

(iii) Undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as "by" or "from" a cooperating country ministry or government official.

(iv) Impair the functionality of an item, such as sterilized equipment or spare parts.

(v) Incur substantial costs or be impractical, such as items too small or other otherwise unsuited for individual marking, such as food in bulk.

(vi) Offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities.

(vii) Conflict with international law.

(2) These exceptions are presumptive, not automatic and must be approved by the Agreement Officer. Apparently successful applicants may request approval of one or more of the presumptive exceptions, depending on the circumstances, in their Marking Plan. The Agreement Officer will review requests for presumptive exceptions for adequacy, along with the rest of the Marking Plan. When reviewing a request for approval of a presumptive exception, the Agreement Officer may review how program materials will be marked (if at all) if the USAID identity is removed. Exceptions approved will apply to subrecipients unless otherwise provided by USAID.

(i) In cases where the Marking Plan has not been complied with, the Agreement Officer will initiate corrective action. Such action may involve informing the recipient of a USAID grant or cooperative agreement or other assistance award or subaward of instances of noncompliance and requesting that the recipient carry out its responsibilities as set forth in the Marking Plan and award. Major or repeated non-compliance with the Marking Plan will be governed by the uniform suspension and termination procedures set forth at 2 CFR 200.338 through 2 CFR 200.342, and 2 CFR 700.14.

(j)(1) *Waivers*. USAID Principal Officers, defined for purposes of this provision at § 700.1, may at any time after award waive in whole or in part the USAID approved Marking Plan, including USAID marking requirements for each USAID funded program, project, activity, public communication or commodity, or in exceptional circumstances may make a waiver by region or country, if the Principal Officer determines that otherwise USAID required marking would pose

compelling political, safety, or security concerns, or marking would have an adverse impact in the cooperating country. USAID recipients may request waivers of the Marking Plan in whole or in part, through the AOR. No marking is required while a waiver determination is pending. The waiver determination on safety or security grounds must be made in consultation with U.S. Government security personnel if available, and must consider the same information that applies to determinations of the safety and security of U.S. Government employees in the cooperating country, as well as any information supplied by the AOR or the recipient for whom the waiver is sought. When reviewing a request for approval of a waiver, the Principal Officer may review how program materials will be marked (if at all) if the USAID Identity is removed. Approved waivers are not limited in duration but are subject to Principal Officer review at any time due to changed circumstances. Approved waivers "flow down" to recipients of subawards unless specified otherwise. Principal Officers may also authorize the removal of USAID markings already affixed if circumstances warrant. Principal Officers' determinations regarding waiver requests are subject to appeal to the Principal Officer's cognizant Assistant Administrator. Recipients may appeal by submitting a written request to reconsider the Principal Officer's waiver determination to the cognizant Assistant Administrator.

(2) *Non-retroactivity*. Marking requirements apply to any obligation of USAID funds for new awards as of January 2, 2006. Marking requirements also will apply to new obligations under existing awards, such as incremental funding actions, as of January 2, 2006, when the total estimated cost of the existing award has been increased by USAID or the scope of effort is changed to accommodate any costs associated with marking. In the event a waiver is rescinded, the marking requirements will apply from the date forward that the waiver is rescinded. In the event a waiver is rescinded after the period of performance as defined in 2 CFR 200.77 but before closeout as defined in 2 CFR 200.16., the USAID mission or operating unit with initial responsibility to administer the marking requirements must make a cost benefit analysis as to requiring USAID marking requirements after the date of completion of the affected programs, projects, activities, public communications or commodities.

(k) The USAID Identity and other guidance will be provided at no cost or

fee to recipients of USAID grants, cooperative agreements or other assistance awards or subawards. Additional costs associated with marking requirements will be met by USAID if reasonable, allowable, and allocable under 2 CFR part 200, subpart E. The standard cost reimbursement provisions of the grant, cooperative agreement, other assistance award or subaward must be followed when applying for reimbursement of additional marking costs.

(End of award term)

Angelique M. Crumbly,
Agency Regulatory Official, U.S. Agency for
International Development.

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OFFICE OF PERSONNEL MANAGEMENT

5 CFR Parts 890 and 892

RIN 3206-AN08

Federal Employees Health Benefits Program Self Plus One Enrollment Type

AGENCY: Office of Personnel
Management.

ACTION: Final rule.

SUMMARY: The United States Office of Personnel Management (OPM) is issuing a final rule to amend the Federal Employees Health Benefits (FEHB) Program regulations to add an additional enrollment type called "self plus one" for premium rating and family member eligibility purposes.

DATES: This rule is effective September 17, 2015.

FOR FURTHER INFORMATION CONTACT: Chelsea Ruediger at Chelsea.Ruediger@opm.gov or (202) 606-0004.

SUPPLEMENTARY INFORMATION: The U.S. Office of Personnel Management (OPM) issued a Notice of Proposed Rulemaking on December 2, 2014 to amend title 5 of the Code of Federal Regulations parts 890 and 892 to include a self plus one enrollment type to comply with the 2013 Bipartisan Budget Act. During the comment period on the proposed rule, OPM received 64 comments including 5 from Federal Employees Health Benefits (FEHB) Program carriers, 2 from employee organizations or unions, 1 from a carrier organization, and 56 from individuals, many of them enrollees in the FEHB Program. These comments are addressed below.

General Comments Regarding Self Plus One

OPM received a variety of comments, mostly from FEHB enrollees, expressing excitement about the self plus one enrollment type. Commenters indicated that the enrollment type will benefit them personally and financially.

One commenter requested justification for the implementation of the self plus one enrollment type and expressed concern over the level of complexity that this additional statutorily required enrollment type introduces to consumer choice in the FEHB Program. The commenter noted that under the current two-tier system, “the typical enrollee . . . has a choice of about 20 plan options” and projected that options available for families may double and premiums might vary greatly.

OPM is updating 5 CFR parts 890 and 892 to comply with provisions of the 2013 Bipartisan Budget Act. This more closely aligns insurance offerings for Federal employees with those available in the commercial market and to more equitably spread costs among the enrollment types offered.

OPM is aware that creation of a new enrollment tier may create additional complexity. However, this complexity is limited because the rule only introduces a new enrollment type. Benefits design will not differ from other enrollment types offered within the same plan option, which minimizes the complexity introduced by the rule. To alleviate potential concerns about complexity during the introductory year, § 892.207(d) has been amended in this final rule to include a one-time limited enrollment period to be held in early 2016. Final dates for the Limited Enrollment Period will be announced by OPM following the publication of this rule. During this period, enrollees will be allowed to decrease enrollment from self and family to self plus one. Enrollment changes made in conjunction with the limited enrollment period will be effective on the first day of the first pay period following the one in which the appropriate request is

received by the employing office. Because enrollees who do not participate in premium conversion (pre-tax deduction of premiums), including annuitants, may decrease their enrollment at any time, this limited enrollment period is intended only for premium conversion participants. No new enrollments, changes in plan or plan option, or increases in enrollment will be allowed in conjunction with the limited enrollment period.

In advance of Open Season each year, OPM, agencies and carriers inform employees and annuitants of their enrollment options and provide them with decision-making tools. Given the addition of the self plus one enrollment type, this communications strategy will be augmented for the 2015 Open Season. OPM communications will encourage enrollees to carefully review the options available to them for plan year 2016.

An FEHB carrier requested clarification that “enrollees will need to make a positive election through their agency or retirement office in order to switch from self only or self and family to self plus one.” This statement is correct. Just as is the case under the current two-tier system, enrollees must inform their agency, either through an electronic or paper copy of the Standard Form 2809, when they increase or decrease coverage. Agencies are responsible for submitting this information to carriers. This requirement will be no different for self plus one.

Comments on Effective Dates

Several commenters requested additional information about the timing of the implementation of the self plus one enrollment type. Others requested that OPM delay implementation by at least one year in order to conduct additional analysis. Another questioned the decision to implement the new self plus one enrollment option for plan year 2016, as this date was not required by law.

The effective date in this final rule has not been altered. The Bipartisan

Budget Act was passed in 2013 and OPM has been working diligently to implement this statutory mandate within a reasonable timeframe. Enrollees who have been looking forward to this change will now be able to select a self plus one enrollment type during the 2015 Open Season for effective dates in January of 2016.

Comments on Family Member Eligibility

OPM received three comments about family member eligibility. Two commenters asked about the eligibility of domestic partners and cohabitating (unmarried) opposite sex couples. A third comment asked if a sibling could be covered.

