# FEHB Program Carrier Letter
## Health Maintenance Organizations

**U.S. Office of Personnel Management**
**Healthcare and Insurance**

**Letter No. 2012-12(a)** **Date: April 19, 2012**

Fee-for-service [n/a] Experience-rated HMO [11] Community-rated HMO [11]

**Subject: 2013 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals**

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2013 through December 31, 2013. Please refer to our annual Call Letter (Carrier Letter 2012- 09) dated March 29, 2012 for policy guidance. Benefit policies from prior years remain in effect unless otherwise noted. The Guidance and instructions are in three parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Preparing Service Area Changes
- Part Three: Benefits for HMOs

This year's deadlines are as follows:

- **No later than May 11, 2012:** Please send your community benefit package and non-Federal group benefit package we purchased.
- **No later than May 31, 2012:** Please send your complete proposal for benefit changes and clarifications to your contract specialist on a CD-ROM (or other electronic means) in addition to a hard copy. Your proposal should include corresponding language describing all proposed brochure changes. Your OPM contract specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.
- **Within five business days following receipt of close-out letter or by date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2013 brochure. See Attachment VII-Preparing Your 2013 Brochure.

Carriers are strongly encouraged, as always, to follow our guiding principles of affordability and value based benefit design when preparing proposals. This year you will see an increased focus on quantitative data which we need to measure each plan's overall performance. For some items, we ask for historical data to establish a baseline for performance reviews. In addition, we appreciate your continued timely efforts to submit benefit and rate proposals and to produce and distribute brochures.

Enclosed is a checklist (Attachment XVI) showing all the information to include with your benefit and rate proposals. Please return a completed checklist with your submission.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

# 2013 FEHB Proposal Instructions

## Part One - Preparing Your Benefit Proposal

### Experience-rated Plans

- Submit a copy of a fully executed employer group contract (i.e., *certificate of coverage*) by May 11, 2012, that non-Federal subscribers purchased in 2012.

- **If you have not made changes to the level of coverage we already purchase,** then submit a statement to that effect. **If you have made changes,** submit a copy of the new benefit description as explained in **Benefit Changes** below. You must file your proposed benefit package and the associated rate with your state, if your state requires a filing.

### Community-rated Plans

We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions (as indicated in the *Call Letter for the 2009 contract year*). If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB consumers. You should also identify each of the differences between your current benefit package and the proposed offering, and include the impact on your community-rated price proposal.

The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.

The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there is an impact on premiums.

Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your contact in the Office of the Actuaries regarding the alternate community package and requirements for the use of Similarly Sized Subscriber Groups (SSSGs) in the rating process.

- Submit a copy of a fully executed community-benefit package by May 11, 2012 (a.k.a. master group contract or subscriber certificate), including riders, co-pays, co-insurance, and deductible amounts that your non-Federal subscribers purchased in 2012. If the community benefit package is different from the FEHB's, also send a current copy of the benefit package that we purchased. Please highlight the difference(s) between the FEHB benefits and the package you based it upon. **Note:** If you offer a "national plan" then you need to send us your community benefit package for each state that you cover.

- Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB

offering. The material must show all proposed benefit changes for FEHB for the 2013 contract term, except for those still under review by your state.

**If you have not made changes to the level of coverage we already purchase,** then submit a statement to that effect. **If you have made changes,** submit a copy of the new benefits description. If your state requires you to file this documentation, file the benefit package and the associated rate with the state first. We will accept the community-benefit package you project will be sold to the majority of your non-Federal subscribers in 2013.

**Note:** Your FEHB rate must be consistent with the community-benefit package it is based on. Benefit differences must be accounted for in your rate proposal or you may end up with a defective community rate.

**All HMOs**

1. Complete Attachment II Benefit Change Worksheet that compares your proposed 2013 benefit package and the 2012 benefit package that we purchased. Include on your chart:

   A. Differences in co-pays, co-insurance, numbers of coverage days, and coverage levels in the two packages.

   B. For community-rated plans only, indicate whether you include the costs of the differences within your community-rate or in addition to the community-rate you charge to the other groups that purchase this benefit package, and to the FEHB Program; and the number of subscribers/contract holders who purchased the 2012 package and who are expected to purchase the 2013 package.

   C. Describe your state's filing process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to May 31, 2012, and you obtain approval and submit approval documentation to us by June 30, 2012. If the state grants approval by default, i.e., it does not object to proposed changes within a certain period after it receives the proposal, please so note. The review period must have elapsed without objection by June 30, 2012.

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

3. Please highlight and address any state-mandated benefits that you have not specifically addressed in previous negotiations. State-mandated benefits should be reported if finalized by May 1, 2012, or if they were not specifically addressed in previous negotiations.

Please send the following material by **May 31, 2012**:

Your benefit proposal must be complete. The timeframes for concluding benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

- A signed contracting official's form (Attachment I)
- A comparison of your 2012 benefit package (adjusted for FEHB benefits) and your 2013 benefit package (see #1 above)
- Benefit package documentation (see **Benefit Changes** below)
- A plain language description of each proposed **change** (Attachment II) and the revised language for your 2013 brochure
- A plain language description of each proposed **clarification** (Attachment III) and the revised language for your 2013 brochure

If you anticipate significant changes to your 2013 benefit package, please discuss them with your OPM Contract Specialist before you prepare your submission.

## Benefit Changes

Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II as a template for submitting benefit changes. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if there is no rate change. Also, please answer the following questions in worksheet format for **each** proposed benefit change. Indicate if a particular question does not apply and use a separate page for **each** change you propose. We will return any incorrectly formatted submissions.

