FEHB Program Carrier Letter
All Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

FEHB ☒ PSHB ☒

Letter Number 2024-06

Date: March 7, 2024

Fee-for-service [6] Experience-rated HMO [6] Community-rated HMO [3]

Subject: Technical Guidance and Instructions for 2025 Benefit Proposals

Updated August 5, 2024

Enclosed are the Technical Guidance and Instructions for preparing your benefit proposals for the contract term January 1, 2025, through December 31, 2025. Guidance applicable to Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) plans are noted throughout the document. Additionally, differentiations for Fee-For-Service (FFS), Health Maintenance Organizations (HMO): Community-Rated (CR); Experience-Rated (ER); Current HMOs; and New HMOs are annotated as well. Please read through the Technical Guidance carefully and contact your Health Insurance Specialist with questions.

OPM's annual policy and proposal guidance for FEHB and PSHB Programs health benefit proposals are issued in two documents:

1. The Call Letter (Carrier Letter 2024-04) dated February 8, 2024, outlines policy goals and initiatives for the 2025 contract year; and
2. The Technical Guidance and Instructions for 2025 Benefit Proposals provides detailed requirements for items listed in the Call Letter that you must address in your benefit proposals.

The 2025 Rate Instructions are not included with these benefit instructions. Information regarding the 2025 Rate Instructions for Community-Rated HMO

Carriers, Experience-Rated HMO Carriers, and Fee-For-Service Carriers will be sent via separate Carrier Letters.

OPM's primary areas of focus for the upcoming plan year for Carriers are: FEHB and PSHB Coordination with Medicare; FEHB and PSHB Prescription Drug Coverage; Fraud, Waste, and Abuse; and continued focus on initiatives from prior years. Those initiatives include Contraception Benefits, Fertility Benefits, Maternal Health, Mental Health and Substance Use Disorder Services, Gender Affirming Care and Services, and Prevention and Treatment of Obesity. We continue to encourage all FEHB and PSHB Carriers to thoroughly evaluate their health plan options with a focus on improving quality and affordability.

Each Carrier is responsible for ensuring that each benefit proposal complies with all applicable Federal laws and regulations. As a reminder, all Carriers must commit to the FEHB Program Guiding Principles and PSHB Program Guiding Principles, as applicable. For the 2025 proposal submissions, FEHB Carriers will continue the same process as previous years while PSHB Carriers will submit their 2025 proposals via Carrier Connect.

We appreciate your efforts to submit benefit proposals in a timely manner. We look forward to working closely with you on these activities. Coordination of the implementation of PSHB, including new enrollments for all Postal Service employees and annuitants, along with our regular Open Season activities, will certainly be complex. Our collaboration will ensure its success again this year.

Sincerely,

Laurie Bodenheimer
Associate Director
Healthcare and Insurance

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Schedule

We offer the following charts with deadlines that are part of the benefit and rate proposal negotiation process. Benefit proposals must be complete upon submission. The deadlines for concluding negotiations are firm and we cannot consider late proposals.

Benefit and Rate Proposal Important Dates

FEHB Carriers

Dates	Activity
May 3	**Community Benefit Package for New and Current HMOs** Send the Community Benefit Package (Certificate of Coverage, Evidence of Coverage, Master Group Contract or Agreement) by email to your Health Insurance Specialist. The Community Benefit Package is the commercial health insurance coverage sold to the majority of non-Federal employees.
May 31	**Benefit Proposal and Rate Proposal** As required by 5 CFR § 890.203, all FEHB Carriers must send a complete proposal for each contract for any benefit changes and clarifications to your Health Insurance Specialist by email, in addition to a hard copy. Proposals must include language describing all proposed brochure changes or clarifications. Your Health Insurance Specialist will discuss the benefit proposal with you. Rate proposals must be sent to your Health Insurance Specialist with the benefit proposal **and** uploaded to the Rate Submission Tool.

Dates	Activity

May 31	**Drug Formularies**
	All 2024 FEHB Carriers must submit their 2024 drug formularies to Research and Oversight Repository (ROVR), as instructed in Appendix X Attachment A FEHB Drug Formulary Templates.
	
	All FEHB Carriers must submit the following formulary templates sent out with this Technical Guidance. The completed templates should be emailed to OPMPharmacy@opm.gov, with a copy to your Health Insurance Specialist.
	• **Current FEHB Carriers making any changes to formularies** (all changes to 2024 formularies) in 2025 must submit a completed Attachment C Formulary Comparison Between 2024 and 2025 Template.
	• **New FEHB Carriers or FEHB Carriers offering new plans** must submit an Attachment B 2025 FEHB Drug Formulary Template.
	• **FEHB Carriers offering MA-PD EGWP or PDP EGWP** must submit:
	  ○ Attachment F Comparison Between the proposed CMS Base, EGWP, and FEHB Formularies and Cost Share template; and
	  ○ Approved CMS Base Formulary, upon CMS approval.

June 3-14	**Benefits Plus (BP) Training** OPM hosts three online training sessions for BP during the timeframe listed. Carriers should attend one session. OPM will provide the 2025 BCT User Manual no later than June 3.
June 14	**BP Open for Carrier Data Entry** Please contact BPBCT@opm.gov for password resets, technical questions or if you have suggestions on changes to BP.
June 14	**FEHB Aggregate Healthcare Cost and Utilization Data Report** Carrier Letter 2024-05 requires Carriers to submit a pharmacy aggregate cost and utilization report to OPM and provides instructions for the submission. For questions, please contact OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist.
June 30	**FEHB HMOs Submit State-Approved Benefit Packages to OPM** Last day to submit proof of state approval for newly proposed benefits or service area expansions.
August 12	**BP Updates** FEHB Carriers must complete input of final data for Health Insurance Specialist review, including zip codes and plan-specific updates.

Dates	Activity
August 31	**Access to Providers** If you are a new plan, proposing a new service area, or changing your service area, provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts.

PSHB Carriers

Dates	Activity
March 13	**Carrier Connect Training** Training for OPM's new web-based application for PSHB benefit and rate proposals.
April 1	**Carrier Connect Opens for 2025 PSHB Benefit and Rate Proposal Submissions** PSHB Carriers must use Carrier Connect to submit all benefit and rate proposal materials.
May 31	**Community Benefit Package for HMOs** The Community Benefit Package (Certificate of Coverage, Evidence of Coverage, Master Group Contract or Agreement) is the commercial health insurance coverage sold to the majority of non-Federal employees. This must be submitted in Carrier Connect.
May 31	**Benefit and Rate Proposals** As required by 5 CFR § 890.203, all PSHB Carriers must submit a complete proposal for each contract in Carrier Connect.
May 31	**Drug Formularies – See instructions in Carrier Connect** • **Carriers** must submit a proposed CMS Base, PSHB, PSHB EGWP, and FEHB formularies via Carrier Connect. • **Carriers offering equivalent FEHB plans in 2025** must submit corresponding 2025 FEHB formularies. • **Carriers not offering a FEHB plan in 2025** must submit 2024 FEHB formularies along with any proposed changes. • **All Carriers** must submit their CMS-approved base formulary, upon CMS approval.
June 30	**PSHB HMOs Submit State-Approved Benefit Packages to OPM** Last day to submit proof of state approval for newly proposed benefits or service area expansions.

Brochure Important Dates

All Carriers

Dates	Activity
June 3-14	**Brochure Creation Tool (BCT) Training** OPM hosts 3 online training sessions for BCT during the timeframe listed; Carriers must attend one session. OPM will provide the *2025 BCT User Manual* no later than June 3.
June 14	**BCT Open for Carrier Data Entry** Please contact BPBCT@opm.gov for password resets, technical questions or if you have suggestions on changes to the BCT.
July 26	**Brochure Templates** OPM will send the *2025 Brochure templates*.
August 23	**Initial Carrier Submission** Carriers must complete initial update or submission of brochure language in BCT no later than August 23 or a date set by your Health Insurance Specialist, whichever is earliest.
September 6	**Rate Import** Carriers must complete import of approved rate information into BCT.
September 20	**Brochure Finalization** Carriers must finalize brochures by this date. OPM sends brochure quantity forms, as well as other related Open Season instructions, to Carriers after Health Insurance Specialist approves brochure for printing. **Summary of Benefits and Coverage are due the same date as the final brochure.**
October 11	**Brochure Shipment** Orders for Carrier brochures must be received by the Retirement Services vendor.

Note: Within five (5) business days following your receipt of the close-out letter or the date set by your Health Insurance Specialist, please send them an electronic version of your 2025 brochure.

Part I: 2025 Benefit Proposal Instructions for All Carriers

PSHB Carriers: Content within Part I applies and PSHB Carriers are required to submit all benefit proposal materials in Carrier Connect, OPM's new web-based application for PSHB benefit and rate proposals. Proposal instructions not found within Carrier Connect are annotated within each section below.

Enrollment Types

Enrollment Type	Enrollment Code "Identifier"	Description
Self Only	• FEHB: Codes ending in 1 and 4 • PSHB: Codes ending in A and D	Self Only enrollment provides benefits for only the enrollee.
Self Plus One	• FEHB: Codes ending in 3 and 6 • PSHB: Codes ending in C and F	Self Plus One enrollment provides benefits for the enrollee and one designated eligible family member.
Self and Family	• FEHB: Codes ending in 2 and 5 • PSHB: Codes ending in B and E	Self and Family enrollment provides benefits for the enrollee and all eligible family members.

Notes

- For Self Plus One, the catastrophic maximum, deductibles, and wellness incentives must be for dollar amounts that are less than or equal to corresponding amounts in the Self and Family enrollment.
- Benefits, including all member copays and coinsurance amounts, must be the same regardless of enrollment type of the same plan option.
- Carriers with High Deductible Health Plans (HDHPs) must be aware of 26 U.S.C. § 223, which requires that deductibles, catastrophic maximums, and premium pass-through contributions for Self Plus One or Self and Family coverage be twice the dollar amount of those for Self Only coverage. Note that family coverage is defined under 26 CFR § 54.4980G-1 as including the Self Plus One coverage category.

Federal Preemption Authority

The law governing the FEHB Program at 5 U.S.C. 8902(m) gives FEHB and PSHB contract terms preemptive authority over state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits.

