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

**U.S. Office of Personnel Management
Healthcare and Insurance**

Letter Number 2023-06

Date: March 24, 2023

Fee-for-service [6]

Experience-rated HMO [6]

Community-rated HMO [6]

**Subject: Technical Guidance and Instructions for 2024
Benefit Proposals**

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

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

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

The 2024 Rate Instructions for Community-Rated HMO Carriers are not included with these benefit instructions but will be released in an upcoming Carrier Letter. Information

regarding the 2024 Rate Instructions for Experience-Rated HMO and Fee-For-Service Carriers will be sent via a separate Carrier Letter.

OPM's focus for the upcoming plan year are on the following critical Program priorities: Fertility Benefits, FEHB and Medicare Coordination, and Pharmacy Benefit Design. Recognizing that several Biden-Harris Administration initiatives from the 2023 Plan Year will span beyond one plan year and that there may be more action that Carriers can take on these initiatives, OPM is continuing to emphasize the importance of Gender Affirming Care and Services, Prevention and Treatment of Obesity, Maternal Health and Mental Health and Substance Use Disorders. We continue to encourage all FEHB Carriers to thoroughly evaluate their health plan options with a keen eye and focus on improving quality and affordability in the FEHB Program.

It is incumbent on all Carriers to ensure that each benefit proposal complies with all applicable Federal laws and regulations. As a reminder, all Carriers must adhere to the [FEHB Program Guiding Principles](#). In addition, all Carriers must have a vigorous and effective fraud detection and prevention program along with programs to prevent, identify, and recoup any improper payments.

We appreciate your efforts to submit benefit proposals in a timely manner and to produce and distribute brochures. We look forward to working closely with you on these activities to ensure a successful Open Season again this year.

Sincerely,

Laurie Bodenheimer
Associate Director
Healthcare and Insurance

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Schedule

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

Within five (5) business days following receipt of the close-out letter or by the date set by your Health Insurance Specialist, please send them an electronic version of your fully revised 2024 brochure.

This year’s deadlines are as follows:

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

Dates	Activity
May 31	<p>Drug Formularies</p> <p>All 2023 FEHB Carriers must submit their 2023 drug formularies to Research and Oversight Repository (ROVR) as instructed in Attachment IV, FEHB Drug Formulary Template. The Formulary Template is a separate Excel document sent out with this Technical Guidance.</p> <p>Returning FFS and HMOs changing formularies or moving to new formularies in 2024 must submit a 2024 FEHB Drug Formulary Template. The completed 2024 templates should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist, by May 31, 2023.</p> <p>New FFS and HMOs must submit a 2024 FEHB Drug Formulary Template. The completed 2024 templates should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist, by May 31, 2023.</p>
June 5-16	<p>Benefits Plus and Brochure Creation Tool (BCT) Training</p> <p>OPM hosts online training on the use of these tools. Carriers should plan to attend.</p> <p>Please contact BPBCT@opm.gov for password resets, technical questions or if you have suggestions on changes to Benefits Plus or the BCT.</p> <p>OPM will provide the <i>2024 BCT User Manual</i> no later than June 5.</p>
June 14	<p>Benefits Plus and BCT open for Carrier data entry.</p>

Dates	Activity
June 15	<p>Aggregate Healthcare Cost and Utilization Data Report</p> <p>Carrier Letter 2023-05 requires Carriers to submit pharmacy aggregate cost and utilization reports to OPM and provides instructions for the submission. For questions, please contact OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist.</p>
June 30	<p>HMOs submit state-approved benefit packages to OPM</p> <p>Last day to submit proof of state approval for newly proposed benefits or service area expansions.</p>
July 26	<p>OPM will send the <i>2024 FEHB Brochure templates</i>.</p>
August 14	<p>Benefits Plus Updates</p> <p>Carriers must complete input of final data for Health Insurance Specialist review of all data, including zip codes, and plan-specific updates within Benefits Plus.</p>
August 23	<p>Brochure Creation Tool (BCT)</p> <p>Carriers must complete initial update or submission of brochure language in BCT no later than August 23 or a date set by your Health Insurance Specialist, whichever is earliest.</p>
August 31	<p>Access to Providers</p> <p>Provide the number of primary care physicians, specialty physicians (by their specialty), and hospitals in the proposed area with whom you have executed contracts.</p>
September 6	<p>Brochure Creation Tool</p> <p>Carriers must complete import of rate information into BCT.</p>

Dates	Activity
September 22	<p>All 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.</p> <p>Summary of Benefits and Coverage are due the same date as the final brochure.</p>
October 13	<p>Brochure Shipment</p> <p>Carrier brochures are due to the Retirement Services vendor.</p>

Part I: 2024 FEHB Benefit Proposal Instructions for All Carriers

Enrollment Types

- *Self Only* (codes ending in 1 and 4) – Self Only enrollment provides benefits for only the enrollee.
- *Self Plus One* (codes ending in 3 and 6) – Self Plus One enrollment provides benefits for the enrollee and one designated eligible family member.
 - The catastrophic maximum, deductibles, and wellness incentives must be for dollar amounts that are less than or equal to corresponding benefits in the Self and Family enrollment.
- *Self and Family* (codes ending in 2 and 5) – Self and Family enrollment provides benefits for the enrollee and all eligible family members.

Please note the following:

- Benefits, including all member copays and coinsurance amounts, must be the same regardless of enrollment type of the same plan option.
- FEHB 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.

Please visit OPM’s website for FEHB Program [eligibility criteria](#).

Federal Preemption Authority

The law governing the FEHB Program at 5 U.S.C. 8902(m) gives FEHB 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)

Submit a copy of a fully executed community benefit package (e.g., *Certificate of Coverage or Evidence of Coverage*) by May 5, 2023, 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 2023. If you offer a plan in multiple states, please send us your community benefit package for each state that you intend to cover.

Community-Rated HMOs

In a cover letter accompanying your community benefit package, describe your state's filing 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 and a copy of the state's approval document. If necessary, please ensure these documents have been translated to English. We usually accept proposed benefit changes for review if you submitted the changes to your state prior to May 31, 2023, and you obtain approval and submit approval documentation to us by June 30, 2023. 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, 2023.

