FEHB Program Carrier Letter

All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2019-01 **Date: March 14, 2019**

Fee-for-service [1] Experience-rated HMO [1] Community-rated HMO [1]

SUBMISSION OF PROPOSALS

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program Carriers. This letter sets forth the policy goals and initiatives for the FEHB Program for 2020. You must submit your benefit and rate proposals for the contract term beginning January 1, 2020 on or before **May 31, 2019**. Please send your proposals to your Health Insurance Specialist via **email and overnight mail**. OPM expects to complete benefit negotiations by July 31 and rate negotiations by mid-August to ensure a timely Open Season. As a reminder, Call Letter responsiveness is evaluated by your Contracting Officer as an element of Plan Performance Assessment (PPA).

FEHB PROGRAM BENEFITS AND INITIATIVES

During rate and benefit negotiations for the 2020 plan year, OPM will continue to focus on maintaining and improving quality and affordability in the FEHB Program in accordance with the Agency's five-year Strategic Plan. We congratulate Carriers on the significant progress made in the 2019 plan year, including lower average premium increases and improvements in PPA scores. We ask that you continue to offer innovative proposals that focus on OPM's strategic priorities, as described in this Call Letter. Our quality initiatives for the upcoming plan year relate to preventive services, patient safety, and mental health and substance use disorder services. To maintain the focus on affordability of plan premiums, Carriers are also asked to review pharmacy benefits, to further implement value-based benefit design, and to address potential fraudulent payments. Additionally, we ask Carriers to enhance transparency tools related to prescription drugs and medical services.

I. Quality

The 2018 PPA cycle demonstrated increases in the average score reported by FEHB Carriers on combined Clinical Quality, Customer Service, and Resource Use (QCR) measures. We appreciate efforts Carriers are making on these important result-oriented metrics and encourage your continued focus on improvements aimed at greater quality and enhancing the health and well-being of individuals covered under the FEHB Program. Carriers are reminded that the Clinical Quality measure *Comprehensive Diabetes Care* joins *Controlling High Blood Pressure, Prenatal Care (Timeliness)*, and *Use of Imaging Studies for Low Back Pain* (a Resource Use

measure), as one of the four high priority measures in the 2020 PPA. Carrier Letter 2018-01 also emphasized ways to manage diabetes and high blood pressure through comprehensive disease and medication management programs. *Colorectal Cancer Screening* joins *Cervical* and *Breast Cancer Screening*, *Flu Vaccinations for Adults*, and other Clinical Quality weighted measures that focus on prevention. We are pleased that once risk factors are identified, more members are being referred to evidence-based health interventions, and that comprehensive secondary prevention programs such as cardiac rehabilitation and diabetes management are available to those with underlying disease. We encourage Carriers to identify ways in which they can further redirect members to improve their health status through additional primary and secondary prevention programs for their most prevalent chronic conditions. In addition, OPM expects your 2020 proposal to address each of the following topics.

Mental Health and Substance Use Disorder Services

Access to Care - One of the hallmarks of the FEHB Program is our continuing emphasis on mental health parity for nearly twenty years, as evidenced through Carrier letters, presentations, and surveys. The National Alliance on Mental Illness (NAMI) recent report, *The Doctor is Out*, found that people with mental illness experience significant barriers to finding affordable, accessible care.[1] Approximately 55 percent of counties throughout the U.S. do not have practicing psychiatrists, psychologists or social workers.[2] OPM strongly encourages Carriers to remain focused on the provision of mental health benefits by improving access to and availability of treatment. We ask Carriers to address known Health Professional Shortage Areas for Mental Health Services, as defined by the Health Resources and Services Administration.[3] You should closely monitor both provider access and availability, and you should consider leveraging telehealth services to address provider shortages while educating members regarding the availability of these services.

