Office of the Insurance Commissioner

K-12 School District

Health Benefits Information and Data Collection Project

Year 4 Report to the Washington State Legislature

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EXECUTIVE SUMMARY

Under Engrossed Substitute Senate Bill 5940 (ESSB 5940), the Legislature directed the Office of the Insurance Commissioner (OIC) to conduct the data gathering and reporting specified in Sections 4 and 5 of the law in order to support specific goals that are stated within the legislation. The OIC competitively procured consulting assistance in support of this project, and in August 2012 selected Treinen Associates Inc. ("Treinen") as their contractor. This report to the Washington State Legislature represents the culmination of the data collection and reporting activities for Year 4 of the K-12 School District Health Benefits Data Collection Project.

Full Participation

In Year 4 of the project, the OIC is pleased to report that 100% of the 295 K-12 school districts ("districts"), representing over 200,000 employees and dependents, and their 10 medical insurance carriers ("carriers"), representing 482 health plans, and over $1 billion in calendar-year 2015 health premiums, submitted data in response to the collection effort.

This report and the supporting exhibits demonstrate that districts, their carriers, and the OIC have fully met the requirements of Sections 4 and 5 of ESSB 5940.

Data Quality

Due to the Data Quality Assurance activities of the Project Team, data collection for Year 4 again yielded information that one may consider accurate and reliable. For example:

- Prior to the Project Team's Data Quality Assurance activities in Year 4, the aggregate discrepancy between carrier-reported data and district-reported data in terms of enrollment was 5.47%. After the conclusion of these activities, the aggregate discrepancy was only 3.44%.
- Prior to the Project Team's Data Quality Assurance activities in Year 4, the aggregate discrepancy between carrier-reported data and district-reported data in terms of medical insurance premiums was approximately 10%. After the conclusion of these activities, the aggregate discrepancy was only 8.26%.

These variations between the district-reported and carrier-reported data are expected, and are due in large part to the timing of data reporting. This report discusses in detail this topic within the subsections entitled "Variations in District Data" and "Variations in Carrier Data" in Chapter 2, as well as within footnote 17 on page 19. These variations do not constitute a data integrity issue and are well within a reasonable threshold to support the analysis and reporting required under ESSB 5940.

Data Collection

The legislation requires that OIC report on a "summary of the benefit packages" offered by K-12 districts.[1] The law requires that the OIC summarize the data by district benefit packages, not by district. As required, Treinen gathered employee census and health-benefit information from all 295 K-12 districts. Additionally, Treinen gathered detailed healthcare data (claims experience, benefit plan information, and enrollment) for both insured and self-funded arrangements from the 10 carriers providing healthcare benefits to the K-12 districts.

All data provided by participants was self-reported. (Note that the project scope of work was limited to data collection and excluded any data interpretation or evaluation by Treinen or the OIC.) For Year 4, the Project Team received and processed all of the required data from all of the districts and carriers within the timeframes set forth for the project.[2]

The data collected from carriers involved employee healthcare plans only. Data collection, as required under ESSB 5940, specifically excluded other types of employee benefits such as dental, vision, life insurance, and disability insurance. For the purposes of this project, employee health-benefit plans include medical and pharmacy plans, but *exclude* separately purchased dental and vision plans and other types of insurance benefits. However, districts were required to report the aggregated cost of separately purchased dental and vision plans.

Data Validation

While Treinen did not formally audit the collected data for accuracy, Treinen built and applied many automated validations[3] (for example, reasonableness checks and cross-validations) to the data. These data validations proved extremely valuable, as they caught innumerable errors and inconsistencies, resulting in data correction and resubmission by many carriers and districts.

[1] Please see ESSB 5940 Section 4(2)(iv)(A).

[2] Please see point 2 within the subsection entitled “Variations in Carrier Data” within Chapter 2 for an explanation of the timespans involved in the project.

[3] Described in detail below within the subsection entitled “Data Validations” and in further detail within the appendix exhibits 23a and 23b).

Report Organization and Content Highlights

The Project Team uses two major artifacts to report the data collection results:

- The Report to the Legislature (this document), and
- Supporting exhibits (included as the appendix), which summarize the collected data. Supporting exhibits include:
  - Aggregated demographic information
  - Total claims and premiums paid by benefit package
  - Large (high-dollar) claims for all K-12 carriers and administrators combined.

This report is broken into six sections. The Purpose and Background section of the report outlines the purpose and legislative goals of ESSB 5940, describes the scope of this report, identifies the authorized contractor that performed the work, acknowledges the contributions of stakeholders and participants, and describes the contents of the rest of the report (as specified under RCW 48.02.210 ***"School District Health Insurance Benefits — Annual Report").***

Chapter 1 summarizes K-12 districts' current purchasing options, the carriers currently contracted to provide healthcare benefits, and the Data Call that Treinen executed in support of the data collection effort. In brief:

- K-12 districts purchase health care directly through insurers, through the Washington Education Association (WEA) plans, the Public Employees Benefit Board (PEBB) program under the Health Care Authority (HCA), or self-fund their healthcare coverage (administered by insurers or other third parties).
- All 295 K-12 districts (100%) submitted data.
- Ten carriers provided data for 482 health plans covering 199,021 K-12 district members (employees and dependents).
- Carriers reported health premiums of $1.1 billion for calendar year 2015 (calendar year 2015).
- Despite extensive validation checks between district-reported data and carrier-reported data, some small disparities and inconsistencies in the source data persist.
- Small variations exist between the amounts reported by carriers versus districts for the number of health plans, reported premiums, and enrollment numbers. These variations are expected, and are due in large part to the timing of data being reported (this topic is discussed in detail within the subsections entitled "Variations in District Data" and "Variations in Carrier Data" in Chapter 2). These variations do not constitute a data integrity issue.
- While districts accurately collect, maintain and report employee-level enrollment data, they do not consistently maintain or report dependent-level data. Thus, district-reported member (that is, employee plus covered dependent) counts vary significantly from carrier-reported member counts.

- Substantial improvements (for example, in the reporting of covered dependents and in the extract programs that produce data for the vast majority of districts), were made by the Washington Schools Information Processing Cooperative (WSIPC). Despite these improvements, district-reported dependent data is much less accurate than carrier-reported dependent data. For this reason, some exhibits source the enrollment data from carrier-reported data while the rest of the data in the exhibit comes from the district-reported data. Please see the descriptions of exhibits A6 and A12 within the appendix for further details.

Chapter 2 describes the Data Call, the data collection process, and its results. The major activities included gathering stakeholder input; leveraging WSIPC technology and data assets; data validation and quality assurance; Year 4 data collection processing improvements; and developing statistical summaries.

Chapter 3 summarizes the district data. The results show:

- Districts report total premium dollars of $1.1 billion; districts contributed (on average) 79.3% toward premiums, while employees contributed 20.7%.
- The average employee contribution, as a percentage of premiums for full family coverage, was 38.2% for full-time employees and 41.2% for part-time employees.
- The average employee contribution, as a percentage of premiums for employee-only coverage, was 9.1% for full-time employees and 12.1% for part-time employees.
- The average full-time employee contribution for employee plus dependent (ED) coverage (that is, any coverage other than employee-only) was $334.03. In contrast, the average contribution for employee-only coverage was $68.42. Hence, for full-time employees, the ratio for ED to employee-only coverage was 4.9 to 1.
- For part-time employees, the average employee contribution for ED coverage was $375.09. In contrast, the average contribution for employee-only coverage was $83.83. Thus, for part-time employees, the ratio of ED to employee-only coverage was 4.5 to 1.
- For full-time employees, the average employee-contribution ratio of full family coverage to employee-only coverage was 8.1 to 1.
- For part-time employees, the average employee-contribution ratio of full family coverage to employee-only coverage was 7.1 to 1.
- As reported by the carriers for the plan year ending in 2015, the average premium for all health plans combined for a full-time employee with ED coverage was $1,149.34 per month. The lowest reported premium was $565.00 per month; the highest reported premium was $11,135.52 per month.

Chapter 4 summarizes the carrier data. The results show:

- Carriers provided 462 separate health plans that ended in calendar year 2015.
- The average monthly enrollment for calendar year 2015 was 105,668 employees. In total, the monthly average for employees and dependents combined was 199,021 members.
- Carriers report that total premiums paid during calendar year 2015 were $1.1 billion.[4]
- Claims paid during calendar year 2015 were $995.3 million, generating a paid claims loss ratio of 89.6% in 2015. The loss ratio is total paid claims divided by total premiums.[5]
- Administrative costs totaled $119.5 million, or approximately 10.8% of the $1.1 billion ($1,110.9 million) in reported premiums. Of the total administrative costs:
  - Broker commissions were $6.6 million (about 0.6%).
  - State premium taxes and other assessments were $56.4 million (about 5.1%).
  - Carrier administration was $56.2 million (about 5.1%).
  - Network access fees of $0.3 million (<0.1%).
  - Third-party administrator (TPA) fees were $32,600 (<0.1%).
  - Reserves for incurred but not reported (IBNR) liabilities totaled $60.3 million (about 5.4% of premium). Note: IBNR is an estimate of the total amount owed by the insurer to all eligible claimants who experienced a claim loss, but for which the carrier has not yet recorded. Since the insurer knows neither the volume of claim losses (the frequency), nor the severity of each loss (the amount), IBNR liability is an actuarial estimate.
- Other reserves for claims and rate stabilization totaled $3.5 million (about 0.3% of premium).

  Note: A Claims or Rate Stabilization Reserve (CSR or RSR) applies to a carrier rating pool. Plans use a CSR or RSR as a hedge against unexpectedly frequent or severe claims.
- Chapter 4 also presents the actuarial values of the 462 plans that ended in calendar year 2015. The range of actuarial values of district plans ranges from 0.5538 to 0.9692.

  Note: Actuarial value is the plan's expected reimbursement of medical expenses. For example, a value of 0.8700 would indicate that a plan, on average, pays 87% of total expected medical expenses. Depending on specific circumstances, individuals may see reimbursements that are more or less than the actuarial value.

[4] Note that small differences in the premium and enrollment numbers as reported by the carriers, as opposed to those reported by the districts, is generally due to the timing of the counts and do not represent a data integrity issue.

