FEHB Program Carrier Letter
All Carriers

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

Letter No. 2001-09 **Date:** April 10, 2001

Fee-for-service [07] Experience-rated HMO [08] Community-rated [08]

SUBJECT: Call Letter for Contract Year 2002

This letter contains our annual guidance and negotiations objectives for proposed benefit and rate changes from Federal Employees Health Benefits (FEHB) Plans. Your proposal for the contract term beginning January 1, 2002, is due by **May 31st**. While that is the regulatory deadline for your written submission, I strongly encourage you to talk soon with your contract specialist about any changes you are considering.

To assure a timely Open Season, we will begin negotiations when we receive your request for benefit and rate changes. Specific instructions concerning information required to support requests for rate changes will be sent separately. We will operate under a schedule that will ensure completion of all negotiations -- benefits and rates -- by **August 17, 2001**.

As you know, we have experienced four straight years of rate increases significantly higher than the rate of inflation. We must work together during the upcoming negotiations to keep health care in the FEHB Program affordable. The President's Budget outlines a broad approach. Among the initiatives under consideration are: options to ensure that the Program offers high quality and cost effective health plans; incentives to Federal employees and annuitants to choose their plans wisely; and coordination of annuitant health benefits with future reforms to Medicare. It is likely that each approach would require legislation, and we will keep you informed as these initiatives evolve. For 2002, we expect to fine tune in a few areas and continue to make progress in several others. Again, carrier proposed benefit changes must be cost neutral.

Before detailing our expectations for contract year 2002, I want to thank you for your continued cooperation and collaboration on all aspects of the Federal Employees Health Benefits Program. With your active involvement, we have measurably improved benefits for mental health and substance abuse. Your willingness and ability to find effective approaches at minimal cost made this achievement possible. In addition, you took important initial steps to improve patient safety by reporting on your current and future patient safety programs, and helping educate consumers about steps they can take to avoid medical errors. By participating in our pilot project to collect data on measures of clinical outcomes, you helped us explore effective ways to assess the quality of care being delivered to FEHB members. You also have been effective partners in completing our initiative to develop customer-focused Plan brochures written entirely in plain language. As we move forward to 2002, I know we will continue to work together to provide affordable, high quality healthcare.

Moving Forward

The President's Budget includes the following proposals regarding FEHB appropriations language:

- **Abortion coverage**: The President's Budget proposes to retain these provisions, consistent with Administration policy on these issues.

- **Contraceptives coverage**: The President's Budget proposes to delete this provision because it is unnecessary, and, in general, it is inappropriate to legislate benefit mandates in an appropriations bill.

We will keep you informed of any changes that result from the appropriations process as we continue to work together on the several initiatives we began last year.

Mental Health and Substance Abuse Benefits

We particularly want to thank you for the work you have done with us to successfully implement benefit increases in this area. Implementation is going smoothly. There are no new initiatives in this area for 2002. Like last year, we expect that you will keep cost sharing, day/visit limits, and catastrophic maximums for out-of-network services substantially the same while we evaluate the initiative.

As you know, we accepted a provision last year that allowed plans to limit parity benefits when patients do not substantially follow their treatment plans. Our intent was to provide an incentive for people to get the services they need. However, some stakeholder groups expressed concern that the provision could be misused to cut off critical services to people in need. Therefore, we continue to affirm our original intent that all members will receive medically necessary services in their approved treatment plans and will work with you to clarify our policy in your Plan brochure.

Most of you are involved to some degree in the evaluation of our mental health and substance abuse initiative currently underway under the joint auspices of the Department of Health and Human Services and OPM. We need your continued support of this effort so that we can learn more about the effects of the initiative on access and cost.