Community Benefit Package (All HMOs)

The Community Benefit Package is the commercial health insurance coverage sold to the majority of non-Federal employees. Submit a copy of your fully executed Community Benefit Package (e.g., *Certificate of Coverage or Evidence of Coverage*) by May 3, 2024, including riders, copays, coinsurance, and deductible amounts (e.g., prescription drugs, durable medical equipment) for your plan with the largest number of non-Federal subscribers in 2024. If you offer a plan in multiple states, please send us your Community Benefit Package for each state that you intend to cover.

Community-Rated HMOs

In a cover letter to your Contracting Officer accompanying your Community Benefit Package, describe your state's process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent to us along with a copy of the state's approval document.[1] OPM usually accepts proposed benefit changes for review if you submit changes to your state prior to May 31, 2024, and obtain approval and submit approval documentation to us by June 30, 2024. Please let us know if the state grants approval by default (i.e., it does not object to proposed changes within a certain period after it receives the proposal). The review period must have elapsed without objection by June 30, 2024.

Please include the name and contact information (phone number, email) of the state official responsible for reviewing your plan's benefits. If your plan operates in more than one state, provide the information for each state. If applicable, please include which state you have designated as the situs state. We may contact states about benefits as necessary.

[1] If necessary, provide a translation in English.

Notes

Current FEHB CR-HMO Carriers:

If the community benefit package is different from the proposed plan you offer to the FEHB, include a current copy of the current benefit package that we purchased. In your narrative, please highlight the difference(s) between the proposed FEHB benefits and the community package you based it upon.

Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2025 contract term, including those still under review by your state.

If you have not proposed changes to the level of coverage we already purchase, then submit a statement to that effect. If you have made changes, submit a narrative of the new benefits description. If your state requires you to file this documentation, file the benefit package you project will be sold to the majority of your non-Federal subscribers in 2025.

New FEHB CR-HMO Carriers:

Your materials must show all proposed benefits for FEHB for the 2025 contract term, including those still under review by your state. We will accept the community benefit package for review that you project will be sold to the majority of your non-Federal subscribers in 2025.

PSHB CR-HMO Carriers:

Your materials must be submitted in Carrier Connect.

Experience-Rated HMOs

You must file your proposed benefit package (e.g., *Certificate of Coverage or Evidence of Coverage*) and the associated rate with your state, if the state requires it.

Notes

Current FEHB ER-HMO Carriers:

Carriers that propose changes to the level of coverage under the current benefit package must submit a narrative of the new benefit description as explained in the Benefit Changes section. If no changes have been proposed, submit a statement to that effect.

New FEHB ER-HMO Carriers:

Carriers that choose to use a Certificate of Coverage that varies from the one submitted with the application must submit the new Certificate and attach a chart with the following information:

- Benefits that are covered in one package, but not the other;
- Differences in coinsurance, copays, numbers of days of coverage and other levels of coverage between one package and the other; and
- The number of subscribers/contract holders who currently purchase each package.

PSHB ER-HMO Carrier:

Your proposed materials must be submitted in Carrier Connect.

Benefit and Rate Proposal Information for All Carriers

Your benefit and rate proposal must be complete. The timeframes for concluding benefit negotiations are firm and we will not consider late proposals. Your benefit proposal must include:

Benefit Proposal Information	Current FEHB HMO Carriers	New FEHB and All PSHB HMO Carriers	All FEHB and PSHB FFS Carriers
A Signed Contracting Official's Form	Yes	Yes	Yes
A comparison of your 2024 benefit package (adjusted for FEHB benefits) and your 2025 benefit package.	Yes	No	No
Benefit package documentation (See Benefit Changes below).	Yes	No	Yes

Benefit Proposal Information	Current FEHB HMO Carriers	New FEHB and All PSHB HMO Carriers	All FEHB and PSHB FFS Carriers
A plain language narrative description of each proposed Benefit Change and the revised language for your 2025 brochure.	Yes	No	Yes
A plain language narrative description of each proposed Benefit Clarification and the revised language for your 2025 brochure.	Yes	No	Yes
Benefits package documentation (e.g., complete proposed brochure template with all benefit information).	No	Yes	No
Benefit Difference Comparison Chart In-Network Benefits Spreadsheet	Yes	Yes	No
A copy of your rate proposal. Instructions regarding your rate proposal will be sent in a separate Carrier Letter.	Yes	Yes	Yes
Drug Formulary (See Appendix X for instructions. The 2024 Formulary, 2025 Formulary, and Formulary Comparison Between 2024 and 2025 are separate documents included with this Technical Guidance).	Yes	Yes	Yes

Benefit Proposal Information for Carriers offering an MA-PD EGWP or PDP EGWP	Current FEHB HMO Carriers	New FEHB and All PSHB HMO Carriers	All FEHB and PSHB* FFS Carriers
FEHB Carrier EGWP Checklist (See Appendix IX for instructions.).	Yes	Yes	Yes
Comparison Between CMS Base, EGWP, and FEHB Formularies and Costs Sharing (See Appendix XI for instructions. The template is a separate document included with this Technical Guidance).	Yes	Yes	Yes
CMS Medicare Part D Waivers (See Appendix VIII for instructions.).	Yes	Yes	Yes
Draft communications to enrollees, including information on the opt out process.	Yes	Yes	Yes

Note

PSHB Carriers:

- Your proposed materials (marked as 'Yes' in the tables above under 'All FEHB and PSHB FFS Carriers' column) must be submitted in Carrier Connect.
- Questions on the EGWP Checklist (Appendix IX) will be available as prompts in Carrier Connect.

Benefit Changes (Current Fee-For-Service plans and HMOs)

Your proposal must include a narrative description of each proposed benefit change. Please use the Benefit Change Worksheets in Appendix III and Appendix IV as the template to submit benefit changes. You must show all changes, however small, that result in an increase or decrease in benefits, even if there is no rate change. This must be inclusive of process changes that would impact a member's benefits (e.g., state mandate imposing a limit on opioids due to regulation).

You must respond to each of the items in Information Required for Proposal in the Benefit Change Worksheet format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incomplete Benefit Change Worksheet submissions.

Cost Neutrality

When proposing an increase in benefits, Carriers must propose benefit reductions within the same plan option to offset any potential increase in premium, with limited exceptions as authorized by OPM. As indicated in Carrier Letter 2019-01, OPM will consider Carrier-generated proposals for exceptions to this cost neutrality requirement. For the 2025 Plan Year, these exceptions are as follows:

- **Exception 1:** A Carrier may propose benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

    - Maintain a meaningful difference between plan options and describe the difference;
    - Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
    - Provide evidence to support that cost neutrality is met in Plan Year 2025.
- **Exception 2:** A Carrier may propose benefit enhancements 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.
- **Exception 3:** Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.
- **Exception 4:** Any prescription drug benefit changes FEHB and PSHB Carriers need to make to continue to meet CMS Creditable Coverage requirements in 2025 do not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

FEHB Information Required for Proposal

If you anticipate changes to your benefit package, please discuss them with your Health Insurance Specialist before preparing your submission.

- Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2025" section in a plain language narrative, using active voice, and written from the member's perspective. Show clearly how the change will affect members and the complete range of the change. For instance, if you propose to add inpatient hospital copays, indicate whether the change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, show each change clearly.
- Describe the rationale for the proposed benefit change.
- State the actuarial value in (a) the existing benefit and (b) your overall benefit package. If an increase, describe whether any other benefit

change within that plan option offsets the increase. Include the cost impact of the change as a bi-weekly amount for the Self Only, Self Plus One, and Self and Family rates. Indicate whether there is no cost impact, or if the proposal involves a cost trade-off with another benefit and what benefit is being used as the offset. If you are proposing an exception to the cost neutrality requirement, note the exception category (1, 2, 3, or 4) and provide the information necessary to support that exception as described above.

Note

PSHB Carriers:

- If you offered a 2024 FEHB plan benefit package and anticipate significant changes between that and your proposed 2025 PSHB plan benefit package, please discuss them with your Health Insurance Specialist before preparing your submission. Your proposed materials must be submitted in Carrier Connect.

Benefit Clarifications (Current Fee-For-Service plans and HMOs)

Clarifications help members understand how a benefit is covered. Clarifications are not benefit changes and have no premium impact. Please use the Benefit Clarification Worksheet as a template for submitting all benefit clarifications.

Information required for proposal:

- Provide the current and proposed language for each proposed clarification and reference all sections and page numbers of the brochure it affects. Prepare a separate Benefit Clarification Worksheet for each proposed clarification. You may combine more than one clarification to the same benefit, but you must present each one clearly on the worksheet using plan language.
- Explain the reason for the proposed clarification.

Note
PSHB Carriers:
- Your proposed benefits change materials must be submitted in Carrier Connect.

Alternate Benefit Package (Community-Rated HMOs)

OPM will allow HMOs the opportunity to adjust their offering in response to local market conditions. If you choose to offer an alternate benefit package, you must clearly state your business case for the offering. We will accept an alternate benefit package only if it is in the best interest of the Government and FEHB or PSHB enrollees.

- The alternative benefit package may include greater cost sharing for members to offset premiums.
- The alternative benefit package may not exclude benefits that are required of all FEHB or PSHB plans.
- Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your Health Insurance Specialist and your contact in the Office of the Actuaries regarding any questions about the alternate benefit package. Be sure you refer to the rate instructions to adjust your rate proposal to account for the alternate package.

Your FEHB and PSHB rate must be consistent with the Community Benefit Package on which it is based. Benefit differences must be accounted for in your rate proposal, or you may end up with a defective community rate.

Note
PSHB Carriers:
- Your proposed benefits change materials must be submitted in Carrier Connect.

FEHB Benefit Difference Comparison Chart (All FEHB HMOs)

You must complete the FEHB Benefit Difference Comparison Chart (Appendix VI) with the following information:

- Differences in copays, coinsurance, deductibles (subject to/or not), coverage levels (including visit and/or day limits, etc.) between the community benefit and 2025 FEHB proposed packages. In-network benefits are entered on a separate tab than out-of-network benefits.
- Highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 31, 2024, or if they were not specifically addressed in previous negotiations. Remember, you must obtain state approval and submit the documentation to us by June 30, 2024.
- Include whether riders are required within your proposed 2025 FEHB benefit package. Indicate the name of the Community Benefit Package, including the entity noted as having the largest number of non-Federal employee subscribers/contract holders who purchased the 2024 package and who are expected to purchase the 2025 package.