[5] The loss ratio is the ratio of total claims divided by the total premiums. For example, if an insurance company pays $85 in claims for every $100 in collected premiums, then its loss ratio is 85% with a profit ratio/gross margin of 15%, or $15 in this example. Some portion of the $15 must pay all operating costs, and what is left is the net profit.

Chapter 5 recaps the Year 4 Data Collection Project, summarizing keys to project success; acknowledging project participants, authors and contributors; and introducing the detailed data in the appendix.

Overall, Year 4 of the K-12 Health Benefits Data Collection Project attained the maximum possible participation by districts and carriers, and gathered highly accurate and reliable information, fully meeting the requirements of ESSB 5940.

PURPOSE AND BACKGROUND

Engrossed Substitute Senate Bill (ESSB) 5940[6]

In April 2012, ESSB 5940 was signed into law requiring every school district in the state of Washington and their ***"benefit providers[7]"*** (health carriers) to annually submit certain information, specified in detail below, with respect to each "health plan"[8] or "benefit package"[9] offered to district employees. The health insurers submit this information to the Office of the Insurance Commissioner (OIC). Sections 4 and 5 of ESSB 5940 specify the data presented in this report. These sections authorize the OIC to collect the required data and produce an annual report to the Legislature.

ESSB 5940 requires annual reporting for calendar year 2012 and beyond.

This report to the Washington State Legislature, together with the associated exhibits, constitutes the outcome of the data collection and reporting activities for Year 4 of the K-12 School District Health Benefits Data Collection Project.

The stated purpose of ESSB 5940 is to gather information in order ***"to improve current practices and inform future decisions with regard to health insurance benefits"[10]*** purchased by districts**.** The basis for this data collection effort is that the Legislature found that each year school districts spend approximately $1 billion in public funds on the purchase of medical benefits for over 200,000 public school employees and their dependents.

Note: "Health plan" or "health-benefit plan" as described in the Data Call and referred to herein includes medical care and pharmacy services only.

[6] ESSB 5940 amended RCW 28A.400.280, 28A.400.350, 28A.400.275, and 42.56.400; adding a new section to chapter 48.02 RCW; adding a new section to chapter 41.05 RCW; adding a new section to chapter 44.28 RCW; adding a new section to chapter 48.62 RCW; and creating a new section.

[7] "Benefit providers" as defined under RCW 28A.400.270 include insurers, third-party claims administrators, direct providers of employee fringe benefits, health maintenance organizations, healthcare service contractors, and the Washington State Health Care Authority (HCA) or any plan offered by the authority.

[8] "Health plan" or "health benefit plan" as defined under RCW 48.43.005 means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for healthcare services, with certain exceptions, as defined within the statute.

[9] A "benefit package" consists of one or more health plans across multiple districts of similar size, or aggregated health plans with similar actuarial value.

[10] ESSB 5940 Section 1 (1)(b). Note: "health insurance benefits" includes medical and pharmacy benefits only.

The data provided with this report relates to the 2015 calendar year. The carriers and districts submitted the data based on the overall plan summary and financial performance of each "health-benefit plan" across carriers and districts. This report includes a summary of each district's health-benefit plans and aggregated financial data and other information.[11] It does not include dental or vision information or employee-pay-all voluntary plans.

ESSB 5940 specifically excluded Educational Service Districts and thus the Data Call excluded them.

ESSB 5940 requires that the HCA should establish targets to achieve greater equity between single and family premiums, study consolidated district employee health-benefits purchasing, and address the costs of and possible alternatives to existing programs. HCA duly reported as required, and one may view that report here:

http://hca.wa.gov/assets/program/K12EmployeeBenefits.pdf

ESSB 5940 also requires that JLARC review the exhibits and reports on district health benefits submitted by the OIC and the HCA, and report progress toward achieving legislative goals, including greater equity between premiums for family and employee-only coverage and greater affordability for family health-benefit coverage. JLARC duly reported as required, and one may view that report here:

http://leg.wa.gov/jlarc/AuditAndStudyReports/Pages/K12HealthBenefits.aspx

ESSB 5940 also requires that by December 1, 2012, and by December 1 of each year thereafter, the OIC should submit a report on district health-insurance benefits, and make the report available to the public on the OIC's web site (www.insurance.wa.gov). This document is the report for Year 4 of the project. By December 1 of2016, the OIC will submit it to the Governor's Office, the HCA, and the Legislature, and publish it on the OIC's web site.

Limited Scope Review

This report does not attempt to evaluate or draw any conclusions with respect to the submitted data. Treinen undertook a limited scope review to check for reasonableness and consistency of the data. Treinen found no significant material defects in the submitted data.

This report does not address areas of legislative or contractual compliance across carriers or districts. However, of the 10 carriers contacted in Year 4 of the project, 100% submitted data as requested, as did all 295 districts.

[11] Pursuant to ESSB 5940 Section 5 2(b), this report shall consist of summary data and other information described in RCW 28A.400.275

Non-Disclosure

To maintain the confidentiality and privacy of information of district employees and their dependents, ESSB 5940 does not require reporting of Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA). To protect privacy, the report aggregates data by health plan. In addition, ESSB 5940 permits aggregation across multiple districts and plans for smaller districts, plans with similar benefits, or similar actuarial values. Such aggregated information is reported by carriers as "benefit packages," consisting of one or more health plans across multiple districts.

