submitted cost or pricing data which was incomplete, inaccurate, or noncurrent; and

(3) Simple interest on the MLR penalty from the date on which the penalty should have been paid to the FEHB Fund to the date on which the penalty was or will be actually paid to the FEHB fund. The interest rate shall be calculated as specified in paragraph (c)(1) of this clause.

■ 9. In 1652.216–70, revise paragraphs (b)(2), (3), (7), and (8) to read as follows:

1652.216–70 Accounting and price adjustment.

* * * * *

(b) * * *

(2) Effective January 1, 2013 all community-rated plans must develop the FEHBP's rates using their State-filed rating methodology or, if not required to file with the State, their standard written and established rating methodology. A carrier who mandated by the State to use traditional community rating will be subject to paragraph (b)(2)(ii) of this clause. All other carriers will be subject to paragraph (b)(2)(i) of this clause.

(i) The subscription rates agreed to in this contract shall meet the FEHB-specific MLR threshold as defined in FEHBAR 162.170–14. The ratio of a plan's incurred claims, including the carrier's expenditures for activities that improve health care quality, to total premium revenue shall not be lower than the FEHB-specific MLR threshold published annually by OPM in its rate instructions.

(ii) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the carrier's similarly sized subscriber group (SSSG) as defined in FEHBAR 1602.170–13. The subscription rates shall be determined according to the carrier's established policy, which must be applied consistently to the FEHBP and to the carrier's SSSG. If the SSSG receives a rate lower than that determined according to the carrier's established policy, it is considered a discount. The FEHBP must receive a discount equal to or greater than the carrier's SSSG discount.

(3) If subject to paragraph (b)(2)(ii) of this clause, then:

(i) If, at the time of the rate reconciliation, the subscription rates are found to be lower than the equivalent rates for the SSSG, the carrier may include an adjustment to the Federal group's rates for the next contract period, except as noted in paragraph (b)(3)(iii) of this clause.

(ii) If, at the time of the rate reconciliation, the subscription rates are found to be higher than the equivalent rates for the SSSG, the carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the SSSG, except as noted in paragraph (b)(3)(iii) of this clause.

(iii) Carriers may provide additional guaranteed discounts to the FEHBP that are not given to the SSSG. Any such guaranteed discounts must be clearly identified as guaranteed discounts. After the beginning of the contract year for which the rates are set, these guaranteed FEHBP discounts may not be adjusted.

* * * * *

(7) Carriers may provide additional guaranteed discounts to the FEHBP. Any such guaranteed discounts must be clearly identified as guaranteed discounts. After the beginning of the contract year for which the rates are set, these guaranteed FEHBP discounts may not be adjusted.

(8) Carriers may not impose surcharges (loadings not defined based on an established rating method) on the FEHBP subscription rates or use surcharges in the rate reconciliation process. If the carrier is subject to the SSSG rules and imposes a surcharge on the SSSG, the carrier cannot impose the surcharge on FEHB.

* * * * *

[FR Doc. 2014–30633 Filed 1–6–15; 8:45 am]

BILLING CODE 6325–63–P

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN07

Federal Employees Health Benefits Program: Enrollment Options Following the Termination of a Plan or Plan Option

AGENCY: Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The U.S. Office of Personnel Management (OPM) is issuing a proposed rule to amend the Federal Employees Health Benefits (FEHB) Program regulations regarding enrollment options following the termination of a plan or plan option.

DATES: OPM must receive comments on or before March 9, 2015.

ADDRESSES: Send written comments to Chelsea Ruediger, Planning and Policy Analysis, U.S. Office of Personnel Management, Room 4312, 1900 E Street NW., Washington, DC 20415. You may also submit comments using the *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

FOR FURTHER INFORMATION CONTACT: Chelsea Ruediger at (202) 606–0004.

SUPPLEMENTARY INFORMATION: When a plan or plan option in the Federal Employees Health Benefits (FEHB) Program terminates, OPM provides the enrollees of that plan or plan option a time period in which they may elect to enroll in a new plan or plan option. This proposed rule clarifies the actions that OPM and employing agencies may take when an enrollee fails to make an enrollment election during the time period provided.

