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

U.S. Office of Personnel Management
Healthcare and Insurance

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Fee-for-service [4] Experience-rated HMO [4] Community-rated HMO [4]

Subject: Technical Guidance and Instructions for 2022 Benefit Proposals

Enclosed are the Technical Guidance and instructions for preparing your benefit proposals for the contract term January 1, 2022 through December 31, 2022. **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 2021-03) dated February 17, 2021 outlines policy goals and initiatives for the 2022 contract year; and
2. The Technical Guidance and Instructions for Preparing Proposals for the 2022 Plan Year provides detailed technical requirements for the items listed in the Call Letter that must be addressed in your benefit proposals.

The 2022 Rate Instructions for Community-Rated HMO Carriers are not included with these benefit instructions but will be released in an upcoming Carrier Letter. The 2022 Rate Instructions for Experience-Rated HMO and Fee-For-Service Carriers will be sent directly from OPM's Office of the Actuaries to the Carriers.

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, as well as supporting the Biden Administration's priority focus on health care access and equity.

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 business days following receipt of the close-out letter or by the date set by your Health Insurance Specialist, please send him/her an electronic version of your fully revised 2022 brochure.

This year's deadlines are as follows:

Dates	Activity
May 7	**Community Benefit Package (Certificate of Coverage, Evidence of Coverage, Master Group Contract or Agreement) for New and Returning HMOs** 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.
May 31	**Benefit Proposal and Rate Proposal** As required by 5 CFR § 890.203, **all** FEHB Carriers must send a complete proposal for 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.
May 31	**Drug Formularies** All 2021 FEHB Carriers must submit their 2021 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. **FFS and Returning HMOs** changing formularies or moving to new formularies in 2022 must submit a 2022 FEHB Drug Formulary Template. **New HMOs** must submit a 2022 FEHB Drug Formulary Template.

Dates	Activity
June 7-18	**Benefits Plus and BCT Training** OPM hosts online training on the use of these tools. Carriers should plan to attend. Please contact BPBCT@opm.gov for password resets, technical questions or if you have suggestions on changes to Benefits Plus or the BCT. OPM will provide the *2022 Brochure Creation Tool (BCT) User Manual* no later than June 7.
June 14	**Benefits Plus and BCT** open for Carrier data entry.
July 28	OPM will send the *2022 FEHB Brochure templates.*
August 16	**Benefits Plus Updates** Carriers must complete draft of all data and plan-specific updates within Benefits Plus.
August 25	**Brochure Creation Tool** Carriers must complete initial update or submission of brochure language in BCT.
September 8	**Brochure Creation Tool** Carriers must complete import of rate information into BCT.
September 24	**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 the brochure for printing.
October 12	**Brochure Shipment** Carriers Brochures are due to the Retirement services vendor.

Part 1: 2022 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:

- All other benefits, such as copays and coinsurance amounts, must be the same regardless of enrollment type.
- 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 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, 2021, including riders, copays, coinsurance, and deductible amounts (e.g., prescription drugs, durable medical equipment) that your plan with the largest number of non-Federal subscribers purchased in 2021. 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, 2021 and you obtain approval and submit approval documentation to us by June 30, 2021. 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, 2021.

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 2022 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 2022.

Notes for New HMOs: Your material must show all proposed benefits for FEHB for the 2022 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 2022.

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 from Returning HMOs

- A signed Contracting Official's Form.
- A comparison of your 2021 benefit package (adjusted for FEHB benefits) and your 2022 benefit package.
- Benefit package documentation (See Benefit Changes below).
- A plain language description of each proposed Benefit Change and the revised language for your 2022 brochure.
- A plain language description of each proposed Benefit Clarification and the revised language for your 2022 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 from 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 from 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 2022 brochure.
- A plain language description of each proposed Benefit Clarification and the revised language for your 2022 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 Workshee*t 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 directed by OPM. As indicated in Carrier Letter 2019-01, OPM will consider Carrier-generated proposals for exceptions to this cost neutrality requirement for the 2022 plan year, as follows:

1. 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 2022.
2. 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).
3. Exception 3: Carriers may propose benefit changes to provide greater value to enrollees with Medicare coverage without demonstrating cost neutrality.
4. Exception 4: As indicated in Carrier Letter 2021-03, OPM will consider a waiver to the cost neutrality requirement for proposals of coverage for benefits for certain medical foods and coverage for fertility preservation in FEHB members with the possibility of iatrogenic infertility.
5. Exception 5: OPM will consider a waiver to cost neutrality for high value services FEHB Carriers offer under the pharmacy benefit as described in Medication Management Programs.

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.

1. Describe the benefit change completely. Show the proposed brochure language, including the "Changes for 2022" 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.
2. Describe the rationale for the proposed benefit change.
3. State the actuarial value of the change and if the change represents an increase or decrease in (a) the existing benefit and (b) your overall benefit package. If an increase,

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:

1. Show the current and proposed language for each proposed clarification and reference all portions of the brochure it affects. Prepare a separate benefits clarification worksheet for each proposed clarification. You may combine more than one clarification to the same benefit, but you must present each one clearly on the worksheet using plain language.
2. 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 alternate benefit package may include greater cost sharing for members to offset premiums.
- The alternate 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 the alternate benefit package and 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:

1. Differences in copays, coinsurance, coverage levels in the packages. In-network benefits are entered on a separate tab than out-of-network benefits.
2. Please highlight and address any state-mandated benefits. State-mandated benefits should be reported if finalized by May 31, 2021, 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, 2021.

3. Please include whether riders are required within your proposed 2022 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 2021 package and who are expected to purchase the 2022 package.

Part II: 2022 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 service area changes.** Service areas and provider networks must be adequately available for the 2022 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.

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.

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 “back 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, 2021. OPM grants an extension for submitting state approval supporting documentation until June 30, 2021.

