
**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 2022-04

Date: March 16, 2022

Fee-for-service [4]

Experience-rated HMO [4]

Community-rated HMO [4]

Subject: Technical Guidance and Instructions for 2023 Benefit Proposals

Enclosed are the Technical Guidance and Instructions for preparing your benefit proposals for the contract term January 1, 2023, through December 31, 2023. **Please note that the Technical Guidance is being released as a single document for all FEHB Carriers. 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] will be noted throughout the document. Similarly, guidance that is applicable to all Carriers will be 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 2022-03) dated February 17, 2022 outlines policy goals and initiatives for the 2023 contract year; and
2. The Technical Guidance and Instructions for Preparing Proposals for the 2023 Plan Year provides detailed technical requirements for the items listed in the Call Letter that must be addressed in your benefit proposals.

The 2023 Rate Instructions for Community-Rated HMO Carriers are not included with these benefit instructions but will be released in an upcoming Carrier Letter. The 2023

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 is advancing health equity and ensuring the federal government, as the largest employer in the country, offers competitive, comprehensive health insurance benefits to its employees, annuitants, other eligible groups, and their families. We continue to encourage all FEHB Carriers to thoroughly evaluate their health plan options to find ways to maintain 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 2023 brochure.

This year's deadlines are as follows:

Dates	Activity
April 30	Aggregate Healthcare Cost and Utilization Data Report CL 2021-09 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.

Dates	Activity
May 6	<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>
May 31	<p>Drug Formularies</p> <p>All 2022 FEHB Carriers must submit their 2022 drug formularies 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>FFS and Returning HMOs changing formularies or moving to new formularies in 2023 must submit a 2023 FEHB Drug Formulary Template.</p> <p>New HMOs must submit a 2023 FEHB Drug Formulary Template.</p>

Dates	Activity
June 6-17	<p>Benefits Plus and 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>2023 Brochure Creation Tool (BCT) User Manual</i> no later than June 6.</p>
June 15	<p>Benefits Plus and BCT open for Carrier data entry.</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 27	<p>OPM will send the <i>2023 FEHB Brochure templates</i>.</p>
August 15	<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 24	<p>Brochure Creation Tool</p> <p>Carriers must complete initial update or submission of brochure language in BCT no later than August 24th 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>

Dates	Activity
September 7	Brochure Creation Tool Carriers must complete import of rate information into BCT.
September 23	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. Summary of Benefits and Coverage (SBC) are due the same date as the final brochure.
October 11	Brochure Shipment Carrier brochures are due to the Retirement Services vendor.

Part I: 2023 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. OPM no longer requires plans to comply with benefit requirements for Federally Qualified Health Maintenance Organizations.

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 7, 2022, 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 2022. 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, 2022, and you obtain approval and submit approval documentation to us by June 30, 2022. 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, 2022.

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 2023 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 2023.

Notes for New HMOs: Your material must show all proposed benefits for FEHB for the 2023 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 2023.

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 2022 benefit package (adjusted for FEHB benefits) and your 2023 benefit package.
- Benefit package documentation (See [Benefit Changes](#) below).
- A plain language description of each proposed Benefit Change and the revised language for your 2023 brochure.
- A plain language description of each proposed [Benefit Clarification](#) and the revised language for your 2023 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 2023 brochure.
- A plain language description of each proposed [Benefit Clarification](#) and the revised language for your 2023 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 2023 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 2023.
- 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 cost neutrality if indicated in a prior Carrier Letter.

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 2023” 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 it is based on. 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, 2022, 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, 2022.
- Please include whether riders are required within your proposed 2023 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 2022 package and who are expected to purchase the 2023 package.

Part II: 2023 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 commercial, non-Federal members from an additional geographic area that surrounds, or is 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.

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 2023 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. 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, 2022. OPM grants an extension for submitting state approval supporting documentation until June 30, 2022.

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
- You 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, 2022. 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: 2023 Call Letter Initiatives for All FEHB Carriers

Health Equity

In accordance with [Executive Order 13985](#), *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* (EO 13985), and [Executive Order 14035](#), *Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce* (EO 14035), OPM remains committed to promoting and ensuring health equity, and to improving care access, delivery, quality, and affordability in the FEHB Program.

OPM, through the FEHB Program, is focused on improving maternal health access, quality, and outcomes for patient populations, including Black and American Indian/Alaska Native (AI/AN) women, who have borne a disproportionate share of maternal health morbidity and mortality. OPM is also committed to ensuring that LGBTQ+ individuals have equitable access to health care and health insurance coverage, including gender affirming care and services offered to the Federal Workforce as emphasized in EO 14035.

