FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

FEHB ☒ PSHB ☐

Letter Number 2024-07

Date: March 11, 2024

Fee-for-service [7] Experience-rated HMO [5] Community-rated HMO [4]

Subject: Update on Aggregate Healthcare Cost and Utilization Data Reporting Requirements

This Carrier Letter updates guidance to all Federal Employees Health Benefits (FEHB) Carriers on their obligation to supply aggregate healthcare cost and utilization data to the U.S. Office of Personnel Management (OPM) and builds on the reporting requirements outlined in Carrier Letters 2020-17, 2021-09, and 2023-05. Postal Service Health Benefits Carriers will not be required to report data until 2026. Reporting requirements for Carriers offering Medicare Advantage Prescription Drug or Prescription Drug Plan Employer Group Waiver Plans will be provided in separate guidance.

This letter:

- Requires submission of the data by June 14, 2024.
- Renames the file name and data field previously known as 'Pharmacy Rebates File (RXRB)' and 'Rebates and Other Credits' to 'Manufacturer Payments File' (RXMP) and 'Manufacturer Payments,' respectively.
- Adds two new data fields to the Pharmacy Cost & Utilization File (RXCU): 'Dispensing Fee Paid' and 'Medication Administration Fee Paid.'
- Removes one data field, 'Taxes.'
- Adds a new 'Rebates Passed to Members at Point of Sale' data field to the 'Manufacturer Payments File.'

- Updates the submission of the FEHB enrollment codes for FEHB plans. There must be separate records for each three-digit enrollment code, for which utilization is not zero.
- Updates descriptions/instructions with valid values in the Aggregated RXCU and RXMP File Layout tables for the following fields:
    - Pharmacy Type (RXCU & RXMP)
    - Specialty Claim Indicator (RXCU)
    - Prior Authorization Indicator (RXCU)
    - Step Therapy Indicator (RXCU)
    - In Network Indicator (RXCU)
    - Compound Code Indicator (RXCU)
    - Days Supplied (RXCU)
    - Plan Paid Amount (RXCU)
    - Patient Pay Amount (Liability) (RXCU)
    - Other Payer(s) Paid Amount(s) (RXCU)
    - Total Amount Paid by All Sources (RXCU)
    - Gross Amount Due (RXCU)
    - Manufacturer Payments (previously Rebates and Other Credits) (RXMP)
- Provides detailed requirements for the pharmacy cost (including manufacturer payments) and utilization data requested that are the minimum necessary for FEHB Program oversight.
- Provides guidance for file submission to the Research and Oversight Repository (ROVR).

In the event of a conflict between this letter and a prior FEHB Carrier Letter, this letter supersedes.

Background

5 U.S.C § 8910 mandates that OPM make a continuing study of the operation and administration of the FEHB Program and requires Carriers to furnish reasonable reports that OPM determines to be necessary to enable it to carry out its functions. This is further outlined in Section 1.7 of the Fee-For-Service, Experience-Rated, and Community-Rated contracts.

One of OPM's strategic goals is to provide affordable and high-quality health plans to FEHB enrollees and their families. Since 2019, FEHB Carriers have reported aggregate pharmacy cost (including 'Manufacturer Payments,' previously named 'Rebates and Other Credits') and utilization data to OPM. This data gives OPM important insight into the operation and administration of FEHB pharmacy benefits and is essential for effective FEHB Program oversight and evidence-based decision-making. OPM will continue to collect pharmacy cost and utilization data on an annual basis. This letter details additional information on the FEHB pharmacy data collection and submission process.

Submission Time Frame

No later than June 14, 2024, FEHB Carriers must submit pharmacy cost (including manufacturer payments) and utilization data files for the 2023 plan year. If the Carriers have participated in the FEHB Program in the previous year, data must be included for all the plans that were offered in the previous plan year whether the plans are offered in the current plan year or not.

Aggregate Pharmacy Cost and Utilization Data Files

FEHB Carriers are required to submit the following two files every year:

- Pharmacy Cost and Utilization (RXCU) file
- Manufacturer Payments (RXMP) file

Files must be submitted using the detailed data requirements and file layouts for both file types included in Attachment 1. The fields to be included

in the files, their variable names, and their order are outlined in Attachment 1. Additional updates on the data reporting requirements are provided based on OPM's experience with Carrier file submissions in previous years.