To prevent public disclosure of proprietary carrier-provided information, the report does not disclose certain data collected. De-identification of proprietary information does not compromise the integrity of the data presented. All health plan information required by ESSB 5940 is present within this report.

Contracts or Agreements with K-12 Districts

ESSB 5940 requires that any contract or agreement for employee benefits executed after April 13, 1990 between a district and their health insurer or employee bargaining unit would be ***"null and void"***[12] unless it contained an agreement ***"to abide by state laws relating to school district employee benefits."***

Any contract or agreement for employee benefits must agree to provide the data required under ESSB 5940. Districts and the carriers must meet specific reporting requirements, including reporting progress by the district and the carriers toward greater affordability for full family coverage and coverage for the lowest-paid and part-time employees, healthcare cost savings, and significantly reduced administrative costs. Contracts must also offer districts a high-deductible health plan option with a health savings account.

Contractor for the OIC

ESSB 5940 authorized the OIC to enter into a Personal Services Agreement with a third-party contractor in order to fulfill the OIC's responsibilities under this act and to facilitate data collection efforts for Year 2 of the project and beyond.

[12] ESSB 5940 Section 4(1)

The OIC undertook a formal procurement process. The OIC subsequently awarded the contract to design and execute the data collection project to Treinen Associates Inc. (Treinen), a consulting firm based in Olympia, Washington. The contract requires Treinen, in each project year, to:

- Design and build[13] a database to house the collected data.
- Design and build a computer application allowing viewing, processing, and managing of collected data.
- Design and build a suitable vehicle for data collection (the district and carrier Data Collection Spreadsheets).
- Prepare Data Call instructions for districts and for carriers.
- Develop a formal engagement process.
- Engage in preliminary pilots, to test the various components of the Data Calls.
- Engage with key stakeholders.
- Engage with districts and their respective carriers or plan administrators in order to collect the required data.
- Summarize the collected data in a series of statistical exhibits.
- Prepare a summary report.

The OIC and Treinen signed an agreement for non-disclosure of data, except for the purposes of ESSB 5940, and for compliance with all required data protection practices.

This report and its associated exhibits summarize the required data collected for Year 4.

Definition of Terms

This document refers to Year 4 of the OIC K-12 Health Benefit Data Collection Project as “the project.”

This document frequently refers to Treinen Associates Inc. as “Treinen.”

This document refers to the team carrying out the project, consisting of employees and subcontractors of Treinen, as “the Project Team.”

The “Data Call” referred to throughout this document is the act of broadcasting to districts and to their carriers, including HMOs, a request for data relating to health benefits for K-12 employees. The Data Call consisted of a Data Collection Spreadsheet, a set of instructions, and a cover letter.

[13] The Project Team did the most of the work of initially designing and building these technical artifacts in Years 1 and 2 of The Project. In Years 3 and 4, the Project Team has progressively implemented enhancements to the tooling built in prior years.

Note that the Data Collection Spreadsheet, instructions, and cover letter issued to carriers (the Carrier Data Call) differ substantially from those issued to districts (the District Data Call). This is because the data collected from carriers is substantively different from that collected from districts. The two datasets are complimentary but largely distinct.

The Project Team issued the Year 4 Data Call, relating to the preceding calendar year, on January 30, 2016.

The terms "health carrier," "insurer," "administrator," or "entity" describe any organization or third party, including HMOs, offering healthcare benefits to and contracts with K-12 districts. These organizations may offer plans that are fully insured or self-funded, purchased through an association, or as part of a wider community pool. There is no attempt in the data collection process to identify district-specific funding arrangements (that is, fully insured versus self-funded) and purchasing options (for example, an insurance company or an HMO) directly or via an association or community pool. The information provided herein is specific to the requirements of ESSB 5940 only.

Acknowledgements

We sincerely thank all individuals who made this report possible. The engagement effort was a resounding success due to the contributions and efforts of individuals within the following organizations:

- The Office of the Insurance Commissioner (OIC)
- School-district personnel (superintendents, business managers, office managers, information technology staff, HR staff, financial and accounting staff, and so on)
- All nine Educational Service Districts (ESDs)
- The Washington School Information Processing Cooperative (WSIPC)
- K-12 carriers, HMOs, and third-party administrators: Aetna, Group Health Cooperative, Kaiser Permanente, KPS Health Plans, Premera Blue Cross, Providence Health Plans, Regence BlueShield, United Healthcare, MODA Health (new in Year 3), and the Public Employees Benefits Board (PEBB)[14]
- K-12 benefit insurance brokers, producers, and consultants who supported the data collection process
- Stakeholders who have, across several project years, participated in stakeholder meetings and provided important and useful feedback and guidance:
  - Senate budget staff
  - House budget staff
  - The Joint Legislative Audit and Review Committee (JLARC)
  - The Health Care Authority (HCA)
  - Washington Education Association (WEA)
  - The Office of Financial Management (OFM)
  - The Office of the Superintendent of Public Instruction (OSPI)

[14] The Washington State Health Care Authority (HCA) oversees the Public Employees Benefits Board (PEBB) Program that provides insurance coverage for eligible employees of state agencies, higher education, certain employer groups, and their families. PEBB programs are offered through Group Health Cooperative, Kaiser, and the Uniform Medical Plan (UMP) administered by Regence. The Project Team combines these plans for reporting purposes, and treats PEBB as a "carrier."

