
FEHB Program Carrier Letter

All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2017-01

Date: January 11, 2017

Fee-for-service [1]

Experience-rated HMO [1]

Community-rated HMO [1]

SUBJECT: Federal Employees Health Benefits Program Call Letter

SUBMISSION OF PROPOSALS

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. You should submit your benefit and rate proposals for the contract term beginning January 1, 2018 on or before **May 31, 2017**. Please send your proposals to your Health Insurance Specialist via **overnight mail, FAX, or email**. We expect to complete benefit and rate negotiations by mid-August to ensure a timely Open Season. As a reminder, your Contracting Officer will consider responses to the topics in the Call Letter in evaluating your responsiveness to OPM, as it remains an important element of the Plan Performance Assessment program.

FEHB PROGRAM BENEFITS AND INITIATIVES

I. Introduction

The annual call for benefit and rate proposals sets forth the policy goals and initiatives for the FEHB Program for 2018 and beyond. OPM continues to seek innovative ways to provide enrollees with timely access to health services and to improve delivery of care. We encourage all carriers to thoroughly evaluate options to improve affordability, reduce costs, improve the quality of care, and protect the health of their enrolled populations. Any proposed benefit enhancements must be offset by proposed reductions so that premiums are not increased due to benefit changes.

This year, we are focusing on the themes of:

- Managing Prescription Drugs;
- Ensuring Access to Care;
- Population Health;
- Alternative Payment Models; and
- Plan Performance Assessment.

These initiatives are discussed below.

II. Managing Prescription Drugs

Rising drug prices and increasing drug utilization continue to drive up FEHB Program premiums. In 2015, 25.5 percent of the total FEHB healthcare budget was spent on drugs. Most FEHB carriers also report a significant increase in drug cost per member per year.

For 2017, nearly all FEHB carriers revised formulary management or utilization management to reinforce the effective use of selected classes of prescription medications to achieve improved health outcomes while managing drug costs. Additionally, 90 percent of all carriers updated their outreach to promote adherence or minimize member disruption. OPM acknowledges these efforts but strongly encourages carriers to re-examine opportunities to reinforce or add proven utilization management techniques. We are particularly interested in proposals that optimize safe use and evidence based formulary management of drugs for mental health conditions, substance use disorders, immunosuppression, diabetes, HIV, seizure disorders, and cancer.

Transparency. OPM appreciates efforts carriers have made to provide drug cost calculators that display up-to-date information about the formulary tier, member cost-share and utilization management requirements for covered prescription drugs. Effective drug use calculators should be accurate, intuitive, easy to navigate and understand, and be member-friendly. We strongly encourage carriers to improve interactive cost calculator functionality for the 2018 plan year. Static formulary lists do not meet this requirement.

Innovative Proposals. We strongly encourage carriers to submit proposals on the following topics along with detailed analysis and adequate data to transparently support their conclusion. All such submissions should include details of how the proposal conforms to FEHB contracting requirements:

Value-Based Insurance Design (VBID) refers to structuring enrollee cost-sharing and other health plan design elements to encourage the use of high-value clinical services that have the greatest potential to positively impact enrollee health. These interventions can also improve the quality of care and reduce the cost of care for members with chronic diseases. An example of VBID is decreasing or eliminating patient cost sharing to improve members' access and appropriate use of effective drugs.

Value Based Contracting Strategies that take into account clinical effectiveness or outcome of the drug. Manufacturer drug rebates are linked to the defined value metric. Examples of value based contractual strategies include:

- Outcome based rebate models whereby rebates are increased if pre-defined clinical outcomes are not achieved.
- Indication-based rebate models that vary the rebates for a drug based on its clinical effectiveness for different indications. For example, a medication might be used to treat one condition with high levels of success but an unrelated condition with less effectiveness.

Coordination of specialty drugs between the medical and pharmacy benefit - Certain specialty drugs may be covered under the pharmacy and/or the medical benefit depending on the route of administration. The complexity of specialty medications, billing system limitations, and provider management make cost trend management of specialty medications covered in the medical benefit challenging. Strategies to address this circumstance include:

- Assess drug placement in the medical benefit versus the pharmacy benefit. A shift in benefit channel may lead to significant cost saving; however, carriers must also examine the complete cycle of care and consider the possible member and provider disruption.
- 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.
- Specialty management programs such as utilization and trend management programs can be applied to drugs managed under the medical benefit.

OPM continues to emphasize the safe and effective use of prescription medications while managing drug costs. Your 2018 proposal should highlight how you will address the coordination of specialty drugs between the medical and pharmacy benefit through benefit structure or program initiatives.

