Association of Federal Health Organizations
1101 Vermont Ave NW, Suite 1002, Washington DC 20005
— Established 1983 —

May 26, 2023

Hon. Kiran Ahuja
Director
U.S. Office of Personnel Management
1900 E St. NW
Washington DC 20415

Re: RIN 3206–AO43 / Submitted via regulations.gov

Dear Ms. Ahuja:

Thank you for the opportunity to comment on the Interim Final Rule ("IFR") concerning the implementation of the Postal Service Health Benefits Program ("PSHBP"), 88 Fed. Reg. 20,383 (April 6, 2023). The Association of Federal Health Organizations ("AFHO") is a trade association of Federal Employees Health Benefits ("FEHB") plan carriers whose combined enrollment encompasses approximately 80% of the FEHB Program's total enrollment.

AFHO generally supports the IFR's framework for establishing the PSHBP. We offer the following comments to build out that framework.

1. The FEHB Act, 5 U.S.C. § 8910(d) states

> The Office, in consultation with the Department of Health and Human Services, shall develop and implement a system through which the carrier for an approved health benefits plan described by section 8903 or 8903a will be able to identify those annuitants or other individuals covered by such plan who are entitled to benefits under part A or B of title XVIII of the Social Security Act in order to ensure that payments under coordination of benefits with Medicare do not exceed the statutory maximums which physicians may charge Medicare enrollees.

Due to this statutory mandate, OPM must expand its information sharing rule, 5 CFR § 890.1612, to include the entire FEHB Program and allow carrier access to that database for coordination of benefits and Section 111 reporting purposes.

OPM also must include a field for the last day of work preceding retirement in this Medicare COB database because Medicare Part A, if in effect, becomes primary to FEHB coverage on that day. In addition, CMS requires carriers to share this data with CMS via its Section 111 report. See Attachment A, AFHO comments on CMS Section 111 Civil Monetary Penalty Final Rule. Next year, CMS will begin to impose civil monetary penalties for Section 111 reporting violations. See

Attachment B, CMS Medicare Secondary Payer and Certain Civil Money Penalties; Extension of Timeline for Publication of Final Rule.

2. The IFR does not resolve a pre-contract costs issue OPM created for PSHBP carriers.

   FAR Cost Principle 32 states,

   > Precontract costs mean costs incurred before the effective date of the contract directly pursuant to the negotiation and in anticipation of the contract award when such incurrence is necessary to comply with the proposed contract delivery schedule. These costs are allowable to the extent that they would have been allowable if incurred after the date of the contract (see 31.109).

   The FEHBAR, 48 CFR § 1631.205-77, limits the FAR cost principle by stating, "Precontract costs (FAR 31.205-32) shall be allowed only to the extent provided for by advance agreement in accordance with FAR 31.109." However, and likely impermissibly, OPM has stated that the agency will not accept advance agreements on PSHBP pre-contract costs.

   OPM explained on the second day of the FEHB carrier conference, April 20, 2023, that the agency intends to decide on carrier PSHBP applications in November 2023. Therefore, to resolve this cost allowability issue, OPM should make the PSHBP contract effective November 1, 2023, for contract accounting purposes.

3. OPM confirmed at its carrier conference that PSHBP participating carriers are not required to carry over all of their FEHB plan options to the PSHBP. Many FEHBP nationwide carriers offer multiple options, and regional carriers offer coverage in various regions, which are treated as separate plans.

   We recognize that the IFR, 5 C.F.R. § 890.1605(c), states as follows:

   > (c) Automatic enrollment. Each Postal Service employee or Postal Service annuitant who is enrolled in a current plan and does not enroll or make an election not to enroll for the initial contract year, will be automatically enrolled in a PSHB plan by OPM as follows:
   > (1) In a PSHB plan by the carrier of the individual's current plan if the carrier offers only one plan under this subpart.
   > (2) If the carrier of the individual's current plan offers more than one health benefits plan or option under this subpart, in the plan and option offered by that carrier that provides coverage with equivalent benefits and cost sharing to the individual's current plan and option, as determined by OPM.

> (3) If there is no such plan as identified by OPM in paragraph (c)(1) or (2) of this section, in the lowest-cost nationwide plan option offered under this subpart that is not a high deductible health plan and does not charge an association or membership fee as determined by OPM.
> (4) All enrollments under paragraph (c)(1) of this section will be in the same enrollment type as the current enrollment type.

As we understand this rule if a carrier offers two or three options in the FEHBP and only one of those options in the PSHBP, all of the automatic enrollees from the FEHBP only option(s) would be moved over to the carrier's PSHBP plan regardless of equivalence of benefits and cost sharing. However, suppose a carrier offers three options in the FEHBP and two in the PSHBP. In that case, OPM must determine whether automatic enrollment will be made to one of those options based on equivalence of benefits and cost sharing.

We ask to (1) confirm our statutory understanding and (2) offer to inform carriers moving two out of three options to the PSHBP where automatic enrollees in the FEHB only option would land before the portal for accepting PSHBP applications opens on June 25, 2023

Thank you for considering these comments.

Sincerely,

Rocky Midgett

Rocky Midgett
Chairman

cc: Board of Directors
David M. Ermer

ATTACHMENT A

Association of Federal Health Organizations

1413 K St. NW, 6th Floor, Washington, DC 20005-3405
Established 1983

April 20, 2020

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert Humphrey Building
Washington, DC

Submitted via regulations.gov

Re: RIN CMS-6061-P

Dear Ms. Verma:

The Association of Federal Health Organizations ("AFHO") hereby responds to your agency's notice of proposed rulemaking soliciting public comment on specific practices for which civil money penalties (CMPs) may or may not be imposed on group health plans ("GHP") for failure to comply with Medicare Secondary Payer reporting requirements applicable to GHPs ("Section 111"), 42 U.S.C. § 1395y(b)(7).[1]

AFHO is a trade association of Federal Employees Health Benefits ("FEHB") plan carriers. AFHO's members provide GHP coverage to over 75% of the FEHB Program's total enrollment of federal and postal employees and annuitants. AFHO's members or their claims administrators are responsible reporting entities ("RRE") for purposes of the GHP reporting provisions of Section 111, see 42 U.S.C. § 1395y(b)(7)(A). FEHBP RREs generate a very large volume of Section 111 reports because half of the Program's eight-million enrollees are federal and postal annuitants

Section 111, 42 U.S.C. § 1395y(b)(7), requires that RREs shall —

> (i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this subchapter; and
>
> (ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

[1] Each AFHO members reserves the right to submit individual comments on this notice.

Section 111 further authorizes the Centers for Medicare and Medicaid Services ("CMS") to impose stiff civil money penalties (CMPs) on non-compliant RREs. *Id.*[2] We appreciate the fact that CMS intends to impose such penalties prospectively following finalization of this proposed rule. 85 Fed. Reg. at 8796.

On December 11, 2013, CMS issued an advanced notice of proposed rulemaking on this topic. AFHO timely submitted comments in response to that advance notice which submission may be found on regulations.gov (RIN CMS-6061-ANPRM) . AFHO timely commented on this advance notice of proposed rulemaking, Attachment A hereto.

We continue to urge that GHP RRE reliance on, and usage of, information obtained from federal government employers and retirement systems should not be treated as willful noncompliance with Section 111 reporting requirements.

Factual Background

1. Section 111 adopts the Employee Retirement Income Security Act's ("ERISA"), 29 U.S.C. § 1002, terminology – plan sponsors and participants. However, the FEHB Program is exempt from ERISA, 29 U.S.C. § 1003, and consequently it is structured in accordance with the FEHB Act, 5 U.S.C. Ch. 89, not ERISA. It is not clear who the plan sponsor for FEHB Program purposes is because the FEHB Act, 5 U.S.C. Ch. 89, does not define or use that term. CMS may want to discuss this issue with OPM, which is the FEHB Program's administrator.

2. Even when the identity of the plan sponsor is clear, the Medicare law does not impose penalties on unresponsive plan sponsors and participants. In other words, the Medicare Act provides the RREs with no leverage to obtain the information that CMS requires.

3. RREs for FEHB plans must rely on federal government agencies (the employers of federal employees and the administrators of federal retirement systems for federal retirees) to supply the information that falls within the scope of Section 111 reporting. OPM's focus appropriately is on providing accurate enrollment records to FEHB Program carriers. Although that information generally overlaps with the Secretary's Section 111 requirements, there are exceptions that lead to Section 111 reporting errors.