Improving the Quality of Healthcare by Reducing Medical Errors and Increasing Patient Safety

In response to the November 1999 Institute of Medicine (IOM) report *To Err Is Human*, and the Quality Interagency Coordination Task Force's (QuIC's) December 1999 report *Doing What Counts for Patient Safety*, we asked you in last year's call letter to do at least the following:

1. Report to us on your current patient safety initiatives;
2. Report to us on how you will strengthen your patient safety program for the future;

3. Help us provide Plan members with consumer information and education regarding patient safety; and
4. Work with your providers, independent accreditation agencies, and others to implement patient safety improvement programs.

Additionally, we encouraged you to appoint an individual or office within your organization to manage your patient safety efforts and serve as our point of contact. We also suggested that you encourage your network providers to participate in error reporting that facilitates the identification and correction of systemic problems. Finally, we encouraged you to consider patient safety strategies endorsed by others, including gathering information about institutions adopting the Leapfrog Group's hospital patient safety measures -- Computer Physician Order Entry (CPOE) Systems, Evidence-based Hospital Referral (EHR), and ICU Physician Staffing (IPS) -- and annotating your provider directories accordingly.

This year we would like you to update the information you provided from last year. If you have not done so already, please tell us where responsibility for patient safety efforts has been located in your organization. Also, we remain interested in detailed information on steps you have taken to encourage providers to address safety. Finally, we are very interested in examples of consumer and patient information you have used during the year to increase awareness.

Accreditation

Accreditation of a health plan or of a significant component of a health plan's activity demonstrates a commitment to providing quality, cost-effective health care. Accreditation sends an important message to consumers about their health and the importance of choosing a health plan that consistently delivers good care. Further, we support the efforts of accrediting organizations to add patient safety standards to their accreditation protocols. Last year, we alerted you that we would expect you to begin seeking accreditation from a nationally recognized, independent organization in 2002.

To further that effort, HMOs with 500 or more FEHB enrollees will need to provide us with an accreditation plan along with their benefits and rate submission. We would like you to develop a business plan that includes timelines for seeking an accreditation decision. As we noted in Carrier Letter 2001-04, the HEDIS measures you are already reporting on for our pilot project are used by accrediting organizations for managed care and network accreditation purposes. We see this as a useful first step as you develop your accreditation plan.

For FFS/PPO plans, you should submit with your benefit and rate submission a business plan that outlines the steps you plan to take toward achieving accreditation. We encourage you to look at provider credentialing, utilization management, and other modules now in use by the accrediting organizations as steps toward achieving accreditation. You may outline an approach that takes incremental steps on a regional basis, but we will need to see timeframes for each step in the process. Collaborative efforts such as those being undertaken by groups such as the Coalition for Affordable Quality Healthcare can expedite the process by eliminating redundancies and inefficiencies.

Other Benefit Issues

Preferred Providers. We are receiving an increasing number of complaints from members about referrals to out-of-network providers. Members who make every effort to use network providers are often surprised when they learn that they have been treated out-of-network and that their out-of-pocket costs are higher as a result. While we understand that the reasons for situations like this are varied, we encourage you to seek ways to increase the level of awareness of the issue and provide appropriate assistance to members who seek the services of network providers for their needs.

Speech Therapy. We intend for you to provide speech therapy in all situations where it is medically necessary. If you limit coverage for speech therapy to rehabilitation only, please remove that limit. Consistent with this guidance, you may limit the benefit in other ways, such as through visit or dollar limits.

Medicare Coordination of Benefits. Proper coordination of benefits with Medicare is an important responsibility of employers and health plans. When performed effectively, coordination helps to control health care expenditures and ensures accountability throughout the health care system. Coordination with Medicare is an important part of your contract requirements. We are aware that some plans are paying primary when they should be paying secondary. Similarly, other plans are paying secondary when they should be paying primary. We are working closely with the Health Care Financing Administration (HCFA) to develop better guidance regarding coordination of benefits between Medicare and FEHB, and will provide you with this information in a future carrier letter.

