FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2023-05

Date: March 6, 2023

Fee-for-service [5] Experience-rated HMO [5] Community-rated HMO [5]

Subject: Update on Aggregate Healthcare Cost and Utilization Data Reporting Requirements

The purpose of this Carrier Letter is to clarify guidance to all Federal Employees Health Benefits (FEHB) Carriers on their obligation to supply aggregate healthcare cost and utilization data to the U.S. Office of Personnel Management (OPM). This letter builds on the reporting requirements outlined in the Carrier Letters 2020-17 and 2021-09 for Aggregate Healthcare Cost and Utilization Data Reporting Requirements.

This letter:

- Extends the due date for the submission of files from April 30 to June 15.
- Provides detailed requirements for the pharmacy cost (including rebates) and utilization data requested that is the minimum necessary for FEHB Program oversight.
- Adds a new valid value, L, for Long Term Care pharmacy to report in Pharmacy Type.
- Provides guidance for file submission to Research and Oversight Repository (ROVR) formerly Health Insurance Data Warehouse (HIDW).

In the event of a conflict between this letter and a prior FEHB Carrier Letter, this letter supersedes.

Background

5 U.S.C § 8910 mandates that OPM make a continuing study of the operation and administration of the FEHB Program and requires Carriers to furnish reasonable reports that OPM determines necessary to enable it to carry out its functions. This is further outlined in Section 1.7 of the Fee-For-Service, Experience-Rated, and Community-Rated contracts.

One of OPM's strategic goals is to provide affordable and high-quality health plans to FEHB enrollees and their families. Since 2019, FEHB Carriers have reported aggregate pharmacy cost (including rebates) and utilization data to OPM. This data gives OPM important insight into the operation and administration of the FEHB pharmacy benefit and is essential for effective FEHB Program oversight and evidence-based decision-making. OPM will continue to collect pharmacy cost and utilization data on an annual basis. This letter details additional information on the FEHB pharmacy data collection and submission process.

Submission Time Frame

No later than June 15, FEHB Carriers will submit cost (including rebates) and utilization data files every year for the previous plan year. If the Carrier has participated in the FEHB Program, data must be included for all plans offered in the previous plan year whether the plans are offered in the current plan year or not.

Aggregate Pharmacy Cost and Utilization Data Files

FEHB Carriers are required to submit the following two files every year:

- Pharmacy Cost and Utilization (RXCU) file
- Pharmacy Rebates (RXRB) file

Files should be submitted using the detailed data requirements and file layouts for both file types included in Attachment 1. The fields to be included in the files, their variable names and order remain the same. Additional

clarification on the data reporting requirements has been provided based on OPM's experience with Carrier file submissions in previous years.

Files Submission

Each Carrier will submit the files using a Secure File Transfer Protocol (SFTP) account and encryption. Guidance for file submission to Research and Oversight Repository (ROVR) formerly Health Insurance Data Warehouse (HIDW) is provided in Attachment 2. FEHB Carriers that are already set up for submitting files to ROVR (formerly HIDW) do not have to take any additional action.

Conclusion

OPM is committed to providing affordable and high-quality health plans to FEHB enrollees and their families. If you have any questions or concerns, please contact OPMPharmacy@opm.gov with a copy to ROVRSupport@opm.gov and your Health Insurance Specialist.

Sincerely,

Laurie E. Bodenheimer
Associate Director
Healthcare and Insurance

Attachment 1: Detailed data requirements and file layouts

The detailed data requirements and file layouts in this attachment must be read and followed carefully before providing the requested information in Pharmacy Cost and Utilization (RXCU) and Pharmacy Rebates (RXRB) files. The files will be processed automatically; incorrect or incomplete files will be rejected. Rejected files should be resubmitted after addressing the issues identified or a valid justification should be provided for not resubmitting the files.

General requirements applicable to both file types

Carriers should submit the files every year based on the previous plan year pharmacy benefit experience with a three-month runout. The information provided should be based on all records with a date of adjudication (National Council for Prescription Drug Programs (NCPDP) data field 578) in the reporting year paid by 31 March of the following year (three-month runout period).

The three-character FEHB enrollment codes are the codes that appear in the FEHB plan brochure(s) that capture the plan, option, and Self / Self plus One / Self and Family enrollment. Carriers should append data for multiple three-character FEHB enrollment codes in the same file and must be filed for all the records. Carriers are responsible for providing the FEHB Enrollment Codes to other entities such as Pharmacy Benefit Managers (PBMs), that help produce these files.