A significant exception is the date used for the "Termination Date" -- field 11 of the Section 111 GHP MSP Input File Detail Record (see pages A-1 to A-10 of CMS's MMSEA Section 111 MSP Mandatory Reporting GHP User Guide (Rev. 2019/33 December COBR-Q4-2019-v5.6) (hereafter "User Guide")). The description of this "Required" field refers the reader to Section 7.2.6.1 (page 7-32) for additional information and examples as follows:

> Section 7.2.6.1. How to Report a Coverage Termination Date for Active Covered Individuals
>
> The Coverage Termination Date is the last day that the Active Covered Individual is covered through a GHP due to current employment (with the exception of situations involving ESRD). Even though GHP coverage may continue past their last day of employment, (e.g., the covered individual stops working mid-month but retains coverage until the end of the month), the submitted coverage termination date should be the last day that the Active Covered Individual was employed). Medicare becomes primary payer once current employment ends.

The User Guide (page 7-32) then provides the following example:

[2] We express concern about CMS's proposal to impose daily penalties on allegedly non-compliant GHP RREs when the Section 111 reporting system does not readily accept changes outside of the quarterly reporting period.

> Example #1:
>
> Covered individual retires on June 10, 2013 but retains GHP coverage until June 30, 2013. The RRE must submit the last day of current employment (June 10, 2013) in the Coverage Termination Date (Field 11). **Do not submit the day after the last date the beneficiary was covered by the GHP (July 1, 2013) in the Coverage Termination Date**. Medicare becomes primary on June 11, 2013.

(Emphasis in the original.) Among the federal employee termination events that can result in MSP Termination Date reporting are:

1) The federal employee cancels their FEHB coverage;

2) The federal employee changes their coverage from one FEHB Plan to another;

3) The federal employee separates from federal service without entitlement to a retirement annuity; and

4) The federal employee retiring from federal service.

FEHB Plans are informed by federal agencies of each of these events through the use of SF 2809 Health Benefits Election Form or SF 2810 Notice of Change in Health Benefits Enrollment (enclosed with this comment letter for your ease of reference). Frequently, the effective dates reported by federal agencies to FEHB Plans for these events differ from the MSP Termination Date as defined in CMS's Section 111 GHP User Guide. For example, in the event of involuntary loss of FEHB coverage, the employee's enrollment will terminate, subject to a 31-day extension of coverage, on the earliest of the following dates:

- the last day of the pay period in which the employee separates from service (unless he/she transfers, retires, or begins receiving Workers' Compensation benefits);
- the last day of the pay period in which the employee separates after he/she meets the requirements for an immediate annuity under the FERS MRA+10 provision and he/she postpones receipt of his/her annuity (see chapter 42A of the CSRS/FERS Handbook for Personnel and Payroll Offices);
- the last day of the pay period in which the employee changes to a position that is excluded from coverage;
- the last day of the pay period in which the employee dies, unless he/she has a family member eligible to continue enrollment as a survivor annuitant;
- the last day of the pay period that includes the 365th day of continuous leave without pay status or the last day of leave under the Family and Medical Leave Act, whichever is later;
- the last day of the last pay period in pay status, if he/she hasn't had 4 consecutive months of pay status after he/she has exhausted the 365 days continuation of coverage in leave without pay status;
- the day he/she is separated, furloughed, or placed on leave of absence to serve in the uniformed services for duty over 30 days, if he/she elects in writing to have his/her employing office terminate his/her enrollment;

- the date that is 24 months after the date of his/her separation, furlough, or leave of absence to serve in the uniformed services for active duty over 30 days, or the date of his/her entitlement to continued coverage ends, whichever is earlier;
- the day on which his/her TCC expires; or
- the last day of the pay period for which withholding was made when he/she is a temporary employee enrolled under 5 U.S.C. 8906a whose pay is insufficient to pay the withholdings and he/she did not or could not choose a plan for which his/her pay would cover the premiums

In the event of cancellation of coverage, e.g., to pick up spousal coverage, FEHB coverage ends on the last day of the pay period in which his/her employing office receives his/her Health Benefits Election Form (SF 2809) or other enrollment request. Source: https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/termination-conversion-and-temporary-continuation-of-coverage/ This is the only information provided by federal agencies to FEHB Plan RREs, and FEHB Plan RREs are not in a position to alter these dates.

A particularly relevant example of these potential discrepancies is the reporting of a federal employee's last day of work when retiring from federal service. That is the date on which Medicare switches from secondary to primary carrier status.[3] On the SF 2810 form, OPM will tell FEHB Plans the date on which the enrollee transfers from his active employment payroll office to OPM's retirement office for annuitant enrollment purposes. While there is a rough equivalence between this transfer date and the actual retirement date, the actual dates can vary. OPM does not provide FEHB Plans with the actual retirement date because due to the complicated federal retirement system and the retirement application processing backlog at OPM, that date often is not determined until months later.

While FEHB plans could solicit this information from individual participants, the complex federal retirement system and the ability of federal employees to continue to receive workers compensation beyond age 65 makes this approach difficult to implement. Moreover, the participant response rate to the plans' inquiries and the accuracy of the participant responses received are unknown.

Recommendation

FEHB Plan RREs must be able to rely upon, and report under Section 111 the information provided by the various employing agencies and the administrator of the federal employees' retirement systems, OPM. Consequently, CMPs should not be imposed on a FEHB Plan RRE for relying on data that they receive from the federal employer, the federal employer's retirement system, or the federal workers compensation program.

Specifically, we ask that CMS add the following exemption to Section 402.1(c)(21)(iv)[4]:

[3] Under the FEHB Act, federal and postal employees who retire under one of the federal retirement programs, FERS or CSRS, with at least five years of coverage under the FEHBP preceding their retirement date have the right to continue their FEHB coverage into retirement with the full government contribution.

[4] We wish to note that the first exemption listed in this proposed rule appears to be missing several words as it currently reads in a garbled manner as follows:

> (iv) A civil money penalty (CMP) is not imposed if—
> (A) It is associated with a specific policy or procedural change ? ? ? is not imposed for a minimum of two reporting periods following the implementation of that policy or procedural change;

> (c) A civil monetary penalty (CMP) is not imposed if –
>
> * * *
>
> (C) It is associated with data provided to a Federal Employees Health Benefits Plan entity from a participating employer, the federal retirement system administered by the U.S. Office of Personnel Management, or the federal workers compensation system administered by the U.S. Department of Labor's Office of Workers Compensation Programs.

Rationale Supporting Recommendation

The preamble to the proposed rule, CMS states in pertinent part under the headings "CMPs and 'Good Faith Efforts' to Obtain Information to Report" and "Proposed Safe Harbors" that

> Multiple commenters were also concerned about their ability to obtain all of the required information for reporting and requested safe harbors for non-compliance due to non-cooperation on the part of the reportable individual. This situation has been addressed under ''good faith efforts'' in this section.
>
> [C]oncerns about ''good faith efforts'' were received from the NGHP industry and not the GHP industry, which we believe is reflective of fundamental differences between the two industries and the relationships between those plans and the individuals in question. Our understanding is that NGHP applicable plans may be in an adversarial relationship at times with the reportable individual, whereas the reportable individual is typically the client of a GHP.

85 Fed. Reg. at 8795. This statement is plainly erroneous. Both AFHO and the Blue Cross Blue Shield Association, representing the largest submitters of Section 111 data, called the CMS's attention that FEHB carriers are dependent upon the Office of Personnel Management ("OPM") for the accuracy of Section 111 data.[5] This predicament is not due to an adversarial relationship between FEHBP carriers and OPM but rather to the fact that the information that OPM collects for its own purposes does not fully align with Section 111 requirements.

Recently, the U.S. Court of Appeals for the District of Columbia Circuit observed that

> Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decision making. *See, e.g., Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932, 433 U.S. App. D.C. 25 (D.C. Cir. 2017) (critiquing an agency for "brush[ing] aside critical facts" and not "adequately analyz[ing]" the consequences of a decision); *Getty v. Federal Sav. & Loan Ins. Corp*., 805 F.2d 1050, 1055, 256 U.S. App. D.C. 346 (D.C. Cir. 1986) (analyzing whether an agency actually considered a concern rather than merely stating that it considered the concern).

Gresham v. Azar, 950 F.3d 93, 103 (Feb. 14, 2020). Here CMS has ignored our comments to date. We ask the agency to avoid litigation under 5 U.S.C. § 706 by granting RREs submitting Section 111 data for

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We added "? ? ?" where words appear to be missing.

[5] In its comments on the advance notice of proposed rulemaking, the Kaiser Foundation raised the same concern in the context of GHP reliance on employer eligibility data.