As you know, FEHB Program enrollees 65 and older fall into three categories: 1) Not covered by Medicare; 2) Medicare is secondary to the FEHB Program; and 3) Medicare is primary to the FEHB Program. Coordination of benefits for each group must be done correctly. The primary/secondary payer relationships are detailed in your FEHB brochure; briefly,

- **Not Covered by Medicare**. Many FEHB Program enrollees age 65 and older are not covered by Medicare. These enrollees are full FEHB Program enrollees and are entitled to the full benefit package.

- **Medicare is Secondary**. Generally, FEHB Program members in this category are working for the Federal government. It is important that your plan cover these members as primary and bill Medicare only as the secondary payer.

- **Medicare is Primary**. Generally, FEHB Program members in this category are annuitants. Fee-for-Service plans usually process these claims under “crossover” arrangements with Medicare carriers and intermediaries. This arrangement is economical to the Program and provides a seamless coordination to the member. HMO plans are required to provide their complete set of services to their Medicare members and then bill Medicare for its share of covered services. In order to keep our premiums as low as possible, all plans and especially HMOs need to review their Medicare billing practices to ensure correct administration of these provisions.

Your response to the Call Letter should address your current service and billing practices regarding your age 65 and older members. Please indicate any steps you plan to take to improve your service to these members and to improve coordination of benefits with Medicare.

Alternative Benefits and Durable Medical Equipment. Increasingly, effective delivery of health care is embracing an expanding array of alternative services and products. Where there is demonstrated medical effectiveness, and consistent with your overall strategy for benefit design, we encourage you to consider services such as chiropractic, acupuncture, biofeedback and others that are being used increasingly for pain management and as alternative treatments.

Also, there have been significant advances in health-related assistive technologies. While devices such as orthotics and prosthetics have traditionally been covered as durable medical equipment, newer devices often include mobility and other capabilities that offer great promise to persons with chronic illnesses and disabilities. We encourage you to periodically review your benefit structure for durable medical equipment to ensure it remains contemporary and takes appropriate notice of the availability and effectiveness of new products as they become available.

Smoking Cessation. Because of its widespread health effects, smoking is the leading preventable cause of death in the United States. We encourage plans to provide benefits for smoking cessation that follow the Public Health Service's treatment guidelines. Consistent with these guidelines, primary care visits for tobacco cessation should be covered with the standard office visit co-payment. Individual or group counseling for tobacco cessation should be covered with no co-payment. Prescriptions for all Food and Drug Administration-approved medications for treatment of tobacco use should be covered with the usual pharmacy co-payments. Further information about the Public Health Service's treatment guidelines may be found at http://www.surgeongeneral.gov/tobacco/.

Pharmaceuticals. We remain committed to managing the escalating costs of prescription drug benefits. All of us need to examine and implement ways to control costs and utilization effectively, and we will work with you to that end. As we noted last year, the emphasis should be on benefit structures that encourage sound decision-making rather than simply shifting costs to members.

Other Issues

Effective Date for Enrollment Changes. As we told you last year, effective January 1, 2002, we will establish January 1 as the standard effective date for all open season changes.

Enrollment Code Data Field. As we have discussed in the past two call letters, we will be expanding from a 3-digit enrollment code to one that has 10-digits eventually. While we have no immediate implementation plans, you should incorporate this change as you plan any systems modifications. At a future date, we will convene a working group with Plan and Federal agency representatives to develop system requirements and file formats.

Conclusion

Like last year, we will send information on submission requirements for your benefit and rate proposals by mid April. We will send information on how to prepare your brochure by the beginning of May. Finally, as noted in the beginning of this letter, we remain committed to providing FEHB members with affordable, quality health care. We will accept carrier-proposed benefit improvements 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, please review the effect of any proposed benefit changes on language throughout your brochure (e.g., cost sharing, catastrophic protection and lifetime maximums). We prefer that you limit benefit enhancements to areas addressed in this letter, but will consider all that you propose.

We look forward to receiving your rate and benefit proposals. Again, please discuss any changes you are considering with your contract specialist as soon as possible.

Sincerely,

Abby L. Block
Assistant Director
for Insurance Programs