Specifically, OPM encourages Carriers to adopt the following steps[4] to address significant provider shortage and access issues:

- Promote integration of mental health and primary care;
- Expand mental health provider networks;
- Utilize reimbursement models that integrate health, mental health and substance use disorder care, such as the Collaborative Care Model[5]; and

[1] National Alliance on Mental Illness. (2017). *The Doctor is Out*. https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf
[2] U. S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues." https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf
[3] Shortage areas: https://data.hrsa.gov/tools/shortage-area/hpsa-find
[4] National Alliance on Mental Illness. (2017). *The Doctor is Out*. https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf
[5] Collaborative Care Model: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf

- Cover services provided by out-of-network providers at in-network rates when needed to provide timely access to specialized care.

Please include in your proposal a specific description of the strategies you will use to address this issue in 2020.

Addressing the Opioid Epidemic - Reducing opioid misuse continues to be a critical priority, as evidenced by enactment of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment* (SUPPORT) *for Patients and Communities Act*,[6] which was signed into law by President Donald J. Trump on October 24, 2018. We applaud the efforts that FEHB Carriers have made to mitigate the opioid epidemic, including putting in place requirements outlined in Carrier Letter 2018-01. The number of opioid prescriptions dispensed to FEHB Program members and the number of unique members receiving opioid prescriptions have fallen consistently over the past three years. FEHB Carriers have also implemented programs for providers and members to improve safe dispensing, utilization, and disposal of opioids, as well as increased access to naloxone-based rescue agents. We ask Carriers to place continued emphasis on these and other efforts to prevent and treat opioid misuse in order to foster further progress.

Opioid use in pregnancy - According to the CDC's Morbidity and Mortality Weekly Report, the number of women with opioid use disorder (OUD) giving birth more than quadrupled from 1999 to 2014.[7] OUD in pregnancy has been associated with numerous adverse outcomes ranging from neonatal abstinence syndrome (NAS) to stillbirth and maternal mortality.[8] The complexity and coordination of care required to care for mother and child during the prenatal, perinatal and postnatal stages can result in gaps in care if adequate resources and policies are not in place.[9] FEHB Carriers are strongly encouraged to implement or review processes in place for the early detection, access to treatment, and coordination of care for pregnant women with OUD and the affected babies.

A comprehensive, multi-pronged strategy will continue to be necessary to overcome the opioid epidemic. In addition to reviewing and expanding on the services provided above, FEHB Carriers' 2020 proposals should describe how they will:

- Ensure access to programs to identify and refer members at risk for opioid use disorder such as point-of-sale edits, retrospective data review and outreach referral programs;
- Promote evidence-based pain management through coverage of and access to non-pharmacological therapies and non-opioid medications or devices used to treat pain;
- Assess telehealth services for OUD and other substance use disorder treatments;

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[6] See https://www.congress.gov/bill/115th-congress/house-bill/6/all-actions?overview=closed#tabs

[7] Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. MMWR Morb Mortal Wkly Rep 2018; 67:845–849. DOI: http://dx.doi.org/10.15585/mmwr.mm6731a1

[8] Ibid.

[9] Substance Abuse and Mental Health Services Administration. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978

- Improve access to opioid addiction treatment programs, family-focused residential treatment and comprehensive opioid recovery centers; review the adequacy of access to care for high-risk populations such as pregnant women and youth;
- Review and/or develop policies to extend duration of addiction treatment or length of stays as medically appropriate;
- Identify improvements the Carrier has made from the results of their retrospective review of care management for pregnant women with OUD where two or more claims for NAS were paid in 2018; and
- Promote a comprehensive, coordinated care approach that includes medical, pharmacy, behavioral and mental health to provide care coordination and recovery support to members with OUD.

We plan to request additional data regarding utilization of key services related to opioid prescribing, pain management and addiction care through the Automated Data Collection (ADC). Additional information will be provided in the Technical Guidance.

Tobacco Cessation/E-cigarettes - The FEHB Program has been a long-time leader in ensuring coverage for tobacco cessation benefits and successful in reducing tobacco use in the FEHB population. Carrier Letters 2001-09 and 2010-06 communicated the ongoing requirement for all plans to provide comprehensive smoking cessation benefits. This requirement is now referred to as the FEHB tobacco cessation benefit and applies to all FDA-recognized tobacco products.

