized contracting official of your Plan.
- ✓ Benefit changes must be precisely described and supported by your best estimate of their impact on premium rates. Only changes supported by actuarial justification will be considered.
- ✓ Proposed brochure language must be submitted with your request for benefit changes and clarifications. A copy of the first proof of the Plan's 1994 FEHB brochure must be marked-up to reflect the Plan's proposal. Be sure to include language for a "How Benefits Change in 1994" page, as well as language for how the proposal affects benefits, exclusions, limitations, definitions and procedures. Your proposed language should be set forth in plain English and reflect the proposal accurately and clearly.

Additional benefit proposal instructions appear in the enclosure.

Proposals submitted by overnight delivery should be sent to:

Office of Personnel Management
Office of Insurance Programs
1900 E Street, NW., Room 3415
Washington, DC 20415

Proposals submitted by regular mail should be sent to:

Office of Personnel Management
Office of Insurance Programs
P.O. Box 707
Washington, DC 20044

Evaluation of Proposed Benefit Changes

Your benefit proposal will be evaluated according to the health needs of Federal enrollees, the effectiveness of your utilization and cost controls, the economic consequences of the proposal and the efficiency of your administration of the FEHB contract.

Disclosure Policy Under Freedom of Information

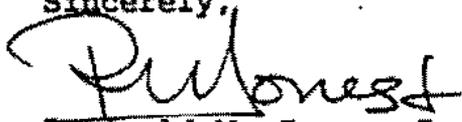
Any information included in your letter may be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your letter that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure when a request for information is made. We will make our decision based on your justification for nondisclosure submitted with your letter. If we decide that any item of information that you believe is exempt from disclosure is not exempt, we will so inform you before it is disclosed.

Execution of 1994 Contracts

All contracts for 1993 and earlier must be signed prior to the completion of this year's benefit and rate negotiations. 1994 FEHE contracts will be sent to each carrier in time for the contract to be signed by December 31, 1993. Additional information and requirements will be sent to you shortly. Your assistance in this effort will be appreciated.

Sincerely,



Reginald M. Jones, Jr.
Assistant Director for
Insurance Programs

Enclosures