PART 2

2022
PROPOSAL INSTRUCTIONS

PART 2

PROPOSAL INSTRUCTIONS

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❖ Proposal Submission Requirements

If a ***carrier*** has more than 1,500 FEHBP contracts at the time of the rate proposal submission:

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

If a ***carrier*** has less than 1,500 FEHBP contracts at the time of the rate proposal submission, the carrier must choose between the following options:

- 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 2021 income from the Federal group will be greater than or equal to $2,000,000, the carrier must complete Attachments I, IA, IB, II, IIA, IIB, IIC, and IID and submit Attachments I, IA, IB, IIC, and IID. A carrier should not send Attachments II, IIA, and IIB 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 2021 income from the Federal group will be less than $2,000,000, the carrier must complete and submit Attachments I, IA, IIC, and IID. The carrier need not complete or retain Attachments IB, II, IIA, and IIB. A carrier that chooses this option **will be considered a small carrier**.

Since small carriers will not submit detailed documentation, the Office of the 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 2021 Federal group income will be $2,000,000 or more, the Office of Actuaries may request detailed documentation.

❖ Instructions for Attachment I – Small Carriers

Please complete the "Attachment I" tab in the accompanying Excel file.

If your 2021 Federal group income will be greater than or equal to $2,000,000, you must complete and keep on file Attachments II, IIA, and IIB before submitting Attachment I.

Q1. Indicate the method of community rating used.

Q2. Enter the proposed 2022 Federal group rates on Line A of Attachment I.

If your 2021 income from the Federal group is greater than or equal to $2,000,000, enter the Line 5c rates from Attachment II on Line A of Attachment I.

Q3. If OPM owes you money as a result of the 2021 reconciliation, OPM will reimburse the amount due through an increase in your 2022 rates. Compute the appropriate increase based on the results of the 2021 reconciliation and enter the amount on Line B of Attachment I.

If you owe OPM as a result of the 2021 reconciliation, OPM will recoup the amount due through a decrease in the carrier's 2022 rates. Compute the appropriate decrease based on the results of the 2021 reconciliation and enter the amount on Line B of Attachment I.

Q4. Line C of Attachment 1 is the proposed 2022 Federal group rates after adjustments (Line A ±Line B).

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

To the right of the Attachment I table (see columns M-Q), we try to demonstrate how the Government Contribution affects the enrollee's contribution. We do not know what the government contribution will be for 2022, however, this sheet allows you to estimate what the increase from last year will be and see how your assumptions affect the enrollee's share of the premium.

Please enter your bi-weekly 2021 net-to-carrier contract rates agreed to during the summer of 2020 in cells O4-Q4. These rates are not the brochure rates (which are the net-to-carrier rates times 1.04). In cells M12-M15 you can input your estimate of the increase or decrease in the government contribution. The defaults are 0%, 3%, 6%, and 9% and are not intended to represent our expectation of the change in the government contribution. Cells O40-Q43 show the increase/decrease in the enrollee contribution given the assumptions in cells M12-M15.

❖ Instructions for Attachment II – Large Carriers

Please complete the "Attachment II" tab in the accompanying Excel file. Please provide any additional backup in an Excel file and keep all of the formulas in the spreadsheet. You may add worksheets to "Proposal Tables Attachments I, II, and IIA.xlsx" to help demonstrate your rate buildup. Item numbers correspond to line numbers on Attachment II.

1. Proposed FEHB Rates before Loadings for January 1, 2022

This is the carrier's best possible estimate of the 2022 FEHB bi-weekly Self Only, Self Plus One, and Self and Family rates. These rates must be based on the carrier's community rate(s) or on an OPM approved ACR methodology. On the Backup Line 1 Form, indicate in detail how the Line 1 rates were derived.

Traditional Community Rating (TCR) and *Community Rating By Class (CRC)*

Complete the TCR & CRC Backup Line 1 Form in the accompanying Excel file or provide an equivalent document and enter the resulting Self Only, Self Plus One, and Self and Family rate on Line 1 of Attachment II.

Adjusted Community Rating (ACR)

Complete the ACR Backup Line 1 Form in the accompanying Excel file or provide an equivalent document and enter the resulting Self Only, Self Plus One, and 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 or, in the case of an ACR rated carrier, loadings to include benefits not included in claims data. Provide all backup calculations and clearly indicate all utilization and cost assumptions for each special benefit loading.

