Changes for 2011

As stated in the Call letter, the Patient Protection and Affordable Care Act provides for coverage of a dependent until age 26 beginning with the first day of the plan year that is six months following enactment. For the Federal Employees Health Benefits (FEHB) Program, that means January 1, 2011. All carriers must cover dependent children until their 26th birthday (through age 25). Previously, carriers were required to cover dependent children until their 22nd birthday. Since this change will also affect a carrier's commercial business, carriers may only add a Children's Loading to the FEHB's rates, if it adds a loading to all of its commercial business. The FEHB loading must be calculated in the same manner as the loading given to commercial business.

Reminders for 2011

- **Rating Guidelines** Our instructions are broken down into the following sections:

  Part 1: 2011 Community Rating Guidelines - includes pertinent definitions and an overall view of our community rating policy.

  Part 2: 2011 Proposal Instructions & Forms – includes line by line instructions for completing the 2011 proposal, the proposal template, backup forms and the proposal questionnaire.

  Part 3: 2011 Reconciliation Instructions & Forms – includes line by line instructions for completing the 2011 reconciliation, the reconciliation template, backup forms and the reconciliation questionnaire.

Only Parts 1 and 2 are contained in this package. Part 3 will be sent in the spring of 2011.

- **Standard submission form**: We are reminding carriers that they must use the attachments contained in these instructions (I and/or II as appropriate) for their final 2011 rate submission. We encourage backup documentation; however, final proposed rates must be submitted in the template provided.

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❖ 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).

<u>TCR and CRC Rating</u>

Carriers using TCR or CRC are expected to develop rates from a community-based revenue requirement (normally in the form of a ***<u>capitation rate</u>***) 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 <u>actual</u> in-force group data.

<u>CRC</u>
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 no larger than 1.0.

<u>Standard Format</u>

The following method is required for CRC carriers:

1. Derive a CRC adjustment factor (AF) 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.

2. Determine the adjusted capitation rate for the Federal group (AF x capitation rate).

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 x .40) + (.20 x .80) + (.45 x 1.20) + (.25 x 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:

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 AF.

4. If a carrier using CRC for the Federal group is eligible to charge a Medicare loading, this loading should be computed similar to OPM's suggested method (see page 6 of Part 2 of this package).

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Reconciliation Procedures

For carriers using TCR or CRC, the reconciliation involves updating the estimated ***capitation rate*** used in the proposal with the carrier's actual 2011 capitation rate (or equivalent).

The 2011 reconciliation must be based on the same factors and procedures used to derive the 2011 self and family rates in the 2011 proposal. The reconciliation must use the actual January 1, 2011 capitation rate and the same ***step-up factors*** used in the proposal (exceptions to this rule are described in the second paragraph of the Demographics section on page 6).

If you are a TCR or CRC carrier and derive your rates differently than described, the principles above still apply. To compute the Line 1 rates, go through the same procedure used in the original proposal, substituting actual rates for proposed rates. The procedures used should also be the same as those used for the SSSGs.

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:

1) The carrier must have a documented ACR method established and implemented by the beginning of the contract period.

2) The carrier must keep on file all data necessary to justify the ACR rate (e.g. claims, utilization). This data is subject to review and audit by the Office of the Inspector General. If the carrier uses a claims based ACR method, a backup of the claims database must 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) Any method used to convert paid claims to incurred claims must be consistent for all claims-based ACR rated groups.

3) 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. Generally, an ACR rated carrier is **not** entitled to the extension of coverage loading. See page 6 of Part 2 of these instructions for further details.

4) If claims include annuitants age 65 and over, claims must be reduced by an amount equal to Medicare income from the Centers for Medicare and Medicaid 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 must be saved and stored on an individual claim basis.

5) In addition to CMS reimbursements, FEHBP claims must be reduced by income attributed to FEHBP group enrollees from all other sources such as prescription drug rebates, coordination of benefits, and settlements.

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).

Reconciliation Procedures

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 for all claims-based ACR groups before January 1 of the contract period may be updated in the reconciliation**. Some examples are listed below**:**

(i) **Trend Factor -** If a carrier uses an estimated trend factor in the 2011 proposal and changes the factor before January 1, 2011 for all claims-based ACR groups, the revised factor must be used in the 2011 reconciliation. The factor must be consistent with the lowest such factor used for either SSSG.