Family member eligibility is defined in title 5 U.S. Code section 8901 and includes spouses and children up to age 26. As stated in the supplementary information of the proposed rule, family member eligibility guidelines remain the same as in place under the two tier system. Domestic partners, cohabitating (unmarried) couples, and siblings are not considered eligible family members under the law at this time.

Switching a Covered Family Member

The proposed rule outlined the circumstances in which an enrollee with a self plus one enrollment would be allowed to switch their covered family member. Some commenters expressed concerns that these provisions might lead to adverse selection. OPM believes that adequate protection against adverse selection is provided in the manner in which Qualifying Life Events (QLEs) allowing such a change have been limited. Further, the general rule applies that the change must be consistent with the QLE experienced. The following chart, which was published with the proposed rule, clarifies which QLE codes will allow an enrollee to switch a covered family member outside of Open Season (definitions for each of the event codes can be found on the SF2809 at http://www.opm.gov/forms/pdf_fill/sf2809.pdf):

Change	Permitted for the following event codes
For Enrollees Participating in Premium Conversion	
Switch covered family member under a self plus one enrollment	1B, 1C, 1I, 1J, 1M, 1N, 1O, 1P, 1Q, 1R
For Annuitants (decreases in enrollment type are allowed at any time)	
Switch covered family member under a self plus one enrollment	2A, 2B, 2F, 2G, 2H, 2I, 2J
For Former Spouses Under the Spouse Equity Provision (decreases in enrollment type are allowed at any time)	
Switch covered family member under a self plus one enrollment	3B, 3C, 3F, 3G, 3H, 3I

Change	Permitted for the following event codes
For Temporary Continuation of Coverage (TCC) for Eligible Former Employees, Former Spouses, and Children (decreases in enrollment type are allowed at any time)	
Switch covered family member under a self plus one enrollment	4B, 4C, 4D, 4F, 4G, 4H
For Employees Not Participating in Premium Conversion (decreases in enrollment type are allowed at any time)	
Switch covered family member under a self plus one enrollment	5B, 5C, 5F, 5G, 5H, 5I, 5J, 5N

One carrier organization requested that OPM require a 30 day advance notice to carriers before allowing a switch in covered family member in order to prevent overpayments as well as verification of alternative health insurance for the family member being removed. OPM declines to make this change. It is expected that carriers will utilize current standard operating procedures to process the switching of a covered family member; generally changes are effective at the beginning of the next pay period after receipt by the agency.

A commenter urged OPM to treat the switch as a cancellation for the family member who is being removed from the self plus one enrollment, thereby rendering the individual ineligible for the 31 day extension of coverage. Just as is the case under the two tier system, under § 890.401(a)(1) eligibility for the 31 day extension of coverage is provided for covered family members whose coverage is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or in part. For family members, terminations are typically based on a loss of eligibility such as, in the case of a child, turning age 26; or, in the case of a spouse, a divorce. Cancellation is typically a voluntary election to no longer be covered under an FEHB plan, for example when a family member becomes eligible for other group coverage. Switching a covered family member may occur as the result of either a termination or a cancellation. Therefore, OPM declines to make this change.

One commenter urged OPM to apply a blanket policy against discretionary retroactive switching of a covered family member. Section 892.207(b) has been updated in the final rule to include switching a covered family member in order to accommodate this suggestion. Enrollment changes made under § 892.207 are, in general, effective on the first day of the first pay period following the one in which the appropriate request is received by the employing office. In addition, paragraph (f)(2) has been added to § 890.302 in the final rule to specify that the effective

date for switching a covered family member will be prospective. A definition of the term “switching a covered family member” has also been added to § 890.101.

One commenter requested that OPM clarify that “enrollees cannot switch the covered family member under the self plus one without a QLE to validate dependent eligibility.” As described in the proposed rule, and supported in the final rule, enrollees must experience a QLE in order to switch their covered family member.

One commenter requested additional information about how carriers will be notified of the designated covered family member under the self plus one enrollment. The Standard Form 2809 and electronic enrollment transmissions will be utilized just as they are currently to communicate enrollment information. Additionally, OPM is assessing other methods, including updating enrollment systems government-wide to allow for the transmittal of changes in the designated family member from agencies to carriers.

One commenter asked that OPM require the capture of a Social Security Number for dependents. As this is outside the scope of this rule, we decline to comment at this time.

Qualifying Life Events (QLE)

One commenter requested that OPM clarify whether or not enrollees must experience a QLE in order to decrease enrollment outside of Open Season. Under § 892.208, enrollees who participate in premium conversion must experience a QLE in order to decrease enrollment outside of Open Season. Under § 890.301(e), enrollees who do not participate in premium conversion may decrease enrollment at any time. This final rule has not altered these requirements.

Another commenter requested that OPM clarify that “retired federal employees/annuitants will have the option to change plans and/or enrollment types upon retirement, regardless of Medicare eligibility or age at the time of retirement.”

Retirement is not a QLE and therefore no changes may be made based solely on retirement. Retirement is a change from one payroll office to another. After an individual is retired, under the provisions in § 890.301(e), they may decrease enrollment or cancel coverage at any time. QLEs are still required for increasing coverage or changing plans outside of Open Season.

It was requested that OPM clarify the process for handling an annuitant who, upon experiencing the death of her spouse, forgets to decrease her enrollment to self only. As this question is beyond the scope of this regulation, OPM declines to comment at this time.

Additional guidance was requested regarding carrier responsibilities to notify enrollees and agencies when a family member has aged out of eligibility or passed away. OPM encourages carriers to contact their enrollees when a child ages out or if they learn of the death of a covered family member in order to inform the enrollee of their QLE opportunity at that time.

Alternative Enrollment Types

Four commenters suggested alternative enrollment types. One commenter suggested that OPM provide rates based on the number of family members enrolled. Another suggested an enrollment type available to only those enrolled in both FEHB and Medicare. A third commenter suggested that, instead of self plus one, OPM alter eligibility guidelines to allow spouses and dependents to enroll in their own right in self only enrollments. Finally, an FEHB carrier commented that OPM should implement a four-tier system: Self only, employee and spouse, employee and one non-spousal family member, and self and family. Commenters urged OPM to consider methods for encouraging or requiring Medicare enrollment. One suggested that OPM should consider reducing premiums for annuitants enrolled in Medicare as FEHB is the secondary payer. Another expressed concerns that the addition of the self plus one enrollment type would exacerbate an existing problem in which younger

enrollees subsidize higher cost annuitants.

OPM is unable to implement these suggested changes. The FEHB statute only allows the following enrollment types: Self only, self plus one, and self and family. Any other enrollment types, including separate enrollment tiers for individuals enrolled in Medicare, would require legislative change.

Definition of Self Plus One

OPM received four comments indicating that the definition of self plus one in the proposed rule, which does not preclude an individual with only one eligible family member from enrolling in self and family, has potentially negative consequences. These commenters indicated the definition, coupled with concerns that self plus one premiums and/or enrollee shares may rise above self and family premiums and/or enrollee shares, could result in revenue shortfall for carriers. They predicted that some consumers with only one eligible family member will likely select a self and family enrollment if the enrollee share is lower, leading to a financial loss for plans with higher claims costs for self plus one enrollments.

Individual choice is, and always has been, one of the hallmarks of the FEHB Program. Before the addition of the self plus one enrollment type, individuals have been free to select a self only or self and family enrollment, regardless of whether or not they have eligible family members. In that tradition, the final rule adopts the proposed rule's provision, providing individuals the freedom to select among all three enrollment types available, regardless of the number of their eligible family members.

One commenter requested that OPM use this opportunity to expressly state that all eligible family members are covered under a self and family enrollment. Current regulatory language, which has not been altered in this rule, already adequately expresses this. Section 890.302(a)(1) states that an enrollment for self and family includes all family member who are eligible to be covered by the enrollment. Further, the definition of self and family, as added by this final rule states that self and family enrollment means an enrollment that covers the enrollee and all eligible family members.

Government Contribution Calculations

The government contribution to premium is calculated based on weighted average of the subscription charges described in 5 U.S. Code section 8906. One commenter points out that most carriers are unable to predict the

government contribution for their plans because they do not cover an adequate portion of the total market to estimate actual FEHB enrollment to determine the weighted average. Thus, many plans propose total premiums to OPM without a complete understanding of what the government and enrollee contributions will be, putting them at a disadvantage in a competitive market. Given the additional uncertainty for plan year 2016, with the addition of the self plus one enrollment type, the commenter requested that OPM provide carriers more flexibility to adjust final premium rates during the negotiation process after the government contribution has been calculated. OPM will adhere to standard operating procedures for plan year 2016 final rate negotiations.