### Information Required for Proposal:

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2012" section in "plain language" that is, in the active voice and from the member's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital co-pay, indicate whether this change will also apply to in-patient hospitalizations under the emergency benefit. **If there are two or more changes to the same benefit, please show each change clearly.**
- Describe the reason(s) for the proposed benefit change. Tell us whether this change is part of your proposed benefit package or if the change is one you submitted to the state for approval (include documentation). State how you will introduce the change to other employers (e.g., group renewal date). State the percentage of your contract holders/subscribers that now have this benefit and the percentage you project will have it by January 2013.

- State the actuarial value of the change and whether it represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If it is an increase, describe whether any other benefit offsets your proposal.

- If the change is not part of the proposed benefit package, is the change a rider? If yes,

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

- State the percentage of your subscribers/contract holders who now purchase this rider and the percentage you project it will cover by next January 1. What is the maximum percentage of all your subscribers/contract holders you expect to cover by this rider and when will that occur?

- Include the cost impact of this rider as a bi-weekly amount for Self Only and Self and Family on Attachment II 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 II to your rate calculation.

- If the change requires new providers, furnish an attachment that identifies the new providers.

**Benefit Clarifications**

**Clarifications are not benefit changes.** Please use Attachment III as a template for submitting clarifications**.** Clarifications help members understand how a benefit is covered**.**

Information Required for Proposal:

- Show the current and proposed language for each proposed clarification and reference all portions of the brochure it affects. **Prepare a separate worksheet for each proposed clarification**. You may combine more than one clarification to the same benefit, but you must present each one clearly on the worksheet. Remember to use plain language.

- Explain the reason for the proposed clarification.

# Part Two – Preparing Service Area Changes

Unless you inform us of changes, we expect your current FEHB service area and provider network to be available for the 2013 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed-care industry, there are geographic areas where our customers have more limited choices than in other areas.

Please consider expanding your FEHB service area to all areas in which you have authority to operate. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose**.

We will provide detailed instructions for submitting your ZIP Code files in September. However, please note that we will ask you to provide your ZIP Codes in a comma delimited text file format and we will provide instructions for uploading your files to our secure web portal.

- **Service Area Expansion** - You must propose any service area expansion by May 31, 2012. We may grant an extension for submitting supporting documentation to us until June 30, 2012.

- **Service Area Reduction** - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain.

## Important Notices

- The information you provide about your delivery system must be based on executed contracts. We will not accept letters of intent.

- All provider contracts must have "hold harmless" clauses.

- We will assign new codes as necessary. In some cases, rating area or service area changes require a re-enrollment by your FEHB members. We will advise you if this is necessary.

## Service Area Expansion Criteria

We will evaluate your proposal to expand your service area according to these criteria:

- Legal authority to operate

- Reasonable access to providers

- Choice of quality primary and specialty medical care throughout the service area

- Your ability to provide contracted benefits

- Your proposed service area should be geographically contiguous

You must provide the following information:

- **A description of the proposed expansion area in which you are approved to operate:**

  Provide the proposed service area expansion by ZIP Code, county, city or town (whichever applies) and provide a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure.

- **The authority to operate in proposed area:**

  Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.

- **Access to providers:**

  Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have **executed** contracts. You must update this information by August 31, 2012. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of your initial submission.

**Service Area Reduction Criteria**

We will evaluate your proposal to reduce your service area or enrollment area according to the following criteria:

- We will accept the elimination of the corresponding service area, if you propose to eliminate an entire enrollment area
- Service area reductions should be associated with the following:

  - Significant loss of provider network
  - Poor market growth
  - Reduction applies to other employer groups
  - Reduction may apply to consolidation of two or more rating areas, or splitting rating areas

You must provide the following information:

- **A description of the proposed reduced service and enrollment area:**

  Provide the proposed service area reduction by zip code, county, city or town (whichever applies) and provide a map of the old and new services areas. Provide the exact wording of how you will describe the service area change in the brochure.

- **All state approvals that apply or associated with the revised service area.**

We will not accept service area proposals that result in service areas that are not contiguous or consistent with the residency of the federal population or proposals that seek to provide services only to lower cost enrollees.

## Federal Employees Health Benefits Program statement about Service Area Expansion

## (COMPLETE THIS FORM ONLY IF YOU ARE PROPOSING A SERVICE AREA EXPANSION)

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2013 Benefits and Service Area Proposals. Specifically,

1. All provider contracts include "hold harmless" provisions.

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 is accurate as of the date of this statement.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

# Part Three – Benefits for HMOs

**The policies established in prior years remain in effect unless we have stated otherwise**. You should work closely with your contract specialist to develop a complete benefit package for 2013. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to *Call Letter* (Carrier Letter 2008-06) dated March 11, 2008. The FEHB policies include the following:

We expect that you cover state-mandated benefits even if your community package does not specifically reference them.

As stated in the 2013 Call Letter, our three primary initiatives this year are:

- Implementing additional requirements under the Affordable Care Act;
- Improving the delivery and cost efficiency of prescription drugs; and
- Advancing quality of care principles.

## I. CALL LETTER INITIATIVES

### A. Implementing the Affordable Care Act

#### 1. Lifetime and Annual Limits on Essential Health Benefits

FEHB plans have historically not imposed lifetime limits and we will continue to enforce this requirement.

In addition, FEHB plans are expected to eliminate annual limits on essential health benefits (EHB), regardless of grandfathered plan status.

On December 16, 2011, the Department of Health and Human Services (HHS) released a Bulletin (http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) describing its approach to define EHB under the Affordable Care Act. On February 17, 2012, HHS issued a FAQ (http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf) to provide additional guidance on the subject.

Information Required for Proposal: Attachment IV- Lifetime and Annual Limits on Essential Health Benefits

#### 2. Clinical Trial Coverage

FEHB plans are expected to comply with certain coverage requirements for clinical trials next year, in advance of required implementation for 2014, regardless of grandfathered status. The requirements are described in detail in Attachment V.