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

Notes for Returning HMOs: If the community benefit package is different from the proposed plan you offer to the FEHB, also send a current copy of the benefit package that

we purchased. Please highlight the difference(s) between the FEHB benefits and the package you based it upon.

Attach all community-based riders (e.g., prescription drugs, durable medical equipment) and other changes to the basic package that show additions or modifications to the FEHB offering. The material must show all proposed benefit changes for FEHB for the 2024 contract term, including those still under review by your state.

If you have not made changes to the level of coverage we already purchase, then submit a statement to that effect. If you have made changes, submit a copy 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 2024.

Notes for New HMOs: Your material must show all proposed benefits for FEHB for the 2024 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 2024.

Experience-Rated HMOs

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

Note for Returning HMOs: Carriers that have made changes to the level of coverage purchased by OPM must submit a copy of the new benefit description as explained in the Benefit Changes section. If no changes have been made, a statement to that effect must be submitted.

Note for New HMOs: Carriers that have decided to use a Certificate of Coverage that varies from the one submitted with the application must submit the new document 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 Proposal Information for All FEHB Carriers

Your benefit 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 for Returning HMOs

- A signed [Contracting Official's Form](#).
- A comparison of your 2023 benefit package (adjusted for FEHB benefits) and your 2024 benefit package.
- Benefit package documentation (See [Benefit Changes](#) below).
- A plain language description of each proposed Benefit Change and the revised language for your 2024 brochure.
- A plain language description of each proposed [Benefit Clarification](#) and the revised language for your 2024 brochure.
- Benefit Difference Comparison Chart In-Network Benefits Spreadsheet.
- Drug Formulary (See [Attachment IV](#) for instructions. The FEHB Drug Formulary Template is a separate Excel document sent out with this Technical Guidance).

Benefit proposal information for New HMOs

- A signed [Contracting Official's Form](#).
- Benefits package documentation (e.g., complete proposed brochure template with all benefit information).
- Benefit Difference Comparison Chart In-Network Benefits Spreadsheet.
- Drug Formulary (See [Attachment IV](#) for instructions. The FEHB Drug Formulary Template is a separate Excel document sent out with this Technical Guidance).

Benefit proposal information for Fee-For-Service Carriers

- A signed [Contracting Official's Form](#).
- Benefit package documentation (See [Benefit Changes](#) below).
- A plain language description of each proposed Benefit Change and the revised language for your 2024 brochure.
- A plain language description of each proposed [Benefit Clarification](#) and the revised language for your 2024 brochure.
- Drug Formulary (See [Attachment IV](#) for instructions. The FEHB Drug Formulary Template is a separate Excel document sent out with this Technical Guidance).

Benefit Changes (Fee-For-Service Carriers and Returning HMOs)

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

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

Cost Neutrality

In general, OPM continues to require that when proposing an increase in benefits, FEHB Carriers must propose corresponding benefit reductions within the same plan option to offset any potential increase in premium, with limited exceptions as authorized by OPM. As indicated in [Carrier Letter 2019-01](#), OPM will consider Carrier-generated proposals for exceptions to this cost neutrality requirement for the 2024 Plan Year, as follows:

- Exception 1: A Carrier may include benefit enhancements in one plan that are offset by reductions in another of its plan options, thereby achieving cost neutrality. Carriers proposing such a change must:
 - Ensure that a meaningful difference between plan options will continue to exist if the change is approved, 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 will be achieved in Plan Year 2024.
- 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: OPM will consider a waiver to the cost neutrality requirement for proposals of coverage for fertility benefits as outlined in Carrier Letter 2023-04 and further detailed in this Technical Guidance.

Information required for proposal: If you anticipate significant changes to your benefit package, please discuss them with your Health Insurance Specialist before preparing your submission.

- Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2024" section in plain language, using the active voice, and written from the member's perspective. Show clearly how the change will affect members and the complete range of the change. For instance, if you propose to add inpatient hospital copays, indicate whether the change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, show each change clearly.
- Describe the rationale for the proposed benefit change.
- State the actuarial value in (a) the existing benefit and (b) your overall benefit package. If an increase, describe whether any other benefit change within that plan option offsets the increase. Include the cost impact of the change as a bi-weekly amount for the Self Only, Self Plus One, and Self and Family rates. Indicate whether there is no cost impact, or if the proposal involves a cost trade-off with another benefit and what benefit is being used as the offset. If you are proposing an exception to the cost neutrality requirement, note the exception category (1, 2, 3, or 4) and provide the information necessary to support that exception as described above.

Benefit Clarifications (Fee-For-Service Carriers and Returning HMOs)

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

Information required for proposal:

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

Alternate Benefit Package (Community-Rated HMOs)

OPM will allow HMOs the opportunity to adjust benefit payment levels 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 for review only if it is in the best interest of the Government and FEHB enrollees.

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

Please consult with your Health Insurance Specialist and your contact in the Office of the Actuaries regarding any questions about the alternate benefit package. Also ensure that you refer to the rate instructions.

Your FEHB 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.

FEHB Benefit Difference Comparison Chart (All HMOs)

You must complete the FEHB Benefit Difference Comparison Chart (in Excel, electronic template sent out with Technical Guidance) with the following information:

- Differences in copays, coinsurance, deductibles (subject to/or not), coverage levels (including visit and/or day limits, etc.) in the packages. In-network benefits are entered on a separate tab than out-of-network benefits.
- Please highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 31, 2023, 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, 2023.
- Please include whether riders are required within your proposed 2024 FEHB benefit package. Indicate the name of the community benefit package, including the entity noted as having the largest number of non-Federal employee subscribers/contract holders who purchased the 2023 package and who are expected to purchase the 2024 package.

Part II: 2024 Service Area Proposal Instructions for All HMOs

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-Federal 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 Program enrollees. OPM will provide model language for stating your policy in your brochure.

Limitations on the Number of Plan Options within a Service Area

Carriers may not have unlimited Contracts or Plan offerings under the FEHB Program. 5 CFR 890.201(b)(3)(i) allows each Health Benefits Plan to have up to three options, or two options and a high deductible health plan within a contiguous service area.