Note

PSHB Carriers:

- Not applicable

Part II: 2025 Service Area Proposal Instructions for All HMOs

PSHB Carriers: PSHB Carriers must use materials and instructions from Carrier Connect. Proposal instructions not found within Carrier Connect are annotated within each section below.

Service Area Eligibility

Federal employees and annuitants (for FEHB plans) or Postal Service employees and annuitants (for PSHB plans) who live or work within the approved service area are eligible to enroll in your plan. If you enroll non-FEHB or non-PSHB members from an additional geographic area that surrounds, is contiguous with or adjacent to your service area, you may propose to enroll Federal and Postal Service employees and annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to serve enrollees who work but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB and PSHB Program enrollees. OPM will provide model language for stating your policy in your brochure.

Limitations on the Number of Plan Options within a Service Area

A Carrier can offer up to three options, or two options and a high deductible health plan within a contiguous service area, per OPM contract.

Although FEHB regulations do not specify a limit on the number of contracts a Carrier may have with OPM, OPM retains discretion to administer FEHB and PSHB in the best interests of enrollees. OPM aims to minimize administrative burden and unneeded complexity that does not provide valuable choice, including by limiting the number of contracts and options it allows with each Carrier. To have an equitable competition and reasonable choice that focuses on quality and value, Carriers should be offering no more than three options within a service area.

OPM has permitted an exception to the limit of three options across a Carrier’s plans in a service area to offer a meaningfully different benefit

design in the best interest of the enrollees and prospective enrollees. We are not currently entertaining proposals for more than three options by a Carrier in a service area in the FEHB and PSHB Programs.

FEHB Carriers with current permitted exceptions should review their contracts and options offered and their 2025 FEHB Proposal should include a consolidation of service areas or plan options and remove overlap or redundancy to maintain greater overall FEHB Program value. OPM will determine during benefit negotiations if it would be in the FEHB enrollees' best interest to consolidate or terminate any Carrier's FEHB contracts, plans, or options.

Note

PSHB Carriers:

- Please describe your proposed service area. You must also complete the service area geographic data (i.e., state, county, and ZIP code data) for each plan code in Carrier Connect.

Service Area Changes

Current HMO Carriers proposing service area changes and new HMO Carriers proposing changes in their service area since they submitted their application to the FEHB and PSHB Programs should refer to the guidance in this section.

All HMOs must inform OPM of proposed service area changes. Your service area(s) must remain in place for the 2025 contract term. Reducing a service area to prevent adverse selection in a portion of a previously approved service area, such as a single ZIP code, will not be allowed. In addition, proposals for service areas leaving out a county or single ZIP code within a larger covered area will not be allowed. Proposed reductions in service areas must include a justification for the reduction, a map demonstrating the change to the service area, an enrollment report for the proposed reduced service area and a report on the aggregate claims paid for the previous two years.

There are areas where our members have more limited choice than in other areas. Please consider expanding your FEHB and PSHB service area to all areas in which you have authority to operate. FEHB Carriers must upload a .CSV file to Benefits Plus of covered ZIP Codes for your existing service area and any new service area expansion that you propose. ZIP Codes must be listed in a single column, one row per ZIP Code. Please review these files carefully for accuracy before submission.

Note

PSHB Carriers:

- Your materials, documenting a change from the service area of your 2024 FEHB plan from which reserves are credited to your 2025 PSHB plan offering must be submitted in Carrier Connect. Service areas for PSHB must be the same as FEHB for the 2025 plan year.

Healthcare Delivery Network

The information you provide about your provider network(s) must be based on executed contracts. We will not accept letters of intent. All provider contracts must have a "hold harmless" clause that precludes the provider from pursuing or "balance billing" a member for costs in excess of the allowed amount under the plan.

New Enrollment Codes (Community-Rated HMOs)

OPM will assign new enrollment codes as necessary. In some cases, rating area or service area changes require reenrollment by your FEHB members. We will advise you if this is necessary. All PSHB Carriers will receive new enrollment codes.

Service Area Expansion Criteria

You must propose any service area expansion by May 31, 2024. OPM grants an extension for submitting state approval supporting documentation until June 30, 2024.

OPM will evaluate your proposal to expand your service area based on the following criteria:

- Legal authority to operate;
- Adequate choice of quality primary and specialty medical care throughout the service area;
- Your ability to provide contracted benefits; and
- Your proposed service area is geographically contiguous.

You must provide the following information:

- A description of the proposed expansion area in which you are approved to operate.
- The proposed service area expansion by ZIP Code, county, city, or town (whichever applies) and a map of the old and new service areas. Provide the exact narrative of how you will describe the service area change in the brochure.
- Your authority to operate in the proposed area. Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and contact information of the person at the state agency who is familiar with your service area authority.
- Reasonable access to network providers. Please provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts. You must include the mental health/behavioral health providers in your reports and identify areas with limited access to those providers separately. You must also submit updated information to OPM by August 31, 2024. The update must reflect any changes (non-renewals, terminations, or additions) in the number of executed provider contracts that have occurred since the date of your initial submission.

Note

PSHB Carriers:

- Service areas must be the same between the FEHB and PSHB Programs for 2025. Your proposed materials documenting a change from the service area of your 2024 FEHB plan from which reserves are credited to your 2025 PSHB Plan service area, must be submitted in Carrier Connect.

New Rating Area (Current Community-Rated HMOs only)

OPM will evaluate your proposal to add a new rating area (or split a current service area) according to these criteria:

- Why the area has been added;
- How it relates to the previous service area (for example, the new rating area is a portion of an existing area that has been split into two or more sections); and
- How your current enrollment will be affected by the addition of this new rating area.

Note

PSHB Carriers:

- Your proposed new rating area materials must be submitted in Carrier Connect.

Service Area Reduction Criteria (Current HMOs only)

Please explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain.

OPM will evaluate your proposal to reduce your service area or enrollment area according to the following criteria:

- The reduction proposed eliminates an entire service area.
- The reduction is associated with the following:
    - Significant loss of network providers;
    - Poor market growth;

    - Applies to other employer groups;
    - Applies to consolidation of two or more rating areas (current Community-Rated HMOs only); and
- Splitting rating areas (current Community-Rated HMOs only).

You must provide the following information:

- A description of the proposed reduced service area or enrollment area. Provide the proposed service area reduction by ZIP Code, county, city, or town (whichever applies) and provide a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure if you are a current HMO.
- All state approvals that apply or are associated with the revised service area. We will not accept service area proposals for service areas that are not contiguous or consistent with the residency of the Federal population or proposals that seek to provide services only to lower-cost enrollees.

Note
PSHB Carriers:

- The services areas must be the same between the FEHB and PSHB Programs for 2025. Your proposed materials must be submitted in Carrier Connect.

Part III: 2025 Call Letter Initiatives for All Carriers

FEHB and PSHB Coordination with Medicare

Coordination with Employer Group Waiver Plans (EGWP)

As OPM announced in Carrier Letter 2023-06, beginning with the 2024 plan year, OPM accepted proposals to include Prescription Drug Plan (PDP) EGWPs with automatic group-enrollment. For plan year 2025, as indicated in the annual Call Letter 2024-04, OPM will again entertain proposals for PDP EGWPs with automatic group-enrollment and Medicare Advantage Prescription Drug (MA-PD) Plan EGWPs. PSHB Carriers **must** propose a PDP EGWP with automatic group-enrollment for Medicare-eligible members; PSHB Carriers **may, in addition**, propose to offer MA-PD EGWPs.

All FEHB Carriers and PSHB Carriers are expected to follow the guidance in previous FEHB Carrier Letters. PSHB plans must follow the requirements of the Postal Service Reform Act (PSRA) as well as OPM regulations and guidance.

Additionally, FEHB Carriers and PSHB Carriers must educate members using a variety of communication methods regarding FEHB or PSHB coordination with Medicare including the potential effects of the Income Related Monthly Adjustment Amount (IRMAA) surcharge and the restriction against using manufacturer coupons. Carriers must provide customer service before, during, and after enrollment to individuals enrolled in or being enrolled in PDP EGWP products. Members should be able to timely access multiple customer service channels such as telephone, online chat, or email.

Furthermore, pharmacy claims must be adjudicated at the point of sale using processes that are seamless for the member. To accomplish that, we strongly encourage Carriers to utilize a single ID card that includes all relevant pharmacy benefits information.

EGWP Oversight

Carriers are expected to implement comprehensive monitoring and oversight processes to ensure seamless coordination of drug benefits and member access to care. Carriers must submit all requested information detailed in

the EGWP Checklist (Appendix IX). Please also provide your proposed internal compliance monitoring and oversight plan.

Carriers must provide OPM with additional reporting to allow OPM to conduct oversight of the coordination of FEHB and PSHB benefits with the Medicare EGWP product. Guidance is forthcoming.

Member Experience

As stated in Carrier Letter 2024-04 and Carrier Letter 2024-05, Carriers must continue to monitor, assess and seek improvements to the member experience by applying innovative solutions and technologies. OPM expects pharmacy networks and drug pricing that are most cost-effective for the member and for the FEHB and PSHB Programs. Your proposal(s) must describe how you address the following:

Current and prospective enrollees and their family members must have convenient access to accurate, current information about the formulary tier, member cost-share, and utilization management requirements for covered prescription drugs. Online formularies must be straightforward and easy for members to understand regarding drugs/products covered, expected member cost-share, and means of accessing the drug, whether available at retail, mail, or specialty pharmacies.

In addition, we expect that current and prospective enrollees and their family members can easily retrieve pricing-related information across a variety of pharmacy networks, pricing for brand/generic, a list of formulary alternatives, including biosimilars, and therapeutic indications. In your proposal, you must:

- Provide a URL to your online formulary and describe pharmacy network arrangements. OPM expects pharmacy networks and drug pricing that are most cost-effective for the member and for FEHB and PSHB.
- Explain how you are monitoring member transparency tools, evaluating the monitoring results, identifying any gaps, and making corrections to address the identified gap areas.

As stated in Carrier Letter 2024-05, OPM continues to encourage enhanced provider tools such as e-prior authorization and real-time benefit tools (RTBT) for your providers to view accurate pharmacy benefits coverage and exchange clinical information, which results in quicker prior authorization turnaround times, reduced prescription abandonment rates, and increased member satisfaction.

