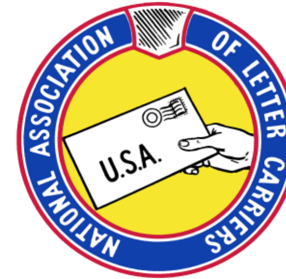
The NALC Health Benefit Plan

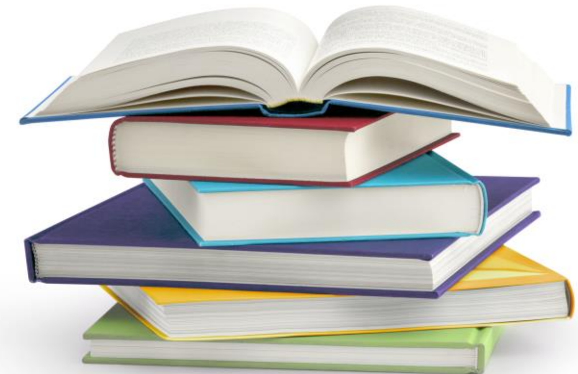


Deconstructing the Plan – How the Plan's benefits are designed from the inside out

Learning Objectives

Become familiar with the Federal Employees Health Benefits (FEHB)Program

- Identify the different types of FEHB Plans
- Define an Experience Rated Plan
- Understand the purpose of the Annual Call Letter for New Benefits
- Be familiar with:
  - the process and timeline for negotiating the next year's benefits
  - the role of the Plan Brochure
  - the role of Carrier Letters
  - Understand how taking advantage of wellness and condition management programs offered can positively impact premiums
- Know:
  - the respective responsibilities of OPM and Plans
  - the OPM Reporting Requirements



Federal Employees Health Benefit Program
(FEHB Program)

- The Federal Employees Health Benefits (FEHB) Program is the largest employer sponsored health benefits program of its kind.
- FEHB Program carriers cover most active, full-time civilian employees and retirees of the U.S. Government and U.S. Postal Service and their families.
- The Program now provides benefits to more than 8 million enrollees and dependents.

Statutory Basis for the FEHB Program

The FEHB Program was established by an Act of Congress in 1959, the program began covering employees on July 1, 1960.

The Civil Service Commission (now the Office of Personnel Management (OPM)) was authorized to write any regulations necessary to carry out the Act establishing the Program.

The NALC Health Benefit Plan and OPM

The NALC Health Benefit Plan began in 1950 and in 1960 we signed our first contract to participate in the FEHB Program.

Each year, the Plan negotiates new benefits and signs a contract to renew our participation in the FEHB Program.

In addition to meeting all the terms of our contract and requirements specified in periodic Carrier Letter guidance issued by OPM, each year we must file numerous reports with OPM demonstrating our compliance.

Types of Health Plans in the FEHB Program

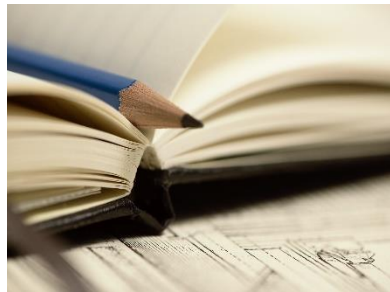
The establishing law stipulates four (4) distinct types of health plans:

- One (1) Government-wide Service Benefit Plan with two (2) benefit levels – Blue Cross Blue Shield (aka/ FEP)
- One (1) Government-wide Indemnity Plan with two (2) benefit levels – GEHA Elevate and Elevate Plus
- Employee Group Sponsored Plans – **NALC HBP** falls within this group
- Community Rated/Experience Rated HMOs

Standard OPM Contract

The main responsibilities of OPM and each carrier are codified in the Standard OPM Contract.

There are different versions of the Standard OPM contract each of which incorporates one of two contract financing methods (Experience Rating and Community Rating):



- Experience Rated (applicable to NALC HBP and the Government-wide Service Benefit and Indemnity plans)
- Experience Rated HMO
- Community Rated HMO

What is Experience Rated?

This means that the premium rates are based on the claims experience of the group, rather than on a fixed per member / per month rate.

Experience rating in the FEHB is retrospective, that is, gains and losses are carried forward in the next year's premiums. Premium is based on the specific claims of the carrier's federal enrollees.

Any excess premium over obligations and agreed-upon profit is returned to the group and held in reserves.

What are Reserves?

Reserves are the funds available for paying the claims for benefits and administrative expenses required to operate a health plan.

Reserve Types

There are 3 types of reserves that make up the reserves:

1. The contingency reserves
2. The special reserves
3. The accrued claims reserves (claims that have been accrued but not yet paid)

Reserve Balance

If the sum of the contingency reserve and the special reserve is in excess of a targeted reserve balance, the premium is set lower so excess reserve funds will be drawn down.

