Reminders for 2022

Self Plus One
In no event can Self Plus One rates be higher than Self and Family rates. Carriers should set a differential between tiers that is appropriate for the population they expect to cover.

Carriers should clearly show how the rates for the three tiers are derived. The differential used to derive the rates in the proposal cannot change in the reconciliation.

Error Reporting
Prior to a plan being notified of an audit, if a carrier discovers that a previous rate proposal, reconciliation, and/or MLR Calculation submitted to OPM is incorrect (e.g., through the discovery of an error or omission), the carrier must notify OPM and prepare and submit to OPM amended proposals, reconciliations, or MLR Calculation. Submissions should include a newly executed Certificate of Accurate Pricing and /or Certificate of Accurate MLR Calculation. Carriers can only resubmit a reconciliation if they find a mistake. They cannot resubmit the reconciliation where the only change is an additional discount given to FEHB to avoid paying an FEHB MLR penalty.

Documentation
The carrier must rate its FEHB plan using its documented community rating methodology. Carriers must submit documentation to OPM supporting their rate buildup.

Actuarial Value
In prior years we have requested the actuarial value of your plan options using the Center for Medicare and Medicaid Serves (CMS) Minimum Value Calculator. Beginning this year, we are requiring carriers to use the CMS Actuarial Value Calculator to provide us with your plan options' actuarial value.

PART 1

2022
COMMUNITY RATING GUIDELINES

PART 1
2022 COMMUNITY RATING GUIDELINES
TABLE OF CONTENTS

PART 1
2022 COMMUNITY RATING GUIDELINES

PART 1
2022 COMMUNITY RATING GUIDELINES

❖ Community Rating Policy

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

TCR and CRC Rating

Carriers using TCR or CRC are expected to develop rates from a community-based revenue requirement (normally in the form of a ***capitation rate***) which is documented and verifiable. Once the capitation rate is established it may be converted to Self Only, Self Plus One, and 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 their other groups and the process must be documented in the rating methodology. All demographic factors must be based on **actual** in-force group data.

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

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

If industry factors are used, the factor 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.

Standard Format*:* 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 Only, Self Plus One, 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

PMPM to Self Only Factor = 1.2
Self Only to Self Plus One Factor = 2.0
Self Only to Self and Family Factor = 2.9

Self Only Rate = $68.40 x 1.2 = $82.08
Self Plus One Rate = $82.08 x 2.0 = $164.16
Self and 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).

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 2022 capitation rate (or equivalent).

PART 1
2022 COMMUNITY RATING GUIDELINES

The 2022 reconciliation must be based on the same factors and procedures used to derive the 2022 Self Only, Self Plus One, and Self and Family rates in the 2022 proposal. The reconciliation must use the actual January 1, 2022, 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 7).

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 other groups and documented in the rating methodology.

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, such as, the carrier's rating manual, rating policies and procedures, and/or state-filed rating methodology may be requested. If a carrier does not file or does not have a documented rating manual or methodology, OPM may require the rate development of other groups to establish what rating method the carrier uses in practice. OPM will look at other groups only to determine the process by which the rates were built. OPM will not evaluate whether another group received a discount.

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., factors, utilization). This data is subject to review and audit by the Office of the Inspector General (OIG). If the carrier uses a claims-based ACR method, a backup of the claims database must be saved for audit purposes and the claims used to compile the ACR rate must be provided to the OIG in response to their annual claims data request.

3) Once the experience period and claims are set in the proposal, they cannot be changed after the proposal has been submitted.

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, subrogation, and settlements.

6) Loadings for administrative expenses must be documented in the carrier's rating methodology and must be consistent with the methodology used to rate large groups.

7) Any trend factor used for the Federal group must be the same factor the carrier used for other groups and documented in the rating methodology (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 2022 proposal and changes the factor before January 1, 2022, for all claims-based ACR groups, the revised factor must be used in the 2022 reconciliation. The factor must be documented in the carrier's rating methodology and should be consistent with what is used for other insured groups.

(ii) **Administrative Cost Factor -** If a carrier uses an estimated administrative cost factor in the 2022 proposal and changes the factor before January 1, 2022, for all claims-based ACR groups, the revised factor must be used in the 2022 reconciliation. The factor must be documented in the carrier's rating methodology and should be consistent with what is used for other insured groups.

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 Only/Self Plus One/Self and Family enrollment mix) were used in the proposal, the same figures must be used in the reconciliation. The Self Only/Self Plus One/Self and Family enrollment mix may not be revised to reflect the open season for 2022.