Information Required for Proposal: Attachment V- Clinical Trial Coverage

### 3. Preventive Services

Last year, we requested FEHB plans to eliminate cost-sharing for all recommended in-network preventive services, immunizations, screenings, tobacco cessation services and medications. Please check the latest posting by the Advisory Committee on Immunization Practices (ACIP) at http://www.cdc.gov/vaccines/pubs/ACIP-list-by-date.htm for the full list of required vaccinations as some have changed. Note that, unless otherwise specified, plans must cover these requirements no later than the start of the plan year which follows the year in which the recommendation becomes effective.

Plans must submit proposals that cover preventive services, including birth control, with no cost-sharing, regardless of grandfathered status. The Affordable Care Act adds new preventive services requirements for 2013 that go beyond recommendations of the United States Preventive Services Task Force. See http://www.hrsa.gov/womensguidelines/.

Information Required for Proposal: Attachment VI- Preventive Services

### 4. 2013 Brochure

FEHB plans are required to provide a "Summary of Benefits" for 2013, in advance of required implementation for 2014, regardless of grandfathered status. To evaluate our "Going Green" goals to help reduce FEHB administrative costs, please provide your cost savings information on the worksheet provided. You will receive additional guidance in a forthcoming carrier letter.

Information Required for Proposal: Attachment VII-Preparing Your 2013 Brochure

### 5. Grandfathered Plans

You will only need to complete the certification for options that you anticipate will remain grandfathered for plan year 2013, based on benefit changes. Please read the certification carefully as it lists specific regulatory requirements that allow a plan to remain grandfathered under the Affordable Care Act.

We will confirm requested grandfather status once final benefits and rates are negotiated.

**Note: If one or more of your plan options was grandfathered in 2012, but will no longer meet regulatory requirements for 2013 then all Affordable Care Act requirements for non-grandfathered plans must be met in 2013.**

Information Required for Proposal: Attachment VIII-Grandfathered Status Certification

## B. Improving the Delivery & Cost Efficiency of Prescription Medications

OPM continues to explore innovative methods to reduce pharmacy spending and to develop effective prescription drug management without cost shifting or burdening members. The rate proposal, which you will receive separately, has our pharmacy data request.

Information Required for Proposal:

- Describe effective prescription drug management without cost shifting or burdening enrollees;
- Describe proposals to implement specialty drug programs that manage these costs;
- Describe how you are managing the control of drug administrative cost such as dispensing fees; and
- Complete Attachment IX for four issues below.

**(1) Generic Medications**

OPM's target for 2013 is to achieve an overall FEHB average generic dispensing rate of at least 75 percent**.** The Generic Dispensing Rate (GDR) is defined as the percentage of total prescriptions filled with generic drugs.

**(2) Specialty Pharmacy**

OPM's target is to stabilize the growth and cost of specialty drugs by keeping cost trends below the industry average of 14 to 20 percent.

**(3) Pharmacy Benefit Managers Accreditation**

FEHB plans should provide the highest quality pharmacy services to Federal employees, retirees and their families as demonstrated by the accreditation status of their pharmacy benefit managers (PBMs) or pharmacy components.

**(4) Control of Dispensing Fees**

Carriers will provide OPM with baseline data on the administrative fees in their current PBM contracts and describe how they intend to mitigate inflation in those fees. Examples are dispensing fees for generic drugs, brand name drugs, and for specialty drugs.

**C. Advancing Quality of Care**

**1. Quality**

OPM supports enhanced care coordination and the principles underlying patient centered medical homes (PCMH). To the greatest extent possible, we encourage participation in pilots offered by states or other Federal agencies, including the Comprehensive Primary Care (CPC) initiative sponsored by the Centers for Medicare and Medicaid Innovation Center. Read about this important initiative at http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html We invite you to propose arrangements through which your FEHB members can participate in the new CPC activities.

Information Required for Proposal: Attachment X-Quality of Care: PCMH

Additionally, we support the goals of the HHS' *Partnership for Patients, Better Care, Lower Costs* to reduce hospital readmissions by 20 percent and decrease preventable hospital acquired

conditions by 40 percent when compared with 2010. We expect that you will make concerted efforts to improve the quality and safety of health care by addressing both those concerns.

> Note: Plans will receive separate guidance in a forthcoming Carrier Letter describing how to measure applicable rates for FEHB populations.

We seek to eliminate elective deliveries before 39 weeks' gestation to reduce prematurity and adverse neonatal outcomes. We encourage you to describe initiatives supporting this goal in your benefit proposal, including those in place through your plan, participating hospitals or network providers.

> Note: The forthcoming Carrier Letter regarding readmission and preventable conditions will include data requests reflecting maternity care and prematurity.

### 2. Wellness

In your proposal, please describe all wellness programs you intend to offer - including any quantitative data or other measures of their effectiveness - that can improve employee productivity, enhance healthy lifestyles and lower long-term healthcare costs.

FEHB plans are expected to continue programs to manage obesity as part of their focus on members' health and wellness. Your 2013 benefit proposal should update weight management coverage to ensure that enrollees receive all appropriate support to achieve and sustain a healthier weight.

> Information Required for Proposal: Narrative information on all wellness programs with outcome data and Attachment XI-Weight Management

## II. BENEFITS & SERVICES

### A. New Guidance: Coverage of Applied Behavior Analysis (ABA)

The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy. Accordingly, plans may propose benefit packages which include ABA.

> Information Required for Proposal: Describe what benefit package you intend to offer and describe how you will deliver these services through appropriate providers.

### B. Continued Focus from Previous Years

### 1. Health & Wellness

We continue to encourage you to offer financial incentives to enrollees who (a) complete a health risk assessment or biometric assessment or (b) participate in wellness activities or treatment plans to improve their health status.

Information Required for Proposal: Attachment XII-Health & Wellness

## 2. Increase FEHB providers

We continue to encourage you to increase the number of health care providers in FEHB plan networks who are board certified or have training in geriatrics.

