FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2022-12

Date: July 13, 2022

Fee-for-service [10] Experience-rated HMO [10] Community-rated HMO [11]

Subject: No Surprises Act, Reporting on Pharmacy Benefits and Drug Costs, and Other Provisions of the Consolidated Appropriations Act, 2021

This Carrier Letter provides guidance to Carriers to implement certain provisions of the Consolidated Appropriations Act, 2021 (CAA), including the No Surprises Act (NSA) and certain pharmacy reporting provisions.

On January 1, 2022, the NSA took effect. The NSA amended the FEHB Act at 5 U.S.C. 8902(p). Under this new provision, each FEHB contract now directs the Carrier to comply with certain requirements of the NSA in the same manner as they apply to a group health plan or health insurance issuer. Under the NSA, FEHB enrollees and their covered family members are protected from surprise medical bills when they receive emergency services, non-emergency services from non-participating providers at participating facilities, and air ambulance services from non-participating providers of air ambulance services, under circumstances defined in the NSA. Other NSA requirements apply to health care providers, facilities, and providers of air ambulance services with respect to FEHB covered individuals in the same manner as they apply generally to individuals covered by non-FEHB health insurance under group health plans or coverage offered by health insurance issuers.

The CAA also includes provisions related to continuity of care, provider directories, insurance identification (ID) cards, balance billing disclosures, gag clauses on price and quality data, and prescription drug and health care

spending reporting. Although these provisions were not included in the amendment at 5 U.S.C. 8902(p), OPM's intent is to afford comparable patient protections to all FEHB-covered individuals as provided to similarly situated individuals covered by non-FEHB health insurance under group health plans or coverage offered by health insurance issuers. Fully aligning the FEHB Program with the rest of the health insurance industry allows for equity, uniformity and transparency in the application of those protections. For these reasons, OPM has co-authored the CAA implementing regulations[1], and bilaterally negotiated with Carriers the inclusion of terms in the 2022 FEHB contracts that include such consumer protections and reporting requirements.

Independent Dispute Resolution (IDR) - Notice of Initiation and Written Payment Determination (a binding determination)

Under 5 CFR 890.114(d), a Carrier must provide notice to OPM of its intent to initiate the IDR process, or its receipt of written notice that a provider, facility, or provider of air ambulance services has initiated the Federal IDR process, upon sending or receiving such notice.[2]

While the regulation is specific to the Federal IDR process, pursuant to bilateral negotiations of FEHB contract terms, OPM and the Carrier may agree to apply state law to determine the total amount payable to out-of-

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[1] On February 23, 2022, the United States District Court for the Eastern District of Texas, in the case of *Texas Medical Ass'n v. United States Department of Health and Human Services, et al.*, Case No. 6:21-cv-425 (E.D. Tex.), vacated portions of the interim final rule, Requirements Related to Surprise Billing: Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021), issued by the Departments of Health and Human Service, Labor, and the Treasury ("the Departments"), along with OPM, that governs aspects of the payment determination process under the Federal independent dispute resolution process. OPM and the Departments are complying with the Court's Order. That Order does not affect the requirements discussed in this Carrier Letter.

[2] OPM and the Departments of Health and Human Services, Labor and the Treasury issued interim final rules on October 7, 2021 to implement the Federal IDR process under the No Surprises Act. 86 FR 55980. The Departments also issued Federal IDR Process Guidance for Disputing Parties. Under the interim final rules and guidance, the initiating party must provide the notice of initiation to the other party and to the Departments. Notice to the Departments must be submitted through the Federal IDR Portal.

network (OON) providers and facilities; this may include adoption of state IDR process for determining OON rates (where the state permits access to the process). When OPM allows the adoption of the state law to apply, Carriers are not expected to submit state notice of initiation of state law process to OPM at this time.

Our goal is to eventually receive Federal IDR-related information directly from the Department of Health and Human Services (HHS). Regarding state IDR-related reporting, OPM currently has no such plans to receive reporting directly from the various states. The following instructions only apply to Federal IDR reporting.