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, 2022, **and** the revisions were used for other insured groups with a January 1st effective date, 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, 2022 enrollment in each area (which you provide in the Table 1 report to OPM). Also, when 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), which may not exceed 25% of the total premium. (In accordance with Carrier Letter 2018-01, Federal Employees Health Benefits Program Call Letter, the premium pass-through amount to a member's HRA or HSA account is no longer limited to 50 percent of the plan deductible); 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 2022.

❖ 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.

❖ Miscellaneous Remarks

Estimated Premium Underpayment Percent

Carriers will have the opportunity to apply to Federal Employees Insurance Operations (FEIO) to receive a Premium Underpayment Loading for 2022. The application will be due in the spring of 2022. In the 2022 Proposal, you may estimate what this loading will be. This percentage will be updated in the 2022 Reconciliation to match the amount approved by FEIO. Please refer to Carrier Letter 2013-13 Applications for Premium Remittance Shortfalls for more information.

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.

Late Payment Loadings

Late payment loadings are not allowed.

Surcharges

OPM will not accept any ***surcharge*****.**

Error Reporting

If a carrier discovers that a previous rate proposal, reconciliation, and/or MLR Calculation 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, reconciliations, or MLR Calculation (including a newly executed Certificate of Accurate Pricing and/or Certificate of Accurate MLR calculation).

Carriers can only resubmit a reconciliation if they find a mistake. They cannot resubmit the reconciliation where the only change is an additional discount given to FEHB to avoid paying an FEHB MLR penalty.

Note: The above policy does not apply to proposals, reconciliations, and/or MLR Calculations 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 Federal Employee Insurance Operations (FEIO).

❖ FEHB Medical Loss Ratio (MLR)

The following rules on pages 9 to 13 apply to carriers that are not state mandated to use Traditional Community Rating (TCR). Carriers that are state mandated to use TCR should follow the instructions for Similarly-Sized Subscriber Groups that begin on page 13.

The U.S. Office of Personnel Management (OPM) has issued a Final regulation amending the Federal Employees Health Benefits (FEHB) regulations at 5 CFR Chapter 89 as well as the Federal Employees Health Benefits Acquisition Regulation (FEHBAR) at 48 CFR Chapter 16.

This regulation applies to community rated carriers and can be found here. Note that state mandated TCR plans will continue to follow Similarly-Sized Subscriber Group (SSSG) rules.

2022 MLR Timeline

1) Submit 2022 Rate Proposal by May 31, 2021.
2) Submit 2022 Rate Reconciliation by April 30, 2022.
3) Submit the 2022 FEHB MLR Calculation Form by September 30, 2023. The FEHB MLR Calculation Form will be provided to carriers in the summer of 2023.
4) Submit calendar year 2022 claims data supporting MLR in 2023 to OIG per Carrier Letter. This applies to all ACR and CRC carriers, including small plans with income in the prior calendar year greater than $2,000,000. Large ACR carriers will also be required to submit their claims data used in its FEHB rate development (i.e., the experience period(s)) in addition to the above. See "Audits" Section on page 18 for more details.
5) Submit any penalty due OPM based on the FEHB-specific MLR calculation within 60 days of notification of the amounts due.

Plans are required to submit the Rate Proposal, Rate Reconciliation, and FEHB MLR Calculation Form through the Rate Submission Tool at FEHB TOOLS - RATES webpage. Please contact the Office of the Actuaries at actuary@opm.gov to request access to the Rate Submission Tool.

General Information

HHS MLR guidelines will apply for issues not covered in these instructions.

First Year Groups
A plan in its first year in the FEHB will not be subject to the MLR rules.

Prior Year Income less than Federal Acquisition Regulation Amount
If the plan's FEHB income in 2021 is less than $2,000,000, the plan is not subject to the MLR rules.

Rate Buildup
The carrier must rate its FEHB plan using its documented community rating methodology. Carriers will update the estimated contract rates with the January 1st community rate and will settle the difference with OPM. The reconciliation payments will be included in the denominator of the MLR calculation. See the MLR Premium Income section for more details.

Except for the elimination of the SSSGs, the reconciliation process and contingency reserve mechanism do not change under the MLR rules.

Payment due plan for enrollment discrepancy
If a carrier receives a Premium Underpayment Loading, the amount of premium received from this loading must be included in the premium used in the MLR Calculation.

