

**2009 FEHB RATE INSTRUCTIONS -
COMMUNITY-RATED PLANS**

Table of Contents

OPM Community Rating Guidelines – 2009

Changes for 2009	4
Submission Requirements.....	4
New Rating Areas	5
High Deductible Health Plans (HDHPs).....	5
Community Rating Policy.....	6
TCR and CRC Rating	6
ACR Rating.....	7
Similarly Sized Subscriber Groups (SSSGs)	9
Basis of SSSG Concept.....	9
Rules for SSSG Selection	9
Definition... ..	10
HDHP.....	11
Enrollment and Contract Renewal Dates.....	11
SSSGs and Discounts.....	11
Early Rate Quote.....	12
Multi-Year Rate Agreements	12
Purchasing Alliances.....	12
Total Replacement Groups	12
Recovery of Discounts.....	12
Surcharges.....	12
Special Adjustments to SSSG rates	13
Rate Extension for SSSGs	13
Discounts with HDHPs.....	13
Rating Period Beyond 24 Months.....	13
Consistency of Rating Methods.....	13
Examination of Non-SSSG Groups	13
Miscellaneous Remarks	14
State Taxes	14
Special Loading for Enrollment Discrepancies	14
Late Payment Loadings.....	14
Rate Reconciliation Audits	14
Error Reporting	14

Table of Contents

Instructions

Instructions for Attachment I – Small Carriers.....	15
Instructions for Attachment II – Large Carriers	16

Attachments

Attachment I - Rate Proposal – Small Carriers.....	20
Attachment IA - Certificate of Accurate Cost or Pricing Data.....	21
Attachment II - Rate Proposal – Large Carriers	22
Attachment II – Backup Forms	
Backup Line 1 Form.	23
Backup Special Loading Form.....	24
Backup Medicare Form.....	25
Potential SSSGs Form.....	26
Attachment IIA - The Community Rated Questionnaire.....	27
Attachment IIB - Carrier Contacts.....	39
Attachment IIC - Utilization Data.....	40

Appendix

Appendix I – Definitions	41
Appendix II – Examples of Rating Regions	43
Appendix III – Selection of SSSGs Examples.....	44

OPM Community Rating Guidelines - 2009

❖ Changes for 2009

- We have eliminated the 30 month rule for SSSGs. The 30 month rule for determining if a group is an SSSG for an ACR rated plan stated:

***New Business** – If the group’s initial contract period is more than 24 months, the group could qualify as an SSSG for the period beyond the first 24 months. The federal group would be rated like the SSSG to determine any applicable discounts on the portion of the rating period beyond 24 months.*

***First Year Renewal** – Anytime the first year renewal period of a group extends beyond the 30 month timeframe (initial contract period plus first year renewal period), then the group would not be eligible for exclusion under the first year renewal rule.*

- We have eliminated the SSSG exclusion for ACR rated groups in their second contract year. ACR rated groups will now be eligible to be SSSGs beginning with the group’s second contract year.
- Definitions of underlined, italicized key terms are now located in Appendix I on page 41. If you are reading an electronic version of these guidelines, the terms are hyperlinked. Pressing the Control button and clicking on the term will redirect you to the definition page.
- The \$500,000 maximum regarding small plan submission requirements has been changed to \$650,000. See the ‘Submission Requirements’ section below for further details.
- We are clarifying that carriers must use the Attachments I and/or II (as appropriate) contained in these instructions for their final 2009 rate submission. We encourage backup documentation; however, final proposed rates must be submitted in the template provided.
- Administrative Service Organizations (ASOs) have been added to the list of groups to be excluded from SSSG consideration.
- We are considering enacting the following rule prior to the 2009 reconciliation: Plans that terminate at the end of 2009 will be subject to the same reconciliation requirements as plans that renew for 2010. Further notification will be sent as new information becomes available.

❖ Submission Requirements

If a [carrier](#) has more than 1500 FEHBP contracts at the time of the rate proposal:

- The carrier is considered a large carrier. The carrier must complete and submit Attachments II, IIA, IIB, and IIC.

If a [carrier](#) has less than 1500 FEHBP contracts at the time of the rate proposal, the carrier must choose between the following options:

OPM Community Rating Guidelines - 2009

- Submit the same detailed documentation required for large carriers (see above). A carrier that chooses this option will be considered a large carrier.

OR

- If the carrier's 2008 income from the Federal group will be greater than or equal to \$650,000, the carrier must complete Attachments I, IA, II, IIA, IIB, and IIC and submit Attachments I, IA, IIB, and IIC. A carrier should not send Attachments II and IIA to OPM; however, these documents must be kept on file and available for OPM review in accordance with the records retention clause of the contract. A carrier that chooses this option will be considered a small carrier;
- If the carrier's 2008 income from the Federal group will be less than \$650,000, the carrier must complete and submit Attachments I, IIB, and IIC. Such a carrier need not complete or retain Attachments IA, II and IIA. A carrier that chooses this option will be considered a small carrier.

Since small carriers will not submit detailed documentation, the Office of Actuaries will evaluate these carrier's proposed rates by using its reasonableness test. Rates failing this test will be further reviewed. For small carriers whose 2008 Federal group income will be \$650,000 or more, the Office of Actuaries may request detailed documentation.

❖ **New Rating Areas**

If a carrier proposes a rate for a new area (or splits a current area), a letter must be submitted explaining:

- Why the area has been added;
- How it relates to the previous service area (for example, the new area is a portion of an existing area that has been split into two or more sections); and
- How the carrier's current enrollment will be affected by the addition of this new area.

❖ **High Deductible Health Plans (HDHPs)**

A carrier who proposes a rate for a HDHP must:

- Meet the requirements of the Medicare Modernization Act (MMA) of 2003 for High Deductible Health Plans;
- Be rated in accordance with the guidelines set forth in these instructions;
- Include the amount to be deposited to the enrollee's HSA/HRA (pass-through amount) not to exceed 25% of the total premium; and
- Have a minimum deductible and a maximum yearly out of pocket cost to the enrollee consistent with the requirements set forth by the Internal Revenue Service for 2009. For 2008, the

OPM Community Rating Guidelines - 2009

minimum deductible was \$1,100 Self and \$2,200 Family and the maximum out of pocket cost to the enrollee was \$5,600 Self and \$11,200 Family.

❖ Community Rating Policy

The three standard methods of community rating considered acceptable are Traditional Community Rating (TCR), Community Rating by Class (CRC) and Adjusted Community Rating (ACR)

TCR and CRC Rating

Carriers using TCR or CRC for 2009 are expected to develop rates from a community-based revenue requirement (normally in the form of a capitation rate) which is documented and verifiable. Once the capitation rate is established it may be converted to self and family rates using the carrier's standard procedures.

Carriers using demographic factors (such as family size) based on group-specific data for the Federal group must also use group-specific data for the SSSGs. All demographic factors must be based on actual in-force group data.

CRC

A carrier using CRC for the Federal group must provide a standard presentation of its rating method. If the carrier cannot comply with OPM's standard format, it must submit its rate manual and/or other official documents that demonstrate the actuarial soundness of the CRC method. The standard presentation required assumes the carrier begins with an overall capitation rate (an example of the format is given below in the Standard Format section).

