

1601.106

1601.106 OMB approval under the Paperwork Reduction Act.

The Paperwork Reduction Act of 1980 (Pub. L. 96-511) requires Federal agencies to obtain approval from the Office of Management and Budget (OMB) before collecting information from ten or more members of the public. The information collection and recordkeeping requirements contained in this regulation have been approved by the OMB. The following OMB control numbers apply.

Provision	Control No.
FEHBAR 1604.705	3206-0145
FAR 9.1	3206-0145

[52 FR 16037, May 1, 1987. Redesignated at 70 FR 31378, June 1, 2005]

Subpart 1601.3—Agency Acquisition Regulation (FEHBAR)

1601.301 Policy.

(a) Procedures, contract clauses, and other aspects of the acquisition process for contracts in the FEHBP shall be consistent with the principles of the FAR. Changes to the FAR that are otherwise authorized by statute or applicable regulation, dictated by the practical realities associated with the unique nature of health care procurements, or necessary to satisfy specific needs of the Office of Personnel Management shall be implemented as amendments to the FEHBAR and published in the FEDERAL REGISTER, or as deviations to the FAR in accordance with FAR subpart 1.4.

(b) Internal procedures, instructions, and guides that are necessary to clarify or implement the FEHBAR *within* OPM may be issued by agency officials specifically designated by the Director, OPM. Normally, such designations will be specified in the OPM Administrative Manual, which is routinely available to agency employees and will be made available to interested outside parties upon request. Clarifying or implementing procedures, instructions, and guides issued pursuant to this section of the FEHBAR must—

(1) Be consistent with the policies and procedures contained in this regu-

48 CFR Ch. 16 (10-1-13 Edition)

lation as implemented and supplemented from time to time; and

(2) Follow the format, arrangement, and numbering system of this regulation to the extent practicable.

PART 1602—DEFINITIONS OF WORDS AND TERMS

Sec.

1602.000-70 Scope of part.

Subpart 1602.1—Definitions of FEHBP Terms

1602.170 Definition of terms.

1602.170-1 Carrier.

1602.170-2 Community rate.

1602.170-3 Comprehensive medical plan.

1602.170-4 Contractor.

1602.170-5 Cost or pricing data.

1602.170-6 Director.

1602.170-7 Experience rate.

1602.170-8 FEHBP.

1602.170-9 Health benefits plan.

1602.170-10 Letter of credit.

1602.170-11 Negotiated benefits contracts.

1602.170-12 OPM.

1602.170-13 Similarly sized subscriber groups.

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

1602.170-15 Subcontractor.

1602.170-16 Large Provider Agreement.

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

SOURCE: 52 FR 16038, May 1, 1987, unless otherwise noted.

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

Office of Personnel Management

1602.170-7

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]