Audit
Carriers are required to maintain all MLR and rate proposal documentation. All data is subject to audit. We recognize that the claims part of the MLR claims/premium ratio may not match the paid claims seen in the carriers' renewal exhibits. Similarly, we recognize that claims extracts supporting the MLR Calculation and rate renewal may not be identical. The carrier should explain any accounting differences between the claims submitted in the MLR and rate submissions that are not explicitly related to the timing variance. The carrier must be able to fully support all claim values.

Claims

Only FEHB claims associated with benefits covered in the plan's FEHB contract may be included in the MLR calculation. All FEHB enrollees (including those with and without Medicare) covered under the Plan and their claims, premiums, and other related expenses must be included in the FEHB MLR calculation.

Completion
FEHB claims incurred in calendar year 2022 and paid through June 30, 2023 must be included in the MLR calculation; no other claims will be considered. No completion factor may be applied.

Small Group Adjustment
The following table will be used to adjust the MLR for plans with fewer than 18,000 FEHB contract months in calendar year 2022. The resulting MLR will be referred to as the Adjusted FEHB MLR.

Number of FEHB Contract Months	Additive Adjustment to the Calculated MLR
> 18,000	0.0%
1,200-18,000	(18,000 – number of FEHB contract months)/16,800 x 5.0%
<1,200	+ 5.0%

Cost Allocation
Capitation and other costs considered as claims for MLR calculation that can be attributed to an FEHB benefit should be allocated in accordance with HHS instructions. The costs to be allocated must be

incurred in calendar year 2022 and paid through June 30, 2023. If these amounts are not verifiable in a source document, a value that can be verified and is paid prior to June 30, 2023, must be used. A completion factor may not be included. Any other method must be explained by the carrier and approved by OPM's Office of the Actuaries.

Coordination of Benefits
Claims included in the numerator of the MLR calculation must be net of income attributed to FEHB group enrollees from all other sources such as Medicare and Medicaid Services (CMS), prescription drug rebates, coordination of benefits, subrogation, and settlements related to claims incurred in calendar year 2022 and recovered by June 30, 2023.

Plans that receive a Medicare risk payment for their FEHB enrollees who enrolled in their Part C plan must add the risk payment received to the FEHB premium income, which is included in the denominator of the FEHB MLR calculation. The carrier must include all claims paid for these enrollees in the numerator of the MLR calculation.

High Deductible Health Plan (HDHP)
The pass-through amount put into a Health Savings Account (HSA) will be included in the numerator and the denominator of the FEHB MLR calculation. Only the portion of a Health Reimbursement Account (HRA) that is used for claims incurred during a MLR Calculation Year and paid through June 30, 2023 is included in the numerator of the FEHB MLR calculation.

Quality Improvement Activities Expenses (QIA)
Beginning in 2017, Centers for Medicare & Medicaid Services (CMS) gives insurers the option to report their QIA in the MLR reporting form as either 0.8% of earned premium or their actual QIA expenses. OPM is not making any changes to its current practice in reporting QIA in the FEHB MLR. If carriers include QIA in the FEHB MLR it must be based on their actual QIA expenses.

FEHBP Income

OPM will provide to carriers the incurred premium to be used in the MLR calculation from the OPM subscription income reports. The OPM supplied subscription income **must** be used in the MLR Calculation and is not subject to audit.
The denominator of the FEHB MLR calculation will be equal to the following:

(a) OPM supplied 2022 subscription income; plus
(b) Any amount due the plan as a direct result of reconciling the 2022 rates. This **excludes** amounts owed or due OPM from previous years' reconciliations*; less
(c) Any amount due OPM as a direct result of reconciling the 2022 rates. This **excludes** amounts owed or due OPM from previous years' reconciliations**.

*Any amount withheld due to an outstanding audit will be included in (b).
** Amounts recovered from the carrier due to an audit will be included in (c).

Performance Adjustment
If the performance adjustment that is based on 2022 Overall Performance Score is withheld from 2023 premiums, the following will apply. OPM will subtract the amount withheld from 2023 premiums,

which is based on 2022 Overall Performance Score, from the 2022 subscription income provided for use in the 2022 FEHB MLR Calculation. OPM will add the amount withheld from 2023 premiums to the 2023 subscription income provided for use in the 2023 FEHB MLR Calculation.

OPM will not include any performance adjustment payments in the OPM provided subscription income for purposes of the FEHB MLR Calculation.