Notice of IDR Initiation

1. For Federal IDR Initiation, Carriers must submit:
    - A copy of the "Notice of IDR Initiation" form (if available). If the Notice of IDR Initiation form is not available, the Carrier must submit the following information:
        - Date of Notice
        - IDR Reference Number
        - Carrier Name
        - Health care provider/Health care facility/Provider of Air Ambulance Services Information
        - Type of qualified item(s) or service(s):
            - Emergency item(s)/service(s)
            - Post-stabilization service(s)
            - Professional service(s)
            - Hospital-based service(s)
            - Item(s)/service(s) furnished by a non-participating provider at a participating health care facility
            - Out-of-network air ambulance service(s)
            - Other (provide description): ____________________
        - Description of IDR item(s) or service(s): ____
        - Date of item(s) or service(s): ____________________
2. Notices must be sent to the following email address:
    - **IDR@opm.gov**

3. The frequency of such reporting shall be:
    - Carrier-initiated IDR: **Concurrently with notice to the Departments of Labor, HHS, and the Treasury (collectively, the Departments) through the Federal IDR portal.**
    - Receipt of provider/facility/air ambulance-initiated IDR: **On a monthly basis: notices received in one month are due by the 20th of the following month.**

Written Payment Determination (a binding determination)

Under the Federal IDR process, a certified independent dispute resolution entity (IDRE) will issue a decision in the form of a written payment determination (which is a binding determination) by selecting one of the parties' offers as the out-of-network rate for the covered IDR item or service. This decision is sent to both parties and the Departments, but not OPM. While the regulation is silent on whether Carriers are required to submit a written payment determination to OPM, OPM believes it is reasonable and prudent to report such information in order to allow for a complete record and accounting of each reported Federal IDR case. Therefore, pursuant to 5 U.S.C. 8910, OPM is requiring Carriers to submit the written payment determination in a similar manner as that required of the Notice of IDR Initiation form.

Submission must be monthly to IDR@opm.gov. Determinations received in one month are due by the 20th of the following month.

Medicare Limiting Charge under 5 U.S.C. 8904(b) and NSA

Under 5 U.S.C. 8904(b) and 5 CFR 890 subpart I, fee-for-service (FFS) Carriers must limit payments for inpatient hospital services and physician services that are covered under Medicare Part A or B, and the FEHB plan, for "retired enrolled individuals," which refers to annuitants, certain former spouses, and their covered family members, not employed in a position which confers FEHB coverage, who are over age 65 and do not have Medicare Part A or Part B. For inpatient hospital services provided by

hospital providers with in force Medicare participation agreements[3], FFS Carriers are required to base payments on the equivalent amount allowed by Medicare, reduced by any FEHB plan deductible, coinsurance, copayment, or preadmission certification penalty that is the responsibility of the retired enrolled individual. For physician services, FFS Carriers are required to determine the payment amount by taking the lower of the Medicare approved amount applicable to participating physicians or non-participating physicians, as applicable, or the amount charged by the provider, and reducing this amount by any FEHB plan deductible, coinsurance, or payment that is the responsibility of the retired enrolled individual. In these cases, hospitals and participating physicians may not balance bill the retired enrolled individual beyond charges allowed under Medicare. FFS Carriers may not pay an amount in excess of that permitted by regulation.

When services are provided to retired enrolled individuals, FFS Carriers must determine whether the services fall under 8904(b). If the service is covered by 8904, the carrier must apply 8904(b). If not, then the individual may be protected under the terms of the NSA for the services provided.

In some cases, 8904(b) and the NSA, by their terms, would **both** appear to apply to services provided to retired enrolled individuals. For example, both 8904(b) and the NSA may apply to charges from an out-of-network physician who has provided services in an in-network hospital to a retired enrolled individual. In cases where the terms of both 8904(b) and the NSA would otherwise apply to the services, 8904(b) must take precedence and Carriers are to apply 8904(b) in processing the claim, not the NSA. In these cases, the payment amount must be limited in accordance with the terms of 8904(b) and 5 CFR 890 subpart I, and the retired enrolled individual may not be balance billed beyond the equivalent of charges allowed under Medicare.

[3] Pursuant to 890.903, this includes hospital providers that "receive Medicare Part A payments in accordance with the diagnosis related group (DRG) based prospective payment system (PPS)." Payments must be pursuant to 890.904.