Information Required for Proposal: Attachment XIII-Geriatric Providers

## 3. Affinity Products

We encourage you to add products on the "non-FEHB" page of your plan brochure that may be of interest to members and ineligible family members, especially individual policies for domestic partners as well as for members who may seek additional insurance products, such as short-term disability.

Information Required for Proposal: Attachment XIV-Affinity Products

## 4. Organ/Tissue Transplants

We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance. When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following table in Attachment XV:

- Table 1– OPM's required list of covered organ/tissue transplants. Although we no longer require coverage for autologous transplants for breast cancer, plans may continue to offer it.

Information Required for Proposal: Attachment XV: 2013 Organ/Tissue Transplants and Diagnoses

## 5. Describing Prescription Drug Co-Pays in the Guide to Federal Benefits

Plans that use levels or tiers to denote different prescription drug co-pays must clearly describe the coverage and difference between each level or tier in the 2013 brochure. The *2013 Guide to Federal Benefits* will illustrate the prescription drug co-pays at the following levels.

- Level I – generally includes generic drugs, but may include some brand formulary or preferred brands. Usually represents the lowest co-pays.
- Level II – generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range co-pays.
- Level III – may include all other covered drugs not on Levels I and II, i.e. non-formulary or non-preferred and some specialty drugs.

If your plan has more than three co-pay levels for prescription drug coverage, please work with your OPM Contract Specialist to ensure that we accurately reflect your coverage in the *2013 Guide to Federal Benefits.*

6. **Point of Service Product**

We will consider proposals to offer a Point of Service (POS) product under the FEHB Program. Your plan's proposal must demonstrate experience with a private sector employer who has already purchased the POS product.

**7. Infertility Treatment**

We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. **This requirement does not include related prescription drugs.** Your brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.

**Federal Preemption Authority**

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not pre-empt state laws that increase our enrollees' benefits unless the state mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

**Department of Health and Human Services (HHS) Benefits**

All HMOs *must* offer certain benefits that the Department of Health and Human Services (HHS) requires for Federally-qualified plans, **without limits on time and cost,** except as prescribed in the Public Health Service Act and HHS regulations. These required benefits include:

- Non-experimental bone marrow, cornea, kidney, and liver transplants
- Short-term rehabilitative therapy (physical, occupational, and speech), if significant improvement in the patient's condition can be expected within two months
- Family planning services include all necessary non-experimental infertility services such as artificial insemination with either the husband's or donor sperm. You do not have to cover the cost of donor sperm if it is not in your community package. You may exclude benefits for conception by artificial means or assisted reproductive technology to the extent permitted by applicable state law and excluded in your community package
- Pediatric and adult immunizations, in accordance with accepted medical practice
- Allergy testing, treatment and allergy serum
- Well-child care from birth

- Periodic health evaluations for adults
- Home health services
- In-hospital administration of blood and blood products (including "blood processing")
- Surgical treatment of morbid obesity, when medically necessary
- Implants – you must cover the surgical procedure, but you may exclude the cost of the device if the device is excluded in your community package

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

# Attachment I: FEHB Carrier Contracting Official

The Office of Personnel Management (OPM) will not accept any contractual action from

_____ (Carrier),
including those involving rates and benefits, unless it is signed by one of the persons named below (including the executor of this form), or on an amended form accepted by OPM. This list of contracting officials will remain in effect until the carrier amends or revises it.

The people named below have the authority to sign a contract or otherwise to bind the Carrier

for _____ (Plan).

Enrollment code (s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

By: _____
(Signature of contracting official) (Date)

_____
(Typed name and title)

_____ _____
(Telephone) (FAX)

_____
(Email)

# Attachment II
# [Insert Health Plan Name]: Benefit Change Worksheet #1
# [Insert Subsection Name]

*Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes on page 5 to complete the worksheet.*

Benefit Change Description

Applicable options:

| | | | |
|---|---|---|---|
| High Option | ☐ | CDHP | ☐ |
| Standard Option | ☐ | HDHP | ☐ |
| Basic | ☐ | | |

| Item | Narrative Description |
|---|---|
| Current Benefit | |
| Proposed Benefit | |
| Proposed Brochure Language | |
| Reason | |
| Cost Impact / Actuarial Value | |

**Additional Questions:**

I. Actuarial Value:
- (a) Is the change an increase or decrease in existing benefit package?
- (b) If an increase, describe whether any other benefit is off-set by your proposal

II. Is the benefit change a part of the plan's proposed community benefits package?
- (a) If yes, when?
- (a) If approved, when? (attach supporting documentation)
- (b) How will the change be introduced to other employers?
- (c) What percentage of the plan subscribers now have this benefit?
- (d) What percentage of plan subscribers do you project will have this benefit by January 2013?

III. If change is not part of proposed community benefits package, is the change a rider?
- (a) If yes, is it a community rider (offered to all employers at the same rate)?
- (b) What percentage of plan subscribers now have this benefit?
- (c) What percentage of plan subscribers do you project will have this benefit by January 2013?
- (d) What is the maximum percentage of all subscribers you expect to be covered by this rider?
- (e) When will that occur?

IV. Will this change require new providers?
- (a) If yes, provide a copy of the directory which includes new providers

## Attachment III

### [Insert Health Plan Name]: Benefit Clarification Worksheet #1
### [Insert Subsection Name]

***Please refer to Benefit Clarifications on page 6 to complete the worksheet.***

***Please Note: If the benefit clarification equates to a benefit change, you must indicate it as a benefit change in the Benefit Change Worksheet.***

**Benefit Clarification Description**

Applicable options:

| | | | |
|---|---|---|---|
| High Option | ☐ | CDHP | ☐ |
| Standard Option | ☐ | HDHP | ☐ |
| Basic | ☐ | | |

| Current Benefit Language | Proposed Benefit Change | Reason For Benefit Clarification |
|---|---|---|
| | | |

# Attachment IV: Affordable Care Act – Lifetime and Annual Limits on Essential Health Benefits

**Essential Health Benefits**

The Secretary of Health and Human Services issued preliminary guidance on essential benefits and asked issuers to make a good faith effort to comply with a reasonable interpretation of the term "essential health benefits." Please read the two HHS documents on "essential health benefits" – citations for both appear earlier in this Technical Guidance.