Carriers should submit NDCs in HIPAA 11-digit format without dashes for all drugs/products that have an NDC. Submit other appropriate identifiers (IDs) only for non-drug products or services that do not have NDCs. The requirements have references to the drug, product, or service ID and qualifier to accommodate non-drug items, but most products should be drugs and most IDs should be National Drug Codes (NDCs). Please refer to Table 3 - NCPDP External Code List (ECL) for 436-E1: Product / Service ID Qualifier provided in this document below for valid values. The value for NDC

for example is 03. Please provide a detailed mapping if other values are used.

The files must be submitted in the general form now defined for files: ASCII or UTF-8 encoded, pipe-delimited plain text files with no padded characters; one record per line with a consistent number of pipes on all records; a header record in the first row with variable names in the same order, with matching letter case provided in the file layouts.

Aggregated Pharmacy Cost and Utilization (RXCU) File Requirements

The information provided in the pharmacy cost and utilization (RXCU) file should be the number of scripts, sum totals of quantities dispensed, days supplied, and amounts in each field between 14-23 for each unique combination of values in fields 1-13 in Table 1 - Aggregated Pharmacy Cost and Utilization (RXCU) File Layout provided in this document below.

Each file must contain all fields for each three-digit FEHB enrollment code that appears in the plan brochure(s) and each drug/product/service ID by pharmacy type, specialty claim indicator, age band, etc. The breakdown of utilization/costs (non-zero amounts in any of the fields 14-23) for each unique combination of values in fields 1-13 in the file layout should be included in the file.

The first row of the ASCII or UTF8 encoded pipe delimited text file should contain the variable names exactly as provided by OPM in the file layout, in the same order, separated by the pipe operator |. Variable names are case-sensitive and the header record in the RXCU file should look like the sample provided below for reference.

fehbEnrCode|pharmacyType|productID|productIDQualifier|productName|productDescription|specialty|priorAuthYN|stepTherYN|formularyStatus|networkYN|compundCode|ageBand|scripts|users|daysSupplied|quantityDispensed|planPaid|memberPaid|otherPayerPaid|amountPaidAllSources|taxes|grossAmount

The pipe character | should not appear inside any of the fields. It should be used only to delimit fields. If there are n fields in the file, there should be n-1 pipe operators in each record, one after each field except the last one. There should be exactly 22 pipes between 23 fields on every record in the RXCU files. Each row in the text file should represent a separate record and there should not be blank records at the end of the file.

Null values should be represented by ||. Spaces, dots, quotations, NA, or any other characters should not be included between the pipe characters delimiting the end of the previous field and the end of the null field. Zero values for numeric fields (e.g., zero copays) should be represented as 0 for counts and 0.00 for amounts, not null or missing values. Dollar amounts should include the dot but no commas or dollar signs. Do not pad values with spaces or any other characters.

Table 1 - Aggregated Pharmacy Cost and Utilization (RXCU) File Layout

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP
1	FEHB Enrollment Code	fehbEnrCode	Character (3)	The three-digit FEHB enrollment code as it appears in the FEHB plan brochure. There should be separate records for each three-digit enrollment code, that is, for Self / Self plus One / Self and Family enrollment for each plan option for which utilization or amounts are not all zero.	
2	Pharmacy Type	pharmacyType	Character (1)	R for Retail M for Mail S for Specialty L for Long Term Care	

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP
3	Product / Service ID	productID	Character (14)	NDC in HIPAA 11-digit format without dashes for the drugs/products that have an NDC. NDC should be 11 characters long and leading zeros should be included. NDC should not be padded with spaces to fill 14 characters which is the maximum allowed length. NDC values are validated using reference data from First Databank (FDB) and Medi-Span. If it is a product without an NDC (e.g., syringes, diapers, etc.) then use another appropriate code (e.g., Universal Product Code (UPC)). Please refer to Table 3 - NCPDP External Code List (ECL) for 436-E1: Product / Service ID Qualifier provided in this document below for valid values. Please provide a detailed mapping if other values are used.	407-D7

