FEHB Program Carrier Letter

All FEHB and PSHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

FEHB ☒ PSHB ☒

Letter Number 2026-08

Date: March 31, 2026

Fee-for-service [8] Experience-rated HMO [8] Community-rated HMO [9]

Subject: Technical Guidance and Instructions for 2027 Benefit Proposals

Enclosed are the Technical Guidance and Instructions for preparing your benefit proposals for the contract term January 1, 2027, through December 31, 2027. Guidance applicable to Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) Fee-For-Service (FFS) and Health Maintenance Organizations (HMOs): Community-Rated (CR), Experience-Rated (ER), Current HMO, and New HMO plans are noted throughout the document. 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 Program health benefits proposals are issued in two documents:

1. The Call Letter outlines policy goals and initiatives; and
2. The Technical Guidance and Instructions for Benefit Proposals provide detailed requirements for items listed in the Call Letter that you must address in your benefit proposals.

The Rate Instructions are not included with these benefits instructions. Information regarding the Rate Instructions for Community-Rated HMO Carriers and Experience-Rated Carriers will be sent via separate Carrier Letters.

Each Carrier is responsible for ensuring that every benefit proposal complies with all applicable Federal laws and regulations. As a reminder, all Carriers must commit to the FEHB or PSHB Program Guiding Principles and submit their proposals via Carrier Connect.

We appreciate your efforts to submit benefit proposals timely. We look forward to working closely with you on these activities.

Sincerely,

D. Shane Stevens

Digitally signed by D. Shane Stevens
Date: 2026.03.31 10:26:56 -04'00'

D. Shane Stevens

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 Dates	PSHB Dates	Activity
March 20		Carrier Connect Training on the Pharmacy module Training for OPM's web-based application for Pharmacy module.
April 1		**Carrier Connect Opens for Upcoming Plan Year Benefit and Rate Proposal Submissions** Carriers must use Carrier Connect to submit all benefit and rate proposal materials.
May 2		**Community Benefit Package for New and Current HMOs** Send the Community Benefit Package (Certificate of Coverage, Evidence of Coverage, Master Group Contract or Agreement) for 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 Carriers must send a complete proposal for each contract containing any proposed benefit changes and clarifications in Carrier Connect.
May 31		**Current Year Drug Formularies** **All Carriers** must submit their current year's drug formularies to Research and Oversight Repository (ROVR).

FEHB Dates	PSHB Dates	Activity
May 31		**Proposed Upcoming Year Drug Formularies** **All Carriers** must submit their *proposed* formularies in Carrier Connect for each of the following: • Proposed non-EGWP (i.e., commercial) formulary • Proposed CMS Base formulary, if applicable. This formulary is for OPM's internal review purposes only. The version submitted must align with the version submitted to CMS for the EGWP formulary provided to OPM • Proposed PDP EGWP formulary, if applicable Proposed MA-PD EGWP formulary, if applicable
No Later Than June 15		**Aggregate Healthcare Cost and Utilization Data Report** Carrier Letter 2024-07 requires Carriers to report pharmacy aggregate cost and utilization to OPM and provides instructions for the submission. For questions, please contact your Health Insurance Specialist and opmpharmacy@opm.gov.
October 15		**Final Drug Formularies** **All Carriers** must submit their *final* formularies that will be offered to members during Open Season in Carrier Connect for each of the following: • Final non-EGWP (i.e., commercial) formulary • Final CMS Base formulary, if applicable. This formulary is for OPM's internal review purposes only. The version submitted must align with the version submitted to CMS for the EGWP formulary provided to OPM. • Final PDP EGWP formulary, if applicable • Final MA-PD EGWP formulary, if applicable.

Brochure Important Dates

FEHB Dates	PSHB Dates	Activity
June 2-12		**Brochure Creation Tool (BCT) Training** OPM hosts three (3) online training sessions for BCT during the timeframe listed; Carriers must attend one session. OPM will provide the Upcoming Year's BCT User Manual no later than June 13.

FEHB Dates	PSHB Dates	Activity
June 15		**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.
June 30		**HMOs Submit State-Approved Benefit Packages to OPM** Last day to submit proof of state approval for newly proposed benefits or service area expansions.
July 27		**Brochure Templates** OPM will send the Upcoming Year's Brochure templates.
FEHB August 21	PSHB August 7	**Initial Carrier Submission** Carriers must complete initial update or submission of brochure language in Carrier Connect (BCT for FEHB carriers) no later than August 22 or a date set by your Health Insurance Specialist, whichever is earliest.
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.
September 18		**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.**
FEHB October 9	PSHB N/A	**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 Upcoming Year's brochure.

Part I: Benefit Proposal Instructions for All Carriers

The guidance in the Benefit Proposal Instructions applies to both FEHB and PSHB Carriers unless otherwise indicated. All Carriers are required to submit all materials in Carrier Connect, OPM's web-based application for FEHB and PSHB benefit and rate proposals, unless instructed otherwise. Please note that guiding prompts will also be available within Carrier Connect during the submission process. 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 group health insurance coverage sold to the majority of non-Federal subscribers. Submit a copy of your fully executed Community Benefit Package (e.g., Certificate of Coverage or Evidence of Coverage) by May 2, 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 the current year. If you offer a plan in multiple states, please send us your Community Benefit Package for each state that you intend to offer coverage.

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.[•] OPM usually accepts proposed benefit changes for review if you submit changes to your state prior to May 31 and obtain approval and submit approval documentation to us by June 30. 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.

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 information for each state. If

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

applicable, please include which state you have designated as the situs state. We may contact states about benefits as necessary.

Notes

Current CR-HMO Carriers:

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

Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes of the basic package that show additions or modifications to the Federal Health Benefits offering. The material must show all proposed benefit changes for the Federal Health Benefits upcoming year's 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 the upcoming year.

New CR-HMO Carriers:

Your materials must show all proposed benefits for Federal Health Benefits for the upcoming year's 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 the upcoming year.

Experience-Rated HMOs

You must demonstrate that you have filed 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 ER-HMO Carriers:

Carriers that propose changes to the level of coverage that 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 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.

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 HMO Carriers	New HMO Carriers	All FFS Carriers
A signed Contracting Officials Form	Yes	Yes	Yes
A comparison of your current year's benefit package and your upcoming year's benefit package.	Yes	No	No
Benefit package documentation (See Benefit Changes below).	Yes	No	Yes
A plain language narrative description of each proposed Benefit Change and the revised language for your upcoming year's brochure.	Yes	No	Yes

Benefit Proposal Information	Current HMO Carriers	New HMO Carriers	All FFS Carriers
A plain language narrative description of each proposed Benefit Clarification and the revised language for your upcoming year's 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

Benefit Proposal Information for Carriers offering an MA-PD EGWP or PDP EGWP	Current HMO Carriers	New HMO Carriers	All FFS Carriers
Draft communications to enrollees, including information on the opt out process.	Yes	Yes	Yes

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 Worksheet as the template to submit benefit changes. You must show all changes, however minor, 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 the cost neutrality requirement. For the upcoming Plan Year, the 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 the upcoming Plan Year.
- **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 (i.e., within three years).
- **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 Federal Health Benefit Carriers need to make to continue to meet CMS Creditable Coverage requirements in the upcoming year do not need to be cost neutral. Carriers have the option to change benefits, increase premiums, or a combination of both.

Information Required for Proposal

If you anticipate changes to your benefit package, please discuss them with your Health Insurance Specialist before preparing your submission. The Benefit Change Worksheet must be filled out completely, including narrative,

rationale, bi-weekly cost impact to the premium and any trade-off for cost neutrality.

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 plain language.
- Explain the reason for the proposed clarification.

Notes

Additionally, if you offered a FEHB and/or PSHB plan benefit package in the current year and anticipate significant changes between that and your proposed FEHB and/or 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.

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, FEHB and 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 plans.

- Proposals for alternative benefit changes that would fail to meet the minimum 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 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.

Proposed benefits change materials must be submitted in Carrier Connect.

Benefit Difference Comparison Chart (All HMOs)

You must complete the *Benefit Difference Comparison Chart Spreadsheet* 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 upcoming year's 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, 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.
- Include whether riders are required within your proposed 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 current year's package and who are expected to purchase the upcoming year's package.

