➢ Instructions for Attachment III

Large carriers must complete lines 1 through 7 and line 10 of the reconciliation sheet. OPM will complete lines 8, 9, 11 and 12 for large carriers. Small carriers must complete lines 1 through 12 and use the results on line 12 to compute a 2006 rate adjustment.

OPM requires a reconciliation because most carriers estimated their 2006 rates. You must recalculate the rates, based on the carrier's actual community rates to determine if money is due OPM or you.

The enrollment data you used in the proposal should have been current data. **If you used group-specific demographic assumptions (i.e., family size, self/family enrollment mix, etc.) in the proposal, you must use the same figures in the reconciliation.** You may not revise the self/family enrollment mix to reflect the 2005 open season.

If, however, you used carrier-wide enrollment-mix or other demographic assumptions, and you revised these assumptions after you submitted the proposal (and before Jan. 1, 2006) and you used the revisions for your SSSGs, you should base the reconciliation on the revised assumptions.

There are certain other factors you **should** change for the reconciliation. If your rate is a weighted average of rates in several geographic areas, you should base the weight factors in the reconciliation on the March 31, 2006, enrollment in each area (which you provide OPM). Also, if you recalculate the Medicare loading, you should use the latest Medicare enrollment available.

➢ Special Reconciliation Instructions for Using ACR

If a carrier uses ACR, it may use a prospective method based on actual Federal claims data or a method based on utilization data to calculate their rates. **In either case, the carrier must keep on file all data necessary to support the ACR rate (i.e., claims, utilization etc.). You must save backup tapes of your claims database for audit purposes. Note: this information should also be available for the SSSGs.**

If a carrier uses a method not based on actual claims data they should do the reconciliation similar to TCR or CRC reconciliation. The following special rules that apply for a claims-based ACR method were stated in the 2006 rate instructions and are as follows:

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) you used in the proposal.

2) If you used completion factors to convert paid claims to incurred claims, such factors must be the same for all groups for which you used a claims-based ACR method.

3) Any method you used to convert paid claims to incurred claims must be consistent for all groups you rated by a claims-based ACR method.

4) If claims include special benefits claims, you should take no special benefits loadings (either in the proposal or reconciliation). Note that claims should reflect extension of coverage, which means that you should not take the extension of coverage loading.

5) If claims include those of annuitants age 65 and over, you must reduce claims by an amount equal to Medicare income from CMS (Centers for Medicare or Medicaid Services) or we must receive a credit for monies received from CMS. (See ACR Questions QA10 and QA11) **The amount of Medicare income from CMS must be clearly stated.**

6) Loadings for administrative expenses must be either:

   a) a flat community rated pm/pm amount or

   b) a standard percentage of claims

   c) a method consistently applied to the FEHBP and the SSSGs.

7) Any trend factor used for the Federal group must be the same as the trend factor the carrier used for other groups (that is, you may not base a trend factor for the Federal group on the Federal group's experience).

The reconciliation for a carrier using a claims-based ACR method for the Federal group should differ only slightly from the original rate proposal. The only components that can change are:

1) **Trend Factor**. If you used an estimated trend factor in the 2006 proposal and later changed it (before January 1, 2006) for all groups for which you used a claims-based ACR method, you must use the revised factor in the 2006 reconciliation.

2) **Administration Cost Factor**. If you used an estimated administration cost factor in the 2005 proposal and later changed it (before January 1, 2006) for all groups for which you used a claims-based ACR method, you must use the revised factor in the 2006 reconciliation.

Both the trend factor and the administration cost factor must be consistent with the lowest such factors used for either SSSG.

➢ Lines By Line Instructions

The following gives a line-by-line explanation of how to fill out the reconciliation sheet. Item numbers correspond to line numbers on Attachment III.

1. Actual FEHBP Rates - 2006
This is the most significant part of the reconciliation process. Please do it carefully. Refer to the Part I instructions on page 15.

2. Special Benefit Loadings
Refer to the Part II instructions on page 16.

3. FEHBP Rates Plus Special Loadings
The sum of Lines 1 and 2.

4a. Extension of Coverage Loading
If you are entitled to this loading, multiply Line 3 by .004 (or the same factor you used in the proposal).

4b. Children's Loading
Refer to Part III instructions on Page 17.

4c. Medicare Loading
Refer to Part IV instructions on page 17.

4d. Subtotal
Add lines 3, 4(a), 4(b), and 4(c)

4e. Enrollment Discrepancies Loading
This is a special 1% load to the rates which compensates the carrier for possible enrollment discrepancies.