Age and sex are accepted as legitimate factors for CRC. **A large carrier using CRC must furnish a table showing the age-sex distribution on which it based the Federal group's CRC adjustment factor.** Furthermore, carriers must clearly show how the table was used to derive the adjustment factor. Any proposed factor other than age and sex must be supported with carrier documentation showing how the factor predicts utilization.

If industry factors are used, the following policy applies:

- The industry factor used for the Federal group in the rate proposal must be 1.0 or less. The proposed factor may change in the reconciliation, but in no case can it be larger than 1.0.
- The Federal group industry factor must be no larger than the lowest industry factor used for an SSSG and must be 1.0 or less.

Standard Format

The following method is required for CRC carriers:

1. Derive a CRC adjustment factor (AF), which is used to adjust the capitation rate. A carrier should base this adjustment factor on the age-sex distribution of the Federal group, although we do allow certain variations of this concept.

OPM Community Rating Guidelines - 2009

2. Determine the adjusted capitation rate for the Federal group (AF x capitation).
3. Convert the adjusted capitation rate to self and family rates using the same method that would be used under TCR.

Example:

Class	Percentage Distribution of Members	Relative Utilization Factor
1	.10	.40
2	.20	.80
3	.45	1.20
4	.25	1.60

$$AF = (.10 \times .40) + (.20 \times .80) + (.45 \times 1.20) + (.25 \times 1.60) = 1.14$$

Capitation	= \$60.00 pm/pm
Adjusted Capitation	= \$60.00 x 1.14 = \$68.40
1st Level Step-Up Factor	= 1.2
2nd Level Step-Up Factor	= 2.9
Self Rate	= \$68.40 x 1.2 = \$ 82.08
Family Rate	= \$82.08 x 2.9 = \$238.03

Note The Following:

1. Carriers must include CRC worksheets (i.e. sheets showing the relative utilization factors and the age/sex distribution for the Federal group) with their submission.
2. The relative utilization factors used for the federal group must be the same as those used for all of the carrier's CRC-rated groups.
3. Federal annuitants over age 65 should generally not be included in the calculation of the CRC factor.
4. A carrier using CRC for the Federal group should compute a Medicare loading similar to OPM's suggested method (see page 17).

ACR Rating

A carrier using ACR must use a method based on utilization data or a prospective method based on actual Federal claims data. The method must be completely and clearly explained. Additional documentation from carriers using ACR, including the carrier's rating manual, may be requested.

The following rules apply for carriers using ACR for the Federal group:

OPM Community Rating Guidelines - 2009

- 1) The carrier must have a documented ACR method established and implemented by 2009.
- 2) **The carrier must keep on file all data necessary to justify the ACR rate (i.e., claims, utilization etc.) This data is subject to review and audit by the Office of the Inspector General. If the carrier uses a claims based ACR method, backup tapes of the claims database should be saved for audit purposes.**
- 3) Once the experience period and claims are set in the proposal, they cannot be changed after the proposal has been submitted. The carrier may offer a discount to the FEHBP rates at any time before the rates are finalized.

The following rules apply for carriers using a claims-based ACR method:

- 1) The experience period and the claims used within that period may not change in the reconciliation. It must be the same period and the same claims used in the proposal.
- 2) If completion factors were used to convert paid claims to incurred claims, such factors must be the same for all claims-based ACR rated groups.
- 3) Any method used to convert paid claims to incurred claims must be consistent for all claims-based ACR rated groups.
- 4) If claims include special benefit claims, a carrier cannot take any special benefit loadings in either the proposal or reconciliation. If claims reflect extension of coverage, a carrier cannot take an extension of coverage loading.
- 5) If claims include those of annuitants age 65 and over, claims must be reduced by an amount equal to Medicare income from the Centers for Medicare or Medicare Services (CMS) or we must receive a credit for monies received from CMS. **The amount of Medicare income from CMS should be clearly stated.** Support for the adjustments to these claims should be saved and stored on an individual claim basis.
- 6) Loadings for administrative expenses must be either:
 - a) a flat community rated pm/pm amount;
 - b) a standard percentage of claims; or
 - c) a method consistently applied to the FEHBP and the SSSGs.
- 7) Any trend factor used for the Federal group must be the same factor the carrier used for other groups (that is, a trend factor for the Federal group may not be based only on the Federal group's experience).

Note that if a carrier uses an ACR method based on Federal claims data, its reconciliation will differ very little from the proposal. **Only factors that are changed before January 1, 2009 for all claims-based ACR groups may be updated in the reconciliation.** Some examples are listed below:

OPM Community Rating Guidelines - 2009

- (i) **Trend Factor** - If a carrier uses an estimated trend factor in the 2009 proposal and changes the factor before January 1, 2009 for all claims-based ACR groups, the revised factor must be used in the 2009 reconciliation. The factor must be consistent with the lowest such factor used for either SSSG
- (ii) **Administration Cost Factor** - If a carrier uses an estimated administration cost factor in the 2009 proposal and changes the factor before January 1, 2009 for all claims-based ACR groups, the revised factor must be used in the 2009 reconciliation. The factor must be consistent with the lowest such factor used for either SSSG.

❖ Similarly-Sized Subscriber Groups (SSSGs)

Basis of SSSG Concept

The SSSG concept was developed to ensure that OPM receives an equitable and reasonable market-based rate. At the time of reconciliation, OPM will determine the FEHBP rate by selecting the lower of the rates derived by using rating methods consistent with those used to derive the SSSG rates. For the 2009 rate year, OPM will focus on the rating methods used for the two SSSGs to determine if the carrier appropriately derived the Federal group rates.

Rules for SSSG Selection

Two SSSGs must be selected in each rate code area at the time of reconciliation.

In order to limit potential SSSGs to preselected groups, a carrier may choose to submit ten potential SSSGs with this rate submission.

If a carrier chooses to:

- **Submit a list of ten potential SSSGs with this proposal** – The two groups closest in size to the Federal group at the time of reconciliation among the first five potential SSSGs will become SSSGs. From the first five, if at least two groups do not continue to contract with the plan, then the sixth group on the list will be reviewed. If that group also does not qualify the list will be followed until two SSSGs are chosen. The ten groups included in this proposal must meet the SSSG requirements (i.e. not be retrospective experience rated, not be Provider Partners, etc.) Those ten groups will be different than the ten groups you are asked to identify by the Office of the Inspector General (OIG). The ten groups you identify for OIG will include all groups with which the plan contracts. For your convenience the list of these groups may also be provided in this submission.
- **Not submit a list of ten potential SSSGs with this proposal** – The carrier will select two groups which meet the SSSG requirements at the time of reconciliation as the SSSGs.

See Appendix II for specific cases of SSSG selection based on rating regions and rate code areas.

OPM Community Rating Guidelines - 2009

Definition

Similarly Sized Subscriber Groups (SSSGs) are a comprehensive medical plan's employer groups that:

- (1) As of the date specified by OPM in the rate instructions, have a subscriber enrollment closest to the FEHBP subscriber enrollment;
- (2) Use any rating method other than retrospective experience rating;
- (3) Reside in the federal group's rating region; and
- (3) Have at least 5% of the total subscriber enrollment in the federal group's rate code area.