Part II: Service Area Proposal Instructions for All HMOs

The guidance in the Service Area Proposal Instructions applies to both FEHB and PSHB Carriers unless otherwise indicated. All Carriers are required to submit all benefit proposal materials in Carrier Connect. Additional materials and instructions are provided within Carrier Connect unless otherwise annotated within each section below.

Service Area Eligibility

Federal employees and annuitants 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 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.

Limitation 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 continuous service area, per OPM contract.

Although 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 offer quality and valuable choice, including by limiting the number of contracts and options it allows with each Carrier.

We are not entertaining new proposals for more than three options by a Carrier in a service area in the FEHB and PSHB Program for the upcoming year.

All Carriers with current permitted exceptions should review their contracts and options offered and their upcoming year’s proposal should include a consolidation of service areas or plan options and remove overlap or

redundancy to maintain greater overall FEHB and PSHB Program value. OPM will determine during benefit negotiations if it would be in the enrollees' best interest to consolidate or terminate any participating Carrier's contracts, plans, or options.

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 Program should refer to the guidance in this section.

All HMOs must inform OPM of proposed service area changes.

You must provide the following information:

- A description of the proposed expansion area to which you are approved to operate OR the proposed reduced service or enrollment area.
- The proposed service area changes by ZIP code, county, city, or town (whichever applies) and a map of the old and new service areas.
    - Reductions must include a justification for the reduction, an enrollment report for the proposed reduced service area and a report on the aggregate claims paid for the previous two years.
- Provide the exact wording/narrative of how the service area change will be described in the brochure.

Your service area(s) must remain in place for the upcoming year's contract term.

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 members. We will advise you if this is necessary.

Service Area Expansion Criteria

There are areas where our members have more limited choice. Please consider expanding your service area to all areas in which you have authority to operate. Propose any service area expansion by May 31. OPM grants an extension for submitting state approval supporting documentation until June 30.

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 also provide the following information:

- 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, reflecting any changes (non-renewals, terminations, or additions) in the number of executed provider contracts that have occurred since the date of your initial submission.

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.

Service Area Reduction Criteria (Current HMOs only)

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 ZIP code within a larger covered area will not be allowed.

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 also provide the following information:

- All state approvals that apply or are associated with the revised service area. We will not accept service area proposals for the service areas that are not contiguous or consistent with the residence of the Federal population or proposals that seek to provide services only to lower-cost enrollees.

Part III: 2027 New Benefits and Initiatives

Note to Carriers: throughout Parts III – V of this guidance, use of the words "should," "expects" and "encourage(s)" indicates OPM's intention that the related information must be discussed in the Carrier's benefit proposals, and that failure to include such information renders a benefit proposal unresponsive.

Site of Care Optimization Program Requirements

Effective with 2027 benefit proposals, Carriers must endeavor to operate medical site of care (SOC) initiatives that reduce total cost of care. Carriers should leverage their respective FEHB/PSHB claims experience to identify and implement medical SOC strategies so members receive medically necessary services in the most efficient and cost-effective care setting available. Careful attention to SOC initiative design should also ensure members experience timely access to care and sustained or improved member satisfaction rates. OPM strongly encourages Carriers to implement potential cost-saving SOC strategies such as:

- Expanding use of Ambulatory Surgery Centers (ASC) and Office-Based Surgeries[1]
- Using Urgent Care and Virtual-First Access for Low-Acuity Conditions[2]
- Using Hospital-at-Home/Enhanced Outpatient Monitoring (where supported)[3,4]
- Using freestanding infusion centers, physician–office-based infusion suites, ambulatory infusion centers and home-based infusion services when clinically appropriate.[5, 6, 7]

Carriers are also reminded of support for including other accredited, independent diagnostic testing facilities[8] that align with cost-saving objectives and enhance member satisfaction, consistent with the intent of the medical SOC initiative. Given the general indictor that freestanding infusion centers, physician–office-based infusion suites, ambulatory infusion

[1] Ambulatory Surgery Center Association; Commercial Insurance Cost Savings in Ambulatory Surgery Centers
[2] Tele-Urgent Care for Low Acuity Conditions: A Systemic Review; Department of Veteran Affairs, April 2022
[3] Hospital-Level Care at Home for Adults Living in Rural Settings: A Randomized Clinical Trial. JAMA Network Open. 2025;8(12): e2545712.
[4] Cost-Effective Components of a Patient-Reported Symptom Monitoring System for Chemotherapy. JAMA Network Open. 2025;8(11): e2542289.
[5] Site-of-Care-Challenges-81919.pdf
[6] Location, Location, Location: Spending Differences for Physician-Administered Outpatient Medications by Site of Treatment
[7] Example of Site of Care Redirection Program for Infusions, page 133
[8] Code of Federal Regulations: Independent diagnostic testing facility

centers and home-based infusion services offer cost saving opportunities over hospital outpatient departments (HOPDs), OPM is interested in how Carriers are covering non-HOPD infusion centers. Carriers should explain in their plan proposals how they cover these options, and the cost savings driven by the SOC. Carriers must clearly indicate preferred SOC sites in their directories.

Site of Care (SOC) Submission Expectations:

Plan proposals should include a SOC policy summary detailing proposed 2027 medical SOC initiatives. Carriers should describe in their plan proposals how they use site-neutral or capped rates for clinically comparable, non-emergent services; expand episode or bundled payments; or align benefits to favor lower cost, high-value sites (e.g., through tiered cost sharing or selective prior authorization waivers when members use designated settings). In addition to the SOC strategy, plan proposals are asked to include a description of how the plan intends to or currently approaches each of the following:

- Baseline, gross and net savings targets for selected SOC initiative(s) – 2027 full-year baseline and 2028 targets;
- Targeted Healthcare Common Procedure Coding System (HCPCS), clinical criteria, exception pathways, transition plans, provider/member outreach;
- Member access safeguards such as medically necessary exclusions from the site of care program, and continuity of care protections;
- Outcomes monitoring strategies that may include site of service mix, per unit allowed amounts by setting, denial/exception rates, time-to-decision, and safety measures;
- Member and provider tools which will show site of care options to efficiently and effectively navigate site of care options; and
- Plan brochure language that relays the medical SOC policy and helps members to understand why or how the policy impacts them.

Costs associated with developing and implementing medical SOC initiatives are an allowable cost under the contract for experience-rated Carriers.

OPM will review submissions on medical SOC initiatives for description of strategies, reasonableness of targets, evidence of member access safeguards and protections, and projected outcomes for 2027. Carriers may be asked to provide member-level support, policy artifacts, or additional

analytics during this cycle and are reminded that Carriers are to anticipate further development of medical SOC expectations and reporting requirements in future contracting cycles.

Part IV: Continued Focus from Previous Years

Increased Focus on Non-Pharmaceutical Coverage Options

Non-pharmaceutical interventions (NPIs) are the mechanism of treatment or intervention that uses prevention or care protocols that have a physical, nutritional or psychosocial focus. NPIs that have been demonstrated to prevent or delay costly complications of disease for obesity, hypertension, and diabetes include nutrition and lifestyle counseling, intensive behavioral therapy, supervised exercise therapy, physical therapy, stress management/mental health support via psychotherapy and cognitive behavioral therapy, pain management, and collaborative care models.[9] While Carriers may offer all of these interventions to members, Carriers must indicate how they provide care coordination that is critical to successful health outcomes and increase the efficiency of premium dollars.

Some Carriers have limited availability of providers in several categories (e.g., nutritionists, health coaches) in their networks, potentially inhibiting timely access to NPIs. Carriers may also have significant prior authorization barriers or have placed NPIs in wellness case management programs where there is optional or limited utilization. Where cost-effective, carriers should remove barriers to NPI access and describe removal efforts in their plan proposals.

For Plan Year 2027, OPM is requiring Carriers to adjust their benefit proposals to include a coordinated approach with coverage of NPIs that are accessible. For purposes of this guidance, a coordinated approach means the integration of non-pharmaceutical interventions across providers, care settings, and benefit design to ensure seamless access, continuity of care, and alignment with the member's overall treatment plan. Offering NPIs is intended to provide an additional option to plan enrollees, not to restrict access to pharmaceuticals and other forms of care. Carriers may develop an internal, provider-based, Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) coded interventions or have an app-based program that includes both remote monitoring and human coaching. Either of these options must have a coordinated approach as a medical and not a wellness benefit. For example, if Carriers elect to include Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy or

[9] Non-Pharmacological Interventions for the Management of Chronic Health Conditions and Non-Communicable Diseases

commercial digital heart health platforms as part of their NPI offerings, the proposed platform or program must demonstrate cost and health outcome measures of success for large employer-sponsored populations.