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

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

You must provide the following information:

1. A description of the proposed expansion area in which you are approved to operate.
2. 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.
3. 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.
4. 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, 2021. 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:

1. Why the area has been added;
2. 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
3. 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:

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

You must provide the following information:

1. 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.
2. 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: 2022 Call Letter Initiatives for All FEHB Carriers

The Biden Administration maintains a focus on access to affordable, quality health care with an emphasis on health equity. OPM encourages FEHB Carriers to propose new approaches to delivering services more equitably to diverse populations of race and ethnicity, gender identity, sexual orientation, disability, and socioeconomic status, among others. As stated in the Call Letter, our primary initiatives for the 2022 plan year are:

- COVID-19 Pandemic
- Mental Health and Substance Use Disorder Services
- Addressing the Opioid Epidemic
- Prescription Prior Authorization
- Surprise Billing
- Transparency in Coverage
- Addressing Low Value Care (USPSTF Ratings)
- Benefits for Certain Medical Foods
- Coverage for Fertility Preservation in FEHB Members with the Possibility of Iatrogenic Infertility

COVID-19 Pandemic

FEHB Carriers are reminded to review COVID-19 guidance in Carrier Letter 2020-02, Carrier Letter 2020-08, and Carrier Letter 2020-19. Please describe the following in your proposals:

1. Efforts to communicate with members on the importance of COVID-19 vaccinations, addressing vaccine hesitancy and where they can get vaccinated.
2. Efforts taken with providers and pharmacies to reduce the time it takes to provide results for COVID-19 diagnostic testing.
3. Efforts at ensuring reimbursement to pharmacies for administering COVID-19 vaccines and diagnostic tests when ordered by a pharmacist.
4. Efforts at ensuring pharmacy access to COVID-19 vaccines and diagnostic tests.

5. Efforts at ensuring members have equitable access to diagnostic tests, therapeutics, vaccines, and telehealth coverage.

Mental Health and Substance Use Disorder Services

During the COVID-19 pandemic, isolating shelter-in-place and social distancing present a unique set of difficulties for members suffering from mental and behavioral health conditions such as depression, anxiety, or substance use disorders (SUD). For many with these conditions, isolation can further exacerbate the condition and, for those in recovery for SUD, can be a powerful trigger to relapse, especially forced isolation. Carrier Letter 2021-03 highlights OPM's expectation that all FEHB Carriers will strengthen their efforts to ensure mental health and SUD parity, remain focused on the provision of mental health and behavioral services. Additional information is provided below.

Mental Health Services

OPM strongly encourages FEHB Carriers to remain focused on the provision of mental health benefits by continual monitoring of both provider access and availability, ensuring care coordination during care transitions, and leveraging ongoing telehealth expansion to address provider shortages while educating members regarding the availability of these services. FEHB Carriers must also ensure mental health parity exists for our members seeking mental health services. **The following items must be addressed in your proposal:**

1. Describe efforts to provide member and provider education about the availability of mental health services and how to access such services. Describe additional efforts to destigmatize mental health disorders and services.
2. Describe efforts to leverage ongoing telehealth expansion to address provider shortages within mental and behavioral health including member education regarding the availability of these services.

3. A summary of your evaluation of provider shortage areas and mental health provider network adequacy. What changes have been made to improve availability and access to mental health services?
4. Describe efforts to ensure integration of mental and behavioral health into primary care. Include a description of efforts to ensure coordination of care especially during transitions of care.
5. Carriers are reminded that parity requirements in the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended, apply to both quantitative treatment limitations (QTLs) such as cost sharing, visit limits, or deductibles, and to nonquantitative treatment limitations (NQTLs), such as medical necessity criteria or formulary design for prescription drugs. Please describe ongoing efforts to ensure this parity exists in our member experiences.[1]

Substance Use Disorder Services

OPM encourages FEHB Carriers to approach access and reimbursement for SUD services through strong integration with necessary mental health and primary care services. **Proposals are also expected to explain efforts at stigma reduction through provider and member education.**

1. Describe your education outreach to FEHB members and providers to reduce stigma associated with SUD services.
2. Please describe efforts including reimbursement models aimed at increasing the use of integrated mental health, behavioral health and primary care or other collaborative team-based models that address mental and behavioral health. Also, describe efforts to ensure SUD and mental health care coordination.

FEHB Carriers are also encouraged to pay attention to and have programs in place to address special populations such as pregnant women and rural populations that lack adequate providers and adolescent and youth who may

[1] See section 2726 of the Public Health Service Act, as amended by the Consolidated Appropriations Act, 2021. See also https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

require treatment for SUD. **Please include the following responses in your proposal:**

1. Describe any evidence-based targeted programs that you have in place to support the following populations: pregnant women, adolescent and youth, and rural populations.
2. Rural populations often face numerous barriers to treatment such as lack of appropriate providers or treatment centers, smaller social networks and greater transportation distances to treatment.[2] Expanding SUD telehealth services, encouraging the delivery of coordinated care leveraging telehealth technologies and the use of integrated behavioral health and primary care can provide comprehensive, multidisciplinary services to more patients. Describe efforts put in place to remove or lower barriers to care for members located in rural areas.
3. Pregnant women with SUD require a comprehensive, multi-faceted coordinated treatment approach to care.[3] Proposals must include a description of efforts at engagement, affordability, and access to treatment, in order to provide comprehensive, multi-faceted care of pregnant women with substance use disorders. Describe efforts aimed at encouraging coordinated prenatal care and substance use treatment.
4. Youth and adolescents have different needs and treatment and intervention approaches will differ from that of adults. Proposals must include a description of efforts at engagement, affordability, and access to treatment, in order to provide comprehensive, multi-faceted care of youth and adolescents with substance use disorders. Describe efforts at ensuring a network of providers who are trained

[2] Rigg, K. K., S. M. Monnat, and M. N. Chavez. 2018. Opioid-related mortality in rural America: Geographic heterogeneity and intervention strategies. International Journal of Drug Policy 57, 119-129. https://doi.org/10.1016/j.drugpo.2018.04.011.
[3] Substance Abuse and Mental Health Services Administration. 2016. A collaborative approach to the treatment of pregnant women with opioid use disorders [HHS Publication No. SMA 16-4978]. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Available at: https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf.

in taking care of youth and adolescents. What programs do you have in place to provide therapy and recovery support for youth and adolescents?

Addressing the Opioid Epidemic

Carrier Letter 2021-03 highlights OPM's expectation that all FEHB Carriers will strengthen their efforts to prevent and treat opioid use disorders (OUDs) and have in place ongoing prevention, treatment, and support strategies for addressing and reducing opioid-involved overdose deaths. Additional information to be included in your proposal is provided below.