III. Ensuring Access to Care

Unexpected Bills from Out-of-Network Providers. We would like to acknowledge plans that have taken steps to limit unexpected out-of-network billing for members through various education and outreach efforts. The fact remains that FEHB members continue to encounter unexpected charges from out-of-network providers who render services within in-network facilities. OPM remains focused on minimizing unnecessary cost to members. OPM strongly encourages carriers to remain focused on this concern by employing multiple strategies including, but not limited to, the following:

- Working with contracted facilities to steer members to in-network providers;
- Examining how emergency room care, regardless of network status, is reimbursed and billed;
- Implementing the use of bundled payments for episodes of care commonly impacted by out-of-network billing, such as services involving emergency, radiology, pathology, anesthesia, and neonatology providers;
- Reviewing facility contracts to ensure in-network medical providers are available; and
- Developing consumer resources that provide greater transparency about out-of-network provider status and cost.

Please include in your proposal a specific description of the new strategies you will leverage to address this issue in 2018. In addition, your proposal should address negotiating one-time contracts with out-of-network providers to protect members from balance billing.

Telehealth Services. We are pleased that many plans are beginning to offer members more services through telehealth. This includes virtual visits for primary care, urgent care, behavioral health, in-home monitoring of chronic illnesses, and dermatology. Industry data show that telehealth can reduce avoidable hospital visits as well as provide regular access to care in remote and rural areas.¹ OPM continues to encourage carriers to leverage this

¹ <http://www.aha.org/research/reports/tw/15jan-tw-telehealth.pdf>

tool and to describe the areas in which you intend to implement or to expand it for the 2018 plan year. We are especially interested in proposals that demonstrate increased value or projected savings to healthcare costs.

We call particular attention to the fact that telebehavioral health services are becoming more accessible and can help support access to care. A 2009 Substance Abuse and Mental Health Services Administration survey found that less than one quarter of the estimated 45 million American adults who have a mental illness received treatment. This modality can be a viable alternative to expand network boundaries, address privacy concerns, and provide needed treatment.

IV. Population Health

Comprehensive Diabetes Management. FEHB Plan Performance Assessment results indicate that carriers are beginning to make progress toward achieving diabetes control. A comprehensive approach to diabetes involves screening, effective prevention, and evidence based management. Together, these can improve the health of our population, reduce long-term complications, and control costs.

In October 2015, the United States Preventive Services Task Force (USPSTF) endorsed blood glucose testing as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. The USPSTF notes that patients with abnormal blood glucose should be referred to intensive behavioral counseling interventions to promote a healthful diet and physical activity. Carriers must ensure that network providers are aware of how their patients can access this covered benefit. A list of nationally recognized diabetes prevention programs meeting this requirement is available online at CDC's website². We also note that the Centers for Medicare and Medicaid Services (CMS) is now covering diabetes prevention programs for eligible Medicare beneficiaries when delivered by recognized providers.³

For individuals diagnosed with diabetes, successful management involves adherence to clinical guidelines, self-monitoring, regular testing of HgbA1c, and access to appropriate medications. Carriers can facilitate these steps by marketing any covered diabetes education programs, reminding clinicians of the American Diabetes Association treatment algorithms,⁴ and removing barriers to timely testing and treatment. This may involve reviewing the formulary placement of antidiabetic medications and insulin preparations, and/or working with laboratory contractors to implement "standing orders" for periodic HgbA1c testing. Pharmacy counter protocols, medication therapy management, and disease management programs can reinforce the need for self-monitoring, clinical follow-up, and laboratory testing. Incentives for diabetes management programs, medications, and supplies are appreciated as long as they comply with tax rules and regulations.⁵ Proposals should include specifics of each carrier's comprehensive diabetes management efforts. Please refer to the technical guidance for additional details.

² https://nccd.cdc.gov/DDT_DPRP/Registry.aspx

³ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-02-2.html>

⁴ http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf

⁵ <https://www.irs.gov/government-entities/federal-state-local-governments/de-minimis-fringe-benefits>

Mental Health and Substance Use Disorder (SUD). The White House Mental Health and Substance Use Disorder Parity Task Force released its final report⁶ in October 2016. The report highlights progress since the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and underscores areas where there are still opportunities to improve. The Task Force report specifically recognizes significant efforts made by FEHB carriers to ensure parity, and directs OPM to “undertake a detailed review of non-quantitative treatment limits (NQTLs) applicable to substance use disorder benefits, and take corrective action as indicated by the findings.” In preparation, FEHB carriers should carefully consider the list of compliance “warning signs” compiled by the Department of Labor⁷ when preparing their proposals.

SUD, including the misuse of opioids, has reached epidemic proportions.⁸ SUD is now widely recognized as a chronic condition that involves changes in brain physiology. It is frequently observed with mental and physical health comorbidities, has a high rate of relapse, and requires ongoing treatment. The use of prescription opioids to manage pain is associated with a risk of dependence and SUD in the intended recipient, as well as the opportunity for diversion and/or misuse by others who have access to stored medications. Adherence to the Centers for Disease Control and Prevention (CDC) prescribing guidelines⁹ can help mitigate this risk.