**We ask that you carefully consider whether a particular benefit is essential by taking into account medical evidence and best practices for your other health plan offerings**.

Essential health benefits include items and services within the following 10 categories: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, including behavioral health treatment, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

**Lifetime Limits**

Does your plan have any lifetime limits? Yes___ No___.

If yes, please list each specific limit and its justification.

**Annual Limits**

Please complete the table below listing any services for which your plan now enforces annual limits.

| LIST EACH SERVICE IN PLAN YEAR 2012 THAT HAS ANNUAL LIMITS |
|---|
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# Attachment V: Affordable Care Act - Clinical Trial Coverage Requirement

Section 2709 of the Public Health Service Act, as amended by the Affordable Care Act, requires group health plans to provide coverage for approved clinical trials. Specifically, health plans may not deny the individual participation in certain clinical trials; may not deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and may not discriminate against an individual on the basis of that individual's participation in such trial.

Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

FEHB plans are expected to comply with these coverage requirements for clinical trials next year, in advance of required implementation for 2014, and regardless of grandfathered status.

Please indicate your plan policies regarding clinical trials in the table below:

| CLINICAL TRIAL COVERAGE REQUIREMENT | YES | NO |
|---|---|---|
| Routine patient costs for individual participation in phase I, II, III or IV clinical trials conducted to prevent, detect or treat cancer that is Federally funded;** conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application. | | |
| Routine patient costs for individual participation in phase I, II, III or IV clinical trial conducted to prevent, detect or treat life-threatening diseases or conditions* that are Federally funded;** conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application. | | |
| Please describe the implementation process for any clinical trials you will cover. | | |

*Life threatening condition or disease means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

**Federally funded means that the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1) The National Institutes of Health
2) The Centers for Disease Control and Prevention
3) The Agency for Health Care Research and Quality
4) The Centers for Medicare and Medicaid Services
5) Cooperative group or center any of the entities described in 1-4 above or the Department of Defense or the Department of Veterans Affairs
6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7) If the study or investigation has been reviewed and approved through a system of peer review that has been approved by the Secretary of HHS and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review, then the Department of Veterans Affairs, the Department of Defense or the Department of Energy.

# Attachment VI - Affordable Care Act: Preventive Services

Last year, FEHB plans were requested to eliminate cost-sharing for all recommended in-network preventive services, immunizations, screenings, tobacco cessation services and medication. Please check the latest posting by the Advisory Committee on Immunization Practices (ACIP) at http://www.cdc.gov/vaccines/pubs/ACIP-list-by-date.htm for the full list of required vaccinations as some have changed. Plans are required to cover these requirements no later than the start of the plan year which follows the year in which the recommendation becomes effective.

The Affordable Care Act adds some new preventive service requirements for 2013 that go beyond recommendations of the USPSTF. The list of services is available at http://www.hrsa.gov/womensguidelines/.

FEHB plans are required to provide the following preventive services with **no cost sharing** for plan year 2013. Please complete the effective date for each type of service listed below. If you are already offering it, list what year it began.

| Preventive Service | HHS Guideline | Frequency | Effective Date |
|---|---|---|---|
| **Well-woman visits** | Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713 of the Public Health Service Act. | Annual, although several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs and other risk factors. * | |
| **Screening for gestational diabetes** | Screening for gestational diabetes | In pregnant women between 24 and 28 weeks of gestation and at first prenatal visit for pregnant women identified to be at high risk for diabetes. | |
| **Human papillomavirus testing** | High-risk human papillomavirus DNA testing in women with normal cytology results | Screening should begin at 30 years of age and should occur no more frequently than every 3 years. | |
| **Counseling for sexually transmitted infections** | Counseling on sexually transmitted infections for all sexually active women | Annual | |
| **Counseling and screening for human immune-deficiency virus** | Counseling and screening for human immune-deficiency virus infection for all sexually active women | Annual | |

| | | | |
|---|---|---|---|
| **Contraceptive methods and counseling **** | All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. | As prescribed | |
| **Breastfeeding support, supplies, and counseling.** | Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. | In conjunction with each birth. | |
| **Screening and counseling for interpersonal and domestic violence.** | Screening and counseling for interpersonal and domestic violence. | Annual. | |

* Refer to recommendations listed in the July 2011 IOM report entitled Clinical Preventive Services for Women: Closing the Gaps concerning individual preventive services that may be obtained during a well-woman preventive service visit.

** Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii). 45 C.F.R. §147.130(a)(1)(iv)(B). See the *Federal Register* Notice: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act.

# Attachment VII - Preparing Your 2013 Brochure

Summary of Plan Benefits

The Affordable Care Act requires group health plans to provide a summary of plan benefits and coverage based on standards developed by the Secretary of the Department of Labor. We intend to start the process of implementing the summary requirements for the 2013 contract year. We will provide you more detailed information on how this process works as soon as it becomes available.

Going Green

We appreciate your efforts to support our "Going Green" goals to help reduce FEHB administrative costs. Once again, you may provide paper copies of plan brochures to new members or only upon request to current members and may send Explanations of Benefits, newsletters and other plan materials electronically.

