Proposed Rules

Federal Register
Vol. 83, No. 35
Wednesday, February 21, 2018

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AN51

Federal Employees Health Benefits Program Regulations: Revised Guaranteed Issue Conversion Requirements and Technical Updates

AGENCY: Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The Office of Personnel Management proposes to amend the guaranteed issue conversion requirements for the Federal Employees Health Benefits (FEHB) Program. Guaranteed issue insurance policies are available in all 50 states and the District of Columbia. These rules update the requirements and timeframes for FEHB Carriers to offer assistance to enrollees who may wish to enroll in guaranteed issue conversion contracts and ensure that terminating enrollees are able to receive assistance from FEHB Carriers if they choose to enroll in guaranteed issue non-group policies. This rule also updates the title of the Director for Retirement and Insurance.

DATES: Comments are due on or before April 23, 2018.

ADDRESSES: You may submit comments, identified by docket number and/or Regulatory Information Number (RIN) and title, by any of the following methods:

- *Federal Rulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Delon Pinto, Senior Policy Analyst, Planning and Policy Analysis, U.S. Office of Personnel Management, Room 4312, 1900 E Street NW, Washington, DC 20415.

All submissions received must include the agency name and docket number or RIN for this document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Delon Pinto, Senior Policy Analyst, at *Delon.Pinto@opm.gov* or (202) 606–0004.

SUPPLEMENTARY INFORMATION:

Authority for This Rulemaking

The Federal Employees Health Benefits (FEHB) Program is administered by the Office of Personnel Management (OPM) in accordance with Chapter 89 of Title 5 of the U.S. Code and our implementing regulations (title 5, part 890 and title 48, chapter 16). The statute establishes the basic rules for benefits, enrollment, and participation. OPM is authorized to contract with health insurance Carriers; approve health plans for participation in the program; negotiate with Carriers about benefit and premium levels; determine the times and conditions for an annual open enrollment period known as ''open season'' during which eligible individuals may elect coverage or change plans; make information available to employees concerning plan options; evaluate health plans on key parameters of clinical quality, customer service, resource use in comparison with national benchmarks and contract oversight requirements; apply administrative sanctions to health care providers that have committed certain violations; and administer the program's financing.

OPM is also responsible for maintaining the funds that hold contingency reserves for the plans and the fund that receives premium payments from enrollees and Federal agencies, from which premiums are disbursed to participating plans. OPM determines whether retiring employees or survivor annuitants meet the requirements to continue health insurance coverage; takes the action necessary to terminate, accept, or continue enrollment; oversees the automatic deduction of premiums from monthly annuity checks and credits the premiums, along with the applicable Government contribution, to the proper account; processes all enrollment changes; notifies affected Carriers of enrollment changes; and keeps enrolled retirees advised of rate and benefit changes within their plan.

Background

Under Section 8902 of Title 5 of the U.S. Code, OPM may only contract with health insurance Carriers who offer terminating enrollees the opportunity to convert to a non-group policy without restrictions on pre-existing conditions. This was an additional protection to ensure that individuals could receive health insurance coverage if they no longer had access to group or non-group coverage. Currently, Carriers must offer a non-group policy to terminating enrollees. Subject to certain exceptions, all non-grandfathered health insurance policies offered in the individual market must be sold to individuals on a guaranteed issue basis.

Discussion of Proposed Changes

OPM has determined that the existing FEHB Program requirement that health insurance Carriers offer the option to convert to a non-group contract providing health benefits to FEHB enrollees and covered family members upon termination of their FEHB coverage can be revised to allow more flexibility to enrollees or covered family members and Carriers. As a result, in addition to or as an alternative to enrollment in a conversion plan offered by the Carrier when an enrollee's or covered family member's FEHB coverage is terminated, the enrollee or covered family member can enroll in a guaranteed issue non-group policy. OPM will continue to offer enrollees and covered family members a 31-day extension of coverage, which may be extended to 60 days if the enrollee or covered family member can prove that the 31-day extension did not provide sufficient opportunity to convert to a non-group contract.

Additionally, the timeframe in which an agency must notify a terminating enrollee of his or her right to convert has been decreased from 60 days to 15 days to minimize the risk of a gap in coverage for the enrollee. OPM arrived at 15 days by reviewing the enrollment deadlines for non-group coverage options available to enrollees and calculating a reasonable time frame for notice that would allow terminating enrollees to subsequently enroll in coverage before the 30 day temporary extension of coverage expired.