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP
4	Product / Service ID Qualifier	productIDQualifier	Character (2)	Code qualifying the type of Drug ID. Most products should be drugs, for which the productID should be an NDC and the values for the productIDQualifier should be 03. Please refer to Table 3 - NCPDP External Code List (ECL) for 436-E1: Product / Service ID Qualifier provided in this document below for valid values.	436-E1
5	Product / Service Name	productName	Character (80)	Product or Service Description or Product Label Name. e.g., CYMBALTA CAP 20MG	397
6	Product Description	productDescription	Character (80)	Short name/description of the drug/product. e.g., CYMBALTA	601-20
7	Specialty Claim Indicator	specialty	Numeric (1)	1 if Specialty Claim 2 if not a Specialty Claim	A37
8	Prior Authorization Indicator	priorAuthYN	Character (1)	Y if Prior Authorization N if not	461-EU
9	Step Therapy Indicator	stepTherYN	Character (1)	Y for Step Therapy N if not	

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP
10	Formulary Status	formularyStatus	Character (1)	Indicates the formulary status of the drug. Valid values are I, J, K, N, P, Q, T, Y. Please refer to Table 4 - NCPDP External Code List (ECL) for 257: Formulary Status provided in this document below for additional information on valid values.	257
11	In Network Indicator	networkYN	Character (1)	Y for In-Network N for Out of Network Pharmacy	266
12	Compound Code Indicator	compundCode	Numeric (1)	0 for Not specified 1 for Not a Compound 2 for a Compound	406-D6
13	Age Band	ageBand	Numeric (2)	Age Band of the patient as of the date the prescription was filled. Valid values are 1 for 0-5 years, 2 for 6-10 years, 3 for 11-17 years, 4 for 18-22 years, 5 for 23-34 years, 6 for 35-44 years, 7 for 45-54 years, 8 for 55-64 years, 9 for 65-74 years, 10 for 75-84 years, and 11 for 85+ years.	

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP
14	Number of Scripts	scripts	Numeric	The number of prescriptions adjudicated for the drug/product. Do not double-count partial fills.	
15	Unique Users	users	Numeric	The number of unique patients using the drug/product.	
16	Days Supplied	daysSupplied	Numeric	The total number of days supplied for the drug (NDC).	405-D5
17	Quantity Dispensed	quantityDispensed	Numeric	The total quantity dispensed for the drug (NDC).	442-E7
18	Plan Paid Amount	planPaid	Numeric	The total amount paid by the plan.	281
19	Patient Pay Amount (Liability)	memberPaid	Numeric	The total amount paid by the patient (total member liability).	505-F5
20	Other Payer(s) Paid Amount(s)	otherPayerPaid	Numeric	The total amount paid by other payers.	225
21	Total Amount Paid by All Sources	amountPaidAllSources	Numeric	The total amount paid by all sources. Should equal the sum of the plan paid, the patient paid, and the other payers paid amounts.	894

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP
22	Taxes	taxes	Numeric	The total sales taxes paid by all parties (flat and percentage taxes paid by the plan, patient, and other payers).	
23	Gross Amount Due	grossAmount	Numeric	The total amount claimed from all sources.	430-DU

The numerical values in columns 14-23 are sum totals for each drug/product for which there is utilization or nonzero amounts broken down by the distinct combinations of values in columns 1-13. The amount columns 18-23 should be numeric values with at least 2 decimal places. Zero values should be reported as 0.00.

Aggregated Pharmacy Rebates (RXRB) File Requirements

An accompanying pharmacy rebates (RXRB) file should be submitted for each pharmacy cost and utilization (RXCU) file. Please refer to Table 2 - Aggregated Pharmacy Rebates (RXRB) File Layout provided in this document below. The information provided should be based on all rebates and other credits and fees (such as price protection and manufacturer administrative fees) for the plan year utilization/costs (the rebates and other credits associated with drug costs/utilization included in the RXCU file).

The total rebates and other credits such as price protection and manufacturer administrative fees for the drug/product should be allocated to the respective three-character FEHB enrollment code and distribution channel. Carriers' standard allocation methodology should be used or allocated proportionally to FEHB Plan and Enrolment Code and Pharmacy Type. If rebates or other credits are based on a market basket of drugs/products and are not specific to the drug/product, separate rebates and other credits for each drug/product should be calculated by multiplying the total rebates and credits on the market basket by the percentage represented by each drug/product in the market basket (and distribute by FEHB enrollment code and Pharmacy Type). With the extended reporting deadline, we expect reporting on actual rebates collected rather than projections for the last quarter.