Any group with which an FEHBP carrier enters into an agreement to provide health care services may be an SSSG including (but not limited to) the following groups:

- (1) Government entities;
- (2) Groups with multi-year contracts;
- (3) Groups having point of service products; and
- (4) Purchasing alliances (see exceptions noted below).

The following groups should be **excluded** from SSSG consideration:

- (1) Groups the carrier rates by the method of retrospective experience rating;
- (2) Groups consisting of the carriers own employees;
- (3) Medicaid groups, Medicare groups, and groups that have only a stand alone benefit (such as dental only);
- (4) A purchasing alliance whose rate-setting is mandated by the state or local government;
- (5) A purchasing alliance in which at least 90% of groups in the alliance have less than 100 enrollees and the remaining percentage of groups (10% or less) would not have sufficient aggregate enrollment to qualify as SSSG on their own;
- (6) Administrative Service Organizations (ASOs);
- (7) A new group (e.g., a group starting its first contract year between July 2, 2008, and July 1, 2009);
- (8) Provider Partners ;

OPM Community Rating Guidelines - 2009

- (9) Any employee group with at least a 100% increase in enrollment within the last 12 months (from most recent available enrollment); and
- (10) Groups covered under a separate line of business that meets all of the following criteria:
 - It must be a separate organizational unit, such as a division.
 - It must have separate financial accounting with “books and records that provide separate revenue and expense information.”
 - It must have a separate work force and separate management involved in the design and rating of the healthcare product.

HDHP

HDHP plans require a unique set of SSSGs if:

- (1) The carrier’s HDHP product is rated independently from its other FEHBP product(s); or
- (2) The HDHP is the only FEHBP product the carrier offers in the [rate code area](#).

It is acceptable that a carrier use an SSSG with a different rating methodology from the HDHP if the SSSG is closest in size to the Federal group and meets all other SSSG criteria.

Enrollment and Contract Renewal Dates

Group size for the selected SSSGs in the current year’s reconciliation and the potential SSSGs in the following year’s proposal should be determined on the same day and based on the most recent enrollment available, but no later than March 31 of the current year.

For the 2009 rate year, the specific guidelines for SSSGs are as follows:

- (1) All group enrollments (the Federal group and the SSSG enrollments) should be the latest 2008 enrollment available to the carrier up to March 31, 2008.
- (2) The contract [renewal date](#) for 2009 SSSGs should be between July 2, 2008 and July 1, 2009.

❖ SSSGs and Discounts

Discounts should be applied to Attachment II’s Line 5a rates.

OPM requires the Federal group rates to be at least equivalent to the rates for the SSSGs.

Therefore, we expect the Federal group to receive at least the largest rate discount and any other advantage given to either SSSG. Discounts should be determined by the rating methodology applied within the [rating region](#).

OPM Community Rating Guidelines - 2009

Early Rate Quote

If the carrier gives an early rate quote to an SSSG based on a lower community rate and does not revise it at a later date, we will interpret the SSSG rate as a discounted rate.

Multi-Year Rate Agreements

If a group has negotiated a multi year contract and is determined to be an SSSG, the following rules will apply:

First year of a multi year agreement - The process of determining discount as defined above applies.

Second and all subsequent years of a multi year agreement - The process of determining discounts as defined above applies. Furthermore, any additional costs incurred in previous years of the multi year rate agreement may be considered when determining the discount.

Purchasing Alliances

If a carrier's SSSG is a purchasing alliance that consists of more than one rate, a minimum of the weighted average of all discounts (based on enrollment) must be applied to the Federal group.

Total Replacement Groups

The first 2 % discount given to a total replacement group will not be viewed as a discount if it is the carrier's policy to adjust the rates of all total replacement groups by this amount. If some of the replacement groups are given non standard or preferential discounts, this policy will not apply.

Recovery of Discounts

The FEHBP must receive all discounts given to an SSSG in the rate reconciliation of the same year the discounts were given. If the carrier can show discounted funds are recovered from an SSSG, the carrier can recoup these funds from the FEHBP.

A carrier cannot recover an FEHBP discount if the discount is created by a carrier's decision to:

- Voluntarily omit a loading a carrier is entitled to take
- Provide a larger than expected or larger than required discount to FEHBP
- Use an unconventional rating methodology in order to give FEHBP a lower rate

If a Federal group discount is set at time of proposal based upon an estimated SSSG discount, it may be reduced during or after the reconciliation process to be consistent with the actual SSSG discount. Note: The estimate of the expected SSSG discount used at proposal must be agreed to by OPM.

Surcharges

OPM will not accept any surcharge which is not established by a carrier's defined rating methodology regardless of whether the SSSG receives the surcharge.

OPM Community Rating Guidelines - 2009

Special Adjustments to SSSG Rates

We will consider adjustments to SSSG rates based on estimated new business if:

- 1) The carrier can give a reasonable justification;
- 2) The method is not intended to give a discount; and
- 3) It is the carrier's policy to make such adjustments.

The following are two examples of acceptable justifications:

- 1) Closure of competitive HMOs in the SSSGs area.
- 2) Mergers or Divestitures.

Rate Extensions for SSSGs

If an SSSG's rate is extended beyond twelve months (i.e. the carrier allows an SSSG to change its renewal date), a premium adjustment that reflects the entire value of the extension must be made for the SSSG in the following year, or the rate extension will be considered as a discount. The renewal date for such a group would be the anniversary date after the last rate change.

Discounts with HDHPS

If either of the SSSGs is given a discount, that discount should only be applied to the insurance portion and not the pass through.

Rating Period Beyond 24 Months

If an SSSG is rated ACR and its initial contract period is more than 24 months, the federal group would be rated like the SSSG to determine any applicable discounts on the portion of the rating period extending beyond 24 months.

Consistency of Rating Methods

The carrier is expected to use the same rating method for the Federal group as it uses for the SSSGs though different rating methods are acceptable in some situations. **If, however, the carrier rates an SSSG using a method inconsistent with the carrier-established policies, the Federal group is entitled to a discount based on the SSSG rating method applied to the Federal group.**

Examination of Non-SSSG Groups

At times, OPM may examine the rates of non-SSSG groups. The examination is to verify the equivalence of the Federal group and SSSG rates. For example, if an SSSG had a special benefit (e.g., dental benefit) not included in the Federal group benefit package, OPM would compare what the carrier charged the SSSG with what it charged other groups for the benefit to verify the SSSG received no hidden discount. An OPM review of a non-SSSG commercial group does not make it a potential SSSG.

OPM Community Rating Guidelines - 2009

❖ **Miscellaneous Remarks**

State Taxes

5 U.S.C. 8909(f)(1) prohibits the imposition of taxes, fees, or other monetary payment, directly or indirectly, on FEHBP premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico or by any political subdivision or other governmental authority of those entities. If the Attachment II, Line 1 rates include an amount to recover such monies from the FEHBP, an adjustment for this amount in the form of a negative special benefit loading in the Special Benefit Loadings section of Attachment II must be made.

Special Loading for Enrollment Discrepancies

The 1997 amendment to the Standard Contract for Federal Employees Health Benefits contract provides for a special premium loading of 1% to account for enrollment discrepancies. **The carrier must explicitly take this loading, but may eliminate all or some of its effect by also giving the Federal group a discount.**

Note that a carrier's contract with the FEHBP states in Section 3.6(b) "the Carrier accepts the adjustment to the subscription charges in full resolution of all obligations of the Government in connection with the subscription payments as described in this section 3.6 and waives any rights it may have to claims for subscription payments under Section 3.1(a)."