5. Total FEHBP Rates - 2006
Add lines 4(d) and 4(e).

6. Contract Rate - 2006
For large carriers, the negotiated, biweekly, net-to-carrier contract rates, as agreed to during the summer of 2005. This rate is not the brochure rate (which is the net-to-carrier rate times 1.04).

NOTE: SMALL CARRIERS SHOULD PLACE IN LINE 6 THE RATES FOUND ON

LINE C, ATTACHMENT I OF THEIR ORIGINAL 2006 RATE PROPOSAL

7. Difference
Subtract line 6 from line 5.

10. Brochure Printing Costs
Refer to the part V instructions on page 18.

8, 9, 11, and 12
For large carriers, OPM's actuarial staff will fill in these lines. Enrollment will be based on the March 31, 2006, semi-annual headcount.

➢ Additional Instructions for Small Carriers Only

Small carriers must do some additional work on Attachment III. Since small carriers do not send this document to OPM, you must complete Line 12, Attachment III, which requires completing Lines 8, 9, and 11.

Detailed instructions are as follows:

8. March 31, 2006 Enrollment
Normally, OPM would put the March 31, 2006 headcount enrollment numbers on Line 8. Since these numbers will not be available at the time the small carrier does the calculation, the carrier should use its March 31, 2006 Table 1 enrollment numbers. The Table 1 report is the enrollment data the carrier normally submits to OPM in April.

9. Payment Due Carrier/ (FEHBP)
To compute Line 9, multiply the amounts on Line 7 by line 8; then times 26 (since the rates are bi-weekly).

11. Outstanding Amount Due Carrier/ (FEHBP)
This is any amount due the carrier or OPM from previous years. As an example, suppose OPM owed the carrier $50,000 last year, and the 2006 rates were purposely increased to pay the carrier this debt. In the 2006 rate reconciliation, $50,000 would be placed in line 11.

12. Total Amount Due Carrier/ (FEHBP)
The sum of lines 9 through 11.

A small carrier must use the amount on line 12 to determine the 2007 rate adjustments. You will place the 2006 rate adjustments on Line B of your 2007 rate proposal sheet (Attachment I) which we will send you at a later date. An example of how you might compute the rate adjustments follows.

Example:

Assume the amount on line 12 is $76,000. You must determine a self and family loading equivalent to this amount. Suppose the carrier expects the Federal group enrollment in 2007 to increase by 10 percent over the 2006 enrollment (i.e., 2006 enrollment will be 220 self and 440 family). Then, the adjustment could be $2.66 self and $5.32 family, since

[220 x $2.66 x 26] + [440 x $5.32 x 26] = $76,000

OPM will allow reasonable flexibility in determining the amount of the rate adjustment based on reasonable enrollment assumptions. All assumptions will be subject to audit or verification at a later date. Therefore, you must keep on file all supporting calculations for the Federal group's rates and the SSSG rates.

Important Special Instruction to Small Carriers:

Line 6, Attachment III is for the 2006 contract rates. Small carriers should put the rates from Line C, Attachment I of the original rate proposal onto Line 6, Attachment III. This avoids the possibility that OPM would pay twice to a small carrier whose 2006 rates were reduced by OPM to generate a contingency reserve payment.

➢ Backup: Line 1 Form Instructions

These instructions should be used to fill out the corresponding backup forms. Your reconciliation is a revision of your original proposal.

TCR and CRC Carriers

For carriers using TCR or CRC, the reconciliation usually involves substituting the carrier's actual 2006 capitation rate (or equivalent) for the estimates you used in the proposal. The enrollment mix and all other demographic assumptions remain the same as in the proposal (with some exceptions, as indicated earlier**). Note that these "actual" rates should be the basis for the Federal group's rates and for the rates of both SSSGs.**

Community-rated carriers use different rating methods. Those using TCR or CRC usually base their rates on a "per member per month" or capitation rate that is converted to self and family rates by "step-up" factors. These factors are related to family size and market considerations, and are in accordance with the standard documented procedures.

There is usually a step-up factor that converts the capitation rate to a self rate and another factor that converts the self rate to a family rate. Some carriers have a step-up factor that converts the capitation rate directly to a family rate.

The 2006 reconciliation must be based on the same factors and procedures used to derive the 2006 self and family rates in the 2006 proposal submitted in May 2005. The reconciliation must use the **actual** January 1, 2006, capitation rate. Use the **same** step-up factors you used in the proposal (unless the step-up factors were changed before January 1, 2006 as the result of a revision of carrier-wide demographic assumptions and you used the revisions for your SSSGs).

Some carriers using TCR or CRC derive rates in other ways. The principles described above still apply. To compute the Line 1 rates, simply go through the same procedure used in the original proposal, substituting actual rates for the proposed rates. The procedures you use should also be the same as those used for your SSSGs.