Pass-Through Transparency

Carriers are reminded that current PBM transparency standards apply to all contracts.[2] Pass through transparency drug pricing standards apply to Experience-Rated Health Maintenance Organizations (HMOs) and Fee-For-Service Carriers.

Furthermore, Fee-For-Service and Experience-Rated HMO Carriers with non-capitated arrangements with their PDP sponsor must ensure that your PDP sponsor or PBM can demonstrate it has passed through 100 percent of rebates, indirect/direct subsidies, remuneration, discounts, and any other payments collected on your behalf for all Medicare medical and pharmacy benefits.

We require every Carrier to demonstrate how manufacturer discounts and other cost offsets under Medicare Part D are appropriately accounted for in your rate proposal. Please see the rate proposal instructions.

Please refer to the OPM contract and Carrier Letter 2024-02 for additional information.

FEHB and Medicare Part D Coordination

Employer Group Waiver Plans (EGWPs)

FEHB carriers offering EGWPs must complete Appendix IX (EGWP Checklist) of the Technical Guidance.

[2] Current PBM Transparency standards are set forth in the FEHB standard contract, Section 1.28 for Experience- rated HMOs, Section 1.26 for Fee-For-Service plans, and Section 1.29 for Community-rated HMOs.

Medicare Advantage Prescription Drug (MA-PD) EGWP

An FEHB Carrier may propose a plan option that offers an eligible member the opportunity to choose the Carrier's MA-PD EGWP to receive additional, enhanced coverage. If you make such a proposal to offer your MA-PD EGWP to eligible members, you must ensure that you or your sponsors are in full compliance with CMS guidance related to the MA-PD EGWP, including those requirements contained in the Medicare Prescription Drug Eligibility and Enrollment | CMS.

Carriers offering a MA-PD EGWP must use the EGWP checklist in Appendix IX to provide all required responses in its MA-PD EGWP proposals for 2025.

Prescription Drug Plan EGWP (PDP EGWP)

OPM welcomes proposals from Carriers to offer PDP EGWPs.

Carriers offering a PDP EGWP must use the EGWP checklist in Appendix IX to provide all required responses in its PDP EGWP proposals for 2025.

Automatic Group Enrollment

This section applies to Carriers offering PDP EGWPs only. Carriers must:

- Individually notify all Medicare-eligible individuals that you intend to group enroll them in the PDP EGWP you are offering;
- Send this notice to individuals not less than 21 calendar days prior to the effective date of the enrollment in your PDP;
- Obtain OPM approval of all group enrollment notifications prior to sending to individuals;
- Fully describe how you will educate individuals including the advantages of the EGWP, how you process enrollments, the availability of customer service to these individuals before, during, and after enrollment, and the potential impact of the IRMAA surcharge;
- Ensure individuals are aware they may affirmatively opt out of such group enrollment at any time during the plan year, how to accomplish that, and any consequences of opting out. Your opt out process must be straightforward, transparent, and easy to understand;

- If an individual opts out of group enrollment in a PDP EGWP, you may not group enroll that individual at a future date;
- Include specific language with respect to group enrollment in Section 9 of the FEHB brochures; and
- Allow individuals who have opted out of the PDP EGWP to opt in again once during the Plan Year.

PDP EGWP Pharmacy Coverage Must Be Equal to or Greater Than FEHB Coverage Alone

Carriers must ensure that members receive pharmacy benefits that are equal to or greater than the FEHB benefit alone for each EGWP-covered drug. Describe in detail:

- The proposed CMS base formulary that will be submitted to CMS, the enhanced EGWP formulary that will be in effect during the plan year, and your FEHB plan formulary as indicated in Appendix X. The information you provide must show that the FEHB members will receive drug coverage that is equal to or greater than the FEHB plan drug coverage in **all instances**. Carriers must submit their CMS-approved base Medicare Part D formulary to OPM once approved by CMS by sending an email to OPMPharmacy@opm.gov.
- How you will ensure that eligible members enrolled in an EGWP have formulary access to all drugs covered under the corresponding FEHB formulary at same or lower cost-share than they would have otherwise been responsible for if enrolled solely in the FEHB plan.
- Your plan to ensure seamless coordination of providing the same or lower cost-share as described above.

Formulary management is a dynamic process; Carriers must not make negative changes to FEHB formularies solely to accommodate the 'equal or better' requirements for PDP EGWP formularies.

PSHB and Medicare Part D Coordination

Subject to limited exceptions, the PSRA requires PSHB Carriers to provide prescription drug benefits to any Postal Service annuitant and member of

family who is a Medicare eligible individual through employment-based retiree health coverage.

This coverage must be established through a CMS-approved PDP EGWP or a contract with a PDP EGWP sponsor. A Carrier may additionally offer eligible enrollees the choice of enrolling in an MA-PD EGWP as an alternative to the PDP EGWP. OPM is promulgating regulations through notice and comment rulemaking to implement the guidance described in this section. It is in the best interest of Carriers that have applied to offer PSHB plans, for OPM to describe how it intends to implement 5 U.S.C. 8903c relating to the integration of Medicare Part D in the PSHB Program.

When using group enrollment for PDP EGWPs, PSHB Carriers must comply with all the requirements for group enrollment contained in CMS guidance, including the Medicare Prescription Drug Benefit Manual and the PDP Enrollment and Disenrollment Guidance. This includes the ability for the annuitant and their Medicare-eligible family member to opt-out of the EGWP.

OPM expects that PSHB Carriers comply with the same requirements for group enrollment and provide seamless member experiences specified above for FEHB Carriers. Similar to FEHB Carriers, PSHB Carriers offering PDP EGWPs must ensure that equivalent pharmacy benefits are based on the Carrier's corresponding FEHB plan pharmacy benefits, not a Carrier's FEHB EGWP plan benefits. To demonstrate compliance with the guidance, Carriers must submit all necessary evidence, supporting documentation and expound on necessary details to your Health Insurance Specialist(s) by May 31, 2024, via Carrier Connect. Carriers should also pay close attention to the following information related to group enrollment and PSHB equivalent benefits and cost share.

PSHB Equivalent Pharmacy Benefits and Cost-Share

Pursuant to the PSRA, in 2025 (the initial contract year), each Carrier must provide benefits and cost-sharing that are equivalent to the benefits and cost-sharing of the Carrier's corresponding 2025 FEHB plan, except to the extent needed to integrate Medicare Part D prescription drug benefits. Carriers must submit the proposed CMS base formulary, enhanced PSHB

EGWP formulary, and corresponding PSHB formulary via Carrier Connect by May 31, 2024. As noted elsewhere, OPM will offer further instructions and training on using Carrier Connect to submit formularies. Please also note additional instructions related to document submissions pertaining to PSHB drug benefits.

- Carriers must submit via Carrier Connect a CMS-approved Medicare Part D formulary as soon as it receives approval from CMS.
- Individuals enrolled in a PSHB plan's Part D PDP EGWP must have formulary access to all drugs covered under the corresponding FEHB formulary at the same or lower cost-share **in all instances**. Where this standard cannot be met due to limitations in integrating Medicare Part D prescription drug benefits, you must provide justification explaining why a difference is required.
- PSHB Carriers offering equivalent FEHB plans in 2025 must submit corresponding 2025 FEHB formularies via Carrier Connect.
- PSHB Carriers not offering a 2025 FEHB plan must offer the benefits and cost sharing that are equivalent between the Carriers' 2024 FEHB plan and 2025 PSHB plan. Those Carriers must submit their 2024 FEHB formulary via Carrier Connect.

Part IV: Continued Focus from Previous Year for All Carriers

Contraception Benefits

As noted in previous guidance, including Carrier Letter 2022-17 and Carrier Letter 2024-03, Carriers and their plans must:

- Cover, without cost sharing, at least one form of contraception from each category listed in Women's Preventive Services Guidelines supported by the Health Resources & Services Administration (HRSA).

The following case study is an example of a plan that did not follow the contraceptive requirements. In this section we address the cost share component.

> Within the category of "combined oral contraceptive," there are multiple products containing ethinyl estradiol and norethindrone acetate. A member is prescribed a branded Pill A (ethinyl estradiol/norethindrone acetate/iron), but the plan did not cover branded Pill A without cost sharing because the plan said that Pill A contained the same content as generic drugs in the combined oral contraceptive category. However, Branded Pill A is distinct from other combination contraceptive pills (generic or branded) in that category because (1) it contained additional medications (iron), (2) the dosage combinations were different, and (3) the Pill A has a unique regimen (i.e., each pack contains 26 days of active pills, as opposed to the standard 21-day active packs).

While the plan did cover one form of generic medication in this contraceptive class, the plan incorrectly classified Branded Pill A as the same as its covered generic medication and charged the member a cost share for Branded Pill A.

- Provide an easily accessible, transparent, and sufficiently expeditious exceptions process that leads to a response within 24 hours.

Continuing with the case study, we review the plan's exceptions process.

When the member or provider utilized the plan's exception process for branded Pill A and cited medical necessity, the plan's exception review was not completed for 7 days after the initial submission of requested information. The plan's review process required the member to incur out-of-pocket costs to access to their medication and maintain adherence to their medically necessary treatment.

The plan did not follow OPM's guidance requiring an easily accessible, transparent, and sufficiently expedient exceptions process and did not defer to a provider's determination of medical necessity.

- Defer to a provider's determination of medical necessity.

Carriers must recognize the 'Dispense as Written' (DAW) designation on a prescription as the prescriber's expression of medical necessity for contraceptive drugs and drug-led devices; in which case, the contraceptive drug or drug-led device must be covered without cost sharing.

Barriers to contraceptive coverage remain that cause member difficulty accessing coverage without cost sharing.

Given such barriers, OPM **strongly encourages** Carriers to cover, without cost sharing, all FDA-approved contraceptive drugs and drug-led devices other than those for which there is at least one therapeutic equivalent drug or drug-led device that is covered without cost sharing.[3] OPM will consider a contraceptive drug or drug-led device to be therapeutically equivalent to another drug or drug-led device if the drug products or drug-led devices are identified as therapeutic equivalents (that is, designated with a code with the first letter "A") in the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations.

