

## APPENDIX 7

### PLAN UTILIZATION AND RATE REVIEW INFORMATION

NAME OF PLAN: \_\_\_\_\_

SERVICE AREA COVERED: \_\_\_\_\_

PREMIUM RATES BASED ON:

- COMMUNITY RATED EXPERIENCE
- STATE EMPLOYEE EXPERIENCE\*
- LOCAL EMPLOYEE EXPERIENCE\*
- OTHER (PLEASE SPECIFY BASIS)
- \* USE SEPARATE ADDENDUM 1 PAGES

This Rate Review information shall be provided June 3, 2016. It must be submitted directly to the Board's Actuary in the prescribed Excel format via e-mail. The accompanying data shall also be submitted on the same date in the prescribed format via a secure file transfer.

The Department will provide written guidelines to the plan concerning the definitions, group numbers or subgroups, report period, and other information required to prepare this report. Additional data may be required on different subgroups (COBRA participants, for example) throughout the contract year.

#### STATE OF WISCONSIN ACTUARIAL DATA REPORT GENERAL TABLE DESCRIPTION

Based upon the membership, experience data, trend assumptions, and assumed administrative costs provided, the data and calculations provided in TABLES 1-15 of the Addendum 1 utilization and experience data request calculate prospective premium rates for calendar year 2015. Any plan for which proposed calendar year 2017 premium rates differ from those developed in Addendum 1 TABLES 1-15 will be required to submit its justification and applicable renewal calculation.

#### TABLE 1 – MONTHLY ENROLLMENT AND PREMIUMS

TABLE 1 will calculate average contract size and contract mix figures based upon data provided. The number of member months and contracts for the period 1/1/2015-3/31/2016 should be input for single coverage in Columns B and C and for family coverage in Columns D and E.

The contractual premium rates by coverage tier should be entered on line 30. Row 31 should be the dental benefit component of the 2015 premium applicable to the prior dental benefit. Row 32 should include any other adjustments that may have been made to the contractual premium rates. The net premium is calculated on row 33 as row 30 less rows 31 and 32.

The remainder of the worksheet will auto calculate, including rows 43-44 that calculate average contract size and mix for single and family coverage.

## TABLE 2 – ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

The first section of TABLE 2 requests the member counts for the period of 4/1/2015-3/31/2016 by age group and sex (regardless of whether the member is an employee or a dependent).

The second section of TABLE 2 requests the member counts for December 2015 by age group and sex (regardless of whether the member is an employee or a dependent).

The third section of TABLE 2 requests the member counts for March 2016 by age group and sex (regardless of whether the member is an employee or a dependent).

A box at the bottom of TABLE 2 will show the automatically calculated average age and average age/sex factor.

The age calculation should be based on the employee or dependent's age on the first day of the month.

All counts should reconcile to TABLE 1.

## TABLE 3 – ACTUARIAL DATA REPORTS

**TABLE 3A: APRIL 1, 2015 THROUGH MARCH 31, 2016 FEE FOR SERVICE CLAIMS**

**TABLE 3B: APRIL 1, 2015 THROUGH MARCH 31, 2016 CAPITATION ENCOUNTER**

### GENERAL DESCRIPTION

TABLE 3 requests fee-for-service claims and capitation encounter experience information for all health plans, whether they are experience rated or fully or partially capitated. There are separate sections for medical fee-for-service and capitation encounter data (TABLES 3A and 3B, respectively). Please complete those portions of the data request that are applicable to your type of plan.

➤ Category: One report is requested for each of the following eight categories:

- i. State of Wisconsin Employee Plan, Non-Medicare, Non Graduate Assistant
- ii. State of Wisconsin Employee Plan, Medicare
- iii. State of Wisconsin Employee Plan, Graduate Assistant
- iv. State of Wisconsin Local Plan, Non-Medicare
- v. State of Wisconsin Local Plan, Medicare
- vi. State of Wisconsin High Deductible Plan
- vii. Total Organization, Non-Medicare/Commercial
- viii. Total Organization, Medicare

**A title worksheet is included in the first tab of the workbook. Use the dropdown box to specify the category of each report.**

For the Medicare lines of business (State & Local), the experience and membership provided should include only those members who are Medicare-eligible (no non-Medicare eligible spouses or other dependents). Please respond to the questions in TABLE 11 and indicate if this is not the case.

**Please note that the Total Organization refers to all commercial group business for your organization, including the State of Wisconsin but excluding Medicaid participants.** If you offer more than one plan option to either Non-Medicare or Medicare State of Wisconsin Employee or Local Plan participants, please include a separate report for each option.