If, on the other hand, experience has been greater than expected and the reserves are less than the targeted reserve balance, the premium will be increased to replenish the reserve funds.

What could affect the Reserve Level?

- Medical bill inflation
- Higher than expected claims (for example COVID)
- Significant high dollar claimants
- Lower than expected claims

Annual Call Letter for New Benefits

Whether a plan is seeking to be a health plan in the program for the first time, or is an established plan:

- The Call Letter sets out new and/or continuing initiatives and objectives sought for the next benefit year. The Technical Guidance provides additional detail and information for preparing our proposal.
- Each plan must submit a proposal for benefits and rates based upon the initiatives and objectives in the Annual Call Letter. Unless stipulated in the Call Letter we must submit a cost neutral proposal.
- The Call Letter can be issued as early as January, but a plan's response must be submitted to OPM no later than May 31.

FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2023-04

Date: March 1, 2023

Fee-for-service [4] Experience-rated HMO [4] Community-rated HMO [4]

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. This letter sets forth the policy goals and initiatives for the FEHB Program for 2024. You must submit your benefit and rate proposals for the contract term beginning January 1, 2024 on or before May 31, 2023. 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

OPM's focus for the upcoming plan year are on the following critical Program

FEHB Program Carrier Letter
All Fee-For-Service Carriers and Health Maintenance Organizations (HMOs)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2023-06

Date: March 24, 2023

Fee-for-service [6] | Experience-rated HMO [6] | Community-rated HMO [6]

Subject: Technical Guidance and Instructions for 2024 Benefit Proposals

Enclosed are the Technical Guidance and Instructions for preparing your benefit proposals for the contract term January 1, 2024, through December 31, 2024. **Guidance applicable to the different Carrier types [Fee-For-Service (FFS), Health Maintenance Organizations (HMO) – Community-Rated (CR) or Experience-Rated (ER), Returning HMOs, and New HMOs] is noted throughout the document. Similarly, guidance that is applicable to all Carriers is noted as such. Please read through the Technical Guidance carefully and contact your Health Insurance Specialist with questions.**

OPM's annual policy and proposal guidance for Federal Employees Health Benefits (FEHB) Program health benefit proposals is issued in two documents:

1. The Call Letter (Carrier Letter 2023-04) dated March 1, 2023, outlines policy goals and initiatives for the 2024 contract year; and
2. The Technical Guidance and Instructions for 2024 Benefit Proposals provides detailed technical requirements for the items listed in the Call Letter that must be addressed in your benefit proposals.

Member Benefits Input

Ever wonder what the Plan does with requests we receive from Members regarding benefits?

- The Plan does take into consideration the requests we receive during the year regarding benefits.
- Keep in mind each benefit must have a cost analysis.
- The Plan has implemented Wellness Programs to offset the cost of adding additional benefits.

How Wellness Programs Impact Your Premium

Did you know that the NALC Health Benefit Plan offers Wellness Programs?

- A healthier population requires fewer Doctor visits, ER visits and Prescription Medications
- Wellness programs help to catch problems/issues early and help manage disease states
- A member with a managed disease state has more positive outcomes

Rate and Benefit Negotiation Timeline

- Benefit and Rate Submission by May 31
- Contract Specialist reviews the proposed benefits
  - Clarify and confirm specifically how initiatives are addressed
  - Obtain further explanation of the intent of particular benefits
  - Conference call to review what OPM intends to accept or decline
- Benefit negotiations will typically conclude in July/August
  - Formal benefit "close out" letter sent by Contract Specialist
- Rate negotiations will typically conclude in August/September and will be followed by drafting and finalization of new brochure language.

Plan Brochure

Once benefits have been agreed upon, OPM and each carrier jointly prepare a brochure describing each plan option approved.

- The brochure is intended to be a complete statement of benefits available to the enrollee, including the plan's benefits, limitations, and exclusions.

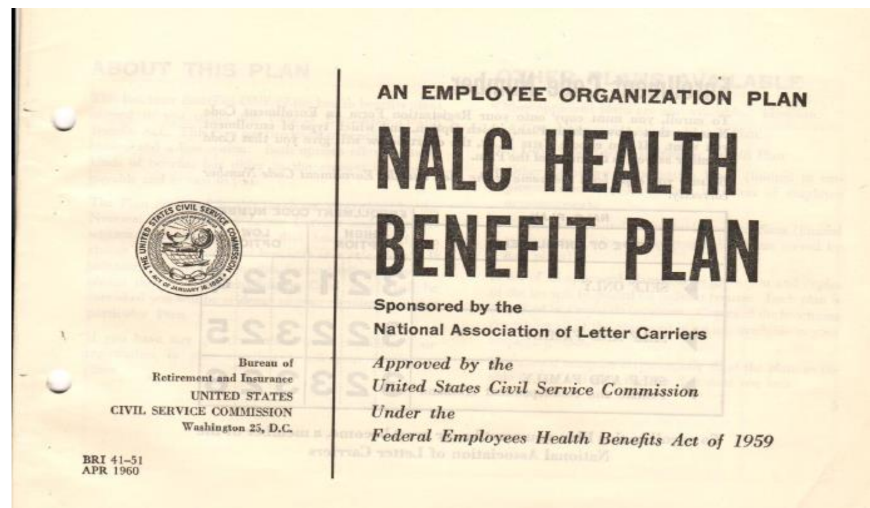
- When finalized the brochure is incorporated into the contract between OPM and the plan.