If the loading is a benefit you sell to other groups, there should be a uniform price (i.e., a capitation rate or standard set of three-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.

Instructions for Attachment II

You must 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 Special Benefits Loading Form in the accompanying Excel file or provide an equivalent document and enter the loading(s) on Line 2 of Attachment II.

3. FEHB Rates Plus Special Loadings

Line 3 of Attachment II is the sum of Lines 1 and 2.

4.1 Extension of Coverage Loading

Extension of Coverage is the automatic continuation of health benefits coverage for 31 days after FEHB eligibility terminates, except by the enrollee's cancellation of coverage.

If entitled to the Extension of Coverage Loading, multiply Line 3 by 0.004 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 backup documentation must be kept available for audit review. OPM reserves the right to deny this loading.

4.2 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.

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 is received than is needed to cover the cost of benefits for this group, the Medicare loading should be negative. If less income is received than is needed, 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 QG11 and QG12.

A carrier claiming a Medicare loading must have appropriate documentation to justify the distribution of its Medicare population submitted in QG14.

If you use ACR to compute your rates, you must be sure you have considered the effect of COB (coordination of benefits) income received from CMS. You should pay particular attention to QA5 and QA6 of the questionnaire. **A carrier using a claims-based ACR method will normally not have a Medicare loading.**

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.

EXAMPLE:

Medicare Coverage	Distribution of Federal Annuitants and Covered Spouses*	Cost of Benefits	FEHBP Preminm**	Money from CMS	Gain (Loss) to Carrier
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 x $30 = $ 3,000
(2) Revenue Loss: (65 x $10) + (10 x $30) + (50 x $70) = $4,450
(3) Net Loss = $4,450 - $3,000 = $1,450

* From QG14, Attachment IIA
** If you use this method, the FEHBP premium should be the self rate

This positive loading of $1,450 could be spread over the Self Only, Self Plus One, and 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 Medicare Loading Form in the accompanying Excel file or provide an equivalent document and enter the Loading on Line 4b of Attachment II.

4.3 Subtotal

Line 4c of Attachment II is the sum of Lines 3, 4a and 4b.

Instructions for Attachment II

4.4 Estimated Premium Underpayment Percent

Carriers will have the opportunity to apply to the Federal Employees Insurance Operations (FEIO) to receive a Premium Underpayment Loading for 2022. The application will be due in the first quarter of 2022. On Line 4d you may enter an estimate of this percentage. This percentage will be updated in the 2022 Reconciliation to match the amount approved by FEIO.

4.5 Premium Underpayment Loading [(4c)x(4d)]

Line 4e of Attachment II is the result of multiplying Line 4c by Line 4d.

5.1 Proposed FEHB Rates – 2022

Line 5a of Attachment II is the sum of Lines 4c and 4e.

5.2 Discount

Enter the amount of discount, if any, on Line 5b(i), SSSG Discount, or Line 5b(ii), Other Discount, on Attachment II. The SSSG discount line should only be used by carriers that are state-mandated to use TCR. An SSSG discount may be adjusted at the time of reconciliation to reflect the actual discount applied. Other discounts may not be adjusted.

5.3 Final Proposed FEHBP Rates – 2022

Line 5c of Attachment II is the total of Lines 5a and 5b.

To the right of the Attachment II table (see columns L-P), we try to demonstrate how the Government Contribution affects the enrollee's contribution. We do not know what the government contribution will be for 2022, however, this sheet allows you to estimate what the increase from last year will be and see how your assumptions affect the enrollee's share of the premium.

Please enter your bi-weekly 2021 net-to-carrier contract rates agreed to during the summer of 2020 in cells N4-P4. These rates are not the brochure rates (which are the net-to-carrier rates times 1.04). In cells L12-L15 you can input your estimate of the increase or decrease in the government contribution. The defaults are 0%, 3%, 6%, and 9% and are not intended to represent our expectation of the change in the government contribution. Cells N40-P43 show the increase/decrease in the enrollee contribution given the assumptions in cells L12-L15.

Attachment IA – Small Carrier Questionnaire

1. Are you state mandated to rate large groups TCR?

   [ ] Yes [ ] No

Questions 2 and 3 are asked to determine the OPM provided subscription income used in the MLR Calculation. In lieu of answering these questions you may provide a copy of Attachment III from the 2020 and 2021 reconciliation.