Late Payment Loadings

Late payment loadings are not acceptable.

Rate Reconciliation Audits

OPM's Office of the Inspector General (OIG) will perform rate reconciliation audits of carriers' 2009 rate reconciliations on a selected basis beginning in May 2009. Although these audits will focus on the 2009 rate reconciliation, the audit staff may need to analyze rate information for the Federal group and other groups from previous years. Keep all documentation used to develop the 2009 rates available for review by the audit staff. (Rate reconciliation audits of the 2008 reconciliations will begin in May 2008.)

Error Reporting

If a carrier discovers that a previous rate proposal and/or reconciliation submitted to OPM is incorrect (e.g., through the discovery of an error or omission), the carrier **must**:

- 1) Notify OPM; and
- 2) Prepare and submit to OPM amended proposals or reconciliations (including a newly executed Certificate of Accurate Pricing).

Note: The above policy does not apply to proposals and/or reconciliations that have already been or are currently in the process of being audited by OPM's audit staff or audits that have been resolved by OPM's Office of Insurance Programs (OIP).

Instructions

❖ Instructions for Attachment I – Small Carriers

If your 2008 Federal group income will be greater than or equal to \$650,000, you must complete and keep on file Attachments II and IIA before submitting Attachment I.

Q1. Indicate the method of community rating used.

Q2. Enter the proposed 2009 Federal group rates on Line A of Attachment I.

If the carrier's 2008 income from the Federal group is greater than or equal to \$650,000, enter the Line 5c rates from Attachment II on Line A of Attachment I.

Q3. If OPM owes the carrier money as a result of the 2008 reconciliation, OPM will reimburse the amount due through an increase in the carrier's 2009 rates. Compute the appropriate increase based on the results of the 2008 reconciliation and enter the amount on Line B of Attachment I.

If the carrier owes OPM as a result of the 2008 reconciliation, OPM will recoup the amount due through a decrease in the carrier's 2009 rates. Compute the appropriate decrease based on the results of the 2008 reconciliation and enter the amount on Line B of Attachment I.

Q4. Enter the proposed 2009 Federal group rates after adjustments (Line A \pm Line B) on Line C of Attachment I.

OPM completes the section below Line C based on negotiations between the carrier and Office of Actuaries. When we determine that sufficient excess has built up in the contingency reserve, we will propose a reduction to the carrier's rates in order to generate a contingency reserve payment.

Instructions

❖ Instructions for Attachment II – Large Carriers

Item numbers correspond to line numbers on Attachment II.

1. Proposed FEHBP Rates – 2009

This is the carrier's best possible estimate of the 2009 FEHBP biweekly self and family rates. These rates must be based on the carrier's community rate(s) or on an OPM approved ACR methodology. Indicate in detail how the Line 1 rates were derived.

Traditional Community Rating (TCR)

Complete the TCR & CRC Backup Line 1 Form on page 23 (or equivalent) and enter the resulting Self and Family Rate on Line 1 of Attachment II.

Community Rating By Class (CRC)

Complete the TCR & CRC Backup Line 1 Form on page 23 (or equivalent) and enter the resulting Self and Family Rate on Line 1 of Attachment II.

Adjusted Community Rating (ACR)

Complete the ACR Backup Line 1 Form on page 23 (or equivalent) and enter the resulting Self and Family Rate on Line 1 of Attachment II.

2. Special Benefit Loadings

Special Benefit Loadings are loadings to account for differences between the Federal group's benefit package and the carrier's community benefits package. Provide all backup calculations and clearly indicate all utilization and cost assumptions for the special benefit loadings.

If the loading is a benefit that you sell to other groups, there should be a uniform price (i.e., a capitation rate, or standard set of two-tiered community rates) for the benefit. Indicate clearly in your backup calculations the adjustments (if any) you have made to the uniform loading to arrive at the Federal loading

You should offset through negative loadings any benefits not provided to the Federal group which are part of the carrier's basic package. You should enter a cost of \$0.00 for benefit differences with no cost.

Complete the Backup Special Benefits Loading Form on page 24 (or equivalent) and enter the loading(s) on Line 2 of Attachment II.

3. FEHBP Rates Plus Special Loadings

Add Lines 1 and 2 and enter the sum on Line 3 of Attachment III.

Instructions

4a. Extension of Coverage Loading

If entitled to the Extension of Coverage Loading, multiply Line 3 by .004 and enter the result on Line 4a of Attachment II.

Generally, an ACR rated carrier is **not** entitled to this loading. If an ACR rated carrier thinks they are entitled to the Extension of Coverage Loading, a detailed explanation must be submitted with this proposal and back up documentation must be kept available for audit review. OPM reserves the right to deny this loading.

4b. Medicare Loading

The purpose of the Medicare loading is to adjust a carrier's premium to provide the correct income for FEHB retirees age 65 and older since most other groups generally cover their retirees by Medicare Advantage Plans or Medicare Supplement Plans and are excluded from the employee plan.

Federal annuitants who retired after December 31, 1983 are entitled to coverage under Part A and Part B of Medicare when they reach age 65. In addition, the majority of retirees over age 65 who retired before 1984 are covered under Medicare as a result of employment in the private sector.

A carrier must document the Medicare status of Federal annuitants and their covered spouses age 65 and over, and compute a Medicare loading. Compute the cost of benefits for the Federal annuitants and compare the cost with the income received on behalf of these annuitants from OPM and CMS. If more income than is needed to cover the cost of benefits is received for this group, the Medicare loading should be negative. If less income than is needed is received, the loading should be positive. Clearly explain your method and provide backup calculations.

The difference between the cost for these enrollees and revenue received from CMS should roughly equal the premium charged to Medicare enrollees for either Medicare Supplement Plans or Medicare Advantage Plans with adjustments made for differences in levels of benefits. Please verify the reasonableness of your loading. We will verify the accuracy of your calculation based on the answers you provide in questions Q40 and Q41.

The best source of data for your Medicare distribution is the match tape we send to you each year. However, do not include annuitants from that tape with codes X, Z, or N who are under age 65 in your count of no coverage. **A carrier claiming a Medicare loading must have appropriate documentation to justify the distribution of its Medicare population submitted in Q43.**

If you use ACR to compute your rates, you must make sure that you have considered the effect of COB (coordination of benefits) income the carrier received from CMS. You should pay particular attention to Q22 and Q23 of the questionnaire. **A carrier using a claims-based ACR method will normally not have a Medicare loading.**

Instructions

Below is an example of the method we suggest. If you use a reasonable and well documented method for other groups, you should also use it for the Federal group.