> Given the challenges relating to the accuracy of data upon which RREs rely to report on the MSP status of GHP members, Kaiser believes RREs that take appropriate measures to obtain the data from GHPs, but are given incorrect or inaccurate data should not be faulted for noncompliance and thus not be subject to CMPs.

FEHB plans an exemption from Section 111 CMPs when the carrier can provide evidence that the error(s) triggering the CMP was due to a problem with OPM-provided data, as stated under "Recommendation". That outcome also would be in the interest of comity between OPM and CMS.[6]

In closing, we note that it is hornbook law that CMPs should be reserved for those who are willfully non-compliant. See *Commack Self-Service Kosher Meats, Inc. v. Hooker*, 680 F.3d 194, 209 (2d Cir. 2012), following *In re Chapman*, 166 U.S. 661, 667 (1897):

> [N]othing is better settled, than that statutes should receive a sensible construction, such as will effectuate the legislative intention, and, if possible, so as to avoid an unjust or an absurd conclusion.

Thank you for considering these comments.

Sincerely,

Rocky Midgett

Rocky Midgett
Chairman

cc: Board of Directors
Sylvia Pulley, Chief, Contracts Division I, Healthcare and Insurance
Stephanie Thompson, Chief, Contracts Division II, Healthcare and Insurance
Delon Pinto, Chief, Contracts Division III, Healthcare and Insurance
Cindy Butler, Deputy Assistant Director, Healthcare and Insurance
Edward DeHarde, Assistant Director, Healthcare and Insurance
Laurie Bodenheimer, Acting Director, Healthcare and Insurance
David Ermer

[6] Both the Medicare and FEHB Programs are funded from the U.S. Treasury. The late U.S. appellate judge Abner J, Mikva once observed "there is another concept that is in play and should be reckoned with by the judges and other decision makers. And the concern ought to be about 'comity.' Comity is defined in the dictionary as "'mutual consideration between or as if between equals.'"

ATTACHMENT A

Association of Federal Health Organizations

1413 K St. NW, 6th Floor, Washington, DC 20005-3405
Established 1983

February 10, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert Humphrey Building
Washington, DC

Submitted via regulations.gov

Re: CMS-6061-ANPRM

Dear Ms. Tavenner:

The Association of Federal Health Organizations ("AFHO") hereby responds to the advance notice of proposed rulemaking soliciting public comment on specific practices for which civil money penalties (CMPs) may or may not be imposed on group health plans for failure to comply with Medicare Secondary Payer reporting requirements applicable to group health plans ("Section 111"), 42 U.S.C. § 1395y(b)(7). [1]

AFHO is a trade association of Federal Employees Health Benefits ("FEHB") plans. AFHO's members provide group health plan ("GHP") coverage to over 75% of the FEHB Program's total enrollment of federal and postal employees and annuitants. AFHO's members or their claims administrators are responsible reporting entities ("RRE") for purposes of the GHP reporting provisions of Section 111, see 42 U.S.C. § 1395y(b)(7)(A).

Section 111, 42 U.S.C. § 1395y(b)(7), requires that RREs shall —

> (i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this subchapter; and
>
> (ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

Section 111 further imposes stiff $1,000 per day civil money penalties (CMPs) on non-compliant RREs. *Id.*

Approximately half of the FEHB Program's enrollments are federal and postal annuitants. A sizeable segment of this annuitant cadre is eligible and enrolled for Medicare Part A and/or Part B coverage. AFHO member contracts with the U.S.

[1] Each AFHO members reserves the right to submit individual comments on this notice.

Office of Personnel Management establishing FEHB plans require them to properly coordinate benefits with Medicare. Their compliance with this obligation is subject to independent public accountant and OPM Inspector General audit.

For decades, AFHO members have cooperated with CMS via data sharing agreements, and we welcomed the information sharing improvements that accompanied the implementation of Section 111. AFHO members expend substantial resources to properly coordinate benefits with Medicare. We recommend that CMS maintain a compliance assistance approach to Section 111 by imposing CMPs only when the RRE knowing, willfully, and repeatedly fails to comply with the reporting requirements.

We further recommend that GHP RRE reliance on, and usage of, information obtained from employers and retirement systems, particularly when those employers or retirement systems are federal government agencies, should not be treated as wilful noncompliance with Section 111 reporting requirements. Please consider the following:

1. Section 111 adopts the Employee Retirement Income Security Act's ("ERISA"), 29 U.S.C. § 1002, terminology – plan sponsors and participants. However, the FEHB Program is exempt from ERISA, 29 U.S.C. § 1003, and consequently it is structured in accordance with the FEHB Act, 5 U.S.C. Ch. 89, not ERISA.[2] It is not clear who is the plan sponsor for FEHB Program purposes because the FEHB Act, 5 U.S.C. Ch. 89, does not define or use that term.[3] CMS may want to discuss this issue with OPM, which is the FEHB Program's administrator.

2. Even when the identity of the plan sponsor is clear, the Medicare law does not impose penalties on uncooperative plan sponsors and participants. In other words, the Medicare Act provides the RREs with no leverage to obtain the information that CMS requires. See May 1, 2013 CMS Alert to Employers, available at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/AlertToEmployers050609.pdf

3. RREs for FEHB plans must rely on federal government agencies (the employers of federal employees and the administrators of federal retirement systems for federal retirees) to supply the information that falls within the scope of Section 111 reporting. OPM's focus appropriately is on providing accurate enrollment records to FEHB Program carriers. Although that information generally overlaps with the Secretary's Section 111 requirements, there are exceptions.

   A significant exception is the date used for the "Termination Date" -- field 11 of the Section 111 GHP MSP Input File Detail Record (see pages A-2 to A-10 of CMS's MMSEA Section 111 MSP Mandatory Reporting GHP User Guide (Rev. 2013/30 September COBR-Q4-M9-v4.2)). The description of this "Required" field refers the reader to Section 7.2.6.1 (page 7-34) for additional information and examples as follows:

   Section 7.2.6.1. *How to Report a Coverage Termination Date for Active Covered Individuals* provides the following instructions:

---

[2] FEHB plans meet ERISA's definitions of employee welfare benefit plan and governmental plan. 29 U.S.C. § 1002(2), (37).

[3] The FEHB Act was enacted in 1959, 15 years before ERISA.

> The Coverage Termination Date is the last day that the Active Covered Individual is covered through a GHP due to current employment (with the exception of situations involving ESRD). Even though GHP coverage may continue past their last day of employment, (e.g., the covered individual stops working mid-month but retains coverage until the end of the month), the submitted coverage termination date should be the last day that the Active Covered Individual was employed). Medicare becomes primary payer once current employment ends.

The User Guide then provides the following example:

Example #1:

> Covered individual retires on June 10, 2013 but retains GHP coverage until June 30, 2013. The RRE must submit the last day of current employment (June 10, 2013) in the Coverage Termination Date (Field 11). Do not submit the day after the last date the beneficiary was covered by the GHP (July 1, 2013) in the Coverage Termination Date. Medicare becomes primary on June 11, 2013.

Among the events that can result in MSP Termination Date reporting are:

1) The federal employee cancelling their FEHB coverage;
2) The federal employee changing their coverage from one FEHB Plan to another;
3) The federal employee separating from federal service without entitlement to a retirement annuity; and
4) The federal employee retiring from federal service.

FEHB Plans are informed by federal agencies of each of these events through the use of SF 2809 *Health Benefits Election Form* or SF 2810 *Notice of Change in Health Benefits Enrollment* (enclosed with this comment letter for your ease of reference). Often, the effective dates reported by federal agencies to FEHB Plans for these events may not be the same date as the MSP Termination Date as defined in CMS's Section 111 GHP User Guide. Nevertheless, we emphasize that this is the only information provided by federal agencies to FEHB Plans, and FEHB Plans are not in a position to alter these dates.

One detailed example of these potential discrepancies is the reporting of a federal employee's last day of work when retiring from federal service. That is the date on which Medicare switches from secondary to primary carrier status. On the SF 2810 form, OPM will tell FEHB Plans the date on which the enrollee transfers from his active employment payroll office to OPM's retirement office for annuitant enrollment purposes. While there is a rough equivalence between this transfer date and the actual retirement date, the dates can vary. OPM does not provide FEHB Plans with the actual retirement date because due to the complicated federal retirement system and the retirement application processing backlog at OPM, that date often is not determined until months later.

While, in theory, FEHB plans could solicit this information from individual participants, the complicated federal retirement system and the ability of federal employees to continue to receive workers compensation beyond age 65 makes this approach difficult to implement. . Moreover, the participant response rate to the plans' inquiries and the accuracy of the participant responses received are unknown.

