

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.

[62 FR 47573, Sept. 10, 1997]

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).

[55 FR 27414, July 2, 1990, as amended at 62 FR 47573, Sept. 10, 1997; 76 FR 38284, June 29, 2011]

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.

[62 FR 47574, Sept. 10, 1997, as amended at 70 FR 31378, June 1, 2005; 76 FR 38285, June 29, 2011]

1602.170-6 Director.

Director means the Director of the Office of Personnel Management.

[52 FR 16038, May 1, 1987. Redesignated at 62 FR 47574, Sept. 10, 1997]

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.

[70 FR 31378, June 1, 2005]