Federal Tax
If the carrier calculates the Federal income tax attributable to the FEHB plan (to be subtracted from premium in the denominator of the FEHB plan's MLR calculation) based on its calculation of net income attributable to the FEHB plan, the carrier's calculation must tie to its financial statements and Federal income tax filing. If a tax rate is used in this calculation, and it is not the same rate that was used for the HHS Large Group MLR filing, the carrier must use its corporate effective tax rate for the year.

For purposes of this FEHB plan net income calculation, a carrier must determine its FEHB plan's expenses using the Carrier's reasonable, usual, and customary allocation practices (for example, direct allocation or indirect allocation that is premium, enrollment, or activity-based); except that a carrier may first directly attribute specific expenses and remove expenses that do not specifically apply to the FEHB plan, and then indirectly allocate remaining expenses (if any) using the Carrier's reasonable, usual, and customary allocation practices.

MLR Calculation

Aggregation
The carrier must aggregate by Plan as defined in Appendix 1.

MLR Calculation Form
OPM will send carriers the FEHB specific MLR Calculation form in the summer of 2023. The FEHB MLR Calculation Form will instruct plans on how to calculate the FEHB MLR.

FEHB MLR Target
The 2022 FEHB MLR Target will be 85.0%.

Corridor Calculation
If the plan's Adjusted FEHB MLR is 85.0% (the 2022 FEHB MLR Target) or higher no penalty is due OPM. If the plan's Adjusted FEHB MLR is below 85.0%, the carrier pays a penalty equal to the difference between the 85.0% and plan's actual Adjusted FEHB MLR, multiplied by the denominator of the plan's FEHB MLR calculation.

If the plan's Unadjusted FEHB MLR is above 90.0%, the plan receives a credit equal to the difference between the plan's Unadjusted FEHB MLR and 90.0%, multiplied by the denominator of the plan's FEHB MLR calculation. This credit can only be used to offset future FEHB MLR penalties. Credits received from the 2022 MLR Calculation will be available to offset any FEHB MLR penalties due based on the FEHB MLR Calculation for years 2023 through 2027. Upon exiting the Program, the carrier will not be paid the amount of the credit.

The upper bound of the Corridor Calculation and the amount of years the Corridor Calculation credit will be available to offset future FEHB MLR penalties will be put forth when the FEHB-specific MLR Target for the year is released.

❖ Similarly-Sized Subscriber Groups (SSSGs)

The following rules apply to carriers that are required by state mandate to rate groups using TCR. Carriers that are not state mandated to rate using TCR should follow the FEHB MLR instructions that begin on page 9 of the Community Rating Guidelines.

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 SSSG to determine if the carrier appropriately derived the Federal group rates.

Definition

Similarly Sized Subscriber Group (SSSG) is a non-FEHB *employer group* that:

(1) As of the date specified by OPM in the rate instructions, has a ***subscriber enrollment*** closest to the FEHBP subscriber enrollment;

(2) Uses traditional community rating;

(3) Reside in the federal group's ***rating region***; and

(4) Have at least 5% of the total ***subscriber enrollment*** in the federal group's ***rate code area*.**

Any group with which an entity enters into an agreement to provide health care services is a potential SSSG (including groups that are traditional community rated and covered by separate lines of business, government entities, groups that have multi-year contracts, groups having point-of-service products, and ***purchasing alliances***) except as specified below.

An entity's subscriber groups may be included as an SSSG if the entity is any of the following:

(1) The carrier;

(2) A division or subsidiary of the carrier;

(3) A separate line of business or qualified separate line of business of the carrier; or

(4) An entity that maintains a contractual arrangement with the carrier to provide healthcare benefits.

A subscriber group covered by an entity meeting any of the criteria above may be included for comparison as a SSSG if the entity meets any of the following criteria:

(1) It reports financial statements on a consolidated basis with the carrier; or

(2) Shares, delegates, or otherwise contracts with the carrier, any portion of its workforce that involves the management, design, pricing, or marketing of the healthcare product.

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 receive only excepted benefits;
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, 2021, and July 1, 2022);
8. ***Provider Partners***;
9. 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).

In the event that a State-mandated TCR carrier has no SSSG, then it will be subject to the FEHB specific MLR requirement.

Rules for SSSG Selection

One SSSG must be selected in each ***rate code area*** at the time of reconciliation.

The group's size is determined by the number of contracts that purchase a TCR product.