Report Contents

The information and data within this report is submitted in a format and according to a schedule established by the OIC under RCW 48.02.210 ***"School District Health Insurance Benefits — Annual Report."***

This report presents Year 4 healthcare data collected from K-12 districts and their respective carriers.

The report includes:

a. A summary of each district's health insurance benefit plans for medical and pharmacy plans;
b. Each district's aggregated financial data, the overall performance of each health plan, and other information;[15]
c. Innovative features of district health benefits;
d. Innovative features of carrier health-benefit plans;
e. Data to provide an understanding of employee health-benefit plan coverage and costs; and
f. Data necessary for districts to more effectively and competitively manage and procure health plans.

Attached to this report are a series of exhibits, included as the appendix, showing summaries of the collected data. These exhibits include plans offered to each group of district employees; plan cost-sharing provisions such as deductibles and coinsurance; aggregated employee and dependent demographic information; total claims; premiums paid by benefit package; and large claims data by claimant with primary diagnosis. Large claim data is on an aggregated basis for all carriers combined. The report summarizes data for all exhibits to protect district employee Protected Health Information (PHI), as defined by HIPAA.

[15] The aggregated financial data and other information included herein are required under RCW 28A.400.275 "Employee Benefits — Contracts or Agreements — Submission of Information to the Office of the Insurance Commissioner — Annual Reports."

Project Sponsor and Stakeholders

The Office of the Insurance Commissioner (OIC) of the state of Washington sponsors this data collection project. Below is a list of the stakeholders:

Key Stakeholders

- The Washington State Governor's Office
- Legislators in both houses of the state of Washington

Active Participants and Contributors

- Carriers, including HMOs
- The Public Employees Benefits Board (PEBB)
- School Districts
- Washington School Information Processing Cooperative (WSIPC)
- Treinen Associates Inc.

Stakeholders with an Advisory or Consultative Role

- The Office of the Insurance Commissioner (OIC)
- The Health Care Authority (HCA)
- The Joint Legislative Audit Review Committee (JLARC)
- The Office of Superintendent of Public Instruction (OSPI)
- Staff from the Washington State House of Representatives
- Staff from the Washington State Senate
- The Office of Financial Management (OFM)

Stakeholders with a Professional Interest

- Benefit Insurance Brokers, Producers, and Consultants
- Washington Association of School Business Officials (WASBO)
- Washington Education Association (WEA)
- Labor Organizations
- Lobbyists
- Other professional organizations

Legislative Goals

The goals of ESSB 5940 follow:

"The Legislature finds that the Legislature and districts need better information to improve current practices and to support future decision-making with respect to health insurance benefits. To understand the current purchasing arrangements that exist within the K-12 environment, the legislature has established the following goals:[16]

a. To improve transparency of K-12 purchasing by collecting key data across the K-12 districts and their respective carriers;
b. To create greater affordability for family coverage for the same health-benefit plan and greater equity between the costs of single versus family coverage;
c. To promote healthcare innovations and cost savings and significantly reduce administrative costs; and
d. To provide greater parity in state allocations for state employee and K-12 employee health benefits.

Note: ESSB 5940 indicates: *"the Legislature intends to retain current collective bargaining for benefits, and retain state, district, and employee contributions to benefits."*

Data Validation

In Year 2 the Project Team designed, built, tested, and implemented a series of data validations to ensure data quality. In Years 3 and 4, the Project Team greatly extended and refined the Year 2 data validations. Validation categories follow:

- Category 0 — Basic edits like ensuring completion of required fields, correct data types (that is, numeric, currency, text, and so on), and other data-integrity checks.
- Category 1 — Specific validations of individual data elements. For example, ensuring for some data elements that the Plan-Year Ending value is within 2015.
- Category 2 — Complex validations within a single submission. For example, the sum of monthly premiums reported in a one section equals the total premiums reported in another section.
- Category 3 — Comparisons with prior submissions within a project year. For example, ensuring that certain amounts (particularly premiums and enrollment numbers) do not vary more than a specified percentage between submissions.
- Category 4 — Comparisons between carrier and district submissions within a project year. For example, ensuring enrollment counts or premiums do not vary more than a specified percentage between carrier-reported data and district-reported data.

[16] Pursuant to ESSB 5940 Section 1(2)(a)(b)(c)(d)

The "Check My Spreadsheet" macro of the carrier and district Data Collection Spreadsheets encapsulates Category 0 validations. This macro allows districts and carriers to find out if their data passes a large number of edits, and to make any required corrections before submitting data to the Project Team. This catches enormous numbers of errors in the data, saves huge amounts of time for all concerned, and results in submitted data that is accurate, internally consistent, and free of obvious errors.

Additionally, the OIC Application performs a similar set of Category 0 data validations whenever submitted data processes and loads into the project database. In other words, Category 0 validations occur both within the Check My Spreadsheet utility and within the OIC Application itself.

