

Year 2 Data Call Instructions – Carrier Input

Issue	Response																												
<p>Section 8 Rate Set Code</p>	<p>It is the code to match to the set of rates for each plan. Each unique set of rates should have a unique Rate Set Code.</p> <p>Section 8 J is the Rate Set Code, which ties to the Rate Set Code in Section 11. It is the rate-set matching for the plan (and employee group) in Section 8. Section 8 may have multiple instances of a plan code if there are multiple employee groups.</p> <p>Section 8 K is the Rate Set Description, which describes to which employee group the rates tie.</p> <p>Here’s an example, using made-up values:</p> <table border="1" data-bbox="808 751 1546 1432"> <thead> <tr> <th>Plan Code</th> <th>Rate Set Code</th> <th>Rate Set Description</th> <th>Note</th> </tr> </thead> <tbody> <tr> <td>A</td> <td>1</td> <td>Certificated</td> <td>This might be District 1’s certificated employees with Plan A.</td> </tr> <tr> <td>A</td> <td>2</td> <td>Classified</td> <td>This might be District 1’s classified employees with Plan A.</td> </tr> <tr> <td>A</td> <td>3</td> <td>Certificated</td> <td>This might be District 2’s certificated employees with Plan A.</td> </tr> <tr> <td>B</td> <td>4</td> <td>Certificated</td> <td>This might be District 1’s certificated employees with Plan B, if they offer both Plan A and Plan B.</td> </tr> <tr> <td>C</td> <td>1</td> <td>Certificated</td> <td>Two different plans may have the same rates but this is highly unlikely.</td> </tr> <tr> <td>...</td> <td>...</td> <td>...</td> <td>...</td> </tr> </tbody> </table> <p>Rate Set Code 1: \$400 EE, \$800 ES, \$700 EC, \$1,100 EF            Rate Set Code 2: \$500 EE, \$1,000 ES, \$900 EC, \$1,400 EF</p>	Plan Code	Rate Set Code	Rate Set Description	Note	A	1	Certificated	This might be District 1’s certificated employees with Plan A.	A	2	Classified	This might be District 1’s classified employees with Plan A.	A	3	Certificated	This might be District 2’s certificated employees with Plan A.	B	4	Certificated	This might be District 1’s certificated employees with Plan B, if they offer both Plan A and Plan B.	C	1	Certificated	Two different plans may have the same rates but this is highly unlikely.	...	...	...	...
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<p>Section 5 Exp OtherAdmin (Column I)</p>	<p>This field cannot be zero. It is the carrier’s administration fees or administration expense. This is the carrier’s retention, or the cost of doing business exclusive of taxes, PPO access fees, commissions, or payments to third parties. Exp_OtherAdmin represents the carrier’s administrative expense component of the premium.</p>																												

Section 4 Plan Type (Column G)	<p><u>Definition of Plan Types</u></p> <p><u>HMO:</u> An HMO is licensed as an HMO providing managed health care services from contracted providers on a prepaid basis; generally an HMO requires members to select a primary care provider (PCP) who acts as “gatekeeper” to direct access to medical care. An HMO provides benefits for services from participating providers and facilities only with no out-of-network benefits, except emergency care. However, some HMOs offer an “open access” or “point-of-service” (POS) plan which is a combination of HMO and traditional insurance. The network for a POS plan is different than a network for an HMO plan. For purposes of the K-12 project, a POS plan should be indicated to be a PPO, not an HMO.</p>
	<p><u>PPO or POS:</u> This plan type provides in-network benefits for services from participating providers/facilities and out-of-network benefits for services provided by non-participating providers/facilities. Generally these plans allow participants to access their choice of providers with higher level benefits provided for services from in-network providers/facilities. Any “open access” HMO or Point-of-Service plan with both in-network and out-of-network benefits should designate the plan as a “PPO” plan type.</p>
	<p><u>Closed-Network:</u> This is similar to an HMO but not necessarily licensed as an HMO, and such a network requires members to receive services from participating providers/facilities only; there are no out-of-network benefits, except emergency care. Please use “Closed-Network” for non-HMO plans for those plans with in-network only benefits and no out-of-network benefits, except emergency.</p>
	<p><u>In-Network:</u> This plan type refers to an HMO product which is not filed as an HMO. Benefits are provided for in-network participating providers/facilities only and no out-of-network benefits, except emergency. This is the same as Closed-Network.</p>
Section 4 Desc Covered Benefits (Column J) <b>ERROR!</b>	<p>The description in this column was in error. Plan summaries are not required for Year 2. Complete Section 10 and provide appropriate plan design information including deductible levels, co-insurance, copays, and other cost-share features. The CostShare_Code in Section 10 should match the CostShare_Code in this Section 4.</p>
Section 8 Rate Set Desc (Column K)	<p>This is the Rate Set Description, which describes to which employee group the rates tie.</p>
Section 10 Plan Cost-Share Designs CostShare Code	<p>There is no standard for the CostShare_Code. It can be a numeric, alpha, or alpha-numeric field that represents each unique set of plan benefits. If each plan is different and does not share cost-sharing values with other plans, then each plan will have its own cost-share code. You could use “1” for the</p>

	<p>first unique benefit design, “2” for the second one, and so on. Or, you could give them names that represent the benefits. Whatever method you chose is fine, as long as the code is 20 characters or less in length.</p>
Section 5, Item K	<p>Average LOS is not measured on a per 1,000 basis. It is the total inpatient days divided by the total admissions. Or total inpatient days per 1,000 divided by total admissions per 1,000. Either way the answer is the same.</p>
Section 5 - Items R and S – it is understood that the prescriptions offered for longer than 30-day fills should be adjusted to correspond to 30-day fills; how do we report prescriptions that are less than 30 days.	<p>You should divide the number of days actually given by 30. So a 7-day fill would be 0.233 prescriptions. A 34-day fill would be 1.133 prescriptions.</p>
Section 5 – How do we report a script? How do we report a 7-day supply?	<p>It would count as 0.233 prescriptions for 1 and 0.467 for 2.</p>
Section 5 – Notes on utilization computation (page 16)	<p>Page 16, item #2 indicates columns W through AE are per 1,000, but with the changes made to the Data Call, these columns no longer exist. The instructions should say that columns L through S are per 1,000, not columns W through AE.</p>
Section 6 – Benefit Package Performance by Month – (for 2013, all months)	<p>Page 17, column G “Total_Premiums” – leave blank; column H – “Total_MedPremiums” report medical premiums including pharmacy; exclude separate vision and dental plans</p>
Section 8 – Plan Code Rates and Enrollment by District – For Plan Years Ending in 2013	<p>Page 20, column G “Total_Premiums” – leave blank; column H – “Total_MedPremiums” report medical premiums including pharmacy; exclude separate vision and dental plans</p>