OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890; 48 CFR Parts 1602, 1615, 1632, and 1652

RIN 3206–AM39

Federal Employees Health Benefits Program: New Premium Rating Method for Most Community Rated Plans; Withdrawal

AGENCY: U.S. Office of Personnel Management.

ACTION: Interim final rule; withdrawal.

SUMMARY: The U.S. Office of Personnel Management (OPM) is withdrawing an interim final regulation that appeared in the **Federal Register** of June 23, 2011 (76 FR 36857). The document amends the Federal Employees Health Benefits (FEHB) regulations at 5 CFR Chapter 89 and also the Federal Employees Health Benefits Acquisition Regulation (FEHBAR) at 48 CFR Chapter 16 and would replace the procedure by which premiums for community rated FEHB carriers are compared with the rates charged to a carrier's similarly sized subscriber groups (SSSGs).

DATES: The interim final rule published on Thursday, June 23, 2011 at 76 FR 36857 is withdrawn as of June 29, 2011.

FOR FURTHER INFORMATION CONTACT: Louise Dyer, Senior Policy Analyst, (202) 606–0770, or by e-mail to *Louise.Dyer@opm.gov.*

SUPPLEMENTARY INFORMATION: This rule is being withdrawn due to the version submitted to the **Federal Register** was incorrect and contained numerous errors. In today's issue of the **Federal Register**, you will find the correct version of the interim rule.

U.S. Office of Personnel Management.

Edward M. DeHarde,

Program Manager, National Healthcare Operations.

[FR Doc. 2011–16280 Filed 6–28–11; 8:45 am]

BILLING CODE 6325–24–P

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

48 CFR Parts 1602, 1615, 1632, and 1652

RIN 3206–AM39

Federal Employees Health Benefits Program: New Premium Rating Method for Most Community Rated Plans

AGENCY: U.S. Office of Personnel Management.

ACTION: Interim final rule with request for comments.

SUMMARY: The U.S. Office of Personnel Management (OPM) is issuing an interim final regulation amending the Federal Employees Health Benefits (FEHB) regulations and also the Federal Employees Health Benefits Acquisition Regulation (FEHBAR). This interim final regulation replaces the procedure by which premiums for community rated FEHB carriers are compared with the rates charged to a carrier's similarly sized subscriber groups (SSSGs). This new procedure utilizes a medical loss ratio (MLR) threshold, analogous to that defined in both the Affordable Care Act (ACA, Pub. L. 111–148) and the Department of Health and Human Services (HHS) interim final regulation published December 1, 2010 (75 FR 74864). The purpose of this interim final rule is to replace the outdated SSSG methodology with a more modern and transparent calculation while still ensuring that the FEHB is receiving a fair rate. This will result in a more streamlined process for plans and increased competition and plan choice for enrollees. The new process will apply to all community rated plans, except those under traditional community rating (TCR). This new process will be phased in over two years, with optional participation for non-TCR plans in the first year.

DATES: This interim final rule is effective July 29, 2011. Comments are due on or before August 29, 2011.

FOR FURTHER INFORMATION CONTACT: Louise Dyer, Senior Policy Analyst, (202) 606–0770, or by e-mail to *Louise.Dyer@opm.gov*.

SUPPLEMENTARY INFORMATION: The Office of Personnel Management is issuing an interim final regulation to establish a new rate-setting procedure for most FEHB plans that are subject to community rating. Currently, a carrier's rates for its community rated FEHB plans are compared with the rates the carrier charges to its similarly sized subscriber groups (SSSGs) during a reconciliation process in the plan year. This interim final regulation replaces this SSSG process with a requirement that most community rated plans meet an FEHB-specific medical loss ratio (MLR) target. Plans that are required to use traditional community rating (TCR) per their state regulator will be exempt from this new rate-setting procedure. This MLR-based rate setting process will ensure the Government and Federal employees are receiving a fair market rate and a good value for their premium dollars.

ACA Medical Loss Ratio Requirement

Effective for 2011, most health insurance policies, including those issued under FEHB, are required to meet a medical loss ratio standard set forth in Federal law, or pay rebates to the individuals insured. This MLR requirement was enacted in the ACA in a new section 2718 of the Public Health Service Act titled ''Bringing Down the Cost of Health Care Coverage,'' and is intended to control health care costs by limiting the percentage of premium receipts that can be used for non-claim costs (costs for purposes other than providing care or improving the quality of care). The details of this ACA-required MLR formula comparing non-claim costs to overall expenditures were promulgated in an HHS interim final regulation published in the Federal Register on December 1, 2010 (75 FR 74864). Non-claim costs include plan administration costs, marketing costs, and profit. ACA requires that health insurance issuers, beginning in calendar year 2011, meet an MLR of 85% for large groups, (i.e., non-claim costs may not exceed 15%). If an issuer does not meet the MLR target, it must pay a premium rebate.

FEHB-Specific MLR Threshold

Under this OPM regulation, in addition to being subject to the ACA-required MLR, most FEHB community rated plans will be required to meet an FEHB-specific MLR threshold for the annual rates negotiated for their Federal enrollment. This new requirement will be included in 48 CFR 1615.402(c)(3)(ii) and will be phased in over two years. If the plan falls below the FEHB-specific MLR threshold, the plan must pay a subsidization penalty into a newly established Subsidization Penalty Account (defined in 5 CFR 890.503(c)(6)). The FEHB-specific MLR threshold will be set in OPM's annual rate instructions to FEHB plans published in the spring of each year, rather than by regulation. If the plan has met or exceeded the FEHB-specific MLR threshold, there is no exchange of funds or adjustment of premiums necessary.

This rule establishes a process by which FEHB community rated plans (other than plans using TCR) will calculate and submit the MLR for their FEHB plans. This process will take place after the end of the plan year and after the carrier has calculated and submitted to HHS the ACA-required MLR. Under this regulation, premium rates for community rated plans will continue to be negotiated prior to the plan year based on the plan's community rating methodology. There