➤ Report Period

The report should include all services rendered from April 1, 2015 through March 31, 2016.

➤ Benefit Description

Refer to the section immediately following for a detailed description of services to be included in each benefit category. If you are unable to follow these definitions, indicate the reason why and the actual definition used.

➤ Total Number of Admissions

For hospital inpatient services, the total number of admissions rendered for all members during the Report Period.

➤ Total Number of Days

For hospital inpatient services, the total number of hospital days rendered for all members during the Report Period.

➤ Total Billed Charges

For all services, the total billed charges. Billed charges are defined as undiscounted charges for covered services during the requested Report Period. The experience should not include any billed charges for services not covered by the plan, The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

➤ Total Allowed Charges

For all services, the total allowed charges. Allowed charges are defined as discounted charges for covered services during the requested Report Period. The experience should not include any allowed charges for services not covered by the plan. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

➤ Total COB (including Medicare)

For all services, the total amount paid for covered services by another carrier or Medicare through coordination of benefits during the requested Report Period.

➤ Total Member Cost Share

For all services, the total member cost share. Member cost share is defined as any participant/member liabilities such as copayments, coinsurance or deductibles applicable for covered services during the requested Report Period.

➤ Total Paid Charges

For all services, the total paid claims. Paid claims are defined as discounted charges net of employee cost-sharing during the requested Report Period. In other words, the experience should not include any participant/member liabilities such as copayments, coinsurance or deductibles. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

➤ Total Number of Member Months

The Total Number of Member Months is the number of months each member and dependent is eligible for benefits during the Report Period. Please note that this cell is linked to the total 4/1/2015-3/31/2016 member months from TABLE 1.

➤ Annual Admissions Per 1,000

For hospital inpatient services, calculated as the total Number of Admissions divided by the Total Number of Member Months, times 12,000.

➤ Annual Days Per 1,000

For hospital inpatient services, calculated as the Total Number of Days divided by the Total Number of Member Months, times 12,000.

➤ Average Length of Stay

For hospital inpatient services, calculated as the Total Number of Days divided by Total Number of Admissions.

➤ Average Paid Charges Per Day

For hospital inpatient services, calculated as Total Paid Charges divided by the Total Number of Days.

➤ Average Paid Charges Per Member Per Month

Calculated as Total Paid Charges divided by the Total Number of Member Months.

➤ Total Number of Services

For non-hospital inpatient services, the total number of services rendered for all members during the Report Period. Please note the services are defined in the Benefit Description section.

➤ Annual Services Per 1,000

For non-hospital inpatient services, calculated as Total Number of Services divided by the total Number of Member Months, times 12,000.

➤ Average Paid Charges Per Service

For non-hospital inpatient services, calculated as the Total Paid Charges divided by the Total Number of Services.

➤ Fee For Service Incurred Claim Factor

This factor is the estimated percentage of paid claims for the specified Report Period that have not yet been recorded or paid. Incurred Claims will be calculated as  $(1 + \text{Incurred Claim Factor})$  multiplied by the Total Paid Charges.

➤ Number of Runout Months

This is the number of months of experience that have been included in Paid Charges beyond the specific incurred Report Period of 4/1/2015-3/31/2016. For example, if a plan includes experience for claims that were incurred from 4/1/2015-3/31/2016 and paid through 5/31/2016, the Number of Runout Months would equal two, and the Incurred Claim Factor should be reflective of the Number of Runout Months.

➤ Incurred Fee-For-Service Total

Incurred claims will be calculated as  $(1 + \text{Incurred Claim Factor})$  multiplied by the Paid Charges. This represents the total amount of claims that have been incurred in the Reporting Period.

➤ Total Capitation Paid

The total capitation payments paid during the Report Period. This will calculate automatically from Total Paid Capitation during the Report Period entered on Table 4.

## **BENEFIT DESCRIPTION FOR TABLES 3A and 3B**

TABLE 3A requests medical fee-for-service utilization and claims experience for the period 4/1/2015-3/31/2016. TABLE 3B requests medical capitation encounter data for the period 4/1/2015-3/31/2016.

The following benefit descriptions should be used in developing the Actuarial Data Report. Where possible, Current Procedural Terminology Codes—CPT 2014 Professional Edition, (CPT-4 codes) has been included to aid in the summarization of information. The appropriate HCFA Common Procedure Coding System (HCPCS) Level II codes are also included. For services affected by the Medicare Resource Based Relative Value System (RBRVS), both the CPT code ranges used prior to RBRVS and the evaluation and management CPT code ranges introduced by RBRVS have been included.