Last year we asked you to estimate savings from your paper reduction initiatives. Please provide the following information on your categorical and overall cost savings:

| **Plan name** | **Printing Savings** | **Shipping Savings** | **Postage Savings** | **If other savings, specify** | **Total Savings** |
|---|---|---|---|---|---|
| | | | | | |

Timeline: 2013 Brochure Process

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software to generate a Section 508-compliant PDF. This year's deadlines and significant dates are:

| **DEADLINES** | **REQUIRED ACTIVITY** |
|---|---|
| May 31 | Plans submit Section 5 Benefits information with proposal if suggesting new option |
| July 2 | Plans receive *2013 FEHB Brochure Handbook* via listserv |
| July 2 | OPM will provide *2013 Brochure Creation Tool (BCT) User Manual* |
| July 2-August 31 | OPM circulates updated FEHB Brochure Handbook pages by listserv |
| September 4 | Plans must enter all data into Section 5 Benefits and update all plan specific information in the brochure tool. Plans will be unable to make changes after this date so that Contract Specialists can review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis. |
| September 10 | OPM sends brochure quantity form to plan after Contract Specialist approves brochure for printing as well as other related Open Season instructions. |
| August 24 | OPM's deadline to finalize all language and shipping labels |

In July, we will provide in-house training to refresh plans on the use of the Brochure Creation Tool with 10 individual sessions held at OPM. We will notify plans via the FEHB Carriers listserv about the training dates and times. Please send any comments or questions pertaining to the Brochure Creation Tool to Lionell Jones at lionell.jones@opm.gov or Angelo Cueto at angelo.cueto@opm.gov.

# Attachment VIII-Grandfathered Status Certification

The Patient Protection and Affordable Care Act, as amended ("the Act"), imposes coverage, premium and notification requirements for group health plans. Certain existing group health plans, referred to as "grandfathered plans," are exempt from some of those requirements.

According to regulations published jointly by the Departments of Treasury, Labor and Health and Human Services (http://cciio.cms.gov/programs/marketreforms/grandfathered/index.html), health plans existing on March 23, 2010 may meet the definition of a grandfathered health plan by making only certain limited changes to benefits and rates each year and by complying with certain notification and records retention requirements.

The checklist below lists the regulatory requirements. If an FEHB plan chooses to assert grandfathered status for plan year 2013, it must certify that the applicable plan option, based on its proposed benefit changes from **2010 to 2013**, meets the definition of a grandfathered plan. (Be aware that a group health plan ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010. You are not certifying to this requirement.) If the plan option meets all the requirements listed below, plans should certify that this option is considered grandfathered under the Act, pending final rate determinations.

**You only need to submit this certification if you assert that a particular plan option continues to meet the requirements to remain grandfathered for 2013.**

Grandfathered plans should note these record keeping and notification requirements for 2013:

- Include a statement in plan materials describing benefits (plan brochure) that the plan believes it is a grandfathered health plan and include contact information for enrollee complaints. OPM will provide standard plan language for FEHB brochures disclosing a plan's grandfathered status.

- Maintain records documenting terms of the plan in effect on the date the Affordable Care Act was enacted.

# Attachment VIII-Grandfathered Status Certification-Page 2

**Plan Name and Option:**

**Carrier Codes:**

| Category | Requirement (Change from 2010) | Met by 2013 Benefit Package: Yes or No |
|---|---|---|
| Benefits | Benefit option has not eliminated all or substantially all benefits to diagnose or treat a particular condition. Plan has not eliminated benefits considered necessary to treat a particular condition. | |
| Cost Sharing (coinsurance) | Benefit option has not made any increase in percentage cost sharing amount. | |
| Fixed Cost Sharing (Deductible or Out-of-Pocket Limit) | Benefit option has not increased deductibles or out-of-pocket- limits more than medical inflation* plus 15 percentage points. | |
| Fixed- Amount Copayment | Benefit option has not increased copayments more than the greater of: 1) $5 increased by medical inflation* ($5 plus medical inflation times $5) or 2) medical inflation plus 15 percentage points (by expressing copayment as a percentage). | |
| Changes in annual limits | Benefit option has not imposed an overall annual limit on the dollar value of all benefits. | |

* Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted). Increase is computed by subtracting 387.142 (CPI-U for March 2010) from the indexed amount for any months before the new change is to take effect.

I certify that this plan option meets the requirements of the Patient Protection and Affordable Care Act as a Grandfathered plan (pending final rate determinations.)

**Signature of authorized contracting official:**

**Name** **Date**

**Title**

Please return this page to your OPM Contract Specialist for each grandfathered plan option under the FEHB Program. Your Contract Specialist will provide the deadline to return this certification.

# Attachment IX: Pharmacy
# Table 1: Generic Dispensing Rate (GDR)

Remember to prepare your data worksheet to return to OPM actuaries.

Have you already reached our target GDR of at least 75%? Yes __No___. If yes, you may skip the rest of this worksheet.

If not, please describe what activities - beyond those currently in place - you will implement to reach this target for 2013? Please describe the three activities that are most likely to help you reach this goal.

| | |
|---|---|
| **Generic Initiative** | |
| Target Beneficiary Population | |
| Anticipated participation rate | |
| Expected beneficiary impact | |
| Projected results: each target population | |
| **Generic Initiative** | |
| Target Beneficiary Population | |
| Anticipated participation rate | |

| | |
|---|---|
| Expected beneficiary impact | |
| Projected results: each target population | |
| **Generic Initiative** | |
| Target Beneficiary Population | |
| Anticipated participation rate | |
| Expected beneficiary impact | |
| Projected results: each target population | |

## Attachment IX: Pharmacy
## Table 2: Specialty

Remember to prepare your data worksheet to return to OPM actuaries.

Have you already reached our specialty pharmacy target of keeping cost trends below the industry average of 14 to 20 percent? Yes/No. If yes, you may skip the rest of this worksheet.

