PART 1602—DEFINITIONS OF WORDS AND TERMS

Authority: 5 U.S.C. 8903c and 8913; 40 U.S.C. 486(c); 48 CFR 1.301.

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Parent topic: SUBCHAPTER A—GENERAL

1602.000-70 Scope of part.

This part defines words and terms commonly used in this regulation.

Subpart 1602.1—Definitions of FEHBP Terms

1602.170 Definition of terms.

In this chapter, unless otherwise indicated, the following terms have the meaning set forth in this subpart.

1602.170-1 Carrier.

Carrier means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, delivering, paying for, or reimbursing the cost of health care services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, including a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services, in consideration of premiums or other periodic charges payable to the carrier.

1602.170-2 Community rate.

(a) *Community rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to “a combination of cost and price analysis” relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) *Adjusted community rate* means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group, except as described in 1615.402(c)(4).

1602.170-3 Comprehensive medical plan.

Comprehensive Medical Plan means a plan as defined under 5 U.S.C. 8903(4).

1602.170-4 Contractor.

Contractor means carrier.

1602.170-5 Cost or pricing data.

(a) *Experience-rated carriers.* Cost or pricing data for experience-rated carriers includes:

(1) Information such as claims data;

(2) Actual or negotiated benefits payments made to providers of medical services for the provision of healthcare, such as capitation not adjusted for specific groups, including mental health benefits capitation rates, per diems, and Diagnostic Related Group (DRG) payments;

(3) Cost data;

(4) Utilization data; and

(5) Administrative expenses and retentions, including capitated administrative expenses and retentions.

(b) *Community rated carriers.* Cost or pricing data for community rated carriers is the specialized rating data used by carriers in computing a rate that is appropriate for the Federal group and similarly sized subscriber groups (SSSGs). Such data include, but are not limited to, capitation rates; prescription drug, hospital, and office visit benefits utilization data; trend data; actuarial data; rating methodologies for other groups; standardized presentation of the carrier's rating method (age, sex, etc.) showing that the factor predicts utilization; tiered rates information; “step-up” factors information; demographics such as family size; special benefit loading capitations; and adjustment factors for capitation. After the 2012 plan year, reconciled rates for community rated carriers, other than those required by state law to use Traditional Community Rating (TCR), will be required to meet an FEHB-specific medical loss ratio threshold published annually in OPM's rate instructions to FEHB carriers.

1602.170-6 Director.

Director means the Director of the Office of Personnel Management.

1602.170-7 Experience-rate.

Experience-rate means a rate for a given group that is the result of that group's actual paid claims, administrative expenses (including capitated administrative expenses), retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and economic trends. Actual paid claims include any actual or negotiated benefits payments made to providers of services for the provision of healthcare such as capitation not adjusted for specific groups, including mental health benefits capitation rates, per diems, and DRG payments.

1602.170-8 FEHBP.

FEHBP means the Federal Employees Health Benefits Program.

1602.170-9 Health benefits plan.

Health benefits plan means a group insurance policy, contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, arranging for, delivering, paying for, or reimbursing any of the costs of health care services.

1602.170-10 Letter of credit.

Letter of credit means the method by which certain carriers, and their underwriters if authorized, receive recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each carrier participating in the letter of credit arrangement for payment under this part, the terms “carrier reserves,” and “special reserves” include any balance in the carrier's letter of credit account.

1602.170-11 Negotiated benefits contracts.

Negotiated benefits contracts are FEHBP contracts in which benefits provided and subscription income are based on either community rating or experience rating.

1602.170-12 OPM.

OPM means the Office of Personnel Management.

1602.170-13 Similarly sized subscriber groups.

(a) A *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; and,

(3) Meets the criteria specified in the rate instructions issued by OPM.

(b) 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, and groups having point-of-service products) except as specified in paragraph (c) of this section.