For large carriers, we require documentation of your actual community rates, as explained in Attachment IV. If your State requires that you file your rates with the State Insurance (or other)

Department, **enclose a copy of that filing**. Otherwise, follow the instructions in Attachment IV.

So that OPM's actuaries can easily verify the rates on Line 1, we require that:

1) your computations be clear

2) you highlight the actual community rates and step-up factors used in your computations.

An example of an acceptable presentation of the line 1 calculation follows.

Example:

Actual capitation rate as of 1/1/06:		$20.00*
First level step-up factor used in proposal:	1.2**	
Actual Self Rate: ($20 x 1.2)		$24.00
Second level step-up factor used in proposal:	2.9**	
Actual Family Rate: ($24 x 2.9)		$69.60

*see insurance filing
**see attached sheet from original proposal

ACR Carriers
Carriers using ACR should refer to the "Special Reconciliation Instructions for Carriers Using ACR" on pages 11 and 12 of this document.

You must go through the same procedure you used to derive the Line 1 rates in the original 2006 rate proposal, changing the trend factor and/or administration cost factor if appropriate.
All other parts of the reconciliation should be done the same way you did the original proposal.

Please keep in mind that the reconciliation for a carrier using a claims-based ACR method should differ only slightly from the original rate proposal.

➢ Backup: Special Benefit Loadings Form Instructions

OPM sometimes purchases special benefits that are not in the carrier's basic community package. The cost of the special benefit must not change if it was approved by OPM during the 2006 rating period.

If the special benefit is a community-rated rider, enter either the self and family rates filed with the State Insurance Department or calculate the actual loading based on the actual capitation rate

for the special benefit. The procedure would be similar to that used for the Line 1 rates. If you do not file with the State, submit other appropriate documentation for this rider.

If the special benefit loading is a function of the carrier's community rate (say a percentage of the Line 1 rate), calculate the Line 2 rate by multiplying the actual Line 1 rate by the same percentage used in the 2006 rate proposal.

➢ Backup: Children's Loading Form Instructions

This loading usually is a function of the community rate plus any special loadings. If the actual rates are different from those in the 2006 rate proposal, the children's loading will differ. Recalculate, using the same method used in the original proposal.

You may take this loading 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 you included overage dependents in your group-specific demographics (especially the average family size) and use these numbers to create your self and family rates (through step-up factors, etc.), YOU ARE NOT ENTITLED TO A CHILDREN'S LOADING.

We present a "suggested method" format for your convenience. If you have another method, please use it and give the details of your method.

If the actual biweekly cost per child is known, and the average number of children per family is known, the children's rate may be computed by multiplying the two figures together. In general, if you can compute the overall rate for children in a more accurate way than that suggested in line (C) of the suggested method shown on the Form, use that result in line(C).

Enter the loading on line 4b of Attachment III.

➢ Backup: Medicare Loading Form Instructions

If you derived this loading using estimated community rates, recompute the derivation, using the actual community rates and the latest Medicare enrollment distribution available. Also, if you used estimated revenue from the Centers for Medicare and Medicaid Services (CMS) to derive this loading, you should now use the CMS approved numbers. **Include a copy of the original derivation so we can easily see the difference between the estimated and actual loading.**

If you use CRC or ACR to derive your rates, you must make sure that you have considered the effect of Coordination-Of-Benefits (COB) income the carrier received from CMS. A carrier using a claims-based ACR method will normally not have a Medicare loading. You should pay particular attention to questions QC16, QA10, and QA11 of the questionnaire.

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 QG8.

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. Most other groups generally cover their retirees by Medicare Plus Choice Plans or Medicare Supplement Plans and are excluded from the employee plan.

The HMO must compute the cost of benefits for the Federal annuitants, and compare this with the income it receives on behalf of these annuitants from OPM and CMS. If a plan receives more income than is needed to cover the cost of benefits for this group, the Medicare loading should be negative. If the plan receives less income than is needed, the loading should be positive.

We suggested a method to derive the loading in the 2006 rate instructions, but want to make clear here that the HMO may derive the loading in any reasonable way that it can document.

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 Plus Choice 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 QG9 and QG10.

➢ Backup: Brochure Costs Form Instructions

This is the amount the carrier actually spent to produce the **OPM-approved quantity** of brochures. We will evaluate for reasonableness. Submit any documentation you think will be helpful to us in evaluating the reasonableness of your requested amount**. Note that the amount claimed may be for OPM brochures or rate sheets only. No costs for provider directories, business cards, or other promotional materials** may be included.