An FEHB carrier requested that OPM provide additional information to carriers concerning rate setting for plan year 2016. In addition, they cautioned OPM against applying the same government contribution for both self plus one and self and family enrollments for plan year 2016 as this method might lead to increased "unpredictability of which subscribers will choose which tier." Many commenters requested additional information about the weighted averages that would be used to determine the government contribution for plan year 2016.

The 2013 Bipartisan Budget Act provides OPM with flexibility in the first year that self plus one is offered to "determine the weighted average of the subscription charges that will be in effect for the contract year for enrollments for self plus one under such chapter based on an actuarial analysis."¹ The weighted average is used to calculate the Government contribution, according to a formula set in statute (5 U.S.C. 8906). OPM takes a count of enrollments with Government contributions in March of each year (referred to in the following paragraphs as the "March enrollment count"). This March enrollment count is used to determine the maximum Government contribution for the following plan year. For each enrollment type, OPM sums the product of the new premium and the March enrollment count for each option and divides the sum by the total number of individuals enrolled in that enrollment type.

Because we do not have self plus one data from our March 2015 enrollment count, OPM has determined that it will use the 2015 self and family March

enrollment count to calculate the weighted average for both the 2016 self plus one and self and family enrollment types. The weighted average for self plus one will be based on the 2016 self plus one premiums and the 2015 self and family March enrollment count. OPM provides rate-setting guidance to carriers on an annual basis. For the 2016 plan year, OPM requested that carriers propose self plus one premiums that are no greater than self and family premiums.² Although OPM does not expect this policy to change in the out years, the right to reevaluate is reserved.

Rate-Setting and the Cost of Self Plus One

Comments were received that indicated the addition of the self plus one enrollment type would translate into cost savings for enrollees with only one eligible family member. Commenters in this category praised OPM for implementing the new enrollment type. Other commenters expressed concerns about rate setting for the new self plus one enrollment type. In particular, a concern that self and family premiums would rise drastically in plan year 2016 in order to accommodate the new self plus one enrollment type. It was suggested that OPM impose a 10% cap on such growth in the final rule, especially for the first year of implementation. Others expressed concerns about the differential between the three enrollment tiers. OPM was asked to clarify whether or not the enrollee share of a self plus one enrollment would be less than or exactly equal to two self only enrollments. One carrier projected that, although self plus one premiums might not rise above self and family premiums, the differential between the two would be negligible, calling into question the cost-benefit of such a change given the high administrative burden of implementation.

Other commenters expressed concerns about actual claims costs. One highlighted the unique nature of the FEHB risk pool because the annuitant population is combined with the active employee population, indicating that many annuitants, who traditionally have higher claims costs, have only one eligible family member and therefore might make up the bulk of self plus one enrollees. Two commenters pointed out that HMO plans might be especially impacted. They expressed concerns that, if OPM were to require that self

¹ Full text available at <http://www.gpo.gov/fdsys/pkg/BILLS-113hjres59enr/pdf/BILLS-113hjres59enr.pdf>.

² United States Office of Personnel Management, Federal Employees Health Benefits Program Call Letter, Fiscal Year 2016, Issued March 13, 2015. <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-02.pdf>

plus one total premiums remain below self and family total premiums, the end result would be an even more dramatic increase for self and family enrollees. The commenter projected that this change would render some regional HMOs non-competitive, forcing them out of the FEHB market.

The final rule does not set differentials between tiers, nor does it impose caps on premium growth. Under the three tier system, carriers will set rate differentials between tiers that are appropriate for the expected population, just as they do under the two tier system. An artificial cap is unwarranted because plans must set rates that reflect the costs of the population they will be covering. Further, enrollees have free choice to stay in their current plan or shop for a less expensive plan or option that meets their needs. Because the FEHB Program is market-based, artificial caps on premium are likely to cause adverse consequences such as inadequate rates for some products.

One commenter requested that rate information be provided earlier than normally scheduled to provide individuals adequate time to analyze their options. Given the rate negotiation process outlined in § 890.501, OPM cannot set the government contribution before September 1st for the following plan year.

Comments on the Regulatory Impact Analysis

Commenters who discussed OPM's Regulatory Impact Analysis (RIA) in the proposed rule asked that OPM provide a more robust analysis for public comment. Four commenters suggested that the RIA provided in the proposed rule was insufficient under requirements outlined in the Administrative Procedures Act, Executive Order 12866, Executive Order 13563, and the Congressional Review Act. They suggested a delay in implementation in order to conduct additional analysis, provide details to the public, and allow for an additional comment period. One commenter stated OPM had failed to properly justify the change and to explain the potential impacts on the FEHB Program. Multiple commenters disagreed with OPM's assertion that self plus one premiums would likely be lower than self and family. One commenter noted that the RIA failed to discuss the possibility of rate differentials between the enrollment types. The commenter suggested that all carriers should be required to maintain the same differentials between their plan tiers. The commenter requested an actuarial analysis of the method that will be

utilized to determine the weighted average of all FEHB plans for plan year 2015.

OPM believes the analysis provided in the proposed rule fulfills legal requirements. As noted in the proposed and reiterated in the final rule, this change is being implemented to comply with the 2013 Bipartisan Budget Act. In addition, this change aligns insurance offerings with those available in the commercial market and more equitably spreads costs among the enrollment types offered.

Information Provided to Carriers

Four commenters requested that we clarify information for carriers. One commenter asked OPM to release details, including the final rule, by March 31, 2015 to allow carriers ample time to prepare. Another commenter asked for additional details on enrollment and eligibility under the new self plus one enrollment type; however, provided no specific questions.

One commenter asked that OPM clarify benefits structures including deductibles and out of pocket maximums. OPM addressed these issues through normal carrier communications including the annual call letter, carrier letters, and teleconferences. OPM utilizes several methods for communicating with carriers including, but not limited to carrier letters, brochure tools, and teleconferences. Some of the information requested during the public comment period either has already been released or is forthcoming via these alternative communication methods.

Systems Updates

OPM received three comments relative to the systems updates required to implement the new self plus one enrollment type. One commenter also asked that the brochure template language be available early. Two commenters suggested that OPM improve processes by which dependent information is communicated to carriers. An employee organization noted that the number of enrollment changes in Open Season 2015 is likely to far exceed the average Open Season and expressed concerns that the overall system would not be able to handle this increased number of enrollment changes.

OPM has carefully and deliberately been reviewing, modifying, and testing internal systems to ensure that enrollee information is accurately collected and disseminated to carriers. In addition, numerous communications have been distributed on the required systems

changes with agencies, carriers, and enrollment systems. We are confident that, through all of these efforts, all necessary systems updates will be completed in time for a smooth implementation of the self plus one enrollment type in plan year 2016.

Paperwork Reduction Act (PRA)

OPM has reviewed this final rule for PRA implications and has determined that it does not apply to this section.

Regulatory Impact Analysis

Executive Order 12866 and Executive Order 13563 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 that may have economically significant effects (*i.e.*, effects of \$100 million or more in at least one year). Given that there are approximately 8.2 million members participating in the FEHB Program, including approximately one million two-person self and family enrollments, and participation involves hundreds of dollars per member per month, we cannot rule out the possibility that this final rule's changes to the FEHB Program will have effects that meet the threshold for economic significance. We do expect the overall federal budget impact of this final rule to be net neutral, though this is subject to uncertainty.

The new enrollment tier will align FEHB Program offerings with the commercial market and serve to more equitably spread costs across different enrollment types; in other words, it will shift costs among program participants. For plan year 2016, OPM has required that that the self plus one enrollment type have total premiums no greater than self and family total premiums.

Current FEHB Enrollment Trends

In plan year 2015 there were over 4 million FEHB contracts. This includes 1.89 million self only contracts (47%) and 2.13 million self and family contracts (53%).

During a typical year, approximately 6% of FEHB enrollees change their enrollment by selecting a new plan option or a new enrollment type (approximately 8% of active employees and 4% of annuitants). However, as this is the first time the FEHB Program has experienced a large-scale programmatic change as the addition of a new enrollment type, it is expected that

movement will be greater in the coming years as enrollees learn more about their options.

Predicting Enrollment Trends Under the Three Tier System

In order to estimate the impact of the addition of the self plus one enrollment type, OPM has conducted an analysis to predict the potential shift in enrollment that may occur.