(ii) **Administrative Cost Factor -** If a carrier uses an estimated administrative cost factor in the 2011 proposal and changes the factor before January 1, 2011 for all claims-based ACR groups, the revised factor must be used in the 2011 reconciliation. The factor must be consistent with the lowest such factor used for either SSSG.

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Note: Discounts will be considered when determining the lowest trend and administrative cost factor.

If a carrier uses a method based on utilization data, the reconciliation should be performed similar to a TCR or CRC reconciliation.

Demographics

If group-specific demographic assumptions (e.g. family size, self/family enrollment mix) were used in the proposal, the same figures must be used in the reconciliation. The self/family enrollment mix may not be revised to reflect the open season for 2011.

If, however, a carrier-wide enrollment-mix (or other demographic assumption) was used and the assumption was revised after the proposal was submitted but before Jan. 1, 2011 and the revisions were used for your SSSGs, the reconciliation must be based on the revised assumption.

Certain factors **must** change for the reconciliation. If the Federal group rates are based on a weighted average of rates in several geographic areas, the weight factors in the reconciliation must be based on the March 31, 2011 enrollment in each area (which you provide OPM). Also, if the Medicare Loading is recalculated, the latest Medicare enrollment available must be used.

❖ 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 2011. For 2010, the minimum deductible was $1,200 Self and $2,400 Family and the maximum out of pocket cost to the enrollee was $5,950 Self and $11,900 Family.

❖ 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.

❖ 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. OPM will focus on the rating methods used for the two SSSGs to determine if the carrier appropriately derived the Federal group rates.

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 carrier's 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 an SSSG on their own;

(6) Administrative Service Organizations (ASOs);

(7) A new group (i.e., a group starting its first contract year between July 2, 2010, and July 1, 2011);

(8) A second year group (a group starting its second contract year between July 2, 2010, and July 1, 2011) that normally would be rated by adjusted community rating.

(9) ***Provider Partners***;

(10) Any employee group with at least a 100% increase in enrollment within the last 12 months (from most recent available enrollment but no later than March 31 of the current year); and

(11) Groups that are covered under a separate line of business which meet 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.

Rules for SSSG Selection

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

A carrier must choose between the following two options. In order to limit potential SSSGs to pre-selected groups, a carrier may choose the first option below and submit ten potential SSSGs with this rate submission.

- **Submit a list of the ten potential SSSGs closest in enrollment to FEHB 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 or no longer meet SSSG requirements, then the sixth group on the list will be reviewed for SSSG eligibility. 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.

In addition, the carrier must also keep on file a list of **all** potential SSSGs ranked by the group's most recent enrollment (but no later than March 31 of the current year). SSSGs will be chosen from the list on file, in the same manner as above, in the event that at least nine of the potential SSSGs (from the list of ten provided to OPM) no longer qualify to be SSSGs at the time of reconciliation

- **Do not submit a list of ten potential SSSGs with this proposal –** The carrier will select two groups that meet the SSSG requirements at the time of reconciliation as the SSSGs.

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

High Deductible Health Plans (HDHPs)

HDHPs 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.

❖ SSSGs and Discounts

OPM requires the Federal group net-to-carrier 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***. To assist in determining rate equivalency during time of audit, we recommend carriers have a well-documented carrier rating policy on file.

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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:

The carrier must provide OPM documentation showing how the multi-year rate was derived for the group. This documentation should clearly show how the carrier accounted for the multi-year rate (i.e., application of additional trend).

First year of a multi-year agreement - The process of determining discount as defined above applies. To clarify, this means using the same population and group claims data available at the time the carrier developed the multi-year contract rate, the carrier must calculate a one year contract rate. The billed rate is then compared to the one year contract rate to determine a discount.

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. To clarify, this means a one-year contract rate is developed for the subsequent anniversaries of the multi-year contract effective date. The rate should be based on the population and group claims data used to develop the multi-year contract, but based on the community rate and factors, such as trend, retention, etc. as of the later effective date. To determine a discount, any additional revenue received in previous years may be used to offset a discount in a subsequent year.