Files Submission

Each Carrier will submit the files using a Secure File Transfer Protocol (SFTP) account and encryption. Guidance for file submission to Research and Oversight Repository (ROVR) is provided in Attachment 2. The requirements for file submissions remain the same as in prior years. FEHB Carriers that are already set up for submitting files to ROVR do not have to take any additional action.

Conclusion

OPM is committed to providing affordable and high-quality health plans to FEHB enrollees and their families. If you have any questions or concerns, please contact OPMPharmacy@opm.gov with a copy to ROVRSupport@opm.gov and your designated Health Insurance Specialist(s).

Sincerely,

Laurie E. Bodenheimer
Associate Director
Healthcare and Insurance

Attachment 1: Detailed data requirements and file layouts

We ask that you read and carefully follow the detailed data requirements and file layouts in this attachment before providing the requested information in Pharmacy Cost and Utilization (RXCU) and Manufacturer Payments (RXMP) files. Files will be processed automatically, and incorrect or incomplete files will be rejected. Rejected files must be resubmitted after addressing the issues identified or providing a valid justification for not resubmitting the files.

General requirements applicable to both file types

Carriers must submit the files every year based on the previous plan year pharmacy benefit experience with a three-month runout. The information provided must be based on all records with a date of adjudication (National Council for Prescription Drug Programs (NCPDP) data field 578) in the reporting year paid by March 31 of the following year.

The three-character FEHB Enrollment Codes are the codes that appear in the FEHB plan brochure(s) that capture the plan, option, and Self / Self plus One / Self and Family enrollment type. **There must be separate records for each three-digit enrollment code, for which utilization is not zero.** Carriers must append data for multiple three-character FEHB enrollment codes in the same file. A valid FEHB Enrollment Code for the Carrier must be included for all records. Carriers are responsible for providing the FEHB Enrollment Codes to other entities, such as Pharmacy Benefit Managers (PBMs), that help produce these files.

Carriers must submit National Drug Codes (NDCs) in HIPAA 11-digit format without dashes for all drugs/products that have an NDC. Submit other appropriate identifiers (IDs) only for non-drug products or services that do not have NDCs. The requirements have references to the drug, product, or service ID and qualifier to accommodate non-drug items, but most products must be drugs and most IDs must be NDCs. Please refer to Table 3 - NCPDP External Code List (ECL) for 436-E1: Product / Service ID Qualifier, provided

in this document below, for valid values. The value for NDC, for example, is 03. Please provide a detailed mapping if other values are used.

The files must be submitted in the general form now defined for files: ASCII or UTF-8 encoded, pipe-delimited plain text files with no padded characters; one record per field with a consistent number of pipes on all records; a header record in the first row with variable names in the same order, with matching letter case provided in the file layouts.

Aggregated Pharmacy Cost and Utilization (RXCU) File Requirements

The information provided in the Pharmacy Cost and Utilization (RXCU) file must be the number of scripts, sum totals of quantities dispensed, days supplied, and amounts in each field between 14-25 for each unique combination of values in fields 1-13 in Table 1 - Aggregated Pharmacy Cost and Utilization (RXCU) File Layout, provided in this document below.

Each file must contain all fields for each three-digit FEHB Enrollment Code that appears in the plan brochure(s) and each drug/product/service ID by pharmacy type, specialty claim indicator, age band, etc. The breakdown of utilization/costs for each unique combination of values in fields 1-13 in the file layout must be included in the file.

The first row of the ASCII or UTF-8 encoded, pipe-delimited text file must contain the variable names exactly as provided by OPM in the file layout, in the same order, separated by the pipe operator (|). Variable names are case-sensitive, and the header record in the RXCU file must look like the sample provided below for reference.

fehbEnrCode|pharmacyType|productID|productIDQualifier|productName|productDescription|specialty|priorAuthYN|stepTherYN|formularyStatus|networkYN|compundCode|ageBand|scripts|users|daysSupplied|quantityDispensed|planPaid|memberPaid|otherPayerPaid|dispensingFee|medAdminFee|amountPaidAllSources|grossAmount.