> AFHO would be happy to meet with CMS and OPM, which administers the FEHBP, to discuss an appropriate resolution of this ongoing problem.

In sum, RREs for FEHB plans must be able to rely upon, and report under Section 111 the information provided by the various employing agencies and the administrator of the federal employees' retirement systems, OPM. Consequently, CMPs should not be imposed on a GHP RRE for (a) reporting data that the RRE had no reason to believe was wrong or (b) failing to report data that they cannot obtain from the employer or the employer's retirement system. CMPs should be reserved for those who are willfully non-compliant. *See Commack Self-Service Kosher Meats, Inc. v. Hooker*, 680 F.3d 194, 209 (2d Cir. 2012), *following In re Chapman*, 166 U.S. 661, 667 (1897):

> [N]othing is better settled, than that statutes should receive a sensible construction, such as will effectuate the legislative intention, and, if possible, so as to avoid an unjust or an absurd conclusion.

Thank you for considering these comments.

Sincerely,

Larry Waligora

Larry Waligora
Chairman

cc: Board of Directors
Sylvia Pulley, Chief, Contracts Division I, Healthcare and Insurance
William Stuart, Chief, Contracts Division II, Healthcare and Insurance
Cindy Butler, Chief, Contracts Division III, Healthcare and Insurance
Anne Easton, Deputy Director, Planning and Policy Analysis
John O'Brien, Director, Healthcare and Insurance
David Ermer

Health Benefits Election Form

Form Approved:
OMB No. 3206-0160

Uses for Standard Form (SF) 2809

Use this form to:

- Enroll or reenroll in the FEHB Program; or
- Elect not to enroll in the FEHB Program *(employees only)*; or
- Change your FEHB enrollment; or
- Cancel your FEHB enrollment; or
- Suspend your FEHB enrollment *(annuitants or former spouses only)*.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a. ***Employees automatically participate in premium conversion unless they waive it, see page 7.***
2. Annuitants in retirement systems other than the Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs (OWCP).

   Note: Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants and former spouses and children of CSRS/FERS annuitants -- ***Do not use this form.*** *Instead, use form OPM 2809, which is available at www.opm.gov/retire, or call the Retirement Information Office toll-free at 1-888-767-6738.*
3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
4. Individuals eligible for Temporary Continuation of Coverage (TCC) under the FEHB Program, including:
   - Former employees (who separated from service);
   - Children who lose FEHB coverage; and
   - Former spouses who are not eligible for FEHB under item 3 above.

Instructions for Completing SF 2809

Type or Print. We have not provided instructions for those items that have an explanation on the form.

Part A — Enrollee and Family Member Information

You must complete this part.

Item 2. See the Privacy Act and Public Burden Statements on page 5.

Item 5. If you are separated but not divorced, you are still married.

Item 7. If you have Medicare, check which Parts you have, including prescription drug coverage under Medicare Part D.

Item 8. If you have Medicare, enter your Medicare Claim Number. This number is on your Medicare Card.

Item 9. If you are covered by other health insurance, either in your name or under a family member's policy, check yes and complete item 10.

Item 10. Provide the information requested on any other health insurance that covers you. An FEHB Self and Family enrollment covers all eligible family members. If you or a family member is covered under another FEHB enrollment, check the FEHB box and STOP. Contact your Human Resources office or retirement system immediately as this is a dual coverage situation. Examples of how this could occur are:

- You are enrolling in an FEHB Self Only plan while your spouse has an FEHB Self and Family plan (which automatically covers you).
- You are enrolling in an FEHB Self and Family plan while your spouse has an FEHB Self Only or Self and Family plan.
- You are an employee under age 26 and have no dependents. You are enrolling in your own FEHB plan while you are covered under your parent's FEHB Self and Family plan.
- You are an annuitant who is reemployed in the Federal government. You are enrolling in an FEHB plan as an employee while you are covered under your own or a family member's FEHB plan.

No person may be covered under more than one FEHB enrollment. However, in certain unusual circumstances, your agency may allow you to enroll in order to:

- Enable an employee under age 26 who is covered under a parent's Self and Family FEHB enrollment to enroll in FEHB to cover his or her own spouse and/or child;
- Enable an employee under age 26 who is covered under a parent's Self and Family FEHB enrollment, but lives outside his or her parent's HMO service area, to have FEHB coverage;
- Enable an employee who separates or divorces to enroll in FEHB to cover family members who move outside the HMO service area of the covering FEHB Self and Family enrollment.

In these unusual situations, each enrollee must notify his or her plan as to which family members are covered under which enrollment. See Dual Enrollment information on page 4.

If your enrollment is for Self and Family, complete information for your family members. (If you need extra space for additional family members, list them on a separate sheet and attach.)

The instructions for completing items 11 through 22 for your initial family member also apply to the information you provide for additional family members.

Item 12. Please provide Social Security Numbers for your dependents if they have one. If your dependents do not have Social Security Numbers, leave blank; benefits will not be withheld. *(See Privacy Act Statement on page 5.)*

Item 15. Provide the code which indicates the relationship of each eligible family member to you.

Code	Family Relationship
01	Spouse
19	Child under age 26
09	Adopted Child
17	Stepchild
10	Foster Child
99	Disabled child age 26 or older who is incapable of self support because of a physical or mental disability that began before his/her 26th birthday.

Item 16. If your family member does not live with you, enter his/her home address.

Item 17. If your family member has Medicare, check which Parts he/she has, including prescription drug coverage under Medicare Part D.

Item 18. If your family member has Medicare, enter his/her Medicare Claim Number. This number is on his/her Medicare Card.

Item 19. If your family member is covered by other group insurance, such as private, state, or Medicaid, check the box and complete item 20.

Item 20. Provide the information requested on any other health insurance that covers this family member. ***If your family member is covered under another FEHB plan, see instructions for item 10.***

Item 21. If your family member does not live with you, enter his/her email address.

Item 22. If your family member does not live with you, enter his/her preferred telephone number.

Family Members Eligible for Coverage

Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your children under age 26.

Eligible children include your legitimate or adopted children; stepchildren; recognized natural children; or foster children who live with you in a regular parent-child relationship.

Other relatives (for example, your parents) are ***not*** eligible for coverage even if they live with you and are dependent upon you.

If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the natural or adopted children under age 26 of ***both you and your former or deceased spouse.***

In some cases, a disabled child age 26 or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical disability that existed before his/her 26th birthday and renders the child incapable of self-support.

Note: Your employing office can give you additional details about family member eligibility including any certification or documentation that may be required for coverage. "Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, annuitant, former spouse eligible for coverage under the Spouse Equity provisions, or individual eligible for TCC.

Part B — FEHB Plan You Are Currently Enrolled In

You must complete this part if you are changing, cancelling, or suspending your enrollment.

Item 1. Enter the name of the plan you are enrolled in from the front cover of the plan brochure.

Item 2. Enter your present enrollment code from your plan ID card.

Part C — FEHB Plan You Are Enrolling In or Changing To

Complete this part to enroll or change your enrollment in the FEHB Program.

Item 1. Enter the name of the plan you are enrolling in or changing to. The plan name is on the front cover of the brochure of the plan you want to be enrolled in.

Item 2. Enter the enrollment code of the plan you are enrolling in or changing to. The enrollment code is on the front cover of the brochure of the plan you want to be enrolled in, and shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live (or in some cases work) in a geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part H authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Part D — Event That Permits You To Enroll, Change, Or Cancel

Item 1. Enter the event code that permits you to enroll, change, or cancel based on a Qualifying Life Event (QLE) from the Table of Permissible Changes in Enrollment that applies to you.

Explanation of Table of Permissible Changes in Enrollment

The tables on pages 7 through 14 illustrate when: an employee who participates in premium conversion; annuitant; former spouse; person eligible for TCC; or employee who waived participation in premium conversion may enroll or change enrollment. The tables show those permissible events that are found in the regulations at 5 CFR Parts 890 and 892.

The tables have been organized by enrollee category. Each category is designated by a number, which identifies the enrollee group, as follows:

1. Employees who participate in premium conversion
2. Annuitants (other than CSRS/FERS annuitants), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs
3. Former spouses eligible for coverage under the Spouse Equity provision of FEHB law
4. TCC enrollees
5. Employees who waived participation in premium conversion

Following each number is a letter, which identifies a specific Qualifying Life Event (QLE); for example, the event code "1A" refers to the initial opportunity to enroll for an employee who elected to participate in premium conversion.