Although OPM's FEHB regulations do not specify a limit on the number of contracts a Carrier may have with OPM, OPM retains discretion to administer FEHB in the best interests of enrollees. OPM aims to minimize administrative burden, and unneeded complexity that does not provide valuable choice, including by limiting the number of contracts and options it allows with each Carrier. To have an equitable competition and reasonable choice that focuses on quality and value, Carriers should only be offering three options within a service area, irrespective of the number of contracts it may have.

While OPM may have exercised discretion in the past to allow a Carrier to have contracts that offer more than three options across its Plans in a service area, we are evaluating whether these exceptions are still in the best interest of the FEHB Program. An exception should offer a meaningfully different benefit design and be in the best interest of the enrollees.

FEHB Carriers should review their contracts and options offered and include in their 2024 FEHB Proposal consolidation where appropriate if you find overlap or redundancy to maintain greater overall FEHB Program value. OPM may ultimately determine it would be

in the FEHB enrollees' best interest to consolidate or terminate any carrier's contracts, plans, or options.

Service Area Changes

Returning HMOs proposing service area changes and New HMOs proposing changes in their service area or plan designation since applying to the FEHB Program should refer to the guidance in this section.

All HMOs must inform OPM of proposed service area changes. Service areas and provider networks must be adequately available for the 2024 contract term. OPM is committed to providing as much choice to our members as possible. Given consolidations in the healthcare industry, there are geographic areas where our members have more limited choices than in other areas. Reducing a service area to prevent adverse selection in a portion of a previously approved service area, such as a single ZIP code, will not be allowed. In addition, proposals for service areas leaving out a county or single ZIP code within a larger covered area will not be allowed. Proposed reductions in service areas must include a justification for the reduction, a map demonstrating the change to the service area, an enrollment report for the proposed reduced service area and a report on the aggregate claims paid for the previous two years.

Please consider expanding your FEHB service area to all areas in which you have authority to operate. This will allow greater choice for our members. You must upload a .CSV file to Benefits Plus of covered ZIP Codes for your existing service area and any new service area expansion that you propose. ZIP Codes should be listed in a single column, one row per ZIP Code. NOTE: Please review these files carefully for accuracy before submission.

Healthcare Delivery System

The information you provide about your delivery system must be based on executed contracts. We will not accept letters of intent. All provider contracts must have "hold harmless" clauses that preclude the provider from pursuing or "balance billing" a member for fees in excess of the allowed amount under the plan.

New Enrollment Codes (Community-Rated HMOs)

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

Service Area Expansion Criteria

You must propose any service area expansion by May 31, 2023. OPM grants an extension for submitting state approval supporting documentation until June 30, 2023.

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

- Legal authority to operate;
- Reasonable access to providers;
- Choice of quality primary and specialty medical care throughout the service area;
- Your ability to provide contracted benefits; and
- Your proposed service area must be geographically contiguous.

You must provide the following information:

- A description of the proposed expansion area in which you are approved to operate.
- The proposed service area expansion by ZIP Code, county, city, or town (whichever applies) and a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure.
- The 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.
- Access to providers. 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 update this information by August 31, 2023. The update must reflect any changes (non-renewals, terminations, or additions) in the number of executed provider contracts that may have occurred since the date of your initial submission.

New Rating Area (Returning 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 had 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 (Returning HMOs only)

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

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

- We will accept the elimination of the corresponding service area only if you proposed to eliminate an entire enrollment area.
- Service area reductions should be associated with the following:
 - Significant loss of network providers;
 - Poor market growth;
 - Reduction applies to other employer groups;
 - Reduction may apply to consolidation of two or more rating areas (Returning Community-Rated HMOs only); and
 - Splitting rating areas (Returning Community-Rated HMOs only).

You must provide the following information:

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

Part III: 2024 Call Letter Initiatives for All FEHB Carriers

I. Fertility Benefits

New requirements related to fertility benefits outlined in the [2023 Call Letter](#) are being implemented to assist FEHB enrollees in building their families.

Carriers are required to provide coverage of artificial insemination (intrauterine insemination, intravaginal insemination, and intracervical insemination). If there are other artificial insemination procedures, please include them in your proposal. This requirement to cover artificial insemination does not include a requirement to cover donor sperm, although Carriers may elect to cover the cost. Your proposals must outline your artificial insemination benefit coverage with a detailed description of coverage requirements and any cycle or dollar limits that will be imposed.

Carriers are required to cover oral and injectable drugs associated with artificial insemination procedures when deemed medically necessary. Clinical criteria should be evidence-based, transparent and readily accessible. Please refer to [Carrier Letter 2023-03](#) for additional guidance on OPM's expectation for pharmacy benefit management. Carriers should describe in their proposals how they meet the drug coverage requirement above, including any utilization management or drug exception processes applied.

An in-vitro fertilization cycle can range from \$15,000 to \$30,000 with medications accounting for up to 35 percent of the total cost¹. The \$15,000-30,000 range varies based on what services an individual needs. Services such as intracytoplasmic sperm injection (ICSI), preimplantation genetic testing, cryopreservation of embryos, and others are not required by every individual undergoing IVF, but they can significantly increase the cost of a single cycle. Injectable medications usually cost \$3000-\$6000 per cycle. To make a meaningful contribution to the total cost of IVF, Carriers are required to cover the cost of IVF-related drugs for three cycles annually. Coverage of these drugs should be folded into existing prescription drug benefits and can be administered effectively through each Carrier's pharmacy benefit manager. Please refer to [Carrier Letter 2023-03](#) for additional guidance on OPM's expectation for pharmacy benefit management. Carriers should describe in their proposals how they meet the IVF-related drug coverage requirement above, including any utilization management or drug exception processes applied.

The [2015 Call Letter](#) stated "while plans are not required to offer infertility benefits, if they do, they must ensure that benefit definitions and coverage descriptions use terms that are relationship neutral" and the [2015 Technical Guidance](#) went into more detail stating "brochures should include a definition of infertility, age limits if medically indicated,

¹ "[How Much Does IVF cost?](#)" Forbes, 23 January 2023

relationship or gender specifics as appropriate” and provided examples of infertility definitions with gender neutral language for Carriers’ consideration. The 2015 guidance made it clear that no changes to benefit coverage were being required at the time.