The first row of the ASCII or UTF8 encoded pipe delimited text file should contain the variable names exactly as provided by OPM in the file layout, in the same order, separated by the pipe operator |. Variable names are case-sensitive and the header record in the RXRB file should look like the sample provided below for reference.

fehbEnrCode|pharmacyType|ndc11|productDescription|rebates

The pipe character | should not appear inside any of the fields. It should be used only to delimit fields. If there are n fields in the file, there should be n-1 pipe operators in each record, one after each field except the last one. There should be exactly 4 pipes between 5 fields on every record in the

RXRB files. Each row in the text file should represent a separate record and there should not be blank records at the end of the file.

Null values should be represented by ||. Spaces, dots, quotations, NA, or any other characters should not be included between the pipe characters delimiting the end of the previous field and the end of the null field. Zero values for numeric fields (e.g., zero copays) should be represented as 0 for counts and 0.00 for amounts, not null or missing values. Dollar amounts should include the dot but no commas or dollar signs. Do not pad values with spaces or any other characters.

Table 2 - Aggregated Pharmacy Rebates (RXRB) File Layout

#	Field	Variable Name	Data type	Description	NCPDP
1	FEHB Enrollment Code	fehbEnrCode	Character (3)	The three-digit FEHB enrollment code as it appears in the FEHB plan brochure. There should be separate records for each three-digit enrollment code, that is, for Self / Self plus One / Self and Family enrollment for each plan option for which utilization or amounts are not all zero.	
2	Pharmacy Type	pharmacyType	Character (1)	R for Retail, M for Mail, S for Specialty, L for Long Term Care	
3	NDC-11	ndc11	Character (11)	NDC in HIPAA 11-digit format without dashes which identifies the drug name. NDC should be 11 characters long and leading zeros should be included. NDC values are validated using reference data from First Databank (FDB) and Medi-Span.	
4	Product Description	productDescription	Character (80)	Short name/description of the drug/product. e.g., CYMBALTA	601-20

#	Field	Variable Name	Data type	Description	NCPDP
5	Rebates and Other Credits	rebates	Numeric	Total rebates and other credits and fees such as price protection and manufacturer administrative fees for the drug/product allocated for the respective three-character FEHB enrollment code and distribution channel (Pharmacy Type). Please use your standard allocation methodology or allocate proportionally to FEHB Enrolment Code and Pharmacy Type. If rebates and other credits and fees are based on a market basket of drugs/products and are not specific to the drug/product, please calculate the separate rebate for this drug/product by multiplying the total rebate on the market basket by the percentage represented by this drug/product in the market basket (and distribute by FEHB enrollment code and Pharmacy Type). If the last quarter information is not available, please estimate the total rebates and other credits for the year from the experience over the first three quarters.	

The numerical values for rebates and other credits in column 5 are sum totals for each drug/product broken down by the distinct combinations of FEHB Enrollment code, distribution channel, and product values in columns 1-4. This should be a numeric value with at least 2 decimal places. Zero values should be reported as 0.00.

Table 3 - NCPDP External Code List (ECL) for 436-E1:
Product/Service ID Qualifier

Extract from the NCPDP External Code List (ECL) provided below.
Ø stands for the digit 0, so it isn't confused with the letter O.

VALUE	PRODUCT/SERVICE ID QUALIFIER NAME	COMMENTS
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
ØØ	Not Specified	Only to be used when needed to conform to fixed file layout specifications.
Ø1	Universal Product Code (UPC)	Formatted 11 digits (N)
Ø2	Health Related Item (HRI)	Formatted 11 digits (N)
Ø3	National Drug Code (NDC)	NCPDP Formatted 11 digits (N)
Ø4	Health Industry Business Communications Council (HIBCC)	Variable A/N
~~Ø5~~	Department of Defense (DOD)	This value was deleted in the publication of the July 2ØØ7 ECL and should not be used by any of the standards from that date forward.
Ø6	Drug Use Review/ Professional Pharmacy Service (DUR/PPS)	
Ø7	Common Procedure Terminology (CPT4)	5 character (A/N)
Ø8	Common Procedure Terminology (CPT5)	5 character (A/N)
Ø9	Health Care Financing Administration Common Procedural Coding System (HCPCS)	5 character (A/N)
1Ø	Pharmacy Practice Activity Classification (PPAC)	

