FEHB Program Carrier Letter
All FEHB and PSHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

FEHB ☒ PSHB ☒

Letter Number 2025-01

Date: January 15, 2025

Fee-for-service [1] Experience-rated HMO [1] Community-rated HMO [1]

Subject: Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter

Introduction

This is our call for benefit and rate proposals for Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) Program Carriers (for brevity, referred throughout this document as Carriers). This combined Call Letter outlines OPM's policy goals and initiatives for benefit proposals from Carriers in Plan Year 2026.

Submission of Proposals

Carriers must submit their benefit and rate proposals on or before May 31, 2025, for the contract term beginning January 1, 2026. OPM expects to complete benefit negotiations by July 31, 2025, and rate negotiations by mid-August to ensure a timely Open Season.

Call Letter Instructions

The Call Letter outlines benefit policy and strategic initiatives of importance to all Carriers, unless specifically noted as applying to one of the two Programs. As a reminder, Call Letter responsiveness is evaluated by a Contracting Officer as an element of Plan Performance Assessment (PPA) for all Carriers.

Please note that there will be two separate Technical Guidance documents, one for FEHB Carriers and one for PSHB Carriers, which we expect to issue soon. Carriers are directed to pay close attention to the relevant sections of the Call Letter and the respective Technical Guidance for the Program(s) to which they intend to submit proposals.

Unless otherwise specified, previous guidance remains in force and applies to both the FEHB and PSHB Programs.

FEHB and PSHB Program Benefits and Initiatives

OPM's primary areas of focus for the upcoming Plan Year for Carriers are:

1. Easing Administrative Burden on Enrollees;
2. Preventive Care;
3. Fertility Benefits;
4. Mental Health Parity and Network Adequacy; and
5. Prevention and Treatment of Obesity.

I. Easing Administrative Burden on Enrollees

A recent survey from the Kaiser Family Foundation found that 58 percent of people with health coverage say they encountered at least one problem using their coverage in the past year, including those related to claims processing and denials and how to find information about provider networks. The survey found that these challenges do not just add time and frustration to Americans' daily lives, they can impact decisions people make about when to seek care – or whether they seek it at all.

As a result, OPM will require FEHB and PSHB plans to:

- make it easier to submit out-of-network claims online;
- provide clear information about the Carrier's Plan in-network providers, including at the office location level, if there are multiple practice offices within a service area; and

- make the information on how to appeal claim denials more accessible on the Carrier's Plan website.

OPM recognizes that requiring Carriers to implement all three requirements during Plan Year 2026 has the potential for some cost implications, as well as technology hurdles. To alleviate undue burden on the Carriers and to address premium stabilization and affordability for Plan Year 2026, we elaborate below our expectations for how Carriers should implement these three requirements.

Online Claims Filing

While members can rely upon in-network providers to file medical claims with Carriers directly, members generally file their own claims when they have received services from an out-of-network provider/pharmacy or have paid out of pocket for a covered item or service. In most cases, Carriers provide their preferred claims form online and direct the member to mail the form to the Carrier. To make the member claim-filing process more convenient and user-friendly, OPM is directing all Carriers to implement an online claims filing process that members will be able to access through the Carrier's Plan website no later than the end of Plan Year 2026. This process must allow members to use a secure online portal to:

- Complete and submit fillable claim forms directly;
- Submit supporting documentation for the claim; and
- Timely acknowledge receipt of filed claims and clearly articulate the timeframe for review and processing.

The online filing process is meant to supplement, not replace, the current method the Carrier uses to accept member-filed claims, such as by mail. Carriers must describe in their proposals their timeline for compliance with this online claim filing requirement, as well as how they plan to keep this data secure.

Effective Provider Directory Tools

OPM has long required Carriers to offer to members easy-to-use online provider search tools. More recently, in Carrier Letter 2020-01, we noted that lack of transparency regarding a provider's contracting status with a Carrier can often lead to unexpected costs for enrollees. In Carrier Letter 2022-12, we directed Carriers to use a good faith, reasonable interpretation of the statutory law to comply with the provider directory accuracy requirements of the No Surprises Act. As recently as Carrier Letter 2024-08 (Network Provider Data Reporting Requirements), we noted our commitment to supporting member decision-making and experience by providing access to transparent, up-to-date information on providers' network status and availability to accept new patients and/or to offer telehealth services.