Item 2. Enter the date of the QLE using numbers to show month, day, and complete year; *e.g., 06/30/2011*. If you are electing to enroll, enter the date you became eligible to enroll (for example, the date your appointment began). If you are making an open season enrollment or change, enter the date on which the open season begins.

Part E — Election NOT to Enroll

Place an "X" in the box only if you are an employee and you do NOT wish to enroll in the FEHB Program. ***Be sure to read the information titled*** *Employees Who Elect Not to Enroll or Who Cancel Their Enrollment.*

Part F — Cancellation of FEHB

Place an "X" in the box only if you wish to cancel your FEHB enrollment. Also enter your present plan name and enrollment code in ***Part B. Be sure to read the information titled*** *Employees Who Elect Not to Enroll or Who Cancel Their Enrollment.*

Note For Parts E and F. *If you are Electing Not to Enroll or Cancelling your enrollment because you are covered as a spouse or child under another FEHB plan, your agency must enter the enrollee's name, Social Security number, and FEHB enrollment code in REMARKS.*

Cancellation of Enrollment

Employees participating in premium conversion may cancel their FEHB enrollment only during the open season or when they experience a Qualifying Life Event. Employees who waived participation in premium conversion, annuitants, former spouses, and individuals enrolled under TCC may cancel their enrollment at any time. However, if you cancel, neither you nor any family member covered by your enrollment are entitled to a 31-day temporary extension of coverage, or to convert to an individual, nongroup policy. Moreover, family members who lose coverage because of your cancellation are not eligible for TCC. Be sure to read the additional information below about cancelling your enrollment.

Employees Who Elect Not to Enroll (Part E) or Who Cancel Their Enrollment (Part F)

To be eligible for an FEHB enrollment after you retire, you must retire:

- Under a retirement system for Federal civilian employees, and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

- The 5 years of service immediately before retirement (i.e., commencing date of annuity entitlement), or
- If fewer than 5 years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 60 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the table beginning on page 7. Some employees delay their enrollment or reenrollment until they are nearing 5 years before retirement in order to qualify for FEHB coverage as a retiree; however, there is always the risk that they will retire earlier than expected and not be able to meet the 5-year requirement for continuing FEHB coverage into retirement. ***When you elect not to enroll or cancel your enrollment you are voluntarily accepting this risk.*** An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note for temporary [under 5 U.S.C. 8906a] employees eligible for FEHB without a Government contribution: *Your decision not to enroll or to cancel your enrollment will* ***not*** *affect your future eligibility to continue FEHB enrollment after retirement.*

Annuitants Who Cancel Their Enrollment

CSRS and FERS annuitants and their dependents should not use this form but use form RI 79-9, *Health Benefits Cancellation/Suspension Confirmation*, which is available at www.opm.gov/retire, or call 1-888-767-6738.

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. Your employing office or retirement system can advise you on events that allow eligible annuitants to reenroll. If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you cancel the enrollment because you become covered under FEHB as a new spouse or employee, your eligibility for FEHB coverage under the Spouse Equity provisions continues. You may reenroll as a former spouse from 31 days before through 60 days after you lose coverage under the other FEHB enrollment.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Temporary Continuation of Coverage (TCC) Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. Family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees or 36 months for dependents who lose coverage).

Note 2: Former spouses (Spouse Equity) and TCC enrollees who fail to pay their premiums within specified timeframes are considered to have voluntarily cancelled their enrollment.

Part G — Suspension of FEHB

CSRS and FERS annuitants and their dependents should not use this form but use form RI 79-9, *Health Benefits Cancellation/Suspension Confirmation*, which is available at www.opm.gov/retire, or call 1-888-767-6738.

Place an "X" in the box only if you are an annuitant or former spouse and wish to suspend your FEHB enrollment. Also enter your present plan name and enrollment code in Part B.

You may suspend your FEHB enrollment because you are enrolling in one of the following programs:

- A Medicare Advantage plan or Medicare HMO,
- Medicaid or similar State-sponsored program of medical assistance for the needy,
- TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life),
- CHAMPVA, or
- Peace Corps.

You can reenroll in the FEHB Program if your other coverage ends. If your coverage ends ***involuntarily***, you can reenroll from 31 days before your other coverage ends through 60 days after your other coverage ends. If your coverage ends ***voluntarily*** because you disenroll, you can reenroll during the next open season.

You must submit documentation of eligibility for coverage under the non-FEHB Program to the office that maintains your enrollment. That office must enter in REMARKS the reason for your suspension.

Part H — Signature

Your agency, retirement system, or office maintaining your enrollment cannot process your request unless you complete this part.

If you are registering for someone else under a written authorization from him or her to do so, sign your name in Part H and attach the written authorization.

If you are registering for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for TCC as his or her court-appointed guardian, sign your name in Part H and attach evidence of your court-appointed guardianship.

Part I - Agency or Retirement System Information and Remarks

Leave this section blank as it is for agency or retirement system use only.

Guides to Federal Benefits and Plan Brochures

Guides to Federal Benefits contain plan and rate information. Be sure you have the correct guide for your enrollee category, as more than one guide is issued.

FEHB Plan brochures contain detailed information about plan benefits and the contractual description of coverage.

Where to Obtain Guides and Brochures

The Guides, plan brochures, and other information, including links to plan websites, are available on the FEHB website at ***www.opm.gov/insure/health***.

Guides and plan brochures may be available from your employing office or the office that maintains your enrollment.

Your plan will send you its paper brochure when you first enroll. You may also get copies of plan brochures by contacting the plans directly at the telephone numbers shown in the Guide.

Electronic Enrollments

Many agencies use automated systems that allow their employees to make changes using a touch-tone telephone, or a computer instead of a form. This may be Employee Express or another automated system. If you are not sure whether the electronic enrollment option is available to you, contact your employing office.

Dual Enrollment

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the FEHB Program. Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 26 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment. See instructions for item 10 for more information.

Temporary Continuation of Coverage (TCC)

The employing office must notify a former employee of his or her eligibility for TCC. The enrollee, child, former spouse, or their representative must notify the employing office when a child or former spouse becomes eligible.

- For the eligible child of an enrollee, the enrollee must notify the employing office within ***60 days*** after the qualifying event occurs; e.g., child reaches age 26.
- For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within ***60 days*** after the former spouse's change in status; e.g., the date of the divorce.

An individual eligible for TCC who wants to continue FEHB coverage may choose any plan for which he or she is eligible, option, and type of enrollment. The time limit for a former employee, child, or former spouse to enroll with the employing office is within ***60 days*** after the Qualifying Life Event, or receiving notice of eligibility, whichever is later.

Effective Dates

Except for open season, most enrollments and changes of enrollment are effective on the first day of the pay period after the employing office receives this form and that follows a pay period during any part of which the employee is in pay status. Your employing office can give you the specific date on which your enrollment or enrollment change will take effect.

Note 1: *If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.*

Note 2: *If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.*

Agency Distribution of SF 2809

Agencies must distribute one copy of the completed SF 2809 to each of the following, as appropriate:

- Official Personnel Folder
- New Carrier
- Old Carrier
- Payroll Office
- Enrollee

Privacy Act Statement

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or Social Security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the OPM may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We estimate this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team, (3206-0160), Washington, D.C. 20415-3430. The OMB number, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Federal Employees Receiving Premium Conversion Tax Benefits
Table of Permissible Changes in FEHB Enrollment and Premium Conversion Election

Premium Conversion allows employees who are eligible for FEHB the opportunity to pay for their share of FEHB premiums with pre-tax dollars. Premium conversion plans are governed by Section 125 of the Internal Revenue Code, and IRS rules govern when a participant may change his or her election outside of the annual open season. **All employees who enroll in the FEHB Program automatically receive premium conversion tax benefits,** unless they waive participation. When an employee experiences a Qualifying Life Event (QLE) as described below, changes to the employee's FEHB coverage **(including change to Self Only and cancellation)** and premium conversion election may be permitted, so long as they are **because of and consistent with** the QLE's. For more information about premium conversion, please visit *www.opm.gov/insure/health*.

