

**OFFICE OF PERSONNEL
MANAGEMENT****5 CFR Part 890; 48 CFR Parts 1602,
1615, 1632, and 1652**

RIN 3206-AM39

**Federal Employees Health Benefits
Program: New Premium Rating Method
for Most Community Rated Plans;
Withdrawal****AGENCY:** U.S. Office of Personnel
Management.**ACTION:** Interim final rule; withdrawal.

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

DATES: The interim final rule published on Thursday, June 23, 2011 at 76 FR 36857 is withdrawn as of June 29, 2011.

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

SUPPLEMENTARY INFORMATION: This rule is being withdrawn due to the version submitted to the **Federal Register** was incorrect and contained numerous errors.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

U.S. Office of Personnel Management.

Edward M. DeHarde,*Program Manager, National Healthcare
Operations.*

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

BILLING CODE 6325-24-P

ACTION: Interim final rule with request
for comments.

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 The purpose of this interim final rule is to replace the outdated SSSG methodology with a more modern and transparent calculation while still ensuring that the FEHB is receiving a fair rate.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

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

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

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

ACA Medical Loss Ratio Requirement

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

FEHB-Specific MLR Threshold

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

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

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MANAGEMENT****5 CFR Part 890****48 CFR Parts 1602, 1615, 1632, and
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for Most Community Rated Plans****AGENCY:** U.S. Office of Personnel
Management.

will continue to be a reconciliation process starting April 30 of the plan year to update any new information received after rates were set but prior to January 1 of the plan year, including book rates filed with the state. Once SSSGs have been phased out, most community rated plans will no longer be required to submit SSSG information and the reconciliation process will not include comparison with SSSGs. Instead of the SSSG comparison, there will be a separate settlement with OPM after the end of the plan year based on the FEHB-specific MLR threshold.

OPM will base its MLR definitions on the HHS interim final rule of December 1, 2010. However, while the HHS MLR will be calculated as a three-year sum, the FEHB-specific MLR threshold will be calculated on a one-year basis to be consistent with the annual renegotiation of FEHB premiums. The HHS interim final regulation allows for a credibility adjustment for the "special circumstance of smaller plans, which do not have sufficient experience to be statistically valid for purposes of the rebate provisions." The FEHB-specific MLR threshold calculation may also include a credibility adjustment, but, if used, the threshold will be lower, due to the relative small size of FEHB enrollee populations. The FEHB-specific MLR threshold target may be different from the ACA large group MLR of 85%. In calculating the FEHB-specific MLR threshold, plans will be aggregated as defined in that year's annual rate instructions issued to carriers.

The use of an FEHB-specific MLR threshold in FEHB community rate setting will allow for the removal of SSSGs for non-TCR plans while preserving incentives for carriers to provide health insurance that is affordable and that has appropriate controls on administrative overhead. In recent years, there have been a declining number of fully insured plans in the commercial market. Carriers are increasingly unable to find groups similarly sized to the FEHB group for comparison and are withdrawing from the program as a result.

This OPM regulation requires that the FEHB-specific MLR threshold calculation take place after the ACA-required MLR calculation and any rebate amounts due to the FEHB as a result of the ACA-required calculation will not be included in the FEHB-specific MLR threshold calculation. The HHS interim final MLR rule requires health insurance issuers to submit their MLR calculation by June 1 of the year following the MLR reporting year. Issuers must report information related to earned premiums and expenditures

in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. The HHS interim final regulation specifies that the report will include claims incurred in the MLR reporting year and paid through March of the following year.

To complete the FEHB-specific MLR threshold calculation after the carrier calculated the ACA-required MLR, FEHB carriers will report claims incurred in the plan year and paid through March 31 of the following year. FEHB carriers will report the same categories of information for the FEHB-specific MLR threshold calculation as reported for the ACA-required MLR calculation; however, the FEHB-specific MLR threshold calculation data will be based only on the FEHB population of the health plan. Data will be reported to OPM with the rate filing for the year following the MLR reporting year. Specific dates for reporting MLR will be included in the rate instructions which are typically released in April of each year.

Under the current SSSG methodology, adjustments due to SSSG discounts are either deposited into plan-specific contingency reserve accounts or factored into reduced premiums for enrollees in the following plan year. Under this rule, if the FEHB-specific MLR threshold calculation process requires an FEHB carrier to pay a subsidization penalty, it will not be deposited into its own contingency reserve fund but will instead be deposited into a Subsidization Penalty Account established in the U.S. Treasury by OPM for this purpose. These funds will be annually distributed, on a pro-rata basis, to the contingency reserves of all non-TCR community rated plans.

