FEHB Program Carrier Letter
All Experience-Rated Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2024-01

Date: January 23, 2024

Fee-for-service [1] Experience-rated HMO [1] Community-rated HMO [n/a]

Subject: Experience Rated Carrier Reporting Requirements

This Carrier Letter updates reporting requirements for Experience Rated Carriers previously outlined in CL 2006-22, CL 2011-03, and CL 2012-20. In the event of a conflict between this letter and a prior FEHB Carrier Letter, this letter supersedes.

Experience Rated Plan Reporting

Experience Rated Carriers must submit quarterly the Triangle, Letter of Credit Account (LOCA) and Incurred But Not Reported (IBNR) reports described below. Reports should be submitted to the Rate Submission Tool using the 'Additional Reporting' option by the 15th of the month following the end of each quarter. These reports must be submitted timely. Late submissions or failure to report may impact a Carrier's negotiated service charge.

Triangle Table Reports

Triangle table reports detail FEHB claims by paid and incurred month and are used by OPM's Office of the Actuaries to analyze FEHB rate proposals and monitor emerging experience.

A separate triangle report must be submitted for each plan option. Each report must, at minimum, include the following tabs within the workbook:

- Medical Claims (claims paid through the medical benefit including medical drug claims)
- Pharmacy Claims (claims paid through the pharmacy benefit net of Point of Sale rebates, if applicable)
- Drug Rebates (rebates paid through the pharmacy benefit net of Point of Sale rebates, and rebates paid through the medical benefit by incurred year and paid quarter)
- PDP EGWP offsets including CMS Direct Subsidies, Low Income Subsidies, CMS reinsurance payments and Manufacturer discounts, if applicable
- Total Claims

Tabs for specific claims, such as Dental claims, may also be broken out in a separate tab if preferred.

Claims for all members enrolled, including Tribal members, are to be included in triangle reports. Triangle reports must cover, at minimum, the prior 48 months. If the option has been offered in the FEHB for less than 48 months, include all months since first offering.

For any items that would not typically appear in a traditional claims triangle report but would impact the total claims experience of an option for rate development purposes, please include these items in distinct rows by paid date below the triangle table. For example, capitation payments, Medicare Part B premium reimbursements, reinsurance recoveries not already reflected in the triangle table, and HSA pass throughs should be detailed below the triangle table. Carriers should add or delete rows beneath the triangle table to reflect the experience of a particular option.

Letter of Credit Account (LOCA) Reports

LOCA Reports detail the amount drawn by month from the LOCA and what portion of that amount is drawn for claims by option.

Carriers must also provide an explanation if LOCA draws (less offsets to draws such as drug rebates) do not tie to reported paid claims and other allowed costs.

CL 2012-20 required the amount drawn for claims reported in the LOCA reports to be broken down by Tribal and Non-Tribal members. We are no longer requiring this breakdown.

Incurred But Not Reported (IBNR) Reports

IBNR reports provide estimates of the expected remaining claims liability by month of incurred service. These reports provide a carrier's estimate of total claims incurred in a given period.

A separate IBNR report must be submitted for each option. The IBNR estimates by month should cover at least the prior 36 months. A separate IBNR estimate should be developed for medical and drug claims, as well as estimates of total ultimate claims by year.

Fee-for-Service (FFS) Plan Reporting

In addition to the Experience Rated Reporting discussed above, all FFS plans must annually submit C-Table reports for claims incurred in a given year and paid through June 30 of the following year. These reports should be submitted to the Rate Submission Tool using the 'Additional Reporting' option by July 31 of the year following the plan year being reported. These reports must be submitted timely. Late submissions or failure to report may impact a Carrier's negotiated service charge.

C-Table Reports

C-Table reports include the C1 and C2 report. The C1 report details claims incurred by category or service in a given plan year by option. The C2 report details utilization information by category or service incurred in a given plan year by option. FFS Carriers must submit these reports on an annual basis.

Submit a C1 and C2 Table report for each option. Each report must include the following tabs:

- Actives
- Annuitants with Medicare A only
- Annuitants with Medicare A and B
- Annuitants without Medicare
- Total

For options that offer a MA-PD or PDP EGWP to their eligible FEHB members where there is a fully capitated agreement between the Carrier and the PDP sponsor, provide a separate tab for these members. For example, an option with this type of PDP EGWP would provide the tabs listed above for non-PDP EGWP members and a separate tab for PDP EGWP members. For options that offer a PDP EGWP to their eligible FEHB members where there is not a fully capitated agreement between the Carrier and the PDP sponsor, any offsets to drug claims that occur through the PDP and are not already captured in the claims reported in the C-table (direct subsidy, etc.) should be captured separately as a line item either in or below the C-table. An additional line item for EGWP drug claims in the Drug section separate from the non-EGWP retail and mail order drug claims should also be included.

Rebates not already reflected in the C-table reports and any other adjustments to claims, such as subrogation, should be listed below the table. We expect any point of sale drug rebates will be reflected in the C-table values. If this is not the case, please provide explanation.

Report Templates

A template for the Triangle, LOCA, IBNR, and C-Table reports, as applicable will be emailed directly to your actuarial contact listed in the Rate Submission Tool. Any information or files in addition to what is included in the templates a carrier would like to provide can be submitted along with the required reports. Please contact us for approval if deviation from the template is required.

Timing of Reports

Please make any updates to meet the criteria outlined in this letter as soon as possible but no later than the due date for the second quarter 2024 reports (July 15, 2024).

Please direct any questions regarding the reporting outlined in this Carrier Letter to actuary@opm.gov.

Sincerely,

Laurie E. Bodenheimer
Associate Director
Healthcare and Insurance