FEHB Carriers should describe their approach to ensuring an ongoing comprehensive, multi-faceted prevention, treatment, and support approach for addressing and reducing the effect of the ongoing opioid crisis.
Proposals must also include the following:

1. Prevention strategies in place to reduce the incidence of prescription opioid overuse or misuse including member and provider education, drug disposal strategies etc.
2. Efforts to ensure evidence-based prescribing practices.
3. Initiatives to ensure the availability of and access to naloxone.
4. Efforts to expand access to medication-assisted treatment (MAT) and services.
5. Efforts to expand access to non-opioid pain medications and non-pharmacologic benefits for pain management.
6. Initiatives addressing polysubstance use and co-morbidities.
7. Efforts to promote a comprehensive, coordinated care approach that includes medical, pharmacy, behavioral and mental health to provide care coordination and recovery support to members with OUD.
8. Recovery and support resources in place to ensure that OUD treatment gains are maintained.

Prescription Prior Authorization

Carrier Letter 2021-03 outlines OPM's expectation that all FEHB Carriers will strengthen their efforts to adopt electronic tools that can streamline the prior authorization (PA) process. FEHB Carriers must have in place a process to review all expiring PAs and must notify members a minimum of 45 days before the expiration of a PA for a maintenance medication. PAs used in this context are any FEHB Carrier processes that are employed to ensure that a prescribed medication is appropriate and medically necessary. **Proposals should address the following information below:**

1. Describe how you ensure that the PA criteria and decisions are evidence-based, timely, transparent and collaborative with involved stakeholders (providers, pharmacists and patients).Describe how PA criteria are reviewed, how often and what clinical and data analytic tools are used. How are changes to PA criteria communicated?
2. Do you differentiate the application of PAs based on provider performance on quality measures, adherence to evidence-based medicine or other contractual agreements? If so, please describe.
3. Describe efforts at promoting the use of electronic prior authorization (e-PA) tools that use existing national standard transactions for electronic PAs, such as National Council for Prescription Drug Programs (NCPDP) standards. Are these tools embedded within the provider electronic health record (EHR) or is this is a standalone tool that prescribers can access? Describe efforts to increase efficiency and reduce administrative burden associated with PAs and other utilization management edits. Include a description of efforts taken to reduce paper records and reduce the use of faxes to exchange clinical information between the health plan/pharmacy benefit manager (PBM), pharmacies and providers?
4. Describe the processes to review all expiring PAs. Include selection criteria, timelines, member and provider notification processes and templates (if applicable). Indicate if you are planning to put in place or already have a process to automatically renew PAs. Include criteria that must be met to qualify for an automatic PA renewal.

5. Continuity of patient care is extremely important especially for members on stable chronic therapies. Describe processes you have in place to minimize disruptions to therapy and ensure continuity of care during transitions.

Surprise Billing

The Consolidated Appropriations Act, 2021 (Public Law 116-260) was enacted on December 27, 2020. This law impacts the FEHB Program in multiple ways including provisions designed to curb surprise billing, promote parity in mental health and substance use disorder (SUD) benefits, and increase transparency. OPM will take necessary actions to ensure compliance with the new law and will be providing FEHB-specific guidance to carriers in the near future. We recommend Carriers review the law and begin preparations for compliance.

Transparency in Coverage

Carriers are now required to follow the Transparency in Coverage final rule, which was published by Departments of Health and Human Services, Labor, and the Treasury (collectively, the "Departments") on November 12, 2020. **OPM asks FEHB Carriers to describe in their proposals their timeline for coming into compliance with the rule, and how they plan to disclose:**

1. Personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request. Carriers must make such information available for an initial list of 500 items and services[4] identified by the Departments effective January 1, 2023. Carriers must make cost-sharing information available for all other items and services effective January 1, 2024.

[4] See Table 1 of the Departments' rule, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf#page=93.

2. Three separate machine-readable files must include detailed pricing information. The first file must show negotiated rates for all covered items and services between the plan and in-network providers. The second file must show both the historical payments to, and billed charges from, out-of-network providers. The third file must detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan at the pharmacy location level. Carriers must display these data files in a standardized format and provide monthly updates, beginning on January 1, 2022.

Addressing Low Value Care (USPSTF Ratings)

A list of current services with a grade of "D" from the US Preventive Services Task Force (USPSTF) is listed below. FEHB Carriers should carefully note the USPSTF ratings. Preventive care services should be restricted to services with a rating of "C" or higher. Services with a rating of "D" must not be covered as preventive care. FEHB Carriers should also check the recommendations listed on the USPSTF website at least quarterly on an ongoing basis for any additions or deletions to the list of "D" ratings and act on recommendations as appropriate.

United States Preventive Services Task Force – Recommendations Rated D (Accessed November 2020)

Status	Type	Year	Topic Name	Age Group	Grade	Category
Published	Screening	2020	Bacterial Vaginosis in Pregnant Persons to Prevent Preterm Delivery: Screening	Adolescent; Adult	D, I	Infectious Diseases, Obstetric and Gynecologic Conditions
Published	Screening	2019	Abdominal Aortic Aneurysm: Screening	Adult, Senior	B, C, D, I	Cardiovascular Disorders (Heart and Vascular Diseases)

Status	Type	Year	Topic Name	Age Group	Grade	Category
Published	Screening	2019	Asymptomatic Bacteriuria in Adults: Screening	Adolescent, Adult, Senior	B, D	Infectious Diseases, Obstetric and Gynecologic Conditions
Published	Preventive medication	2019	Breast Cancer: Medication Use to Reduce Risk	Adult, Senior	B, D	Cancer
Published	Counseling, screening	2019	BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing	Adult, Senior	B, D	Cancer
Published	Screening	2019	Pancreatic Cancer: Screening	Adult, Senior	D	Cancer
Published	Screening	2018	Cervical Cancer: Screening	Adolescent, Adult, Senior	A, D	Cancer
Published	Screening	2018	Cardiovascular Disease Risk: Screening with Electrocardiography	Adult, Senior	D, I	Cardiovascular Disorders (Heart and Vascular Diseases)
Published	Screening	2018	Prostate Cancer: Screening	Adult, Senior	C, D	Cancer