<u>Medicare Coverage</u>	Distribution of Federal Annuitants and Covered Spouses*	<u>Cost of CMS Benefits</u>	<u>FEHBP Premium**</u>	<u>CMS COB</u>	<u>Gain (Loss) to Carrier</u>
A + B	100	\$120	\$50	\$100	\$30
A	65	120	50	60	(10)
B	10	120	50	40	(30)
None	50	120	50	0	(70)

(1) Revenue Gain: $100 \times \$30 = \$3,000$
(2) Revenue Loss: $(65 \times \$10) + (10 \times \$30) + (50 \times \$70) = \$4,450$
(3) Net Loss = $\$4,450 - \$3,000 = \$1,450$

* From Question 43, Attachment IIA
** If you use this method, the FEHBP premium should be the single rate

This positive loading of \$1,450 could be spread over the self and family contracts in any reasonable manner. Note that whether the loading comes out negative or positive depends on the distribution of Federal enrollees by Medicare status.

Complete the Backup Medicare Loading Form on page 25 (if appropriate) and enter the Loading on Line 4b of Attachment II.

4c. Children's Loading

All carriers in the FEHBP must cover unmarried dependent children until their 22nd birthdays (through age 21). If the carrier has a different age limit for children's coverage, a loading to the Federal family rate may be appropriate.

This loading may be taken only if the carrier's normal practice is to take such a loading for all other groups whose age limit for children's coverage differs from the carrier's community standard.

In general, if overage dependents were included in group-specific demographics (especially the average family size) and these numbers were used to create self and family rates (through step-up factors, etc.), a children's loading is not appropriate.

If a carrier is entitled to a children's loading, a detailed explanation of the method used and backup documentation must be provided. If a carrier believes they are entitled to a children's loading but does not have a general method of computing this loading, contact the Office of the Actuaries for assistance.

Enter the Children's Loading on line 4c of Attachment II.

Instructions

4d. Subtotal

Add Lines 3, 4(a), 4(b), and 4(c) and enter the sum on Line 4d of Attachment II.

4e. Enrollment Discrepancies Loading

Multiply Line 4d by .01 and enter the result on Line 4e of Attachment III. A carrier must explicitly take this loading but may eliminate some or all of its effect by giving the Federal group a discount.

5a. Proposed FEHBP Rates – 2009

Add Lines 4(d) and 4(e) and enter the total on Line 5a of Attachment II.

5b. Discount

Enter the amount of discount, if any, on Line 5b of Attachment II.

5c. Final Proposed FEHBP Rates – 2009

Add Lines 5(a) and 5(b) and enter the total on Line 5c of Attachment II.

Attachment I

2009 RATE PROPOSAL - SMALL CARRIERS		
(Use BIWEEKLY Net-To-Carrier Rates)		
CARRIER NAME	STATE	CODE
Q1. What type(s) of community rating do you propose to use for the Federal group in 2009?		
TCR (Traditional Community Rating)		
CRC (Community Rating By Class)		
ACR (Adjusted Community Rating)		
	SELF	FAMILY
Q2. What are the 2009 proposed Federal group rates? If your 2008 Federal group income is greater than or equal to \$650,000, enter the rates from Line 5c, Attachment II on this line. Line A:		
Q3. Enter the adjustment to the 2009 proposed Federal group rates as a result of the reconciliation of the 2008 Federal group rates. If your actual 2008 Federal group rates were higher than estimated in the 2008 proposal, the 2009 rates should be increased to recover the loss. Likewise, if the actual 2008 Federal group rates were less than estimated in the 2008 proposal, the 2009 rates should be decreased to return the gain to OPM. Line B:		
Q4. What are the proposed 2009 Federal group rates after adjustments? (Line A ± Line B) Line C:		
OPM will complete the section below if it is necessary to reduce the proposed rates in order to draw down the contingency reserve.		
Amount of excess contingency reserve:		
Rate reduction necessary to generate a contingency reserve payment approximately equal to the excess. Line D:		
2009 FEHBP Rates Line E:		

Attachment IA

**Certificate of Accurate Cost Or Pricing Data
For Community Rated Carriers**

This is to certify that, to the best of my knowledge and belief:

- 1) The cost or pricing data submitted (or, if not submitted, maintained and identified by the carrier as supporting documentation) to the Contracting Officer or the Contracting Officer's representative or designee in support of the **2008** FEHBP rates were developed in accordance with the requirements of 48 CFR Chapter 16 and the FEHBP contract and are accurate, complete, and current as of the date this certificate is executed; and
- 2) The methodology used to determine the FEHBP rates is consistent with the methodology used to determine the rates for the carrier's Similarly Sized Subscriber Groups.

Firm	
Name	
Title	
Signature	
Date	

Attachment II

2009 RATE PROPOSAL – LARGE CARRIERS (Use <u>BIWEEKLY</u> Net-To-Carrier Rates)		
CARRIER NAME	STATE	CODE
	SELF	FAMILY
1. Proposed Unadjusted Federal Group Rates for Jan 1, 2009		
2. Special Benefit Loadings		
(a)		
(b)		
(c)		
3. Federal Group Rates Plus Special Loadings		
4. Standard Loadings		
(a) Extension of Coverage Loading [.004 x (3)]		
(b) Medicare Loading		
(c) Children's Loading		
4d. Subtotal [(3) + (4a) + (4b) + (4c)]		
4e. Enrollment Discrepancies Loading [.01 x (4d)]		
5a. Proposed Federal Group Rates For 2009 [(4d) + (4e)]		
5b. Discount		
5c. Final Proposed Federal Group Rates For 2009 [(5a) + (5b)]		

Attachment II Backup

➤ **Backup Line 1 Form**

Enter the results on Line 1 of Attachment II.

If neither of these Forms is appropriate, create/modify a form and place it here.

Backup Line 1 Form – TCR & CRC	
Beginning Capitation Rate	
Age/Sex Factor	
Resulting Capitation Rate	
Percentage of Self Contracts	
Percentage of Family Contracts	
Average Family Size	
Revenue Ratio (Family/Self Ratio)	
1 st Level Step-Up Factor (Self/Capitation)	
Self Rate	
Family Rate	

Backup Line 1 Form – ACR	
Experience Period	
Total Paid Claims (before any COB)	
Total COB (including CMS)	
Annual Trend	
Total Trend from Experience Period	
Expected Claims	
Administration (& Profit)	
Total Expected Claims + Admin + Profit	
Members	
Per Member Rate	
Percentage of Self Contracts	
Percentage of Family Contracts	
Average Family Size	
Revenue Ratio (Family/Self Ratio)	
1 st Level Step-Up Factor (Self/Capitation)	
Self Rate	
Family Rate	

Attachment II Backup

Backup Special Benefit Loadings Form

Enter the Special Benefit Loadings (if appropriate) under Line 2 of Attachment II.

Backup Special Benefits Loading Form			
Benefit	Cost/Member	Self Rate	Family Rate
(a)			
(b)			
(c)			
(d)			
(e)			
(f)			
(g)			
(h)			
(i)			
(j)			

Note: Include any necessary backup calculations to support these loadings here.

Attachment II Backup

Backup Medicare Loading Form

Enter Medicare Loading (if appropriate) on Line 4b of Attachment II.

Backup Medicare Loading Form					
Medicare Coverage	(A) Count	(B) Cost Of Benefits	(C) FEHB Premium	(D) CMS COB	Plan Cost A*(B-C-D)
Part A Only					
Part B Only					
Parts A & B					
No Coverage					
Total		(E)			
Total FEHBP Members (F)					
Cost Per Member (E / F)					
Self Loading					
Family Loading					

Or

Alternative Backup Medicare Loading Form					

Attachment II Backup

POTENTIAL SSSGS	
NAME	ENROLLMENT/ AS OF
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Attachment IIA

2009 Community Rate Questionnaire

Q1. What type(s) of community rating do you propose to use for the Federal Group in 2009?