The pipe character | must not appear inside any of the fields. It must be used only to delimit fields. If there are *n* fields in the file, there must be n-1 pipe operators in each record, one after each field except the last one. There must be exactly 24 pipes between 25 fields on every record in the RXCU files. Each row in the text file must represent a separate record and there must not be blank records at the end of the file.

Null values must be represented by ||. Spaces, dots, quotations, NA, or any other characters must not be included between the pipe characters delimiting the end of the previous field and the end of the null field. Zero values for numeric fields (e.g., zero copays) must be represented as 0 for counts and 0.00 for amounts, not null or missing values. Dollar amounts must include the dot but no commas or dollar signs. Do not pad values with spaces or any other characters.

Table 1 - Aggregated Pharmacy Cost and Utilization (RXCU) File Layout

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP (Standard) Field
1	FEHB Enrollment Code	fehbEnrCode	Character (3)	The three-digit FEHB Enrollment Code as it appears in the FEHB plan brochure. There must be separate records for each three-digit enrollment code, for which utilization or amounts are not all zero.	
2	Pharmacy Type	pharmacyType	Character (1)	Indicates the type of pharmacy that dispensed or administered the product: R for Retail M for Mail S for Specialty L for Long Term Care O for Any Other Types	
3	Product / Service ID	productID	Character (14)	ID of the product dispensed or service provided. NDC in HIPAA 11-digit format without dashes for the drugs/products that have an NDC. NDC must be 11 characters long and leading zeros must be included. NDC must not be padded with spaces to fill 14 characters which is the maximum allowed length. NDC values are validated using reference data from First Databank (FDB) and Medi-Span. If it is a product without an NDC (e.g., syringes, diapers, etc.) then use another appropriate code (e.g., Universal Product Code (UPC)). Please refer to Table 3 - NCPDP External Code List (ECL) for 436-E1: Product / Service ID Qualifier provided in this document below for valid values. Please provide a detailed mapping if other values are used.	(A) 407-D7

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP (Standard) Field
4	Product / Service ID Qualifier	productIDQualifier	Character (2)	Code qualifying the type of Product ID. Most products must be drugs, for which the productID must be an NDC and the values for the productIDQualifier must be 03. Please refer to Table 3 - NCPDP External Code List (ECL) for 436-E1: Product / Service ID Qualifier provided in this document below for valid values.	(A) 436-E1
5	Product / Service Name	productName	Character (80)	Product or service description or product label name. e.g., CYMBALTA CAP 20MG	(A) 397
6	Product Description	productDescription	Character (80)	Short name/description of the drug/product. e.g., CYMBALTA	(Z) 601-20
7	Specialty Claim Indicator	specialty	Numeric (1)	Indicates whether a claim was dispensed by a specialty pharmacy or a specialty drug: 1 if Specialty Claim 2 if not a Specialty Claim	(A) A37
8	Prior Authorization Indicator	priorAuthYN	Character (1)	Indicates the claim was subject to Prior Authorization: Y if Prior Authorization N if not	(R) D68-17
9	Step Therapy Indicator	stepTherYN	Character (1)	Indicates the claim was subject to Step Therapy: Y if Step Therapy N if not	(R) D69-1E
10	Formulary Status	formularyStatus	Character (1)	Indicates the formulary status of the drug. Valid values are I, J, K, N, P, Q, T, Y. Please refer to Table 4 - NCPDP External Code List (ECL) for 257: Formulary Status provided in this document below for additional information on valid values.	(A) 257