If not, please describe what activities - beyond those currently in place - you will implement to reach this target for 2013? Please describe the three activities that are most likely to help you reach this goal.

| | |
|---|---|
| **Specialty Initiative** | |
| Target beneficiary population | |
| Anticipated participation rate | |
| Expected beneficiary impact | |
| Projected results: each target population | |
| **Specialty Initiative** | |
| Target beneficiary population | |
| Anticipated participation rate | |

| | |
|---|---|
| | |
| Expected beneficiary impact | |
| Projected results: each target population | |
| **Specialty Initiative** | |
| Target beneficiary population | |
| Anticipated participation rate | |
| Expected beneficiary impact | |
| Projected results: each target population | |

## Attachment IX: Pharmacy
## Table 3: PBM Accreditation

| | |
|---|---|
| Is your PBM separately accredited? | Yes/No |
| If yes, what is the accrediting organization? | |
| What was the accreditation effective date? | |
| What is the accreditation expiration date? | |
| If your PBM is not separately accredited, is it included in your overall accreditation? | Yes/No |
| What is the accrediting organization? | |
| What was the accreditation effective date? | |
| What is the accreditation expiration date? | |
| If you have a separate PBM that is not yet accredited, what are your plans to obtain that credential? | |

## Attachment IX: Pharmacy
## Table 4: Control of Dispensing Fees

| | |
|---|---|
| What are the average fees in your current PBM agreement? | |
| Generics | |
| Brand | |
| Specialty Drugs/Biologics | |

# Attachment -X: Quality of Care – Patient Centered Medical Home (PCMH)

| Requested Data Item | Data Response |
|---|---|
| What percentage of your in-network primary care practitioners were recognized as medical homes at the start of 2012 plan year? | |
| What percentage of your in-network primary care practitioners do you project will be recognized as medical homes at the start of the 2013 plan year? | |
| How many covered lives were enrolled/attributed to a PCMH practice in 2011? | |
| How many covered lives were enrolled/attributed to a PCMH practice in 2012? | |
| How many are projected for 2013? | |

PCMH Narrative Responses

1. What criteria do you use to recognize a practice as meeting the definition of medical home or advanced primary care?

2. Describe all applicable provider or health system payment incentives, along with your evaluation of their effectiveness.

## Attachment X: Quality of Care – PCMH-Page 2

3. How are members invited to participate in a PCMH?

4. How will members learn about quality outcomes associated with the PCMH practices?

5. List the results of each specific outcome metric you use - exclusive of HEDIS and CAHPS - to evaluate the quality and continuity of care delivered in the PCMH practices (e.g. % decrease admissions; % decrease ER utilization, etc).

6. Are you able to propose including an FEHB population in the Comprehensive Primary Care initiative? Yes/No___.

   If yes, what arrangements will you make for these members to participate?

# Attachment XI: Weight Management

List each covered service for weight management. In addition, list any specific exclusions that may limit access to weight management services, for both adults and children.

| Requested Data Item | Adults (use 1 cell/response) | Children (use 1 cell/response) |
|---|---|---|
| Covered service/initiative | | |
| | | |
| | | |
| | | |
| | | |
| Exclusions | | |
| | | |
| | | |
| | | |

Describe SUSTAINED RESULTS from one recent initiative for adults and provide quantitative outcome data.

| | |
|---|---|
| Initiative | |
| Target Population | Adults ages ___ - ___ |
| Participation rate | |
| Outcome results | |

Describe SUSTAINED RESULTS from one recent initiative for children and provide quantitative outcome data.

| | |
|---|---|
| Initiative | |
| Target Population | Children ages ___ - ___ |
| Participation rate | |
| Outcome results | |

# Attachment XII: Health/Wellness

What percentage of your enrollment has completed a health risk or biometric assessment in the last two years?
What do you think is your most effective financial incentive program to engage members in their own health management?
How has your financial incentive program helped to improve or change members' health outcomes?

1. Describe sustained results from one recent initiative for adults:

| | |
|---|---|
| **Describe Initiative** | |
| **Target Population** | Adults ages ___ - ___ |
| **Participation rate** | |
| **Results** | |

2. Describe sustained results from one recent initiative for children:

| | |
|---|---|
| **Describe Initiative** | |
| **Target Population** | Children ages ___ - ___ |
| **Participation rate** | |
| **Results** | |

# Attachment XIII: Geriatric Providers

| Plan Year | 2012 | 2013 |
|---|---|---|
| Do you have a mechanism to identify providers with geriatric training or certification (including those PCPs with these qualifications) in your FEHBP directory? | | |
| How many enrollees do you have over age 65? | | |

# Attachment XIV: Affinity Products

Please indicate yes/no in each column on the table below:

| Product | 2012-Yes/No | 2013-Yes/No |
|---|---|---|
| Do you offer individual policies for domestic partners? | | |
| Do you list individual policies for domestic partners on your non-FEHB page? | | |
| Do you offer short-term disability coverage? | | |
| Do you list short-term disability coverage on your non-FEHB page? | | |

# Attachment XV: 2013 Organ/Tissue Transplants and Diagnoses:

## Table 1: Required Coverage

| **I. Solid Organ Transplants: Subject to Medical Necessity** | **Reference** |
|---|---|
| Cornea | Call Letter 92-09 |
| Heart | Call Letter 92-09 |
| Heart-lung | Call Letter 92-09 |
| Kidney | Call Letter 92-09 |
| Liver | Call Letter 92-09 |
| Pancreas | Call Letter 92-09 |
| Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas | Carrier Letter 2001-18 |
| Lung: Single/bilateral/lobar | Carrier Letter 91-08 |
| **II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis.** | |
| **Allogeneic transplants for:** | |
| Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia | |
| Advanced Hodgkin's lymphoma – relapsed | |
| Advanced non-Hodgkin's lymphoma - relapsed | |
| Acute myeloid leukemia | |
| Advanced Myeloproliferative Disorders (MPDs) | |
| Amyloidosis | |
| Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) | |
| Hemoglobinopathy | |
| Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) | |
| Myelodysplasia/Myelodysplastic Syndromes | |
| Paroxysmal Nocturnal Hemoglobinuria | |
| Severe combined immunodeficiency | |
| Severe or very severe aplastic anemia | |
| **Autologous transplants for:** | |
| Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia | Call Letter 96-08B |
| Advanced Hodgkin's lymphoma – relapsed | Call Letter 96-08B |
| Advanced non-Hodgkin's lymphoma - relapsed | Call Letter 96-08B |
| Amyloidosis | |
| Neuroblastoma | Call Letter 96-08B |