**Note: There have been no changes to the mapping this year and the required data submission utilizes identical methodology.**

### **A. HOSPITAL INPATIENT**

This benefit includes daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. Services are counted as the number of admissions and the number of days confined. Ancillary charges should not include professional charges for hospital-based physicians.

#### **1. Non-Maternity**

a. Medical: A medical admission includes a confinement without a major surgery and without a diagnosis indicating a substance abuse or psychiatric condition.

b. Surgical: A surgical admission includes a confinement primarily resulting from a surgery or multiple surgeries.

c. Mental Health: A psychiatric admission includes a confinement with a primary diagnosis involving a psychiatric condition.

d. Substance Abuse: A substance abuse admission includes a confinement with a primary diagnosis involving an alcohol and/or drug abuse condition.

## **2. Maternity**

a. Maternity Deliveries: This benefit includes hospital inpatient room and board and ancillary services for normal and cesarean deliveries for the mother. Charges for the well newborn baby should be included, but newborn admissions and days should be excluded.

b. Maternity - Non-Deliveries: This benefit includes hospital inpatient room and board and ancillary services for complications of pregnancy and pregnancies that do not result in a delivery due to miscarriage or therapeutic abortion.

c. Neonatal ICU: This benefit includes hospital inpatient room and board and ancillary services for premature infants or other neonatal care.

## **3. Extended Care Facility**

This benefit includes daily room and board and ancillary services in an approved extended care facility. The facility may be either the extended care ward of a community hospital or an independent skilled nursing facility. Ancillary services include inpatient nursing care, pathology and radiology procedures, drugs and supplies.

## **B. HOSPITAL OUTPATIENT**

### **1. Emergency Room**

This benefit includes services for emergency accident and medical care performed in the emergency area of a hospital outpatient facility. Services are counted as the number of visits to the emergency room. Charges should include facility charges only and not professional charges.

### **2. Outpatient Surgery**

This benefit includes hospital outpatient services for surgery, including surgery performed in a hospital outpatient facility or a freestanding surgical facility. Services are counted as the number of surgical procedures and not the number of outpatient surgical encounters. Charges should include facility charges only and do not include professional charges.

### **3. Radiology**

This benefit includes the technical component of radiology services performed by a hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

### **4. Pathology**

This benefit includes the technical component of pathology services performed by the hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

## 5. Outpatient Mental Health

This benefit includes mental health outpatient services. Services are counted as the number of visits to the outpatient mental health facility. Charges should include facility charges only and not professional charges.

## 6. Outpatient Substance Abuse

This benefit includes substance abuse outpatient services. Services are counted as the number of visits to the outpatient substance abuse facility. Charges should include facility charges only and not professional charges.

## 7. Other

This benefit includes hospital outpatient services other than emergency room, surgery, radiology and pathology, such as physical therapy, maternity non-delivery, and supplies. Services are counted as the number of procedures. Charges should include facility charges only and not professional charges.

## 8. Other Facility

a. Hospice: This benefit includes all facility charges and services provided in a hospice for a terminally ill patient and family. Charges incurred in the hospice ward of a hospital are included as well as in a stand-alone hospice facility.

b. Transitional Care: This benefit includes substance abuse rehabilitation services provided in a transitional care program. Services may be provided in a hospital outpatient or day care setting and charges would include professional and facility charges.

## C. PHYSICIAN

### 1. Surgical Services

a. Inpatient Surgery:

(1) Professional Surgeon (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgeries performed by a surgeon on an inpatient basis. Services are counted as the number of inpatient surgical procedures and not the number of surgical admissions. Charges should include normal pre-surgical and post-surgical encounters with the surgeon and would include both primary and assistant surgeon charges.

b. Anesthesia:

(1) Inpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140 or 10040-69990 with anesthesia modifier)

This benefit includes services by an anesthesiologist or anesthesiologist for non-maternity and maternity surgeries performed in an inpatient setting. Services are counted as the number of inpatient surgical procedures requiring anesthesia. Charges should include inpatient pre-surgical and post-surgical encounters, and the usual monitoring procedures.

(2) Outpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140, or 10040-69990 with anesthesia modifier)

Same as above except in an outpatient setting, including a hospital outpatient department, freestanding surgical facility or physician's office.

c. Maternity:

(1) Normal Deliveries (CPT-4 Codes 59400-59430, 59610-59614)

This benefit includes physician obstetrical care for normal deliveries and complications of pregnancy that result in a normal delivery. Services are counted as the number of maternity cases that result in a normal delivery. Charges should include delivery care and standard pre- and post-natal visits.