[] Traditional Community Rating (TCR)

a. [] Standard (Book) Rating

b. [] Variable (Group Specific) Rating

[] Community Rating By Class (CRC)

[] Adjusted Community Rating (ACR)

Q2. Are you proposing a rate for a HDHP in 2009?

[] YES

[] NO

If no, skip to Q5 for TCR, Q8 for CRC or Q19 for ACR

If yes, is your HDHP rated separately from your traditional HMO?

[] YES

[] NO

Note: If the HDHP is rated separately from your other federal products and you opt to submit a list of potential SSSGs with this proposal, a separate list of potential SSSGs will be required for the HDHP.

Q3. Do any of your other groups have an HDHP?

[] YES

[] NO

Q4. What is the annual deductible and pass through amount for your proposed HDHP?

Deductible: _____ Self

Pass Through Amount: _____ Self

_____ Self

_____ Family

_____ Family

Questions 5 through 7 pertain to carriers that use Traditional Community Rating (TCR) for the Federal Group.

Q5. Do you use a standard set of tiered rates applicable to all groups with a tiered rate structure?

[] YES

[] NO

If Yes, what are they?

Attachment IIA

Self _____ Family _____

Self _____ Couple _____ Family _____

Q6. Do you begin your rate development with a capitation rate, and then convert it to the self and family rates?

YES NO If Yes, what is the capitation rate?

Capitation Rate = _____

Note that you may check both Q5 and Q6 "Yes" if you use a standard set of tiered rates that are derived from a capitation rate.

Q7. Do you use "step-up" factors to convert the capitation rate to the self and family rates?

YES If Yes, **Go To Q32** NO If No, explain, then **Go To Q33**

Questions 8 - 18 pertain to carriers that use Community Rating by Class (CRC) for the Federal Group.

Q8. Do you use CRC for all your groups?

YES NO If No, what is your criteria for using CRC?

Q9. What CRC factors do you use?

Age Sex Other _____, _____, _____,

Q10. What capitation rate do you begin with?

Capitation Rate = _____

Attachment IIA

Q11. What is the adjustment factor you use to adjust the capitation?

Adjustment Factor = _____

What is your adjusted capitation rate? Adjusted Capitation Rate = _____

Explain how you derived the CRC adjustment factor. **In particular, on what population data are the CRC utilization factors based? How often do you update the data on which the CRC utilization factors are based?**

Q12. Give a simple narrative explanation of how you derive your rates including how you adjust the capitation rate.

DO NOT SKIP THIS QUESTION. WHAT WE WANT IS A SIMPLE NARRATIVE EXPLANATION OF HOW YOU DERIVE YOUR RATES. IF THERE ARE OTHER SHEETS WITH DETAILED CALCUATIONS, TELL US HERE IN SIMPLE LANGUAGE WHAT IS DONE ON THOSE SHEETS.

Q13. Have you enclosed any worksheets (i.e. sheets showing age/sex distribution and relative utilization factors) that you used to derive the CRC adjustment factor? **Please note that you must have documented support for the CRC age/sex factors.**

YES NO NA

If No or NA, explain. (**Note: We normally expect to see the worksheets from which you derive the CRC adjustment factor. These may be submitted separately.**)

Attachment IIA

Q14. Do you use "step-up" factors to convert the adjusted capitation rate to the self and family rates?

YES NO If No, explain

Q15. Explain how you derive the "relative utilization factors" associated with your age/sex distribution sheet.

Note that we would expect the factors to be based on the utilization experience of the different age groups of the total employee population the carrier services. In some cases, a carrier might use factors based on some other large population. Please make it clear to us exactly where your relative utilization factors come from, and on what population they are based.

IMPORTANT! DO NOT SKIP THIS QUESTION

Q16. When you derive the CRC adjustment factor, do you include the number of Federal annuitants, over age 65, anywhere in the calculation? What about the number of Federal annuitants **under** age 65? In general, explain how you use the group of Federal retirees (if at all) in your calculation of the CRC factor.

IMPORTANT! DO NOT SKIP THIS QUESTION

YES NO If yes, have you given us a credit for Medicare Reimbursement?

Q17. If you use industry factors as part of your CRC method, do **you anticipate that either of your SSSGs will have an industry factor less than 1.0?**

YES NO

Attachment IIA

Q18. If you answered Q17 Yes, did you apply to the Federal group rates the lowest industry factor anticipated for an SSSG?

YES NO

If No, explain. The Federal group should receive the lowest industry factor less than 1.0 given to an SSSG.

Questions 19 through 31 pertain to carriers that use Adjusted Community Rating (ACR) for the Federal Group. If you do not use ACR in any part of your rate development, Go To Q32.

Q19. Do you use ACR for all your groups?

YES NO If No, what is your criteria for using ACR?

Q20. What method of ACR do you use to rate the Federal group in 2009?

A Method Based On Federal claims

Other

Note: You should have on file any claims/utilization data supporting the rates for the Federal group.

Q21. If your answer was "Other" for Q20, give a simple, but comprehensive explanation of how you developed your rates. Use extra sheets if necessary.

Attachment IIA

Q22. Are age 65 and older retirees included in the claims or utilization data used to determine the ACR factor or rates?

YES NO If No, a standard Medicare loading should be taken.

Q23. If you answered yes to Q22, are CMS reimbursements included in the Federal group's experience?

YES NO

If No, a negative Medicare loading should be taken to account for all monies received from CMS or monies saved because Medicare was the primary payer (i.e. responsible for most of the claim payments).

If Yes, there should be no Medicare loading.

Q24. Did you reduce claims used in the rate development by COB income that the carrier received from other insurance carriers (excluding CMS)?

YES NO

If No, credit should be applied to the Federal group for any monies received from other insurance carriers.

Questions 25 through 31 are for carriers that answered Q20 by checking “A Method Based On Actual Federal Claims Data”

Q25. If you used an ACR method using Federal claims data to compute rates, clearly explain this method. **DO NOT SKIP THIS QUESTION, AND DO NOT REFER US TO OTHER SHEETS. WHAT WE WANT HERE IS A SIMPLE NARRATIVE DESCRIPTION OF YOUR METHOD.**

Attachment IIA

Q26. Do you use completion factors to derive incurred claims?

YES NO

Q27. If you answered Yes to Q26, you should use the same set of completion factors for all your groups. Do you?

YES NO NA If No, explain.

Q28. Explain how you compute the administrative charge.
IMPORTANT! DO NOT SKIP THIS QUESTION

Q29. Did the claims used in the rate development reflect special benefits?

YES NO

Q30. Do you derive an adjusted capitation rate by using an ACR factor that was derived from actual claims data?

YES NO If Yes, Adjusted Capitation Rate = _____

Q31. Do you use step-up factors to convert an adjusted capitation rate to the self and family rates?

YES NO If No, **Go To Q33**

Q32. a. If you use step-up factors, what are they? Specifically, what step-up factor do you use to convert the capitation rate (or the adjusted capitation rate) to the self rate? What step-up factor do you use to convert the self rate to the family rate?