[3] For purposes of this Carrier Letter, a drug-led device refers to a combination product, as defined under 21 CFR 3.2(e), that is comprised of a drug and a device, and for which the drug component provides the primary mode of action. The primary mode of action of a combination product is the single mode of action (that is, the action provided by the drug, device, or biological product) that provides the most important therapeutic action of the combination product. See 21 U.S.C. § 353(g)(1)(C) and 21 CFR 3.2(m).

OPM requires Carriers to provide education on the availability of contraceptive care and information about how to access contraceptive coverage. Details on requirements for member and provider education is in Carrier Letter 2024-03.

Proposals should describe the following components of your contraception benefit: applicable medical policies, how you educate members and providers about the contraceptive benefit, and communication strategies on how members and providers can access the contraceptive exceptions process.

Fertility Benefits

OPM requires Carriers to ensure their definitions of infertility and related medical policies are placed in all member-facing materials including, but not limited to, Plan brochures and websites that are easily located and understood by the member. We note that several Carriers do not have their medical policies visible in member facing materials, as required in Carrier Letter 2023-04. If you are one of these Carriers, your Health Insurance Specialist will reach out to address this situation.

We thank Carriers for implementing the expanded fertility requirements outlined in the 2023 Call Letter and applaud those that have gone above and beyond in their benefit offerings. We encourage Carriers to ensure your fertility benefits are structured in a manner that leads to the best pre- and postnatal outcomes for mother and child.

Proposals should clearly include how your plan addresses the requirements outlined in the 2023 Call Letter, including how you are using evidence-based fertility design such as:

- genetic testing when medically indicated;
- evidence-based embryo transfer; and
- removal of any treatment mandates or mandatory step therapies or artificial barriers prior to consideration of fertility procedure eligibility.

If your benefits package includes cycle or dollar limits for coverage of Assisted Reproductive Technology (ART) medical procedures, please indicate

how the use of such limits support positive pregnancy outcomes for this benefit and avoid unintended consequences such as multiple births, premature or low weight births or other poor birth outcomes. ART coverage of donor sperm is not required to be covered; however, Carriers may elect to cover if medically indicated.

Your proposals must outline your current and proposed, if applicable, artificial insemination benefit coverage. Carriers are required to provide coverage of artificial insemination (intrauterine insemination, intravaginal insemination, and intracervical insemination). While coverage of artificial insemination is required, donor sperm coverage is not; Carriers may elect to cover if medically indicated. If cycle requirements or dollar limits are included for artificial insemination procedures, your proposal must indicate how these limits contribute to positive pregnancy outcomes in a cost-efficient manner.

Carriers are required to cover drugs associated with artificial insemination procedures when medically necessary. Clinical criteria should be evidence-based, transparent and readily accessible. Carriers are also required to cover the cost of in vitro fertilization (IVF)-related drugs for three cycles annually. Coverage of these drugs should be folded into existing prescription drug benefits and can be administered effectively through each Carrier's pharmacy benefit manager. Please refer to Carrier Letter 2024-05 for additional guidance on OPM's expectation for pharmacy benefit management. Describe in your proposals how you meet the IVF-related drug coverage requirement above, including any utilization management or drug exception processes applied.

In addition to the requirements outlined above, OPM continues to strongly encourage FEHB and PSHB Carriers to provide members with access to fertility specialists within their networks, ideally reproductive endocrinologists or similarly credentialed specialists, at fertility centers of excellence or via benefit fertility programs so that members can access medically necessary and cost-effective fertility treatments. OPM strongly encourages Carriers to consider the inclusion of fertility vendors in your plan design that demonstrate cost-efficient navigation and access to increased

pregnancy and live birth rates, and decreased miscarriage rates and high-risk births.[4,5]

Maternal Health

Optimal maternal health and perinatal outcomes and maternal health disparities remain an OPM priority and continued focus of the Biden-Harris Administration. OPM appreciates the efforts Carriers have taken in response to prior Call Letters.

Please ensure your plan proposal(s) include how you will continue to pursue and expand efforts in improving maternal health outcomes, including but not limited to the following strategies:

- Communication of the availability of your pre-conception, prenatal, and perinatal services to FEHB and PSHB members at risk for high-risk pregnancies or at risk for severe maternal morbidity, mortality, or post-partum hospital readmissions, especially programs and policies that minimize delays in access to maternity care within the first three weeks of delivery.
- Coverage, reimbursement and services of certified nurse midwives and home nurse visits as noted in previous Carrier Letters for at least six months post-partum if needed, especially in maternal populations that are more at risk for prenatal and post-partum disparities.
- Coverage, reimbursement, and services for board-certified lactation specialists as part of your in-network breastfeeding support coverage (as identified by the US Surgeon General's Call to Action to Support Breastfeeding) in the prenatal and post-partum period.
- Coverage, reimbursement, and access to doulas (in-person or virtual).[6]

[4] Key Benefit Components - Midwest Business Group on Health (mbgh.org)
[5] SART: Society for Assisted Reproductive Technology
[6] Karwa, Smriti MPH; Jahnke, Hannah PhD; Brinson, Alison MSPH; Shah, Neel MD; Guille, Constance MD; Henrich, Natalie PhD, MPH. Association Between Doula Use on a Digital Health Platform and Birth Outcomes. Obstetrics & Gynecology ():10.1097/AOG.0000000000005465, December 5, 2023. | DOI: 10.1097/AOG.0000000000005465.

- Strategies and policies that help to avert costly interventions such as contracting with hospitals that have received the Healthy People 2030 goal of a cesarean birth rate of 23.6% or lower, hospitals who have been recognized by Leapfrog for maternity care safety, hospitals that have received the "Birthing-Friendly"[7] or the Baby-Friendly Hospital Initiative designation process.
- Screening and treatment services for prenatal, perinatal, and post-partum mental health conditions for at least six months postpartum.[8]

Mental Health and Substance Use Disorder Services

Network Adequacy/Provider Directories

Carriers must have adequate contracted (in-network) providers to deliver mental health (MH) and substance use disorder services (SUD), collectively known as behavioral health services, to members. Carrier Letter 2023-06 reinforced requirements for provider directories and reminded Carriers that enrollees should be able to find available providers who are accepting new patients. Carrier Letter 2023-15 asked Carriers to submit reports about behavioral health network adequacy. Based on the results of these Carrier reports, OPM is reiterating its expectation that online and print provider directories must clearly indicate whether or not a provider is accepting new patients. Your proposals must provide a full narrative description of how provider directories communicate to members whether or not MH/SUD providers[9] are accepting new patients.

Substance Use Disorder Services

Addressing the opioid epidemic requires a multi-pronged approach as described in Carrier Letter 2021-03, Carrier Letter 2020-01 and related guidance. According to Carrier Letter 2024-05, Carriers must make

[7] CMS Announces Key Actions to Reduce Maternal Mortality and Morbidity | CMS
[8] Assessment and Treatment of Perinatal Mental Health Conditions | ACOG
[9] MH/SUD providers include, but at not limited to, child psychiatrists and psychologists; other psychiatrists and psychologists; psychiatric nurse practitioners; master's level MH counselors, marriage and family therapists, independent clinical social workers, and advanced social workers; non-master's level MH counselors; board certified SUD addiction medicine physicians; and other non-physician SUD professionals. This list is adapted from the Department of Labor's Technical Release 2023-01P (July 25, 2023).

naloxone-based agents or other non-naloxone-based products indicated for the emergency treatment of opioid overdose and education related to opioid overdose readily accessible with at least one opioid rescue agent available without cost-share. Please describe in your proposal how you make at least one opioid rescue agent available without cost-share.

Gender Affirming Care and Services

In accordance with Executive Order 14035, OPM has consistently strongly encouraged Carriers to cover comprehensive gender affirming care and services. As explained in Carrier Letter 2023-12, Carriers may not categorically exclude from coverage services related to gender affirming care, such as hormone therapy, genital surgeries, breast surgeries, and facial gender affirming surgeries. Further, Carriers are reminded that they must establish coverage policies and medical necessity determinations in a consistent, neutral manner that does not limit or deny services to enrollees in a discriminatory manner, and that plans should cover procedures or treatments for gender dysphoria when plans cover the same procedures or treatments for other diagnoses. You must continue to provide comprehensive coverage of gender affirming care.

Prevention and Treatment of Obesity

OPM reminds Carriers of the importance of a comprehensive obesity benefit as shared in Carrier Letter 2023-01 which includes nutrition and physical activity supports, intensive behavioral counseling, coverage of anti-obesity medications when medically indicated, and updates to criteria for metabolic surgery. Carriers are reminded that the FDA indications for anti-obesity medications reinforce that nutrition, behavioral interventions and physical activity regimens should accompany drug treatment of obesity.

Please submit proposals that continue to enhance or expand upon all aspects of this benefit and that also minimizes any barriers to members' access to intensive behavioral interventions, such as behavior-based weight loss and weight loss maintenance interventions. As part of their coverage of anti-obesity medications, Carriers should also have a medication management program in place to review, assess, and address information related to the

use of medications that may contribute to obesity particularly as the landscape of FDA approved pharmaceuticals available to treat obesity continues to evolve.

Part V: Appendices

The information required in the following appendices must be completed and returned to OPM as part of your Plan Year 2025 proposal. FEHB carriers will submit these worksheet appendices as part of their proposal. If you have questions, please contact your Health Insurance Specialist.

FEHB

Not all appendices are applicable to each FEHB Carrier. The list and table below organize the appendices by their applicability to Carrier types.