Brochure: 1960 vs. Today

The NALC Health Benefit Plan was one of the original plans in the FEHB Program.

- The 1960 Plan Brochure – 23 half-pages

- The 2023 Plan Brochure – 208 pages



AN EMPLOYEE ORGANIZATION PLAN

NALC HEALTH BENEFIT PLAN

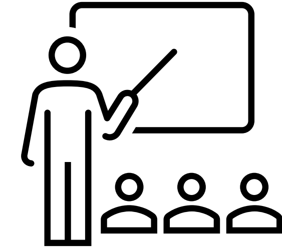
Sponsored by the
National Association of Letter Carriers

Approved by the
United States Civil Service Commission
Under the
Federal Employees Health Benefits Act of 1959

Bureau of
Retirement and Insurance
UNITED STATES
CIVIL SERVICE COMMISSION
Washington 25, D.C.

BRI 41-51
APR 1960

Carrier Letters



- To supplement the Contract, OPM periodically issues Carrier Letters.
- Carrier Letters offer important guidance and must be adhered to in the same way as provisions of the Contract.
- Some Carrier Letters, such as the Call Letter for New Benefits, are issued with annual or other periodic frequency.
- On occasion, their intent and or instruction may not be clear, or otherwise require dialog with carriers before their guidance can be fully implemented.

OPM's Responsibilities

- contracting with plans for participation in the FEHB Program;
- negotiating benefit and rate changes;
- providing boilerplate brochure language and approving plan-specific text on benefits for the brochures;
- publishing FEHB regulations including Carrier Letters (aka/ sub-regulatory guidance);
- receiving and depositing premium withholdings and contributions, remitting premiums to carriers, and accounting for the Program's funds;
- making final determinations of the applicability of the FEHB law to specific employees or groups of employees;

OPM's Responsibilities
(Continued)

- studying and evaluating the operation and administration of the FEHB law and the plans offered under it, and reporting findings to Congress;
- ordering corrections of administrative errors if it would be against equity and good conscience not to do so;
- providing guidance to agencies (e.g. Benefits Administration Letters);
- auditing carriers' operations under the law;
- resolving disputed health insurance claims between the enrollee and the carrier;
- conducting employing agency FEHB responsibilities for retired employees and survivor annuitants.

Carriers Responsibilities

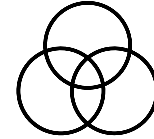
- adjudicating claims of, and providing health benefits to, enrollees and covered family members in accordance with its contract with OPM;
- producing and distributing brochures;
- furnishing each person enrolled in its health plan an identification card or other evidence of enrollment;
- contacting and working with agency payroll offices to reconcile enrollment records;
- acting on enrollee requests for reconsideration of disputed claims;
- maintaining financial and statistical records and reporting on the operation of its plan;
- developing and maintaining effective communication and control techniques to ensure that its subcontractors comply with regulations and OPM instructions.

OPM Reporting

The Plan is required to file many reports with OPM each year as defined in our Contract and in Carriers Letters. Below is a list of some of these reports.

- Plan Performance / Service Award Factors
- Quality Assurance
- CAHPS (Consumer Assessment of Healthcare Providers and Systems)
- HEDIS (Healthcare Effectiveness Data and Information Set)
- Fraud, Waste and Abuse
- Debarment
- Audited Financials & Unaudited Financials

Plan Performance / Service Award Factors



OPM Contracting Officers will apply a weighted guidelines method in developing the performance-based percentage for FEHB Program contracts. For experience-rated plans, the performance-based percentage will be applied to projected incurred claims and allowable administrative expenses. OPM will assess performance of FEHB carriers according to four factors:

(1) **Clinical quality**. OPM will consider elements within such domains as preventive care, chronic disease management, medication use, and behavioral health. This factor incorporates elements from the FAR factor "contractor effort."

(2) **Customer service**. OPM will consider elements within such domains as communication, access, claims, and member experience/engagement. This factor incorporates elements of the FAR factor "contractor effort."

(3) **Resource use**. OPM will consider elements within such domains as utilization management, administrative, and cost trends. This factor incorporates "contractor effort," "contract cost risk," and "cost control and other past accomplishments."