Qualifying Life Events (QLE's) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				**Premium *Conversion Election Change that May Be Permitted***		***Time Limits in which Change May Be Permitted***
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*[1]	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1	**Employee electing to receive or receiving premium conversion tax benefits**							
1A	Initial opportunity to enroll, for example: • New employee • Change from excluded position • Temporary employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last child loses coverage, for example, child reaches age 26, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse or dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event.						
1D	Any change in employee's employment status that could result in entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G.)*	Yes	N/A	N/A	N/A	***Automatic Unless Waived***	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part-time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change
1F	Employee restored to civilian position after serving in uniformed services.[2]	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position

Qualifying Life Events (QLE's) that May Permit Change in FEHB Enrollment or Premium Conversion Election		***FEHB Enrollment Change that May Be Permitted***				**Premium Conversion Election Change that May Be Permitted**		***Time Limits in which Change May Be Permitted***
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1G	Employee, spouse or dependent: • Begins nonpay status or insufficient pay[3] or • Ends nonpay status or insufficient pay if coverage continued • *(If employee's coverage terminated, see 1D.)* • *(If spouse's or dependent's coverage terminated, see 1M.)*	No	No	No	Yes	Yes	Yes	Within 60 days after employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollments or, if already outside the area, moves further from this area.[4]	N/A	Yes	Yes	N/A *(see 1M)*	No *(see 1M)*	No *(see 1M)*	Upon notifying employing office of move
1J	Transfer from post of duty within a State of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse.	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after arriving at new post
		Employees may enroll or change beginning 31 days before leaving the old post of duty.						
1K	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	N/A	N/A	N/A	During employee's final pay period
1L	Employee becomes entitled to Medicare and wants to change to another plan or option. [5]	No	No	Yes *(Changes may be made only once.)*	N/A *(see 1P)*	N/A *(see 1P)*	N/A *(see 1P)*	Any time beginning on the 30th day before becoming eligible for Medicare
1M	Employee or eligible family member loses coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan[6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence *(Employees in an FEHB HMO, also see 1I.)*	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage
		Employees may enroll or change beginning 31 days before the event.						
1N	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-Federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area
1O	Employee or eligible family member loses coverage due to discontinuance in whole or part of FEHB plan.[7]	Yes	Yes	Yes	Yes	Yes	Yes	During open season, unless OPM sets a different time

Qualifying Life Events (QLE's) that May Permit Change in FEHB Enrollment or Premium Conversion Election		*FEHB Enrollment Change that May Be Permitted*				*Premium Conversion Election Change that May Be Permitted*		*Time Limits in which Change May Be Permitted*
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*Cancel or Change to Self Only*	*Participate*	*Waive*	*When You Must File Health Benefits Election Form With Your Employing Office*
1P	Enrolled employee or eligible family member gains coverage under FEHB or another group insurance plan, including the following: • Medicare (Employees who become eligible for Medicare and want to change plans or options, see 1L.) • TRICARE for Life, due to enrollment in Medicare. • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under Chapter 67, title 10. • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (includes state, local, or foreign government or private sector employment).[8]	No	No	No	Yes[9]	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-Federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M.)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available *(If no other coverage is available, see 1M)*	No	No	No	Yes[9]	Yes	Yes	Within 60 days after QLE
1R	Employee or eligible family member becomes eligible for assistance under Medicaid or a State Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Yes[9]	Yes	Yes	Within 60 days after the date the employee or family member becomes eligible for assistance.

(If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.)

1. Employees may change to Self Only outside of open season only if ***the QLE caused*** the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside of open season only if ***the QLE caused*** the enrollee and all eligible family members to acquire other health insurance coverage.

2. Employees who enter active military service are given the opportunity to terminate coverage. Termination for this reason does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement. Additional information on the FEHB coverage of employees who return from active military service is available in the Frequently Asked Questions section of the FEHB website at *www.opm.gov/insure/health*.

3. Employees who begin nonpay status or insufficient pay ***must*** be given an opportunity to elect to continue or terminate coverage. A termination differs from a cancellation as it allows conversion to nongroup coverage and does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement.

4. This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who ***change from Self Only to Self and Family or from one plan or option to another*** a different timeframe than that allowed under 1M. For change to self-only, cancellation, or change in premium conversion status, see 1M.

5. This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to Self Only, cancellation, or change in premium conversion status, see 1P.

6. If employee's membership terminates (e.g., for failure to pay membership dues), the employee organization will notify the agency to ***terminate*** the enrollment.

7. Employee's failure to select another FEHB plan is deemed a cancellation for purposes of meeting the requirements for continuing coverage after retirement.

8. Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.

9. Employees may change to Self Only outside of Open Season only if the QLE caused all eligible family members to acquire other health insurance coverage. Employees may cancel enrollment outside of Open Season only if the QLE caused the enrollee and all eligible family members to acquire other health insurance coverage.

Tables of Permissible Changes in FEHB Enrollment for Individuals Who Are Not Participating in Premium Conversion

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

QLE's That Permit Enrollment or Change		*Change Permitted*			*Time Limits*
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2	**Annuitant (Includes Compensationers)** ***Note for enrolled survivor annuitants: A change in family status based on additional family members can only occur if the additional eligible family members are family members of the deceased employee or annuitant.***				
2A	Open Season	No	Yes	Yes	As announced by OPM.
2B	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after the event.
2C	Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan and TRICARE for Life), Peace Corps, or CHAMPVA, and who later ***involuntarily*** loses this coverage under one of these programs.	May Reenroll	N/A	N/A	From 31 days before through 60 days after involuntary loss of coverage.
2D	Reenrollment of annuitant who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage.	May Reenroll	N/A	N/A	During open season.
2E	Restoration of annuity or compensation (OWCP) payments; for example: • Disability annuitant who was enrolled in FEHB, and whose annuity terminated due to restoration of earning capacity or recovery from disability, and whose annuity is restored; • Compensationer whose compensation terminated because of recovery from injury or disease and whose compensation is restored due to a recurrence of medical condition; • Surviving spouse who was covered by FEHB immediately before survivor annuity terminated because of remarriage and whose annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because student status ended and whose survivor annuity is restored; • Surviving child who was covered by FEHB immediately before survivor annuity terminated because of marriage and whose survivor annuity is restored.	Yes	N/A	N/A	Within 60 days after the retirement system or OWCP mails a notice of insurance eligibility.
2F	Annuitant or eligible family member loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
2G	Annuitant or eligible family member loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see events 2C and 2D); • Loss of coverage under a non-Federal health plan.	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.
2H	Annuitant or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
2I	Annuitant or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
2J	Employee in an overseas post of duty retires or dies.	No	Yes	Yes	Within 60 days after retirement or death.
2K	An enrolled annuitant separates from duty after serving 31 days or more in a uniformed service.	N/A	Yes	Yes	Within 60 days after separation from the uniformed service.
2L	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
2M	Annuitant's annuity is insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Employing office will advise annuitant of the options.
3	**Former Spouse Under The Spouse Equity Provisions** ***Note: Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.***				
3A	Initial opportunity to enroll. Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open Season.	No	Yes	Yes	As announced by OPM.
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who later ***involuntarily*** loses this coverage under one of these programs.	May reenroll	N/A	N/A	From 31 days before through 60 days after involuntary loss of coverage.
3E	Reenrollment of former spouse who suspended FEHB enrollment to enroll in a Medicare Advantage plan, Medicaid, or similar State-sponsored program, or to use TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), Peace Corps, or CHAMPVA, and who wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage.	May reenroll	N/A	N/A	During open season.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to Self Only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement system will advise former spouse of options.
4	**Temporary Continuation of Coverage (TCC) For Eligible Former Employees, Former Spouses, and Children.** ***Note: Former spouse may change to Self and Family only if family members are also eligible family members of the employee or annuitant.***				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	 Yes Yes Yes	 Yes N/A N/A	 Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open Season: • Former employee • Former spouse • Child who ceases to qualify as a family member	 No No No	 Yes Yes Yes	 Yes Yes Yes	As announced by OPM.
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
4F	Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment (but see event 4E); • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.
4G	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
4I	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5	**Employees Who Are Not Participating In Premium Conversion**				
5A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5B	Open Season.	Yes	Yes	Yes	As announced by OPM.
5C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce	Yes	Yes	Yes	From 31 days before through 60 days after event.
5D	Change in employment status; for example: • Reemployment after a break in service of more than 3 days; • Return to pay status following loss of coverage due to expiration of 365 days of LWOP status or termination of coverage during LWOP; • Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay; • Restoration to civilian position after serving in uniformed services; • Change from temporary appointment to appointment that entitles employee receipt of Government contribution; • Change to or from part-time career employment.	Yes	Yes	Yes	Within 60 days of employment status change.

QLE's That Permit Enrollment or Change		Change Permitted			Time Limits
Event Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
5E	Separation from Federal employment when the employee is or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
5F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
5G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment; • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
5H	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
5I	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
5J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
5K	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
5L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
5M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.
5N	Employee or eligible family member becomes eligible for assistance under Medicaid or a State Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Within 60 days after the date the employee or family member becomes eligible for assistance.