Category 1 — Specific validations on individual data elements, and Category 2 — Complex cross-validations within a single submission, occur both in the Check My Spreadsheet and the OIC Application as data loads.

Category 3 and 4 validations occur within the OIC Application. These validations are separate from the Check My Spreadsheet macro.

Category 4 validations, which compare all district-submitted data to all carrier-submitted data, run after receipt of all required data, which has passed all lower-level validations, and has been loaded to the project database.

The Project Team built considerable flexibility into its approach to data validation on the application side:

- One may globally enable or disable validations on a per-carrier basis.
- One may enable or disable individual validations on a per-carrier basis.
- Validations may be set to generate either an error or a warning.
- Each validation has a variance, expressed as a percentage, which one may tailor for each validation. A condition that falls outside of the specified variance generates an error or warning.
- The project's actuary provides guidance to specify default validation parameters, and the Project Team adjusts the parameters according to each carrier's specific circumstances.

Please see Exhibit 23 for a detailed description of the Year 4 data validations.

CHAPTER 1: K-12 CURRENT HEALTH PURCHASING OPTIONS

This chapter provides an overview of the current K-12 school-district health-benefits purchasing arrangements, as well as summary information from data provided by reporting districts and carriers.

There are 295 districts statewide with a wide variety of benefit plans obtained directly through insurers, the Washington Education Association (WEA), the Public Employees Benefits Board (PEBB) program under the Health Care Authority, or directly by exercising the option to self-fund.[17]

The vast majority of districts purchase healthcare coverage through carrier-provided purchasing arrangements, such as the WEA, or as part of community-rated plans. Risk or rating pools established exclusively for K-12 districts.

The data collection project received district data from all 295 districts, covering 104,429 employees and 163,387 members (that is, employees plus covered dependents), as reported by the districts.

The data collection project received carrier data from 10 carriers, inclusive of PEBB. The carriers reported total medical premiums of $1,110,867,442 and reported 554 health plans offered in 2015, including terminated plans and unused plans. Carriers provided financial data (enrollment, premiums, and claims) for 554 health plans covering a monthly average of 105,668 employees and 199,021 members for calendar year 2015. The carriers provided actuarial values on all active plans.

Note that differences in the premium and enrollment numbers as reported by the carriers, as opposed to those reported by the districts, is generally due to the timing of the counts and do not represent a data integrity issue. Due to the design of the Data Call,[18] carriers generally reported somewhat higher enrollment numbers, while enrollments summarized from the plan-level data or from districts are slightly lower.

Note that districts accurately maintain (and report) employee member data, but do not consistently maintain (or report) dependent member information. As a result, one may consider carrier-reported data to be more accurate than district-reported data, with respect to covered dependent and member counts.

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[17] Self-funding an employee benefit requires an Administrative Services Only (ASO) arrangement with a third-party administrator, setting up financial reserves to cover costs for claims incurred and not reported (IBNR), and additional steps.

[18] In both Section 6 and Section 8 of the Carrier Data Call, carriers report enrollment on a yearly basis, whereas districts, in Section 7 of the District Data Call, report enrollment based on a 'snapshot date', which in Year 4 of the project, was October 1, 2015.

One may illustrate the net outcome of this data collection design as follows: if, for District X, 100 employees switch at some point in 2015 from Carrier 1 to Carrier 2, then both carriers (quite correctly) report 100 employees, thus resulting in double-counting of those employees on the carrier side.

Taken together, these aspects of data-collection design result in carrier reporting of enrollment that is higher than district reporting of the same population.

The only possible remedy to make carrier-reported enrollment align more perfectly with district-reported enrollment would be to require both districts and carriers to report enrollment on a monthly basis. This is not a practical solution, and it would place an undue burden on districts.

The 10 carriers are:

- Aetna
- Group Health Cooperative
- Kaiser Permanente
- KPS Health Plans
- MODA Health[19]
- Premera Blue Cross
- Providence Health Plans
- Regence BlueShield
- United Healthcare
- The Public Employees Benefits Board (PEBB), which sponsors plans administered by Group Health, Kaiser, and Regence

A summation of the current K-12 district data follows:

Table 1 shows all 295 K-12 districts statewide by district size, in terms of the total number of employees.

Table 2 shows a summary of enrollment by carrier for reporting carriers.

Table 3 shows plan types by reporting carrier. The types of health plans include Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and High-Deductible Health Plans (HDHPs). The other reported plan types are unique and similar to HMO-type plans.

[19] MODA Health withdrew from the Washington State markets in 2016 (Year 5).