| | |
|---|---|
| **III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity** | |
| **Allogeneic transplants for:** | |
| Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) | |
| **Autologous transplants for:** | |
| Multiple myeloma | Carrier Letter 94-23, Call Letter 96-08B |
| Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors | Carrier Letter 94-23, Call Letter 96-08B |
| **IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.** | |
| **Autologous transplants for:** | |
| Epithelial ovarian cancer | Carrier Letter 94-23 Call Letter 96-08B |
| Childhood rhabdomyosarcoma | |
| Advanced Ewing sarcoma | |
| Advanced Childhood kidney cancers | |
| Mantle Cell (Non-Hodgkin lymphoma) | |
| **V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity** | |
| **VI. Tandem transplants: Subject to medical necessity** | |
| **Autologous tandem transplants for:** | |
| AL Amyloidosis | |
| Multiple myeloma (de novo and treated) | |
| Recurrent germ cell tumors (including testicular cancer) | Call Letter 2002-14 |

## Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

| | **Does your plan cover this transplant for 2013?** | |
|---|---|---|
| **Blood or Marrow Stem Cell Transplants** | **Yes** | **No** |
| **Allogeneic transplants for:** | | |
| Early stage (indolent or non-advanced) small cell lymphocytic lymphoma | | |
| Multiple myeloma | | |
| Multiple sclerosis | | |
| Sickle Cell | | |
| Beta Thalassemia Major | | |
| Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) | | |
| **Non-myeloablative allogeneic transplants for:** | | |
| Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia | | |
| Advanced Hodgkin's lymphoma | | |
| Advanced non-Hodgkin's lymphoma | | |
| Breast cancer | | |
| Chronic lymphocytic leukemia | | |
| Chronic myelogenous leukemia | | |
| Colon cancer | | |
| Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) | | |
| Early stage (indolent or non-advanced) small cell lymphocytic lymphoma | | |
| Multiple Myeloma | | |
| Multiple Sclerosis | | |
| Myeloproliferative Disorders | | |
| Myelodysplasia/Myelodysplastic Syndromes | | |
| Non-small cell lung cancer | | |
| Ovarian cancer | | |
| Prostate cancer | | |
| Renal cell carcinoma | | |
| Sarcomas | | |
| Sickle Cell disease | | |
| **Autologous transplants for:** | | |
| Chronic myelogenous leukemia | | |
| Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) | | |
| Early stage (indolent or non-advanced) small cell lymphocytic lymphoma | | |
| Small cell lung cancer | | |

| | | |
|---|---|---|
| **Autologous transplants for the following autoimmune diseases:** | | |
| Multiple sclerosis | | |
| Systemic lupus erythematosus | | |
| Systemic sclerosis | | |
| Sclerodema | | |
| Scleroderma-SSc (severe, progressive) | | |

# Table 3: Recommended For Coverage

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

| | **Does your plan cover this transplant for 2013?** | |
|---|---|---|
| **Solid Organ Transplants** | **Yes** | **No** |
| Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis | | |
| **Blood or Marrow Stem Cell Transplants** | | |
| **Allogeneic transplants for:** | | |
| Advanced neuroblastoma | | |
| Infantile malignant osteopetrosis | | |
| Kostmann's syndrome | | |
| Leukocyte adhesion deficiencies | | |
| Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) | | |
| Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) | | |
| Myeloproliferative disorders | | |
| Sickle cell anemia | | |
| X-linked lymphoproliferative syndrome | | |
| **Autologous transplants for:** | | |
| Ependymoblastoma | | |
| Ewing's sarcoma | | |
| Medulloblastoma | | |
| Pineoblastoma | | |
| Waldenstrom's macroglobulinemia | | |

# Attachment XVI: 2013 Technical Guidance Submission Checklist

| Topic/Attachment Number | In Proposal Yes/No | Worksheet Completed Yes/No |
|---|---|---|
| FEHB Contracting Official (Attachment I) | | |
| Benefit Changes: worksheet for each (Attachment II) | | |
| Benefit Clarifications: worksheet for each (Attachment III) | | |
| Lifetime and Annual limits for essential health benefits (Attachment IV) | | |
| New clinical trial coverage requirements (Attachment V) | | |
| Expanded preventive services (Attachment VI) | | |
| Going Green cost savings (Attachment VII) | | |
| Grandfathered Status Certification, if applicable (Attach VIII) | | |
| Pharmacy - Generic Medications (Attachment IX ) | | |
| Pharmacy - Specialty (Attachment IX ) | | |
| Pharmacy - PBM (Attachment IX) | | |
| Pharmacy - Control of Dispensing Fees (Attachment IX) | | |
| PCMH (Attachment X) | | |
| Hospital readmissions & preventable hospital acquired conditions | Separate OPM guidance forthcoming | Not applicable |
| Early elective deliveries | Separate OPM guidance forthcoming | Not applicable |
| Weight management (Attachment XI) | | |
| Applied Behavior Analysis (ABA) services | | None required |
| Health & Wellness (Attachment XII) | | |
| Providers with geriatric expertise (Attachment XIII) | | |
| Affinity products (Attachment XIV) | | |
| Organ/Tissue Transplants (Attachment XV) | | |
| Technical Guidance Submission Checklist (Attachment XVI) | Not required | |

***Please return this checklist with your CY 2013 benefit and rate proposal***