(2) Cesarean Deliveries (CPT-4 Codes 59510-59515, 59618-59622)

This benefit includes physician obstetrical care for cesarean deliveries and complications of pregnancy that result in a cesarean delivery. Services are counted as the number of maternity cases that result in a cesarean delivery. Charges should include delivery care and standard pre-natal and post-natal visits.

(3) Other OB Services (CPT-4 Codes 59000-59350, 59812-59899)

This benefit includes physician obstetrical care for pregnancies that do not result in a delivery due to a complication, miscarriage or therapeutic abortion as well as other obstetrical services that are not related to a delivery (e.g. amniocentesis, fetal monitoring, etc.). Services are counted as the number of procedures.

Charges should include surgical care and standard pre-natal visits.

d. Outpatient Surgery:

(1) Outpatient Surgical Center (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit provides for surgery by a physician in a hospital outpatient department or a freestanding surgical facility. Services are counted as the number of outpatient procedures and not the number of outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with a surgeon.

(2) Office (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgery by a physician in the physician's office. Services are counted as the number of office outpatient surgical procedures and not the number of office outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with the physician.

## **2. Physician — Inpatient Visits**

- a. Hospital Visits (CPT-4 Codes 99217-99239, 99289-99300, 99460, 99462-99465, HCPCS Codes M0064-M0100)

This benefit includes visits to hospitals by a physician. Services are counted as the number of visits. Physician visits by the surgeon in the case of a surgery should be included in the surgery benefit.

- b. Critical Care Visits (CPT-4 Codes 99170-99199, 99289-99292, 99466-99480)

This benefit includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician (e.g. cardiac arrest, shock, bleeding, respiratory failure, etc.). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Services are counted as the number of procedures.

- c. Mental Health Visits (CPT-4 Codes 90785-90899; HCPCS Codes G0176-G0177, H0001-H2999, M0064-M0100)

This benefit includes visits to hospitals for a psychiatric patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

- d. Substance Abuse Visits (CPT-4 Codes 90791-90792, 90832-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes visits to hospitals for a substance abuse patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

- e. Extended Care Visits (CPT-4 Codes 99304-99318, HCPCS Codes M0064-M0100)

This benefit includes physician visits to approved extended care facilities. Services are counted as the number of procedures.

- f. Home Health Visits (CPT-4 Codes 99324-99350, 99500-99602, HCPCS Codes M0064-M0100)

This benefit includes physician visits in the insured's home or a custodial facility. It does not include visits by a nurse. Services are counted as the number of visits.

## **3. Office Services**

- a. Office Visits (CPT-4 Codes 99143-99150, 99201-99215, HCPCS Codes M0064-M0100)

This benefit includes visits to a physician's office. Physical exams, well baby exams and any pre-surgical or post-surgical visits are included elsewhere. Services are counted as the number of visits. Charges should include professional fees of the primary physician or the referral physician. Charge levels should include only the physician's time; the charges for lab or x-ray procedures performed in the physician's

office and medications are included elsewhere.

b. Therapeutic Injections (J Codes) (CPT-4 Codes 96360-96379; HCPCS Codes J0120-J8999, J9019, J9042)

This benefit includes professional services and materials associated with therapeutic injections when administered by the staff of the attending physician. Immunizations are not included. Services are counted as the number of procedures.

c. Allergy Testing/Allergy Immunotherapy (CPT-4 Codes 95004-95079, 95115-95199, HCPCS Codes G0008-G0010, J0171-J8999)

This benefit includes professional services and materials associated with allergy tests when administered by the staff of the attending physician. This benefit also includes professional services and materials associated with allergy immunotherapy (serum, syringes, etc.) when administered by the staff of the attending physician. Services are counted as the number of procedures.

d. Chemotherapy Drugs (HCPCS Codes J9000-J9999, excluding codes J9019 and J9042.)