Worksheet Appendix	Applicable to:		
	FFS	Current HMO (ER & CR)	New HMO
Appendix I: Technical Guidance Submission Checklist	Yes	Yes	Yes
Appendix II: Carrier Contracting Officer	Yes	Yes	Yes
Appendix III: Benefit Change Worksheet for Community-Rated HMOs	No	Yes, only CR	No
Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	Yes	Yes, only ER	No
Appendix V: Benefit Clarification Worksheet	Yes	Yes	Yes
Appendix VI: Attachment E: FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet	No	Yes	Yes
Appendix VII: FEHB Program Statement About Service Area Expansion	No	Yes	Yes

Worksheet Appendix	Applicable to:		
	FFS	Current HMO (ER & CR)	New HMO
Appendix VIII: CMS Medicare Part D Waivers. Please follow instructions in Appendix VIII.	Yes	Yes	Yes
Appendix IX: FEHB Carrier EGWP Checklist. Please follow instructions in Appendix IX.	Yes, if currently offering or proposing an EGWP	Yes, if currently offering or proposing an EGWP	Yes, if proposing an EGWP
Appendix X: Attachment A: FEHB 2024 Formulary Template and Attachment B: FEHB 2025 Formulary Template Attachment C: Formulary Comparison Between 2024 and 2025 Template Please complete the template based on 2024 and 2025 formularies. Please follow instructions in Appendix XII.	Yes	Yes	Yes
Appendix XI: Attachment F: Formulary Comparison Between CMS Base, Enhanced EGWP, and FEHB Please complete the template based on CMS Base, Enhanced EGWP, and FEHB formularies. Follow instructions in Appendix XI.	Yes, if currently offering or proposing an EGWP	Yes, if currently offering or proposing an EGWP	Yes, if proposing an EGWP
Appendix XII: Instructions for 2024 and 2025 FEHB Drug Formulary Information Completion and Submission	Yes	Yes	Yes

PSHB

PSHB Carriers submit via Carrier Connect completed:

- Appendix II: Carrier Contracting Officer;
- Appendix III: Benefit Change Worksheet for Community-Rated HMOs;
- Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs;
- Appendix V: Benefit Clarification Worksheet;
- Appendix VIII: CMS Medicare Part D Waivers; and
- Appendix X Attachment D: 2025 PSHB Drug Formulary Template

Additionally, questionnaires provided in Appendix IX: EGWP Checklist will be available as prompts for PSHB Carriers in Carrier Connect.

Appendix I: FEHB Carrier Technical Guidance Submission Checklist

Please return this checklist with your 2025 benefit and rate proposal.

Not all appendices are applicable to each Carrier. Please refer to the Appendices section and, if you have further questions, please contact your Health Insurance Specialist.

Appendix	**Appendix completed and in proposal?** **Yes/No/NA**
Appendix II: FEHB Carrier Contracting Official	Yes
Appendix III: Benefit Change Worksheet for Community-Rated HMOs	Yes
Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	Yes
Appendix V: Benefit Clarification Worksheet	Yes
Appendix VI: A FEHB Benefit Difference Comparison Chart In-Network Benefits (HMOs only) *	Yes
Appendix VII: FEHB Program Statement About Service Area Expansion	Yes
Appendix VIII: CMS Medicare Part D Waivers	Yes
Appendix IX: FEHB Carrier EGWP Checklist	Yes
Appendix X: FEHB Drug Formulary Templates * Attachment A FEHB 2024 Formularies Attachment B FEHB 2025 Formularies Attachment C Formulary Comparison Between 2024 and 2025 Attachment D PSHB 2025 Formularies	Yes
Appendix XI: Attachment F: Formulary Comparison Between CMS Base, FEHB, and EGWP Template *	Yes

*Please note that the Attachment E: FEHB Benefit Difference Comparison Chart In-Network Benefits; Attachments A-D: FEHB Drug Formulary Templates; and Attachment F: Formulary Comparison Between CMS Base, FEHB, and EGWP Template are Excel documents included with the 2025 Technical Guidance.

Appendix II: Carrier Contracting Official

The Office of Personnel Management (OPM) will not accept any contractual action from _____ (Carrier), including those involving rates and benefits, unless it is signed by one of the persons named below (including the executor of this form), or on an amended form acceptable by OPM. This list of contracting officials will remain in effect until the Carrier amends or revises it. An updated worksheet should be submitted any time revisions are made.

Please submit this worksheet containing the signature of the contracting official.

Verifiable digital signatures are acceptable.

The people named below have the authority to sign a contract or otherwise to bind the Carrier for _____ (Plan).

Enrollment code(s): _____

Typed Name	Title	Signature	Date

_____ _____

Signature of Contracting Officer Date

_____ _____

Typed Name Title

_____ _____

Email Telephone

Appendix III: Benefit Change Worksheet for Community-Rated HMOs

_____

[Insert Health Plan Name]

_____

[Insert Subsection Name]

Please complete **a separate worksheet** for each proposed benefit change.

Please refer to Benefit Changes section to complete the worksheet.

Benefit Change Description

List option(s) Benefit Change applies to (for example, High or HDHP):

_____

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	

Item	Narrative Description
Reason	
Cost Impact / Actuarial Value (See Note 1)	
Exception to Cost Neutrality Requested (If applicable; see Note 2)	

Notes:

1. Actuarial Value:
   a. Is the change an increase or decrease in existing benefit package?

      _____

   b. If it is an increase, describe whether any other benefit is offset by your proposal.

      _____

   c. What is the cost impact of this change as a bi-weekly amount for Self Only, Self Plus One, and Self and Family rate?

      _____

If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero as appropriate.

---

2. Exception to Cost Neutrality: Indicate which exception applies and provide the information as indicated.

Exception 1: A Carrier may propose benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

a. Maintain a meaningful difference between plan options and describe the difference;
b. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
c. Provide evidence to support that cost neutrality is met in Plan Year 2025.

Exception 2: A Carrier may propose benefit enhancements 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.

Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.

Exception 4: Any prescription drug benefit changes FEHB Carriers need to make to continue to meet CMS Creditable Coverage requirements in 2025 do not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

3. Is the benefit change a part of the plan's proposed community benefits package?
   a. If yes, when?

      _____

   b. If approved, when? (Attach supporting documentation)

      _____

   c. How will the change be introduced to other employers?

      _____

   d. What percentage of the plan subscribers now have this benefit?

      _____

   e. What percentage of plan subscribers do you project will have this benefit by January 2025? _____

4. If change is not part of proposed community benefits package, is the change a rider? _____

   a. If yes, is it a community rider (offered to all employers at the same rate)? _____

b. What percentage of plan subscribers now have this benefit? _____

c. What percentage of plan subscribers do you project will have this benefit by January 2025? _____

d. What is the maximum percentage of all subscribers you expect to be covered by this rider? _____

e. When will that occur? _____

5. Will this change require new providers? _____

If yes, provide a copy of the directory that includes new providers.

Appendix IV: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs

_____

[Insert Health Plan Name]

_____

[Insert Subsection Name]

Please complete **a separate worksheet** for each proposed benefit change.

Please refer to Benefit Changes section to complete the worksheet.

Benefit Change Description

List option(s) Benefit Change applies to (for example, High or HDHP):

_____

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	

Item	Narrative Description
Reason	
Cost Impact / Actuarial Value (See Note 1)	
Exception to Cost Neutrality Requested (If applicable; see Note 2)	

Notes:

1. Actuarial Value:
   a. Is the change an increase or decrease in existing benefit package?

      _____

   b. If it is an increase, describe whether any other benefit is offset by your proposal.

      _____

   c. What is the cost impact of this change as a bi-weekly amount for Self Only, Self Plus One, and Self and Family rate?

      _____

   If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero as appropriate.

   _____

2. Exception to Cost Neutrality: Indicate which exception applies and provide the information as indicated.

Exception 1: A Carrier may propose benefit enhancements in one plan option that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:

a. Maintain a meaningful difference between plan options and describe the difference.
b. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
c. Provide evidence to support that cost neutrality is met in Plan Year 2025.

Exception 2: A Carrier may propose benefit enhancements 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.

Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.

Exception 4: Any prescription drug benefit changes FEHB Carriers need to make to continue to meet CMS Creditable Coverage requirements in 2025 do not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

Appendix V: Benefit Clarification Worksheet

[Insert Health Plan Name]

[Insert Subsection Name]

Please refer to Benefit Clarifications section to complete the worksheet.

Please note: Clarifications help members understand how a benefit is covered; it is not a benefit change. If a benefit is a clarification, there should not be a change in premium.

Benefit Change Description

List option(s) Benefit Change applies to (for example, High or HDHP):

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Appendix VI: Instructions for Attachment E – FEHB Benefit Difference Comparison Chart (All FEHB HMOs)

The FEHB Benefit Difference Comparison Chart is an Excel Spreadsheet included with the Technical Guidance as Attachment E. Please refer to the FEHB Benefit Difference Comparison Chart section and follow the Excel Spreadsheet Template for instructions.

If you have questions, please contact your Health Insurance Specialist.

Appendix VII: FEHB Program Statement About Service Area Expansion

New HMOs and Current HMOs complete this form only if you are proposing a service area expansion. Please refer to the Service Area Expansion section of the 2025 Technical Guidance. If you have additional questions, please contact your Health Insurance Specialist.

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2025 Benefits and Service Area Proposals. Specifically,

1. All provider contracts include "hold harmless" provisions that preclude the provider from pursuing or "back billing" a member for fees in excess of the allowed amount under the plan.
2. All provider contracts are fully executed at the time of this submission. We understand that letters of intent are not considered contracts for purposes of this certification.
3. All the information provided is accurate as of the date of this statement.

_____

Signature of Plan Contracting Official

_____

Name and Title

_____

Plan Name

_____

Date

Appendix VIII: CMS Medicare Part D Waivers

Carriers must submit a list of waivers along with descriptions of how EGWP waivers are applied and the rationale for each waiver offered under the EGWPs provided by the Carrier's FEHB plans and PSHB plans. (Note: Do not submit 'Approved Part D EGWP Waivers' from CMS as this would not provide specific waivers unique to each Carrier nor would it provide unique justification of why the waiver is being utilized).

Waiver Number	Category	Rationale/Description

Example of how to complete Appendix VIII:

Waiver Number	Category	Reason/Description
42 CFR 423.38 c (8)(ii)	Enrollment	[Carrier Name] intends to use Special Enrollment Period's (SEP's) to enroll and disenroll members outside of the normal annual enrollment period

Appendix IX: FEHB Carrier EGWP Checklist

Carriers must enhance the PDP EGWP benefit such that the FEHB member receives an equal or better benefit than they would have received if they had the corresponding FEHB benefit alone (e.g., benefits covered, cost-sharing, etc.). This EGWP Checklist applies solely to drug benefits for Medicare-enrolled individuals. Please provide evidence documents and explanation to demonstrate how Carriers would ensure meeting each element specified on the checklist. If you have any questions, please contact your Health Insurance Specialist and copy opmpharmacy@opm.gov.

The following checklist includes a list of items that Carriers must submit to Health Insurance Specialists for review of FEHB MA-PD EGWP or PDP EGWP submissions during the proposal season in 2024. Please note that Carriers proposing MA-PD plans can skip items 22 and 33 as these specific items do not apply to those FEHB Carriers with MA-PD EGWPs.