OPM determined that the following movement patterns were possible:

- FEHB eligible individuals who are currently not enrolled may choose to enroll in FEHB after self plus one becomes available.
- Current self only enrollees may choose to increase enrollment to include coverage for an eligible family member who is not currently covered under an FEHB enrollment.
- Current self only enrollees may choose to cancel coverage in order to be covered under a spouse or parent's self plus one FEHB enrollment.
- Current self and family enrollees with only one eligible family member may choose to decrease to a self plus one enrollment.
- Current self and family enrollees with two or more eligible family members may choose to decrease to a self plus one enrollment to cover only one of their eligible family members.
- Some FEHB enrollees in either self only or self and family may choose to cancel their enrollments.
- Enrollees in either self only or self and family may choose to remain in their current enrollment type.

Based on available data and experience, OPM estimates that much of the movement that will occur will result in a shift from one enrollment type to another. There are a limited number of circumstances where the addition of the self plus one enrollment type may result in new FEHB enrollees or in enrollees leaving the program. It is difficult to estimate how many individuals may newly enroll in the program. Most employees who do not participate in the FEHB Program do so because they have access to other insurance options. This rule will not alter access to other insurance for FEHB eligible employees. Also, because OPM does not have government-wide eligible and covered family member data, it is not known exactly how many individuals are covered under self and family enrollments, nor is it known how many eligible family members exist but are not currently covered because the enrollee has chosen a self only enrollment.

In order to learn more about potential movement between enrollment types,

OPM requested data on covered enrollees and family members from carriers with the 2014 rate proposals. Carriers reported that over one million self and family contracts had only one dependent listed. Of those enrollments, approximately 60% were annuitants and 40% were active employees. While this number does not capture the universe of enrollees who may choose a self plus one enrollment, it does provide a starting place for estimating the potential movement between tiers.

OPM also examined enrollment data for the Federal Employees Dental and Vision Insurance Program (FEDVIP). FEDVIP has offered self plus one as an enrollment option since its inception in 2007. There are currently approximately 2.7 million FEDVIP contracts. Of those, 41% are self only, 32% are self plus one, and 27% are self and family.

Comparing FEHB and FEDVIP enrollment patterns may be illustrative because the pool of eligible individuals is roughly the same. Most FEDVIP enrollees are also eligible for FEHB. However, there are some key differences between the programs. First, family member eligibility guidelines are slightly different. Eligible children are covered under FEDVIP enrollments until the age of 22 whereas eligible children are covered under FEHB until the age of 26. Second, FEDVIP has lower participation as it is an employee-pay-all program with no government contribution towards the premium. In addition, benefits offered in standalone dental and vision programs are limited, and therefore, enrollee behavior and motivation based on those benefits would be different.

Examining the types of movement that are possible and comparing FEHB enrollment trends with other programs provides only a limited view of the complex factors that affect enrollment decisions for enrollees. Enrollee choice and movement is an individualized decision based on the needs of the enrollee and their dependents. Self plus one uptake is dependent on a combination of factors including premiums, benefits structures, and the level of communication from agencies, carriers, and OPM about new enrollment options.

For most enrollees, the enrollee share for self plus one will be lower than for self and family; however, it is possible that, because of the statutory formula used to calculate the government contribution, some plans may have a higher enrollee share for self plus one than for self and family. This will make it even more important for enrollees to review their enrollment options before selecting a plan and an enrollment type

that meets their needs. OPM is implementing a robust communications strategy to ensure that as many enrollees as possible are aware of the new self plus one enrollment type.

Plan design remains the same between enrollment types offered in the same plan option. Therefore, OPM expects that cognitive costs for enrollees would be relatively low. For those enrollees that do not typically reevaluate their enrollment every Open Season, the cognitive costs of a review of the plans, plan options, and enrollment types available may well be worth incurring, as they may discover better alternatives (though these improvements may represent transfers from other members of society, rather than benefits to society as whole). Ultimately, actual enrollment decisions cannot be predicted with precision. Further, it will likely take years for enrollment numbers to reach an equilibrium following this Program change.³

Cost Analysis

OPM's Fiscal Year 2014 Congressional Budget Justification⁴ included a projection that the addition of the self plus one enrollment would have a net neutral impact on the Federal budget. This projection, based on FEHB carriers' relative costs and population

³ As discussed in more detail elsewhere in this analysis, plan switching—in which federal employees and annuitants with one eligible family member gravitate toward plans with relatively low self plus one premiums and federal employees and annuitants with multiple eligible family members gravitate toward plans with relatively low self and family premiums—would lead to further changes in premiums, and several iterations of switching activity and premium adjustments may occur before the new equilibrium is reached. Moreover, because health insurance decisions tend to be characterized by inertia, the behavioral changes discussed here and throughout this analysis may be relatively rare when this rule is first implemented and then become more widespread over time, as turnover occurs in the federal workforce and there is an accumulation of qualifying life events that cause FEHB participants to reconsider their health insurance choices.

⁴ United States Office of Personnel Management, Congressional Budget Justification Performance Budget, Fiscal Year 2014, Submitted April 2013, available at <https://www.opm.gov/about-us/budget-performance/budgets/congressional-budget-justification-fy2014.pdf>. See also Congressional Budget Office, Cost Estimate, Bipartisan Budget Act of 2013, dated December 11, 2013, available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/Bipartisan%20Budget%20Act%20of%202013.pdf>. In estimating potential premium changes, OPM used data on FEHB enrollees' medical expenditures, while CBO used data on medical expenditures for the general population. Because of the large number of annuitants in the FEHB enrolled population, two-person FEHB enrollments tend to have higher costs than two-person enrollments in the nation as a whole, thus explaining some of the difference between OPM's and CBO's estimates.

distributions, included the following assumptions:

- The average premium for self plus one coverage will be approximately 94% of the cost of existing self and family coverage.
- The average premium for self and family coverage will be approximately 107% of the cost of existing self and family coverage.
- 33% of active employees with existing self and family will shift to self plus one coverage.
- Only 20% of annuitants with existing self and family coverage will retain that coverage (80% will shift to self plus one).

As discussed above, there are several ways in which enrollees may choose to change their enrollment based on the addition of the self plus one enrollment type. The magnitudes of these changes (and the effects experienced by the government that depend on FEHB participants' behavior) would be correlated with the amount that participant premium contributions change. If, as shown above, self plus one premiums are only slightly lower than baseline self and family premiums, then two-person families will have little incentive to transfer family members from other coverage to FEHB. Similarly, if self and family premiums increase only slightly as a result of this rule, then families larger than two people will have little incentive to switch some or all of their members from FEHB to other health insurance coverage. As a result, in this example, a change in the cost of the Program would be contingent, in part, upon the amount of switching into or out of FEHB from/to other health insurance.

Current enrollees with self and family coverage who only have one dependent and choose to decrease enrollment to self plus one, will likely benefit from lower premiums. Those with more than one dependent covered under a self and family enrollment will likely incur higher premiums. A large percentage of annuitants who currently have self and family coverage would likely benefit from the lower total premiums of a self plus one enrollment type, resulting in score-able savings to the government because the government share of annuitant premiums will decrease.

OPM estimated that, in total, savings for annuitants and the government would rise above \$450 million in the first year of self plus one. Conversely, costs for non-Postal employees and the government would rise about \$450 million for the same time frame. This converse relationship between costs associated with annuitants and employees continues into future year

projections and results in the overall net-neutral projection.

Actual cost shifting cannot be measured until rate negotiations are finalized and enrollment changes take place. As enrollees shift from self only and self and family enrollments, OPM will closely monitor the effect on premiums. If premiums for active employees with two or more covered family members rise, there will be increasing costs to government agencies (assuming appropriation of necessary funds).⁵

The impact of this final rule hinges upon the relative premiums for self plus one and self and family enrollment types. Because the self and family option includes coverage for a larger number of people, a natural assumption would be that premiums would be lower for a self plus one enrollment type than for a self and family enrollment type. For plan year 2016, OPM instructed carriers to propose total premiums for self plus one that were less than or equal to total premiums for self and family. In that case, several rule-induced outcomes are likely:

- Federal employees and annuitants who, in the absence of the rule, would choose self and family enrollment for themselves and either a spouse or a child would switch to a self plus one enrollment, resulting in lower total premium payments between employees, annuitants and the federal government.
- Federal employees and annuitants choosing self and family enrollment for themselves and at least two family members would experience an increase in premiums and therefore, in some cases, may choose to switch from FEHB to an alternative health insurance option. If all such families continued with FEHB participation, the government would experience an increase in premium payments that would (in theory) exactly offset the decreases associated with two-person families switching from self and family to self plus one enrollment; however, any switching away from FEHB would mitigate the premium increases experienced by the federal government, instead potentially leading to payment increases by any contributors to the newly-chosen insurance options (an obvious example would be the employer

of a federal employee's or annuitant's spouse if that employer sponsors the newly-chosen insurance).