Districts by Size		
District Size Range	Number of Districts	Percentage of Total
1 – 49	99	33.6%
50 – 149	75	25.4%
150 – 299	34	11.5%
300 – 449	24	8.1%
450 – 599	15	5.1%
600 – 748	7	2.4%
750 – 999	12	4.1%
1,000 – 1,499	9	3.1%
1,500 – 1,999	8	2.7%
2,000+	12	4.1%
Total	**295**	**100.0%**

Table 1 —Districts by Size

Enrollment by Carrier			
Carrier	Employees	Members	% of Total Members
Carrier 01	56,739	108,021	53.8%
Carrier 02	27,238	49,763	24.8%
Carrier 03	8,584	15,939	7.9%
Carrier 04	3,432	6,219	3.1%
Carrier 05	3,218	6,138	3.1%
Carrier 06	979	1,768	0.9%
Carrier 07	2,724	4,707	2.3%
Carrier 08	1,933	4,624	2.3%
Carrier 09	348	630	0.3%
Carrier 10	1,437	2,902	1.4%
Total	106,632	200,711	100.0%

Table 2 — Enrollment by Carrier

Enrolled Employees by Plan Type		
Plan Type	**Employees**	**Percentage of Total**
PPO	81,604	77.3%
HMO	19,160	18.1%
Traditional	2,063	2.0%
Point of Service	1,101	1.0%
High Deductible	728	0.7%
Closed Network	554	0.5%
Open Network	425	0.4%
Total	105,635	100.0%

Table 3 — Enrolled Employees by Plan Type

Note: The collected data shows variations in the number of health plans, reported premiums, and enrollment numbers, which generally reflect differences in the timing of the reporting and do not constitute a data quality issue. For example, some carriers did not carry over plans offered to districts in 2015 into 2016, but the carriers report the plans, as required by ESSB 5940.

CHAPTER 2: DATA COLLECTION PROCESS AND RESULTS

Introduction

As authorized under ESSB 5940, the data collection process for K-12 districts in the state of Washington, and their medical carriers, involved sending a Data Call to all districts and their medical carriers. The Project Team did not request any data directly from any other third party or intermediary.

The Data Call comprised detailed written instructions and a Data Collection Spreadsheet to use for data submission. The Data Collection Spreadsheet contained multiple separate Sections, each containing a different type of data.

Data collection focused on health-benefit plans. However, in addition to health-benefit plans, the Project Team asked each district to report the aggregated cost of separately purchased dental and vision plans. Data collection specifically excluded other types of employee benefits, such as life insurance and disability insurance plans.

A substantial portion of the total data collected originates from the carriers because:

(a) ESSB 5940 requires more carrier-specific data, and

(b) Carriers generally have more resources, systems, processes, and reporting capabilities than most school districts.

The Project Team issued the Carrier Data Call to 10 carriers, including PEBB, and issued the District Data Call to all 295 school districts in Washington State.

Districts relied on many data sources, and on multiple payroll and accounting systems with a wide variety of reporting capabilities. This multiplicity of sources and systems was an impediment to consistent reporting across districts, particularly with respect to district reporting of covered and non-covered dependents. For all these reasons, the process of generating exhibits from the collected data relied more heavily on carrier data than on district data.

There was no attempt to "audit" the completeness or veracity of the data that was collected from either the carriers or districts. However, in order to validate the internal consistency of collected data, the Project Team applied five categories of automated validations as the data was loaded to the project database. Resubmissions were required from some districts and carriers to correct reporting errors uncovered by the run-time validations.

The Project Team performed additional Data Quality Assurance (DQA) activities after collecting and initially accepting all data. The DQA activities resulted in identifying and correcting many reporting errors by carriers and districts. (For more information about data quality, please see the sub-sections below entitled “Data Validation” and “SOW 25”).

The Project Team designed and built a computer application, referred to as the "OIC Application." This application processed submitted or re-submitted data. The essential purpose of this application is to perform validations on submitted data, and (if the data passes the validations) load it to the project database. Ancillary functions include managing the success messages and detailed error messages that the application automatically generates and sends to districts and carriers, and status reporting.

Period of the Information Collected

The language of ESSB 5940 specifies the "prior calendar year"[20] as the period of data to be collected. For Year 4 of the project this means calendar year 2015. Most districts and their carriers align health-benefit plans with an enrollment election date — typically October 1 — for the current school year. As such, data reporting for most district health-benefit plans frequently straddled two plan years: the plan year ending in 2015 and the plan year beginning in 2015 but ending in 2016.

To obtain twelve months of data for calendar year 2015, carrier data reporting is for plan years ending in 2015 plus any remaining months of 2015 for those plans that begin in 2015 but end in 2016. For plans not aligned to the calendar year, this required two different reporting periods in 2015. For example, for plan years ending September 30, this required the capture of 2015 data through September 30, 2015, plus data for the remaining months of October, November, and December 2015. The remaining three months of data represent data for the plan year that ends in 2016.

In addition to calendar-year and plan-year reporting, some carrier data is monthly. For districts, census reporting uses a "snapshot" date as described below.

Any comparison of carrier and district data should note the different periods of data collection.

Snapshot Date

In order to simplify the data collection process for the benefit of districts, census data from districts uses a "snapshot date." The snapshot date selected is October 1, 2015, to align with the OSPI S-275 employee population reporting process.[21] Districts report all district personnel employed as of October 1 of each year to the OSPI on the S-275 report. District census information (population data), including employee and dependent head counts, demographics, full-time equivalent status, employee groups, enrollment information, and coverage elections, is as of the snapshot date of October 1, 2015. Some districts may have reported all participants within the month of October 2015, rather than as of the snapshot date, which does not materially change the data.