Due to the enormous costs SUD has on society, it is essential that FEHB plans recognize the seriousness of this condition and assure access to effective treatments. Medication Assisted Treatment (MAT) has demonstrated effectiveness in patients with SUD. Traditionally the domain of methadone treatment centers, buprenorphine and naltrexone are increasingly used to treat patients with SUD. New regulations expand the types of providers who may prescribe buprenorphine preparations as well as the number of individuals that any single provider can have under active treatment.¹⁰

We appreciate efforts that FEHB carriers have already made to expand access to MAT, yet we strongly encourage all carriers to take additional actions for 2018. Specifically, carriers should consider options to add qualified prescribers to their networks and review formulary placement of opioid reversal agents and MAT. OPM expects that FEHB carriers will not restrict access to naloxone based reversal agents by creating a prior approval requirement. At least one naloxone preparation should be available on a favorable formulary tier, even in jurisdictions where the drug is available without a prescription. Similar to Medicare Part D programs,¹¹ we urge carriers to make coverage for buprenorphine combination products available on favorable tiers, and not to limit coverage to single ingredient preparations. Finally, we request that all carriers have a transition policy in place for any new enrollees to prevent unintended interruptions in pharmacologic treatment for SUD.

⁶ <http://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF>

⁷ <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

⁸ <https://addiction.surgeongeneral.gov/>, “Facing Addiction in America,” The Surgeon General’s Report on Alcohol, Drugs, and Health

⁹ <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

¹⁰ <https://www.hhs.gov/about/news/2016/11/16/additional-steps-expand-opioid-treatment.html>

¹¹ <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf>

Patient Safety. FEHB carriers are reminded that they have a responsibility to reinforce patient safety in network acute care settings. On any given day, about one in 25 hospital patients suffers a healthcare-associated infection (HAI), leading to almost \$30 billion per year in avoidable medical costs across the United States.¹² In addition to the direct consequences of HAIs, treatment with broad-spectrum antibiotics contributes to the development of antibiotic resistant bacteria. The Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) have highlighted the need for urgent action.

Selected infection rates for most US hospitals are publicly posted on Medicare Hospital Compare¹³ and the Leapfrog Hospital Safety Score¹⁴ website. Leading hospitals also report detailed data to CDC's National Healthcare Safety Network. Joint Commission accreditation standards for hospitals and Medicare Conditions of Participation now emphasize effective antibiotic stewardship programs, such as those described by CDC.¹⁵

We strongly encourage FEHB carriers to consider this information in their plan design, hospital contracting decisions, pre-authorization procedures, and case management processes in order to incentivize successful practices or direct FEHB patients to hospitals with better outcomes. Your proposals should describe how you intend to implement this guidance.

V. Alternative Payment Models

Since 2011,¹⁶ OPM has welcomed carriers to explore alternative payment models and share their intentions in annual proposals. Beginning in 2012,¹⁷ OPM invited carriers to facilitate enrollee access to CMS' original Comprehensive Primary Care demonstration. This year, CMS is launching the Comprehensive Primary Care Plus (CPC+)¹⁸ demonstration, which will allow participating payers to include both Medicare and other lines of business. OPM encourages eligible carriers to include FEHB lives and to share insights about how the CPC+ model performs for patients of varying ages and medical needs.

OPM is also interested in learning more about other bundled payments that aim to improve both cost and outcomes. Maternity care examples¹⁹ include payment structures designed to increase the percentage of full-term births and the percentage of vaginal births, while decreasing the percentage of pre-term and early elective births, complications, and mortality. Bundles have also been described as a means to achieve better value in high cost/complex procedures (e.g., joint replacement, coronary artery bypass graft), and control drug costs (e.g., oncology care). Please elaborate in your proposals as applicable.

VI. Plan Performance Assessment

¹² <https://www.cdc.gov/hai/surveillance/>

¹³ <https://www.medicare.gov/hospitalcompare/search.html>

¹⁴ <http://www.hospitalsafetyscore.org/your-hospitals-safetyscore/state-rankings>

¹⁵ <http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.htm>

¹⁶ <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2011/2011-05.pdf>

¹⁷ <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-09.pdf>

¹⁸ <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

¹⁹ <https://hcp-lan.org/groups/cep/maternity-final/>

OPM is pleased that all carriers reporting Clinical Quality, Customer Service, and Resource Use (QCR) performance measures for the 2016 Plan Performance Assessment were able to submit timely results and confirm their final scores. OPM publicly reports the percentage of FEHB carriers that perform above the national average on high priority QCR measures. We congratulate carriers for their overall progress on measures of timely prenatal care and blood pressure control.²⁰ For the 2018 plan year, OPM emphasizes the need for carriers to focus improvement efforts on reducing hospital readmissions. Carriers are also reminded that 2017 is the first year they can earn an Improvement Increment, and this opportunity will continue in 2018. More details on QCR measures and the Improvement Increment are available in Carrier Letters 2016-11 and 2016-14.

VII. Technical Guidance

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

CONCLUSION

OPM's continued goal for the FEHB Program is to pursue innovative ways to restrain rising health care costs while providing opportunities for members to live healthier lives. Please discuss all 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

²⁰ <https://www.performance.gov/node/43492?view=public#indicators>