Expected Impact of Proposed Changes

OPM expects the proposed deregulatory changes to increase the flexibility for Carriers to assist terminating enrollees in finding health insurance coverage and to reduce the costs for Carriers who will have additional options to assist enrollees with finding conversion coverage. Because are proposing to decrease the timeline for notification by employing agencies, we expect individuals to expedite their transition from FEHB coverage to a conversion plan should they choose to enroll in conversion coverage. This increased flexibility will reduce the administrative costs for Carriers. Currently, Carriers must contract with a third party or provide an internal organization to accept any enrollees who may elect conversion coverage offered by the plan. This is a sunk cost regardless of whether enrollees actually elect conversion coverage. This can be a significant expense, particularly if the FEHBP is the only program for which the Carrier must provide this service. If the Carrier has additional flexibility regarding conversion coverage, the Carrier will no longer bear this expense. Depending on how the plan is rated, a portion of this cost will be passed on to the Government and will proportionally reduce premiums. OPM expects these proposed changes to increase the flexibility for Carriers to assist terminating enrollees in finding appropriate health insurance coverage.

OPM does not believe that this regulation will have a large impact on the broader health insurance market since FEHB generally constitutes a smaller percentage of the overall health insurance carrier's book of business. OPM also believes that employees and annuitants make their health care decisions based on a variety of factors, including networks, premiums, etc., so changes in plan enrollments will be determined by individual choice. However, because OPM does not have extensive data to determine the impact of this regulation, we are seeking comments on the following:

1. How will the changes made by this regulation impact the non-group health insurance market?

2. How will the changes made by this regulation impact the choices available to terminating FEHB enrollees?

3. How will the changes made by this regulation impact the administration of conversion coverage by FEHB Carriers?

Regulatory Impact Analysis

OPM has examined the impact of this proposed rule as required by Executive Order 12866 and Executive Order 13563, which directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public, health, and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects of $100 million or more in any one year. This rule has been designated as a ''significant regulatory action,'' under Executive Order 12866.

E.O. 13771: Reducing Regulation and Controlling Regulatory Costs

This proposed rule is expected to be an E.O. 13771 deregulatory action. Details can be found in the ''Expected Impact of the Proposed Changes'' section of the rule.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities.

Federalism

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

List of Subjects in 5 CFR Part 890

Administration and general provisions, Administrative practice and procedure, Administrative sanctions imposed against health care providers, Benefits for former spouses, Benefits for United States hostages in Iraq and Kuwait and United States hostages captured in Lebanon, Benefits in medically underserved areas, Contributions and withholdings, Department of Defense Federal Employees Health Benefits Program demonstration project, Employee benefit plans, Enrollment, Government employees, Health benefits plans, Limit on inpatient hospital charges, physician charges, and FEHB benefit payments, Reporting and recordkeeping requirements, Retirement, Temporary continuation of coverage, Temporary extension of coverage and conversion, Transfers from retired FEHB Program.

U.S. Office of Personnel Management.

Kathleen M. McGettigan,

Acting Director.

Accordingly, OPM proposes to amend 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; Pub. L. 111–148, as amended by Pub. L. 111–152.

■ 2. Amend § 890.401 by revising paragraphs (a)(1), (b)(2), and (c) to read as follows:

§ 890.401 Temporary extension of coverage and conversion.

(a) * * *

(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. In the event this 31-day temporary extension period provides insufficient opportunity for the enrollee to exercise his or her right to convert to a non-group contract with an effective date commencing before or immediately upon the end of the 31-day temporary extension of coverage, the Carrier may, on a case-by-case basis, provide an additional extension of coverage not to exceed a total of 60 days as appropriate to avoid an interruption in coverage. The enrollee or covered family member must explain to the Carrier in writing the circumstances for seeking additional extension, and the Carrier must notify the OPM Contracting Officer of any extension granted, or obtain prior approval of any extension request that is proposed for denial.

* * * * *

(b) * * *

(2) Except when a plan is discontinued in whole or in part or the

Director orders an enrollment change, a person whose enrollment has been changed from one plan to another, or from one option of a plan to the other option of that plan, and who is confined to a hospital or other institution for care or treatment on the last day of enrollment under the prior plan or option, is entitled to continuation of the benefits of the prior plan or option during the continuance of the confinement. Continuation of benefits shall not extend beyond the 91st day after the last day of enrollment in the prior plan or option. The plan or option to which enrollment has been changed shall not pay benefits with respect to that person while he or she is entitled to any inpatient benefits under the prior plan or option. The gaining plan or option shall begin coverage according to the limits of its FEHB Program contract on the day after the day all inpatient benefits have been exhausted under the prior plan or option or the 92nd day after the last day of enrollment in the prior plan or option, whichever is earlier. For the purposes of this paragraph (b)(2), ''exhausted'' means paid or provided to the maximum benefit available under the contract.