Carriers may receive charges from physicians who "opt out" of Medicare (a different designation than physicians who are non-participating in Medicare). In most cases, "opt-out" physicians enter into contracts with patients advising them that the physician will not bill Medicare, Medicare will not pay for services, and setting forth payment terms between the physician and the patient. By its terms, 8904(b) applies to services from physicians who are participating or non-participating in Medicare, and therefore does not apply to charges from "opt-out" physicians. The NSA may apply if the services provided by the "opt-out" physician fall under its protections.

Good Faith Compliance

On August 20, 2021, the Departments issued Frequently Asked Questions (FAQs) Part 49. OPM adopts the Departments' FAQs for purposes of the FEHB Program. Consistent with the FAQs, pending future rulemaking or guidance, Carriers must use a good faith, reasonable interpretation of the statutory law to comply with NSA provisions that became effective on January 1, 2022. Those NSA provisions include provisions relating to ID cards (see Question 4 of the FAQs); provider directories (see Question 8 of the FAQs); balance billing disclosures (see Question 9 of the FAQs); and continuity of care (see Question 10 of the FAQs). The Departments' FAQs also address good faith compliance with a prohibition on gag clauses on price and quality data (see Question 7 of the FAQs); OPM incorporated that prohibition in the 2022 FEHB Contracts.

OPM provides the below additional guidance to Carriers on our expectations relating to continuity of care and provider directories.

Continuity of Care

OPM plans to propose amendments to FEHB Carrier contracts following future rulemaking by the Departments and OPM, in order to reconcile the NSA's continuity of care requirements with the FEHB contracts' existing transitional care requirements, which were first promulgated in 2000 pursuant to the Patients' Bill of Rights. Until FEHB contracts are revised, Carriers may rely on the existing transitional care requirements to

demonstrate good faith compliance with the NSA's continuity of care requirements, except with respect to the care during the entire duration of pregnancy. To demonstrate good faith compliance with the NSA's continuity of care provisions relating to the entirety of pregnancy, Carriers must apply the current transitional care clause to women in any trimester of pregnancy instead of just those in the second or third trimester. Carriers should update their websites, as soon as practicable, to notify enrollees about the extension of transitional care to the entire duration of pregnancy.

Provider Directories

If an FEHB covered individual receives items or services from a non-participating provider or non-participating facility, and the Carrier provided inaccurate information in a plan's provider directory or response protocol that stated that the provider or facility was a participating provider or participating facility, then the Carrier must:

1. Impose only a cost-sharing amount that is not greater than the cost-sharing amount that would be imposed for items or services furnished by a participating provider or participating facility, and
2. Count those cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum.

Prescription Drug and Health Care Spending Reporting

Under 5 U.S.C. 8910, OPM must make a continuing study of the operation and administration of the FEHB Program, including surveys and reports on FEHB plans and on the experience of these plans. Pursuant to this authority, OPM is requiring Carriers to submit prescription drug and health care spending data to HHS by December 27, 2022 and annually thereafter in the same manner as group health plans and health insurance issuers. See the interim final rule entitled, "Prescription Drug and Health Care Spending," which was published on November 23, 2021. See also Prescription Drug Data Collection (RxDC) Reporting Instructions, which include OPM's specific instructions for FEHB Carriers.

Per 5 CFR 890.114(f), the OPM Director will coordinate with the Departments in oversight of prescription drug and health care spending data with respect to Carriers. For FEHB Program oversight and to ensure data quality, OPM will coordinate with HHS to receive these Carrier reports from HHS.

Reporting by Carriers, in the same manner as group health plans and health insurance issuers, is expected to help accomplish the CAA's intended purposes of achieving national health data transparency and lowering costs both for the health benefits industry and for the FEHB Program.

Carriers are reminded that OPM’s current pharmacy reporting requirements remain in effect and OPM appreciates the ongoing efforts of Carriers in meeting these obligations. OPM’s annual aggregate pharmacy data collection, in conjunction with the new data collection, will help OPM make informed decisions regarding the FEHB Program. Among other things, information from both sets of data collection will help to identify any excessive pricing and premium impact of prescription drugs.

If you have any questions, please contact your Health Insurance Specialist.

Sincerely,

Laurie Bodenheimer
Associate Director
Healthcare and Insurance