VALUE	PRODUCT/SERVICE ID QUALIFIER NAME	COMMENTS
11	National Pharmaceutical Product Interface Code (NAPPI)	South African Code
12	Global Trade Identification Number (GTIN)	14 digits (N) – UCC Standard (UPN)
~~13~~	Drug Identification Number (DIN)	This value was deleted in the publication of the July 2ØØ7 ECL and should not be used by any of the standards from that date forward.
15	First Data Bank Formulation ID (GCN)	
28	First Data Bank Medication Name ID (FDB Med Name ID)	
29	First Data Bank Routed Medication ID (FDB Routed Med ID)	
3Ø	First Data Bank Routed Dosage Form ID (FDB Routed Dosage Form Med ID)	
31	First Data Bank Medication ID (FDB MedID)	
32	First DataBank Clinical Formulation ID Sequence Number (GCN_SEQ_NO)	
33	First DataBank Ingredient List ID (HICL_SEQ_NO)	
34	Universal Product Number (UPN)	
36	Representative National Drug Code (NDC)	
42	Gold Standard Marketed Product Identifier (MPid)	
43	Gold Standard Product Identifier (ProdID)	
44	Gold Standard Specific Product Identifier (SPID)	
45	Device Identifier (DI)	
99	Other	

Table 4 - NCPDP External Code List (ECL) for 257: Formulary Status

Extract from the NCPDP External Code List (ECL) provided below.

VALUE	FORMULARY STATUS DESCRIPTION
Blank	Not Specified
I	Drug on Formulary; Non-Preferred - The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category.
J	Drug not on Formulary; Non-Preferred - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category.
K	Drug not on Formulary; Preferred - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice.
N	Drug not on Formulary; Neutral - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.
P	Drug on Formulary - The medication submitted on the claim is included in the list of products in that patient's plan formulary.
Q	Drug not on Formulary - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary.
T	Drug on Formulary; Preferred- Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product.
Y	Drug on Formulary; Neutral - The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.

Attachment 2: Guidance for file submission to Research and Oversight Repository (ROVR)

FEHB Carriers that are already set up for submitting files to ROVR (formerly HIDW) do not have to take any additional action. If a Carrier is not set up to transfer files to ROVR, the point of contact information, the outbound IP addresses or the URLs from which files will be pushed from the Carrier's organization should be sent to ROVR to start the initial setup. Additional details necessary during initial setup to submit the files using a Secure File Transfer Protocol (SFTP) account and encryption will be shared with the Carriers at the time of initial setup.

File naming standards

Files should be named following the standard file naming convention provided below.

<ProgramID>_<SourceID>_<FileTypeID>_<StartDt>_<EndDt>_<TransferDt>.txt.pgp

ProgramID: FEHB etc.

SourceID: Source ID assigned by OPM. Typically, four characters in length.

FileTypeID: RXCU, RXRB, etc.

StartDt, EndDt, TransferDt: All dates should be in CCYYMMDD format.

Sample file names when the ProgramID is FEHB and the SourceID assigned is ATOZ:

FEHB_ATOZ_RXCU_20220101_20221231_20230615.txt.pgp

FEHB_ATOZ_RXRB_20220101_20221231_20230615.txt.pgp

The three IDs and the three dates in the file name should be checked and updated while submitting the files. The first two dates in the file name which represent start and end dates should reflect the timeframe for which the report is being generated. The third date in the file name should match the actual file submission/transfer date or at least be close to it. Even if the three IDs, start and end dates remain the same while resubmitting the file,

the third/transfer date should be updated for every file resubmission. This is required to be able to uniquely identify the file, store the file without replacing the earlier file, figure out which is the latest file, and not create issues with duplicates while processing the data in the files. While submitting the test files, the TST_ prefix must be added to the file name in addition to following the standard file naming convention.

Timeline

Files can be submitted on any day by the deadline. Avoid submitting files between 5:00 am and 8:00 am Eastern time leaving a window for processing files received the day before and for server maintenance.

Notifications

An email notification along with each successful file transfer with the file name and the record count for each file submitted should be sent by the Carrier. If there are amounts included in the file, total amounts should be included in the notification. If there are any changes on the Carrier's end that will impact the file formatting or content, such details should be provided as well.

Contact information

Email communications regarding file submissions should be sent to the ROVR Support mailbox, ROVRSupport@opm.gov. FEHB Carriers should copy Health Insurance Specialists designated to the plans on the email communications with ROVR. Carriers should also copy OPMPharmacy@opm.gov on email communications related to Pharmacy files. Emails sent to ROVRSupport@opm.gov or the former address HIDWSupport@opm.gov will be delivered to the same mailbox. The Carriers are responsible to share their latest point of contact information with ROVR when there are changes.