Issuers failing to meet the FEHB-specific MLR threshold must make any subsidization penalty payment within 60 days of notification of amounts due. This payment would take place via wire transfer, similar to the way carriers make payments required by the current reconciliation process. In the case of carrier non-compliance, this interim final rule includes authority for OPM to garnish premium payments to the carrier in 1632.170(a)(3).

As stipulated in Section 8910 of Title 5 of the U.S. Code, OPM will include a provision in contracts with carriers that requires the carrier to:

- Furnish reasonable reports to OPM to enable it to carry out its functions under this chapter.
- Permit OPM and GAO to examine records, including those from affiliates

and vendors, as may be necessary to carry out the purpose of this chapter.

Under this regulation, the new methodology becomes effective for all non-TCR plans for the 2013 plan year. For the 2012 plan year, all non-TCR FEHB plans have an option of either: (1) Following the SSSG requirements as currently stated and providing OPM the FEHB-specific 2011 and 2012 MLR threshold calculation by the date specified in the 2012 annual instructions; or (2) moving to the FEHB-specific MLR threshold calculation with no requirement to submit SSSG information for 2012. The FEHB-specific MLR threshold for plans choosing the second option for 2012 will be set similar to the average MLR of FEHB's experience rated plans. OPM expects to set the FEHB-specific MLR threshold for 2013 and beyond at a reasonable level consistent with the MLR that community rated plans are currently achieving under the SSSG mechanism, but no lower than 85%. For those plans that stay under the SSSG methodology, there would be no financial impact to the plans from this regulation in the 2012 plan year. Community rated FEHB plans that are required by state law to use TCR will be required to continue using the SSSG methodology.

Background

There are two methods of determining premium rates for FEHB plans: Community rating and experience rating. This regulatory change will apply to those FEHB plans that are subject to community rating. Under current regulation, the community rated plan premiums are compared to the premiums of SSSGs to ensure that FEHB receives the lowest available premium rate.

TCR plans are those that set the same rates for all groups in a community regardless of the health risks and other characteristics of any specific group. Under TCR, an FEHB group must be charged the same premium as all other groups in the area that receive the same set of benefits. Healthier groups subsidize the less healthy groups that use more health services. This subsidization is by design, and the health plan cannot adjust premiums for a specific group to reflect the percentage of premium revenue used for claim costs versus administration. Therefore, OPM believes it inappropriate to impose an MLR-based premium rating methodology on those FEHB plans that use TCR. Currently, the only FEHB plans that use TCR are those operating in states that require it.

Under current regulations, the premiums for community rated FEHB

plans are negotiated with OPM the August before the plan year begins on January 1. Those negotiated rates are based on comparable rates offered to other plans in the community, with some plans adjusting for age, gender, and health risks of the community. Beginning in April of the plan year, OPM conducts a reconciliation process to update any change in rate assumptions that occurred after rates were set but before January 1 of the plan year, such as new book rates filed in the state in which the plan is issued. During this reconciliation process, each FEHB community rated plan determines the two appropriate employer-based subscriber groups that will serve as SSSGs for comparison. If a plan has provided a discounted rate to one of the SSSGs, the plan must match that discount in the rate provided to FEHB. SSSGs are defined in FEHBAR at 48 CFR 1602.170–13.

The FEHB Program has experienced a decline in the number of participating HMO plans in part due to concerns with the comparison of rates to SSSGs. OPM's goal is to offer Federal employees, annuitants, and their families a broad choice of health insurance plans. To that end, where there are significant barriers to entry or aspects of the program that increase risk beyond an acceptable level for carriers, OPM is taking steps to mitigate risks and eliminate barriers to entry.

The current methodology involving SSSG comparison has been cited by some health plans as creating uncertainty and risk in the FEHB Program. Uncertainty and risk have increased over the years as employers have moved away from offering fully-insured products with community rates for their employees. This trend has resulted in fewer appropriately-sized employer groups that can be used in the SSSG calculation. Under the current methodology, SSSGs are sometimes much smaller than the FEHB group, diverging from the original intent of the regulation. There are several cases in which FEHB groups are compared to groups much less than half their size for the purpose of rate determination.