2. Is your income for 2020 greater than $2,000,000?

   [ ] Yes [ ] No

If yes, what is Line 10, Payment Due Carrier/(FEHB), on Attachment III your 2021 Reconciliation?

Plan Code	Option	Line 10 of Attachment III of 2021 Reconciliation	Is the Line 10 amount Positive or Negative?

3. Is your income for 2019 greater than $750,000?

   [ ] Yes [ ] No

If yes, what is Line 10, Payment Due Carrier/(FEHB), on Attachment III of your 2020 Reconciliation?

Plan Code	Option	Line 10 of Attachment III of 2020 Reconciliation	Is the Line 10 amount Positive or Negative?

4. Enter your plan's **2021** Actuarial Value (AV) for In-Network Benefits for a Non-Medicare Enrollee* based on the Center for Medicare and Medicaid Serves (CMS) 2021 Actuarial Value Calculator.** Please leave this question blank if you did not participate in the FEHB in 2021.

Plan Code	Option***	In Network Non-Medicare Actuarial Value

If you were unable to use CMS' 2021 Actuarial Value Calculator, briefly describe why you were unable to use the calculator and how you developed the AV value provided:

* A Non-Medicare enrollee is defined as one who has no Medicare coverage of any kind. A Medicare enrollee is defined as one who has Part A only, Part B only, or both Part A and B of Medicare coverage.

** CMS 2021 Actuarial Value Calculator can be found here:

Regulations and guidance index page from CMS site.

*** Please provide a separate actuarial value for each plan option.

5. Enter your plan's **2022** Actuarial Value (AV) for In-Network Benefits for a Non-Medicare Enrollee* based on the CMS 2021 Actuarial Value Calculator** using the set of 2022 benefits proposed:

Plan Code	Option***	In Network Non-Medicare Actuarial Value

If you were unable to use CMS' 2021 Actuarial Value Calculator, briefly describe why you were unable to use the calculator and how you developed the AV value provided:

* A Non-Medicare enrollee is defined as one who has no Medicare coverage of any kind. A Medicare enrollee is defined as one who has Part A only, Part B only, or both Part A and B of Medicare coverage.

** CMS 2021 Actuarial Value Calculator can be found here:

Regulations and guidance index page from CMS site.

*** Please provide a separate actuarial value for each plan option.

Attachment IB Certificate of Accurate Pricing SSSG Methodology

For Community Rated Carriers (SSSG methodology)

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 2021 FEHB rates were developed in accordance with the requirements of 48 CFR Chapter 16 and the FEHB contract and are accurate, complete, and current as of the date this certificate is executed; and

2) The methodology used to determine the FEHB 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 IB Certificate of Accurate Pricing MLR Methodology

For Community Rated Carriers (MLR methodology)

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 2021 FEHB rates were developed in accordance with the requirements of 48 CFR Chapter 16 and the FEHB contract and are accurate, complete, and current as of the date this certificate is executed.

Firm	
Name	
Title	
Signature	
Date	

Attachment IIB 2022 Community Rate Questionnaire

General Questions

(To be completed by all carriers.)

QG1. What type(s) of community rating do you propose to use for the Federal Group in 2022?

[ ] Traditional Community Rating (TCR)

a. [ ] Standard (Book) Rating

b. [ ] Variable (Group Specific) Rating

[ ] Community Rating By Class (CRC)

[ ] Adjusted Community Rating (ACR)

QG2. Are you proposing a rate for a HDHP in 2022?

[ ] YES [ ] NO **If no, skip to QG5**

If "Yes", is your HDHP rated separately from your traditional HMO?

[ ] YES [ ] NO

QG3. Do any of your other groups have an HDHP?

[ ] YES [ ] NO

QG4. What is the annual deductible and annual pass through amount for your proposed HDHP?

Deductible: _____Self Only _____Self Plus One and Self and Family

Pass through Amount: _____Self Only _____Self Plus One and Self and Family

QG5. 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 Only rate? What step-up factor do you use to convert the Self Only rate to the Self Plus One rate and the Self and Family rate?

Self Only/Capitation = _____

Self Plus One/Capitation = _____

Self and Family/Capitation = _____

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

$$Self/Capitation = \frac{.40 + .30(2) + .30(3.9)}{.40 + .30(2.1) + .30\ (2.6)} = 1.20$$

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?