Currently, not all Plan brochures make the definition of infertility easily apparent to members. Consequently, OPM is requiring that Carriers ensure that their definitions of infertility are placed in all member-facing materials including, but not limited to, Plan brochures and websites such that it is easily located and understood by the member. In addition, all Carriers’ medical policy related to the diagnosis of infertility and available fertility benefits and coverage requirements must be made easily accessible to members in the manner described above. Your medical policy must reflect sound medical principles that address fertility prognosis, medical history, lab and physical examination findings, other prior infertility treatments, as well as other applicable factors.

Unless otherwise noted, for the purposes of current and future guidance related to Assisted Reproductive Technology (ART), OPM will utilize the Centers for Disease Control and Prevention’s (CDC) definition: ART includes all fertility treatments in which either eggs or embryos are handled. In general, ART procedures involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman. They do NOT include treatments in which only sperm are handled (i.e., intrauterine—or artificial—insemination) or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved². OPM expects that brochure language and other consumer facing materials explaining covered and non-covered ART/other fertility benefits will align with this definition.

In addition to the Plan Year 2024 requirements outlined above, OPM continues to strongly encourage FEHB Carriers to provide members with access to discounted or negotiated rates for non-covered ART procedures. This information should be available on a CPT-code basis and described via the affinity benefits shown on the non-FEHB page of the plan brochure. Carriers are also encouraged to propose benefits that expand coverage beyond affinity benefits and the requirements outlined in the Call Letter.

² [CDC Definition of ART](#)

II. FEHB and Medicare Coordination

Coordination with Employer Group Waiver Plans (EGWPs)

OPM announced in [Carrier Letter 2023-02](#) and in the annual Call Letter ([2023-04](#)) that we will entertain proposals that allow FEHB Program members to benefit from Medicare D coverage by enrolling in a Carrier's, or its affiliated sponsor's, CMS-approved Medicare Advantage Prescription Drug Plan Employer Group Waiver Plan (MA-PD EGWPs) or Prescription Drug Plan Employer Group Waiver Plan (PDP EGWPs), and we will now entertain proposals that feature automatic group-enrollment for PDP EGWPs. Carriers must ensure that they or their PDP sponsors are in full compliance with CMS guidance related to the MA-PD or PDP EGWP to be offered to its FEHB members.

Carriers must comply with applicable CMS guidance with respect to their Medicare products including CMS guidance related to group enrollment,³ which states, in part, that:

- All Medicare beneficiaries must be notified that the Carrier intends to enroll them in a PDP that the Carrier is offering; and
- All Medicare beneficiaries must be notified that they may affirmatively opt out of such enrollment, how to accomplish that, and any consequences to group benefits opting out would bring; and
- This notice must be provided not less than 30 calendar days prior to the effective date of the beneficiary's enrollment in the Carrier-sponsored PDP.

Please describe how you will communicate the advantages of remaining in the EGWP and how the member can opt-out if they decide they do not wish to remain enrolled.

The process to opt-out must be straightforward, transparent, and easy to understand. In addition, Carriers must fully describe how they will educate members, process enrollments, and provide customer service to these individuals before, during and after enrollment.

³ The Centers for Medicare & Medicaid Services. (2006). *PDP Guidance Eligibility, Enrollment and Disenrollment*. Available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/-PDP_EnrollmentGuidance+Exhibits_Sep082006.pdf.

Please demonstrate how you will ensure that members receive benefits that are equal to or greater than the standard FEHB benefit for each EGWP covered service and that additional premium cost burdens are not placed on members without appropriate member notice and opportunity for member choice.

You must provide your Medicare Part D EGWP formulary and your FEHB plan formulary as indicated in [Attachment IV](#). The information you provide must show that the FEHB members will receive drug coverage that is equal to or greater than the FEHB plan drug coverage in all instances and that members will receive appropriate coverage of preventive services with no cost share. Please provide your explanation of how you are ensuring this and that the coordination you propose will be made seamless to enrollees. Carriers proposing coordination with a Medicare Part D EGWP must ensure seamless member access. Provide summary results of pre-implementation testing and an assurance that you have made corrections for any inconsistencies found. Carriers must submit this information no later than 90 days before the beginning of Plan Year 2024.

Please provide in your proposal the CMS-proposed Part D EGWP formulary, documentation showing all EGWP waivers applied and the rationale you have for each waiver. You must submit the formulary and benefit packages once they are approved by CMS.

Carriers are expected to implement comprehensive monitoring and oversight processes to ensure seamless coordination of benefits and member access to care. Please describe your proposed method of monitoring and oversight and how you will maintain and report compliance metrics. Carriers are reminded that current PBM transparency standards apply to all contracts.⁴ Pass through transparency drug pricing standards apply to Experience-Rated Health Maintenance Organizations (HMOs) and Fee-For-Service Carriers. Please refer to the OPM contract for additional information.

Carriers must provide OPM with additional reporting needed to allow OPM to conduct oversight of the coordination of FEHB benefits with the Medicare EGWP product. Information on this additional reporting will be provided in a separate Carrier letter.

⁴ The PBM Transparency standards are set forth in the FEHB standard contract, Section 1.28 for Experience-rated HMOs, Section 1.26 for Fee-For-Service plans, and Section 1.29 for Community-rated HMOs.

We will require supporting documentation that demonstrates the cost impact on your rate proposal. We will require that you show documentation of how manufacturer discounts under Medicare Part D and other cost offsets are appropriately accounted for in your rating. Please see rate proposal instructions.

Coordination of Benefits – Medicare Part B vs FEHB drugs

OPM requires that Carriers coordinate benefits for FEHB members that have other health insurance coverage, including Medicare. Approximately 75% of FEHB annuitants eligible for Medicare are currently enrolled in Medicare Part B. Medicare Part B covers outpatient physician services including drugs that are typically administered by a physician in an office setting. Medicare Part B also covers some drugs that are available in the outpatient pharmacy setting such as immunosuppressant drugs, as well as some anti-cancer, anti-emetic, and dialysis drugs. In such instances, existing technology allows a Carrier to electronically coordinate benefits in real time and determine which insurer is the primary payer.