For Plan Year 2026, FEHB Carriers should offer members an easy-to-use provider lookup tool accessed by a link displayed on the Carriers' Plan home web page. At a minimum, members and prospective enrollees should be able to use this tool to search for and filter by the following criteria: provider name, name of the practice or group, location(s), network status, gender, specialty, special interests or areas of focus for the provider, language(s) spoken, whether the provider is accepting new patients, and whether the provider offers telemedicine services. Carriers must make it clear for members and prospective enrollees that they are using the right provider lookup tool for the right plan.

Disputed Claims Information on Carrier's Plan Website

The FEHB and PSHB disputed claims process is essential to ensuring that members may exercise their right to have benefit determinations reconsidered by the Carrier and reviewed by OPM. To ensure this, members need complete and timely information about how the process works and a clear and user-friendly way to access the process. All Carriers should therefore provide easy-to-access information on their website fully explaining the disputed claims process before January 1, 2026. A reference or link to the Plan brochure should be included but is not in and of itself sufficient. At a minimum, this web-based information should include a fact

sheet explaining the process that the member can download. The fact sheet should include:

- A complete description of the disputed claims process, for both post- and pre-service medical and pharmacy claims, including the right of members to request reconsideration by the Carrier and to request review by OPM;
- The required deadlines for the member to request reconsideration and to file a disputed claim with OPM and for the Carrier to respond;
- A clear explanation of how and when the member can receive copies of all relevant material used by the Carrier to make its decision; and
- A link to all forms the Carrier provides for a member to use in filing an appeal (all forms should be fillable online).

This website should be mobile-friendly to allow for viewing on mobile devices. All Carriers should also offer members a variety of ways to file an appeal including secure email, fax, or other secure method.

II. Continued Priorities from Previous Years

Preventive Care

Carriers are required to cover, without cost-sharing, preventive services recommended with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF), as well as immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and women’s health services specified in guidelines issued by the Health Resources and Services Administration (HRSA). All updates to preventive services guidelines and recommendations must be applied as they occur throughout the year by all Carriers.

HIV Preexposure Prophylaxis (PrEP)

The USPSTF recommends that clinicians prescribe HIV preexposure prophylaxis (PrEP) using effective antiretroviral therapy to persons at increased risk of human immunodeficiency virus (HIV) acquisition to decrease the risk of acquiring HIV. This recommendation has an “A” rating.

OPM requires FEHB and PSHB Carriers to cover, without cost-sharing, all U.S. Food and Drug Administration (FDA)-approved drugs indicated for HIV PrEP, consistent with the guidance outlined in the Frequently Asked Questions (FAQs) about Affordable Care Act and Women's Health and Cancer Rights Act Implementation Part 68 (FAQ 68) issued on October 21, 2024, by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the "Departments").

The USPSTF recommendation currently lists the following FDA-approved medications for HIV PrEP:

- Oral tenofovir disoproxil fumarate/emtricitabine (TDF/FTC)
- Oral tenofovir alafenamide/emtricitabine (TAF/FTC)
- Injectable cabotegravir

The USPSTF recommendation for PrEP encompasses several screenings for certain at-risk populations at PrEP initiation and on a regular basis. However, such tests can also be furnished for diagnostic purposes outside of the scope of the USPSTF recommendation for PrEP, and the USPSTF recommendation does not recommend all of those screenings for every individual taking PrEP.

Consistent with FAQ 68 from the Departments, Carriers must also cover, without cost sharing, for in-network providers, specified baseline and monitoring services described in the USPSTF recommendation. This includes testing for HIV infection with an FDA-approved antigen/antibody immunoassay, testing for sexually transmitted infections, pregnancy testing when appropriate, kidney function and serologic testing for hepatitis B prior to initiating a tenofovir-containing therapy, and lipid profile testing prior to initiating TAF/FTC. Furthermore, follow-up care must be covered without cost-sharing.