Maternal Health¹

The United States has one of the highest rates of maternal mortality among high income countries. Additionally, 50,000 women each year experience pregnancy complications or severe maternal morbidity (SMM),² and there are racial and ethnic disparities in maternal mortality and SMM. CDC identifies delivery hospitalizations with SMM by using administrative hospital discharge data and International Classification of Diseases (ICD) diagnosis and procedure codes and currently uses 21 SMM indicators.³ The FEHB Program is a model in maternal health care by focusing efforts on quality, affordability, and equitable access to coverage that spans from preconception to postpartum care. OPM is committed to addressing inequalities by improving prenatal and postpartum support and encouraging innovative methods for improving maternal outcomes in the FEHB Program.

¹ OPM acknowledges that terminology related to pregnancy and childbirth is evolving. For purposes of this guidance, we use terms to align with medical terminology and references.

² [Severe Maternal Morbidity in the United States](#), Centers for Disease Control and Prevention.

³ [How Does CDC Identify Severe Maternal Morbidity? Centers for Disease Control and Prevention](#).

OPM appreciates Carriers' efforts to address maternal health and encourages Carriers to expand prenatal and postpartum support and services.

Prenatal and Postpartum Support

Early and comprehensive prenatal and postpartum care is important for reducing maternal mortality and SMM. Continuous postpartum care can improve maternal outcomes and ensure women receive specialized support when needed, such as for mental health issues and chronic or disabling conditions. This is particularly important for up to 1 year postpartum as many cases of maternal mortality occur in the postpartum period, and most pregnancy related deaths are preventable.⁴

OPM encourages FEHB Carriers to consider expanding coverage and services in support of prenatal and postpartum care including but not limited to childbirth education classes, group prenatal care, home visiting programs, care management for high-risk pregnancies, and self-measured blood pressure monitoring (SMBP) for individuals with hypertension. As stated in [Carrier Letter 2021-03](#), OPM strongly encourages FEHB Carriers to specifically address mental health among pregnant women and in the postpartum year.

Group Prenatal Care

Group prenatal care is designed to improve patient education and opportunities for social support while maintaining the risk screening and physical assessment of individual prenatal care.⁵ Preliminary, observational studies on the impact of group prenatal care demonstrate reduced rates of preterm birth, NICU admissions, low birthweight, and emergency department use during pregnancy, as well as improved parental knowledge of childbirth and child-rearing.⁶

Home Visiting Programs

Home visiting programs may mitigate health disparities and improve health outcomes by providing pregnant and postpartum individuals with screenings, case management, family

⁴ Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017, Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention.

⁵ [Group Prenatal Care](#), American College of Obstetricians and Gynecologists.

⁶ [Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity](#), The Commonwealth Fund.

support, and referrals that address a family’s physical, mental, and health-related social needs.⁷ Home visits have been shown to improve self-efficacy and lower depression rates, as well as decrease pregnancy-related hypertension and lead to fewer delivery complications; and decrease the likelihood for infants to be born preterm or at a low birthweight and result in fewer hospitalizations following emergency room visits.⁸ Home visiting services may include the following: supporting preventive health and prenatal practices; assisting parents with breastfeeding; and helping parents understand child development milestones and behaviors.⁹

Self-measured blood pressure monitoring (SMBP)

Hypertension or high blood pressure before and during pregnancy is associated with an increased risk for maternal complications such as preeclampsia, placental abruption, and gestational diabetes.¹⁰ It also is associated with preterm delivery and infant death. SMBP involves an individual’s regular use of personal blood pressure monitoring devices to assess and record blood pressure across different points in time typically at home. SMBP can be useful in reducing the risk of death and disability associated with hypertension.¹¹ OPM encourages FEHB Carriers to cover validated blood pressure monitors and reimbursement for the clinical support necessary to make SMBP available and effective for women during and following pregnancy.

Innovative Methods for Improving Maternal Care

OPM encourages FEHB Carriers to implement innovative methods to improve overall maternal outcomes. One method is paying more for high-value care than low-value care. As discussed in [Carrier Letter 2019-01](#), OPM reminds Carriers of the importance of reducing cesarean sections where they are not medically indicated. This may reduce the financial incentive to perform cesarean sections for low-risk births. Other examples include improved reimbursement and coverage for certified nurse midwives, birth centers, and

⁷ Lewey, D. Center for Health Care Strategies, (October 2021) [Addressing Racial and Ethnic Disparities in Maternal and Child Health Through Home Visiting Programs](#).

⁸ Id.

⁹ Id.

¹⁰ [Pregnancy Complications](#), Centers for Disease Control and Prevention.