QG6. If you use enrollment-mix or other demographic assumptions at any point in the development of the 2022 Federal group rates (including development of step-up factors), what are they?

% Self Only Contracts_____
% Self Plus One Contracts_____
% Self and Family Contracts_____

Family Size_____
Other:_____

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

QG7. What is the source of your demographic information? Is the same source used for all groups? If not, what is the source of your demographic information for other groups?

QG8. If you do not use step-up factors to convert a capitation rate to the Self Only, Self Plus One, and Self and Family rates, explain how you derive the Self Only, Self Plus One, and Self and Family rates.

QG9. Are the special benefits listed in Line 2, Attachment II of the 2022 proposal different from those that you offered in 2021?

[ ] YES [ ] NO If "Yes", explain.

QG10. With regard to the special benefits shown on Line 2, Attachment II: Are any of them a rider offered to other groups?

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

QG11. 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 Medicare Advantage or Cost Contract with CMS?

[ ] YES [ ] Medicare Advantage Contract [ ] Cost Contract [ ] NO

b. Are any Federal group enrollees covered under these contracts?

[ ] YES [ ] NO [ ] NA

c. If the answer to QG11(a) is "Yes", explain the arrangement you have with CMS, describe all benefit packages you offer enrollees under your Medicare Advantage contract, and the premiums paid (if any) by the individuals enrolled under your Medicare Advantage contract.

QG12. Do you 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.

QG13. Explain how you coordinate benefits for Federal Medicare annuitants and Medicare dependent spouses.

QG14. Show the number of Federal annuitants and their covered spouses age 65 and older enrolled with the carrier. Also include the amount of COB money received from CMS for each of the following categories:

	Counts	COB Amount
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 counts column above should be the total number of Federal annuitants and their covered spouses age 65 and older enrolled with the carrier.

QG15. How do you determine the numbers that you have in the distribution in QG14?

QG16. Do your Attachment II, 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 did not include a negative loading.

QG17. If you use different rating methods (i.e. TCR, CRC, ACR) for different groups, describe your criteria for the use of each method.

QG18. 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 three-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 rate into Self Only, Self Plus One, and Self and Family rates, show the calculations.

Attachment IIB

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 or refer us to another sheet. What we want here is a clear explanation of your Line 1 rates. If there are other sheets with detailed calculations, tell us here in simple language what is done. We want to see how you develop the rates; do not modify your rate development to match our forms or examples.

QG19. In your 2022 Proposal does FEHB receive any discounts, underwriting adjustments, or concessions? TCR plans should not consider estimated SSSG discounts when answering this question.

[ ] YES [ ] NO

If Yes, what is the discount as a percentage?

Please note you will be required to provide this discount to FEHB in the 2022 reconciliation.

QG20. Enter your plan's **2021** Actuarial Value (AV) for In-Network Benefits for a Non-Medicare Enrollee* based on the Center for Medicare and Medicaid Serves (CMS) 2021 Actuarial Value Calculator**. Please leave this question blank if you did not participate in the FEHB in 2021.

Plan Code	Option***	In Network Non-Medicare Actuarial Value

If you were unable to use CMS' 2021 Actuarial Value Calculator, briefly describe why you were unable to use the calculator and how you developed the AV value provided:

* A Non-Medicare enrollee is defined as one who has no Medicare coverage of any kind. A Medicare enrollee is defined as one who has Part A only, Part B only, or both Part A and B of Medicare coverage.

** CMS 2021 Actuarial Value Calculator can be found here:

Regulations and guidance index page from CMS site.

*** Please provide a separate actuarial value for each plan option.

QG21. Enter your plan's **2022** Actuarial Value (AV) for In-Network Benefits for a Non-Medicare Enrollee* based on the CMS 2021 Actuarial Value Calculator**using the set of 2022 benefits proposed:

Attachment IIB

Plan Code	Option***	In Network Non-Medicare Actuarial Value

If you were unable to use CMS' 2021 Actuarial Value Calculator, briefly describe why you were unable to use the calculator and how you developed the AV value provided:

* A Non-Medicare enrollee is defined as one who has no Medicare coverage of any kind. A Medicare enrollee is defined as one who has Part A only, Part B only, or both Part A and B of Medicare coverage.

** CMS 2021 Actuarial Value Calculator can be found here:

Regulations and guidance index page from CMS site.