Purchasing Alliances

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

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 any of the replacement groups are given non standard or preferential discounts, this policy will not apply.

Recovery of SSSG Discounts

The FEHBP must receive all discounts given to an SSSG in the rate reconciliation of the same year the discounts were given.

If an estimated SSSG discount is set at the time of the proposal and agreed upon by OPM, it may be adjusted during or after the reconciliation process to be consistent with the actual SSSG discount.

If discounted funds are recovered from an SSSG, a carrier may recoup the equivalent amount of funds from the FEHBP by submitting appropriate supporting documentation.
No other discount may be adjusted or recovered.

Surcharges

OPM will not accept any **surcharge** regardless of whether the SSSG receives the surcharge.

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; and

2) 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 must only be applied to the insurance portion of the FEHB rate and not the pass through amount.

Rating Period Beyond 24 Months

If an SSSG is rated ACR and its initial contract period is more than 24 months, the federal group will 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 and the OPM's Office of the Inspector General (OIG) audit staff 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 and the OIG audit staff would compare what the carrier charged the SSSG with what it charged non-SSSG groups for the benefit to verify the SSSG received no hidden discount. Review of a non-SSSG commercial group does not make it a potential SSSG.

❖ Audits

All rate agreements between OPM and the carrier are subject to audits by the OPM Office of the Inspector General. The results of such audits may require modifications to previous agreements and subsequent rate adjustments. **Pursuant to contract clause 3.4, Contractor Records Retention (FEHBAR 1652.204-70), OPM requires all carriers to maintain documentation to support all calculations and statements pertaining to the reconciliation. This includes documentation supporting the SSSG rates and the rates for all of the 10 largest groups. And, for carriers using an ACR method, this includes detailed reports (including the database) supporting all data (e.g., claims data) used to derive the rates.**

Rate Reconciliation Audits (RRAs)

Each year, beginning in May, OPM's Office of the Inspector General (OIG) audits the rate reconciliations of some carriers. Although these audits focus on the current year's 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 rates available for review by the audit staff.

Upon completion of the RRA, the Office of the Actuaries (OA) will discuss the results with the carrier. **It is the carrier's responsibility to inform the OA of any disagreement they have with the RRA results and/or final rates before they are finalized.** Once the OA and the carrier agree on the final reconciled rates and final rates are set for the upcoming year, OPM will not accept any new or additional information from the carrier regarding the audited year. OIG will not conduct subsequent audits of that year's rates for these plans.

The only condition under which rates finalized in conjunction with an RRA will be changed is when OPM determines it is justified.

❖ 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. You must make an adjustment for this amount in your reconciliation in the form of a negative Special Benefit Loading if your rates include an amount to recover such monies from the FEHBP.

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 allowed.

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 OIG's audit staff or audits that have been resolved by OPM's Office of Insurance Services Programs (ISP).

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Appendix I

Definitions

ACR – the acronym for Adjusted Community Rating.

Capitation Rate – a per member per month revenue requirement.

Carrier – the entity contracting with OPM.

CRC – the acronym for Community Rating by Class.

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

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

Provider Partners – 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 – any groups bonding together to purchase health insurance.

Rate Code Area – 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 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 total area over which the carrier controls its rates. This is usually the state. See Appendix II and III for examples.

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

Retrospective Experience Rating – experience rating where either gains or losses are carried forward or are settled with a payment between the carrier and the employer group.

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

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Subscriber Enrollment – refers to contract enrollment. For example, this could be the total self and family contract enrollment, or the total self, couples, and family contract enrollment.

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

TCR – the acronym for Traditional Community Rating.

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. Each entity determines rates for groups within its 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.**

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Appendix III

Selection of SSSGs Examples

The following examples illustrate OPM's policies.

<u>Case 1</u> **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.

<u>Case 2</u> **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.

<u>Case 3</u> **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 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.

<u>Case 7</u> **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.

<u>Case 8</u> **Two states, one federal rate code area, one rating region and some groups are in more than 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 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.