¹¹ Self-Measured Blood Pressure Monitoring. Centers for Disease Control and Prevention. Centers for Disease Control and Prevention.

perinatal support services such as doulas and nurse home visits that have proven to be low-cost, effective interventions to improve maternal health outcomes.¹²

Carriers could also consider quality bonuses to maternity providers whose Consumer Assessment of Healthcare Providers & Systems (CAHPS) scores improve across all racial groups. OPM also encourages Carriers to reimburse health systems with Alliance for Innovation on Maternal Health (AIM) patient safety bundles or Joint Commission certification at a higher rate.

We also encourage Carriers to consider utilizing the upcoming [“Birthing-Friendly” designation](#), announced by the Centers for Medicare & Medicaid Services (CMS), for hospitals as a target for payment incentives or other innovative payment methods for network contracting.

Delivering Respectful Maternal Care

In a study of maternal deaths, 46% of Black and 33% of white maternal deaths were considered potentially preventable, and inappropriate or delay in diagnosis or treatment and communication failures are common preventability factors.¹³ Health care professionals play an important role in eliminating preventable maternal mortality. In Carrier Letter [2019-05a](#), we encouraged the use of standard communication processes for identifying patient risk for labor complications. Communication between patients and their providers is critical for patient care. OPM encourages FEHB Carriers to adopt the [CDC’s Hear Her campaign](#) for patients and providers by providing information to raise awareness of potentially-life threatening warning signs during and after pregnancy and improving communication between patients and their healthcare providers.¹⁴

Gender Affirming Care and Services

OPM appreciates the work of Carriers on plan brochure language, claims processing edits, and formulary access as each pertains to providing equitable gender affirming care and services within the FEHB program. There are standards of care to reference when

¹² Pierce-Wrobel C, Green, K. [To Help Fix The Maternal Health Crisis, Look To Value-Based Payment](#), Health Affairs.

¹³ CJ, Harper MA, Atkinson SM, et al. Preventability of pregnancy-related deaths: results of a state-wide review. *Obstet Gynecol.* 2005 Dec;106(6):1228–1234, in Howell, EA. [Reducing Disparities in Severe Maternal Morbidity and Mortality](#), *Clin Obstet Gynecol.*

¹⁴ [Hear Her Campaign](#), Centers for Disease Control and Prevention (CDC).

establishing medical policy and strategies that Carriers can employ to better meet the needs of those members seeking gender affirming care and services.

Standards of Care

Carriers should have a process in place to review the medical literature on gender affirming care and services and align benefits with current medical evidence and standards. Entities such as the World Professional Association for Transgender Health (WPATH) and the Endocrine Society offer standards of care with special focus on the medical needs of transgender and gender diverse individuals while the [Fenway Institute](#) through their [National LGBTQIA+ Health Education Center](#) focuses on educating health care organizations on topics such as inclusive communication and environments. WPATH's [Standards of Care Version 8](#) expected release is Spring 2022. Please describe your process for reviewing the literature and incorporating current medical evidence and standards into your medical benefit policy.

Care Coordinators and Provider Networks

Previous FEHB Carrier Letters and Carrier Conference sessions discuss care coordination approaches such as patient-centered medical home, care management, and medication management, and stress the need for integrative care that includes medical, pharmacy, behavioral and mental health. The Agency for Healthcare Research and Quality (AHRQ) defines [care coordination](#) as the deliberate organization of patient care activities and the sharing of information among all participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. This definition is particularly suitable for those members seeking gender affirming care and services because of the importance of adhering to evidence-based standards that incorporate medical, pharmaceutical, and mental health services, as well as cultural competencies. **Please explain how you will incorporate gender affirming care and services into your care coordination model.**

Carriers are reminded that if network providers are not available to provide medically necessary treatment of gender dysphoria, FEHB Carriers should describe how members are directed to qualified providers with experience delivering this specialized care.

Provider directories should be reviewed and updated accordingly to reflect providers that have the skills and expertise in gender affirming care and services, similar to providers serving those in different languages, age groups, or clinical designations.

FEHB Carriers are reminded that most suitable providers for this member population are those familiar with and experienced in LGBTQ+ health. The Care Coordinator should also be suitably trained in inclusive communications as described in the next section.

Inclusive Member Communication

The [2021 Technical Guidance](#) asked FEHB Carriers to consider strategies to make member-facing materials and communications more inclusive. OPM now requires all FEHB Carriers to ensure the use of inclusive terminology in communication materials, member-accessible resources, and the FEHB Brochure.

Specifically:

- Registration forms and health records include optional fields for members to provide personal pronouns and gender identity.
- All written materials that are member-facing to include websites, downloadable materials, letters, and explanation of benefits (EOBs) use inclusive language pertaining to LGBTQ+ members.
- Training is offered to customer service and support employees to facilitate the use of a member's correct name and personal pronouns during interactions.