For Plan Year 2027, Carriers must submit either a benefit change or benefit clarification that demonstrates how they will provide member access for the following minimum NPIs for diabetes, hypertension and obesity:

Nutrition & Lifestyle Counseling

- Medical Nutrition Therapy (MNT) – CPT 97802, 97803, 97804
- Intensive Behavioral Therapy for Cardiovascular Risk Factors
- Obesity counseling - G0447, G0473
- Tobacco cessation counseling - 99406, 99407

Stress Management & Mental Health

- Psychotherapy & Cognitive Behavioral Therapy (CBT) – 90832, 90833, 90834, 90836, 90837
- Behavioral Health Integration (BHI) – 99484
- Collaborative Care Model (CoCM) – 99492–99494

Weight Management / Obesity Care

- Intensive Behavioral Therapy for Obesity – G0447, G0473
- Medical Nutrition Therapy – 97802–97804
- CDC-recognized Diabetes Prevention Program (DPP) – 0403T or 0488T
- Remote Monitoring & Digital Health
- Remote Physiologic Monitoring (RPM) – 99453, 99454, 99457, 99458
- Remote Therapeutic Monitoring (RTM) – 98975–98977, 98980–98981

The benefit change or clarification must describe how Carriers will communicate to providers and members to promote awareness of non-pharmaceutical treatment options for the diabetes, hypertension and obesity conditions noted above.

Expanding Access to Functional and Lifestyle Medicine

Executive Order 14212 directs Federal agencies to ensure availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention. Please propose how your plan will provide coverage of functional and lifestyle medicine.

Reproductive Services and Maternal Health

Pre-Conception

Please include in your proposals how you create and incentivize the use of screening bundles and outreach programs as outlined in Carrier Letter 2026-07 for women interested in becoming pregnant within the next year. Include in your proposals how you ensure access to treatments for conditions that are recognized to adversely impact fertility, such as obesity, prediabetes, chronic reproductive health conditions to include male factor infertility, and hypertension.

Conception

Carriers are reminded of Carrier Letters 2022-03 and 2023-04, encouraging access to discounted or negotiated rates for non-covered Assisted Reproductive Technology (ART). This information should continue to be available on a CPT-code basis and described in the affinity benefits section of plan brochures. Plan proposals must also discuss how they ensure ART clinics in their networks meet CDC's reporting requests. Carriers are asked to include in their proposals how they provide members with access to discounted or negotiated rates for non-covered ART procedures.

HMOs are also reminded that there is no presumption of evergreen Federal preemptions of State mandates that may have been negotiated in the previous year. Carrier Letter 2025-01 and 2025-05 discuss state laws related to IVF coverage for HMOs with service areas in a state with any IVF coverage mandate. Carriers must include a request to continue to be granted Federal preemption in their PY 2027 proposal to ensure it is considered by the Health Insurance Specialist.

Outcomes-Based Deliveries and Financial Incentives

Carriers are reminded that early and comprehensive coverage of prenatal care, access to birthing centers and responsive postpartum care as described in Carrier Letters such as 2022-03, 2022-04, and 2023-06 help improve maternal outcomes. Carriers are also reminded of OPM's prior emphasis on decreasing medically unnecessary Cesarean-sections (C-sections). In previous letters[10] we have encouraged Carriers to expand efforts and policies that help to avert costly interventions, such as contracting with hospitals

[10] Carrier Letters 2012-17, 2019-05, 2024-06

that have achieved a cesarean birth rate of 23.6% or lower and reimbursement models such as bundled payments for delivery.

Previous guidance strongly encouraged Carriers to utilize financial and other incentives to reduce medically unnecessary C-sections, which on average cost nearly twice as much as a vaginal delivery[11] and jeopardize maternal and neonatal outcomes.[12] Carriers are now required to submit evidence of how they use financial incentives and network management strategies to reduce medically unnecessary C-sections. Materials submitted as part of the 2027 plan proposal should also include the Carrier's C-section trends for each health plan option.

Carriers should note that Current Procedural Terminology (CPT) coding for maternity and obstetrical care is being updated by the American Medical Association with a release date anticipated in late summer to early fall of 2026, with an effective date of January 1, 2027.[13] These changes are expected to impact reimbursement models for labor and delivery to include those recommended to reduce medically unnecessary C-sections such as bundled, episode based, or blended payments. OPM remains interested in current strategies to best determine the impact of these coding changes and to inform future policy initiatives.

Maternal Health Providers

Carrier Letter 2023-06 reinforced requirements for provider directories and reminded Carriers that members should be able to find available providers who are accepting new patients and access these providers within reasonable wait times. All Carriers are permitted to cover Certified Professional Midwives (CPM)[14] and Certified Midwives (CM) where licensed to practice, or Certified Nurse Midwives (CNM)[15] and, to the extent such providers are covered, must list these providers in their directories. If available, provider quality ratings or metrics should be made available to the members.

Carriers should provide member education on the coverage of all Reproductive Services and Maternal Health through their websites, portals, and other member-facing material. Member education should also include information on lifestyle and environmental factors that impact fertility in

[11] Peterson-KFF; Health System Tracker: https://www.healthsystemtracker.org/brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care/
[12] Evidence-Based Strategies to Minimize Unnecessary Primary Cesarean Sections: A Comprehensive Review - PMC
[13] Health Dive: AMA Creates New Maternity Care Coding System, March 2, 2026
[14] North American Registry of Midwives
[15] American Midwifery Certification Board

both males and females and the importance of pre-conception care to include screenings.[16,17]

In addition to the material requested in Carrier Letter 2026-07, plan proposals should provide attestation that to the extent midwives are covered such providers are included in provider directories and an example of their member education. Carriers should also attest that they follow the U.S. Preventive Services Task Force (USPSTF) recommendation regarding Perinatal Depression: Preventive Interventions as a covered benefit without cost.

Personal Health Incentives

OPM encourages Carriers to offer personal health incentives as a tool for members to adopt holistic approaches to health and provide member-directed communications of these programs early in the coverage year. Well-crafted incentives can promote participation in screening activities and reinforce the adoption of healthy behaviors such as those presented in disease management activities and programs.[18] OPM strongly encourages Carriers to review their personal wellness incentives and expand wellness incentives consistent with the guidance in Carrier Letter 2020-01.

The incentive structure must be participatory, available to all enrollees, and not create a tax liability for members. This means the incentive must limit cash or cash equivalent wellness incentive benefits to medical care that falls within the exclusion in Section 213 of the Internal Revenue Code[19] or that is not considered income under IRS rules and guidance.[20]

There are no dollar limits as to the value Plans may offer in terms of wellness incentives; however, any value provided to enrollees must be limited to qualified medical expenses or de minimis incentives.[21] Examples of permissible wellness incentives for non HDHPs include debit cards limited to purchases for qualified medical expenses[22] and reduced copayments for covered benefits. Plan proposals should provide a detailed description of the wellness incentive program.

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[16] What lifestyle and environmental factors may be involved with infertility in females and males? | NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development
[17] Preconception Care: A Strategic Intervention for the Prevention of Neonatal and Birth Disorders - PMC
[18] FEHB Program Carrier Letter 2020-01
[19] 26 USC 213: Medical, dental, etc., expenses
[20] Tax Treatment of Wellness Program Benefits and Employer Reimbursement of Premiums Provided Pre-tax Under a Section 125 Cafeteria Plan
[21] De minimis fringe benefits | Internal Revenue Service
[22] Description of qualified medical expenses 2024 Publication 502

Reducing Opioid Use

We reiterate our policy on opioids, most recently outlined in Carrier Letter 2025-07, that Carriers must promote evidence-based pain management through coverage of and access to NPIs and non-opioid medications and/or devices used to treat pain.

Plan proposals must explain how the Carrier is monitoring opioid prescription volumes and taking steps to identify and remove from their networks providers who they determine to be overprescribing opioids.