Current regulation ends an employee's enrollment in the FEHB Program if he or she fails to make an enrollment election during the time period provided by OPM following a plan termination. This proposed regulation amends 5 CFR 890.301 to require the employing office to enroll automatically these employees into the lowest-cost nationwide plan option based on the enrollee share of the cost of a self only enrollment. Under the proposed regulation, a plan will not be considered the lowest-cost nationwide plan option if it is a High Deductible Health Plan (HDHP) or if it requires a membership fee or an association fee.

For annuitants, current regulation provides that individuals who fail to make an enrollment election during the time provided by OPM following a plan termination shall be considered to be enrolled in the option of the Blue Cross and Blue Shield Service Benefit Plan that OPM determines most closely approximates the terminated plan. The proposed regulation amends 5 CFR 890.306 to provide that these annuitants will be enrolled into the lowest-cost nationwide plan option that is available to the individual based on the same criteria listed above.

Current regulation provides that when a plan discontinuation occurs due to a disaster, employees and annuitants who fail to make an enrollment election within 60 days of the disaster, as announced by OPM, shall be considered to be enrolled in the Standard Option of the Blue Cross and Blue Shield Service Benefit Plan. The proposed rule amends the regulation to provide that these individuals will be enrolled into the lowest-cost nationwide plan option that is available to the individual based on the same criteria listed above. It also provides belated enrollment authority for individuals who, for causes beyond

their control, are unable to make enrollment changes and are enrolled in the lowest-cost nationwide plan.

Since 2004, OPM has allowed up to three plan options under a plan. *See* 69 FR 31721. Accordingly, the proposed rule also updates outdated language in 5 CFR 890.301 and 890.306 that considers the termination of a plan option under a plan with a total of only two plan options. Under the proposed rule, when two or more plan options remain after a different plan option is terminated, the employing office will enroll the employee in the lowest-cost remaining plan option that is not an HDHP.

Conforming edits have been made to 5 CFR 890.806 for former spouses and 5 CFR 890.1108 for enrollees in temporary continuation of coverage status.

We are seeking comment on these provisions.

Paperwork Reduction Act (PRA)

OPM has reviewed this proposed rule for PRA implications and have determined that it does not apply to this action.

Regulatory Impact Analysis

OPM has examined the impact of this proposed rule as required by Executive Order 12866 and Executive Order 13563, which directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public, health, and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects of $100 million or more in any one year. After completing this analysis, OPM has determined that this rule is not considered a major rule.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation only impacts options available for FEHB enrollees when the plan or plan option in which they are enrolled terminates.

Executive Order 12866, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Order 12866.

Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Military personnel, Reporting and recordkeeping requirements, Retirement.

U.S. Office of Personnel Management.

Katherine Archuleta,

Director.

Accordingly, OPM proposes to amend title 5, Code of Federal Regulations, part 890 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

■ 1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; Sec. 890.301 also issued under sec. 311 of Pub. L. 111–03, 123 Stat. 64; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521; Sec. 890.112 also issued under section 1 of Pub. L. 110–279, 122 Stat. 2604; 5 U.S.C. 8913; Sec. 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under sections 11202(f), 11232(e), 11246 (b) and (c) of Pub. L. 105–33, 111 Stat. 251; and section 721 of Pub. L. 105–261, 112 Stat. 2061; Pub. L. 111–148, as amended by Pub. L. 111–152.

■ 2. Amend § 890.301 by revising paragraphs (i)(4)(ii), (iii), and (iv) and adding paragraphs (i)(4)(v) and (n) to read as follows:

§ 890.301 Opportunities for employees who are not participants in premium conversion to enroll or change enrollment; effective dates.

* * * * *

(i) * * *

(4) * * *

(ii) If the whole plan is discontinued, an employee who does not change the enrollment within the time set in paragraph (i)(4)(i) of this section will be enrolled in the lowest-cost nationwide plan option, as defined in paragraph (n) of this section;

(iii) If one or more options of a plan are discontinued, an employee who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP).

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, an employee must change the enrollment within 60 days of the disaster, as announced by OPM. If an employee does not change the enrollment within the time frame announced by OPM, the employee will be enrolled in the lowest-cost nationwide plan option, as defined in paragraph (n) of this section. The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) An employee who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in paragraph (n) of this section, may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

* * * * *

(n) OPM will annually determine the lowest-cost nationwide plan option calculated based on the enrollee share of the cost of a self only enrollment. The plan option identified may not be a High Deductible Health Plan (HDHP) or an option from a health benefits plan that charges an association or membership fee.