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP (Standard) Field
11	In Network Indicator	networkYN	Character (1)	Indicates if the pharmacy dispensing the prescription is considered in network: Y if In Network N if Out of Network	(A) 266
12	Compound Code Indicator	compundCode	Numeric (1)	Code indicating whether the prescription is a compound or not: 0 if Not specified 1 if Not a Compound 2 if Compound	(A) 406-D6
13	Age Band	ageBand	Numeric (2)	Age Band of the patient as of the date the prescription was filled. Valid values are 1 for 0-5 years, 2 for 6-10 years, 3 for 11-17 years, 4 for 18-22 years, 5 for 23-34 years, 6 for 35-44 years, 7 for 45-54 years, 8 for 55-64 years, 9 for 65-74 years, 10 for 75-84 years, and 11 for 85+ years.	
14	Number of Scripts	scripts	Numeric	The number of prescriptions adjudicated for the drug/product. Do not double-count partial fills.	
15	Unique Users	users	Numeric	The number of unique patients using the drug/product.	
16	Days Supplied	daysSupplied	Numeric	Total estimated number of days the prescription will last.	(A) 405-D5
17	Quantity Dispensed	quantityDispensed	Numeric	The total quantity dispensed for the drug/product/supply (NDC), expressed in metric decimal units.	(A) 442-E7
18	Plan Paid Amount	planPaid	Numeric	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement. The total amount paid by the plan.	(A) 281

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP (Standard) Field
19	Patient Pay Amount (Liability)	memberPaid	Numeric	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; including copayments, amounts applied to deductible, over maximum amounts, penalties, etc. (total member liability).	(A) 505-F5
20	Other Payer(s) Paid Amount(s)	otherPayerPaid	Numeric	The total amount of any payment known by the pharmacy from other sources.	(Z) 431-DV
21	Dispensing Fee Paid	dispensingFee	Numeric	Dispensing fee paid included in the Total Amount Paid (509-F9). Amount the pharmacy is paid for dispensing the medication. This does not refer to the administrative fees that Carriers pay Pharmacy Benefit Managers.	(A) 507-F7
22	Medication Administration Fee Paid	medAdminFee	Numeric	Administration fee charge per service claim from supplying a medication to patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc., such as vaccine administration. Of note, this refers to cases where the Professional Service Code (NCPDP field 440-E5) is equal to MA (Medication Administration). This does not refer to the administrative fees that Carriers pay Pharmacy Benefit Managers.	440-E5 (MA)
23	Total Amount Paid by All Sources	amountPaidAllSources	Numeric	Total amount of the prescription regardless of party responsible for payment. (The total amount paid by all sources. Must equal the sum of the plan paid, the patient paid, and the other payer(s) paid amounts.)	(A) 894

#	Field	Variable Name	Type	Description / Instruction with valid values	NCPDP (Standard) Field
24	Gross Amount Due	grossAmount	Numeric	Total price claimed from all sources. For a prescription claim request, this field represents a sum of Ingredient Cost Submitted Dispensing Fee Submitted, Regulatory Fee Amount Submitted, Percentage Tax Amount Submitted, Incentive Amount Submitted, and Other Amount Claimed.	(A) 430-DU

***Note:** The numerical values in columns 14-24 are sum totals for each drug/product for which there is utilization broken down by the distinct combinations of values in columns 1-13. The amount columns 18-24 must be numeric values with at least 2 decimal places. Zero values must be reported as 0.00. Of note, two new data fields, 'Dispensing Fee Paid' and 'Medication Administration Fee Paid,' were added and one data field, 'Taxes,' was removed (seen in field numbers 21 and 22 for 'Dispensing Fee Paid' and 'Medication Administration Fee Paid,' respectively).

Aggregated Manufacturer Payments (RXMP) File Requirements

An accompanying Manufacturer Payments (RXMP) file must be submitted for each Pharmacy Cost and Utilization (RXCU) file. Please refer to Table 2 - Aggregated Manufacturer Payments (RXMP) File Layout provided in this document below. The information provided must be based on all manufacturer payments and other credits and fees (such as price protection and manufacturer administrative fees) for the plan year utilization/costs (the manufacturer payments and other credits associated with drug costs/utilization included in the RXCU file).

The total manufacturer payments and other credits such as price protection and manufacturer administrative fees for the drug/product must be allocated to the respective three-character FEHB enrollment code and distribution channel. The Carrier's standard allocation methodology must be used or allocated proportionally to FEHB Plan and Enrollment Code and Pharmacy Type. If manufacturer payments or other credits are based on a market basket of drugs/products and are not specific to the drug/product, separate manufacturer payments and other credits for each drug/product must be calculated by multiplying the total manufacturer payments and credits on the market basket by the percentage represented by each drug/product in the market basket (and distributed by FEHB enrollment code and Pharmacy Type).