Self/Capitation = _____ Family/Capitation = _____

Attachment IIA

- b. How do you derive the above step-up factors? Explain briefly (we prefer a numerical formula for each factor as the explanation). Example:

$$\text{Self/Capitation} = \frac{.40 + .60 (3.5)}{.40 + .60 (2.9)} = 1.17$$

- c. Are these step-up factors group-specific (i.e., derived using the demographics of the Federal group)? Or, are the step-up factors based on overall population demographics?

Group Specific Based on Overall Carrier Population Demographics

- d. If you use group-specific factors, do you use them for all groups?
If No, what are your criteria for using group-specific factors?

- Q33. a. If you use enrollment-mix or other demographic assumptions at any point in the development of the 2009 Federal group rates (including development of step-up factors), what are they?

% Self Contracts _____ % Family Contracts _____

Family Size _____ Other: _____

What is the "as of" date of the above enrollment? _____

- b. If you use group-specific family size in developing the Federal group rates, were overage dependent children (i.e., children older than the age limit for all unmarried dependents given in Q33a) included in determining the group's family size?

YES NO

Attachment IIA

- Q34. What is the source of your demographic information? Is the same source used for all groups? If not, where do you get the demographic information for other groups?
- Q35. If you do not use step-up factors to convert a capitation rate to the self and family rates, explain in detail what you do.
- Q36. With regard to dependent coverage:
- Your basic community rate includes coverage for all unmarried dependents up to what age? (An answer of age 19 would mean that coverage ceases on the 19th birthday) ___
 - Is there a separate limiting age for coverage of full-time students?
 YES What is it? _____ NO
 - If a group requires dependent coverage to an age different from your normal limiting age, do you adjust that group's rate to allow for this difference?
 YES NO
- Q37. If you are entitled to a children's loading, briefly describe the method used to compute this loading.

Attachment IIA

Q38. Are the special benefits listed in line 2, Attachment II of the 2009 proposal different from those that you offered in 2008?

YES NO If Yes, explain.

Q39. With regard to the special benefits shown in line 2, Attachment II: Are any of them a rider offered to other groups?

YES NO If Yes, indicate which special benefits are riders.

Q40. The FEHBP requires coordination of benefits (COB) with CMS for Federal annuitants and their covered spouses who are entitled to Medicare.

a. Do you have a risk or cost contract with CMS?

YES Risk Contract Cost Contract NO

b. Are any Federal group enrollees in the carrier covered under the carrier's risk or cost contract?

YES NO NA

d. If the answer to Q40(a) is Yes, explain the arrangement you have with CMS, describe all benefit packages you offer enrollees under the risk contract, and the premiums (if any) the individuals enrolled under the risk contract pay the HMO.

Attachment IIA

Q41. Does your HMO sell a Medicare supplement policy?

YES NO

If Yes, describe the benefit packages of any Medicare supplement policies you offer, and the premiums you charge for them.

Q42. Explain how you coordinate benefits for Federal Medicare annuitants and Medicare dependent spouses.

Q43. Show the number of Federal annuitants and their covered spouses age 65 and older enrolled with the carrier using the following categories:

Medicare Part A and Part B	_____
Medicare Part A Only	_____
Medicare Part B Only	_____
Neither Part A nor Part B	_____
Cannot Determine	_____

Note: The sum of the numbers in the 5 blanks above should be the total number of Federal annuitants and their covered spouses age 65 and older enrolled with the carrier.

Note: Important! Before you complete the above table, review the note on page 16 pertaining to the list of Medicare enrollees OPM sends the carrier each year.

Q44. How do you determine the numbers that you have in the distribution in Q43?

Attachment IIA

Q45. Do your Line 1 rates reflect any tax, fee or monetary payment imposed on the carrier by a state or local government?

YES NO

If Yes, have you included a negative loading in the Special Benefits section of the proposal?

YES NO If NO, explain why you included no negative loading.

Q46. If you use different rating methods (i.e. TCR, CRC, ACR) for different groups, describe your criteria for the use of each method.

Q47. BACKUP CALCULATIONS - Attachment II, Line 1 Rates

a) If you use Traditional Community Rating (TCR), show how you derive the rates on Line 1, Attachment II of the proposal. If they are two-tiered rates that you use for all groups, and will be backed by an insurance department filing, state this. If you derived the rates by converting a capitation into self and family rates, show the calculations.

If you use Community Rating By Class (CRC) or Adjusted Community Rating (ACR) show any details of the derivation of the Line 1, Attachment II rates that were not given in the previous parts of this questionnaire.

DO NOT SKIP THIS QUESTION. WHAT WE WANT HERE IS A SIMPLE NARRATIVE EXPLANATION (BACKED UP BY CALCULATIONS) OF HOW YOU DERIVED THE LINE 1 RATES. IF THERE ARE OTHER SHEETS WITH DETAILED CALCULATIONS, TELL US HERE IN SIMPLE LANGUAGE WHAT IS DONE. ON THOSE SHEETS MAKE CERTAIN THAT THE EXPLANATION IN THIS SECTION MAKES IT CLEAR TO US WHERE THE RATES ON LINE 1 COME FROM.

Q48. Are you electing to submit a list of potential SSSGs at this time?

YES NO

If no, the old rules will apply for choosing SSSGs at reconciliation time.

Attachment II B

Carrier Contacts

For information about your rate submission, we should contact:

Name	
Phone Number	
Fax Number	
Email	

OR

Name	
Phone Number	
Fax Number	
Email	

Our counterproposal and rate acceptance letters should be addressed to:

Name	
Address	
Phone Number	
Fax Number	
Email	

Attachment IIC

Utilization Data (Based on Total HMO Population)		
Type of Service	Annual Utilization Per 1000 Members	
1. Prescription Drugs		
	A. Mental	B. Other
2. Office Visits		
3. Inpatient Hospital Days		

Appendix I

Definitions

ACR – ACR is the acronym for Adjusted Community Rating.

Capitation Rate – The capitation rate is a per member per month revenue requirement.

Carrier – A carrier is the entity contracting with OPM.

Employer Groups – Employer groups are any group with which an FEHBP carrier enters into an agreement to provide health care services.

Plan – A plan is a carrier's contract within a rate code area.

Provider Partners – Provider partners are employee groups in which the carrier shares a financial interest, provides medical services to the carrier, or maintains a risk sharing agreement. The fact a carrier conducts business with an employee group does not render it a provider partner.

Purchasing Alliances – Purchasing alliances are any groups bonding together to purchase health insurance.

Rate Code Area – A rate code area is the area under which the rate code covers. In the case where an additional product other than the traditional HMO is offered in the same area, such as a consumer driven plan or HDHP and a different rate code is assigned to that product, the rate code area will be the area covered by the traditional HMO.

Rating Methodology – A rating methodology is a series of well defined procedures a carrier follows to determine the rates it will charge to its subscriber groups. An independent professional must be able to follow these procedures and reach the same conclusion. Some examples that are not considered as a valid rating methodology are:

- Arbitrarily setting rates by a rating committee that meets to determine final rates;
- Setting a fixed rate increase over the prior year rates

Rating Region – The rating region is the total area over which the carrier controls its rates. This is usually the state. See Appendix III for examples.

Renewal Date – The renewal date is the date a rate change (if any) is effective for the SSSG.