Waiver of Proposed Rulemaking

OPM has determined that it would be impracticable, unnecessary, and contrary to the public interest to delay putting the provisions of this interim final regulation in place until a public notice and comment process has been completed. Under section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency, for good cause, finds

that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. FEHB plans must be in possession of full information about OPM's rating methodology prior to July 1, 2011 in order to submit proposals for the 2012 plan year. In the absence of the option of a new rating methodology, FEHB plans have indicated they may discontinue participation in FEHB. Fewer participating FEHB plans would constrain competition and limit choice for FEHB enrollees. This OPM interim final regulation was completed as quickly as possible following the publication of the regulatory definition of medical loss ratio by HHS in December 2010, upon which this rule relies. Further, plans have the option of subjecting themselves to the existing rating methodology during the 2012 plan year, should they choose to do so. Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis, including a 60-day public comment period.

Regulatory Impact Analysis

OPM has examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) 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 is not considered a major rule because OPM estimates that premiums paid by Federal employees and agencies will be very similar under the old and new payment methodologies. This rule will be cost-neutral. OPM's intention is to keep FEHB premiums stable and sustainable using this more transparent methodology.

List of Subjects

5 CFR Part 890

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

48 CFR Parts 1602, 1615, 1632, and 1652

Government employees, Government procurement, Health insurance Reporting and recordkeeping requirements.

U.S. Office of Personnel Management.
John Berry,
Director.

For the reasons set forth in the preamble, OPM amends Part 890 of title 5 CFR and chapter 16 of title 48 CFR (FEHBAR) as follows:

TITLE 5—ADMINISTRATIVE PERSONNEL

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Subpart E—Contributions and Withholdings

■ 1. The authority citation for subpart E of part 890 is added to read as follows:

Authority: 5 U.S.C. 8913; Sec. 890.303 also issued under Sec. 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; Subpart L also issued under Sec. 599C of Public Law 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under Secs. 11202(f), 11232(e), 11246(b) and (c) of Public Law 105–33, 111 Stat. 251; Sec. 721 of Public Law 105–261, 112 Stat. 2061 unless otherwise noted; Sec. 890.111 also issued under Sec. 1622(b) of Public Law 104–106, 110 Stat. 515.

■ 2. Add § 890.503(c)(6) to read as follows:

§ 890.503 Reserves.

* * * * *

(c) * * *

(6) *Subsidization penalty reserve.* This reserve account shall be credited with all subsidization penalties levied against community rated plans outlined in 48 CFR 1615.402(c)(3)(ii)(B). The funds in this account shall be annually distributed to the contingency reserves of all community rated plans subject to the FEHB-specific medical loss ratio threshold on a pro-rata basis. The funds will not be used for one specific carrier or plan.

TITLE 48—FEDERAL ACQUISITION REGULATIONS SYSTEM

CHAPTER 16—OFFICE OF PERSONNEL MANAGEMENT FEDERAL EMPLOYEES HEALTH BENEFITS ACQUISITION REGULATION

SUBCHAPTER A—GENERAL

PART 1602—DEFINITIONS OF WORDS AND TERMS

■ 3. The authority citation for part 1602 continues to read as follows:

Authority: 5 U.S.C. 8913; 40 U.S.C. 486(c); 48 CFR 1.301.

■ 4. Section 1602.170–2(b) is revised to read as follows:

§ 1602.170–2 Community rate.

* * * * *

(b) *Adjusted community rate* means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group, except as described in § 1615.402(c)(4).

■ 5. Section 1602.170–5(b) is revised to read as follows:

§ 1602.170–5 Cost or pricing data.

* * * * *

(b) *Community rated carriers*. Cost or pricing data for community rated carriers is the specialized rating data used by carriers in computing a rate that is appropriate for the Federal group and similarly sized subscriber groups (SSSGs). Such data include, but are not limited to, capitation rates; prescription drug, hospital, and office visit benefits utilization data; trend data; actuarial data; rating methodologies for other groups; standardized presentation of the carrier's rating method (age, sex, etc.) showing that the factor predicts utilization; tiered rates information; "step-up" factors information; demographics such as family size; special benefit loading capitations; and adjustment factors for capitation. After the 2012 plan year, reconciled rates for community rated carriers, other than those required by state law to use Traditional Community Rating (TCR), will be required to meet an FEHB-specific medical loss ratio threshold published annually in OPM's rate instructions to FEHB carriers.

■ 6. Redesignate § 1602.170–14 through § 1602.170–15 as § 1602.170–15 through § 1602.170–16.

■ 7. Add new § 1602.170–14 to read as follows:

§ 1602.170–14 FEHB-specific medical loss ratio threshold calculation.