Item	FEHB Carrier's Task
General Information	
1.	Type of FEHB EGWP being offered a. MA-PD b. PDP c. MA-PD and PDP
2.	Applicable OPM-Carrier arrangement a. Fee-For-Service (FFS) b. Experience-Rated (ER) c. Community-Rated (CR)
3.	Carrier-PBM contract to administer the EGWP (If you have multiple contracts, provide all contracts)
4.	Describe your arrangement with the EGWP sponsor
5.	CMS MA-PD and/or PDP EGWP sponsorship details a. Organization Legal Name b. Organization Marketing Name c. Organization Type d. Organization Address e. Plan Name f. Plan Geographic Name g. Plan Type

Item	FEHB Carrier's Task
	h. Contract Number i. Plan Number
Formularies	
6.	Submit a completed 'Appendix X Attachment B 2025 Formulary Template' for each enhanced EGWP product being offered, including tiered networks, copays, etc.
7.	A formulary analysis that exhibits the following submitted to OPM Pharmacy (opmpharmacy@opm.gov) and cc: the Health Insurance Specialist: See Appendix XI Attachment F for the formulary comparison. a. Completed 'Appendix XI Attachment F Formulary Comparison Between CMS Base, EGWP, and FEHB' template: a comparison showing the differences between • CMS-proposed base formulary[10] • Enhanced formulary for EGWP • FEHB formulary b. Completed 'Appendix XI Attachment F Formulary Comparison Between CMS Base, EGWP, and FEHB' template: a comparison showing the differences between • CMS-approved base formulary[11] • Enhanced formulary for EGWP • FEHB formulary
8.	Provide the URL to your online formulary where current and prospective enrollees can easily retrieve such information as drug cost, tiering, formulary alternatives, pharmacy networks, etc.
9.	Explain how Part D-excluded drugs are covered on the FEHB EGWP
10.	Explain differences between the FEHB EGWP and corresponding FEHB product for the following scenarios: a. Explain how first-fills are handled for these offerings. Examples include if specialty drugs can be filled at retail pharmacies upon the first fill. b. Distinguish differences for filling maintenance medications at retail, mail-order, and Specialty pharmacies. c. Explain the formulary exceptions process for Medicare Part D-excluded drugs. Does this process differ for Part D-included drugs? Does this process differ for corresponding FEHB products?

[10] The CMS-submitted base formulary will not be approved by CMS until after the FEHB proposal close-out. For the FEHB proposal, Carriers must provide the CMS base formulary as it will be submitted to CMS.
[11] Carriers must additionally provide the CMS-approved formulary as soon as receiving approval from CMS.

Item	FEHB Carrier's Task
	d. Explain the tier exceptions process for Medicare Part D-excluded drugs. Does this process differ for Part D-included drugs? Does this process differ for corresponding FEHB products? e. Explain the Transition Fill process for Medicare Part D-excluded drugs. Does this process differ for Part D-included drugs? Does this process differ for corresponding FEHB products? f. Explain other differences between the pharmacy plan offerings.
EGWP Oversight	
11.	Documentation of all waivers being utilized for the EGWP, including justification for using each waiver. Did the sponsor petition CMS for any additional waivers? If so, please explain. See Appendix VIII.
12.	Explain the EGWP sponsor's policies on formulary and nonformulary processes, monitoring, and oversight. This may include SOPs on the P&T process, inclusion and/or exclusion of drugs on a formulary, tiering determinations, UM edits, etc.
13.	Do you engage with an outside firm/entity to monitor and oversee the EGWP sponsor? If 'yes', provide details of the monitoring and oversight plan. If 'no', explain how you monitor and provide oversight of the EGWP sponsor. If the Carrier is the EGWP sponsor, explain internal monitoring and oversight processes.
14.	Describe all incidences of CMS compliance notices within the previous five years. Provide documentation of these incidences.
Pharmacy Networks	
15.	Describe the pharmacy network that FEHB EGWP members will have access to.
16.	Describe how the EGWP pharmacy network differs from the network available to FEHB members.
17.	Will preferred and non-preferred network pharmacies be established? If so, describe these networks.
18.	Describe any requirements to use specific retail pharmacies, specialty pharmacies, and/or mail-order pharmacies.
19.	Provide a network disruption analysis. The network disruption analysis should include, at minimum, the number and percentage of members, number and percentage of claims, and number and percentage of pharmacies that will be impacted by a modification of the pharmacy network.
Member Experience	
20.	Describe your strategy for member education, processing enrollments, and providing member services before, during, and after enrollment.
21.	Describe how pharmacy claims will be adjudicated at the point of sale using a seamless process to the member and the pharmacy. For

Item	FEHB Carrier's Task
	example, members should not have to use two different cards, and a single ID card can contain RxBIN or RxIIN.[12]
22.	Provide a draft of the letter notifying FEHB EGWP beneficiaries that you intend to enroll them in a PDP through a group enrollment process, that the individual may affirmatively opt out of such enrollment, how to accomplish that, and any consequences to group benefits opting out would bring. Note: The opt-out process must be simple and member friendly; for example, it cannot require wet signature, mailing via USPS, etc.
23.	Describe how you have been utilizing prescription drug transparency tools, including formularies, tiering, member cost-share, and utilization management requirements for prospective enrollees of EGWP plans.
24.	Describe how you measure member utilization of prescription drug transparency tools. Include how often these are monitored and how outliers are triaged. Provide any reports or metrics to support measuring utilization of prescription drug transparency tools.
25.	Describe which real-time benefits tools you have implemented for the provider to assess accurate pharmacy benefits coverage and exchange clinical information.
26.	Describe how you measure utilization of real-time benefits tools for the provider to assess accurate pharmacy benefits coverage and exchange clinical information. Include how often these are monitored and how outliers are triaged. Provide any reports or metrics to support measuring utilization of real-time benefits tools.
27.	Describe your process for Part B versus Part D coverage determinations. Does the EGWP formulary contain Part B drugs? Are Medicare Part B drugs covered on the corresponding non-Medicare FEHB formulary? Describe how you coordinate benefits and adjudicate claims for Part B drugs that are covered on the EGWP formulary.
28.	Medicare publishes coordination of benefits guidelines. Describe how you coordinate benefits that are not covered under Medicare Parts A and/or B but are covered under FEHB.
Attestations	
29.	I attest that the FEHB EGWP is unique and will not include non-FEHB members.
30.	I attest that all Affordable Care Act (ACA) Preventive Drugs are covered on the FEHB EGWP.
31.	I attest that all ACA Preventive Drugs are covered at a $0 member cost-share.

[12] The formerly known Bank Identification Number (BIN) defined as a 6-digit identifier is now the Issuer Identification Number (IIN) and is 8 digits in length. When former 6-digit BIN numbers are converted to 8-digit IIN numbers, the conversion is the former BIN number followed by two trailing zeros. Pharmacy and/or Combo ID Card Fact Sheet (ncpdp.org)

Item	FEHB Carrier's Task
32.	I attest that enrollment materials will provide member education on the potential impact of the income-related monthly adjusted amount (IRMAA) premium.
33.	I attest that individuals enrolled in a PDP EGWP will receive coverage at the same or lower cost-share for every drug in the EGWP formularies. [Attestation is applicable for PDP EGWPs only]
34.	I attest that we will comply with all Medicare requirements with the exception of benefits under EGWP waivers, in which case we will comply with all OPM requirements, including but not limited to the PBM Transparency standards.
35.	I attest that we will provide summary results of pre-implementation testing and an assurance that corrections have been made for any inconsistencies found. This will be submitted no later than 30 days prior to the beginning of Contract Year and any additional pre-implementation testing results will be provided as they are completed.
36.	I attest that we will comply with all current and future reporting requirements as defined by OPM.
37.	I attest that any CMS compliance actions, including but not limited to compliance letters, notices of non-compliance, warning letters, and corrective action plans, will be provided to OPM within three business of the PDP or MA-PD Sponsor receiving such notices. This notice must be emailed to OPM Pharmacy at opmpharmacy@opm.gov with a copy to the OPM Contracting Officer and Health Insurance Specialist.
38.	I attest that group auto-enrollment notification letters will be sent to the member/prospective member at least 21 days in advance of the enrollment effective date.
39.	I attest that we will pass through 100 percent of rebates, indirect and direct subsidies, remuneration, and other payments collected on behalf of carriers for all Medicare-eligible medical and pharmacy benefits to OPM.

_____ _____

Signature of Plan Contracting Officer Name and Title

_____ _____

Plan Name Date

Appendix X: Instructions for Attachments A-D - Drug Formularies

FEHB

Drug Formulary Instructions, 2024 Drug Formulary Template, 2025 Drug Formulary Template, Formulary Comparison Between 2024 and 2025, and Formulary Comparison Between CMS Base, FEHB, and EGWP are separate attachments to this Technical Guidance.

Attachment A 2024 Formularies

All carriers must provide a copy of their plans' full 2024 formulary as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as Attachment A "2024 FEHB Drug Formulary Template.xlsx" with this Technical Guidance Document.

Please follow the detailed instructions in the FEHB Drug Formulary Instructions document. The completed templates should be submitted to Research and Oversight Repository (ROVR) by May 31, 2024. If you have any questions regarding file submission, please reach out to OPMPharmacy@opm.gov and ROVRSupport@opm.gov on the emails.

Attachment B 2025 Formularies

All new plans must submit a 2025 Drug Formulary Template to OPM pharmacy, included as Attachment B. Please follow the more detailed instructions in the FEHB Drug Formulary Instructions document. The completed templates should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist by May 31, 2024.

Attachment C Formulary Comparison Between 2024 and 2025

Current FFS and HMOs changing formularies or moving to new formularies (all formulary changes) in 2025 must submit a completed 'Formulary Comparison Between 2024 and 2025 Template', included as Attachment C. The completed template should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist by May 31, 2024.

PSHB

Attachment D 2025 Formularies

All carriers must submit a copy of their plans' full 2025 formulary as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as Attachment D "2025 PSHB Drug Formulary Template.xlsx" with this Technical Guidance Document via Carrier Connect.