Antibiotic Stewardship

Recent research stresses the importance of avoiding administering antibiotics in children from birth to 2 years of age due to the negative impact on the developing gut biome.[23, 24] Plan proposals should show how Carriers will include this population in their provider audit and feedback programs addressing antibiotic utilization.

Avoiding Low-Value Care

Low-value care includes any type of medical treatment or intervention with a high risk of harm compared to its potential benefit, care provided in an inefficient manner, care that is clinically inappropriate, or care for which there are safer, more cost-effective alternatives. This also applies to low-value pharmaceuticals.

Carriers are reminded that they are to avoid covering low-value care by using resources such as the Choosing Wisely initiative of the American Board of Internal Medicine Foundation.[25] Carrier Letters 2021-03 and 2021-05 directed Carriers to not cover services that have been given a 'D' rating by the USPSTF as preventive benefits. In their plan proposals for PY 2027, Carriers must provide their internal procedures on how they are actively denying claims for preventive services rated 'D' by the USPSTF and describe their continuous review process of internal procedures to avoid erroneous payments of low-value care.

Carriers can also refer to and monitor the Wasteful and Inappropriate Service Reduction (WISeR) Model from the Centers for Medicare & Medicaid Services. The primary goal of WISeR is to help patients avoid unnecessary,

[23] Association of Infant Antibiotic Exposure With Childhood Health Outcomes, Mayo Clinic Proceedings, Volume 96, Issue 1, 2021
[24] Early Childhood Antibiotics and Chronic Pediatric Conditions: A Retrospective Cohort Study, *The Journal of Infectious Diseases*, 2025
[25] See Choosing Wisely initiative

inappropriate procedures that may cause potential harm such as pain, bleeding, infection, anxiety, or other adverse effects, and instead promote high-value services aligned with evidence-based care guidelines.[26] For additional information and updates specifically about the WISeR, Carriers can subscribe to the WISeR Model listserv.

Organ/Tissue Transplants

Technology and clinical advancements are continually evolving. Carriers are encouraged to provide coverage during the contract year for transplant services recommended under clinical trials and transplant services that transition from experimental/investigational, consistent with standards of good medical practice in the U.S. for the diagnosed condition. As in past years, we are providing guidance on organ/tissue transplants for 2027. When Carriers determine that a transplant service is no longer experimental, but is medically necessary, they may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year to begin providing such benefits. The following sections are included in the *Organ/Tissue Transplants and Diagnoses* worksheet:

- Section 1 – OPM's required list of covered organ/tissue transplants.
- Section 2 – OPM's recommended coverage of transplants under Clinical Trials. All Carriers are to complete and return the worksheet.
- Section 3 – OPM's recommended list of covered rare organ/tissue transplants. All Carriers are to complete and return the worksheet.

Summary of Benefits and Coverage

All Carriers must provide a Summary of Benefits and Coverage (SBC) for each plan based on standards developed by the Departments of Labor, Health and Human Services, and the Treasury.

Proposal Submittal Instructions

Carriers are required to submit a separate PDF or Word document of their proposal that incorporates their responses to the Call Letter and Technical Guidance under the schema below. A location for submission of the document will be created in Carrier Connect.

[26] See WISeR Model FAQs

1. **Benefits Proposal Summary** – A high-level overview of your proposal for each of your plan options for 2027.

2. **OPM Initiatives** - Responses to OPM Carrier Connect questions and your responses for each of your plan options for 2027.

3. **Service Area Changes Requested** – Include a map highlighting the service area changes and rationale for the change(s).

4. **Benefit Changes** - Include all Benefit Change Worksheets.

5. **Benefit Clarifications** - Include Benefit Clarification Worksheets.

6. **Rate Proposal**

7. **Appendixes and Attachments**

Part V: Formulary Submission Instructions and Carrier Connect Pharmacy Module Enhancements

This guidance provides formulary submission instructions and requirements for the 2027 Benefit Proposals and announces enhancements to the Formulary Submission Module in Carrier Connect. These enhancements include a streamlined drug list upload page that allows Carriers to link drug lists directly to their pharmacy benefit types; updates to the benefits details and brochure pages to incorporate pharmacy benefit packages or benefit designs (MAPD, PDP, FEHB, etc.) associated with each plan option and architecture updates to the pharmacy drug list framework to remove orphan drug lists and strengthen overall data integrity. Together, these updates reflect our ongoing efforts to improve the accuracy, efficiency, and timeliness of formulary submissions while reducing administrative burden for all participating Carriers.

Carriers are expected to meet all established submission deadlines, follow the procedures outlined in this guidance, and take prompt corrective action when instructed.

Annual Proposal Formulary and Pharmacy Benefits Submission Dates

Important dates and key deadlines for the 2027 Formulary and Pharmacy Benefit proposals are listed below. Carriers are strongly encouraged to submit all formulary and pharmacy benefit data well in advance of the established deadlines to allow adequate time for identifying and resolving any technical issues. All submissions for each review stage must be successfully validated in Carrier Connect prior to the applicable deadline.

Important Dates and Deadlines:

Dates	Activity
April 1	Carrier Connect opens for 2027 submissions.

Dates	Activity
May 31	2027 Proposal formulary and pharmacy benefit submission deadline 2026 Formulary file submission deadline. FEHB and PSHB Carriers must submit their drug formulary files to Research and Oversight Repository (ROVR) using the 2025 Formulary Submission File Template (Attachment G).
On or about June 22	2027 Proposal Stage 2 formulary and pharmacy benefit review outcomes communicated, and RMI for resubmission issued.
June 29	All 2027 Proposal Stage 2 review concerns must be resolved.
On or about July 20	Stage 2 Resubmission formulary and pharmacy benefit review outcomes communicated.
October 15	2027 Final formulary and pharmacy benefit submission deadline.
On or about November 4	2027 Final Stage 2 formulary and pharmacy benefit review outcomes communicated, and RMI for resubmission issued.
November 12	All 2027 Final Stage 2 review concerns must be resolved.
On or about December 1	Final Stage 2 resubmission formulary and pharmacy benefit review outcomes communicated.

Carrier Connect Enhancements

Beginning in April 2026, Carrier Connect will introduce a series of significant improvements to the pharmacy module. Given the scope of these system updates, the Carrier Connect team will provide training and detailed operational guidance to ensure Carriers can effectively navigate and use the

redesigned pharmacy module prior to its release. These updates replace the previous formulary page structure with a streamlined drug list upload process, enhanced data validation checks, and clearer linkage between drug lists and corresponding pharmacy benefit types. The release also includes enhancements to the Benefits Details and Brochure pages to support pharmacy benefit packages such as MAPD, PDP, FEHB benefit designs associated with each plan option and architecture updates to the drug list framework designed to eliminate orphan drug lists and strengthen overall data integrity.

OPM recognizes that creating Attachment F, the CMS Base-EGWP-Commercial formulary comparison, has been a significant administrative burden for Carriers. Therefore, OPM will assume responsibility for generating this file based on the submitted formulary files for each plan option under contracts that offer EGWPs. This change will not only reduce administrative workload, but also ensure that the formulary comparisons generated for Stage 2 reviews are standardized across all Carriers.

Carrier Connect enhancements include:

- Streamlined Drug List Upload Functionality
    - New upload page design, multi-select tier assignment, enhanced validation rules, standardized error messaging, duplicate NDC checks, tier-file alignment checks, support for multiple drug lists, and improved system handling of file formats, blank columns, and orphan drug list prevention.
- Improved Pharmacy Benefit Configuration & Validation
    - Updated tier configuration with a maximum of seven (7) tiers, automated consistency checks between benefits, brochure and drug list selections; revised deductible and cost-sharing tables; and improved warning messages when benefit types are adjusted.
- Brochure & Options Page Enhancements
    - Addition of brochure names, pharmacy benefit package visibility and validation updates, improved creation and management of options, FEHB/PSHB alignment fixes, conditional display logic, standardized messaging, CMS Contract/Plan ID fields, and updated accessibility (508) compliance.
- Navigation and User Experience Improvements

    - Replacing outdated formulary pages, adding clearer brochure and drug list upload pages, simplifying page organization, and creating a more consistent and easier-to-use layout across pharmacy sections.
- Integration, Data Quality, and System Governance Enhancements
    - Backend updates to maintain data integrity across benefit years, RMI (Request for More Information) streamlining for drug lists and benefits, read-only carrier data features, configuration migration utility updates, and automated notifications to OPM pharmacy teams.