The first row of the ASCII or UTF-8 encoded, pipe-delimited text file must contain the variable names exactly as provided by OPM in the file layout, in the same order, separated by the pipe operator |. Variable names are case-sensitive, and the header record in the RXMP file must look like the sample provided below for reference.

fehbEnrCode|pharmacyType|ndc11|rebatesPOS|productDescription|manufacturerPpayments

The pipe character | must not appear inside any of the fields. It must be used only to delimit fields. If there are *n* fields in the file, there must be n-1 pipe operators in each record, one after each field except the last one. There must be exactly 4 pipes between 5 fields on every record in the RXMP files. Each row in the text file must represent a separate record and there must not be blank records at the end of the file.

Null values must be represented by ||. Spaces, dots, quotations, NA, or any other characters must not be included between the pipe characters delimiting the end of the previous field and the end of the null field. Zero values for numeric fields (e.g., zero copays) must be represented as 0 for counts and 0.00 for amounts, not null or missing values. Dollar amounts must include the dot but no commas or dollar signs. Do not pad values with spaces or any other characters.

Table 2 - Aggregated Manufacturer Payment (RXMP) File Layout

#	Field	Variable Name	Data type	Description	NCPDP (Standard Field)
1	FEHB Enrollment Code	fehbEnrCode	Character (3)	The three-digit FEHB enrollment code as it appears in the FEHB plan brochure. There must be separate records for each three-digit enrollment code, that is, for Self / Self Plus One / Self and Family enrollment for each plan option for which utilization is not zero.	
2	Pharmacy Type	pharmacyType	Character (1)	Indicates the type of pharmacy that dispensed or administered the product: R for Retail, M for Mail, S for Specialty, L for Long Term Care	
3	NDC-11	ndc11	Character (11)	NDC in HIPAA 11-digit format without dashes which identifies the drug name. NDC must be 11 characters long and leading zeros must be included. NDC values are validated using reference data from First Databank (FDB) and Medi-Span.	
4	Product Description	productDescription	Character (80)	Short name/description of the drug/product, e.g., CYMBALTA	(Z) 601-20
5	Rebates Passed to Members at Point of Sale	rebatesPOS	Numeric (8)	Manufacturer payments passed through (rather than retained by PBMs or plans/issuers/carriers) to members at the point of sale (POS). Please exclude manufacturer cost-sharing assistance.	
6	Manufacturer payments and Other Credits	manufacturerPayments	Numeric	Manufacturer payments mean any and all compensation, financial benefits, or remuneration the PBM or any Third Party receives from a pharmaceutical manufacturer for any dispensing	

#	Field	Variable Name	Data type	Description	NCPDP (Standard Field)
				or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, patient assistance, and any fees received for sales of utilization data to a pharmaceutical manufacturer. Please use your standard allocation methodology or allocate proportionally to FEHB Enrollment Code and Pharmacy Type. If manufacturer payments, other credits, and fees are based on a market basket of drugs/products/supplies and are not specific to the drug/product, please calculate the separate rebate for this drugs/products/supplies by multiplying the total manufacturer payments on the market basket by the percentage represented by this drugs/product/supplies in the market basket (and distribute by FEHB enrollment code and Pharmacy Type). If the last quarter information is not available, please estimate the total manufacturer payments and other credits for the year from the experience over the first three quarters.	

***Note:** The numerical values for Rebates Passed to Members at Point of Sale and manufacturer payments seen in field numbers 5 and 6 are sum totals for each drug/product/supply broken down by the distinct combinations of FEHB Enrollment code, distribution channel, and product values in columns 1-4. This must be a numeric value with at least 2 decimal places. Zero values must be reported as 0.00. New data field 'Rebates Passed to Members at Point of Sale' was added as seen in field #5.

Table 3 - NCPDP External Code List (ECL) for 436-E1: Product/Service ID Qualifier

Extract from the NCPDP External Code List (ECL) provided below. Ø stands for the digit 0, so it isn't confused with the letter O. Please note that the following table includes the most used values and refer to the NCPDP standards for a full list of values as needed.