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 group closest in size to the Federal group at the time of reconciliation among the first five potential SSSGs will become the SSSG. From the first five, if at least one group does 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 one SSSG is 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). The SSSG will be chosen from the list on file, in the same manner as above, in the event that none 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 the group that meets the SSSG requirements at the time of reconciliation as the SSSG.

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***.

Enrollment and Contract Renewal Dates

Group size for the selected SSSG 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 TCR 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 equivalent to or better than the rates for the SSSG. Therefore, we expect the Federal group to receive at least the largest rate discount and any other advantage given to the 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.

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. 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.

Subsidized Rates for Multiple Products

For an SSSG that purchases both a TCR and non-TCR product and the TCR billed rate is subsidized by the non-TCR product(s), then the carrier must show that the total revenue billed to the SSSG is equal to the revenue required by using the standard rating methodology for all products. If the required revenue is less than the billed revenue, an equivalent discount must be given to FEHB. The carrier must provide OPM with the standard methodology for the non-TCR product(s) and demonstrate that this methodology was followed.

If the carrier does not provide information on the non-TCR product, FEHB must be given a discount equivalent to the difference in the billed rate and the required rate using the standard TCR methodology.

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 nonstandard 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 the SSSG is given a discount, that discount must only be applied to the insurance portion of the FEHB rate and not the pass-through amount.

Consistency of Rating Methods

The carrier is expected to use the same rating method for the Federal group as it uses for the SSSGs. **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 (OIG). 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.**

For TCR rated plans this includes documentation supporting the SSSG rates and the rates for all of the 10 groups closest in TCR subscriber size to the FEHBP.

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 and MLR calculations. The HHS MLR filing is not considered a source document.

If the carrier's rating methodology cannot be verified through state filings or rate documentations, OPM and OIG audit staff may examine other groups to determine the carriers rating methodology and practices. Other groups will only be examined when documentation is not available to support the entire FEHBP rate buildup and then only to ensure consistency and determine the process by which the FEHBP rates are built. The purpose is not to determine if the other groups received a discount.

Rate Build Up (Pricing) Claims Data for Audit Purposes

Carriers that use an ACR methodology for 2022 and base their FEHBP rates on group-specific claims or utilization data are required to maintain this claims data used in their FEHBP rate build up. **Carriers**

should use the data layout from the 2021 Carrier Letter for the 2022 rate proposal. Carriers are required to submit the claims data to the OIG for the 2022 rate proposal. The claims data for the FEHBP should be downloaded from a central database at the time the rates are developed. The information will be used for audit and investigative purposes.

The MLR Calculation is subject to audit and carriers must be able to support the information included in the calculation. For example, if a carrier owns a Medical Facility and administration costs are shared between the facility and the plan, the carrier must demonstrate that the administration costs included in the numerator are those of the Medical Facility and not those of the health plan.

❖ Appendix I

Definitions

ACR – the acronym for Adjusted Community Rating.

Adjusted FEHB MLR – the plan's FEHB MLR after the Small Group Adjustment.

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.

MLR – the acronym for Medical Loss Ratio

MLR Calculation Year – the year for which the MLR Calculation applies

MLR Target – MLR threshold, as referenced to in Section 1602.170–14

Plan – all options offered by a carrier within a contractually defined area. Normally this will be a single rate code however multiple rate codes may apply. For example, a carrier that offers a High, Standard and HDHP option in an area will have more than one rate code in the plan.

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 that 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 Only 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 Self Plus One or Self and Family rate.

Subscriber Enrollment – refers to contract enrollment. For example, this could be the total Self Only, Self Plus One, and Self 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.

Unadjusted FEHB MLR – the plan's FEHB MLR before any Small Group Adjustment.

❖ 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.**

❖ Appendix III

Selection of SSSGs Examples

The following examples illustrate OPM's policies.

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

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

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

The FEHBP has two rate code areas in Texas: one in Dallas and one in Houston. One SSSG is 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 the SSSG in Houston.

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

The FEHBP has two rate code areas in Texas: one in Dallas and one in Houston. One SSSG is 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 the SSSG 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. One SSSG is 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. One SSSG is 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 the SSSG 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. One SSSG is 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 the SSSG in Houston.

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

The FEHBP has one rate code for all enrollees. One SSSG is 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 within Texas and Arizona, that has at least 5% of its total enrollment in the federal rate code area, should be compared with the FEHBP enrollment to decide if the group is an SSSG. The group's rates in the two states will be used to determine any discounts.

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

The FEHBP has one rate code for all enrollees. One SSSG is 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.