Together, these enhancements modernize navigation, streamline workflows, and improve the accuracy and consistency of formulary submissions across FEHB and PSHB Carriers.

Annual Proposal Formulary and Pharmacy Benefit Submission Guidance

OPM's authority to collect and review formulary and pharmacy benefit information is established under 5 U.S.C. § 8902 and 8903, which charge OPM with negotiating, approving, and administering health benefits contracts. This responsibility includes ensuring that prescription drug benefits are actuarially sound, compliant with program requirements, and equitable for enrollees. 5 CFR Part 890 further authorizes the agency to require Carriers to submit detailed benefit information—including formularies and drug lists—as part of the annual benefit proposal process and ongoing program oversight. For PSHB Carriers, parallel oversight authority is provided under 39 U.S.C. Chapter 89 and related regulations.

Within this framework, OPM expects all Carriers to provide complete, accurate, and timely formulary and pharmacy benefit submissions. These materials are essential for OPM to assess benefit design; verify compliance with program standards; evaluate cost-sharing structures; and oversee formulary management practices, exclusions, and coverage limitations. Timely and accurate submissions enable OPM to ensure that FEHB and PSHB enrollees receive access to prescription drug coverage that meets statutory and regulatory requirements, while supporting effective program administration and ongoing monitoring.

If you have questions regarding formulary file submissions, please contact OPMPharmacy@opm.gov and copy your Health Insurance Specialist. For

Carrier Connect technical issues, please reach out to CarrierConnect@opm.gov.

Submission Requirements

Carriers must submit complete and accurate formulary and pharmacy benefit information for each benefit type for each plan option as part of the annual benefit proposal. All submissions must be in Carrier Connect using the designated templates, file formats, and instructions provided. Incomplete, inconsistent, or improperly formatted submissions may be returned for correction and could delay review and approval of the Carrier's benefit proposal. Such deficiencies may also trigger compliance actions and may be considered as part of OPM's plan performance evaluation. Contract compliance actions will be determined by contracting staff and may include administrative or contractual actions consistent with contract oversight and compliance requirements.

Proposed Formulary and Pharmacy Benefit Submissions

Carriers must submit proposed formulary files and pharmacy benefits data in Carrier Connect for each contract as part of their complete annual proposal. Only proposed formulary and pharmacy benefits data may be included; files containing current-year formulary or benefit information will not be accepted. All proposed formulary changes, including those listed on the Benefit Change Worksheet, must be reflected in these submissions. Carriers are strongly encouraged to submit materials in advance of the May 31 deadline to allow time to resolve technical issues. All formulary and pharmacy benefits data must be uploaded and validated in Carrier Connect by May 31. Submissions after this date will not be accepted.

Final Formulary and Pharmacy Benefit Submissions

All final formularies for the plan year must be submitted by October 15. Allowable changes during this submission window are limited to formulary enhancements, such as adding new drugs, removing utilization management (UM) requirements, or moving drugs to lower cost-sharing tiers, to ensure that accurate and up-to-date information is available for drug pricing tools and marketing materials during Open Season. Therefore, submissions received after October 15 will not be accepted.

The final formulary submission window is intended to capture enhancements or approved updates made after the close-out letter was issued so that the data accurately reflects the benefits that will be marketed to members

during Open Season. Carriers making non-allowable negative changes during this period will be subject to compliance actions. Compliance actions will be determined by contracting staff and may include penalties up to and including impact to the carrier's contract oversight score, exclusion to market the Carrier's plan during Open Season, and recission of the Carrier's contract. OPM does not expect Carriers to make significant formulary and/or benefit changes at this stage, as the formulary and benefit data submitted on or before the May 31 deadline was used to approve the benefit proposals.

Technical Specifications and Data Validations

Carrier Connect will include enhancements that strengthen data integrity and improve Carrier experience. This section highlights key technical specifications and validation protocols that ensure data submitted through Carrier Connect is complete, accurate, and consistently structured to support OPM's cross-carrier pharmacy benefit oversight and program management activities. Carriers must comply with these requirements and maintain strong internal quality controls to ensure the integrity of all submitted data. Detailed technical instructions on how to navigate the new modules will be provided by the Carrier Connect team.

Technical Specifications

This section highlights key technical specifications within the Carrier Connect pharmacy module that apply to formulary and pharmacy benefit submissions. These standards promote consistency across carriers and support accurate evaluation, validation, and downstream program oversight.

Drug List Upload - Formulary submissions will transition from Excel to a .txt file format to enhance data integrity, minimize formatting variability, and enable more reliable automated validation. Once drug lists are uploaded and validated in Carrier Connect, Carriers will provide a name for each drug list, specify the drug classification system (i.e. USP, Medi-Span, First Databank, Other), and select the applicable tier values. A single drug list may be linked to multiple benefit types (e.g., PDP and MAPD EGWP), and Carriers may upload more than one CMS Base Drug Lists to support their EGWP plan options. The uploaded drug list can then be linked to a pharmacy benefit package.

Drug List File Naming Convention - The 2027 formulary file template is in .txt format. When uploading a .txt drug list file in Carrier Connect, carriers must use the 2027 Formulary File Layout posted on OPM's website under

Technical Guidance and adhere to the required file naming convention. Upon successful upload, each drug list will be assigned a unique drug list ID in Carrier Connect.

2027 .txt File Naming Convention:

ProgramID_AttachmentName_YearID_SourceID_ContractID_FormularyType

- Examples
  - FEHB_AttA_2027_ATOZ_1234_MCARE
  - FEHB_AttA_2027_ATOZ_1234_PDP_FEHB
    - The same drug list can be associated with two pharmacy benefit types, in this example PDP EGWP and FEHB

ProgramID: FEHB for Federal Employees Health Benefit Program, PSHB for Postal Service Health Benefit Program.

AttachmentName: AttA for Attachment A

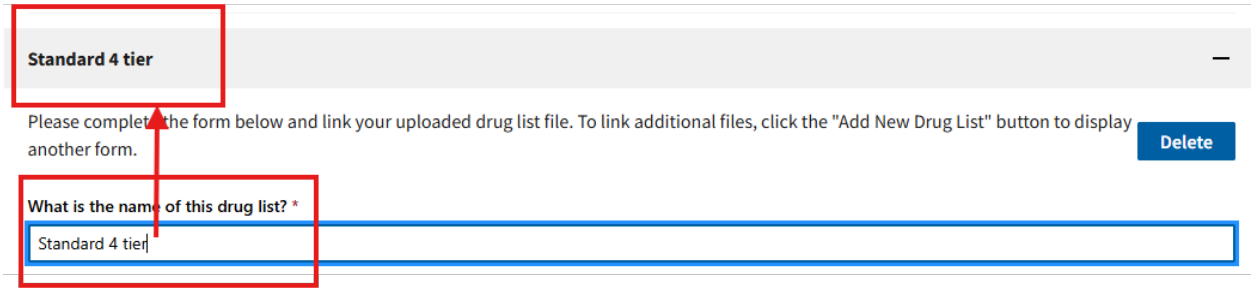
YearID: 2027

CarrierID or SourceID: Four-character ID assigned by OPM. For example, ATOZ

ContractID: OPM assigned contract ID

FormularyType: Type of formulary. For example: PDP, MAPD, FEHB, PSHB.

In addition to the file name for Attachment A, carriers must provide a name that describes the drug list on the Pharmacy: Drug List Upload page (e.g., Standard 4-Tier, Essential 5-Tier). The formulary name will also serve as the accordion heading for each uploaded drug list. Consistent with all required data fields identified by a red asterisk, this field is mandatory, and carriers will be unable to complete the module without entering this information:



Brochure & Options Details - Carriers will input plan options and their associated pharmacy benefit types in this section. A plan option (e.g., High, Standard, etc.) defines the specific rating and benefit configuration for that option, and the system supports up to three plan options per contract. For

each plan option, Carriers must designate one or more pharmacy benefit types (e.g., EGWP PDP, EGWP MAPD, FEHB), which determine the pharmacy coverage parameters. All FEHB contracts must include at least one FEHB benefit type for each plan option. The same requirement applies to PSHB contracts. PSHB contracts must also include a PDP EGWP benefit type for each plan option and may include an MAPD EGWP benefit type for each plan option, if offered. FEHB contracts may include PDP and/or MAPD EGWP benefit types, if offered. All benefit types require entry of a Pharmacy Benefit Type Name e.g.: ABCHealth Standard PDP EGWP; ABCHealth Standard FEHB etc.