*** Please provide a separate actuarial value for each plan option.

QG22. Please fill out the following charts with your March 2021 Enrollment. The number of contracts in Columns A + B below should equal the number of contracts in Columns C + D below.

Plan Name			A	B	C	D
Plan Code	**Plan Option**	**# of Self Only Contracts**	**# of Self Plus One Contracts**	**# of Self and Family Contracts**	**# of Contracts with 2 Members**	**# of Contracts with 3 or More Members**

For each tier, please break out the number of contracts that are held by Active employees, Annuitants without Medicare, and Annuitants with Medicare. Status should be determined by the status of the contract holder. The Annuitants with Medicare category should include annuitants who have Part A only, Part B only, or Part A and B.

Self Only

Plan Code	Plan Option	Actives	Annuitants without Medicare	Annuitants with Medicare

Attachment IIB

Self Plus One

Plan Code	Plan Option	Actives	Annuitants without Medicare	Annuitants with Medicare

Self and Family

Plan Code	Plan Option	Actives	Annuitants without Medicare	Annuitants with Medicare

Two Member Contracts

Plan Code	Plan Option	Actives	Annuitants without Medicare	Annuitants with Medicare

Three or more Member Contracts

Plan Code	Plan Option	Actives	Annuitants without Medicare	Annuitants with Medicare

QG23. Does your proposed rate include a discount? Regulation does not allow the discount to change during the reconciliation. What is the discount you are guaranteeing?

[ ] Percent decrease of _____

[ ] Dollar decrease of _____

[ ] Final rate will not increase at reconciliation

[ ] Factor in the buildup will not change, please explain _____

[ ] Other, please explain:_____

QG24 a. What are the total claims incurred in 2020 and paid through March 31, 2021?

b What are the total claims incurred in 2020 and paid through March 31,2021, attributable to COVID-19?

c. Please provide the breakdown of COVID costs and utilization data for the period stated above in the following categories:

Testing Claims Cost: _____ Unique Members tested: _____

Number of tests: _____

Treatment Claims Cost**: _____ Unique Members treated: _____

Other Claims Cost**:_____

** Please define what costs are included in the Treatment and Other categories:

d. Are you using 2020 experience to set the 2022 rates?

[ ] YES [ ] NO

If yes, how are you adjusting the experience or trend to reflect COVID-19? Please be specific. If no, please explain how you are setting your rate.

QG25. List the top three contributors to your increase in the 2022 rates proposed. Please be specific, for example we would want to see 'Increased utilization of specialty drugs and high-tech imaging' versus 'Increased utilization'. Also provide any significant savings that are offsetting increases to 2022 rates.

Attachment IIB

TCR Questions

(Answer only if the carrier uses TCR to develop rates)

QT1. 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?

Self Only _____ Self and Family _____

Self Only_____ Self Plus One _____ Self and Family _____

QT2. Do you begin your rate development with a capitation rate, and then convert it to the Self Only, Self Plus One, and Self and Family rates?

[ ] YES [ ] NO If "Yes", what is the capitation rate?

Capitation Rate = _____

Note that you may check both QT1 and QT2 "Yes" if you use a standard set of tiered rates that are derived from a capitation rate.

QT3. Do you use "step-up" factors to convert the capitation rate to the Self Only, Self Plus One, and Self and Family rates?

[ ] YES [ ] NO

QT4. Are you electing to submit a list of potential SSSGs at this time?

[ ] YES [ ] NO

If "No", the carrier will select the group which meets the SSSG requirements at the time of reconciliation as the SSSG.

If "Yes":

- **Make sure the Potential SSSGs Form in the accompanying Excel file is filled out.** The carrier must also have a list on file of **all** potential SSSGs ranked by the group's most recent

enrollment (but no later than March 31 of the current year). In creating the potential SSSG list, did you only include the enrollment in TCR products to determine the size of the groups?

[ ] YES [ ] NO

- Has your organization merged with a subsidiary organization or made an acquisition of a new carrier, insurance company, or health plan within the last year?

[ ] YES [ ] NO

If "Yes", have you included the health plans from merged or new organizations in your SSSG consideration?"

[ ] YES [ ] NO If "No", explain why

QT5.Do you include a potential SSSG discount in your 2022 FEHB proposed rates?

[ ] YES [ ] NO

If Yes, what is the discount as a percentage?