Retrospective Experience Rating – Retrospective Experience Rating is experience rating where gains and losses are carried forward.

"Step-up" Factors - A step up factor is one that converts the capitation rate to a self rate. These factors are related to family size and market considerations, and are in accordance with the standard documented procedures. Some carriers have a step-up factor that converts the capitation rate directly to a family rate.

Appendix I

Subscriber Enrollment – Subscriber enrollment refers to contract enrollment. This could be the total self and family contract enrollment, or the total self, couples, and family contract enrollment, or some other sum, depending of the rate structure of the group.

Surcharge – A surcharge is a loading that is not definable based on any established rating method.

Total Enrollment – Total enrollment refers to enrollment in a rating region.

Total Replacement Group – A total replacement group is an employee group where the carrier is the only health insurance provider for that employer in the rate code area.

Appendix II

Examples of Rating Regions

Example 1

HMO ABC operates in Pennsylvania and has two separate rating entities HMO ABC Pittsburgh and HMO ABC Philadelphia. Pittsburgh and Philadelphia determine rates for groups within their area only. Therefore, Pittsburgh is HMO ABC Pittsburgh's **rating region** and Philadelphia is HMO ABC Philadelphia's **rating region**.

Example 2

HMO DEF operates in Florida. It has five separate rating codes throughout the State of Florida. HMO DEF controls the rates for each rate code. Therefore, the State of Florida is the **rating region**.

Appendix III

Selection of SSSGs Examples

The following examples illustrate the above policies.

Case 1 One state, one federal rate code area, one rating region and all groups are in one state:

The FEHBP has one rate code area in Texas. Two SSSGs are required. The carrier operates in the state of Texas with one federal rating region. All the groups the carrier contracts with are in Texas. The carrier controls rates for all of Texas; therefore, Texas is the rating region. The total enrollment in Texas for each group, that has at least 5% of its total enrollment in the federal rate code area, should be compared with the FEHBP enrollment to decide if the group is an SSSG.

Case 2 One state, two federal rate code areas, one rating region and all groups are in one state:

The FEHBP has two rate code areas in Texas: one in Dallas and one in Houston. Two SSSGs are required for each federal rate code area. The carrier operates in the state of Texas with one rating region. All the groups the carrier contracts with are in Texas. The carrier controls rates for all of Texas; therefore, Texas is the rating region. If at least 5% of the total enrollment of a group is in the federal rate code area in **Dallas**, the carrier should use the total enrollment of that group in **Texas**. The carrier should compare the group's total enrollment with the FEHBP's enrollment in **Dallas** to determine if the group is an SSSG for the **Dallas** rate code area. The carrier follows the same procedure to select SSSGs in Houston.

Case 3 One state, two federal rate code areas, two rating regions, and all groups are in one state:

The FEHBP has two rate code areas in Texas: one in Dallas and one in Houston. Two SSSGs are required for each federal rate code area. The carrier operates in the state of Texas with two rating regions. The Dallas rating region controls the rates in Dallas and the Houston rating region controls the rates in Houston. The carrier contracts with the XYZ Corporation in Texas. If at least 5% of the total XYZ Corporation enrollment in the **Dallas** rating region is in the Federal rate code area in Dallas, then the carrier should use the total XYZ Corporation enrollment in **Dallas**. The carrier should compare the group's total enrollment in Dallas with the FEHBP's enrollment in Dallas to determine if the group is an SSSG for the **Dallas** rate code area. The XYZ Corporation's rates in **Dallas** will be used to determine any discounts. The carrier follows the same procedure to select SSSGs in Houston. The XYZ Corporation may be an SSSG in Houston based on its enrollment there.

Case 4 One state, one federal rate code area, one rating region and some groups are in more than one state:

The FEHBP has one rate code area in Texas. Two SSSGs are required. The carrier operates in the state of Texas. The carrier controls rates for all of Texas; therefore, Texas is the rating region. The carrier contracts with XYZ Corporation, which has enrollees in Texas and nine

Appendix III

other states. If at least 5% of the total XYZ Corporation enrollment in Texas is in the federal rate code area, then the carrier should use the total XYZ Corporation enrollment in Texas to compare with the FEHBP enrollment in Texas to determine if the group is an SSSG. The XYZ Corporation's rates in Texas will be used to determine any discounts.

Case 5 One state, two federal rate code areas, one rating region and some groups are in more than one state:

The FEHBP has two rate code areas in Texas: one in Dallas and one in Houston. Two SSSGs are required for each federal rate code area. The carrier operates in the state of Texas with one rating region. The carrier controls rates for all of Texas; therefore, Texas is the rating region. The carrier contracts with XYZ Corporation, which has enrollees in Texas and nine other states. If at least 5% of the total XYZ Corporation enrollment in Texas is in Dallas, then the carrier should use the total XYZ Corporation enrollment in Texas. The carrier should compare the group's total enrollment in Texas with the FEHBP's enrollment in Dallas to determine if the group is an SSSG for the Dallas rate code area. The XYZ Corporation's rates in Texas will be used to determine any Dallas discount. The carrier follows the same procedure to select SSSGs in Houston.

Case 6 One state, two federal rate code areas, two rating regions and some groups are in more than one state:

The FEHBP has two rate code areas in Texas: one in Dallas and one in Houston. Two SSSGs are required for each federal rate code area. The carrier operates in the state of Texas with two rating regions. The Dallas rating region controls the rates in Dallas and the Houston rating region controls the rates in Houston. The carrier contracts with the XYZ Corporation, which has enrollees in Texas and nine other states. If at least 5% of the total XYZ Corporation enrollment in the **Dallas** rating region is in the **federal rate code area in Dallas**, then the carrier should compare the total XYZ Corporation enrollment in the **Dallas** rating region with the FEHBP enrollment in **Dallas** to determine if the group is an SSSG for the **Dallas** rate code area. The XYZ Corporation's rates in **Dallas** will be used to determine any discounts. The carrier follows the same procedure to select SSSGs in Houston.

Case 7 Two states, one federal rate code area, one rating region and groups are in two states:

The FEHBP has one rate code for all enrollees. Two SSSGs are required. The carrier operates in two states: Texas and Arizona. The carrier controls rates for all of Texas and Arizona; therefore, Texas and Arizona is the rating region. The total enrollment for each group the carrier contracts with in Texas and Arizona, that has at least 5% of its total enrollment in the federal rate code area, should be compared with the FEHBP enrollment to decide if the group is an SSSG. The group's rates in the two states will be used to determine any discounts.

Case 8 Two states, one federal rate code area, one rating region and some groups are in more than two states:

Appendix III

The FEHBP has one rate code for all enrollees. Two SSSGs are required. The carrier operates in two states: Texas and Arizona. The carrier controls rates for all of Texas and Arizona; therefore, Texas and Arizona is the rating region. The carrier contracts with XYZ Corporation, which has enrollees in Texas and Arizona and eight other states. If at least 5% of the total XYZ Corporation enrollment in Texas and Arizona is in the federal rate code area, then the carrier should compare the total XYZ Corporation enrollment in Texas and Arizona with the FEHBP enrollment in Texas and Arizona to determine if the group is an SSSG. The XYZ Corporation's rates in Texas and Arizona will be used to determine any discounts.