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.

[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]

1602.170–8 FEHBP.

FEHBP means the Federal Employees Health Benefits Program.

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

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.

[62 FR 47574, Sept. 10, 1997]

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.

[53 FR 51783, Dec. 23, 1988, as amended at 57 FR 14359, Apr. 20, 1992. Redesignated at 62 FR 47574, Sept. 10, 1997]

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.

[62 FR 47574, Sept. 10, 1997]

1602.170–12 OPM.

OPM means the Office of Personnel Management.

[52 FR 16038, May 1, 1987. Redesignated at 53 FR 51783, Dec. 23, 1988 and further redesignated at 62 FR 47574, Sept. 10, 1997]

§ 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