Federal Employees Health Benefits Program

Form Approved: OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

1. Enrollee name *(last, first, middle initial)*	2. Social Security number	3. Date of birth *(mm/dd/yyyy)*	4. Sex ☐ M ☐ F	5. Are you married? ☐ Yes ☐ No

6. Home mailing address *(including ZIP Code)*	7. If you are covered by Medicare, check all that apply. ☐ A ☐ B ☐ D	8. Medicare Claim Number
	9. Are you covered by insurance other than Medicare? ☐ Yes, indicate in item 10 below. ☐ No	

10. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

11. Name of family member *(last, first, middle initial)*	12. Social Security number	13. Date of birth *(mm/dd/yyyy)*	14. Sex ☐ M ☐ F	15. Relationship code

16. Address *(if different from enrollee)*	17. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D	18. Medicare Claim Number
	19. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 20 below. ☐ No	

20. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

21. Email address *(if home address is different from enrollee's)*	22. Preferred telephone number *(if home address is different from enrollee's)*

23. Name of family member *(last, first, middle initial)*	24. Social Security number	25. Date of birth *(mm/dd/yyyy)*	26. Sex ☐ M ☐ F	27. Relationship code

28. Address *(if different from enrollee)*	29. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D	30. Medicare Claim Number
	31. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 32 below. ☐ No	

32. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

33. Email address *(if home address is different from enrollee's)*	34. Preferred telephone number *(if home address is different from enrollee's)*

35. Name of family member *(last, first, middle initial)*	36. Social Security number	37. Date of birth *(mm/dd/yyyy)*	38. Sex ☐ M ☐ F	39. Relationship code

40. Address *(if different from enrollee)*	41. If this family member is covered by Medicare, check all that apply. ☐ A ☐ B ☐ D	42. Medicare Claim Number
	43. Is this family member covered by insurance other than Medicare? ☐ Yes, indicate in item 44 below. ☐ No	

44. Indicate the type(s) of other insurance:

☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

45. Email address *(if home address is different from enrollee's)*	46. Preferred telephone number *(if home address is different from enrollee's)*

(continued on the reverse)

Part B - FEHB Plan You Are Currently Enrolled In *(if applicable)*		Part C - FEHB Plan You Are Enrolling In or Changing To	
1. Plan name	2. Enrollment code	1. Plan name	2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel *(see page 2)*		Part E - Election NOT to Enroll *(Employees Only)*
1. Event code	2. Date of event __ / __ / ____	☐ I do NOT want to enroll in the FEHB Program. *My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.*

Part F - Cancellation of FEHB	Part G - Suspension of FEHB *(Annuitants/Former Spouses Only)*
☐ I CANCEL my enrollment. *My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.*	☐ I SUSPEND my enrollment. *My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.*

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*	2. Date *(mm/dd/yyyy)* __ / __ / ____
3. Email address	4. Preferred telephone number ( )

Part I - To be completed by agency or retirement system

REMARKS

1. Date received *(mm/dd/yyyy)*	2. Effective date of action *(mm/dd/yyyy)*	3. Personnel telephone number ( )
4. Name and address of agency or retirement system		5. Authorizing official *(please print)*
		6. Signature of authorized agency official
7. Payroll office number	8. Payroll office contact *(please print)*	9. Payroll telephone number ( )

FEHB
Federal Employees Health Benefits Program

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.**

If termination is due to death of enrollee enter date of death | Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name | Date of Birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change In Enrollment-Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

Part B - Termination

If Part B on the other side of this form is checked, read the following instructions carefully.

31-Day Extension of Coverage
Your enrollment terminates on the date shown in Part A, item 8, on the front of this form. Coverage under your enrollment continues temporarily for 31 days from the date shown. If you, or any covered member of your family, are a patient in a hospital on the 31st day of this temporary extension, benefits of the plan may continue for the rest of that confinement, but not beyond 60 more days.

Conversion to Nongroup Contract
You may convert your enrollment to a nongroup contract, without evidence of good health. The nongroup contract to which you may convert is one regularly offered by your plan. It may differ from your group plan in benefits, or cost, or both, and you will have to pay the entire cost of the nongroup contract directly to the plan. The nongroup contract is effective on the day after your 31-day extension of coverage ends.

If you are interested in converting to a nongroup contract, write for information to the nearest office of the plan in which you have been enrolled (see the plan's brochure or ask your employing office for the address of the plan's nearest office). The plan will promptly send you an application form and details concerning benefits and rates of the nongroup contract to which you may convert.

Time Limit on Conversion
Normally, to be eligible for conversion, you must send your written request for information to your plan within 31 days after the date shown in Part H. However, if the date shown in Part H is more than 60 days after the date your enrollment terminates (Part A, item 8), you must forward it to your plan within 91 days after the date shown in Part A, item 8.

If you are prevented by causes beyond your control from submitting a timely request for information about conversion to a nongroup contract, you should write to your plan as soon as possible asking approval of a belated conversion opportunity. Explain fully the circumstances that prevented earlier action and attach proof of the loss of group coverage (e.g., Standard Form 50 terminating Federal employment). A plan may consider requests filed within 6 months after group eligibility ends. If your plan needs assistance in processing your request, it should contact OPM.

Temporary Continuation of Coverage
If you are an employee whose enrollment is terminating because you are separating from service (including separation for retirement), you may be eligible to temporarily continue your benefits coverage under the Federal Employees Health Benefits Program after separation. Within 61 days after the date shown in Part A, item 8, on the front of this form, your employing office will formally notify you of your rights regarding temporary continuation of coverage and tell you where you may obtain additional information. You will have 60 days after the later of (1) your date of separation from service, or (2) the date you receive the notice from your employing office in which to elect temporary continuation of coverage.

When your temporary continuation of coverage expires, you will be entitled to the 31-day extension of coverage and the opportunity to convert to a nongroup contract.

Entry on Active Military Duty
If you elected to terminate your enrollment because you are entering military service, you may convert to a nongroup contract even though your family members are entitled to care under the Uniformed Services Health Benefits Program. If you return to civilian duty in the exercise of reemployment rights, your enrollment will be reinstated effective on the day you return to active duty. If you return to civilian duty not in the exercise of reemployment rights, you must, if eligible for coverage, register again the same as a new employee. If you are an annuitant, your enrollment will be reinstated on the day you are separated from military service. You must notify your retirement system of this event by furnishing a copy of your separation papers.

Part C - Transfer of Enrollment

If Part C on the other side of this form is checked, read carefully whichever of the following instructions applies:

Transfer of Employment
Your enrollment has been transferred from your previous agency or payroll office to the agency or payroll office shown in Part H. If you are in a prepaid comprehensive medical plan and you left the area served by the plan, you may be able to change to another plan. For details about your right to change plans, check with your employing office.

Retirement
Your enrollment has been transferred from your employing agency to the retirement system shown in Part H. Your enrollment continues automatically during retirement if you retire on an immediate annuity and you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding retirement. Your share of the cost of your enrollment will be withheld from your annuity.

Death
The enrollment of the deceased employee named in Part A has been transferred to the retirement system shown in Part H. If the deceased employee or annuitant was enrolled for self and family at the time of death, and if at least one member of the family is entitled to a survivor annuity (or the widow(er) is entitled to the Basic Employee Death Benefits under FERS), coverage for each family member who was covered by the employee's enrollment continues automatically.

If there is only one eligible survivor, the enrollment will be changed from family coverage to self only. The survivor's share of the cost of the enrollment will be deducted from the annuity. Application for Death Benefits (Standard Form 2800 or the equivalent) should be filed promptly to avoid any question about health benefits coverage. When the survivor annuity is approved, another form like this one will be issued to show that the enrollment is being continued in the survivor's name.

Employees' Compensation
Your enrollment has been transferred to the Office of Workers' Compensation Programs. Your enrollment continues automatically while you receive monthly compensation from the Office of Workers' Compensation Programs if the Secretary of Labor has held that you are unable to return to duty and if you have been enrolled under the Federal Employees Health Benefits Program for the lesser of (1) all your service since your first opportunity to enroll, or (2) the 5 years of service immediately preceding the start of your compensation. Enrollment of covered family members of a deceased employee or compensationer also continues automatically while they receive monthly compensation, if (1) the deceased employee or compensationer was enrolled for self and family at the time of death, and (2) at least one of the covered family members is entitled to compensation as a surviving beneficiary under the Federal Employees' Compensation Act. The compensationer's or survivor's share of the cost of the enrollment will be deducted from the compensation checks.