Status	Type	Year	Topic Name	Age Group	Grade	Category
Published	Preventive medication	2018	Vitamin D, Calcium, or Combined Supplementation for the Primary Prevention of Fractures in Community-Dwelling Adults: Preventive Medication	Adult, Senior	D, I	Metabolic, nutritional, and Endocrine Conditions
Published	Counseling, Preventive medication	2018	Falls Prevention in Community-Dwelling Older Adults: Interventions	Senior	B, C, D	Injury Prevention, Musculoskeletal Disorders
Published	Screening	2018	Ovarian Cancer: Screening	Adult, Senior	D	Cancer
Published	Preventive medication	2017	Hormone Therapy in Postmenopausal Women: Primary Prevention of Chronic Conditions	Adult, Senior	D	Metabolic, nutritional, and Endocrine Conditions, Obstetric and Gynecologic Conditions
Published	Screening	2017	Thyroid Cancer: Screening	Adult, Senior	D	Cancer
Published	Screening	2016	Genital Herpes Infection: Serologic Screening	Adolescent, Adult	D	Infectious Diseases
Published	Screening	2016	Chronic Obstructive Pulmonary Disease: Screening	Adult, Senior	D	Cardiovascular Disorders (Heart and Vascular Diseases)

Status	Type	Year	Topic Name	Age Group	Grade	Category
Published	Preventive medication	2014	Vitamin Supplementation to Prevent Cancer and CVD: Preventive Medication	Adult, Senior	D, I	Cancer, Cardiovascular Disorders (Heart and Vascular Diseases)
Published	Screening	2014	Carotid Artery Stenosis: Screening	Adult, Senior	D	Cardiovascular Disorders (Heart and Vascular Diseases)
Published	Screening	2011	Testicular Cancer: Screening	Adolescent, Adult, Senior	D	Cancer

Benefits for Certain Medical Foods

OPM is encouraging FEHB Carriers to provide coverage for medical foods exclusive of "grocery items." We intend this to mean that coverage should be provided for certain foods used to treat Inborn Errors of Metabolism (IEM), sometimes defined as a heritable disorder of biochemistry. We do not intend to encourage coverage for special food items which can be routinely obtained in grocery stores at the same or at a minimally higher cost than similar items (e.g., gluten-free cookies, gluten-free pasta).

OPM believes that the current medical consensus supports the need for certain medical foods throughout the lifespan for optimal neurological health.

OPM is especially cognizant of the fact that pregnant women with Phenylketonuria (PKU) who do not receive an appropriate diet during their pregnancy may have children unaffected by PKU, who nevertheless have birth defects related to the metabolically abnormal uterine environment.

Please indicate your coverage level in your proposal, including any annual limits on coverage for certain medical foods.

Coverage for Fertility Preservation in FEHB Members with the Possibility of Iatrogenic Infertility

OPM encourages FEHB Carriers to offer coverage for fertility preservation in members undergoing medical therapies that are likely to result in infertility. In most cases, these will be members receiving therapy for cancer, but many involve the receipt of cytotoxic therapies for rheumatological or other medical conditions. They may also involve surgical or radiation therapies where there is a risk of impairment to the ovaries or testicles.

Coverage should not include long-term storage of cryopreserved gametes which is an ongoing expense related to cryopreservation. FEHB Carriers have discretion to determine the length of time that storage is covered and how many attempts at harvesting gametes are covered.

OPM is not suggesting that fertilization of a cryopreserved egg (or the use of cryopreserved sperm to fertilize an egg) should be part of this coverage. **Your proposals should comply with state guidelines and clearly indicate benefit limitations and exclusions.**

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

Gender Affirming Care and Services

Gender Affirming Care and Services is a rapidly evolving topic as well as an important Biden-Harris Administration priority. As such, it will be a topic of significant focus for the Federal Employees Health Benefits Program (FEHB) and FEHB Carriers in the coming months and years.

First, we want to re-emphasize that our prior guidance remains applicable. Carrier Letter 2015-12 states that effective January 1, 2016, no Carrier participating in the FEHB may have a general exclusion of services, drugs or supplies related the treatment of gender dysphoria. The letter also withdrew

the option for Carriers to continue to maintain the General Exclusion language in Section 6 of their plan brochures.

FEHB Carriers must provide benefits for all covered services when medically necessary for the covered member, including those who are transgender. FEHB Carriers must be sensitive to the fact that every individual with gender dysphoria has unique needs and the types of medically necessary services that the individual may require will be specific to that individual.

Please review your benefits to ensure they reflect the medically necessary care that your plan covers for persons with a gender dysphoria diagnosis.

Your brochure language must specifically identify covered services, requirements for receiving care (such as pre-authorizations, diagnosis(es), age requirements for treatment, presurgical requirements if pursuing gender reassignment surgery), and any lifetime limitations. You must also include a category in your index on gender affirming care services, which clearly articulates where to find information in your brochure on covered services.

We also expect you will review your formularies to ensure equitable and inclusive access. Carrier Letter 2021-02 describes our expectations for a non-discriminatory formulary design that prevents selection bias or discrimination and facilitates appropriate access to affordable prescription drug choices. A non-discriminatory formulary design does not have cost or access barriers imposed by disease or condition.

Acceptable standards of care can be found through the World Professional Association of Transgender Health (WPATH) and the Endocrine Society.

Additionally, we ask that you review all your claims processing edits to ensure you are not improperly denying preventive services for transgender individuals. See Carrier Letter 2011-12 for examples of such erroneous edits.

We further request that Carriers consider:

- Conducting a comprehensive review of all written materials that are member-facing to include your website, downloadable materials, letters, and explanation of benefits (EOBs) and update as needed with inclusive language pertaining to LGBTQ+ members. For example, instead of “pregnant woman,” consider using “pregnant person” or “pregnant individual” and including LGBTQ+ when listing special populations.
- Capturing member gender identity and gender pronoun preferences through member communication.
- Ensuring that your provider directory(ies) include information on whether a provider offers gender affirming care as part of their practice.
- Providing the option for members to use a Care Coordinator to assist and support persons seeking gender affirming services.
- Offering additional training to your customer service and support employees to ensure that they inquire and correctly use a person’s name and gender pronouns.
- We strongly encourage Carriers to be as clear as possible in each plan brochure regarding which gender affirming care services are covered by their plans and the associated costs to the member.
- We appreciate the significant movement in providing gender affirming care and services within our program. As this is an evolving field of care and a Biden-Harris Administration priority, we expect to provide additional information and guidance at a later date.