While cigarette smoking rates continue to decline nationally, the tobacco product landscape has evolved to include a variety of smoked, smokeless, and electronic tobacco products, including e-cigarettes. Although e-cigarettes may have the potential to benefit adult smokers if they transition completely from cigarettes to e-cigarettes, the science on the effectiveness of e-cigarettes for smoking cessation remains inconclusive. Moreover, there is growing concern over the increased use of e-cigarettes in youth.[10] In response to these alarming statistics and influencing factors on our youth, Surgeon General Jerome Adams released an advisory on e-cigarette use among youth.[11] This December 18, 2018 advisory provides specific actions to address this public health epidemic. The FDA categorizes e-cigarettes as tobacco products and is also making significant efforts to curtail youth use, while continuing to evaluate the safety and efficacy of e-cigarettes as a possible cessation tool for adult smokers.[12]

FEHB Carriers are expected to re-invigorate messaging about the tobacco cessation benefit through the following actions:

- Clarify that tobacco cessation benefits are available to those seeking to quit use of all tobacco products, including e-cigarettes;
- Ensure that members have access to tobacco cessation benefits with no Carrier imposed barriers;

[10] See https://www.cdc.gov/mmwr/volumes/67/wr/mm6744a2.htm, and https://www.cdc.gov/mmwr/volumes/67/wr/mm6745a5.htm
[11] See https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf
[12] See https://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/ucm456610.htm#references

- Educate members about the risks of all forms of tobacco product use, including e-cigarettes among youth, and make information available to parents on how to prevent and detect e-cigarette use among children;
- Emphasize to providers the need to screen for all forms of tobacco products, including e-cigarette use, and refer tobacco users to appropriate cessation interventions; and
- Continue to encourage all tobacco product users to quit. Inform users of cessation programs available through smokefree.gov or the 1-800-QUIT-NOW quit line. For those under 18 and unable to use tobacco cessation medications, encourage a visit to smoke free teen at https://teen.smokefree.gov/ for age-appropriate quit methods and tools.

Please describe in your benefit proposals your plan to educate beneficiaries on all tobacco products and provide quit support for all tobacco product users.

Patient Safety

Maternal Health - The United States continues to experience an increase in deaths related to complications in pregnancy or childbirth, and unnecessary procedures place women and infants at risk for short- and long-term health consequences, as well as needlessly increase costs. Cardiovascular disease is a leading cause of maternal mortality, and for many women was present before pregnancy. OPM emphasizes that preventing, detecting, and treating chronic diseases and their comorbidities–including obesity–can have far-reaching impacts.

Many maternal deaths are attributable to preventable or detectable causes, including postpartum hemorrhage, cardiomyopathy, severe hypertension, infection/sepsis, and thrombotic pulmonary embolism.[13,14] Hospitals and practitioners are the focus of many interventions to reduce these occurrences, with many actions also championed by professional societies, including the American College of Obstetricians and Gynecologists (ACOG). FEHB Carriers can support these population health initiatives when designing networks and engaging in hospital contracting. Specifically, please consider the following when making network and contract decisions:

- Utilization of Alliance for Innovation on Maternal Health (AIM) patient safety bundles including readiness, recognition, response, and reporting protocols. Bundles include critical events such as hemorrhage and severe hypertension, as well as care for women with opioid use disorder.
- Standard communication processes for identifying patient risk for labor complications, in particular post-partum hemorrhage. These communication channels can also increase preparedness for other detectable and treatable causes of maternal mortality, such as thrombotic pulmonary embolism.
- Utilization of the Maternal Health Compact, which formalizes connections between facilities to establish consultation or transfer resources during unexpected maternal emergencies.[15]

[13] See https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm
[14] Mann, S. et al. (2018). What we can do about maternal mortality – and how to do it quickly. *NEJM*, DOI:10.1056/NEJMp1810649
[15] Ibid.