Recognizing that inclusive communications go beyond the LGBTQ+ community and are critical to health equity, OPM refers FEHB Carriers to the CDC's [Gateway to Health Communication](#) website and the [Health Equity Guiding Principles for Inclusive Communication](#) resource.

Plan Brochures

OPM strongly encourages FEHB Carriers to provide comprehensive gender affirming care and services. Carriers must be as clear as possible in each plan brochure regarding which gender affirming care services are covered by their plans, the associated costs to the member, and what, if any, prerequisites must be met for those services to be reimbursed. The 2023 FEHB Plan Brochure Template will provide specific language pertaining to gender affirming care and services that plans are expected to use in their own brochures.

Formulary Access

Studies have shown that transgender individuals face additional cost and access barriers to clinically effective, evidence-based medications.^{15, 16}

As a reminder, [Carrier Letter 2022-02](#) describes a non-discriminatory formulary design. OPM expects FEHB Carriers to have effective, evidence-based formularies that prevent selection bias or discrimination and facilitate appropriate access to affordable prescription drug choices. As emphasized in [Carrier Letter 2021-05](#), a non-discriminatory formulary design does not have cost or access barriers imposed by disease or condition.

We will review your proposals for the following:

1. Description of your efforts to review your formularies to ensure that transgender and gender diverse individuals have equitable access to medications including medically necessary hormonal therapies.
2. Description of your efforts to ensure that clinical criteria are evidence-based, transparent, easy to access and do not impose unnecessary barriers to medically necessary care.

Obesity

Stated guidance on bariatric surgery in Carrier Letters 2013-10 and 2014-04 remains current. Obesity is a medical condition that requires medical intervention along with lifestyle and behavior change for optimal outcome. Coronavirus disease 2019 (COVID-19) has increased rates of obesity across age groups, and certain populations continue to be disproportionately impacted by health inequities that increase the prevalence of obesity.

Plan proposals will be reviewed for elements to reduce impacts of obesity in children and adolescents, access to anti-obesity medications, communication efforts, and billing and coding use and education of staff.

Implications in Children and Adolescents

Childhood obesity is a complex, chronic, relapsing condition with serious and costly consequences—undermining physical, social, and mental well-being. Obesity puts children and adolescents at risk for serious short and long-term adverse physical health outcomes, such as cardiovascular disease (CVD), including hypertension, dyslipidemia, insulin

¹⁵ [Lesbian, Gay, Bisexual, and Transgender Health](#), Office of Disease Prevention and Health Promotion.

¹⁶ Sachdeva I, Aithal S, Yu W, Toor P, Tan JCH. [The disparities faced by the LGBTQ+ community in times of COVID-19](#), Psychiatry Res.

resistance, type 2 diabetes, and non-alcoholic fatty liver disease (NAFLD), with a more significant impact on children and families with lower income and those of color. Childhood obesity is also associated with poor psychological and emotional health, increased stress, depressive symptoms, and low self-esteem. Children and adolescents have experienced sharp increases in their rates of weight gain during the COVID-19 pandemic, especially school-aged children and those who already had obesity; now more than ever, children and families need support in achieving and maintaining optimal weight for health.¹⁷

The 2017 USPSTF Grade B Recommendation for childhood obesity included a rigorous systematic evidence review of over 45 behavioral intervention trials to examine the benefits or harms of screening and weight management interventions among children aged 2 to 18 years. The review concluded that family-centered, lifestyle-based weight management interventions with 26 or more hours of intervention contact over 2-12 months are likely to help reduce excess weight in children and adolescents. These multicomponent interventions should teach and demonstrate nutrition, physical activity, and behavioral change strategies. Additional benefits from these multicomponent interventions include improvements in quality of life, depression, parental stress, cardiometabolic risk factors, and parental/caregiver BMI.

As a USPSTF Grade B recommendation, FEHB Carriers must offer childhood obesity screening and treatment interventions as described.

We will review your plan proposal for:

1. Restriction-free coverage of and access to child obesity screening and treatment benefits, including:
 - Screening for obesity-related conditions
 - Counseling using motivational interviewing for nutrition, physical activity and weight-related health behaviors
 - Multidisciplinary providers including, but not limited to, registered dietitians, behavioral health specialists, community health workers, health educators, social workers, exercise specialists, and physical therapists
 - Movement towards contextual screening (social determinants plus mental health conditions)
2. Evidence of an Integrated Chronic Care Model approach to obesity that:

¹⁷ [Longitudinal Trends in Body Mass Index Before and During the COVID-19 Pandemic Among Persons Aged 2–19 Years — United States, 2018–2020 | MMWR \(cdc.gov\)](https://www.cdc.gov/mmwr/mmwr.mm68.e11.htm)