Organ/Tissue Transplants

As in past years, we are providing guidance on organ/tissue transplants for 2022. When you determine that a transplant service is no longer experimental, but is medically accepted, 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 tables are included in the Organ/Tissue Transplants and Diagnoses worksheet:

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

High Value Services/Value-Based Healthcare

Value-Based Insurance Design (VBID) refers to structuring member cost-sharing and other health plan design elements to encourage the use of high-value clinical services that have the greatest potential to positively impact member health. Carrier Letter 2017-01 used decreasing or eliminating patient cost sharing to improve members' access and appropriate use of effective drugs as an example of VBID. We also know that these types of interventions can also improve the quality of care and reduce the cost of care for members with chronic diseases.

High value services,[5] are those that most people will benefit from and have a strong clinical evidence base demonstrating appropriate care. The high value services FEHB Carriers should consider offering at little or no cost are:

- Blood pressure monitors (hypertension)
- Glucometers and testing strips (diabetes)
- Hemoglobin a1c testing (diabetes)
- Low Density Lipoprotein (LDL) testing (hyperlipidemia)
- International Normalized Ratio (INR) testing (hypercoagulability)
- Peak flow meters (asthma)
- Cardiac rehabilitation
- Pulmonary rehabilitation

During the COVID-19 pandemic, cardiovascular health remains a top public health priority – with heart disease and stroke continuing to be leading causes of death in the U.S. Many of the listed high value services have a direct impact on cardiovascular health. According to updated guidance from

[5] https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf, page 73; https://vbidcenter.org/initiatives/vbid-x/.

the U.S. Preventive Services Task Force (USPSTF), people at risk for cardiovascular disease (CVD) should receive behavioral counseling to promote a healthy diet and physical activity.[6] This updated recommendation removes the prerequisite that the adult patient is overweight or obese to be eligible for this preventive service. The updated recommendation targets groups not already covered by an existing USPSTF recommendation: adults with known hypertension or elevated blood pressure, elevated lipid levels or dyslipidemia, and mixed or multiple risk factors (e.g., metabolic syndrome or estimated 10-year CVD risk of ≥7.5%).

Hypertension remains the foremost modifiable indicator of an individual's risk for having an acute cardiovascular event. The *2020 Surgeon General's Call to Action to Control Hypertension* seeks to avert the negative health effects of hypertension by identifying evidence-based interventions that can be implemented, adapted, and expanded in diverse settings across the United States and promote health equity. The Call to Action provides specific actions that health plans can take to help beneficiaries achieve blood pressure control.

Scientific evidence shows that self-measured blood pressure (SMBP) monitoring, also known as home blood pressure monitoring, plus clinical support helps people with hypertension lower their blood pressure and improve control.[7,8] SMBP monitoring is the regular measurement of blood pressure by the patient outside the clinical setting, either at home or elsewhere.

To align with the evidence and support the national initiative on blood pressure control, FEHB Carriers are strongly encouraged to offer coverage of

[6] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd.

[7] Uhlig K, Patel K, Ip S, et al. Self-measured blood pressure monitoring in the management of hypertension: a systematic review and meta-analysis. Ann Intern Med. 2013 Aug 6;159(3):185-94.

[8] Shimbo DS, Artinian NT, Basile JN, et al. Self-Measured Blood Pressure Monitoring at Home: A Joint Policy Statement From the American Heart Association and American Medical Association. Circulation. 2020;142:e42-e63. https://www.ahajournals.org/doi/10.1161/CIR.0000000000000803.

an automatic, upper arm home blood pressure monitor and reimburse for clinician time to train patients to use their device or interpret patient-generated blood pressure readings.[9]

- Provide validated home blood pressure devices at no cost or low-cost sharing to their members for screening and management purposes (recommended devices can be found at U.S. Blood Pressure Validated Device Listing or Blood Pressure Devices Recommended by Hypertension Canada).
- Provide one-time reimbursement for staff to provide patient education/training (Current Procedural Terminology (CPT®) code 99473).[10]
- Provide monthly reimbursement to physicians and other qualified health care professionals to receive, process, and interpret patient readings and communicate back a care plan (CPT® code 99474).[11]

For more information on the other high value services listed for consideration, please go to the Center for Value-Based Insurance Design. **Provide an explanation in your proposal for how you will address high value services for chronic conditions.** As a reminder, OPM's Plan Performance Assessment includes measures pertaining to Controlling High Blood Pressure, Comprehensive Diabetes Care (both high priority measures), Asthma Medication Ratio, and Statin Therapy for Patients with Cardiovascular Disease.

[9] https://chronicdisease.org/resource/resmgr/website-2020/consultants/cvh/smbp/smbp_coverage_topline_analys.pdf.
[10] American Medical Association. SMBP CPT® coding. 2020. https://www.ama-assn.org/system/files/2020-06/smbp-cpt-coding.pdf.
[11] Ibid.

Medication Management Programs

Carrier Letter 2021-02 sets forth OPM's expectation that all FEHB Carriers have a medication management program to optimize the medication needs of the FEHB population. The program must address transitions of care, polypharmacy, complex medication management, including medication appropriateness, effectiveness, and safety.

