FEHB Program Carrier Letter
All FEHB and PSHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

FEHB ☒ PSHB ☒

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

Subject: Application and Tracking of Member Out-of-Pocket Costs

This Carrier Letter clarifies guidance[1] to all Federal Employees Health Benefits (FEHB) Program and Postal Service Health Benefits (PSHB) Program Carriers (hereafter "Carriers") on requirements for tracking and applying members' actual out-of-pocket costs[2] toward the plans' catastrophic maximum(s)[3].

All FEHB and PSHB Carriers are required to track member out-of-pocket costs.

For plan year 2025, OPM **strongly encourages** FEHB and PSHB Carriers to accumulate each member's out-of-pocket costs for plan-covered services toward the plan's catastrophic maximum. Beginning January 1, 2026, all carriers are **required** to accumulate each member's out-of-pocket costs for plan-covered services toward the plan's catastrophic maximum.

[1] Guidance distributed via email titled, "Application of Member Out-of-Pocket Costs to Plan Catastrophic Maximum" sent to carriers on May 23, 2024.

[2] Out-of-pocket costs are defined for purposes of this Carrier Letter as the dollar amount each covered individual spends on deductibles and cost sharing as it relates to covered medical and pharmacy benefits (such as drugs, services, supplies, and equipment). For purposes of this Carrier Letter, we refer to each covered individual as a "member."

[3] Catastrophic maximum is the maximum dollar amount a member or their covered family member(s) pays for covered benefits each plan year.

Background

As part of OPM's ongoing commitment to provide affordable and high-quality health plans with benefit designs that are in the best interest of members, OPM is clarifying carrier responsibilities to apply and track each member's out-of-pocket costs from claims processed for all covered services, regardless of the type of service (medical, professional, pharmacy, DME, etc.) or place of service (inpatient, outpatient, home, etc.)– effective for plan year 2025. This requirement applies to all FEHB and PSHB plans and includes their associated CMS-approved Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) or Medicare Advantage Prescription Drug (MAPD) EGWP, as applicable.

Tracking Member Out-of-Pocket Costs

All FEHB and PSHB Carriers are required to ensure accurate tracking and reporting of each member's out-of-pocket costs to prevent any undue burden on members. Additionally, Carriers must provide clear and accessible information on member out-of-pocket costs in their Explanation of Benefits and member portals and are encouraged to use other appropriate methods to inform members regarding the tracking of their out-of-pocket costs.

Application of Members' Out-of-Pocket Costs

Beginning January 1, 2025, all PSHB and FEHB Carriers are strongly encouraged to accumulate each member's out-of-pocket costs for plan-covered services toward the plan's catastrophic maximum. The plan's catastrophic maximum is the maximum dollar amount an enrollee or their covered family member(s) pays for covered benefits each plan year. Beginning January 1, 2026, all Carriers are required to accumulate each member's out-of-pocket costs for plan-covered services toward the plan's catastrophic maximum. Carriers have flexibility to establish separate medical and pharmacy out-of-pocket (OOP) limits, but both the medical and pharmacy OOP limits must accumulate toward the plan's catastrophic

maximum, including when the member is enrolled in an EGWP offered under the plan. Carriers may not exclude the entire medical or pharmacy OOP limit from the plan's catastrophic maximum.

Each EGWP-enrolled covered individual who incurs out-of-pocket expenses for EGWP-covered pharmacy services will accumulate pharmacy costs individually towards the $2,000 true out-of-pocket cost (TrOOP[4]) limit for Part D drugs in 2025, as statutorily set under section 1860D-2(b)(4)(B)(i)(VII) of the Social Security Act.

If the plan's catastrophic maximum is reached, all members covered under the plan will no longer have an out-of-pocket responsibility for covered pharmacy or medical benefits. As a reminder, all plan accumulations, including EGWPs, must be consistent with the provisions outlined in Section 4 of each plan brochure unless an OPM-approved exclusion is listed in Section 4.