- Provides multicomponent, family-centered intensive behavioral interventions such as a Family Healthy Weight Program (HW Program) consistent with the USPSTF Grade B recommendation for child obesity
 - Comprehensive, intensive, behavioral intervention programs for children ages 6+ with obesity that includes 26 or more hours of intervention contact over 2-12 months
- A focus on clinical treatments for children with excess weight/obesity to include:
 - Primary care management and follow-up weight management
 - Interdisciplinary team-based care
 - Sub-specialist care for co-occurring conditions
 - Anti-obesity pharmacotherapy
 - Metabolic and bariatric surgery

Anti-Obesity Medications

The landscape of pharmaceuticals available to treat obesity continues to evolve and there are currently a variety of Food and Drug Administration (FDA) approved medications available with different mechanisms of action. The FDA indications for anti-obesity medications reinforce that nutrition and physical activity regimens should accompany drug treatment of obesity. Treatment with anti-obesity medications is highly individualized and will depend on the individual's comorbidities, their current medication regimen, and the potential for adverse effects. FEHB Carriers must have adequate coverage of FDA-approved anti-obesity medications on their formulary to meet patient needs.

Please indicate in your proposals how the following FDA-approved anti-obesity medications (listed below) are covered on your formulary. Include tiering information and type of utilization management edits applied (if any).

1. Glucagon-like peptide-1 (GLP-1) receptor agonists that reduce appetite and food/calorie intake
 - a. Liraglutide (*Saxenda*)
 - b. Semaglutide (*Wegovy*)
2. Medications that inhibit GI lipase to prevent fat absorption
 - a. Orlistat (*Xenical*)
 - b. Orlistat (*Alli*)
3. Anti-obesity medications that act as a sympathomimetic, anorectic, or reduces appetite
 - a. Phentermine
 - b. Phentermine – (*Adipex-P*)

- c. Phentermine – (*Lomaira*)
- d. Phentermine/topiramate ER (*Qsymia*)
- 4. Medications that reduce appetite and cravings
 - a. Naltrexone 8 mg/bupropion 90 mg ER (*Contrave*)
- 5. Melanocortin 4 (MC4) receptor agonist that reduces appetite
 - a. Setmelanotide (*Imcivree*)
- 6. Devices that act to promote a sense of fullness by occupying space in the stomach
 - a. (*Plenity*)
- 7. Others

For non-formulary or excluded FDA-approved anti-obesity medications, describe how medical necessity determinations are handled and include the clinical criteria used for the determination.

Communication and Education of Members and Providers

We will be reviewing your proposals for the availability of proactive communication of the obesity benefit, including covered services and the process for accessing them, to all members and providers via multiple channels and methods. This would include:

- Inviting members with elevated risks of obesity-related conditions and known obesity to participate in evidence-based intervention.
- Education for members about obesity as a complex chronic disease, the importance of early intervention and prevention, the family health and psychosocial benefits of engaging in a HW program, and any additional information on benefits related to obesity care in children and families.
- Education for providers (including, but not limited to, dietitian, behavioral health, medical, CHW) regarding prevention, screening, identification, and treatment of children and families with overweight, obesity, and obesity-related health conditions.
- Educating providers about evidence-based services and providing or incentivizing training on motivational interviewing for all clinical staff.
- Providing education to staff on obesity-related stigma and bias and the use of person-first language.

Billing and Coding

We will be reviewing your proposals for coverage of billing and coding used by providers and Carrier claims processing staff. Your proposals should also describe education of claims processing staff about changes to coding for obesity screening and care.

Examples of codes (effective October 1, 2021):

Primary Weight-Related Diagnoses	
International Classification of Diseases (ICD-10)	Description
E66.3	Overweight
E66.8	Obesity, other
E66.9	Obesity, unspecified
E66.01	Morbid/Severe Obesity
R63.6	Abnormal Weight Gain
Z68.53	BMI, pediatric 85th% to less than 95th% for age
Z68.54	BMI, pediatric greater than or equal to 95th% for age
Z71.3	Dietary Counseling and Surveillance
Z71.89	Other Specified Counseling
Current Procedural Terminology (CPT)	
99381-99387	New Patient Preventive Medicine Services
99401-99417	Established Patient Preventive Medicine Services Counseling Risk Factor Reduction and Behavior Change Intervention
99421-99429	Other Preventive Medicine Services

Non Physician Provider Services	
Current Procedural Terminology (CPT)	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, each 15 minutes
97803	Medical nutrition therapy; reassessment and intervention, individual, each 15 minutes
97804	Medical nutrition therapy group (2 or more individuals), each 30 minutes
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral

	in same year for change in diagnosis, medical condition or treatment regimen individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 30 minutes
S9470	Nutritional counseling
S9449	Weight management classes, per session
S9452	Nutrition classes