OPM expects Carriers to coordinate drug coverage at the pharmacy setting for FEHB members with Medicare Part B. To meet this expectation, Carriers are required to submit logic flow documents which describe the coordination of Medicare Part B benefits and FEHB benefits to ensure appropriate billing processes are in place for FEHB members enrolled in Medicare Part B. In addition to logic flow documents, Carriers must provide results from coordination of benefits pre-implementation testing to ensure there is no member disruption at the pharmacy. Results should include efforts taken to correct any inconsistencies found. Carriers must submit this information no later than 90 days before the beginning of plan year 2024. Carriers offering Medicare products to FEHB members must keep abreast of CMS Medicare guidance to remain compliant with CMS and OPM requirements.

III. Pharmacy Benefit Design

Copay Maximizer/Optimizer Programs

As stated in the Call Letter, OPM **will not** entertain any proposals that incorporate copay maximizer or optimizer programs into the prescription drug benefit. Carriers should affirm

in their proposals that they do not integrate copay maximizer or optimizer programs in their plan offerings.

Part IV: Continued Focus from Previous Years for All FEHB Carriers

Maternal Health

The Maternal Health Quality Improvement Act passed as part of the 2022 Consolidated Appropriations Act, with the goal to improve maternal health outcomes and help to eliminate racial inequities in maternal health. Key findings on pregnancy-related deaths in the [Data from Maternal Mortality Review Committees in 36 US States, 2017–2019](#) report showed that over 80% of pregnancy-related deaths were determined to be preventable, pregnancy-related deaths occurred during pregnancy, delivery, and up to a year postpartum and that the leading cause of pregnancy related death varied by race and ethnicity. An [October 2022 GAO report on maternal health](#) noted that outcomes worsened and disparities persisted during the pandemic, with maternal death rates increasing in both Black or African American women and Hispanic or Latina women.

As these new report findings continue to raise concerns in the maternal health field, we re-emphasize the strategies outlined in [Carrier Letters 2022-03](#) and [2022-04](#), such as:

- Expanding coverage and services in support of prenatal and postpartum care;
- Amplifying communication efforts to FEHB members who are either pregnant or of childbearing age;
- Adopting the Hear Her™ Campaign for patients and healthcare providers;
- Increasing reimbursement and expanding coverage for certified nurse midwives, birth centers, and perinatal support services such as doulas and nurse home visits; and
- Monitoring the “Birthing-Friendly”⁵ designation process and seeking to contract with those hospitals that receive the designation.

We recognize and thank you for the work already done implementing these strategies. Please explain in your plan proposals how you will continue to pursue or expand efforts in improving maternal health outcomes.

⁵ [CMS Announces Key Actions to Reduce Maternal Mortality and Morbidity | CMS](#)

Gender Affirming Care

Coverage for medically necessary gender affirming health care for transgender and gender diverse people should align with the clinical judgement of the medical professional who has competencies in the assessment of transgender and gender diverse people seeking gender-related medical and surgical treatment. These competencies are outlined in the World Professional Association for Transgender Health's (WPATH) [Standard of Care version 8](#)⁶ (SOC 8), as is a list of possible medically necessary gender affirming interventions such as gonadectomy, gender affirming facial surgery, and hormone therapy.

The goal of gender affirming care and services in the FEHB Program is to cover medically necessary interventions deemed appropriate for the individual and based on a review of the individual's circumstances and needs. Medical policies related to gender affirming care coverage must be easily accessible to members on each Carrier's website. As part of their plan proposal, FEHB Carriers are invited to submit dollar limits to coverage of medically necessary gender affirming interventions.

Prevention and Treatment of Obesity

OPM expects plan proposals to address the prevention and treatment of obesity as described in [Carrier Letter 2023-04](#) and further detailed in [Carrier Letter 2023-01](#). This means plan proposals must include descriptions of their nutritional and physical activity components that support a comprehensive benefit, coverage of anti-obesity drugs, and any necessary adjustments to their criteria for metabolic surgery. As a reminder, Carriers must cover at least one anti-obesity drug from the GLP-1 class for weight loss and cover at least 2 additional oral anti-obesity drug options. As new anti-obesity drugs are approved by the FDA, OPM expects Carriers to evaluate and update their coverage of anti-obesity drugs. Clinical criteria should be evidence-based, transparent and readily accessible. Please refer to Carrier Letter 2023-03 for additional guidance on OPM's expectation for pharmacy benefit management. Carriers should describe in their proposals how they meet the drug coverage requirement above, including any utilization management or drug exception processes applied.

⁶ This link may not be accessible if using a Virtual Private Network (VPN). OPM recommends accessing it while not on VPN.

Mental Health and Substance Use Disorders

This year's Call Letter addressed our continuing focus on (1) strengthening network adequacy for mental health; (2) ensuring that Carriers continue to conduct comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs); (3) addressing mental health in youth; and (4) addressing treatments for substance use disorders.

Mental Health: Network Adequacy

Mental and physical health are equally important components of overall health. An individual in mental distress may present with physical symptoms just as someone with a physical injury may present with mental distress symptoms. Physical and mental health symptoms can be deeply connected in that chronic physical conditions can cause mental distress and poor mental health can lead to poor physical health or harmful behaviors. Integrated mental health models can bring together physicians and other providers to coordinate an individual's health needs holistically, starting with network adequacy.

Carriers should include in their proposals:

- How mental health and primary care are integrated in their current benefit design;
- A full description of efforts to expand mental health provider networks;
- A full description of current reimbursement model(s) that integrates health, mental health, and substance use disorder care; and
- How their geographical-based provider network is being augmented through telehealth and any other means, including covering services provided by out-of-network providers at in-network rates to provide timely access to specialized care.

Carriers are reminded of our requirements for their provider directories indicated in [CL 2020-03](#). Enrollees should be able to find available providers who are accepting new patients and be able to access these providers within reasonable wait times.

Carriers will be expected to provide an analysis of their network adequacy for mental health and substance use disorder providers this year. A forthcoming Carrier Letter will

detail the information required, timing, and submission details separate from the May 31 benefit and rate proposals. OPM will provide the network adequacy standards from which each plan's analysis will be derived.

Mental Health: Non-Quantitative Treatment Limitations (NQTLs)

The Call Letter reminded Carriers that they have a continuing obligation to conduct comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) as previously noted in [Carrier Letter 2021-16](#). As stated in that Carrier Letter, FEHB Carriers must make their comparative analyses available upon OPM's direction.