Fertility Benefits

OPM appreciates the efforts Carriers have made to date in covering fertility benefits for enrollees and their eligible family members, particularly with

respect to more comprehensive coverage of in vitro fertilization (IVF). We strongly encourage Carriers to both continue and expand these efforts.

State Laws related to IVF Coverage

To support OPM's objective to provide access to fertility benefits for FEHB and PSHB enrollees, Health Maintenance Organizations (HMOs) with service areas in a state with any IVF coverage mandate must include benefits that would satisfy the requirements under state law in their proposal. OPM will exercise its discretion in negotiating these benefits to ensure consistency with FEHB and PSHB Program requirements and policy objectives, as stated in Carrier Letter 2023-04 and Carrier Letter 2024-06. The Technical Guidance for Plan Year 2026 will provide additional information regarding the fertility benefit.

Iatrogenic Infertility

In Carrier Letter 2021-03, OPM encouraged all FEHB Carriers to provide coverage for fertility preservation procedures for persons facing the possibility of "iatrogenic infertility," that is, infertility caused by a medically necessary intervention such as chemotherapy. Carrier Letter 2022-03 made coverage of fertility preservation for iatrogenic infertility a program-wide requirement.

For Plan Year 2026, OPM is requiring that all Carriers continue to provide fertility preservation for individuals facing iatrogenic infertility with the following minimum coverage requirements. All coverage requirements, as listed below, must be clearly outlined in plan brochures:

- Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval;
- Cryopreservation of sperm and mature oocytes; and
- Cryopreservation storage costs for at least one year.

Mental Health Parity and Network Adequacy

On September 9, 2024, the Departments released new final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021). These rules provide content requirements and response timeframes for comparative analyses related to non-quantitative treatment limitations (NQTLs) on mental health or substance use disorder (MH/SUD) benefits required under MHPAEA, as amended by the CAA, 2021. The new regulations require that plans and issuers evaluate and take reasonable action to address material differences in access to MH/SUD benefits compared to medical/surgical (M/S) benefits that result from the application of NQTLs. Carrier Letter 2021-16 advised Carriers of the following if they elect to place NQTLs on any MH/SUD benefits:

- Carriers must perform and document their comparative analyses of the design and application of NQTLs (including medical necessity, prior authorization, list of covered services, step therapies, covered drugs, network composition and access); and
- Carriers must make their comparative analyses available upon OPM's direction.

As discussed in Carrier Letter 2023-15, Carriers must have adequate provider networks for members to access mental health and substance use disorder services. Access and availability to behavioral health networks is critical in order to maintain parity between MH/SUD and M/S benefits. Carrier efforts to remove barriers to care and to ensure parity should focus on timely access to both providers and benefits under the plan.

OPM's continuing priority is to assure that network access barriers do not exist in the FEHB and PSHB Programs. OPM asks Carriers to continue to expand the number of providers in their networks above and beyond those obtained in 2025, including but not limited to, adding options to decrease member appointment wait times and expanding the use of out-of-network provider benefits for MH/SUD services if a MH/SUD provider is not available

for a particular service area or when appointment wait times exceed any applicable aspects required by the regulatory bodies in which Carriers operate. As stated in Carrier Letter 2023-04, Carriers must cover services provided by out-of-network providers at in-network rates, when needed, to provide timely access to specialized care in accordance with the Carriers' accreditation standards.

Additionally, in response to MHPAEA and to support assurance of MH/SUD and M/S parity, OPM will require Carriers to provide network adequacy information from any network-related NQTL comparative analyses (Carrier Letter 2021-16). Provider network data will be instrumental in supporting these goals and ensuring that members have the necessary support from OPM in navigating their access to health care. The Technical Guidance will provide additional information on the collection of this quantitative data.