(a) *Medical loss ratio* (MLR) means the ratio of plan incurred claims, including the issuer's expenditures for activities that improve health care quality, to total premium revenue determined by OPM, as defined by the Department of Health and Human Services.

(b) The FEHB-specific MLR will be calculated on an annual basis, with the prior year's ratio having no effect on the current plan year. This FEHB-specific MLR will be measured against an FEHB-specific MLR threshold to be put forth

by OPM in the annual rate instruction letter to FEHB carriers.

(c) OPM will set a credibility adjustment to account for the special circumstances of small FEHB plans in annual rate instructions to carriers.

SUBCHAPTER C—CONTRACTING METHODS AND CONTRACT TYPES

PART 1615—CONTRACTING BY NEGOTIATION

■ 7. The authority citation for part 1615 continues to read as follows:

Authority: Audit and records—5 U.S.C. 8913; 40 U.S.C. 486(c); 48 CFR 1.301. Negotiation—5 U.S.C. 8902

■ 8. Revise § 1615.402(c)(3) to read as follows:

§ 1615.402 Pricing policy.

* * * * *

(c) * * *

(3) For plan year 2012, plans will have the option of continuing to use the similarly sized subscriber group (SSSG) rating methodology described in paragraph (c)(3)(i) of this section or using the MLR rating methodology described in paragraph (c)(3)(ii) of this section. All non-traditional community rated (TCR) plans will be required to submit FEHB-specific MLR information for every year beginning with plan year 2011.

(i) *Similarly sized subscriber group (SSSG) methodology*. (A) For contracts with 1,500 or more enrollee contracts for which the FEHB Program premiums for the contract term will be at or above the threshold at FAR 15.403–4(a)(1), OPM will require the carrier to provide the data and methodology used to determine the FEHB Program rates. OPM will also require the data and methodology used to determine the rates for the carrier's SSSGs. The carrier will provide cost or pricing data required by OPM in its rate instructions for the applicable contract period. OPM will evaluate the data to ensure that the rate is reasonable and consistent with the requirements in this chapter. If necessary, OPM may require the carrier to provide additional documentation.

(B) Contracts will be subject to a downward price adjustment if OPM determines that the Federal group was charged more than it would have been charged using a methodology consistent with that used for the SSSGs. Such adjustments will be based on the lower of the two rates determined by using the methodology (including discounts) the carrier used for the two SSSGs.

(C) FEHB Program community-rated carriers will comply with SSSG criteria provided by OPM in the rate

instructions for the applicable contract period.

(ii) *FEHB-specific medical loss ratio (MLR) threshold methodology*. (A) For contracts with 1,500 or more enrollee contracts for which the FEHB Program premiums for the contract term will be at or above the threshold at FAR 15.403–4(a)(1), OPM will require the carrier to provide the data and methodology used to determine the FEHB Program rates. OPM will also require the data and methodology used to determine the medical loss ratio (MLR) as defined in the ACA (Public Law 111–148) and as defined by HHS in implementing regulations for all FEHB community rated plans other than those required by state law to use Traditional Community Rating. The carrier will provide cost or pricing data, as well as the FEHB-specific MLR threshold data required by OPM in its rate instructions for the applicable contract period. OPM will evaluate the data to ensure that the rate is reasonable and consistent with the requirements in this chapter. If necessary, OPM may require the carrier to provide additional documentation.

(B) Contracts will be subject to a subsidization penalty if OPM determines that the FEHB group did not meet the FEHB-specific MLR threshold specified in the annual rate instruction to carriers. Such a subsidization penalty will be deposited into a Subsidization Penalty Account held at the U.S. Treasury. This Subsidization Penalty Account will be held in common with all community rated carriers and will be annually distributed to the contingency reserve accounts of all non-TCR community rated plans on a pro-rata basis.

(C) FEHB Program community-rated carriers will comply with the MLR criteria, including the FEHB-specific MLR threshold provided by OPM in the rate instructions for the applicable contract period. FEHB plans that are required by state law to use TCR are exempt from this requirement and will use the SSSG methodology outlined in paragraph (c)(3)(i) of this section.

■ 9. Revise § 1615.406–2 to read as follows:

§ 1615.406–2 Certificate of accurate cost or pricing data for community rated carriers.