This benefit includes professional services and materials associated with chemotherapy drugs when administered by the staff of the attending physician. Services are counted as the number of procedures.

e. Diagnostic Testing

This benefit provides for the following professional services: Service

	<u>CPT-4 or HCPCS Codes</u>
Biofeedback	90901-90911
Gastroenterology	91000-91299
Otorhinolaryngology Services	92502-92505, 92511-92526, 92700
Vestibular Function Tests	92531-92548
Non-Invasive Peripheral Vascular Diagnostic Studies	93875-93998
Pulmonary	94002-94799
Neurology	95782, 95783, 95800-96020
Chemotherapy	96401-96549, HCPCS Codes Q0083-Q0085
Dermatology	96900-96999
Miscellaneous	96101-96125, 96150-96155, 99000-99091, 99175-99199, 99354-99360, 99477-99499, HCPCS Code G9143

Not all of the above procedures are necessarily diagnostic testing. They were included in this benefit because they are related to diagnostic testing. Services are counted as the number of procedures.

f. Urgent Care

This benefit includes services for medical care performed in an urgent care facility. Services are counted as the number of visits to the urgent care center. Charges should include both facility and professional charges.

g. Other (HCPCS Codes A4206-A4608, A4641-A4652, A5051-A9999, B4000-B5200, M0075-M0100)

This benefit includes physician office services not included elsewhere. Services are counted as the number of procedures.

**4. Other Physician Services**

a. Emergency Room Visits (CPT-4 Codes 99281-99288)

This benefit includes visits to the emergency area of a hospital outpatient facility by either a primary care physician or a hospital staff physician. Services are counted as the number of visits.

b. Consults (CPT-4 Codes 99241-99255, 97802-97804, HCPCS G0270-G0271)

This benefit includes a consulting specialist and presumes the primary care physician has due cause to seek consultation. A consultation includes services rendered by a physician or other appropriate source for the further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. Consultations can be provided for both inpatient and outpatient care. Services are counted as the number of consultations.

c. Cardiovascular (CPT-4 Codes 92950-93799; HCPCS Codes M0300-M0301, Q0035)

This benefit includes therapeutic services (e.g. CPR), cardiography (e.g. EKGs), cardiac catheterization and other cardiovascular services performed by a physician. Services are counted as the number of procedures.

d. Dialysis (CPT-4 Codes 90935-90999; HCPCS Codes A4650-A4932, E1500-E1699, M0064-M0100)

This benefit includes services by a physician and staff for dialysis treatment including hemodialysis, peritoneal dialysis and miscellaneous dialysis procedures. Services are counted as the number of procedures.

e. Other Physician Services (CPT-4 Codes 96567-96571, 99143-99150, 99363-99380; Miscellaneous HCPCS Codes)

This benefit includes physician services not allocated to other line items. Services are counted as the number of procedures.

f. Radiology:

- (1) Inpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by a physician when the x-ray is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of radiology services should be included in the hospital inpatient benefit.

- (2) Outpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by the physician when the x-ray is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of radiology services should be included in the Hospital Outpatient - Radiology benefit or in the Physician - Radiology - Office (Combined Professional and Technical) benefit.

- (3) Office - (Combined Professional and Technical) (CPT-4 Codes 70010-77032, 77071-79999; HCPCS Codes Q0092, R0000-R5999)

This benefit includes both the professional and technical component of radiology services when these services are billed together. Services are counted as the number of procedures. Charges should only be included here when the x-ray is performed in an office or clinic setting.

g. Surgical Pathology:

- (1) Inpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional services by a physician when the surgical pathology procedure is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of pathology services should be included in the hospital inpatient benefit.

- (2) Outpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional service by the physician when the surgical pathology procedure is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of pathology services should be included in the Hospital Outpatient - Pathology benefit or in the Physician - Pathology - Office (Combined Professional and Technical) benefit.

- (3) Office (Combined Professional and Technical) (CPT-4 Codes 88300-88399; HCPCS Code Q0091)

This benefit includes both the professional and technical component of surgical pathology services when these services are billed together. Services are counted

as the number of procedures. Charges should only be included here when the lab work is performed in an office or clinic setting.

#### D. OTHER SERVICES

##### **1. Physical Therapy**

(CPT-4 Codes 97001-97002, 97005-97799)

This benefit includes physical therapy when ordered by the attending physician. Services are counted as the number of procedures.

##### **2. Occupational/Speech Therapy**

(CPT-4 Codes 92506-92508, 97003-97004, HCPCS Codes V5362-V5364)

This benefit includes occupational therapy when ordered by the attending physician. Services are counted as the number of procedures.

##### **3. Chiropractic**

(CPT-4 Codes 98940-98943)

This benefit includes visits to a licensed chiropractor's office including those visits involving manipulations. This benefit includes x-rays taken in the chiropractor's office. Services are counted as the number of procedures.