Benefits Details-Pharmacy Benefits – Each plan option's pharmacy benefit type entered on the Brochure & Options Details page will display as a separate accordion. Carriers must configure each pharmacy benefit by defining the number of tiers, selecting a standardized tier label for each selected tier value, and entering all required cost-sharing and benefit parameters.

Formulary Tier and Cost-sharing

Carriers must develop their formulary tier structures in accordance with standard industry practice. Tier 0 is reserved for zero–cost-share drugs, consistent with the requirement that preventive drugs and services be covered without copayments, coinsurance, or deductibles. Drugs indicated for both preventive and therapeutic use may be assigned to a cost-sharing tier, provided the formulary clearly notes that cost sharing does not apply when the drug is used for prevention. Tier 1 must then represent the lowest cost-sharing level, with all subsequent tiers arranged in ascending order of cost sharing.

For PDP EGWP and FEHB or PSHB formularies only, medical benefit drugs are medications administered by healthcare professionals in clinical settings such as outpatient infusion centers, physician offices, or hospitals. These drugs are billed through medical claims rather than pharmacy claims and are reimbursed under the medical benefit. Their utilization management, coverage parameters, and cost-sharing requirements are governed by medical policies. Accordingly, cost-sharing for medical benefit drugs should not be included in pharmacy benefit submissions. Medical benefit drugs may be included in Attachment A. However, they must be assigned to tier 7 if they are **always** billed under the medical benefit. Tier 7 is the Medical Benefit Drug tier.

For MAPD formularies, MAPD EGWPs integrate Medicare Parts A, B, and D, along with additional benefits, into a single plan. The outpatient EGWP formulary is required to include generally self-administered drugs covered under Part D. Certain outpatient drugs may be covered under either Part B or Part D based on the route of administration, indication, or place of service, while some drugs are statutorily covered under Part B only. As outlined in CMS Chapter 6, Appendix C – Summary of Coverage Policy, which describes Medicare outpatient prescription drug coverage and the statutory requirements applicable to Part B-only drugs, these Part B-only drugs are not required to be included on MAPD EGWP outpatient drug formularies submitted to OPM. Pursuant to Carrier Letter (CL) 2023-06 and the applicable standard contract provisions, carriers are reminded that OPM requires coordination of benefits for FEHB and PSHB members who have other health insurance coverage, including Medicare. For prescription drugs covered under Medicare Part B, carriers must coordinate benefits with Medicare. OPM may recover funds if, as a result of a future audit, it is determined that a drug was improperly billed to FEHB or PSHB when payment should have been made under the member's Medicare benefit.

Carriers must select the standardized tier label that most accurately reflects the predominant drug type within that tier. For example, if a tier contains more preferred generics than non-preferred generics, the tier should be designated as Preferred Generic.

Each tier must have a distinct cost-sharing structure (copay or coinsurance) and a corresponding cost-sharing amount. A drug with the same active ingredient, dosage form, strength, and label name must not be assigned different cost-sharing structures or amounts across tiers. For example, if Tier 1 has a $10 copay for a 30-day retail supply and Tier 3 has a $40 copay, all atorvastatin 10 mg tablet NDCs placed on Tier 1 must carry a $10 copay, and all Lipitor 10 mg tablet NDCs placed on Tier 3 must be assigned a $40 copay. Carriers must also specify the pharmacy deductible and identify any tiers exempt from the deductible.

Because most pharmacy benefit designs do not permit extended-day supply at retail or mail order for high-cost drugs, data entry is optional for the two- and three-month retail and mail order tables on the Benefits Details page. In addition, cost-sharing entry is not required for tier labels such as Non-Preferred Drugs, Non-Preferred Brands, Injectables, or Specialty Tier for these cost-sharing tables.

Linking Uploaded Drug Lists to Plan Benefit Packages

Carriers must select or link one drug list whose tier structure matches the number of tiers defined for each plan benefit package. If the tier count is modified, the system will automatically clear the existing drug list selection, and the Carrier must reselect a compliant drug list. For EGWP benefit types, Carriers must also link the applicable uploaded CMS Base Drug List to the applicable EGWP benefit package.

EGWP Pharmacy Benefit Requirements

Carriers offering EGWPs must enter the cost-sharing amount and cost-sharing structure for a 30-day supply of insulin at retail and mail order that meets the insulin cost-sharing requirements under the Inflation Reduction Act. As in prior years, Carriers are not required to enter benefit parameters or cost-sharing for the CMS Base formulary itself.

Data validation

Validation rules are executed at the point of data submission to identify structural inconsistencies, prevent configuration errors, and ensure alignment across formularies, benefit packages, and associated files. All uploaded files and data entries must successfully pass Carrier Connect's validation checks in order to be accepted into the system. Unresolved validation errors will result in file rejection and will prohibit Carriers from submitting or finalizing their pharmacy benefit proposals. This section highlights key validation checks that Carriers must meet to ensure successful submission.

Drug List

Carriers must review **Attachment A: 2027 Formulary Submission File Layout** prior to preparing their formulary file to ensure all required data elements align with the validation rules and can be successfully processed at submission.

- All Change_Type values submitted by May 31 must be set to ADD. Change Type values in subsequent submissions may vary based on the nature of the update.
- NCPDP_Billing_Unit is required only when Quantity_Limit_Type = 1. Acceptable billing units are GM, ML, or EA.
- All existing Carrier Connect validation rules continue to apply to the .txt file format.

- If Quantity_Limit_Type = 1 (Maximum Daily Dose Quantity Limit), Carriers must enter both Quantity_Limit_Amount and Quantity_Limit_Days for the NDC, as specified in the template.
    - Do not use 999 in the Quantity_Limit_Amount field when the NDC has a true quantity limit. If Quantity_Limit_Type = 0 (Quantity Limits Do Not Apply), the Quantity_Limit_Amount and Quantity_Limit_Days fields must be left blank.
    - 999 may be used in limited situations when an NDC has a quantity limit (Quantity_Limit_Type = 1) but does not have a rolling day–based limit, such as for a starter pack.

Drug List Tier Value–Benefit Package Tier Value Cross-Check

The tier values in the uploaded drug list must match the tier values defined for the linked benefit package. Each plan benefit accordion must reflect the same number of tiers as the associated drug list that has been successfully uploaded and linked. A mismatch in tier values will generate a validation error at submission, requiring the Carrier to return to this page and correct the discrepancy before the proposal can be submitted.

Required Data Fields

Carriers must enter data in all required fields, which are indicated by a red asterisk (*). Required fields throughout the various modules and pages in Carrier Connect must be completed in order to finalize the page and submit the proposal. Examples of required data elements include:

- Drug List Upload Page
    - What is the name of this drug list?
- Brochure & Options Details Page
    - Pharmacy Benefit Type Name- this is a descriptor of the benefit type under the plan option that will be marketed to members (e.g., FEHB High, FEHB High PDP EGWP)
- Benefits: Benefits Details Page
    - Does this plan have a pharmacy deductible?

Formulary Review Process

The annual proposed formulary review process consists of two stages designed to ensure data integrity, compliance with program requirements across Carrier’s formulary and benefit submissions.

Stage 1 Structural Checks

Stage 1 of the formulary review process consists of automated structural and data integrity checks applied to Attachment A and pharmacy benefit data submitted through Carrier Connect. These checks are conducted prior to OPM's formulary and pharmacy benefit review to ensure that all submitted data meet baseline quality and structural requirements. This validation step is essential, as accurate and reliable data support proper claims adjudication, compliance with OPM program requirements, and effective program oversight.

To prepare for these checks, Carriers should thoroughly review Attachment A: 2027 Formulary Submission File Layout and conduct internal validation prior to submitting their data. Identifying and correcting discrepancies before upload helps prevent system errors, delays, and rejections. Only data that successfully meet all validation criteria will be accepted into Carrier Connect and advanced to Stage 2 of OPM's review.

Because data integrity is a critical component of program administration and reflects a Carrier's operational performance, submissions with significant or recurring validation failures may result in compliance actions or negatively impact plan performance evaluations.