OPM is advising Carriers that OPM will direct a submission related to comparative analyses via the forthcoming Carrier Letter mentioned above.

When developing their comparative analyses, FEHB Carriers should examine the Department of Labor's (DOL) [Self-Compliance Tool](#), including [Appendix I](#) and [Appendix II](#), as well as [Frequently Asked Questions Part 45 \(FAQs\)](#) prepared jointly by DOL and the Departments of Health and Human Services and the Treasury (collectively, the Departments).

As noted in Question 2 of the FAQs, the Self-Compliance Tool outlines four steps that plans and issuers should take to assess their compliance with MHPAEA for NQTLs. For each step, the Self-Compliance Tool also identifies certain information to support the analysis and the conclusions reached about whether the plan or coverage complies with MHPAEA. This information closely aligns with the information that Carriers must include as part of their comparative analyses. Appendix I provides illustrating examples and Appendix II has a worksheet about provider reimbursement rates. Therefore, Carriers that have carefully applied the guidance in the Self-Compliance Tool should be in a strong position to respond to OPM's requirement to submit comparative analyses upon request.

The [2022 MHPAEA Report to Congress](#), prepared by the Departments, also provides strategies for improvements in access as well as insight into the Departments' enforcement activities and their possible future rulemaking.

Mental Health: Addressing Mental Health in Youth

The United States Preventive Services Task Force (USPSTF) recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years and screening for [anxiety in children and adolescents](#) aged 8 to 18 years. Both recommendations, released in October 2022, acknowledge that screening tools alone are not sufficient to diagnose depression or anxiety. Therefore, if a screening test is positive for depression or anxiety, a confirmatory diagnostic assessment and follow-up is required. While no cost sharing applies to the USPSTF screening recommendations, cost sharing can apply to the diagnostic assessments and follow-up. Plan proposals should reflect how they are amplifying the USPSTF screening recommendations to their providers and members, as well as how they will handle a positive screening for depression or anxiety that requires a diagnostic assessment and follow-up.

Substance Use Disorders

According to the Centers for Disease Control and Prevention (CDC), the Clinical Practice Guideline for Prescribing Opioids for Pain first issued in 2016 helped drive down opioid prescribing levels. However, critics of the 2016 Guidelines believed that while the guidelines helped limit new prescriptions, other harms were realized such as unsafe dose reductions for people already on opioids and medications being cut off for some long-term patients on which they depended. OPM endorses individualized care plans that best meet a patient's pain management needs, minimize the harms, and reduce stigma associated with opioid use. After reviewing the 2022 CDC [Clinical Practice Guideline for Prescribing Opioids for Pain](#), Carriers should indicate in their plan proposals how they will:

- Apply the five guiding principles when implementing the recommendations
- Address opioid alternatives, both non-pharmacologic and non-opioid pharmacologic therapies for acute, subacute, and chronic pain
- Ensure that proposals are consistent with the intended patient populations addressed in the 2022 CDC Clinical Practice Guideline; and
- Provide for exceptions to dosage thresholds and limits based on appropriate clinical criteria and individualized patient needs.

Section 1262 of the Consolidated Appropriations Act, 2023 (CAA) removes the federal requirement for [practitioners to have an X-waiver](#) to prescribe medications such as

buprenorphine for the treatment of opioid use disorder (OUD). Effective immediately, Substance Abuse and Mental Health Services Administration (SAMHSA) will no longer accept waiver applications. This means that all practitioners who have a current Drug Enforcement Administration (DEA) registration that includes Schedule III authority may now prescribe buprenorphine for OUD in their practice if permitted by applicable state law. In their plan proposals, Carriers are asked to address medication assisted treatment (MAT) and confirm what changes they made to their claims systems to accommodate the removal of the waiver.

SAMHSA and DEA are actively working on implementation of a separate provision of the CAA related to training requirements for DEA registration that becomes effective in June 2023.

Carriers are also reminded that Use of Opioids from Multiple Providers (UOP) HEDIS measure will be scored in Plan Year 2024 as part of the Plan Performance Assessment measure set. This UOP measure will provide OPM a better understanding of how FEHB Carriers are managing their networks to ensure patient safety and potentially reduce the risk of iatrogenic harms. Review [Carrier Letter 2022-03](#) for details.

Telehealth

Telehealth services have rapidly expanded during the COVID-19 pandemic, and demonstrably played an important role in the provision of healthcare as noted in the [Health Matters Newsletter 2022-01](#). Please describe new efforts in the following areas in your proposals to:

1. Leverage telehealth to improve health equity. Among other things, describe how telehealth is used for both emergent (e.g., stroke) and nonemergent services (e.g., liver specialists) to mitigate transportation difficulties for both rural and urban populations.
2. Provide audio-only telehealth, which can be helpful in providing access to care for persons with limited broadband availability; persons with certain disabilities; and persons with limited English proficiency who may need a qualified interpreter over the phone.⁷

⁷ See also Department of Health and Human Services, Office of Civil Rights "[Guidance on How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio-Only Telehealth](#)" (June 13, 2022).

3. Leverage telehealth for the provision of mental health and substance use disorder services, including how it addresses network scarcity issues and improves the patient experience.⁸
4. Support the expansion of remote monitoring capabilities in order to improve the quality of care for those with chronic diseases.
5. Assist the efforts of providers to furnish telehealth services, including (1) coordination between free-standing telehealth providers and those having ongoing medical relationships with members; (2) support for brick-and-mortar practices to incorporate telehealth into their repertoire of services; and (3) continuation of reasonable agreements on reimbursement.

Antibiotic Stewardship

The COVID 19 pandemic disrupted efforts to curb antibiotic resistance in clinical settings, thus leading to a deadly rise in [antimicrobial-resistant infections](#). The Healthcare Effectiveness Data and Information Set (HEDIS) measure "[Avoiding Antibiotics in Acute Bronchitis/Bronchiolitis](#)" moved to [high priority status](#) in 2023. OPM expects that FEHB Carriers will refocus and renew the promotion of effective antibiotic stewardship programs in their network providers.