##### **4. Private Duty Nursing/Home Health**

(CPT-4 Codes 99500-99602)

This benefit includes private nursing and home health visits if required by the attending physician and not representing custodial care. Services are counted as the number of procedures.

##### **5. Ambulance**

(HCPCS Codes A0000-A0999)

This benefit includes professional ambulance service. Services are counted as the number of procedures.

##### **6. Durable Medical Equipment/Prosthetics**

(HCPCS Codes A4611-A4640, B9000-B9999, E0100-E1406, E1700-E8002, K0001- K0900, L0100-L9999, Q0081, V5030-V5299, V5336)

This benefit includes appliances, equipment, and prosthetic devices. Appliances and equipment include braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc. Prosthetics includes artificial parts that replace a missing body part or improve a body function (i.e., artificial limb, heart valve, and medically necessary reconstruction). Services are counted as the number of items.

## **7. Laboratory**

(CPT Codes 36415, 80047-88299, 89049-89240; HCPCS Codes G0027, P0000-P9999)

This benefit includes both the professional and technical component of non-physician laboratory services when these services are billed together. Services are counted as the number of procedures.

### **E. ADDITIONAL BENEFITS**

#### **1. Immunizations**

(CPT-4 Codes 90281-90749)

This benefit includes the professional services and materials associated with administering immunizations. Services are counted as the number of procedures.

#### **2. Well Baby Exams**

(CPT-4 Codes 99381, 99391, 99460-99465)

This benefit includes normal periodic examinations of well children under age one. Services are counted as the number of exams.

#### **3. Well Child Exams**

(CPT Codes 99382-99384, 99392-99394, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of children ages 1 through 17. Services are counted as the number of exams.

#### **4. Physical Exams**

(CPT-4 Codes 99385-99387, 99395-99397, 99401-99429, HCPCS Codes M0064- M0100)

This benefit includes routine examinations of adults and children over the age of 17. Services are counted as the number of exams.

#### **5. Vision Services**

(CPT-4 Codes 92002-92287, 92499)

This benefit includes eye exams and other ophthalmology services conducted by a licensed ophthalmologist or optometrist. Services are counted as the number of procedures.

#### **6. Vision Supplies**

(CPT-4 Codes 92310-92371; HCPCS Codes V2020-V2799)

This benefit includes lenses and frames and contact lenses. Services are counted as the number of services.

#### **7. Speech Exams**

(CPT-4 Codes 92506-92508; HCPCS Codes V5301-V5364 (except V5336))

This benefit includes speech exams. Services are counted as the number of procedures.

**8. Hearing Exams**

(CPT-4 Codes 92550-92597; HCPCS Codes V5000-V5020)

This benefit includes hearing exams. Services are counted as the number of procedures.

**9. Podiatrist**

This benefit includes services performed by a licensed podiatrist. There are no specifically identified CPT codes for this treatment. Services are counted as the number of visits.

**10. Mammography Exams**

(CPT Codes 77051-77059)

This benefit includes routine mammography examinations of female adults. Charges should include the x-ray associated with the exam. Services are counted as the number of procedures.

**11. Outpatient Mental Health**

(CPT-4 Codes 90785-90899; HCPCS Codes G0176-G0177, H0001-H2999)

This benefit includes psychiatric treatment by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

**12. Outpatient Substance Abuse**

(CPT-4 Codes 90785-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001- H2999, S9075)

This benefit includes treatment of alcohol and/or drug abuse by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

**13. Other Services**

This line item would include all services that have not been allocated to any of the above line items.

The Total FFS Incurred Claim Factor and the Number of Runout Months should be input at the bottom of this section.

Note that there are a number of calculated fields in this section that are self explanatory.

#### **TABLE 4 – PAID CLAIMS AND ENCOUNTER EXPERIENCE BY MONTH**

TABLE 4 requests medical fee-for-service claims, capitation encounter data and capitation payments by month for the period 1/1/2015-3/31/2016.

Claims and encounter data should be entered for the six main service categories consistent with TABLES 3A & 3B: Hospital Inpatient, Hospital Outpatient, Other Facility, Physician, Other Services and Additional Services. There are separate columns for fee-for-service and encounter data. Data entered by month should not include any incurred claim completion factors.

Additional input is required for total actual capitation payment by month for the same period.