Keep This Form For Your Records

FEHB
Federal Employees Health Benefits Program

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.**

If termination is due to death of enrollee enter date of death | Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name | Date of Birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change In Enrollment-Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

FEHB
Federal Employees Health Benefits Program

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.**

If termination is due to death of enrollee enter date of death | Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name | Date of Birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change In Enrollment-Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

Disposition Instructions To Payroll Offices

Copy 2 - Send to insurance carrier, attached to Transmittal Report to Carrier (SF 2811), at the earliest possible date. Under no circumstances should SF 2810s be accumulated for longer than a week, nor should they be delayed to coincide with applicable payroll deductions.

Copy 3 - Use as payroll action document, if necessary.

Copy 4 - In cases of death or retirement under the Civil Service Retirement System or the Federal Employees Retirement System, send to the Office of Personnel Management together with the Official Personnel Folder copy of each Health Benefits Registration Form (SF 2809) accepted from the employee including any Medical Certificates attached thereto, Individual Retirement Record (SF 2806 [CSRS] or SF 3100 [FERS]) and any other applicable documents. For other retirement systems (including Office of Workers' Compensation Programs, Department of Labor), send these documents (or the equivalent) to the office administering the system.

FEHB
Federal Employees Health Benefits Program

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.**

If termination is due to death of enrollee enter date of death | Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name | Date of Birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change In Enrollment-Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (Note: This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number ( )
	Payroll contact and telephone number ( )
Signature of authorized agency official	Date

Instructions for Employing Offices

Purpose of Form

This form covers health benefits actions **except** enrollments, changes from one plan to another, changes of coverage within a plan and cancellations, which are processed on the Health Benefits Registration Form (Standard Form 2809). When an action requires a change in health benefits enrollment, prepare SF 2810 *As Soon As the Effective Date Is Known* and give the appropriate copies to the enrollee and payroll office **immediately**. Preparation and distribution of copies should not be delayed pending SF 50 action in the case of transfers to another payroll office.

Prompt Action Required for Conversion

Give this form to the enrollee within 60 days after the date shown in Part A, item 8. To be eligible to convert to a nongroup contract, the enrollee must send a written request for information about conversion to a nongroup contract to his or her plan within 31 days after the date shown in Part H, but not later than 91 days after the date shown in Part A, item 8.

Completion of Form

Part A - Identifying Information

1. For items 1, 2, and 6, transcribe from the last SF 2809 or SF 2810, whichever is the most recent.
2. Item 4, use most recent known address.
3. Item 5, use payroll office number of office authorized to process withholdings.
4. Item 8, date as follows for action reported in:
   - B. *Termination* - Last day of pay period in which separation (or other action terminating enrollment) occurs except, when coverage terminates because of completion of 365 days in nonpay status, use the last day of the pay period which includes the 365th day of continuous nonpay status; and when coverage terminates because of military duty not limited to 30 days or less, use date employee is separated, was furloughed or placed on leave of absence for military duty.
   - C. *Transfer In* - Actual date (first day on gaining employing office or retirement system rolls.)
   - D. *Reinstatement* - Actual date.
   - E. *Change In Name Of Enrollee* - Actual date.
   - F. *Change In Enrollment-Survivor Annuitant* - Effective day of sole survivor's annuity.

Part B - Termination

These most frequently occuring actions terminate enrollment:

Separated.
Retired - not eligible to continue enrollment.
Died - no survivor eligible to continue enrollment.
Termination of title to annuity or compensation.
Changed to excluded position or category.
365 days nonpay status completed.
Temporary continuation of coverage expired.

Part C - Transfer In

Gaining office uses this box to report transfer actions such as:

Acceptance of transfer from another agency to payroll office number.
Retired - Acceptance of transfer by retirement system because employee is eligible to continue enrollment as an annuitant.
Death - Acceptance of transfer by retirement system because survivor is eligible to continue enrollment as a survivor annuitant.
Transfer accepted by Office of Workers' Compensation Programs.

Note: Retirement systems (including OWCP) accepting transfer in, show also in "Remarks" whether enrollment is for an *"Employee Annuitant" or "Survivor Annuitant."*

Part D - Reinstatement

State in "Remarks"reason for any action not applicable to active military duty, such as "Reinstatement of erroneous separation."

Part E - Change in Name of Enrollee

Use this box only for reporting changes in name where change of coverage within a plan by SF 2809 is not involved. Show date of birth only where enrollment is changed from employee's or annuitant's name to name of survivor annuitant.

Part F - Change in Enrollment - Survivor Annuitant

Only agencies administering retirement systems will make this determination on the basis of documentary evidence that there is only one survivor annuitant.

Part G - Remarks

Use this box to bring to the attention of the employee, annuitant, or insurance carrier any pertinent information to clarify or support the action being taken.

Part H - Date of Notice

Facsimile signature is acceptable. Date as of day of issuance.

Disposition

Copy 1 - Deliver (or mail) to employee, annuitant or survivor **at the earliest possible date,** but before 60 days from the date shown in Part A, item 8.
Copies 2 and 3 - Send to appropriate insurance carrier and payroll office.
Copy 4 - File in Official Personnel Folder (or its equivalent).

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 402

Office of the Secretary

45 CFR Part 102

[CMS–6061–RCN]

RIN 0938–AT86

Medicare Secondary Payer and Certain Civil Money Penalties; Extension of Timeline for Publication of Final Rule

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Extension of timeline.

SUMMARY: This document announces the 1-year extension of the timeline for publication of the final rule. Section 1871(a)(3)(A) of the Social Security Act (the Act) requires us to establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation. Section 1871(a)(3)(B) of the Act allows us to extend the timeline for publication of the final rule by publishing a **Federal Register** document which includes a brief explanation of the justification for the variation in the timeline.

DATES: As of February 22, 2023, the timeline for the publication of the final rule to finalize the provisions of the proposed rule published on February 18, 2020 (85 FR 8793), is extended until February 18, 2024.

ADDRESSES: This is not a solicitation for comment. The February 18, 2020 proposed rule is available at *https://www.federalregister.gov/d/2020-02085.*

FOR FURTHER INFORMATION CONTACT: Jacqueline Cipa, (410) 786–3259.

SUPPLEMENTARY INFORMATION: In the February 18, 2020 **Federal Register** (85 FR 8793), we published a proposed rule titled ''Medicare Secondary Payer and Certain Civil Money Penalties'' that specified how and when CMS would calculate and impose civil money penalties (CMPs) when group health plan (GHP) and non-group health plan (NGHP) responsible reporting entities (RREs) fail to meet their Medicare Secondary Payer (MSP) reporting obligations, as required under sections 1862(b)(7) and 1862(b)(8) of the Social Security Act (the Act). This document announces an extension of the timeline for publication of the final rule.

Section 1871(a)(3)(A) of the Act requires us to establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation.

Section 1871(a)(3)(B) of the Act allows the regular timeline for publishing Medicare final regulations to vary based on the complexity of the regulation, number and scope of comments received, and other related factors. The initial targeted timeline for a rule cannot exceed 3 years from the date of publishing the proposed regulation, absent exceptional circumstances. For the February 18, 2020 proposed rule, the timeline established by the Secretary provided a targeted publication date of February 18, 2023. The Secretary may extend the initial targeted publication date of the final regulation if the Secretary provides public notice, including a brief explanation of the justification for the variation, no later than the regulation's previously established proposed publication date.

Consistent with the aforementioned statutory provision, we are providing a brief explanation of the agency's circumstances that have led us to vary the timeline for publishing the final rule. These are exceptional circumstances, although the Act does not require exceptional circumstances for such extensions. (For more detailed information, see footnote number 24 in the February 1, 2023 **Federal Register** document (88 FR 6648)). We are not able to meet the initial targeted 3-year timeline for publication due to delays related to the need for additional, time-consuming data analysis resulting from public inquiry. It was not possible to conclude this data analysis on the initial, targeted timeline for the proposed rule because public listening sessions raised additional concerns that CMS believed were important to properly and thoroughly research prior to publishing the final rule. We have decided that it is critical to conduct additional analysis about the economic impact of the rule. We are preparing additional data analysis and predictive modeling to better understand the economic impact of the proposed rule across different insurer types. This data analysis is designed to review the actual current reporting and model potential penalties that would be imposed were the final rule in place. Along with delays resulting from the agency's focus on the COVID–19 public health emergency, we determined that additional time is needed to address the complex policy and operational issues that were raised. We are extending the publication deadline so as to provide the most accurate, complete, and robust data possible to confirm the intent and economic impact of the final rule.

This document extends the timeline for publication of the final rule for one year until February 18, 2024.

Elizabeth J. Gramling,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2023–03621 Filed 2–17–23; 4:15 pm]

BILLING CODE 4120–01–P