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# FEHB Program Carrier Letter

## All Carriers

U.S. Office of Personnel Management  
Insurance Services Programs

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**Letter No. 2011-05**

**Date: March 25, 2011**

Fee-for-service [5]

Experience-rated HMO [5]

Community-rated HMO [3]

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**SUBJECT: Federal Employees Health Benefits Program Call Letter**

### EXECUTIVE SUMMARY

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program carriers. Your benefit and rate proposals for the contract term beginning January 1, 2012 should be submitted to us on or before **May 31, 2011**. Please send your proposals by **overnight mail, FAX, or email** to your contract specialist. We expect to complete benefit and rate negotiations by mid-August to ensure a timely Open Season.

The FEHB Program Carrier Guiding Principles are shown on our website at: <http://www.opm.gov/carrier>. All FEHB carriers must adhere to these principles. We expect timely and accurate processing of claims, including coordination of benefits; prompt and accurate submission of actuarial and financial data, including accounting statements; and we expect all plans to be well managed and financially secure.

We thank you for your continued cooperation and collaboration on the important initiatives undertaken last year. We appreciate the efforts of those plans that implemented Medicare pilot programs in 2011 to improve the value of coverage for annuitants through benefits coordination between FEHB and Medicare. We will evaluate the experience of these programs after two years before deciding whether to expand them.

With your support, we successfully implemented changes to the FEHB Program to comply with the Affordable Care Act, affording important protections for FEHB enrollees and their families such as: providing preventive care and smoking cessation benefits with no cost sharing and covering dependents up to age 26. All of these benefits carry forward. As we work toward the 2012 contract term, we know you will continue to provide Federal enrollees with affordable, high quality healthcare. Key initiatives for 2012 are as follows:

1. We encourage you to submit proposals to implement pilot programs directed at managing patient care such as integrated healthcare systems.
2. We expect you to offer programs that promote health and wellness and which are aimed at improving employee productivity, enhancing healthy lifestyles, and lowering long-term healthcare costs. This includes incentives for enrollees who complete a health risk assessment, are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status.

3. We expect you to provide us with specific proposals to reduce the incidence of both adult and childhood obesity.
4. We expect you to submit proposals to increase and strengthen programs that will demonstrate improved health outcomes, patient safety, and prevent hospital readmissions.
5. We encourage you to submit proposals that aim to reduce racial and ethnic disparities in both health status and healthcare.
6. We expect all carriers to take additional steps to promote the use of generic drugs.
7. We expect you to submit proposals outlining how you will reduce overall pharmacy spending.
8. We strongly encourage you to increase the number of health care providers in FEHB plan networks who are board certified, or have training in, geriatrics.
9. We strongly encourage you to analyze the affinity products described on the “non-FEHB” page of your brochure and to consider including health insurance coverage for other dependents.
10. We are requesting that you submit the medical loss ratio for your plan as well as your best approximation of the actuarial value for each of your plan options.

## **I. Introduction**

OPM continues to look at ways in which we can enhance the FEHB Program by increasing effective competition among health plans; improving the efficiency of the program; addressing affordability issues; introducing more accountability; and, increasing the program’s emphasis on wellness and prevention.

Your proposed benefit changes must be value-based. In other words, we are encouraging innovative proposals aimed at controlling long-term health care costs by encouraging the use of services to produce better health outcomes. You must demonstrate that you have evaluated your proposed benefit changes with regard to their influence on promoting the most effective care (i.e., the care that generally produces the best health outcomes), not just with respect to cost.

We expect your benefit proposals to be consistent with the policies outlined in this Call Letter. Proposals should be cost neutral by offsetting any proposed increases in benefits with the exception of value-based benefit designs that expand consumer awareness about the importance of maintaining healthy lifestyles.

## **II. FEHB Program Benefits and Initiatives**

### **A. Health Plan Accountability**

Quality healthcare is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It also encompasses how well a plan performs in meeting members’ needs and expectations. In our efforts to improve plan accountability, we are

exploring additional metrics and incentives for quality performance. The metrics being developed will be built on the Healthcare Effectiveness Data and Information Set (HEDIS) measures currently submitted by carriers. We will keep you informed about our quality healthcare goals and expectations in a separate letter.