Carriers should review [Carrier Letter 2019-5\(a\)](#) and ensure they are approaching these critical population health issue through the two channels: encouraging appropriate antibiotic prescribing and supporting effective hospital infection control. We remain steadfast in our request for Carriers to:

- Use data on the [Medicare Hospital Compare](#) and [Leapfrog Hospital Safety Grade](#) websites to inform hospital network decisions and contract terms.
- Monitor antibiotic prescribing rates across care settings, including urgent care networks and services.
- Discourage antibiotic prescribing for conditions where they are not indicated, including viral upper respiratory infections and bronchitis, through the use of provider reports showing provider antibiotic prescribing patterns compared to peers to reduce unnecessary prescribing (i.e., post-prescription audit and feedback).
- Support patient education efforts. [Choosing Wisely's patient resources](#) may help increase patient literacy and knowledge about the risks of inappropriate antibiotic use.
- Examine provider incentives and consider aligning payment models accordingly.

⁸ The [results of the 2021 Federal Employee Benefits Survey \(FEBS\)](#) noted that "Federal employees experienced increases in the use of telehealth during the COVID-19 pandemic and that use is greater among those who report seeking treatment for emotional/mental/behavioral health services."

In your plan proposals, please describe how you are implementing and promoting an antibiotic stewardship program within your network, using these strategies.

Organ/Tissue Transplants

Hematopoietic Stem Cell Transplant (HSCT)

Beginning in the 2024 Plan Year, OPM has chosen to align requirements for hematopoietic stem cell transplant (HSCT) coverage with those of the American Society for Transplantation and Cellular Therapy (ASTCT) as published in 2020⁹. 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 FEHB 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 standards of care and evidence, OPM believes that both documents align, without meaningful differences between them.

Table 1 from the [manuscript](#) defines the levels of evidence supporting various indications. OPM recommends that FEHB 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.

As in past years, we are providing guidance on organ/tissue transplants for 2024. When you determine that a transplant service is no longer experimental, but is medically necessary, you may begin providing benefits coverage at that time. FEHB Carriers are not obligated to wait for the next contract year before they 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

⁹ Kanate AS, Majhail NS, Savani BN, et al. [Indications for Hematopoietic Cell Transplantation and Immune Effector Cell Therapy: Guidelines from the American Society for Transplantation and Cellular Therapy](#). Biol Blood Marrow Transplant. 2020. 26 (7) 1247-1256. DOI: <https://doi.org/10.1016/j.bbmt.2020.03.002>.

Carriers are to complete and return this table.

- Section 3 – OPM’s recommended list of covered rare organ/tissue transplants. All Carriers are to complete and return this table.

Summary of Benefits and Coverage

FEHB Carriers will continue to 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.

Aggregate Healthcare Cost and Utilization Data Report

FEHB Carriers are reminded of their obligation to supply aggregate healthcare cost and utilization data to OPM. [Carrier Letter 2023-05](#) provides additional information about this requirement and Carriers should refer to the instructions for details on how to complete and submit the data report.

Part V: Attachments

The following attachments must be completed and returned to OPM as part of your Plan Year 2024 proposal. Not all attachments are applicable to each FEHB Carrier. The list and table below organize the attachments by their applicability to Carrier types. If you have questions, please contact your Health Insurance Specialist.

Worksheet attachment	Applicable to FFS?	Applicable to Returning HMOs (ER & CR)?	Applicable to New HMO?
Attachment I: Technical Guidance Submission Checklist	Yes	Yes	Yes
Attachment II: FEHB Carrier Contracting Officer	Yes	Yes	Yes
Attachment III: Organ/Tissue Transplants and Diagnoses	Yes	Yes	Yes

Worksheet attachment	Applicable to FFS?	Applicable to Returning HMOs (ER & CR)?	Applicable to New HMO?
Attachment IV: FEHB Drug Formulary Template (in Excel, separate document sent out with this Technical Guidance). Please follow additional instructions in the PDF document titled 'FEHB Drug Formulary Instructions' sent out with the Technical Guidance.	Yes	Yes	Yes
Attachment V-a: Benefit Change Worksheet for Community-Rated HMOs	No	Yes, only CR	No
Attachment V-b: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	Yes	Yes, only ER	No
Attachment V-c: Benefit Clarification Worksheet	Yes	Yes	Yes
<i>Attachment VI:</i> FEHB Benefit Difference Comparison Chart In- Network Benefits Spreadsheet (in Excel, separate document sent out with Technical Guidance)	No	Yes	Yes

Attachment I: Technical Guidance Submission Checklist

Please return this checklist with your 2024 benefit and rate proposal.

Not all attachments are applicable to each Carrier. Please refer to the [Attachments section](#) of the 2024 Technical Guidance and, if you have further questions, please contact your Health Insurance Specialist.

Attachment	Attachment completed and in proposal? Yes/No/NA
Attachment II: FEHB Carrier Contracting Official	
Attachment III: Organ/Tissue Transplants and Diagnoses	
Attachment IV: FEHB Drug Formulary Template*	
Attachment V-a: Benefit Change Worksheet for Community-Rated HMOs	
Attachment V-b: Benefit Change Worksheet for Fee-For-Service and Experience-Rated HMOs	
Attachment V-c: Benefit Clarification Worksheet	
Attachment VI: FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet (HMOs only) *	

* Please note that the Attachment IV: FEHB Drug Formulary Template and Attachment VI: FEHB Benefit Difference Comparison Chart In-Network Benefits Spreadsheet are Excel documents sent out with the 2024 Technical Guidance.

Attachment II: FEHB Carrier Contracting Official

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

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

Enrollment code(s): _____

Typed Name	Title	Signature	Date

Signature of Contracting Official

Date

Typed Name and Title

Telephone

Email

Attachment III: 2024 Organ/Tissue Transplants and Diagnoses

Technology and clinical advancements are continually evolving. FEHB 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. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal. If you have further questions, please contact your Health Insurance Specialist.

Section 1: Required Coverage

I. 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

II. Hematopoietic Stem Cell Transplant (HSCT)

Beginning in the 2024 Plan Year, OPM has chosen to align requirements for hematopoietic stem cell transplant (HSCT) coverage with those of the American Society for Transplantation and Cellular Therapy (ASTCT) as published in 2020. 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 plan to update this publication on a 3–5-year basis. It is important to note that requirements for FEHB 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 standards of care and evidence, OPM believes that both documents align, without meaningful differences between them.