Value	Product/Service ID Qualifier Name	Comments
Blank	Not Specified	Used only in Telecommunication Standard Versions 9.Ø through C.4 and Post Adjudication Standard Version 1.Ø. Value was deleted for use in higher versions of these standards.
ØØ	Not Specified	Only to be used when needed to conform to fixed file layout specifications.
Ø1	Universal Product Code (UPC)	Formatted 11 digits (N)
Ø2	Health Related Item (HRI)	Formatted 11 digits (N)
Ø3	National Drug Code (NDC)	NCPDP Formatted 11 digits (N)
Ø6	Drug Use Review/ Professional Pharmacy Service (DUR/PPS)	

Table 4 - NCPDP External Code List (ECL) for 257: Formulary Status

Extract from the NCPDP External Code List (ECL) provided below.

Value	Formulary Status Description
Blank	Not Specified
I	Drug on Formulary; Non-Preferred - The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category.
J	Drug not on Formulary; Non-Preferred - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category.
K	Drug not on Formulary; Preferred - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice.

Value	Formulary Status Description
N	Drug not on Formulary; Neutral - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.
P	Drug on Formulary - The medication submitted on the claim is included in the list of products in that patient's plan formulary.
Q	Drug not on Formulary - The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary.
T	Drug on Formulary; Preferred- Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product.
Y	Drug on Formulary; Neutral - The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.

Attachment 2: Guidance for file submission to Research and Oversight Repository (ROVR)

FEHB Carriers that are already set up for submitting files to ROVR do not have to take any additional action. If a Carrier is not set up to transfer files to ROVR, the point of contact information, the outbound IP addresses or the URLs from which files will be pushed from the Carrier's organization must be sent to ROVR to start the initial setup. Additional details necessary during initial setup to submit the files using a Secure File Transfer Protocol (SFTP) account and encryption will be shared with the Carriers at the time of initial setup.

File naming standards

Files must be named following the standard file naming convention provided below.

<ProgramID>_<SourceID>_<FileTypeID>_<StartDt>_<EndDt>_<TransferDt>.txt.pgp

ProgramID: FEHB etc.
SourceID: Source ID assigned by OPM. Typically, four characters in length.
FileTypeID: RXCU, RXMP, etc.
StartDt, EndDt, TransferDt: All dates must be in CCYYMMDD format.

Sample file names when the ProgramID is FEHB and the SourceID assigned is ATOZ:

FEHB_ATOZ_RXCU_20230101_20231231_20230614.txt.pgp
FEHB_ATOZ_RXMP_20230101_20231231_20230614.txt.pgp

The three IDs and the three dates in the file name must be checked and updated while submitting the files. The first two dates in the file name which represent **start** and **end dates** must reflect the timeframe for which the report is being generated. The **third date** in the file name must match the actual file submission/transfer date or at least be close to it. Even if the

three IDs and start and end dates remain the same while resubmitting the file, the third/transfer date must be updated for every file resubmission. This is required to be able to uniquely identify the file, store the file without replacing the earlier file, figure out which is the latest file, and not create issues with duplicates while processing the data in the files. While submitting the test files, the TST_ prefix must be added to the file name in addition to following the standard file naming convention.

Timeline

Files can be submitted on any day by the deadline. We ask that you avoid submitting files between 5:00 am and 8:00 am Eastern time to leave a window for processing files received the day before and for server maintenance.

Notifications

An email notification along with each successful file transfer with the file name and the record count for each file submitted must be sent by the Carrier. If there are amounts included in the file, total amounts must be included in the notification. If there are any changes on the Carrier's end that will impact the file formatting or content, such details must be provided as well.

Contact information

Email communications regarding file submissions must be sent to the ROVR Support mailbox, ROVRSupport@opm.gov. FEHB Carriers must copy your designated Health Insurance Specialist(s) on the email communications with ROVR. Carriers must also copy OPMPharmacy@opm.gov on email communications related to Pharmacy files. The Carriers are responsible to share their latest point of contact information with ROVR when there are changes.