In addition, we are moving forward with the development of the privacy-protected health claims data warehouse (HCDW). In the past, OPM has not routinely collected, or analyzed, program-wide claims data. The capacities to collect, manage, and analyze health services data on an ongoing basis will allow OPM to: 1) better understand the drivers of cost increases for Federal employees; 2) determine the best approaches to developing worksite wellness programs; and 3) model the potential effects of health system reform or environmental changes on Federal employees. As provided for under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OPM will protect the privacy of individually identifiable health information. Implementation of the HCDW will include the following elements:

- **Data collection and maintenance:** The HCDW project will establish regular data feeds from FEHB plans (and major Pharmacy Benefit Managers); develop/test front end edits to ensure data integrity and consistency across plans; manage data flows; ensure and maintain data quality and integrity; and manage data storage and back-up.
- **Analysis support:** This element will involve designing the database and linking routines to connect claims to individual demographics, provider files, and other OPM maintained data sets, while protecting the privacy and security of personal health information. It will also create de-identified databases that can be used to run specific analyses.
- **Data warehouse application:** Development of this application will allow flexible queries of the data set (not only general demographic queries). For example, analysts will be able to run risk-adjusted profiles, and other useful analytics.

## **B. Integrated Healthcare Systems**

We are encouraging plans to submit proposals for pilot programs aimed at managing health care costs and utilization. These types of systems promote a team-based approach to care for a patient through a spectrum of disease states and across the various stages of life. They facilitate partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. Overall coordination of care is led by a personal physician with the patient serving as the focal point of all medical activity. These systems have the ability to manage the patient's continuum of care across different institutional settings, including ambulatory and inpatient hospital care and possibly post acute care. Studies have shown these types of programs have the potential to lower healthcare costs due to fewer inpatient stays, fewer emergency room visits, and greater use of preventive care.

Proposals for pilot programs should include detailed operational plans, including outreach and other communications to enrollees.

### **C. Health and Wellness**

Improving the health of FEHB Program members continues to be one of our goals. Plans are expected to offer general health and wellness programs that have the potential to improve employee productivity by encouraging healthy lifestyles. Motivating and sustaining healthy behavior change is the key to improving population health, productivity and controlling health care costs. Specifically, we expect plans to offer programs and to cover services aimed at reducing obesity in both children and adults. Complications from being overweight or obese dramatically increase economic costs as a direct result of additional requirements for medical care and a loss of workforce productivity. Obesity in children and adolescents continues to be of great concern since it increases the onset of diabetes and other chronic illnesses in adulthood. Since overweight and obesity are both preventable and treatable, your focus on these programs and services should continue to be a priority in the coming year. Please describe in detail the programs you are offering to encourage healthy lifestyles and to reduce rates of obesity in children and in adults.

We will be closely monitoring plans' performance on HEDIS metrics for Comprehensive Diabetes Care, Cholesterol Management for Patients with Cardiovascular Conditions, and Controlling High Blood Pressure (HMO only), which are all directly related to overweight and obesity. We will take these metrics into consideration in measuring improvement in plan performance from year-to-year.

Last year, we stated our expectations that plans should enhance efforts to promote healthy lifestyles and provide tools enrollees can use to track their own health. We also asked for proposals for incentive programs that encourage enrollees to complete Health Risk Assessment (HRA) tools and to follow treatment plans designed to manage or improve their health. We encourage plans that are not already doing so to offer incentives such as reduced co-payments and deductibles to enrollees who complete an HRA, comply with disease management programs, or engage in other wellness activities. In your response to this call letter, please tell us the number and the percentage of your plan enrollees that has completed an HRA assessment. If your plan does not offer an HRA, we strongly encourage you to include a proposal to offer an HRA tool in 2012. Additionally, please indicate what incentives are currently in place, or will be implemented in the future, to encourage individuals to participate in health management and improvement programs.