If Yes, was the discount as a percentage applied to the entire rate?

[ ] YES [ ] NO If "No", explain why

Attachment IIB

CRC Questions

(Answer only if the carrier uses CRC to develop its rates)

QC1. Do you use CRC for all your groups?

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

QC2. What CRC factors do you use?

[ ] Age [ ] Sex [ ] Other _____, _____, _____

QC3. What capitation rate do you begin with?

Capitation Rate = _____

QC4. 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?**

QC5. Give a simple narrative explanation of how you derive your rates including how you adjust the capitation rate.

Do not skip this question or refer us to another sheet. What we want here is a clear explanation of how you derive your rates. If there are other sheets with detailed calculations, tell us here in simple language what is presented on those sheets.

QC6. 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.)**

QC7. Do you use "step-up" factors to convert the adjusted capitation rate to the Self Only, Self Plus One, and Self and Family rates?

[ ] YES [ ] NO If "No", explain

QC8. 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.

QC9. When you derive the CRC adjustment factor, do you include the number of Federal annuitants, over age 65, anywhere in the calculation?

[ ] YES [ ] NO

If "Yes", have you given us a credit for Medicare Reimbursement?

Do you include the number of Federal annuitants **under** age 65?

[ ] YES [ ] NO

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.

QC10. Do you use an industry factor in your rating?

[ ] YES [ ] NO

If yes, did the Federal group receive a factor of 1.00 or less?

[ ] YES [ ] NO If No, explain

Attachment IIB

ACR Questions

(Answer only if the carrier uses ACR to develop its rates)

QA1. Do you use ACR for all your groups?

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

QA2. What method of ACR do you use to rate the Federal group in 2022?

[ ] A Method Based on Federal Claims

[ ] Other

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

QA3. If your answer was "Other" for QA2, give a simple, but comprehensive explanation of how you developed your rates. Use extra sheets if necessary.

QA4. If you are required to submit an FEHBP MLR, are your claims accounted for in a consistent manner?

[ ] YES [ ] NO

If you answered "No", please explain the difference in the claims used in the FEHBP MLR submission and those included in the ACR development. Do not include the timing and completion factor differences between the two submissions.

QA5. 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.

QA6. If you answered "Yes" to QA5, 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.

QA7. Did you reduce claims used in the rate development by all COB income (e.g. prescription drug rebates, settlements) that the carrier received from other insurance sources excluding CMS?

[ ] YES [ ] NO

If "No", credit must be applied to the Federal group for any monies received from other insurance sources.

Questions QA8 through QA14 are for carriers that answered QA2 by checking "A Method Based on Federal Claims"

QA8. Clearly explain your ACR method using Federal claims data to compute rates. **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.**

QA9. Do you use completion factors to derive incurred claims?

[ ] YES [ ] NO

If "Yes", you should use the same set of completion factors for all your groups. Do you?

[ ] YES [ ] NO [ ] NA If No, explain.

QA10. Complete the following for the claims in the experience period used to calculate your 2022 rates:

Total Claims (not including any COB) _____

Medicare COB_____

Other COB (e.g. Rx rebates, settlements) _____

Net Claims_____

QA11. Explain how you compute the administrative charge.

Important! Do not skip this question.

QA12. Did the claims used in the rate development reflect special benefits?

[ ] YES [ ] NO

QA13. 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 = _____

QA14. Do you use step-up factors to convert an adjusted capitation rate to the Self Only, Self Plus One, and Self and Family rates?

[ ] YES [ ] NO If "Yes", please make sure you answer QG5.

If "No", please explain how you set the differential for the three tiers.

Attachment IIC Carrier Contacts

For information about your rate submission, we should contact:

Name	
Phone Number	
Email	

OR

Name	
Phone Number	
Email	

Our counterproposal and rate acceptance letters should be addressed to:

Name	
Address	
Address	
Address	
Phone Number	
Email	

Attachment IID Utilization Data

2020 Utilization Data (Based on Total HMO Population)	**2020 Utilization Data (Based on Total HMO Population)**	**2020 Utilization Data (Based on Total HMO Population)**
Type of Service	**Annual Utilization Per 1000 Members**	**Annual Utilization Per 1000 Members**
1. Number of Prescriptions		
	A. Mental	**B. Other**
2. Number of Office Visits		
3. Number of Inpatient Hospital Days		