Table 1 from the [manuscript](#) defines the levels of evidence supporting various indications. OPM recommends that FEHB 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

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services recommended under Clinical Trials. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2024? Yes/No
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	
Multiple myeloma	
Multiple sclerosis	
Sickle Cell	
Beta Thalassemia Major	

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2024? Yes/No
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Hodgkin’s lymphoma	
Non-Hodgkin’s lymphoma	
Breast cancer	
Chronic lymphocytic leukemia	
Chronic myelogenous leukemia	
Colon cancer	
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease	
Early stage (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	

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2024? Yes/No
Renal cell carcinoma	
Sarcomas	
Sickle Cell disease	
Chronic myelogenous leukemia	
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	
Early stage (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

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/ investigational. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

Solid Organ Transplants	Does your plan cover this transplant for 2024? Yes/No
Allogeneic islet transplantation	
Blood or Marrow Stem Cell Transplants	
Allogeneic transplants for:	
Advanced neuroblastoma	
Infantile malignant osteopetrosis	
Kostmann's syndrome	
Leukocyte adhesion deficiencies	
Mucopolidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux Lamy syndrome variants)	
Myeloproliferative disorders	
Sickle cell anemia	
X-linked lymphoproliferative syndrome	

Solid Organ Transplants	Does your plan cover this transplant for 2024? Yes/No
Ependymoblastoma	
Ewing’s sarcoma	
Medulloblastoma	
Pineoblastoma	
Waldenstrom’s macroglobulinemia	

Attachment IV: FEHB Drug Formularies

FEHB Drug Formulary Instructions, 2023 Drug Formulary Template, and 2024 Drug Formulary Template are separate documents sent out with this Technical Guidance.

2023 Formularies

All FFS and HMOs must provide a copy of their full 2023 formulary as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as an attachment “2023 FEHB Drug Formulary Template.xlsx” with this Technical Guidance Document.

Please follow the more detailed instructions in the FEHB Drug Formulary Instructions document. The completed templates should be submitted to Research and Oversight Repository (ROVR) by May 31, 2023. If you have any questions regarding file submission, please reach out to OPMPharmacy@opm.gov and ROVRSupport@opm.gov on the emails.

2024 Formularies

New FFS and HMOs must submit a 2024 Drug Formulary Template to OPM.

Returning FFS and HMOs changing formularies or moving to new formularies in 2024 must submit a 2024 Drug Formulary Template. Please follow the more detailed instructions in the FEHB Drug Formulary Instructions document. The completed templates should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist, by May 31, 2023.

Attachment V-a: Benefit Change Worksheet for Community-Rated HMOs

[Insert Health Plan Name]

[Insert Subsection Name]

Please complete **a separate worksheet** for each proposed benefit change. Please refer to [Benefit Changes](#) section to complete the worksheet.

Benefit Change Description

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

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	

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

Notes:

1. Actuarial Value:

- a. Is the change an increase or decrease in existing benefit package? _____
- b. If it is an increase, describe whether any other benefit is offset by your proposal.

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

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

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

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

- a. Ensure that a meaningful difference between plan options will continue to exist if the change is approved, and describe the difference
- b. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
- c. Provide evidence to support that cost neutrality will be achieved in Plan Year 2024.

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: OPM will consider a waiver to the cost neutrality requirement for proposals of coverage for infertility benefits as outlined in Carrier Letter 2023-04 and further detailed in this Technical Guidance.

3. Is the benefit change a part of the plan's proposed community benefits package? _____

- a. If yes, when?

 - b. If approved, when? (attach supporting documentation)

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

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

 - e. What percentage of plan subscribers do you project will have this benefit by January 2024? _____
4. If change is not part of proposed community benefits package, is the change a rider? _____
- a. If yes, is it a community rider (offered to all employers at the same rate)? _____
 - b. What percentage of plan subscribers now have this benefit?

 - c. What percentage of plan subscribers do you project will have this benefit by January 2024? _____
 - d. What is the maximum percentage of all subscribers you expect to be covered by this rider? _____
 - e. When will that occur? _____
5. Will this change require new providers? ___ If yes, provide a copy of the directory which includes new providers.

Attachment V-b: Benefit Change Worksheet for Fee-For- Service and Experience-Rated HMOs

[Insert Health Plan Name]

[Insert Subsection Name]

Please complete **a separate worksheet** for each proposed benefit change. Please refer to [Benefit Changes](#) section to complete the worksheet.

Benefit Change Description

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

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	

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

Notes:

1. Actuarial Value:

- a. Is the change an increase or decrease in existing benefit package? _____
- b. If it is an increase, describe whether any other benefit is offset by your proposal.

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

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

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

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

- a. Ensure that a meaningful difference between plan options will continue to exist if the change is approved, and describe the difference
- b. Provide a clear and specific strategic justification for the potential premium increase in the plan option with the benefit enhancement; and
- c. Provide evidence to support that cost neutrality will be achieved in Plan Year 2024.

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 costneutrality.

Exception 4: OPM will consider a waiver to cost neutrality if indicated in a prior Carrier Letter.

Attachment V-c: Benefit Clarification Worksheet

[Insert Health Plan Name]

[Insert Subsection Name]

Please refer to [Benefit Clarifications](#) section to complete the worksheet.

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

Benefit Change Description

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

Current Benefit Language	Proposed Clarification	Reason for Benefit Clarification

Attachment VI: FEHB Benefit Difference Comparison Chart

The FEHB Benefit Difference Comparison Chart is an Excel Spreadsheet included with the Technical Guidance. Please refer to the [FEHB Benefit Difference Comparison Chart section](#) and follow the Excel Spreadsheet Template for instructions.

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

Attachment VII: Federal Employees Health Benefits Program Statement About Service Area Expansion

New HMOs and Returning HMOs complete this form only if you are proposing a service area expansion. Please refer to the [Service Area Expansion section](#) of the 2024 Technical Guidance. If you have additional questions, please contact your Health Insurance Specialist.

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2024 Benefits and Service Area Proposals. Specifically,

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

Signature of Plan Contracting Official

Name and Title

Plan Name

Date