Prevention and Treatment of Obesity

OPM remains committed to ensuring Carriers offer obesity benefits that include all necessary components of current evidence-based obesity management. OPM is providing updated clarifications and expectations for Carrier obesity benefits, since the science on these interventions has evolved. OPM reminds Carriers that having an overweight or obesity diagnosis is not a lifestyle choice and increased adipose (fat) or weight gain should not be solely attributed to eating disorders. Obesity experts have advised that obesity management and treatment requires an integrated, patient-centered, and individual approach,[1] because obesity is a disease that is impacted by many different factors and causes and affects each patient differently.

Intensive Behavioral Therapy and Comprehensive Obesity Benefits

Previous Carrier Letters have encouraged Carriers to offer obesity benefits that reflect a multi-focal and chronic disease care delivery model that

[1] Obesity definition, diagnosis, bias, standard operating procedures (SOPs), and telehealth: An Obesity Medicine Association (OMA) Clinical Practice Statement (CPS) 2022 - PMC (nih.gov)

includes access to the following components: individualized treatment by multidisciplinary teams, specialty care, medications, bariatric surgery, and intensive behavioral therapy (IBT). OPM guidance requires Carriers to provide a range of FDA approved anti-obesity medications on their formulary that includes at least one anti-obesity drug from the GLP-1 class for weight loss and cover at least two (2) additional oral anti-obesity drug options. While FEHB Carriers must have adequate coverage of FDA approved anti-obesity medications on their formulary to meet patient needs, Carriers are reminded that evidence-based guidelines for all anti-obesity medications, including but not limited to GLP-1s, reinforce that nutrition, physical activity, and IBT regimens should accompany any drug treatment of obesity.[2][3] Carrier Letter 2023-01 and Carrier Letter 2019-01 require Carriers to cover IBT if a member at certain risk levels is referred to such services. IBT is defined as a multicomponent process that includes obesity-related specialists focused on nutrition, physical activity, behavior change components.[4][5]

As part of your proposals for Plan Year 2026, please clarify or update your obesity management benefit to include the following requirements. These components also apply to any third-party vendors you may elect to include to manage or be part of your obesity management network:

- Screening and Support Services: Cover all costs of both the screening and the support services (e.g. obesity focused provider encounters, classes, or related programming) for individuals at these applicable risk levels to prevent complications from obesity, including adult persons at obesity classes 1, 2 and children/adolescents who have a body mass index [BMI] pediatric greater than the 95th percentile. Persons who are overweight and have cardiovascular comorbidities

[2] The 2016 American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) Comprehensive Clinical Practice Guidelines For Medical Care of Patients with Obesity state, "Pharmacotherapy for overweight and obesity should be used only as an adjunct to lifestyle therapy and not alone." According to the AACE/ACE Clinical Practice Guidelines, lifestyle therapy includes three components, a meal plan, physical activity, and behavioral interventions.

[3] Pharmacologic Treatment of Overweight and Obesity in Adults - Endotext - NCBI Bookshelf

[4] Behavioral Approaches to Obesity Treatment - StatPearls - NCBI Bookshelf

[5] https://uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions

are strongly recommended to be eligible for these preventive services;[6][7]

- Child, Adolescent, and Family Healthy Weight Programming: Coverage of child, adolescent, and family programming that includes, but is not limited to, content specified in the CDC Family Healthy Weight Programs (FHWP)[8] for a minimum of 26 contact hours;
- Specialized Obesity Care Teams of Registered Dietitian and Obesity-trained Physicians: In-network coverage of obesity management care teams that have an obesity medicine-trained registered dietitian paired with access to physicians/providers with specialized training in obesity management;
- Frequency and Duration of Services: Coverage of IBT that reflects USPSTF evidence-based content for frequency and duration of services (minimum 1-2 years) and is offered to members with or without anti-obesity medication;
- Provision of Core and Maintenance Phases: Coverage of intensive behavioral therapy programming offered in clinical or community settings, virtual or in-person (not solely app based), that provide a core and maintenance phases similar to evidence-based programs such as the CDC's National Diabetes Prevention Program (NDPP) or VA MOVE for adult members;[9]

[6] final-appendix.pdf (aace.com)
[7] OMA Obesity Algorithm IX - January 2024
[8] An example is the Boys and Girls Clubs of America or at YMCAs with their Healthy Weight and Your Child program. This FHWP is offered for families with children 7-13 years old and is implemented in participating YMCA locations. The program engages children and adults in nutrition education and physical activity to elicit positive change and to help families learn skills for healthier lifestyles. The program structure consists of 25 2-hour sessions that is delivered over 16 weeks.