Recognizing that unnecessary procedures place women and infants at risk, OPM reminds Carriers of the importance of reducing Cesarean birth rates. OPM issued a Utilization Review Newsletter in August 2017 outlining the risks associated with Cesarean sections where they are not clinically indicated. The case for action lies in the understanding that FEHB members are subject to local practices and FEHB Carriers have a compelling interest in quality improvement. OPM urges FEHB Carriers to consider the recommendations and resources provided in the Newsletter. Additional information will be provided in the Technical Guidance.

Preventive Services

A review of plan documents and disputed claims has revealed inconsistent interpretation of FEHB Program requirements that may impact enrollee access to recommended care, cost sharing, and population health. OPM expects FEHB Carriers to cover preventive services endorsed by the below listed entities with no cost sharing when received from an in-network provider.

- All services recommended by the United States Preventive Services Task Force (USPSTF) with an "A" or "B" rating.[16] These include, but are not limited to, screenings, testing, preventive care, and certain medications.
- Adult and child immunizations approved by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).[17]
- Pediatric screenings and preventive care endorsed by the American Academy of Pediatrics Bright Futures Guidelines.[18]
- Women's Preventive Services recommended in guidelines issued by the Health Resources and Services Administration (HRSA)[19], along with contraceptive coverage mandated by section 726 of the Consolidated Appropriations Act, 2018 (P.L. 115-141) or later renewals.

"No cost sharing" means that services are not subject to copayments, coinsurance, deductibles, or annual limits. For all required preventive services, FEHB Carriers must cover the full scope of the recommendations as illustrated in the following:

1. If the A or B rated recommendation is to screen plus counsel and test those at certain risk levels, then all are covered at 100%.
    - Example: Upon screening for breast cancer susceptibility, women with certain risks are recommended for genetic counseling and BRCA testing. In such cases, the screening, genetic counseling, and BRCA testing are all covered without cost sharing. Subsequent treatment for discoveries found through BRCA testing would not be covered under the preventive service benefit.

[16] USPSTF Recommendations: https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
[17] ACIP Recommendations: https://www.cdc.gov/vaccines/acip/
[18] AAP/Bright Futures Guidelines: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf andhttps://brightfutures.aap.org/Pages/default.aspx
[19] HRSA Guidelines: https://www.hrsa.gov/womens-guidelines-2016/index.html

2. If the A or B rated recommendation is to screen and refer to counseling those at certain risk levels, then both the screening and the support services for which the individual is being referred are covered at 100%.
3. When multiple screening options are available, the following guidance applies:
    - If options are listed within an A or B rated recommendation (and not individually rated), then all must be covered without cost sharing.
        - Example: Screening for colorectal cancer starting at age 50 and continuing until age 75 received an A rating. Included within the recommendation, and not individually rated, are four direct visualization tests (colonoscopy, CT colonography, flexible sigmoidoscopy, and flexible sigmoidoscopy with fecal immunochemical test [FIT]) and three stool based tests (guaiac based fecal occult blood test, FIT, and multi-targeted stool DNA test [FIT-DNA]). Each test has a recommended periodicity. All seven screening strategies must be covered with no cost sharing when delivered by a network provider at the recommended screening interval.
    - If options are enumerated and separately rated, then 100% coverage may be limited to only those individually earning an A or B rating.
    - If options are not enumerated, then Carriers may select from among the available options. When this is the case, plan documents must clearly specify which are covered at 100%.
4. Services integral to a screening procedure must be covered as preventive and conversion to another benefit category subject to cost sharing is not permissible after the fact.
    - Example: If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, it is not permissible for an FEHB Carrier to convert the procedure to "diagnostic" and impose cost sharing for removal of a polyp discovered during the screening examination. We do not want to deter members from seeking preventive colonoscopies because there is concern about incurring a cost share for a polyp removal during a colonoscopy performed as a screening procedure. One way many plans have chosen to handle this is to cover only the first colonoscopy of the year as preventive.