■ 3. Amend § 890.306 by revising paragraphs (l)(4)(ii), (iii), (iv), and (v) and adding paragraph (l)(4)(vi) to read as follows:

§ 890.306 When can annuitants or survivor annuitants change enrollment or reenroll and what are the effective dates?

* * * * *

(l) * * *

(4) * * *

(ii) If a plan discontinues all of its existing options, an annuitant who does not change his or her enrollment is deemed to have enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n); except when the annuity is insufficient to pay the withholdings, then paragraph (q) of this section applies.

(iii) If one or more options of a plan are discontinued, an annuitant who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP). In the event that the annuity is insufficient to pay the withholdings, then paragraph (q) of this section applies;

(iv) After an involuntary enrollment under paragraph (l)(4)(ii) or (iii) of this section becomes effective, the annuitant may change the enrollment to another option of the plan into which he or she

was enrolled or another health plan of his or her choice retroactively within 90-days after OPM advises the annuitant of the new enrollment;

(v) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, an annuitant must change the enrollment within 60 days of the disaster, as announced by OPM. If an annuitant does not change the enrollment within the time frame announced by OPM, the annuitant will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n). The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(vi) An annuitant who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in § 890.301(n), may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

* * * * *

■ 4. Amend § 890.806 by revising paragraphs (j)(4)(ii), (iii), and (iv) and adding paragraph (j)(4)(v) to read as follows:

§ 890.806 When can former spouses change enrollment or reenroll and what are the effective dates?

* * * * *

(j) * * *

(4) * * *

(ii) If the whole plan is discontinued, a former spouse who does not change the enrollment within the time set will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n);

(iii) If one or more options of a plan are discontinued, a former spouse who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP);

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, the former spouse must change the enrollment within 60 days of the disaster, as announced by OPM. If a former spouse does not change the enrollment within the time frame announced by OPM, the former spouse will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n). The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) A former spouse who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in § 890.301(n), may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

* * * * *

■ 5. Amend § 890.1108 by revising paragraphs (h)(4)(ii), (iii), and (iv) and adding paragraph (h)(4)(v) to read as follows:

§ 890.1108 Opportunities to change enrollment; effective dates.

* * * * *

(h) * * *

(4) * * *

(ii) If the whole plan is discontinued, an enrollee who does not change the enrollment within the time set will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n);

(iii) If one or more options of a plan are discontinued, an enrollee who does not change the enrollment will enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP);

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, the enrollee must change the enrollment within 60 days of the disaster, as announced by OPM. If the enrollee does not change the enrollment within the time frame announced by OPM, the enrollee will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n). The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) An enrollee who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in § 890.301(n), may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

* * * * *

[FR Doc. 2014–30636 Filed 1–6–15; 8:45 am]

BILLING CODE 6325–63–P

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN14

Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery

AGENCY: Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The United States Office of Personnel Management (OPM) is issuing a proposed rule to amend the Federal Employees Health Benefits (FEHB) Program regulations to clarify the conditional nature of FEHB Program benefits and benefit payments under the plan's coverage as subject to a carrier's entitlement to subrogation and reimbursement recovery, and therefore, that such entitlement falls within the preemptive scope of the U.S.C. FEHB contracts must include a provision incorporating the carrier's subrogation and reimbursement rights and FEHB plan brochures must explain the carrier's subrogation and reimbursement policy.

DATES: Comments are due on or before February 6, 2015.

ADDRESSES: Send written comments to Marguerite Martel, Senior Policy Analyst, Planning and Policy Analysis, U.S. Office of Personnel Management, Room 4312, 1900 E Street NW., Washington, DC; or FAX to (202) 606–4640 Attn: Marguerite Martel. You may also submit comments using the *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

FOR FURTHER INFORMATION CONTACT: Marguerite Martel at *Marguerite.Martel@opm.gov* or (202) 606–0004.

SUPPLEMENTARY INFORMATION: The FEHB Act, as codified at 5 U.S.C. 8902(m)(1) provides: ''The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.'' This proposed regulation reaffirms that a covered individual's entitlement to FEHB benefits and benefit payments is conditioned upon, and limited by, a carrier's entitlement to subrogation and reimbursement recoveries pursuant to a subrogation or reimbursement clause in the FEHB contract. This proposed regulation also reaffirms that a FEHB carrier's rights and responsibilities