The contracting officer will require a carrier with a contract meeting the requirements in 1615.402(c)(2) or 1615.402(c)(3) to execute the Certificate of Accurate Cost or Pricing Data contained in this section. A carrier with a contract meeting the requirements in 1615.402(c)(2) will complete the Certificate and keep it on file at the

carrier's place of business in accordance with 1652.204–70. A carrier with a contract meeting the requirements in 1615.402(c)(3) will submit the Certificate to OPM along with its rate reconciliation, which is submitted during the first quarter of the applicable contract year.

(Beginning of certificate)

Certificate of Accurate Cost or Pricing Data for Community-Rated Carriers

This is to certify that, to the best of my knowledge and belief: (1)(a) The cost or pricing data submitted (or, if not submitted, maintained and identified by the carrier as supporting documentation) to the Contracting officer or the Contracting officer's representative or designee, in support of the ____*FEHB Program rates were developed in accordance with the requirements of 48 CFR Chapter 16 and the FEHB Program contract and are accurate, complete, and current as of the date this certificate is executed; and (b) the methodology used to determine the FEHB Program rates is consistent with the methodology used to determine the rates for the carrier's Similarly Sized Subscriber Groups if complying with § 1602.170–13.

or

(c) the determination of the carrier's FEHB-specific medical loss ratio for ** is accurate, complete, and consistent with the methodology as stated in § 1615.402(c)(3)(ii) if complying with § 1602.170–14.

* Insert the year for which the rates apply. Normally, this will be the year for which the rates are being reconciled.

** Insert the year for which the MLR calculation applies. Normally, this will be the year before the year being reconciled.

Firm: _____

Name: _____

Signature: _____

Date of Execution: _____

(End of certificate)

SUBCHAPTER E—GENERAL CONTRACTING REQUIREMENTS

PART 1632—CONTRACT FINANCING

■ 10. The authority citation for part 1632 continues to read as follows:

Authority: 5 U.S.C. 8913; 40 U.S.C. 486(c); 48 CFR 1.301.

■ 11. Add § 1632.170(a)(3) to read as follows:

§ 1632.170 Recurring premium payments to carriers.

(a) * * *

(3) Any subsidization penalty levied against a community rated plan as outlined in 48 CFR 1615.402(c)(3)(ii)(B) must be paid within 60 days from notification. If payment is not received within the 60 day period, OPM will withhold from the community rated carriers the periodic premium payment payable until fully recovered. OPM will deposit the withheld funds in the subsidization penalty reserve described in 5 CFR 890.503(c)(6).

* * * * *

SUBCHAPTER H—CLAUSES AND FORMS

PART 1652—CONTRACT CLAUSES

■ 12. The authority citation for part 1652 continues to read as follows:

Authority: 5 U.S.C. 8913; 40 U.S.C. 486(c); 48 CFR 1.301.

■ 13. Revise 1652.216–70(b)(2) through (b)(5) as follows:

§ 1652.216–70 Accounting and price adjustment.

* * * * *

(b) * * *

(2) The subscription rates agreed to in this contract shall be based on paragraphs (b)(2)(i) or (ii) of this clause. Effective January 1, 2013 all community rated plans must base their rating methodology on the medical loss ratio (MLR) threshold described in paragraph (b)(2)(i) of this clause unless traditional community rating is mandated in the state where they are domiciled:

(i) The subscription rates agreed to in this contract shall meet the FEHB-specific MLR threshold as defined in FEHBA 1602.170–14. The ratio of a plan's incurred claims, including the issuer's expenditures for activities that improve health care quality, to total premium revenue shall not be lower than the FEHB-specific MLR threshold published annually by OPM in its rate instructions.

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

(3) If the rates are determined by SSSG comparison, then:

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

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

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

(4) If rates are determined by comparison with the FEHB-specific MLR threshold, then if the MLR for the carrier's FEHB plan is found to be lower than the published FEHB-specific MLR threshold, the carrier must pay a subsidization penalty into a subsidization penalty account.

(5) The following apply to community rated plans, regardless of the rating methodology:

(i) No upward adjustment in the rate established for this contract will be allowed or considered by the Government or will be made by the Carrier in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(ii) For contract years beginning on or after January 1, 2009, in the event this contract is not renewed, the final rate reconciliation will be performed. The carrier must promptly pay any amount owed to OPM. Any amount recoverable by the carrier is limited to the amount in the contingency reserve for the terminating plan as of December 31 of the terminating year.

(iii) Carriers may not impose surcharges (loadings not defined based on an established rating method) on the FEHBP subscription rates or use surcharges in the rate reconciliation process in any circumstance.

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