An example of an evidence-based strategy for improving hypertension control is Medication Management. Services provided by a pharmacist to manage medications over multiple visits have been found to improve rates of hypertension control among patients in various settings including outpatient care clinics[12] community pharmacies, and health systems' employee pharmacy.[13] The core elements of Medication Management services include medication therapy review, personal medication record, medication-related action plan, an intervention and/or referral, and documentation and follow-up.[14] There is evidence for improved hypertension control in Medication Management models that involve pharmacists providing recommendations to prescribers and pharmacists independently modifying

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[12]

- Rodis JL, Sevin A, Awad MH, et al. Improving Chronic Disease Outcomes Through Medication Therapy Management in Federally Qualified Health Centers. J Prim Care Community Health. 2017;8(4):324-331. doi:10.1177/2150131917701797.
- Koenigsfeld CF, Horning KK, Logemann CD, Schmidt GA. Medication therapy management in the primary care setting: a pharmacist-based pay-for-performance project. J Pharm Pract. 2012;25(1):89-95. doi:10.1177/0897190011416671.
- Hirsch JD, Steers N, Adler DS, et al. Primary care-based, pharmacist-physician collaborative medication-therapy management of hypertension: a randomized, pragmatic trial. Clin Ther. 2014;36(9):1244-1254. doi:10.1016/j.clinthera.2014.06.030.
- Isetts BJ, Schondelmeyer SW, Artz MB, et al. Clinical and economic outcomes of medication therapy management services: the Minnesota experience. J Am Pharm Assoc (2003). 2008;48(2):203-211. doi:10.1331/JAPhA.2008.07108.
- Bunting BA, Smith BH, Sutherland SE. The Asheville Project: clinical and economic outcomes of a community-based long-term medication therapy management program for hypertension and dyslipidemia. J Am Pharm Assoc (2003). 2008;48(1):23-31. doi:10.1331/JAPhA.2008.07140.

[13] Wittayanukorn S, Westrick SC, Hansen RA, et al. Evaluation of medication therapy management services for patients with cardiovascular disease in a self-insured employer health plan. J Manag Care Pharm. 2013;19(5):385-395. doi:10.18553/jmcp.2013.19.5.385.

[14] Burns, Anne. "Medication therapy management in pharmacy practice: core elements of an MTM service model (version 2.0)." Journal of the American Pharmacists Association 48, no. 3. 2008: 341-353.

medication therapy within their scope of practice. These types of tailored pharmacy interventions have also been found to be cost effective.[15]

Please describe in your proposals how the Medication Management program you have in place meets the goals outlined above. Describe how members are selected, how members and providers are contacted and how outcomes are measured.

Carrier Letter 2017-01 encouraged FEHB Carriers to offer Value-Based Insurance Design (VBID) which refers to structuring member cost-sharing and other health plan design elements to encourage the use of high-value clinical services that have the greatest potential to positively impact member health. These interventions can also improve the quality of care and reduce the cost of care for members with chronic diseases. An example of VBID is decreasing or eliminating patient cost sharing to improve members' access and appropriate use of effective drugs. High value services[16] are those that most people will benefit from and have a strong clinical evidence base demonstrating appropriate care. The high value services FEHB Carriers should consider offering under the pharmacy benefit at little or no cost are:

- ACE Inhibitors
- Anti-depressants
- Anti-psychotics
- Anti-thrombotics/Anti-coagulants
- Beta-blockers
- Glucose Lowering agents
- Inhaled corticosteroids

Please describe in your proposals any medications including drug classes that have been identified as providing high value services that are offered at lower or zero cost to FEHB members. Do not

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[15] Guide to Community Preventive Services. Economic Evidence Supports Pharmacy-Based Interventions for Cardiovascular Disease Prevention. https://www.thecommunityguide.org/content/economic-evidence-supports-pharmacy-based-interventions-cardiovascular-disease-prevention. Accessed August 27, 2020.

[16] https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf page 73; https://vbidcenter.org/initiatives/vbid-x/.

include medications listed on the ACA Preventive Care Drug List or as USPSTF 'A' or 'B' recommended medications.

Antibiotic Stewardship
Appropriate antibiotic stewardship is critical to the effective functioning of the entire healthcare continuum. OPM continues to urge FEHB Carriers to be diligent in reviewing this aspect of performance when selecting network providers. The Healthcare Effectiveness Data and Information Set (HEDIS®) measure A*voidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)* has been scored under the Plan Performance Measure Set since 2018. Carrier Letter 2017-01 offered the Centers for Disease Control and Prevention's (CDC) Core Elements of Outpatient Antibiotic Stewardship and The Joint Commission and Medicare Conditions of Participation (CoP) standards for effective antibiotic stewardship programs to use when making contracting decisions with hospitals and providers. The premise of this guidance is to assure FEHB Carriers contracting with hospitals that are accredited by The Joint Commission and receiving Medicare funding meet the minimum level of agreement with the CoP as described in Title 42 CFR 482.42.

Recognizing our role in reducing the development and transmission of hospital acquired infections (HAIs) and antibiotic resistant organisms as well as implementing best practices for improving antibiotic use where applicable, FEHB Carriers are strongly encouraged 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, by using reports that show provider antibiotic prescribing patterns

compared to peers to reduce unnecessary prescribing (i.e., post-prescription audit and feedback).[17]

- Support patient education efforts. Choosing Wisely's patient resources may help increase patient literacy and knowledge about the risks of inappropriate antibiotic use.

During the 2019 FEHB Carrier Conference, a representative from the Centers for Disease Control and Prevention (CDC) presented the case for antibiotics stewardship and invited Carriers to collaboration and acceleration opportunities with the CDC's 6|18 Initiative. Examples of the highlighted strategies was to incentivize providers to follow CDC's Core Elements of Outpatient Antibiotic Stewardship through audit/feedback programs or physician payment incentives for improved HEDIS® performance. These strategies were again presented during the June 2019 FEHB Best Practices Webinar.

The audit/feedback program included providing example letters that health plans could customize and send to outpatient providers to inform them of their antibiotic prescribing habits in comparison to their peers. These letters are based on the 2019 HEDIS® Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis measure and the 2020 HEDIS® Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure, which was expanded to include patients three months and older and bronchiolitis infections. The letters also offered actions that providers could take to reduce unnecessary antibiotic prescribing and additional educational resources. The 2020 Automated Data Collection (ADC) indicated few FEHB Carriers are using this best practice and the 2020 Plan Performance Assessment (PPA) reporting cycle, reflecting care delivered in 2019, showed an increase in the number of who were among the worst performers compared to all other commercial insurers. Given the urgency of the topic, we believe Carrier attention to this issue is imperative.

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[17] Linder, J.A. et al. (2017). *Effects of behavioral interventions on inappropriate antibiotic prescribing in primary care 12 months after stopping interventions. JAMA*, doi:10.1001/jama.2017.11152.