➢ Backup: SSSG Comparison Form Instructions

Use the SSSG Comparison Form to show the method by which you determined the billed rates for your SSSGs and the Federal group. Indicate in a step-by-step manner how you got from your starting point (in the TCR and CRC cases, this is usually a capitation rate) to the billed rates. If you used ACR for the groups, include utilization data. Explain how the method used for the SSSGs differs from that used for the Federal group.

Include calculations, and be sure to maintain backup documentation for all calculations. This documentation will be subject to audit at a future date. Use additional sheets if necessary.

Make sure that by the time we finish reading your explanation, it will be clear to us why the federal rates differ from the SSSG rates. If you have included rate development sheets for these groups, do not refer us to these sheets at this point. What we want here is a simple explanation of how the SSSG rates differ from the federal group rates.

We give simple examples on the following pages to serve as a guide. Do not hesitate to elaborate in your presentation**. Carriers using ACR should keep in mind that the following is only an example, and that you may need to include more information, depending on how your ACR method works.**

This form will be referred to in SSSG Questionnaire (#13). In the example, the capitation for the Federal group is $100, but only $98 for SSSG #1. In SSSG Question 13, the explanation could be as follows:

SSSG #1 Capitation	$ 98.00
Adjustment for "Gold Plan"*	$ 2.00
Federal Group Capitation	$100.00

* The Federal group has the "Gold Plan", which includes extra psychiatric benefits and a durable medical equipment benefit. SSSG #1 has the "Silver Plan", which is the "Gold Plan' without the aforementioned extra benefits. The capitation for these benefits is as follows:

Psychiatric Benefit	$1.50
DME Benefit	$ .50
Gold Plan Extra Benefits	$2.00

Note: The above enables us to see precisely why the capitation for SSSG #1 is different from the Federal group's capitation. The goal of your explanation is to make any such differences in capitation rates clear to us.

Reconciliation Instructions

EXAMPLE of TCR / CRC COMPARISON SHEET

		Federal Group	SSSG #1	SSSG #2
1.	Group Renewal Date	1-1-06	1-1-06	2-1-06
2.	Rating Method (a)	CRC	CRC	CRC
3.	Capitation (b)	$100.00	$98.00	$101.00
4.	Age/Sex Factor	.92	.98	1.04
5.	Industry Factor (c)	.95	.95	.98
6.	Other Discounts	.95	1.00	.95
7.	Total Discount (d)	.95 x .98	.95 x 1.00	.95 x .98
8.	1st Level Step-Up Factor (e)	1.30	1.12	1.22
9.	**Self Rate** (f)	$111.35	$102.19	$119.31
10.	Family/Self Ratio	2.71	2.80	2.55
11.	**Family Rate**	$301.76	$286.13	$304.24

(a) If all three methods are not the same, explain why.

(b) **IMPORTANT! If these capitation rates are not the same, explain why in QS13.**

(c) The Federal group receives the lowest industry factor < 1.0 given to an SSSG.

(d) **IMPORTANT**: The Federal group receives at least the lowest total discount given to an SSSG. In this case, one SSSG received a total discount of (.95 x 1.00) and the other received a total discount of (.95 x .98) Therefore the Federal group would get a discount of (.95 x .98) , the lower of the two. Note: The Federal group can receive the largest discount.

(e) Show How Factors Are Derived.

(f) $100 x .92 x (.95 x .98) x 1.3 = $111.35

EXAMPLE of an ACR COMPARISON SHEET

This shows one way you might present your ACR rate development. You should modify this example to fit your particular ACR procedure. Note that although this example is for the Federal group only, your comparison sheet must include the SSSGs as well as the Federal group.

		Federal Group	SSSG #1	SSSG #2
a.	Rating Method	ACR		
b.	Group Renewal Date	1/1/06		
c.	Experience Period	1/1/2004-12/31/2004		
d.	Paid Claims			
	Before CMS Reimbursement	**12,000,000**		
	After CMS Reimbursement	**10,000,000**		
e.	Annual Trend (if different, explain)	12%		
f.	Trend From Experience Period To Renewal Period $[(1+ .12/12)^{24}$ Show how you obtained the percentage.	27%		
g.	Expected Claims [(d) x 1.27]	$12,700,000		
h.	Administration (if different, explain)	15%		
i.	Claims + Administration [(g)/(1-.15)]	$14,941,176		
j.	Member Months	100,000		
k.	Per/Person Rate [(i)/(j)]	$149.41		
l.	First Level Step-Up Factor	1.2		
m.	Bi-weekly Self Rate [(l) x (k) x 12/26]	$82.75		
n.	Family/Self Ratio	2.6		
o.	Family Rate [(m) x (n)]	$215.15		
p.	Discount	10%		
q.	Rates After Discount	Self $74.48 Family $193.64		