- Federal employees and annuitants who, in the absence of the rule, would choose self only enrollment in spite of having a spouse who would be eligible for coverage under self and family enrollment may choose self plus one enrollment. This might occur if a self and family premium is greater than the combined premiums for a federal employee's self only enrollment and a spouse's self only enrollment in health insurance through his or her own non-federal employer, but the relevant FEHB self plus one premium is less than the combined premiums.⁶ In this type of scenario in which the federal employee's or annuitant's enrollment increases, the federal government would pay more in premiums (relative to a baseline in which this rule is not finalized) but the federal employee's or annuitant's family would pay less. Any contributors to the insurance in which the family member would be enrolled in the absence of the rule—such as the non-federal employer of the federal employee's spouse in the preceding example—would also pay less.

To the extent that new patterns of enrollment do not change how society uses its resources (*i.e.*, amount or quality of medical services provided), then the effects described above would be transfers between members of society, rather than social costs or benefits.

It is possible that two-person families are, on average, less healthy than larger families; indeed, multiple comments to the docket provided evidence that some plans' expenditures for two-person enrollments are higher than for enrollments with three or more total family members. For the 2016 plan year, because OPM has requested that carriers propose self plus one premiums no greater than self and family premiums, plans with this medical expenditure pattern will presumably set equal premiums for self plus one and self and family enrollment types. In the event that OPM does not repeat this request for future years, plans with higher average expenditures for two-person than for larger families will presumably set premiums higher for self plus one enrollment than for self and family

⁵ United States Office of Personnel Management, Congressional Budget Justification Performance Budget, Fiscal Year 2014, Submitted April 2013, available at <https://www.opm.gov/about-us/budget-performance/budgets/congressional-budget-justification-fy2014.pdf>. See also Congressional Budget Office, Cost Estimate, Bipartisan Budget Act of 2013, dated December 11, 2013, available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/Bipartisan%20Budget%20Act%20of%202013.pdf>.

⁶ Similarly, federal employees and annuitants who, in the absence of the rule, would choose not to participate in the FEHB Program may choose a self plus one enrollment. For example, this outcome might occur if the self plus one option available in the FEHB Program is less expensive than either a family or plus-one enrollment available via a federal employee's spouse or the combined premiums for the federal employee's self only enrollment and the spouse's self only enrollment.

enrollment. If this pattern—in which self plus one premiums are greater than or equal to self and family premiums—held universally, the lack of premium decrease to give federal employees and annuitants an incentive to switch from self and family to self plus one enrollment would lead to the rule’s enrollment impact being negligible.⁷ However, as indicated by docket submissions, relative expenditures on (and thus premiums for) two-person and larger enrollments differ across plans, and hence the effect of adding the self plus one option may be to increase switching between plans, as federal employees and annuitants with one eligible family member gravitate toward plans with relatively low self plus one premiums and federal employees and annuitants with multiple eligible family members gravitate toward plans with relatively low self and family premiums. Plan switching of this type would lead to further changes in premiums and several iterations of switching activity and premium adjustments may occur.

Additionally, the rule imposes implementation costs, such as the costs of systems updates, on FEHB-participating health insurance plans, federal agencies, and on OPM itself. These expenses are encompassed in existing workloads. OPM has no specific estimate for these costs, but expects them to be marginal.

Though regulatory alternatives to this rule are limited due to the statutory mandate, OPM did consider delaying implementation of the rule until the 2017 plan year. OPM rejected this option for two reasons. First, delaying implementation will not provide additional information. Because OPM contracts with a number of carriers, proposed rates are proprietary and cannot be released publically without compromising confidential negotiation processes. Until first year negotiations are completed and enrollment changes occur, OPM would not have a precise understanding of the impact of the self plus one enrollment type on premiums.

Second, implementation has already been delayed. After the passage of the 2013 Bipartisan Budget Act, the first year that implementation would have been possible was plan year 2015. OPM determined that this was not adequate time to implement the new enrollment type and chose to delay implementation

until 2016. OPM, carriers, and Federal agencies are well into the implementation process. Rate negotiations between OPM and FEHB carriers have begun under the assumption that the 2016 plan year would include the self plus one enrollment type. Agencies and carriers are currently implementing the systems changes required to accommodate three tier enrollments. Delaying implementation would adversely impact the Federal benefits Open Season which is scheduled to begin in early November of this year.

Congressional Review Act

OPM has determined that this regulatory action is not subject to the Congressional Review Act, 5 U.S.C. 801–08, because it relates to agency management and personnel. The program is not statutorily for general application but rather governs employment fringe benefits for Federal employees, annuitants and their families. Moreover, OPM has been statutorily granted discretion in terms of deciding how its actions may affect non-agency parties, such as carriers, by its authority to regulate enrollment. See, 5 U.S.C. 8905(a), 8905(g)(2), and 8913(b).

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 adds a self plus one enrollment tier to the current self only and self and family enrollment tiers under FEHB.

Executive Orders 13563 and 12866, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Orders 13563 and 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

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.

5 CFR Part 892

Administrative practice and procedure, Government employees, Health insurance, Taxes, Wages.

U.S. Office of Personnel Management.

Beth F. Cobert,
Acting Director.

Accordingly, OPM is amending title 5, Code of Federal Regulations 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.

■ 2. Amend § 890.101 as follows:

- a. By revising the definitions of “Change the enrollment” and “Covered family member.”
- b. By adding the definitions of “Decrease enrollment type,” “Increase enrollment type,” “Self and family enrollment,” “Self only enrollment,” “Self plus one enrollment,” and “Switch a covered family member” in alphabetical order.

The revisions and additions read as follows:

§ 890.101 Definitions; time computations.

* * * * *

Change the enrollment means to submit to the employing office an appropriate request electing a change of enrollment to a different plan or option, or to a different type of coverage (self only, self plus one, or self and family).

* * * * *

Covered family member means a member of the family of an enrollee with a self plus one or self and family enrollment who meets the requirements of §§ 890.302, 890.804, or 890.1106(a), as appropriate to the type of enrollee.

* * * * *

Decrease enrollment type means a change in enrollment from self and family to self plus one or to self only or a change from self plus one to self only.

* * * * *

Increase enrollment type means a change in enrollment from self only to self plus one or to self and family or a

⁷ This negligible-impact outcome may not occur if the government contribution, as determined by statutory formula, was such that enrollee contributions were lower for self plus one enrollments than for self and family enrollments even in cases where total premiums for self plus one enrollments were greater than or equal to total premiums for self and family enrollments.

change from self plus one to self and family.

* * * * *

Self and family enrollment means an enrollment that covers the enrollee and all eligible family members.

Self only enrollment means an enrollment that covers only the enrollee.

Self plus one enrollment means an enrollment that covers the enrollee and one eligible family member.

* * * * *

Switch a covered family member means, under a self plus one enrollment, to terminate or cancel the enrollment of the designated covered family member and designate another eligible family member for coverage.

* * * * *

■ 3. Amend § 890.201 by revising paragraph (a)(6) to read as follows:

§ 890.201 Minimum standards for health benefits plans.

(a) * * *

(6) Provide a standard rate structure that contains, for each option, one standard self only rate, one standard self plus one rate and one standard self and family rate.

* * * * *

■ 4. Amend § 890.301 by revising paragraphs (e), (f)(3), (g)(1) and (3), (h) heading and introductory text, (i) introductory text, (i)(1), and (m) to read as follows:

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

* * * * *

(e) *Decreasing enrollment type.* (1) Subject to two exceptions, an employee may decrease enrollment type at any time. *Exceptions:*

(i) An employee participating in health insurance premium conversion may decrease enrollment type during an open season or because of and consistent with a qualifying life event as defined in part 892 of this chapter.