### **D. Patient Safety**

FEHB plans are expected to demonstrate their commitment to excellence in providing safe, quality health care for enrollees. The Obama Administration is committed to curbing hospital-acquired conditions, starting with an investment in State actions in the Recovery Act and continuing through the new Innovation Center at the Centers for Medicare and Medicaid Services. In addition, the Affordable Care Act requires Medicare to establish a hospital readmissions reduction program beginning in 2013. Accordingly, in a continued effort to promote patient safety, we are encouraging plans to focus on curbing hospital-acquired conditions and avoidable readmissions. To the extent that plans are participating in Medicare's initiative to protect the over-65 population, we expect you to explore ways to offer similar opportunities for your under-age 65 enrollees.

Evidence has demonstrated that infection rates in hospitals are already high and continue to rise. For example, an estimated 80,000 patients given central lines into their bloodstreams are infected each year in U.S. hospitals and approximately 31,000 of these patients die. Costs associated with these avoidable hospital-acquired infections are estimated at up to \$3 billion. Maintaining strict hygiene standards and implementing strategies as simple as checklists can help to significantly reduce errors, prevent deaths, curb hospital-acquired conditions, and reduce future costs to the health care system.

In addition, a recent study found that simply changing hospital culture to focus on patient safety helped reduce deaths in intensive care units by 10 percent. Similarly, preventing avoidable hospital readmissions can help protect patients from the risk of infection and serves as an indicator that patients are receiving adequate follow-up and outpatient care.

FEHB plans are expected to outline steps they are taking to inform consumers about patient safety measures. In addition, plans should describe their efforts to work with network providers to stem hospital-acquired conditions and reduce avoidable readmission rates. We are particularly interested in model programs for physicians and hospitals to clinically transform the way they practice and deliver patient care for performance improvement and incentive opportunities; model programs designed to reward the delivery of better-coordinated, higher-quality and more cost-effective care; and quality measures that include improvements in care for chronic illnesses, such as diabetes, heart disease and hypertension.

Many FEHB plans have taken steps to steer patients to inpatient settings that are recognized for their excellence in outcomes, such as recognized transplant centers. Inpatient facilities recognized for their quality and health outcomes should be an integral part of plans' provider networks. We encourage those plans that have not established programs that provide an incentive for patients to use Plan-designated facilities for these high-risk procedures to do so. We also encourage you to submit proposals to provide enhanced benefits for patients electing recognized transplant centers for covered procedures in 2012.

Please describe in detail the efforts you are making to improve patient safety and health outcomes. In addition, if your plan is participating in the Medicare program to curb hospital-acquired conditions, provide a complete description of your role, efforts to date, and those planned for the future, including the expected effect on your Medicare eligible population.

## **E. Health Disparities**

Over the years, we have touched on the issue of disparities in healthcare. If a health outcome is seen in a greater or lesser extent between populations, a disparity exists. For example, race or ethnicity can contribute to an individual's ability to achieve good health. As a result, in both the public and private sectors there continues to be an interest in what health insurance plans can do to identify and reduce racial and ethnic disparities in healthcare.

It is important to recognize the impact that social determinants have on health outcomes of specific populations. Determinants of health are defined as the range of personal, social, economic and environmental factors that influence health status. That said, disparities in access to and the quality of health care services persist. Please provide us with a description of the

specific goals and processes you are undertaking or plan to implement in order to reduce these disparities.

The Centers for Disease Control and Prevention (CDC) recently published a Health Disparities and Inequalities Report. In that report, the CDC described the disease conditions which may be linked to health disparities and lack of access to health care. We will be closely evaluating carriers for improvement on HEDIS metrics for Comprehensive Diabetes Care, Cholesterol Management for Patients with Cardiovascular Conditions, and Controlling High Blood Pressure (HMO only) as they are also directly related to health disparities. We will take these metrics into consideration in measuring improvement in plan performance from year-to-year.

## **F. Prescription Medications**

Prescription medications continue to be a major cost driver. While brand-name pharmaceutical costs have escalated quickly, generic drug prices have remained reasonably stable in cost. According to the National Health Expenditure Projections (2009-2019) published by the Centers for Medicare and Medicaid Services, it is estimated that Americans spend about \$234 billion annually on prescription drugs. On average, generic drugs cost 30 to 80 percent less than brand-name drugs, indicating that billions of dollars could be saved by encouraging the use of generic drugs.