## TABLE 5 – MEDICAL TREND ASSUMPTIONS

TABLE 5 requests information regarding the trends used in the rate development. **NOTE: The trend periods used in the calculations are listed at the top of the table.**

**Step 1** shows the calculation of the weighted trend for fee-for-service costs. The weighted trend is the trend assumed by the carrier from the midpoint of the experience period to the midpoint of the rating period. Prepare separate tables for each period. Prepare one table for 2015-2016 and another table for 2016-2017 annual trends.

The first column lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second and third columns represent trend factors for cost and utilization. Estimates of these factors need to be input for both trending periods.

The fourth, fifth, and sixth columns are automatically calculated fields which develop an overall trend factor for both rating periods.

**Step 2** calculates the two year weighted trend for fee-for-service costs. The aggregate trend is calculated by multiplying the sum of one plus the weighted trend for the first period (for only 9 months) times the sum of one plus the weighted trend for the second period.

**Step 3** requests the aggregate trend for capitated services.

The first column lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second column requests the projected annual trend for 2015-2016.

The third and fourth columns automatically calculate an overall weighted annual trend for 2015-2016 based on the trend input and the distribution of capitated service categories.

The fifth, sixth and seventh columns are similar to columns one, two and three and four as described above. However, plans should enter projected annual trend for 2016-2017 in the fifth column.

The two year weighted trend for capitated services is then calculated. The aggregate trend is calculated by multiplying the sum of one plus the weighted trend for the first period times the sum of one plus the weighted trend for the second period.

**Step 4** is where the carrier should explain any special circumstances which may have caused the trends to be unusually high or low.

## **TABLE 6 – MEDICAL ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS**

TABLE 6 requires a breakdown of the administrative expenses and any other miscellaneous costs included in the rate development.

### **Medical Administrative Expenses:**

The first column lists a detailed description of the different expense categories requested.

The second column is the 2015 PMPM cost for the expense category.

The third column is the PMPM cost that was included in the 2016 rate calculation.

The fourth column is the estimated PMPM cost included in the 2017 rate calculation.

## **TABLE 7 – REQUIRED PREMIUM PMPM**

TABLE 7 uses the information provided on TABLES 1 - 6 to calculate the required premium per member per month for calendar year 2017. Please note that these automatically calculate and plans are not required to input data.

Line 1 - is the grand total amount of fee-for-service claims cost PMPM for the experience period as shown in TABLE 3A. This amount includes the incurred claim factor supplied to bring the claims to an incurred level.

Line 2 - is the aggregate fee-for-service trend factor as shown in TABLE 5.

Line 3 - is the claims cost trended to the rating period, which is calculated by multiplying Line 1 by Line 2.

Line 4 - is the total capitation cost PMPM from TABLES 3A and/or 3B.

Line 5 - is the aggregate capitated services trend factor from TABLE 5.

Line 6 - is the total capitation cost trended to the rating period and is calculated by multiplying Line 4 by Line 5.

Line 7 - is the total estimated 2017 administrative cost PMPM as shown on TABLE 6.

Line 8 - is the required medical premium PMPM and is calculated by adding lines 3, 6 and 7.

## TABLE 8 – 2017 CALCULATED RATES

TABLE 8 includes information from TABLES 1 through 7 to automatically calculate the single and family rates.

### **Step 1 details the calculation of the conversion factor used to convert the required premium per member per month to single and family rates.**

Line 1, Column B - is the contract mix from TABLE 1, row 44 Column B.

Line 2, Column B - is the contract mix from TABLE 1, row 44 Column C.

Line 3, Column B - is the sum of the contract mix for single and family, which must equal 100%.

Line 1, Column C - is the average contract size for single from TABLE 1, row 43 Column B. Line

2, Column C - is the average contract size for family from TABLE 1, row 43 Column C. Line

3, Column C - is the average contract size in total from TABLE 1, row 43 Column D.

Line 1, Column D - is the rate ratio for single of 1.0.

Line 2, Column D - is the rate ratio for family of 2.0 for Medicare, 2.5 for non-Medicare.

Line 3, Column D - is the weighted average rate ratio in total for single and family.

Line 1, Column E - is the conversion factor for single and is derived by dividing the total average contract size by the total rate ratio.

Line 2, Column E - is the conversion factor for family and is derived by multiplying the conversion factor for single by the rate ratio for family.

### **Step 2 details the calculation of the 2017 medical rates using the required premium PMPM and the conversion factor.**

Line 4, Column C - is the required premium PMPM from TABLE 7, line 8.

Line 5, Column C - is the conversion factor for single.

Line 6, Column C - is the calculated 2017 rate for single and is derived by multiplying the required premium PMPM by the conversion factor.