To assist in the implementation of an audit/feedback strategy, visit CDC's Core Elements of Outpatient Antibiotic Stewardship.

Resources for Health Plans are under Tracking and Reporting:

- Fact Sheet: Improving outpatient antibiotic use through audit and feedback
- Example Letter: Providing feedback on quality measure performance for the 2019 Healthcare Effectiveness Data and Information Set (HEDIS) Measure Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Example Letter: Providing feedback on quality measure performance for the 2020 Healthcare Effectiveness Data and Information Set (HEDIS) Measure Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

The *Implementation of Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals* and other related tools released in 2017 also provides additional perspective on the importance of antibiotic stewardship programs and guidance on practical strategies to implement antibiotic stewardship programs in small and critical access hospitals that plans can consider in their own systems.

In your proposals, please describe what evidence-based strategies are in place and will be implemented to promote antibiotic stewardship.

Tobacco Cessation

Carrier Letters 2019-01, 2019-05, 2020-01 and 2020-03 stressed the importance of tobacco cessation as a continuing public health priority, and provided FEHB Carriers with multiple supports to invigorate messaging about the FEHB tobacco cessation benefit to providers and members. We remain concerned about the various threats that tobacco product use pose to member health, including the high prevalence of e-cigarette use among youth,[18] the increased risk for severe illness from COVID-19 among adults who smoke,[19] and the prevalence of smoking-attributable diseases among adults such as cancer, heart disease, lung disease, and type 2 diabetes.

As described in the referenced Carrier Letters recommendations pertaining to tobacco smoking cessation, pharmacotherapy and behavioral counseling interventions increase the likelihood of successfully quitting smoking, particularly when used in combination. While improvements have been made, the evidence-based approach of combining pharmacotherapy and behavioral counseling continues to be one of the least reported strategies by Carriers. The latest update from the U.S. Preventive Services Task Force (USPSTF) on *Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons* released January 19, 2021 reiterates the 2015 clinical guidance and reminds us that providing behavioral counseling interventions to support cessation efforts of pregnant persons who use tobacco is strongly recommended.

Recognizing that pharmacists can play a pivotal role in bridging the gap by providing tobacco cessation services, including patient tobacco use screening, counseling, authorized prescribing where permissible, and medication management, we urge FEHB Carriers to seek ways to integrate pharmacists into tobacco cessation services. All pharmacists can recommend

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[18] https://www.drugabuse.gov/news-events/news-releases/2020/12/study-surge-of-teen-vaping-levels-off-but-remains-high-as-of-early-2020 and https://www.drugabuse.gov/drug-topics/trends-statistics/monitoring-future/monitoring-future-study-trends-in-prevalence-various-drugs;
https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e1.htm?s_cid=mm6937e1_w.

[19] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions.

over-the-counter tobacco cessation products and refer individuals to quitlines (such as 1-800-QUIT-NOW) and local prescribers for additional support. Additionally, more states are expanding pharmacists' scope of practice to prescribe tobacco cessation therapies through population-based collaborative practice agreements, template protocols, statewide protocols, or independent prescribing through autonomous prescribing models for all FDA-approved tobacco cessation medications, including nicotine replacement therapy.

A community-based pharmacy's appointment-based model (ABM) provides an operating framework for tobacco cessation services to be delivered efficiently and effectively[20] within the current pharmacy workflow. However, reimbursement of time is a key barrier to the routine delivery of tobacco cessation services in the pharmacy so reimbursement models should support the time that the pharmacy team spends delivering the services to be sustainable. Until these reimbursement models are better established, pharmacy costs may be offset by increased prescription fills or over-the-counter (OTC) sales of tobacco cessation medications and the potential to increase immunization delivery, such as the pneumococcal vaccine. A robust population health management approach for integrating the pharmacist into tobacco cessation efforts is described in Practice Guidance For Expanding Pharmacy-Based Tobacco Cessation Services Within The Appointment-Based Model.

For awareness, efforts to reach youth and young adults continue to expand. For example, the Truth Initiative's, *This is Quitting*, remains a powerful tool that supports youth and young adults seeking to quit e-cigarette use, as well as providing resources for parents of youth and young adults who use e-cigarettes.

[20] https://www.pharmacist.com/sites/default/files/files/Practice_Guidance_Tobacco_Cessation.pdf or American Pharmacists Association. *Practice Guidance for Expanding Pharmacy-Based Tobacco Cessation Services Within the Appointment-Based Model.* https://www.pharmacist.com/ABM/resources.

As a reminder, the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) offer several website syndication opportunities on topics such as chronic conditions and tobacco cessation that eliminate the need for duplication of effort and manual updates. For example, the CDC recently released a page dedicated to helping individuals who smoke better understand quit-smoking medicines and the importance of counseling. To syndicate a CDC page, select the orange syndication button at the top right of the page. It will take you to the CDC's Public Health Media Library, which includes a preview of the page along with the embed code. To access the embed code, click the "Get Embed Code" tab and follow the prompts.

In your proposals, **please explain how you will seek to integrate pharmacists into your tobacco cessation strategy and expand the availability of tobacco use education and prevention resources** to FEHB members.

Preventive Services

Carriers are reminded they must cover items and services that are integral to a recommended preventive service, regardless of how the related item or service is billed. Certain preventive services involve screenings for the presence of diabetes or a variety of sexually transmitted infections, for example. These recommended screenings, typically performed by laboratories, cannot be conducted without first collecting specimens. Carriers must cover both the specimen collection and the recommended preventive service. Carrier Letter 2019-01 provides additional examples of these "full scope" of preventive services and Carrier Letter 2020-19 reiterates this position.