These requirements apply to preventive services only. OPM recognizes that there are other circumstances (such as providing diagnostic evaluations and monitoring ongoing conditions) for which similar tests may be medically necessary and covered with usual cost sharing. Carriers may also elect to cover additional tests, screenings, procedures, or interventions at 100%. For example, some plans cover prenatal care or medications for certain chronic conditions without cost sharing.

Preventive services guidelines are updated periodically by the USPSTF, ACIP, HRSA, and Bright Futures. Preventive services earning an "A" or "B" rating from the USPSTF or endorsement from the relevant entity by December 31 of the previous year should be incorporated into FEHB Carrier benefit proposals the following May, with no partial or phased-in implementation period. Carriers may adopt recommendations earlier as appropriate. For example, new recommendations for cervical cancer screening, fall prevention in older adults, unhealthy alcohol use in adults, obesity screening and counseling for adults, and osteoporosis

screening for women were among those released in 2018 and are expected to be addressed in your 2020 proposal along with the other 2018 recommendations. Recommendations for prophylactic medication to protect newborns from gonorrhea and prevention of perinatal depression were released early in 2019. With our focus on maternal health, Carriers are encouraged to adopt these 2019 recommendations in their 2020 proposals.

II. Affordability

Transparency

Availability of clear cost information is important for consumers who want to make more informed decisions concerning their health care, and research shows that the majority of consumers want this information before getting care.[20,21] However, healthcare consumers have traditionally not had ready access to price information that meets their needs. Enhancing the availability and accessibility of price and quality information is an important strategy for fostering the continued quality and affordability of FEHB plans. OPM recognizes that the functionality and information available on transparency tools may differ for prescription drugs and medical services and acknowledges that Carriers may want to have separate tools for drugs and medical services.

Drug Transparency Tools- In Carrier Letter 2014-03, FEHB Carriers were required to provide a prescription drug cost transparency tool to current and prospective members by plan year 2016. In Carrier Letters 2016-03 and 2017-01, OPM continued to prescribe required improvements to ensure access to this important information. OPM applauds Carriers for efforts to date to enhance interactive prescription drug transparency tools.

Given our continuing focus on transparency, FEHB Carriers must describe in their proposals how they will promote the use of provider tools, when available, such as electronic prior authorization and benefit check tools that display drug formulary and pricing information at the point of prescribing. These provider-level tools can reduce prescription abandonment and result in quicker turnaround times.

Medical Services Transparency Tools- OPM first called on Carriers to provide cost and quality transparency tools for medical procedures in Carrier Letter 2006-09. Since that time, Carriers have made considerable strides in this area, with over 75 percent of FEHB plans indicating in the 2018 ADC that they have provider and hospital cost transparency tools available. However, the ADC also shows that much more work remains: only 36 percent of Carriers reported having provider or hospital quality comparison tools available, and most plans

[20] Accenture Consulting, (2017). Show Me the Money: Why Price Transparency for Patients is Good for Providers, Too. https://www.accenture.com/us-en/insight-show-me-the-money

[21] Schleifer, D., Hagelskamp, C., & Rhinehart, C. (2015). How Much Will it Cost? How Americans Use Prices in Healthcare. https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf

estimated that less than one percent of their membership has used these transparency tools. Additionally, the specificity of the information available in Carrier tools varies widely.

In order to allow individuals to take a more active role in selecting quality, affordable healthcare, OPM calls on Carriers to intensify their efforts in improving transparency tools. Specifically, OPM asks Carriers to describe in their proposals how they would, by 2021, provide robust online search tools that:

- Allow members to estimate accurately the dollar amount they should expect to pay for a defined set of common outpatient and elective in-patient health care procedures and services. These estimates should be personalized based on the member's plan option and deductible status and be available for specified geographical areas;
- Are easy to use and provide complete, accurate, up-to-date information;
- Are readily accessible from prominent links on the Carrier's website; and
- Present network, quality, and cost information together.

Though Carriers must require members to log in to see their account-specific information, Carriers should maximize the information available on their websites, specifically around average or median costs of common procedures, without the necessary log in. In addition, Carriers should develop a strategy for promoting and measuring the use of these tools and should emphasize to members the importance of researching and choosing lower-cost, higher quality options for their health care. OPM encourages Carriers to propose creative methods for incentivizing or rewarding members' use of transparency tools.