Appendix XI: Instructions for Attachment F- Formulary Comparison Between CMS Base, EGWP, and FEHB Formularies and Cost Share

All FFS and HMOs offering a MA-PD EGWP or PDP EGWP must provide a comparison between 2025 CMS base (proposed)[13], EGWP, and corresponding FEHB formularies as well as document the relevant formulary tier definitions and cost share assigned using the comparison template provided as Attachment F. In cases where benefits provided under the PDP EGWP indicate reduced coverage, please explain how these cases will be reconciled to ensure equal to or greater benefits for members in all instances (e.g., policies, processes, lesser of logic principle, coding to correct inconsistencies, etc.).

For FEHB, the completed templates should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist by May 31, 2024.

For PSHB, the 2024 or 2025 FEHB formularies should be submitted via Carrier Connect by May 31, 2024.

[13] Please provide a copy of CMS base formulary submitted to CMS as the approved formulary will not be available at the time of proposals. Carriers must provide the approved CMS base formulary to their Health Insurance Specialist upon receiving the CMS approval.

Appendix XII: Instructions for 2024 and 2025 FEHB Drug Formulary Information Completion and Submission

Please read and follow these instructions carefully before providing the requested information.

Formulary files will be processed automatically, and incorrect/incomplete files will be rejected.

File Naming Convention

Please submit your Drug Formulary Template. Files should be named following the standard file naming convention provided below.

<ProgramID>_<SourceID>_<FileTypeID>_<YearID>_<FormularyID>_<TransferDt>.<FileExtension>

ProgramID: FEHB, etc

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

FileTypeID: FRML for current year formularies in effect, PFRML for proposed next year formularies.

YearID: 2024, 2025, etc.

FormularyID: Unique identifier for the formulary. The three-character FEHB plan code and option for the first plan using the respective formulary (alphabetically) should be used as formulary identifier. For Carriers that have multiple plan options that share the same formulary, please include only one enrollment code in the file name and include all Self Only enrollment codes in cell B7 of the Formulary Tiers sheet(s) of the Excel template. Submit a separate file if you use a different formulary for FEHB members enrolled in a Medicare product. The file names for the main formulary and Medicare formulary for the applicable FEHB plan option(s) should be similar except that the FormularyID should have "_MCARE" included after the enrollment code for the Medicare formulary. Also, indicate a Medicare formulary by inputting Y in cell B11 of each Formulary Tiers sheets.

TransferDt: The transfer date in the file name should match the actual file submission/transfer date or at least be close to it. It should be in CCYYMMDD format.

FileExtension: File extension should be .xlsx.pgp when submitting files to ROVR because the files should be PGP encrypted. File extension should be .xlsx.zip when submitting files via email because the files should be password protected and the password should be sent in a separate email to OPMPharmacy@opm.gov and the Health Insurance specialist.

Sample File Names

Sample file names when the ProgramID is FEHB, the SourceID assigned is ATOZ and the Carrier is submitting current year formulary files encrypted through ROVR:

FEHB_ATOZ_FRML_2024_ZZ1_20240528.xlsx.pgp
FEHB_ATOZ_FRML_2024_ZZ1_MCARE_20240528.xlsx.pgp

Sample file names when the ProgramID is FEHB, the SourceID assigned is ATOZ and the Carrier is submitting proposed formulary files via email:
FEHB_ATOZ_PFRML_2025_ZZ1_20240528.xlsx.zip
FEHB_ATOZ_PFRML_2025_ZZ1_MCARE_20240528.xlsx.zip

The identifiers and the dates in the file name should be checked and updated while submitting the files.

File Resubmission

Even if all the identifiers remain the same while resubmitting the file, the TransferDt value in the file name should be updated for every file resubmission. Resubmitting files with the same transfer date in the file name is not recommended. Unique transfer date 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. When resubmitting formularies, please put Y in cell B5 and the name of the file being replaced in cell B6 of the Drug List sheet.

General Instructions

The Excel file serves as a template to be filled by carriers, if necessary, with the help of their respective PBMs.

Most commonly, carriers would be submitting a separate file with one Drug List and one Formulary Tiers sheet for each plan option. However, because Drug List sheets can be large, if the Drug List sheets for two or more plan options are identical, carriers can submit multiple Formulary Tiers sheets together with the associated Drug List sheet in a single file. However, each file should have only one Drug List sheet. Carriers should not combine drug lists from different plans and options into the same Drug List sheet unless they are identical and the only differences in plan design are in the copay/coinsurance amounts which would be captured in the Formulary Tiers 4 sheets. If you submit multiple Formulary Tiers sheets associated with the same Drug List sheet in one single file, please name the sheets Formulary Tiers 1, Formulary Tiers 2, Formulary Tiers 3, etc. and fill cells B4-B12 to capture the different plans and options on each Formulary Tiers sheet.

For example, if a carrier offers two plan options, High and Standard, whose prescription drug benefit design differs only in the copay/coinsurance amounts, the carrier can submit a single file with one Drug List sheet and two Formulary Tiers sheets. Cells B7 and B8 would capture the plan code(s) and option(s) in each Formulary Tiers sheet while plan design differences such as different copays/coinsurance amounts would be captured in cells A1:R29.

However, if one plan option covers some drugs that are not covered in the other, if the same drug is covered in different tiers, or restrictions (prior authorization, step therapy, quantity/day limits...) apply, then the carrier would have to submit two different files each with one Formulary Tiers and one Drug List sheet.

Do not add additional worksheets (hidden or otherwise) except additional formulary tier worksheets if they share the exact same drug list and only the copay/coinsurance information differs. Please do not insert rows, columns, or move cells in the Drug List and Formulary Tiers sheets. Simply input or

copy-paste information in the row and column space provided. Do not edit, format, or move cells to the left or above those prepopulated by OPM such as table column/row headers (do not change in any way cells A1:A6 and those in rows 9 and 10 of the Drug List sheet, and those in cells A1:A29 and those in rows 16 through 18 of the Formulary Tiers sheet(s)). Please fill only the requested fields with the appropriate type of information. Instructions for filling each field are in the table column/row header or available as placeholder text in the cell. All text fields should be left-aligned and without leading or trailing blanks. All numeric fields should be right-aligned. Please include general notes/comments/clarifications in the General Notes sheet, and notes/comments/clarifications specific to certain drugs or tiers in the Specific Notes columns from the Drug List and Formulary Tiers sheets. Do not include them in any other columns of the Drug List or Formulary Tiers sheet.

Instructions for the Contact Information Sheet

In the Contact Information sheet, please provide the contact information, title, and role of the carrier and PBM employees involved in fulfilling this information request.

Instructions for Formulary Tiers Sheets

All Formulary Tiers sheets in a file should have the exact same drug list with the same drugs covered in the same tiers under the same rules regarding prior authorization, step therapy, quantity, day limits, etc.

Additional instructions appear in row/column headers

Please put ACA preventive zero-cost share drugs, vaccines, and any other drugs that have zero-cost share in the 0 tier.

Please use increasing numbers to denote less preferred tiers that have higher copays/coinsurance. Specialty tiers would thus have the highest numbers. Please make sure that all tier levels that appear in the Drug List also appear and are described in the Formulary Tiers sheet(s).

Do not combine information from different plans and options into a single cell, e.g., by writing $5 copay for High / $10 for Standard. Instead submit separate formulary tier sheets.

Please add the number of formulary tiers in cell of the Formulary Tiers sheets. It will be used to verify that we have read all the tier information you are providing during our automated file processing. Please provide a number not a word, e.g., 4 not "four".

If multiple plans use the same drug list with exactly the same tiering information and only the copay/coinsurance information differs, please fill in separate formulary tier sheets named Formulary Tiers 1, Formulary Tiers 2, etc.

If there are other differences, please create a copy of the template and submit a separate Excel file. There should only be one Drug List Sheet in each file. There can be multiple Formulary Tier sheets that use exactly the same drug list, distinguished by adding a space and numbers 1,2,3... after "Formulary Tiers".

If the formulary is for FEHB enrollees in a Medicare product, indicate by inputting Y in cell B11 of each Formulary Tier sheet.

All information in cells B4-B12 is mandatory. Information in cells B13-B14 is mandatory if applicable, that is if your plan has a separate pharmacy 6 deductible or maximum out-of-pocket.

For every formulary tier, all fields are mandatory if applicable except for Specific Notes. If you would like to add notes, please do so in the Specific Notes column (column R). It is provided so you can add freeform text there instead of other columns, so the appropriate format and length of other fields are preserved.

For example, if your plan design is more complex and does not fit into the provided copay/coinsurance fields, please do not enter text into the copay/coinsurance fields. Instead, please make a detailed note in Specific Notes.

If columns of the Formulary Tiers worksheet do not apply, leave the cells empty. Do not use values such as n/a, none, etc.

Instructions for the Drug List Sheet

Additional instructions appear in row/column headers.

Add the number of the last row in which you entered a drug in the drug list in cell B3 of the Drug List sheet. It will be used to verify that we have read the entire drug list you submit during our automated file processing.

Only include the integer tier number in column E of the Dug List to indicate the Formulary Level, without words such as "Tier" or any other text. Tier numbers should correspond to those in column A of the Formulary Tier sheet(s). There should not be any values in column E of the Drug List that do not exactly match the values in column A of the Formulary Tiers sheet(s).

Put 0 in column E to denote ACA preventive zero cost share drugs, vaccines and any other drugs that have a zero-cost share.

Information in cells B3:B6 is mandatory.

For every prescription drug, all fields are mandatory if applicable except for Specific Notes.

If you would like to add notes, please do so in the Specific Notes column (column K). It is provided so you can add freeform text there instead of other columns, so the appropriate format and length of other fields is preserved. For example, if your plan design is more complex and does not fit into the provided fields, such as variations in how a drug may be processed our template does not capture, please make a detailed note in Specific Notes.

NDCs should only be listed once on the drug list. For drugs that may be utilized on multiple tiers, the drug should be reflected in the tier that has the greatest utilization. A comment should be placed in column K indicating that the drug is available on a different tier, the tier where the drug may appear and the conditions that would apply.

Columns I and J of the drug list should only be populated with numerals. The largest quantity that can be dispensed for a particular NDC should be entered in Column I. Drug units should not be included in column I. In column J, enter the days supply associated with the quantity entered in column I. Drug units and other notes can be placed in column K if necessary.

Instructions for General Notes

Please add any general notes about your submission that aren't specific to a tier or to a drug in the General Notes sheet in a separate row.