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

(i) The carrier;

(ii) A division or subsidiary of the carrier;

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

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

(2) A subscriber group covered by an entity meeting any of the criteria under paragraph (b)(1) of this section may be included for comparison as a SSSG if the entity meets any of the following criteria:

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

(ii) 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.

(c) The following groups must 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-only groups, and groups that receive only excepted benefits as defined at 26 U.S.C. 9832(c);

(4) A purchasing alliance whose rate-setting is mandated by the State or local government;

(5) Administrative Service Organizations (ASOs);

(6) Any other group excluded from consideration as specified in the rate instructions issued by OPM.

(d) OPM shall determine the FEHBP rate by selecting the lowest rate derived by using rating methods consistent with those used to derive the SSSG rate.

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

1602.170-14 FEHB-specific medical loss ratio threshold calculation.

(a) *Medical Loss Ratio* (MLR) means the ratio of plan incurred claims, including the carrier's expenditures for activities that improve health care quality, to total premium revenue determined by OPM, as defined by the Department of Health and Human Services in 45 CFR part 158.

(b) The FEHB-specific MLR will be calculated on an annual basis. This FEHB-specific MLR will be measured against an FEHB-specific MLR threshold to be put forth by OPM no later than 12 calendar months before the beginning of plan years 2014 and beyond. OPM will publish the FEHB-specific MLR threshold no later than 8 months before the beginning of plan year 2013.

(c) In place of the credibility adjustment at 45 CFR 158.230-158.232, OPM will set a separate credibility adjustment to account for the special circumstances of small FEHB plans in annual rate instructions to carriers.

1602.170-15 Subcontractor.

Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

1602.170-16 Large Provider Agreement.

(a) *Large Provider Agreement* means an agreement between—

(1) An FEHB carrier, at least 25 percent of which total contracts are FEHB enrollee contracts, and

(2) A vendor of services or supplies such as mail order pharmacy services, pharmacy benefit management services, mental health and/or substance abuse management services, preferred provider organization services, utilization review services, and/or large case or disease management services. This representative list includes organizations that own or contract with direct providers of healthcare or supplies, or organizations that process claims or manage patient care. A hospital is not considered to be a vendor for purposes of this chapter.

(i) Where the total costs charged to the FEHB carrier for a contract term for FEHB members, including benefits and services, are reasonably expected to exceed 5 percent of the carrier's total FEHB benefits costs, or

(ii) Where the total administrative costs charged to the FEHB carrier for the contract term for FEHB members are reasonably expected to exceed 5 percent of the carrier's total FEHB administrative costs (applicable to agreements where the provider is not responsible for FEHB benefits costs).

(3) As used in this section, the term “carrier” does not include local health plans that serve under an umbrella arrangement with an FEHB carrier.

(b) The FEHB Program Annual Accounting Statement for the FEHB Plan for the prior contract year will be used to determine the 5 percent threshold under Large Provider Agreements.

(c) Large Provider Agreements based on cost analysis are subject to the provisions of FAR 52.215-2, “Audit and Records-Negotiation.”

(d) Large Provider Agreements based on price analysis are subject to the provisions of 48 CFR 1646.301 and 1652.246-70.

1602.170-17 Postal Service.

Postal Service means the United States Postal Service.

1602.170-18 Postal Service annuitant.

Postal Service annuitant has the meaning set forth in 5 U.S.C. 8903c(a)(8).

1602.170-19 Postal Service employee.

Postal Service employee has the meaning set forth in 5 U.S.C. 8903c(a)(9).

1602.170-20 PSHB Carrier.

PSHB Carrier means a carrier that enters into a contract with OPM under 5 U.S.C. 8902 to offer a health benefits plan in the PSHB Program.

1602.170-21 PSHB plan.

PSHB plan means a health benefits plan offered under the PSHB Program.

1602.170-22 PSHB Program.

Postal Service Health Benefits (PSHB) Program means the Program established under 5 U.S.C. 8903c within the Federal Employees Health Benefits Program.