* * * * *

(c)(1) The employing agency must notify the enrollee of the termination of the enrollment and of the right to convert to a non-group contract within 15 days after the date the enrollment terminates.

(2) The individual whose enrollment terminates must request conversion information from the losing Carrier within 15 days of the date of the agency notice of the termination of the enrollment and of the right to convert. The losing Carrier must provide information to the individual that will assist the individual in enrolling in a non-group contract for which the individual is eligible.

(3) When an agency fails to provide the notification required in paragraph (c)(1) of this section within 15 days of the date the enrollment terminates, or the individual fails for other reasons beyond his or her control to request conversion as required in paragraph (c)(2) of this section, he or she may request assistance with conversion to a non-group contract by writing directly to the Carrier. Such a request must be filed within 6 months after the individual became eligible to convert his or her group coverage and must be accompanied by verification of termination of the enrollment; *e.g.,* an SF 50, showing the individual's separation from the service. In addition, the individual must show that he or she was not notified of the termination of the enrollment and of the right to convert, and was not otherwise aware of it, or that he or she was unable, for cause beyond his or her control, to convert. The Carrier will determine if the individual is eligible to convert; and when the determination is affirmative, the individual may convert within 31 days of the determination. If the determination by the Carrier is negative, the individual may request a review of the Carrier's determination from OPM.

(4) When an individual converts his or her coverage any time after the group coverage has ended, the non-group plan coverage is effective on the date governed by the rules applicable to the non-group plan.

(5) An individual who fails to exercise his or her rights to convert to non-group plan during the extension period is deemed to have declined the right to convert unless the Carrier, or, upon review, OPM determines the failure was for cause beyond his or her control.

[FR Doc. 2018–03510 Filed 2–20–18; 8:45 am]

BILLING CODE 6325–63–P

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

12 CFR Part 45

[Docket No. OCC–2018–0003]

RIN 1557–AE29

FEDERAL RESERVE SYSTEM

12 CFR Part 237

[Docket No. R–1596]

RIN 7100–AE96

FEDERAL DEPOSIT INSURANCE CORPORATION

12 CFR Part 349

RIN 3064–AE70

FARM CREDIT ADMINISTRATION

12 CFR Part 624

RIN 3052–AD28

FEDERAL HOUSING FINANCE AGENCY

12 CFR Part 1221

RIN 2590–AA92

Margin and Capital Requirements for Covered Swap Entities; Proposed Rule

AGENCY: Office of the Comptroller of the Currency, Treasury (OCC); Board of Governors of the Federal Reserve System (Board); Federal Deposit Insurance Corporation (FDIC); Farm Credit Administration (FCA); and the Federal Housing Finance Agency (FHFA).

ACTION: Notice of proposed rulemaking and request for comment.

SUMMARY: The Board, OCC, FDIC, FCA, and FHFA (each an Agency and, collectively, the Agencies) are seeking comment on proposed amendments to the minimum margin requirements for registered swap dealers, major swap participants, security-based swap dealers, and major security-based swap participants for which one of the Agencies is the prudential regulator (Swap Margin Rule). The Agencies are proposing these amendments in light of the rules recently adopted by the Board, the OCC, and the FDIC that impose restrictions on certain non-cleared swaps and non-cleared security-based swaps and other financial contracts (Covered QFCs) (the QFC Rules). The QFC Rules amend the definition of ''Qualifying Master Netting Agreement'' in the Federal banking agencies' regulatory capital and liquidity rules to ensure that a Covered QFC is not prevented from being part of a Qualifying Master Netting Agreement solely because the Covered QFC conforms to the new requirements in the QFC Rules. The FCA also plans to propose amendments to its capital rules, including potential revisions to its regulatory definition of ''Qualifying Master Netter Agreement,'' which is expected to be identical to the definition used in the Federal banking agencies' regulatory capital and liquidity rules.

The Agencies are proposing to amend the definition of ''Eligible Master Netting Agreement'' in the Swap Margin Rule so that it remains harmonized with the amended definition of ''Qualifying Master Netting Agreement'' in the Federal banking agencies' regulatory capital and liquidity rules, and amendments to the capital rules that the FCA separately plans to propose. This proposed rule would also ensure that netting agreements of firms subject to the Swap Margin Rule are not excluded from the definition of ''Eligible Master Netting Agreement'' based solely on their compliance with the QFC Rules. The Agencies are also proposing that any legacy non-cleared swap or non-cleared security-based swap (*i.e.,* a non-cleared swap or non-cleared security-based swap entered into before the applicable compliance date) that is not subject to the margin requirements of the Swap Margin Rule would not become subject to the provisions of the