Line 4, Column D - is the required premium PMPM from TABLE 7, line 8.

Line 5, Column D - is the conversion factor for family.

Line 6, Column D - is the calculated 2017 rate for family and is derived by multiplying the required premium PMPM by the conversion factor.

Line 7 - The last line pulls the net 2016 inforce medical only rates for single and family coverage from TABLE 1, row 33 Columns D & E.

## TABLE 9 – CALCULATED LOSS RATIOS

TABLE 9 includes information from TABLES 1 through 8 to automatically calculate the loss ratios for each of the periods.

The experience period loss ratios are calculated by first calculating the monthly revenue from TABLE 1 and pulling the monthly claims and capitation experience from TABLE 4.

The projected 2016 and 2017 loss ratios have a number of calculated fields that utilize the reported claims experience and calculated rates.

## TABLE 10 – CLAIMS IN EXCESS OF \$100,000 Incurred Period: April 1, 2015 through March 31, 2016

Line 1 - is the total amount of paid claims for individuals with paid claims of \$100,000 or greater. Paid claims are defined as medical and pharmacy claims paid by the health plan; do not include pharmacy claims paid by the Department's pharmacy benefit manager in this calculation. For example, if you had five cases with paid claims of \$150,000 each, you would enter the value of  $\$150,000 \times 5 = \$750,000$ .

Line 2 - is the number of individuals with paid claims of \$100,000 or greater.

Line 3 – is the total amount of claims of \$100,000 or greater on an individual basis. For example, if you had five cases with paid claims of \$150,000 each, this cell would calculate as follows:  $\$150,000 \times 5 - \$100,000 \times 5 = \$250,000$ .

Line 4 - is the estimated percentage of paid claims for the specified Report Period that have not yet been recorded or paid. Incurred claims will be calculated as  $(1 + \text{Total Incurred Claim Factor})$  multiplied by the Paid Charges.

Line 5 - is the number of months of experience that have been included in Paid Charges beyond the specific incurred Report Period of 4/1/2015-3/31/2016. For example, if a plan includes experience for claims that were incurred from 4/1/2015-3/31/2016 and paid through 5/31/2016, the Number of Runout Months would equal two.

Line 6 - will be calculated as  $(1 + \text{Incurred Claim Factor})$  multiplied by the Paid Charges. This represents the total amount of claims of \$100,000 or greater that have been incurred in the Report Period.

## TABLE 11 – QUESTIONS REGARDING SUBMITTED DATA

TABLE 11 requests responses to questions regarding the submitted data. We prefer that plans provide responses to the questions in the space provided in TABLE 11. TABLE 11 is considered a part of the required data and must be provided at the same time as all other information.

## **TABLE 12 – TOP PROVIDER REPORT**

TABLE 12 requests plans submit a list of top facility and top professional providers based on Plan Paid dollars for the Addendum population and the time period April 1, 2015 through March 31, 2015. The provider information requested includes name, location, National Provider Identifier number and utilization counts.

Table 12 is only included in three of the eight categories:

- i. State of Wisconsin Employee Plan, Non-Medicare
- ii. State of Wisconsin Employee Plan, Medicare
- iii. State of Wisconsin Local Plan, Non-Medicare

## **TABLE 13 – REQUIRED DATA FORMAT**

Data is to be submitted to the Board's Actuary and match the information in the service categories detailed in TABLES 3A & 3B. It is expected that the data will match both the utilization and billed amounts. In later years more financial information will be required in the detail file.

Please send data for all groups. We are requesting 12 months of incurred data covering the period April 1, 2015 through March 31, 2016 and paid through the most recent and complete month. Both fee-for-service claims and capitation encounter data should be provided with an appropriate code to separate.

The file should be comma delimited and include Control totals for all groups and files sent. The Control totals should include: Total Record Count, Total Billed Amount, Total Allowed Amount and Total Paid Amount .

## **TABLE 14 – SERVICE CATEGORY CODES**

TABLE 14 provides a mapping of the line items in TABLES 3A & 3B. The data should be grouped as described in that section, with the mapping included in the data sets.

## **TABLE 15 – ACTUARIAL CERTIFICATION**

There is a new requirement to have the rate development, supporting reports and detailed data be certified by an actuary who is a Member of the American Academy of Actuaries. There is a box to allow an actuary to enter their certification language.

The actuary should enter his Name, Firm, Phone and Date of the certification.

If vendors are unable to meet the actuarial certification requirement, they should provide acceptable language and justification. The rates should then be certified by their Chief Financial Officer.