Behavioral Counseling Services	
Current Procedural Terminology (CPT)	Description of Service Type of Provider: Behavioral Health (PhD, PsyD, LCSW, LPC, LMFT, or LAC)
G0447	Face-to-face behavioral counseling for obesity, individual, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group, 30 minutes
90832, 34, 37, 47	Psychotherapy, 16-30 minutes; 31-45 min; 46-60 min; family psychotherapy
96156	Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
Individual Intervention – Health and Behavior Codes	
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
+96159	Each additional 15 minutes (List separately in addition to code for primary procedure)
Group Intervention	
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
+96165	Each additional 15 minutes (List separately in addition to code for primary procedure)
Family Intervention WITH patient present	
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

+96168	Each additional 15 minutes (List separately in addition to code for primary procedure)
Family Intervention WITHOUT patient present	
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
+96171	Each additional 15 minutes (List separately in addition to code for primary procedure)

Ensuring the Federal Government Continues to Offer Competitive and Comprehensive Benefits

COVID-19 Pandemic

Over-the-Counter Tests, Vaccines, and Therapeutics

FEHB Carriers are reminded to review COVID-19 guidance in Carrier Letters [2020-02](#), [2020-08](#), [2020-19](#), and [2022-01](#) as well as other Carrier Letters that may be released after this Technical Guidance and prior to May 31, 2022 when preparing benefits proposals. Additional guidance may address long COVID, including correct coding. Please describe the following in your proposals:

1. Efforts at ensuring members have equitable access to diagnostic tests, vaccines, and therapeutics.
2. Efforts taken to cover over-the-counter (OTC) COVID-19 tests without imposing any cost-sharing requirements, prior authorization, or other medical management requirements. Among other things, describe:
 - a. Use of a safe harbor to provide [direct coverage](#) of OTC COVID-19 tests.
 - b. Use of a safe harbor to provide [no less than 8 OTC COVID-19 tests](#) per 30-day pay period per covered individual.
 - c. How you facilitate access to, effective use of, and prompt payment for OTC COVID-19 tests.
 - d. Steps taken to deter fraud and abuse.
3. Efforts taken to provide education and information resources to support FEHB enrollees seeking OTC COVID-19 testing
4. Efforts to communicate with members on the importance of COVID-19 vaccinations including booster doses, addressing vaccine hesitancy, and where they can get

vaccinated.

5. Efforts taken to rapidly cover recently FDA approved or authorized COVID-19 therapeutics available for treatment, pre-exposure preventions, and post-exposure prophylaxis.
6. Efforts at ensuring pharmacy access to select COVID-19 therapeutics, including providing appropriate reimbursement for assessment and administration to pharmacies.

Telehealth

Telehealth services have rapidly expanded during the COVID-19 pandemic, and demonstrably played an important role in the provision of healthcare. Within the FEHB Program, telehealth services for various types of care showed a significant one-year median increase (from 2019 to 2020), including in primary care, urgent care, specialty care, mental health, behavioral health, and remote monitoring.

Please describe the following in your proposals:

1. Efforts to leverage telehealth to improve health equity. Among other things, describe how telehealth is used for both emergent (e.g., stroke) and non-emergent services (e.g., liver specialists) to mitigate transportation difficulties for both rural and urban populations.
2. Efforts to 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.
3. Efforts to support the expansion of remote monitoring capabilities in order to improve the quality of care for those with chronic diseases.
4. Steps taken to 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.

Mental Health and Substance Use Disorders

The COVID-19 pandemic has dramatically increased incidences of mental health and substance use disorders (MH/SUD), which have disproportionately affected certain populations.¹⁸ Please describe the following in your proposals:

1. Efforts taken to address incidences of MH/SUD in the following populations:

¹⁸ [The Implications of COVID-19 for Mental Health and Substance Use](#), KFF.

- a. Adolescents and young adults
 - b. Mothers with school age children
 - c. Pregnant women and women who have given birth within the year
 - d. Healthcare providers, U.S. Postal Service employees, and other [essential workers](#)
 - e. Black, Indigenous, and other People of Color
2. Efforts taken to perform and document comparative analyses of the design and application of non-quantitative treatment limitations on MH/SUD benefits, consistent with [Carrier Letter 2021-16](#).

Medical Foods

Certain nutritional supplements (i.e., medical foods) are medically necessary for the continued health of FEHB members with specific medical conditions (e.g., Inborn Errors of Metabolism) that make ordinary foods potentially toxic. In alignment with many states and DoD's Tricare program, OPM encouraged Carriers to provide coverage for medical foods in its 2021 Carrier Letter ([2021-03](#)) and subsequent Technical Guidance ([2021-05](#)).