(4) **Contract oversight**. OPM will consider an assessment of contract performance in specific areas such as audit findings, fraud/waste/abuse, and responsiveness to OPM, benefits/network management, contract compliance, technology management, data security, and Federal socioeconomic programs.

Plan Performance – Data Security

The NALC Health Benefit Plan's data security measures meet or exceed the information security and data privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the HITECH Act of 2009 (ARRA Title XIII).

NALC HBP has implemented comprehensive information privacy and security policies and procedures that secure protected health information (PHI) against unauthorized use or disclosure.

Quality Assurance Report

The NALC Health Benefit Plan's mission is to provide the best service to our membership. To attain this goal, we strive to meet and exceed the FEHB Quality Assurance Standards. The Q&A Report requires the Plan to measure and report to OPM on the following standards (these standards are defined in our OPM Contract each year):

- Percentage of claims processed accurately
- Percentage of claims coded accurately
- Average number of days for recovery of erroneous claims payments
- Claims timeliness: percentage of claims adjudicated within 30 working days
- Call answer timeliness: number of seconds on hold
- Percentage of initial call resolution
- Call blockage rate: percentage of callers receiving a busy signal
- Call abandonment rate: percentage of abandoned calls
- Percentage of written inquiries responded to within 15 working days
- Percentage of responses within 30 days to members' request for reconsideration
- Number of days members receive ID cards after enrollment

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Plan contracts with the Center for the Study of Services (CSS) to administer the adult version of the CAHPS Health Plan Survey 4.0H for commercial members. CSS is an independent, nonprofit research organization that is certified by the National Committee for Quality Assurance (NCQA) to conduct HEDIS/CAHPS surveys. Respondents report on their experience with the NALC Health Benefit Plan during the previous 12 months. The survey covers various aspects of the Plan's performance, from customer service to the quality of the health care they received.

The responses from this survey are compiled and presented to the Plan. The results are broken down into opportunity areas for the Plan and include our strengths as well as improvement targets.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The Plan collects and reports HEDIS data to the National Committee for Quality Assurance (NCQA) for the following categories:

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes
- Antidepressant Medication Management
- Asthma Medication Ratio
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Colorectal Cancer Screening
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After Emergency Department Visit for Mental Illness
- Flu Vaccinations for Adults
- Prenatal and Postpartum Care (Timeliness of Prenatal Care)
- Statin Therapy for Patients with Cardiovascular Disease
- Use of Opioids from Multiple Providers (Multiple Prescribers)

Fraud, Waste & Abuse

The Fraud and Abuse Report tracks fraud and abuse cases identified by the Plan for a 12-month period. The report reflects the commitment by the Plan and OPM to provide quality services to our enrollees. The following information is included in the report:

- Cases Opened – only cases opened within report period
- Total Dollars Identified as Loss – total dollar amount verified as a loss
- Total Dollars Recovered – dollars actually received
- Actual Savings – dollars saved due to a claim rejection, prepayment review, etc.
- Projected Savings – calculated based on the amount of loss that would have been incurred had the fraudulent conduct not been stopped due to anti-fraud efforts
- Number of Cases referred to Law Enforcement – total cases referred to local, state, or federal law enforcement agencies
- Number of Cases Resolved through negotiated settlement – cases resolved via settlement negotiation
- Number of Arrests – number of cases that resulted in an arrest
- Number of Criminal Convictions – number of cases that resulted in criminal convictions

Debarment

This report provides OPM with the number of providers that we have identified for debarment and the number of enrollees that it affects. OPM debars from participation in the Federal Employees Health Benefits Program (FEHBP) health care providers who have 1) lost professional licensure; 2) been convicted of a crime related to delivery of or payment for health care services; 3) violated provisions of a federal program, or 4) are debarred by another federal agency.

These sanctions are intended to protect the integrity of the FEHBP as well as the health care interests of persons who obtain their insurance coverage through the program. Debarment assures that FEHBP funds will not be paid to sanctioned providers, either directly or indirectly.

Audited & Unaudited Financials

1. Audited Financial Statements as of September 30 with IPA Report on Financial Statements, Internal Controls, and Compliance with Reporting Requirements
2. Unaudited Annual Accounting Statement as of December 31st
3. Schedule of Selected Balances (Unaudited)
4. Third Party Service Organization Control Test (SAS 70)*
5. Report on the application of agreed-upon procedures
6. Corrective Action Plan

Small Business

The Plan supports OPM's efforts to incorporate Small Business Administration awarding of contractor and vendor purchases. The Plan takes proactive measures to identify Small Business firms before making significant purchasing decisions.

Questions?

Thank you for your attention during this presentation. We are here to support Letter Carriers through the NALC Health Benefit Plan.