There are notable changes to previous recommendations as well as new recommendations released in 2020 that require review and compliance. Also noted in Carrier Letter 2019-01 is the request for Carriers to adopt recommendations earlier as appropriate. In March 2021, the USPSTF updated its 2013 guidance on lung cancer screening. The new recommendation calls for lung cancer screening using low-dose computed

tomography (CT) every year for adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. The expectation is that this update captures the benefits of early detection and treatment, especially for women and Black persons. **OPM expects to see language incorporating this updated recommendation in your 2022 PY proposals.**

Please review updates to preventive services endorsed by the below listed entities:

- All services recommended by the United States Preventive Services Task Force (USPSTF) with an “A” or “B” rating. These include, but are not limited to, screenings, testing, preventive care, and certain medications.
- Adult and child immunizations approved by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP).
- Pediatric screenings and preventive care endorsed by the American Academy of Pediatrics Bright Futures Guidelines.
- Women’s Preventive Services recommended in guidelines issued by the Health Resources and Services Administration (HRSA), along with contraceptive coverage mandated by section 726 of the Consolidated Appropriations Act, 2018 (P.L. 115-141) or later renewals.

OPM expects FEHB Carriers to cover all endorsed preventive services with no cost sharing when received from an in-network provider. FEHB Carriers are reminded that as stated in Carrier Letter 2020-19, FEHB Carriers are to provide out-of-network coverage for FDA-authorized or approved COVID-19 vaccines and their administration without cost sharing. “No cost sharing” means that services are not subject to copayments, coinsurance, or deductibles.

Summary of Benefits and Coverage

FEHB Carriers will continue to provide a Summary of Benefits and Coverage (SBC) based on standards developed by the Departments of Labor, Health and Human Services, and the Treasury.

Coordination of Benefits for *All* HMOs

When FEHB Carriers pay secondary Coordination of Benefits (COB) claims, including those with Medicare, they pay the lesser of their allowance or the difference between their allowance and what is paid by the primary plan. You may continue to charge the member copayments or coinsurance on secondary COB claims. If your benefit design includes coinsurance, it must be based on the remaining charge, not on your allowance.

In the following example Medicare is primary and the FEHB Carrier is secondary. The plan design requires the member to pay 10% coinsurance.

- Date of Service 02/10/21 billed: $10,000
- Medicare allowance: $9,000
- Medicare payment: $7,200 (80% of allowance)
- Balance after Medicare payment: $1,800
- Member responsibility: $1,800 x 10% = $180
- Plan pays: $1,800 x 90% = $1,620

If your brochure language does not currently describe this process correctly, please work with your Health Insurance Specialist to ensure that your 2022 brochure does so.

Part V: Attachments

The following attachments must be completed and returned to OPM as part of your Plan Year 2022 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 Official	Yes	Yes	Yes
Attachment III: Organ/Tissue Transplants and Diagnoses	Yes	Yes	Yes
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	No
Attachment VI: 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 2022 benefit and rate proposal.

Not all attachments are applicable to each Carrier. Please refer to the Attachments section of the 2022 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 2022 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 accepted 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

By:

______________________________________ ________________

Signature of Contracting Official Date

______________________________________ ________________

Typed Name and Title Telephone

______________________________________ ________________

Email Fax

Attachment III: 2022 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 transplants 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.

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. Blood or Marrow Stem Cell Transplants: Not subject to medical necessity. Plan’s denial is limited to indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, staging, or the diagnosis.
   - Allogeneic transplants for:

    - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
    - Hodgkin’s lymphoma – relapsed
    - Non-Hodgkin’s lymphoma – relapsed
    - Acute myeloid leukemia
    - Myeloproliferative Disorders (MPDs)
    - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)
    - Hemoglobinopathy
    - Marrow Failure and Related Disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia)
    - Myelodysplasia/Myelodysplastic Syndromes
    - Paroxysmal Nocturnal Hemoglobinuria
    - Severe combined immunodeficiency
    - Severe or very 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 (e.g., Wiskott-Aldrich syndrome)
- Autologous transplants for:
    - Multiple myeloma
    - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell 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
- Advanced Ewing sarcoma
- Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)
- Advanced Childhood kidney cancers

V. Mini-transplants performed in a Clinical Trial Setting (nonmyeloablative, reduced intensity conditioning for 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

Recommended for Coverage – Transplants Under Clinical Trials

Blood or Marrow Stem Cell Transplants	**Does your plan cover this transplant for 2022? Yes**	**Does your plan cover this transplant for 2022? No**
Allogenic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		

Blood or Marrow Stem Cell Transplants	**Does your plan cover this transplant for 2022? Yes**	**Does your plan cover this transplant for 2022? No**
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		
Ovarian cancer		

Blood or Marrow Stem Cell Transplants	**Does your plan cover this transplant for 2022? Yes**	**Does your plan cover this transplant for 2022? No**
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)		

Recommended for Coverage – Rare Organ/Tissue Transplant

Solid Organ Transplants	**Does your plan cover this transplant for 2022? Yes**	**Does your plan cover this transplant for 2022? No**
Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann’s syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler's syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing’s sarcoma		

Solid Organ Transplants	**Does your plan cover this transplant for 2022? Yes**	**Does your plan cover this transplant for 2022? No**
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).

2021 Formularies

FFS and Returning HMOs must provide a copy of the full 2021 formulary as well as document the relevant formulary tier definitions and cost share assigned using the formulary template included as an attachment "2021 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, 2021.

2022 Formularies

New HMOs must submit a 2022 Drug Formulary Template to OPM. **FFS and Returning HMOs** changing formularies or moving to new formularies in 2022 must submit a 2022 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, 2021.

File Naming Convention

Please upload your Drug Formulary Template. Use the following file naming convention for the formulary file(s) you submit: **Formulary2021_ZZZ**, (or **Formulary2022_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., **Formulary2021_ZZZ_a, Formulary2021_ZZZ_b**, etc. or **Formulary2022_ZZZ_a, Formulary2022_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 Vale (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 2022.

   Exception 2: A Carrier may propose benefit enhancements that are not cost neutral in the current year within a single plan options, 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: As indicated in Carrier Letter 2021-03, OPM will consider a waiver to the cost neutrality requirement for proposals of coverage for benefits for certain medical foods and coverage for fertility preservation in FEHB members with the possibility of iatrogenic

infertility.

Exception 5: OPM will consider a waiver to cost neutrality for high value services FEHB Carriers offer under the pharmacy benefit as described in Medication Management Programs.

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 2022? _________________________________
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 2022? _________________________________
   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 Vale (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 2022.

   Exception 2: A Carrier may propose benefit enhancements that are not cost neutral in the current year within a single plan options, 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.

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 sent out 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 2022 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 2022 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