(ii) An employee who is subject to a court or administrative order as discussed in paragraph (g)(3) of this section may not decrease enrollment type in a way that eliminates coverage of a child identified in the order as long as the court or administrative order is still in effect and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation to the agency that he or she has other coverage for the child(ren). The employee may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the enrollee and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) * * *

(3) With one exception, during an open season, an eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, may change from one plan or option to another, or may make any combination of these changes. *Exception:* An employee who is subject to a court or administrative order as discussed in paragraph (g)(3) of this section may not cancel his or her enrollment, decrease enrollment type, or change to a comprehensive medical plan that does not serve the area where his or her child or children live as long as the court or administrative order is still in effect, and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation to the agency that he or she has other coverage for the child(ren). The employee may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(g) *Change in family status.* (1) An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee's family status changes, including a change in marital status or any other change in family status. The employee must enroll or change the enrollment within the period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

(3)(i) If an employing office receives a court or administrative order on or after October 30, 2000, requiring an employee to provide health benefits for his or her child or children, the employing office

will determine if the employee has a self plus one or self and family enrollment, as appropriate, in a health benefits plan that provides full benefits in the area where the child or children live. If the employee does not have the required enrollment, the agency must notify him or her that it has received the court or administrative order and give the employee until the end of the following pay period to change his or her enrollment or provide documentation to the employing office that he or she has other coverage for the child or children. If the employee does not comply within these time frames, the employing office must enroll the employee involuntarily as stated in paragraph (g)(3)(ii) of this section.

(ii) If the employee is not enrolled or does not enroll, the agency must enroll him or her for self plus one or self and family coverage, as appropriate, in the option that provides the lower level of coverage in the Service Benefit Plan. If the employee is enrolled but does not increase the enrollment type in a way that is sufficient to cover the child or children, the employing office must change the enrollment to self plus one or self and family, as appropriate, in the same option and plan, as long as the plan provides full benefits in the area where the child or children live. If the employee is enrolled in a comprehensive medical plan that does not serve the area in which the child or children live, the employing office must change the enrollment to self plus one or self and family, as appropriate, in the option that provides the lower level of coverage in the Service Benefit Plan.

* * * * *

(h) *Change in employment status.* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee's employment status changes. Except as otherwise provided, an employee must enroll or change the enrollment within 60 days after the change in employment status. Employment status changes include, but are not limited to—

* * * * *

(i) *Loss of coverage under this part or under another group insurance plan.* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee loses coverage under this part or another group health benefits plan. Except as otherwise

provided, an employee must enroll or change the enrollment within the period beginning 31 days before the date of loss of coverage, and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or to self only, of the covering enrollment.

* * * * *

(m) *An employee or eligible family member becomes eligible for premium assistance under Medicaid or a State Children's Health Insurance Program (CHIP).* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee becomes eligible for premium assistance under a Medicaid plan or CHIP. An employee must enroll or change his or her enrollment within 60 days after the date the employee or family member is determined to be eligible for assistance.

■ 5. Amend § 890.302 by revising paragraphs (a)(1), (a)(2)(ii), and (c) introductory text and adding paragraph (f) to read as follows:

§ 890.302 Coverage of family members.

(a)(1) An enrollment for self plus one includes the enrollee and one eligible family member. An enrollment for self and family includes all family members who are eligible to be covered by the enrollment. Except as provided in paragraph (a)(2) of this section, no employee, former employee, annuitant, child, or former spouse may enroll or be covered as a family member if he or she is already covered under another person's self plus one or self and family enrollment in the FEHB Program.

(2) * * *

(ii) *Exception.* An individual described in paragraph (a)(2)(i) of this section may enroll if he or she or his or her eligible family members would otherwise not have access to coverage, in which case the individual may enroll in his or her own right for self only, self plus one, or self and family coverage, as appropriate. However, an eligible individual is entitled to receive benefits under only one enrollment regardless of whether he or she qualifies as a family member under a spouse's or parent's enrollment. To ensure that no person receives benefits under more than one enrollment, each enrollee must promptly notify the insurance carrier as to which person(s) will be covered

under his or her enrollment. These individuals are not covered under the other enrollment. Examples include but are not limited to:

(A) To protect the interests of married or legally separated Federal employees, annuitants, and their children, an employee or annuitant may enroll in his or her own right in a self only, self plus one, or self and family enrollment, as appropriate, even though his or her spouse also has a self plus one or self and family enrollment if the employee, annuitant, or his or her children live apart from the spouse and would otherwise not have access to coverage due to a service area restriction and the spouse refuses to change health plans.

(B) When an employee who is under age 26 and covered under a parent's self plus one or self and family enrollment acquires an eligible family member, the employee may elect to enroll for self plus one or self and family coverage.

* * * * *

(c) *Child incapable of self-support.* When an individual's enrollment for self plus one or self and family includes a child who has become 26 years of age and is incapable of self-support, the employing office must require such enrollee to submit a physician's certificate verifying the child's disability. The certificate must—

* * * * *

(f) *Switching a covered family member.* (1) An enrollee with a self plus one enrollment may switch his or her covered family member during the annual Open Season, upon a change in family status, upon a change in coverage, or upon a change in eligibility, so long as switching a covered family member is consistent with the event that has taken place.

(2) Switching a covered family member under a self plus one enrollment will be effective on the first day of the first pay period that begins after the date the employing office receives an appropriate request to switch the covered family member.

■ 6. Amend § 890.303 by revising paragraphs (c), (d)(2)(ii), and the heading of paragraph (d)(3) to read as follows:

§ 890.303 Continuation of enrollment.

* * * * *

(c) *On death.* The enrollment of a deceased employee or annuitant who is enrolled for self plus one or self and family (as opposed to self only) is transferred automatically to his or her eligible survivor annuitant(s) covered by the enrollment, as applicable. For self and family, the enrollment is considered to be that of:

(1) The survivor annuitant from whose annuity all or the greatest portion of the withholding for health benefits is made; or

(2) The surviving spouse entitled to a basic employee death benefit. The enrollment covers members of the family of the deceased employee or annuitant. In those instances in which the annuity is split among surviving family members, multiple enrollments are allowed. A remarried spouse is not a member of the family of the deceased employee or annuitant unless annuity under section 8341 or 8442 of title 5, United States Code, continues after remarriage.

(d) * * *

(2) * * *

(ii) If the surviving spouse of a deceased employee or annuitant is enrolled as an employee with a self plus one or self and family enrollment (or, if both the decedent and the surviving spouse were enrolled in a self only or self plus one enrollment) at the time the surviving spouse becomes a survivor annuitant and the surviving spouse is thereafter separated without entitlement to continued enrollment as a retiree, the surviving spouse is entitled to enroll as a survivor annuitant. The change from coverage as an employee to coverage as a survivor annuitant must be made within 30 days of separation from service.

* * * * *

(3) *Insurable interest survivor annuity.*

* * *

* * * * *

■ 7. Amend § 890.306 by revising paragraphs (e), (f)(1)(i), (g)(1), (l) introductory text, (l)(1), (n), and (r) to read as follows:

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

* * * * *

(e) *Decreasing enrollment type.* (1) With one exception, an annuitant may decrease enrollment type at any time. Exception: An annuitant who, as an employee, was subject to a court or administrative order as discussed in § 890.301(g)(3) at the time he or she retired may not, after retirement, decrease enrollment type in a way that eliminates coverage of a child identified in the order as long as the court or administrative order is still in effect and the annuitant has at least one child identified in the order who is still eligible under the FEHB Program, unless the annuitant provides documentation to the retirement system that he or she has other coverage for the child or children. The annuitant may not elect

self only as long as he or she has one child identified as covered, but may elect self plus one.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the annuitant and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) * * *

(1) * * *

(i) With one exception, an enrolled annuitant may decrease or increase enrollment type, may change from one plan or option to another, or may make any combination of these changes. Exception: An annuitant who, as an employee, was subject to a court or administrative order as discussed in § 890.301(g)(3) at the time he or she retired may not cancel or suspend his or her enrollment, decrease enrollment type in a way that eliminates coverage of a child identified in the order or change to a comprehensive medical plan that does not serve the area where his or her child or children live after retirement as long as the court or administrative order is still in effect and the annuitant has at least one child identified in the order who is still eligible under the FEHB Program, unless the annuitant provides documentation to the retirement system that he or she has other coverage for the child or children. The annuitant may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

* * * * *

(g) *Change in family status.* (1) An enrolled former employee in receipt of an annuity may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the annuitant's family status changes, including a change in marital status or any other change in family status. In the case of an enrolled survivor annuitant, a change in family status based on additional family members occurs only if the additional family members are

family members of the deceased employee or annuitant. The annuitant must change the enrollment within the period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

* * * * *

(l) *Loss of coverage under this part or under another group insurance plan.* An annuitant who meets the requirements of paragraph (a) of this section, and who is not enrolled but is covered by another enrollment under this part may continue coverage by enrolling in his or her own name when the annuitant loses coverage under the other enrollment under this part. An enrolled annuitant may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the annuitant or an eligible family member of the annuitant loses coverage under this part or under another group health benefits plan. Except as otherwise provided, an annuitant must enroll or change the enrollment within the period beginning 31 days before the date of loss of coverage and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or self only, of the covering enrollment;

* * * * *

(n) *Overseas post of duty.* An annuitant may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes within 60 days after the retirement or death of the employee on whose service title to annuity is based, if the employee was stationed at a post of duty outside a State of the United States or the District of Columbia at the time of retirement or death.