Prescription Drugs

In 2017, approximately 27 percent of the total FEHB premium was attributed to prescription medications. The cost of prescription drugs remains a top concern for the FEHB Program, especially as more expensive drugs are expected to come to market over the next several years.

Specialty Drug Management - Specialty drugs may involve the pharmacy and/or medical benefit and are projected to account for a larger amount of total drug spend over the next several years.[22] Specialty medications under the pharmacy benefit can be managed using several strategies, including benefit design, utilization management tools and specialty pharmacy networks. While slightly more complex, strategies to manage drugs billed under the medical benefit may include site-of-care management, utilization management programs and network reimbursement strategies. Specialty medications billed under the medical benefit can be administered in various settings, such as physician's office, hospital outpatient facility, or a home health setting. Costs vary by site of care. Site-of-care programs can redirect patients and medications to the most clinically appropriate and lowest-cost channel without compromising patient outcomes. As in previous years, FEHB Carriers are expected to have a robust specialty management program in place that manages and coordinates drugs under the medical and

[22] Carrier Letter 2017-01: https://www.opm.gov/healthcare-insurance/healthcare/carriers/2017/2017-01.pdf

pharmacy benefit. In addition to outlining how they are meeting the strategies above, Carriers are required to include their site-of-care management program as part of their proposal.

Point-of-Sale Rebates - Health plans or their pharmacy benefit managers (PBMs) are typically able to negotiate with pharmaceutical manufacturers to obtain rebates on branded drugs based on formulary placement and other considerations. FEHB experience-rated contracts require PBMs to credit rebates to Carriers and require Carriers to include these in their net benefit costs. FEHB Carriers are allowed to reflect a portion of the rebate value at the time the claim is adjudicated through point-of-sale rebates. A number of Carriers have implemented such programs, which can lower out-of-pocket drug costs for members whose plan design includes deductibles and/or coinsurance. OPM encourages Carriers to submit innovative proposals to deliver rebate value at the point of sale while keeping premiums affordable. The value of the rebate applied at the point of sale should be identifiable, as should all the components of the drug price.

Incentivizing Generic Drugs - The availability of generic drugs in the United States has significantly lowered the cost of prescription drugs. Increasingly, pharmaceutical manufacturers provide copayment coupons, also known as copay cards, for use on brand drugs to reduce member out-of-pocket expenses. In recent years, the prevalence and utilization of copay cards has increased and has been linked to an increase in brand drug sales.[23] While this is a cost saver for members, pharmaceutical couponing can bypass plan design, increase the use of multi-source brand drugs and thereby lower the Generic Dispensing Rate (GDR).[24]

According to the 2018 ADC, the non-weighted average GDR in the FEHB Program was 92 percent compared to a 98 percent GDR for commercial plans as reported by URAC. OPM appreciates the efforts Carriers have made in the past to incentivize the use of generic drugs when available.

FEHB Carriers must describe any policies and programs they are proposing or already have in place to encourage the use of generic drugs when available. To the extent that a Carrier can demonstrate a mechanism to mitigate the effect of multi-source brand couponing and incentivize the use of generics, without creating an undue financial burden to the member, OPM would be interested in further understanding those mechanisms. FEHB Carriers with a lower-than-average GDR should place particular emphasis on developing robust strategies for improving their GDR.

Additional data regarding pharmacy utilization and trends will be requested as part of each Carrier's response in the ADC.

Value-Based Healthcare and Performance Networks

In last year's Call Letter OPM encouraged Carriers to consider a broad range of strategies to improve clinical quality and provide cost-effective care. These strategies included implementing

[23] Dafny, Ody, Schmitt, American Economic Journal, (2016). *When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization*
[24] GDR Report: https://www.urac.org/sites/default/files/2018-04/URAC_2017%20PBM_Aggregate%20Summary%20Report.pdf

value-based benefit designs that modify cost sharing for high-value and low-value benefits, reducing cost sharing for enrollees who manage chronic conditions and implementing performance-based provider networks. OPM continues to encourage Carriers to propose value- and evidence-based benefit designs and implement value-based purchasing that can improve quality of care and increase member engagement.