Stage 2 Formulary

Carriers must ensure that each drug list is correctly linked to its corresponding pharmacy benefit package; failure to do so will prevent proposal submission in Carrier Connect. Proper linkage is essential to ensure that the correct formulary and benefit package data are used during OPM's Stage 2 review, including formulary comparisons. As part of this process, Carriers will no longer be required to submit Attachment F, as OPM will generate the necessary comparisons internally.

During Stage 2, OPM will assess the submitted formulary and pharmacy benefit data to determine whether Carriers meet applicable OPM requirements. Review concerns (outliers) will be communicated to Carriers in accordance with the dates listed in the Important Dates and Deadlines table. Consistent with prior years, OPM will communicate outcomes through Carrier Connect and will provide each Carrier with an Outlier Workbook in the RMI module. Carriers must review the Outlier Workbook and address each review concern by (1) submitting a revised formulary file, (2) updating benefit data in Carrier Connect, or (3) providing detailed clinical justification supporting the existing formulary or benefit structure. Carriers are afforded one

opportunity to resolve formulary and pharmacy benefit outliers through a resubmission for both the proposed and final formulary and benefit submissions.

All proposed formulary and benefits review concerns must be fully addressed by June 29, 2026.

The final formulary and pharmacy benefit submission deadline on October 15, 2026, provides Carriers with an opportunity to submit enhancements or approved changes to the proposed formulary or pharmacy benefit packages after the close-out letter has been issued. This submission ensures that the formulary and pharmacy benefit packages marketed to members during Open Season are accurate and fully aligned with OPM requirements. As such, we do not expect Carriers to make significant formulary or pharmacy benefit changes. All Carriers must address Final Stage 2 review concerns by November 12, 2026. Failure to resolve all review concerns by this deadline may result in compliance actions or negatively impact plan performance evaluations.

2026 Formulary Submissions in ROVR

All Carriers must submit their 2026 FEHB/PSHB, PDP EGWP, and MA-PD EGWP formulary tier definitions and associated cost-sharing using Attachment G. Completed templates must be submitted to the Research and Oversight Repository (ROVR) no later than May 31, 2026. Files are automatically processed by ROVR; therefore, submissions with incorrect naming, incomplete information, or structural inconsistencies will be rejected.

Carriers must use the file naming standards, noted below, to clearly delineate their formulary file submission to OPM/ROVR.

<ProgramID>_<CarrierID>_<AttachmentName>_<YearID>_<FormularyID>_<PlanOptionName>_<FormularyType>_<TransferDt>.<FileExtension>

ProgramID: FEHB for Federal Employees Health Benefit Program, PSHB for Postal Service Health Benefit Program.

CarrierID or SourceID: Four-character ID assigned by OPM. For example, ATOZ.

AttachmentName: AttG for Attachment G (replacing prior identifier FRML)

YearID: 2026.

FormularyID: Three-character self-only enrollment code. Ending in 1 or 4 for FEHB plans and ending in A or D for PSHB plans.

PlanOptionName: Name of the Plan Option. For example: Standard, Basic, High.

FormularyType: Type of formulary. For example: PDP, MAPD, FEHB, PSHB.

TransferDt: File transfer/submission date. It should be in CCYYMMDD format.

FileExtension: File extension should be .xlsx.pgp. Files should be PGP encrypted with the public key provided by OPM/ROVR prior to submitting files to OPM/ROVR.

If there are questions regarding file submission, or if there are changes to the Carrier contact information for the formulary file submission, please email OPMPharmacy@opm.gov and ROVRSupport@opm.gov and copy your designated Health Insurance Specialist.

Pharmacy Module Questionnaire

The *Pharmacy Module Questionnaire* is a list of items that Carriers must submit via Carrier Connect for review of the pharmacy benefits in the FEHBP and PSHBP during proposal season for the upcoming benefit year. Some items are applicable only to Carriers who are offering and/or proposing to offer EGWP products. While other items are applicable to all Carriers. Pharmacy benefit requirements may change from year to year.

For all Carriers, verification of meeting the FEHB and PSHB pharmacy benefit standards will be evaluated through a formulary and benefits review process. All OPM pharmacy benefit requirements apply to every FEHB and PSHB plan option. Carriers must provide formulary files, pharmacy benefits data, supporting documents, and additional information to demonstrate that each element specified on the questionnaire is met. Carriers with questions on submission requirements should contact OPMPharmacy@opm.gov. For Carrier Connect technical issues, Carriers should contact CarrierConnect@opm.gov. All correspondence should include the assigned Health Insurance Specialist.

Conclusion

The enclosed guidance applies to both Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) plans. Requirements

specific to each program are clearly noted throughout the document. As always, each Carrier is responsible for ensuring that its benefit proposal complies with all applicable Federal laws and regulations. We also remind all Carriers of their commitment to the FEHB Program Guiding Principles and PSHB Program Guiding Principles, as appropriate.

We appreciate your continued commitment to submitting complete and timely benefit proposals. As we prepare for another year of close coordination, your collaboration remains essential. We look forward to working with you to ensure a successful and efficient proposal cycle, reinforced by shared accountability for meeting all requirements and deadlines.

Part VI: Worksheets/Forms

The following applies to both FEHB and PSHB Carriers unless otherwise indicated. The required information below must be completed and returned to OPM as part of your upcoming Plan Year proposal. All Carriers must submit these worksheets and forms as part of their proposal. If you have questions, please contact your Health Insurance Specialist.

All Carriers must submit via Carrier Connect completed:

- Carrier Contracting Official;
- Benefit Change Worksheet for Community-Rated HMOs;
- Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs;
- Benefit Clarification Worksheet; and
- Drug Formulary Templates

Additionally, the Pharmacy Benefit Checklist will be available as prompts for all Carriers in Carrier Connect.

Not all of the below are applicable to each Carrier. The list and table below organize the worksheets and forms by their applicability to Carrier types.

Worksheets and Forms	Applicable to:		
	FFS	Current HMO (ER & CR)	New HMO
Technical Guidance Submission Checklist	Yes	Yes	Yes
Carrier Contracting Official	Yes	Yes	Yes
Benefit Change Worksheet for Community-Rated HMOs	No	Yes, only CR	No
Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	Yes	Yes, only ER	No
Benefit Clarification Worksheet	Yes	Yes	Yes
Benefit Difference Comparison Chart Spreadsheet	No	Yes	Yes
Program Statement About Service Area Expansion	No	Yes	Yes

Worksheets and Forms	Applicable to:		
	FFS	Current HMO (ER & CR)	New HMO
Submittal Instructions	Yes	Yes	Yes
Introduction to Carrier Connect	Yes	Yes	Yes
Organ/Tissue Transplants and Diagnoses	Yes	Yes	Yes
Carrier Pharmacy Benefit Checklist	Yes	Yes	Yes
Drug Formulary Templates	Yes	Yes	Yes

Technical Guidance Submission Checklist

Please return this *Submission Checklist* with your Benefit and rate proposal.

Not all worksheets and forms are applicable to each Carrier. Please refer to the Forms section of the Technical Guidance and if you have further questions, please contact your Health Insurance Specialist.

Worksheets and Forms	**Completed and in the proposal? Yes/No/NA**
Carrier Contracting Official	
Benefit Change Worksheet for Community-Rated HMOs	
Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	
Benefit Clarification Worksheet	
Benefit Difference Comparison Chart-Spreadsheet (HMOs only)	
Program Statement About Service Area Expansion	
Organ/Tissue Transplants and Diagnoses	
Carrier Pharmacy Benefit Checklist	
Formulary Submissions	
• Upcoming Year's Formulary Submission File Template (submitted via Carrier Connect)	
• Current Year's Formulary Submission File Template	

*__Note__ that the Benefit Difference Comparison Chart Spreadsheet and Current Year's Formulary Submission File Template are Excel Document Attachments provided with the Technical Guidance.

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 information, via Carrier Connect, containing the signature of the contracting official.

Verifiable digital signatures are acceptable.

The people named in Carrier Connect 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

Benefit Change Worksheet for Community-Rated HMOs

[Insert Health Plan Name]

[Insert Subsection Name]

Please complete the information, via Carrier Connect, for each proposed benefit change.

Please refer to Benefit Changes section to complete the worksheet.