* * * * *

(r) *Sole survivor.* When an employee or annuitant enrolled for self plus one or self and family dies, leaving a survivor annuitant who is entitled to continue the enrollment, and it is apparent from available records that the survivor annuitant is the sole survivor entitled to continue the enrollment, the office of the retirement system which is acting as employing office must decrease the enrollment to self only, effective on the commencing date of the survivor annuity. On request of the survivor annuitant made within 31 days after the first installment of annuity is paid, the office of the retirement system

which is acting as employing office must rescind the action retroactive to the effective date of the change to self only, with corresponding adjustment in withholdings and contributions.

* * * * *

■ 8. Amend § 890.401 by revising paragraph (a)(1) to read as follows:

§ 890.401 Temporary extension of coverage and conversion.

(a) *Thirty-one day extension and conversion.* (1) An enrollee whose enrollment is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or part, and a covered family member whose coverage is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or in part, is entitled to a 31-day extension of coverage for self only, self plus one, or self and family, as the case may be, without contributions by the enrollee or the Government, during which period he or she is entitled to exercise the right of conversion provided for by this part. The 31-day extension of coverage and the right of conversion for any person ends on the effective date of a new enrollment under this part covering the person.

* * * * *

■ 9. Amend § 890.501 by revising paragraphs (b) introductory text, (b)(2)(i), and (b)(3) to read as follows:

§ 890.501 Government contributions.

* * * * *

(b) In accordance with the provisions of 5 U.S.C. 8906(a) which take effect with the contract year that begins in January 1999, OPM will determine the amounts representing the weighted average of subscription charges in effect for each contract year, for self only, self plus one, and self and family enrollments, as follows:

* * * * *

(2) * * *

(i) When a subscription charge for an upcoming contract year applies to a plan that is the result of a merger of two or more plans which contract separately with OPM during the determination year, or applies to a plan which will cease to offer two benefits options, OPM will combine the self only enrollments, the self plus one enrollments, and the self and family enrollments from the merging plans, or from a plan's benefits options, for purposes of weighting subscription charges in effect for the successor plan for the upcoming contract year.

* * * * *

(3) After OPM weights each subscription charge as provided in

paragraph (b)(2) of this section, OPM will compute the total of subscription charges associated with self only enrollments, self plus one enrollments, and self and family enrollments, respectively. OPM will divide each subscription charge total by the total number of enrollments such amount represents to obtain the program-wide weighted average subscription charges for self only and for self plus one and self and family enrollments, respectively.

* * * * *

■ 10. Amend § 890.804 by revising paragraph (a) to read as follows:

§ 890.804 Coverage.

(a) *Type of enrollment.* A former spouse who meets the requirements of § 890.803 may elect coverage for self only, self plus one, or self and family. A self and family enrollment covers only the former spouse and all eligible children of both the former spouse and the employee, former employee, or employee annuitant, provided such children are not otherwise covered by a health plan under this part. A self plus one enrollment covers only the former spouse and one eligible child of both the former spouse and the employee, former employee, or employee annuitant, provided the child is not otherwise covered by a health plan under this part. A child must be under age 26 or incapable of self-support because of a mental or physical disability existing before age 26. No person may be covered by two enrollments.

* * * * *

■ 11. Amend § 890.806 by revising paragraphs (e), (f)(1)(i), (g)(1), (j) introductory text, and (j)(1) to read as follows:

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

* * * * *

(e) *Decreasing enrollment type.* (1) A former spouse may decrease enrollment type at any time.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the former spouse and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first

day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) * * *

(1) * * *

(i) An enrolled former spouse may decrease enrollment type, increase enrollment type provided the family member(s) to be covered under the enrollment is eligible for coverage under § 890.804, change from one plan or option to another, or make any combination of these changes.

* * * * *

(g) *Change in family status.* (1) An enrolled former spouse may increase enrollment type, change from one plan or option to another, or make any combination of these changes within the period beginning 31 days before and ending 60 days after the birth or acquisition of a child who meets the eligibility requirements of § 890.804.

* * * * *

(j) *Loss of coverage under this part or under another group insurance plan.* An enrolled former spouse may decrease or increase enrollment type, change from one plan or option to another or make any combination of these changes when the former spouse or a child who meets the eligibility requirements under § 890.804 loses coverage under another enrollment under this part or under another group health benefits plan. Except as otherwise provided, the former spouse must change the enrollment within the period beginning 31 days before the date of loss of coverage and ending 60 days after the date of loss of coverage, provided he or she continues to meet the eligibility requirements under § 890.803. Losses of coverage include but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or self only, of the covering enrollment;

* * * * *

■ 12. Amend § 890.1103 by revising paragraphs (a)(2) and (3) to read as follows:

§ 890.1103 Eligibility.

(a) * * *

(2) Individuals whose coverage as children under the self plus one or self and family enrollment of an employee, former employee, or annuitant ends because they cease meeting the requirements for being considered covered family members. For the purpose of this section, children who

are enrolled under this part as survivors of deceased employees or annuitants are considered to be children under a self plus one or self and family enrollment of an employee or annuitant at the time of the qualifying event.

(3) Former spouses of employees, of former employees having continued self plus one or self and family coverage under this subpart, or of annuitants, if the former spouse would be eligible for continued coverage under subpart H of this part except for failure to meet the requirement of § 890.803(a)(1) or (3) or the documentation requirements of § 890.806(a), including former spouses who lose eligibility under subpart H within 36 months after termination of the marriage because they ceased meeting the requirement of § 890.803(a)(1) or (3).

* * * * *

■ 13. Amend § 890.1106 by revising paragraph (a) introductory text to read as follows:

§ 890.1106 Coverage.

(a) *Type of enrollment.* An individual who enrolls under this subpart may elect coverage for self only, self plus one, or self and family.

* * * * *

■ 14. Amend § 890.1108 by revising paragraphs (d), (e)(1), (f)(1) and (2), (h) introductory text, and (h)(1) to read as follows:

§ 890.1108 Opportunities to change enrollment; effective dates.

* * * * *

(d) *Decreasing enrollment type.* (1) An enrollee may decrease enrollment type at any time.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the enrollee and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(e) *Open season.* (1) During an open season as provided by § 890.301(f), an enrollee (except for a former spouse who is eligible for continued coverage

under § 890.1103(a)(3) may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes. A former spouse who is eligible for continued coverage under § 890.1103(a)(3) may change from one plan or option to another, but may not increase enrollment type unless the individual to be covered under the self plus one or self and family enrollment qualifies as a family member under § 890.1106(a)(2).

(f) *Change in family status.* (1) Except for a former spouse, an enrollee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the enrollee's family status changes, including a change in marital status or any other change in family status. The enrollee must change the enrollment within the period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

(2) A former spouse who is covered under this section may increase enrollment type, change from one plan or option to another, or make any combination of these changes within the period beginning 31 days before and ending 60 days after the birth or acquisition of a child who qualifies as a covered family member under § 890.1106(a)(2).

(h) *Loss of coverage under this part or under another group insurance plan.* An enrollee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the enrollee loses coverage under this part or a qualified family member of the enrollee loses coverage under this part or under another group health benefits plan. Except as otherwise provided, an enrollee must change the enrollment within the period beginning 31 days before the date of loss of coverage and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or change to self plus one or to self only, of the covering enrollment.

■ 15. Amend § 890.1202 by revising the definition of "Covered family members" to read as follows:

§ 890.1202 Definitions.

* * * * *

Covered family members as it applies to individuals covered under this subpart has the same meaning as set forth in § 890.101(a). For eligible survivors of individuals enrolled under this subpart, a self plus one enrollment covers only the survivor or former spouse and one eligible child of both the survivor or former spouse and hostage. A self and family enrollment covers only the survivor or former spouse and any eligible children of both the survivor or former spouse and hostage.