Example scenarios

- A Medicare-enrolled annuitant is enrolled in a PSHB Self Plus One enrollment type[5]. The annuitant's spouse is also enrolled in Medicare. The plan's Self Plus One catastrophic maximum is $13,200. The annuitant has incurred $500 (e.g., copays or coinsurance) in Part D EGWP member out-of-pocket costs. The annuitant's spouse has incurred $1,000 in Part D EGWP out-of-pocket costs. In this scenario, a total of $1,500 would accumulate toward the $13,200 plan catastrophic maximum.
    - Note: In their 2025 Rate Announcement, CMS detailed the $2,000 true out-of-pocket costs (TrOOP) limit for 2025 Part D plans[6].

[4] TrOOP is the portion of spending on covered Part D drugs made by the beneficiary or on their behalf by certain third parties. The Inflation Reduction Act (IRA) updated which categories of payments count toward TrOOP spending. The IRA specifically amended the definition of incurred costs that count toward TrOOP for CY 2025 to *include* payments for previously excluded supplemental benefits provided by Part D sponsors and Employer Group Waiver Plans (EGWPs) and *exclude* payments under the new Manufacturer Discount Program. *See* https://www.cms.gov/newsroom/fact-sheets/final-cy-2025-part-d-redesign-program-instructions-fact-sheet

[5] 5 CFR 890.101

[6] *See* https://www.cms.gov/files/document/2025-announcement.pdf

Carriers must apply all Part D EGWP member out-of-pocket costs to the PSHB plan's catastrophic maximum. Carriers are required to adhere to all CMS and OPM guidance.

- A Medicare-enrolled annuitant enrolls in an FEHB plan under a Self and Family enrollment type. The annuitant's covered family members are not enrolled in or eligible for Medicare. The FEHB plan has a separate pharmacy OOP limit of $5,000 and a medical OOP limit of $8,200. The plan's Self and Family catastrophic maximum is $13,200. The FEHB Plan members' out-of-pocket pharmacy costs must apply toward the pharmacy OOP limit regardless of whether or not the enrollee or their covered family members are enrolled in the Medicare Part D EGWP, and those out-of-pocket pharmacy costs must apply toward the plan's catastrophic maximum. Under this example, the enrollee and their covered family members' out-of-pocket pharmacy and medical costs would accumulate as follows:
    - The annuitant has incurred $250 in member Part D EGWP costs and $1,000 in member medical costs.
    - The annuitant's spouse has incurred $500 in non-Part D EGWP pharmacy costs and $2,000 in member medical costs.
    - The annuitant's child has incurred $50 in non-Part D EGWP member pharmacy costs and $500 in member medical costs.
    - In this scenario, a total of $800 would accumulate toward the $5,000 pharmacy OOP limit and $3,500 toward the $8,200 medical OOP limit. Overall, $4,300 would accumulate toward the plan option's $13,200 catastrophic maximum.
- In all instances, members' out-of-pocket costs cannot exceed the applicable plan OOP limit or the plan's catastrophic maximum.

Lastly, all members' out-of-pocket costs for prescription drugs, services and supplies will accumulate toward the plan's annual catastrophic maximum as long as they remain enrolled in their plan during the plan year. For example, individuals who become entitled to Medicare and change their enrollment from their standard drug coverage to the plan's Part D EGWP will not be required to re-start their pharmacy OOP (and plan catastrophic maximum)

accumulation. This also applies to any member who disenrolls from a Part D EGWP mid-year, whereas any out-of-pocket pharmacy accumulation remains accounted for in the plan's pharmacy OOP limit and the plan's catastrophic maximum.

Conclusion

OPM appreciates your continued partnership in providing quality healthcare coverage to our members.

Please reach out to your Health Insurance Specialist with any questions.

Sincerely,

Laurie Bodenheimer
Associate Director
Healthcare and Insurance

Resources

For a glossary of CMS terms, please see: https://www.cms.gov/glossary.

For further guidance on CMS regulations, please refer to: https://www.cms.gov/medicare/regulations-guidance/cms-rulemaking.