As stated in the Call Letter, all plans must cover medical foods in 2023.

Limitations must have a reasonable medical rationale. Examples of limitations that would not be allowed include but are not limited to, age restrictions, restrictions on the method of alimentation (e.g., via nasogastric tube or intravenously), or whether it is the sole source of nutrition. However, as stated last year, reasonable annual limits on coverage are allowed.

Assistive Reproductive Technology (ART)

OPM is interested in supporting family building efforts for covered FEHB enrollees and their eligible family members. This is an area of focus to ensure the Federal government's competitiveness as an employer of choice. We recognize that family building encompasses more than treatment of infertility and want to recognize diversity of family structures as referenced in section 11(d) of EO 14035. While FEHB Carriers currently cover the diagnosis and treatment of infertility, OPM believes that Carriers could do more to address the financial burden of assisted reproductive technology (ART) treatment for those who may require it. In our upcoming Automated Data Collection, we will be asking for information on ART and other family building benefits FEHB Carriers are currently providing in both their FEHB line of business and other lines of business.

Providing enrollees with access to negotiated discount rates for ART treatment, irrespective of an infertility diagnosis, is a good first step in helping to make family building more affordable. This information should be described via the Affinity benefits shown on the non-FEHB page of the plan brochure.

Preventive Services

Carrier Letter 2019-01 clarified OPM's expectations on coverage for preventive services with no cost sharing when received from an in-network provider. "No cost sharing" means that services are not subject to copayments, coinsurance, deductibles, or annual limits, and that all required preventive services must cover the full scope of the recommendations.

Preventive services guidelines are updated periodically by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), United States Health Resources and Services Administration (HRSA), and Bright Futures. A recent example of these updates is in [HRSA's comprehensive preventive care and screening guidelines for women and for infants, children, and adolescents](#). We further advised in Carrier Letter 2019-01 that preventive services earning an "A" or "B" rating from the USPSTF or endorsement from the relevant entity by December 31 of the previous year should be incorporated into FEHB Carrier benefit proposals the following May, with no partial or phased in implementation period. Carriers were offered the option to adopt recommendations earlier as appropriate.

OPM is now revising our position and updating this guidance as follows.

Delaying implementation of any updates or changes made by the USPSTF, ACIP, HRSA, and Bright Futures until provided in the Carrier benefit proposal for the following year could postpone the benefit change as much as two years from the date of the update or change. This would not be to the benefit of our enrollees and could possibly be a detriment to their health and safety.

For the 2023 plan year and beyond all updates to preventive services guidelines by the USPSTF, ACIP, HRSA, and Bright Futures, and preventive services earning an "A" or "B" rating from the USPSTF or endorsement from the relevant entity must be applied as they occur throughout the year, without delay, by all FEHB Carriers. Carriers must update their

benefits/claims systems to reflect these changes as soon as feasibly possible and then incorporate these changes into their FEHB Carrier benefit proposals the following May to memorialize them. Carriers immediately updating their systems to include these changes as they occur will ensure the health, safety, and well-being of our enrollees.

Carriers must reflect in Section 2 of their Plan brochures that these updates may occur throughout the year and to advise enrollees to check the USPSTF, ACIP, HRSA, and Bright Futures sites for any changes or updates. Carrier websites will also need to reflect that these changes may occur and provide a link for enrollees to easily access the information.

Additionally, we remind FEHB Carriers of their continuing obligation to cover, without cost sharing, the full range of contraceptives and contraceptive care for adolescent and adult women as provided in the [Women's Preventive Services Guidelines](#) supported by the Health Resources and Services Administration (HRSA). Such coverage must include all FDA-approved, cleared, or granted contraceptive products that are determined by an enrollee's care provider to be medically appropriate, even if those contraceptive products may be non-formulary or excluded from the Carrier's formulary. Due to complaints received by the Departments of Health and Human Services, Labor, and Treasury, these agencies issued [FAQs Part 51](#), which reiterated and reinforced health plan requirements regarding contraception. FEHB Carriers are required to comply with these requirements. Additional information will be forthcoming in an updated Carrier Letter.

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

Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2023. 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 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 2021-09 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 2023 proposal. Not all attachments are applicable to each FEHB Carrier. The list and table below organize the attachments by their applicability to particular 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)	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 2023 benefit and rate proposal.

Not all attachments are applicable to each Carrier. Please refer to the [Attachments section](#) of the 2023 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 2023 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: 2023 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 pancreatic 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. Blood or Marrow Stem Cell Transplants (not subject to medical necessity)

Plan's denial is limited to indications for transplant such as refractory or relapsed disease, disease cytogenetics, subtype or staging, or the diagnosis.