In alignment with OPM's Strategic Plan, Carriers are also encouraged to propose additional plan options that offer innovative benefit structures and that provide additional meaningful healthcare choices for FEHB Program enrollees.

Controlling Fraud, Waste and Abuse (FWA)

In addition to routine audits of FEHB Carrier operations, OPM's Office of Inspector General (OIG) examines potential healthcare fraud against the FEHB Program by conducting criminal investigations that are coordinated with the Department of Justice and other law enforcement agencies. In the course of its investigations, the OIG has recommended several areas where we believe Carriers should adjust benefit designs to better control fraudulent payments. FEHB Carriers should implement processes that monitor pharmacy claims in order to identify outliers that may be evidence of fraud, waste, and abuse. For example, the OIG has investigated several schemes related to compounding pharmacies billing for unnecessary and high-cost creams, and most recently found multiple cases in which providers overcharged or otherwise submitted fraudulent billing for lidocaine creams. These same schemes involved high dollar coinsurance payments which were found to be waived or significantly reduced for the member, which as a result increases the program costs.

In addition, the OIG has been investigating sober homes, laboratories, hospitals, and providers who have been billing for multiple Urine Drug Test screens (UDT), both qualitative and quantitative, that are not medically necessary, as well as fraudulent screens for individuals not undergoing substance use disorder treatment. Appropriate monitoring processes can identify these types of payments to prevent larger schemes from taking hold.

Accordingly, OPM is requesting that Carriers adjust plan benefits to discourage these schemes and to continue reporting waivers of co-payments related to high dollar compounded medications to the OIG. For further information on industry best practices to control FWA for these and other payment practices, please see Carrier Letter 2017-13.

III. Cost Neutrality

Previously, OPM has required that when proposing an increase in benefits, Carriers must propose corresponding benefit reductions to offset any potential increase in premium, with limited exceptions directed by OPM. This has been applied within individual plans within a contract. For instance, if a Carrier were to propose decreasing a cost sharing in one benefit and this increase in benefits would have an additional cost impact, the Carrier would have to have also proposed benefit decreases in other areas with an equal or greater reduction in cost than the

benefit increase in the same plan option. We continue to believe that imposing cost neutrality on benefit proposals is an important tool in meeting our strategic objective of increasing quality and promoting greater affordability. We will continue to impose cost neutrality; however, for the 2020 plan year, under certain circumstances, we will consider Carrier-generated proposals for exceptions to this requirement. Carrier proposals may include benefit enhancements in one plan option that are offset by reductions in another of that Carrier's plan options to achieve cost-neutrality. Carriers must still maintain a meaningful difference between plan options. If proposing such a benefit change, the Carrier will be required to provide a clear and specific strategic justification for the potential premium increase and demonstrate the projected cost-savings in the current year. We will also entertain proposals that are not cost-neutral in the current year within a single plan option, if the Carrier can show a strategy to achieve cost-neutrality within that option and eventual savings in the near-term future (i.e., within three years).

In addition, we will entertain proposals to provide greater value to enrollees with Medicare coverage without concern for cost neutrality.

Except as noted here, all benefit enhancements must be offset by proposed reductions so that premiums are not increased due to benefit changes.

IV. Technical Guidance

We will provide additional guidance on submission of benefit and rate proposals and preparation of brochures in the Technical Guidance.

CONCLUSION

OPM's goal for the FEHB Program is to provide quality, affordable health benefits for Federal employees, annuitants, and their families. Continuous open and effective communication between OPM contracting staff and Carriers should occur to ensure a seamless negotiation cycle. Please discuss all proposed benefit changes with your Health Insurance Specialist.

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

Sincerely,

Alan P. Spielman
Director, Healthcare and Insurance