■ 16. Amend § 890.1203 by revising paragraph (b) to read as follows:

§ 890.1203 Coverage.

(b) An individual who is covered under this subpart is covered under the Standard Option of the Service Benefit Plan. The individual has a self and family enrollment unless the U.S. Department of State determines that the individual is married and has no eligible children, or is unmarried and has one eligible child, in which case the individual is covered under a self plus one enrollment, or unless the U.S. Department of State determines that the individual is unmarried and has no eligible children, in which case the individual has a self only enrollment.

■ 17. Amend § 890.1205 by revising paragraphs (a) and (b) to read as follows:

§ 890.1205 Change in type of enrollment.

(a) Individuals covered under this subpart or eligible survivors enrolled under this subpart may increase enrollment type if they acquire an eligible family member. The change may be made at the written request of the enrollee at any time after the family member is acquired. An increase in enrollment type under this paragraph (a) becomes effective on the 1st day of the pay period after the pay period during which the request is received by the U.S. Department of State, except that a change based on the birth or addition of a child as a new family member is effective on the 1st day of the pay period during which the child is born or otherwise becomes a new family member.

(b) Individuals covered under this subpart or eligible survivors enrolled under this subpart may decrease enrollment type from a self and family enrollment when the last eligible family member (other than the enrollee) ceases to be a family member or only one family member remains; and may decrease enrollment type from a self plus one enrollment when no family

member remains. The change may be made at the written request of the enrollee at any time after the last family member is lost and it becomes effective on the 1st day of the pay period after the pay period during which the request is received by the U.S. Department of State.

* * * * *

■ 18. Amend § 890.1209 by revising paragraph (c) to read as follows:

§ 890.1209 Responsibilities of the U.S. Department of State.

* * * * *

(c) The U.S. Department of State must determine the number of eligible family members, if any, for the purpose of coverage under a self only, self plus one, or self and family enrollment as set forth in § 890.1203(b). If the number of eligible family members of the individual cannot be determined, the U.S. Department of State must enroll the individual for self and family coverage.

PART 892—FEDERAL FLEXIBLE BENEFITS PLAN: PRE-TAX PAYMENT OF HEALTH BENEFITS PREMIUMS

■ 19. The authority citation for part 892 is revised to read as follows:

Authority: 5 U.S.C. 8913; 5 U.S.C. 1103(a)(7); 26 U.S.C. 125.

■ 20. In § 892.101, the definition of "Qualifying life event" is amended by revising the introductory text and paragraphs (9) and (13) to read as follows:

§ 892.101 Definitions.

* * * * *

Qualifying life event means an event that may permit changes to your FEHB enrollment as well as changes to your premium conversion election as described in Treasury regulations at 26 CFR 1.125-4. For purposes of determining whether a qualifying life event has occurred under this part, a stepchild who is the child of an employee's domestic partner as defined in part 890 of this chapter shall be treated as though the child were a dependent within the meaning of 26 CFR 1.125-4 even if the child does not so qualify under such Treasury regulations. Such events include the following:

* * * * *

(9) An employee becomes entitled to Medicare. (For change to self only, self plus one, cancellation, or change in premium conversion status see paragraph (11) of this definition.)

* * * * *

(13) An employee or eligible family member becomes eligible for premium

assistance under Medicaid or a State Children's Health Insurance Program (CHIP). An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee becomes eligible for premium assistance under a Medicaid plan or a State Children's Health Insurance Program. An employee must enroll or change his or her enrollment within 60 days after the date the employee or family member is determined to be eligible for assistance.

■ 21. Amend § 892.207 by revising paragraph (b) and adding paragraph (d) to read as follows:

§ 892.207 Can I make changes to my FEHB enrollment while I am participating in premium conversion?

* * * * *

(b) However, if you are participating in premium conversion there are two exceptions: You must have a qualifying life event to decrease enrollment type, switch a covered family member, or to cancel FEHB coverage entirely. (See §§ 892.209 and 892.210.) Your change in enrollment must be consistent with and correspond to your qualifying life event as described in § 892.101. These limitations apply only to changes you may wish to make outside open season.

* * * * *

(d) During the first plan year in which the self plus one enrollment type is available, OPM will administer a limited enrollment period for enrollees who participate in premium conversion. During this limited enrollment period, enrollees who participate in premium conversion will be allowed to decrease enrollment from self and family to self plus one during a time period determined by OPM. No other changes, including changes in plan or plan option or increases in enrollment, will be allowed. Enrollments will be effective on the first day of the first pay period following the one in which the appropriate request is received by the employing office.

■ 22. Revise § 892.208 to read as follows:

§ 892.208 Can I decrease my enrollment type at any time?

If you are participating in premium conversion you may decrease your FEHB enrollment type under either of the following circumstances:

(a) *During the annual open season.* A decrease in enrollment type made during the annual open season takes effect on the 1st day of the first pay period that begins in the next year.

(b) *Within 60 days after you have a qualifying life event.* A decrease in enrollment type made because of a qualifying life event takes effect on the first day of the first pay period that begins after the date your employing office receives your appropriate request. Your change in enrollment must be consistent with and correspond to your qualifying life event. For example, if you get divorced and have no dependent children, changing to self only would be consistent with that qualifying life event. As another example, if both you and your spouse are Federal employees, and your youngest dependent turns age 26, changing from a self and family to a self plus one or two self only enrollments would be consistent and appropriate for that event.

(c) If you are subject to a court or administrative order as discussed in § 890.301(g)(3), you may not decrease enrollment type in a way that eliminates coverage of a child identified in the order as long as the court or administrative order is still in effect and you have at least one child identified in the order who is still eligible under the FEHB Program, unless you provide documentation to your agency that you have other coverage for your child or children. See also §§ 892.207 and 892.209. If you are subject to a court or administrative order as discussed in § 890.301(g)(3), you may not change your enrollment to self plus one as long as the court or administrative order is still in effect and you have more than one child identified in the order who is still eligible under the FEHB Program, unless you provide documentation to your agency that you have other coverage for your children. See also §§ 892.207 and 892.209.

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DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

7 CFR Part 319

[Docket No. APHIS-2014-0002]

RIN 0579-AD98

Importation of Kiwi From Chile Into the United States

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: We are amending the fruits and vegetables regulations to list kiwi

(*Actinidia deliciosa* and *Actinidia chinensis*) from Chile as eligible for importation into the United States subject to a systems approach. Under this systems approach, the fruit will have to be grown in a place of production that is registered with the Government of Chile and certified as having a low prevalence of *Brevipalpus chilensis*. The fruit will have to undergo pre-harvest sampling at the registered production site. Following post-harvest processing, the fruit will have to be inspected in Chile at an approved inspection site. Each consignment of fruit will have to be accompanied by a phytosanitary certificate with an additional declaration stating that the fruit had been found free of *Brevipalpus chilensis* based on field and packinghouse inspections. This rule allows for the safe importation of kiwi from Chile using mitigation measures other than fumigation with methyl bromide.

DATES: Effective October 19, 2015.

FOR FURTHER INFORMATION CONTACT: Ms. Claudia Ferguson, Senior Regulatory Policy Specialist, Regulatory Coordination and Compliance, PPQ, APHIS, 4700 River Road Unit 133, Riverdale, MD 20737-1236; (301) 851-2352.

SUPPLEMENTARY INFORMATION:

Background

Under the regulations in “Subpart-Fruits and Vegetables” (7 CFR 319.56-1 through 319.56-73, referred to below as the regulations), the Animal and Plant Health Inspection Service (APHIS) of the U.S. Department of Agriculture prohibits or restricts the importation of fruits and vegetables into the United States from certain parts of the world to prevent plant pests from being introduced into and spread within the United States.

On October 16, 2014, we published in the **Federal Register** (79 FR 62055-62058, Docket No. APHIS-2014-0002) a proposal¹ to amend the regulations by listing kiwi (*Actinidia deliciosa* and *Actinidia chinensis*) from Chile as eligible for importation into the United States under the same systems approach as baby kiwi from Chile, which are eligible for importation under the conditions in § 319.56-53. We also prepared a commodity import evaluation document (CIED) titled “Importation of Fresh Fruits of Kiwi (*Actinidia deliciosa* and *Actinidia chinensis*) from Chile into the United

¹ To view the proposed rule, supporting documents, and the comments we received, go to <http://www.regulations.gov/#!docketDetail;D=APHIS-2014-0002>.