Promoting generic drug use has proven to be an effective method of lowering overall prescription cost increases. We expect you to expand your programs to provide benefits for appropriate substitutions for higher-cost drugs such as lower or no copayments for generic drugs and clinically appropriate therapeutic alternatives.

Programs aimed at managing the cost and use of specialty drugs have also proven to be effective for those health plans that have included them. We encourage health plans which have not focused on benefits management for these higher cost pharmaceuticals to offer proposals to implement programs in 2012.

In addition, all plans are expected to submit proposals outlining a savings plan to reduce their overall pharmacy spending for next year, without simply shifting costs to enrollees. We believe a four percent reduction in overall pharmacy spending should be achievable and each carrier will be required to do its part to help reach that goal. The savings plan should demonstrate how a reduction in pharmacy costs or overall costs is achievable. We will also require Plans to submit information on their current pharmacy costs and current drug benefits structure using standard formats which will be included with the rate instructions. This information will be used to compare pharmacy costs per enrollee, across plans, and for the program as a whole with the intent of ensuring the FEHB program remains competitive.

## **G. Geriatric Care**

Older adults will become the fastest growing age group as the first “baby boomers” turn 65 this year. Accordingly, the ability to provide quality health care to the aging population is increasing in importance. More than 70 million individuals in this group (60 percent) will manage more than one chronic condition by 2030. Older adults are at a much higher risk for developing chronic conditions and disabilities such as: diabetes, arthritis, congestive heart failure, and

dementia. These chronic conditions are the leading cause of death among the older adult population.

As a result of these complex health problems, older adults often experience routine hospitalizations, nursing home admissions, and low-quality care. Chronic disease management, injury prevention, and regular preventive care can all help to increase the quality of life for the aging population. Many older adults access the health care system at numerous points and require professional expertise that meets their specific needs. Most providers receive some type of training on geriatric care; however, the percentage of specialists is relatively small.

More certified specialists are needed to meet the unique needs of the aging population. FEHB plans are encouraged to support and promote quality care for the aging population by increasing the number of physicians in their networks who are board certified, or have training in, geriatric care. The Department of Health and Human Services has made increasing the proportion of the health care workforce with geriatric certification from 2.7 percent to 3.0 percent as part of their Healthy People 2020 Initiative. Despite the fact geriatricians have become scarce relative to the growing older adult population, the deficit can be decreased by internists and family practitioners who receive extra training in caring for the elderly.

In order to improve the health, function, and quality of life of older adults, plans must be equipped to provide care that focuses on health promotion, prevention, disability, and disease management. Please provide data on the number and percentage of providers with this training in your current networks, including particular focus on those geographic areas with a large older population, and your plan to reach out to providers and expand your networks with this additional expertise.

## **H. Affinity Products**

We allow each FEHB plan to describe enrollee-pay-all affinity products on the “non-FEHB” page of its brochure. We have encouraged you to add products that would be attractive to Federal members and we appreciate those plans that have added them to their brochures. We encourage plans to include benefits offered to other large employer groups, but which are not covered under your FEHB plan. We also especially encourage you to offer supplemental health insurance coverage for extended federal family members, such as dependents beyond age 26 and domestic partners.

## **I. Actuarial Value**

We are requesting additional information on the medical loss ratio for FEHB plans. The medical loss ratio is defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options. Along with your estimate, you should provide a description of the definitions used to establish the actuarial value for each option.

### **III. Technical Guidance for Proposals**

Specific requirements for submitting your benefit and rate proposals and information on how to prepare your 2012 brochures will be provided at a later date.

### **CONCLUSION**

Please discuss your benefit changes with your contract specialist before you submit your proposals. Proposed benefit changes must be cost-neutral and all savings from managed care initiatives must accrue to the FEHB Program. We will begin negotiations when we receive your proposals.

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

Sincerely,

John O'Brien, Director  
Healthcare and Insurance