[9] The NDPP requires at least 16 weekly sessions during the first 6 months and at least 6 monthly sessions during the second 6 months. It prioritizes personalized healthy choices over numerical guidelines (such as A1C levels) and accounts for cultural differences (with regard to food and behavior) in its Spanish version. The VA MOVE model has 3 phases: Phase 1 is 16 weeks long consisting of in-person weekly group classes with a corresponding workbook and a food and activity log; Phase 2 offers continued support and education with more flexible class scheduling either in-clinic or remotely; Phase 3 is a monthly group class with continued support for reaching health goals either in-clinic or remotely and continues for as long as the participant desires.

- Patient Monitoring: Coverage for medical, nutritional, and physical activity interventions that include the option for access to in-person or virtual patient monitoring, at least twice monthly during the core phase of the IBT programming. These nutritional and physical activity interventions must reflect the member's cultural preferences and social needs (Carrier Letter 2023-14);

- Medication Review: comprehensive review of all medications to identify potential medications that may be contributors to a member's obesity;

- Program Communication: Documentation of communications describing your obesity management program offering and eligibility criteria clearly available in public-facing materials (websites, brochures, apps, etc.). This requirement for clearly publicizing and communicating your specific medical obesity management program offerings is above and beyond any generalized wellness incentives or fitness discount information you may elect to offer;

- Consideration of Obesity Class Levels, Race/Ethnicity, and Additional Risk Factors: Carriers are asked to clarify or revise their obesity benefits to include coverage for revised obesity class levels by AACE, American College of Cardiology/American Heart Association, or other medical societies to prevent obesity related morbidity and mortality complications. As BMI might not accurately gauge metabolic health in adults with high muscle mass, older adults, and people of Asian descent, Carriers should also provide eligibility for medical nutritional and physical activity programming/intensive behavioral therapy to those members of applicable racial or ethnic minority groups who are at risk for having obesity related complications when they have BMI levels less than 30 (USPSTF B recommendation); and

- Use of ICD-10 CM Codes: ICD-10 CM obesity counseling and management codes have been updated in 2024 to include children, adolescents, and adults who meet these risk factors. Carriers must include access to services connected to these codes as part of their benefits to minimize any barriers to members' access to intensive behavioral interventions, such as behavior-based weight loss and weight loss maintenance interventions.

Additional information related to IBT content, dose frequency, and delivery teams can be found in the Technical Guidance for Plan Year 2026.

Technical Guidance

The 2025 Technical Guidance for FEHB and the 2025 Technical Guidance for PSHB will provide greater detail on what Carriers need to include in their proposals for the initiatives described in this Call Letter, as well as guidance on submission of benefit and rate proposals and preparation of brochures. Please follow the instructions carefully, as the rules for submission for FEHB plans may differ from PSHB plans.

Conclusion

OPM's goal for both the FEHB and PSHB Programs is to provide quality, affordable, and equitable health benefits for Federal and Postal Service employees, Federal and Postal Service annuitants, their family members, and other eligible persons and groups. Continuous open and effective communication between OPM contracting staff and Carriers should occur to ensure a smooth and successful negotiation cycle. Carriers should discuss all proposed benefit changes with their FEHB and PSHB Health Insurance Specialists.

OPM looks forward to the negotiations for the upcoming contract year, and thanks all Carriers for their commitment to the FEHB and PSHB Programs.

Sincerely,

Laurie Bodenheimer
Associate Director
Healthcare and Insurance

Technical Guidance Part III & IV will be added to the separate FEHB and PSHB Technical Guidance Documents