Benefit Change Description

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

Item	Narrative Description
Current Benefit	
Proposed Benefit	

Item	Narrative Description
Proposed Brochure Language	
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 rates?

    _____

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.
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 with have this benefit by January 1st of the upcoming year?

    _____

4. If change is not part of the 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 not have this benefit?

_____

c. What percentage of plan subscribers do you project will have this benefit by January 1st of the upcoming year?

_____

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?

_____

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

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 the Benefit Changes to complete the worksheet.

Benefit Change Description

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

Item	Narrative Description
Current Benefit	
Proposed Benefit	

Item	Narrative Description
Proposed Brochure Language	
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 rates?

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.

Benefit Clarification Worksheet

[Insert Health Plan Name]

[Insert Subsection Name]

Please refer to Benefit Clarification section to complete the worksheet.

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) the Benefit Clarification applies to (for example, High or HDHP):

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Benefit Difference Comparison Chart Spreadsheet (All HMOs)

The *Benefit Difference Comparison Chart* is an Excel Spreadsheet provided with the Technical Guidance. Please refer to the Benefit Difference Comparison Chart section and follow the Excel Spreadsheet Template for instructions. Insert "FEHB" or "PSHB" in the file name when submitting with your proposal.

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

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

We _____ (Plan Name) have prepared the attached service area expansion proposal according to requirements found in the Technical Guidance. 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

Printed Name

Title

Date

Submittal Instructions

When uploading to Carrier Connect, utilize the following format as applicable.

Proposal Formatting

Introduction and Table of Contents – Volume 1(a)

OPM Initiatives – Volume 1(b)

- Initiative A
- Initiative B
- Initiative C

Services area changes, zip code changes – Volume 1(c)

Benefit Changes – Volume 2(a)

- Include all Benefit Change worksheets

Benefit Clarifications – Volume 2(b)

- Include all Benefit Clarification worksheets

Rate Proposal – Volume 3

File Naming Convention

Each file contained in the proposal must be named in the following format and each Volume a separate Adobe PDF or Word document.

[Name of Carrier] – Volume 1(a) – Introduction & Table of Contents
[Name of Carrier] – Volume 1(b) – OPM Initiatives
[Name of Carrier] – Volume 1(c) – Services area changes, zip code changes
[Name of Carrier] – Volume 2(a) – Benefit Changes
[Name of Carrier] – Volume 2(b) – Benefit Clarifications
[Name of Carrier] – Volume 3 – Rate Proposal

Introduction to Carrier Connect

What is Carrier Connect?

Carrier Connect is OPM's web-based application for Carriers to forward Federal Health Benefits applications and submit benefit and rate proposals and materials.

This Multi-factor Authenticated (MFA) system will only permit Plan contacts who are assigned as administrators, to submit information to OPM.

How existing Carrier administrators access Carrier Connect

OPM will register existing Carriers in Carrier Connect. Carriers will receive account creation information and login instructions by email.

How is it used?

Carriers are to upload the following (in accordance with instructions provided within this Technical Guidance) for each contract:

- Carrier Contracting Officer designation
- Benefit Change Worksheet for Community-Rated HMOs
- Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs
- Benefit Clarification Worksheet
- Benefit Difference Comparison Chart
- Community Benefit Packages
- Proof of State-Approved Benefit Packages
- Alternate Benefit Package, if applicable
- CMS Medicare Part D Waivers
- Drug Formulary Templates
- Service Area Changes
- Organ/Tissue Transplants and Diagnoses

As screen prompts, Carriers will respond to:

- Proposed Service Area
- Pharmacy Benefits Checklist

Carriers should also use Carrier Connect to enter contractually required data for the following:

- HEDIS/CAHPS

- Quality Assurance
- Fraud, Waste, and Abuse
- Member Enrollment

All Carriers

Task	Location
New Carrier application	Follow instructions for FEHB and PSHB Carriers
Rate proposal submissions	Carrier Connect
Benefit proposal submissions	Carrier Connect
Brochures	Brochure Creation Tool

Help

General assistance may be found on OPMs Carrier Connect help page. Otherwise, contact CarrierConnect@opm.gov for assistance with:

- Creating a Carrier Connect account
- Using Carrier Connect
- Submitting an application

Contract concerns are to be addressed with their Health Insurance Specialist.

2027 Organ/Tissue Transplants and Diagnoses

The information required in the following worksheet must be completed and returned to OPM as part of your Plan Year 2027 proposal. If you have questions, please contact your Health Insurance Specialist.

Section 1: Required Coverage of Organ/Tissue Transplants

A. Solid Organ and Tissues Transplants: Subject to Medical Necessity

- Cornea
- Heart
- Heart – Lung
- Kidney
- Kidney – Pancreas
- Liver
- Pancreas
- Autologous Pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
- Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs such as the liver, stomach, and pancreas) or isolated small intestine
- Lung: Single/bilateral/lobar

B. Hematopoietic Stem Cell Transplant (HSCT)

Since the 2024 Plan Year, OPM has aligned the requirement for hematopoietic stem cell transplant (HSCT) coverage with those of the American Society for Transplantation and Cellular Therapy (ASTCT) as published in 2020.[27] ASTCT is the professional society for hematopoietic stem cell transplantation in the United States. Authors included both adult and pediatric clinicians, as well as payer representatives. ASTCT plans to update this publication on a 3–5-year basis. It is important to note that requirements for coverage taken from this manuscript are for HSCT only, and no recommendations are made regarding immune effector cell therapy. Since both OPM's previous guidance and ASTCT's manuscript reflect current

[27] Indication for Hematopoietic Cell Transplantation and Immune Effector Cell Therapy: Guidelines from the American Society for Transplantation and Cellular Therapy

standards of care and evidence, OPM believes that both documents align, without meaningful difference between them.

Table 1 from the manuscript defines the levels of evidence supporting various indications. OPM recommends that Carriers cover Standard of Care (S), Standard of Care, Clinical evidence available (C), and Standard of Care, Rare indication (R). Developmental (D) is also recommended for coverage within the context of a clinical trial, and Not generally recommended (N) is not recommended for coverage. **Table 4** from the manuscript lists pediatric indications for HSCT and **Table 5** from the manuscript lists adult (≥ 18 years) indications for HSCT.

Plans must clearly indicate coverage for Blood or Marrow Stem Cell Transplants in their plan brochures under required transplant coverage. Plans may link to the coverage criteria outlined in the manuscript.

Section 2: Recommended for Coverage: Transplants under Clinical Trials

Please return this worksheet with your proposal.

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2027? Yes/No
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	
Multiple myeloma	
Multiple sclerosis	
Sickle Cell	
Beta Thalassemia Major	
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Hodgkin’s lymphoma	
Non-Hodgkin’s lymphoma	
Breast cancer	

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2027? Yes/No
Chronic lymphocytic leukemia	
Chronic myelogenous leukemia	
Colon cancer	
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease	
Early state (indolent or non-advanced) small cell lymphocytic lymphoma	
Multiple Myeloma	
Multiple Sclerosis	
Myeloproliferative Disorders	
Myelodysplasia/Myelodysplastic Syndromes	
Non-small cell lung cancer	
Ovarian cancer	
Prostate cancer	
Renal cell carcinoma	
Sarcomas	
Sickle Cell disease	
Chronic myelogenous leukemia	
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	
Early state (indolent or non-advanced) small cell lymphocytic lymphoma	
Small cell lung cancer	
Multiple sclerosis	
Systemic lupus erythematosus	
Systemic sclerosis	
Scleroderma	
Scleroderma-SSc (severe, progressive)	

Section 3: Recommended for Coverage: Rare Organ/Tissue Transplants

Please return the worksheet below with your proposal.

Solid Organ Transplants	Does your plan cover this transplant for 2027? Yes/No
Allogenic islet transplantation	
Blood or Marrow Stem Cell Transplants	
Allogeneic transplants for:	
Advanced neuroblastoma	
Infantile malignant osteopetrosis	
Kostmann's syndrome	
Leukocyte adhesion deficiencies	
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	
Mucopolysaccharidosis (e.g., Hunters syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux Lamy syndrome variants)	
Myeloproliferative disorders	
Sickle cell anemia	
X-linked lymphoproliferative syndrome	
Ependymoblastoma	
Ewing's sarcoma	
Medulloblastoma	
Pineoblastoma	
Waldenstrom's macroglobulinemia	