- Allogeneic transplants for:

- Acute lymphocytic or non-lymphocytic (i.e., myelogenous [myeloid])leukemia
- Hodgkin's lymphoma – relapsed
- Non-Hodgkin's lymphoma – relapsed
- Myeloproliferative Disorders (MPDs)
- Chronic lymphocytic leukemia/Small lymphocytic lymphoma (CLL/SLL)
- Hemoglobinopathies (e.g., thalassemias, Sickle cell disease)
- Marrow Failure and Related Disorders (i.e., Fanconi's, Pure Red Cell Aplasia)
- Myelodysplasia/Myelodysplastic Syndromes
- Paroxysmal Nocturnal Hemoglobinuria
- Severe combined immunodeficiency
- Severe Aplastic Anemia
- Autologous transplants for:
 - Hodgkin's lymphoma – relapsed
 - Non-Hodgkin's lymphoma – relapsed
 - Amyloidosis
 - Neuroblastoma

III. Blood or Marrow Stem Cell Transplants (not subject to Medical Necessity)

- Allogeneic transplants for:
 - Phagocytic/Hemophagocytic deficiency diseases
 - Immune deficiency diseases other than SCID (e.g., Wiskott-Aldrich syndrome, Kostmann's Syndrome, Leukocyte Adhesion Deficiencies) not amenable to more conservative treatments
- Autologous transplants for:
 - Multiple myeloma
 - Testicular, Mediastinal, Retroperitoneal, and Ovarian germcell tumors

IV. Blood or Marrow Stem Cell Transplants (not subject to Medical Necessity. May Be Limited to Clinical Trials.)

- Autologous transplants for:
 - Breast cancer

- Epithelial ovarian cancer
 - Childhood rhabdomyosarcoma
 - High-risk Ewing's sarcoma
 - High-grade (Aggressive) non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)
 - High risk childhood kidney cancers
- V. Reduced intensity conditioning transplants performed in a Clinical Trial Setting with a diagnosis listed under Section II: Subject to Medical Necessity. There is no defined age limit for the use of reduced intensity conditioning for an allogeneic stem cell transplant.
- VI. Tandem transplants: Subject to medical necessity

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 2023? Yes	Does your plan cover this transplant for 2023? No
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2023? Yes	Does your plan cover this transplant for 2023? No
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
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		

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2023? Yes	Does your plan cover this transplant for 2023? No
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
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		
Autologous transplants for the following autoimmune diseases:		
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 2023? Yes	Does your plan cover this transplant for 2023? No
Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucopolysaccharidosis (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		

Solid Organ Transplants	Does your plan cover this transplant for 2023? Yes	Does your plan cover this transplant for 2023? No
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment IV: FEHB Drug Formularies

(See Attachment IV, FEHB Drug Formulary Template, for instructions. The Formulary Template is a separate Excel document sent out with this Technical Guidance).

2022 Formularies

FFS and Returning HMOs must provide a copy of the full 2022 formulary as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as an attachment “2022 FEHB Drug Formulary Template” with this Technical Guidance Document. Include a Formulary Tier sheet and Drug List for **each** plan option. Please follow the more detailed instructions in the formulary template. Please note that the formulary template has not changed from 2020. The completed templates should be uploaded to Section II of the ADC tool in Benefits Plus by May 31, 2022.

2023 Formularies

New HMOs must submit a 2023 Drug Formulary Template to OPM. **FFS and Returning HMOs** changing formularies or moving to new formularies in 2023 must submit a 2023 Drug Formulary Template. Include a Formulary Tier sheet and Drug List for **each** plan option. Please follow the more detailed instructions in the formulary template. The completed templates should be emailed to OPMPharmacy@opm.gov with a copy to your Health Insurance Specialist, by May 31, 2022.

File Naming Convention

Please upload your Drug Formulary Template. Use the following file naming convention for the formulary file(s) you submit: **Formulary2022_ZZZ**, (or **Formulary2023_ZZZ**, if applicable) where ZZZ represents the three-digit FEHB plan code and option for the first plan using the respective formulary (alphabetically). For Carriers that have multiple plan options that share the same formulary, please include only one enrollment code in the file name and include all Self Only enrollment codes in cell B7 of the Formulary Tiers sheet of the Excel template.

File Resubmission

If you are resubmitting a file, please add a letter in alphabetical order at the end of the file name for each subsequent resubmission: (e.g., **Formulary2022_ZZZ_a**, **Formulary2022_ZZZ_b**, etc. or **Formulary2023_ZZZ_a**, **Formulary2023_ZZZ_b**, if applicable).

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 NeutralityRequested (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 2023.

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 cost neutrality if indicated in a prior Carrier Letter.

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 2023? _____
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 2023? _____
- 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 2023.

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 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 shouldnot 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 2023 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 2023 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