[20] ESSB5940 Section 4(2)

[21] The OSPI S-275 reporting process is an electronic personnel-reporting process that provides a record of certificated and classified employees of districts. State law mandates data collected by the S-275 reporting process, that is necessary for calculating state funding, or that is necessary for responding to requests from the federal government, the Legislature, or other organizations.

Ideally, one would gather two sets of census results from districts, one for each of the two school years within the calendar year, per ESSB 5940. Even better would have been to collect monthly census data. However, both approaches are too onerous, and they could have delayed data collection. Instead, the Project Team collected a single set of census data. This census dataset had a snapshot date of October 1, 2015, near the beginning of the school year that was under way at the time of the data collection.

An additional benefit of the "snapshot" approach is that one can compare, easily and reliably, census results from subsequent years of the project to those of a prior year.

The district census data captures the monthly unit rates by coverage tier — employee only (EE), employee and spouse (ES), employee and children (EC), and employee and family (EF) — as well as district and employee contributions, which together comprise the monthly total premium rates. Unit rates are as of the snapshot date.

For some carrier data, the snapshot date is the plan-year ending date, typically the end of the school plan year (September 30, 2015), particularly to capture reserve balances for claim or rate stabilization reserves (CSR or RSR reserves) or reserves for claims incurred but not reported (IBNR[22] claim reserves). The Project Team also used the snapshot date to capture detailed demographics by plan.

The Project Team reported other information requested from districts and carriers (for example, narratives, plans, performance measures, financial information, and so on) by calendar year, plan year, or annually by month depending on the availability, type, and source of the data. The Project Team requested amounts for the school fiscal year ending in 2015 for annual district totals by expenditure category or payee.

[22] Sometimes called "Incurred But Not Paid (IBNP)."

Statements of Work (SOWs)

SOW 21 — Foundational Documents

The overall objectives of this SOW were to research, assemble, plan, prepare, and publish a set of foundational documents for the project. These include:

- SOW Summary showing amounts and due dates associated with each workstream
- Project Budget
- Project Schedule
- SOW 21 — Word document describing the required Foundational Documents
- SOW 22 — Word document describing Data Call Preparation
- SOW 23 — Word document describing Data Call Execution
- SOW 24 — Word document describing Data Collection
- SOW 25 — Word document describing Data Quality and Validation
- SOW 25 — Word document describing Exhibits and the Year 4 Report

SOW 22 — Data Call Preparation

Introduction

The overall objectives of this SOW were to produce draft versions of all documents and technical artifacts needed for the Data Call, and to engage with districts, carriers, and WSIPC.

The Project Team made revisions and improvements to the custom-built toolset used in previous years by districts and carriers to submit data to the Project Team, and by the Project Team to process and store submitted data. Feedback from districts and carriers, based on their experience while using the toolset provided in Year 3, drove improvements in Year 4. These concerned:

- The Project Database

  The Project Team made incremental improvements to the database design based on what the Project Team learned during Year 3, and as the project unfolded in Year 4.

- The OIC Application

  The Project Team made incremental improvements in the area of automated server-side data validations that the Project Team performs prior to loading district or carrier data to the project database.

- Data Collection Spreadsheets & Instructions

  Improvements to Carrier Data Collection Spreadsheet & Instructions and to District Data Collection Spreadsheet & Instructions included clearer and more precise instructions, as well as minor enhancements to the “Check My Spreadsheet” utility for both districts and carriers. This allowed users to perform pre-validations and get detailed, accurate, and instantaneous feedback on their data before submission, thus improving overall data integrity and shortening the submission/correction cycle.

Activities

Under SOW 22, the Project Team engaged in the following activities:

- Built draft versions of the documents required by the Year 4 Data Call: District Cover Letter, District Instructions, Carrier Cover Letter, Carrier Instructions, FAQs and Process Flow Diagrams
- Amended and performed System Testing[23] on the technical artifacts comprised within the Year 4 Data Call: district Data Collection Spreadsheet; carrier Data Collection Spreadsheet; OIC application and database; Development, Test, and Production environments; data load programs for both district and carrier data; and data validation programs.
- Initial Outreach — in early December of 2015, the Project Team contacted all districts and their medical carriers to let them know that the Year 4 project was under way, to advise them of the project schedule, and to describe differences between Year 4 of the project and prior project years.
- Engagement with WSIPC (see below).

WSIPC

Most districts rely heavily on third-party reporting through the Washington School Information Processing Cooperative (WSIPC), which provides integrated software solutions as well as IT infrastructure and support to member districts (275 districts out of 295). WSIPC hosts databases for the substantial majority of districts in Washington State, and routinely provides data extract routines that allow member districts to comply with the reporting requirements of the Office of Superintendent of Public Instruction (OSPI).

Throughout the data collection phase, WSIPC was instrumental in helping districts comply with the reporting that ESSB 5940 requires. WSIPC provided software that allowed each district to extract much of the required data from their own independent database, which districts supplemented with additional information from other sources before submitting it to the Project Team.

Each district has its own independent database, and it is free to configure and use WSIPC-supplied software as it sees fit, or to use WSIPC-supplied software in tandem with other software not supplied by WSIPC. Consequently, districts use (and report) a wide variety of different payroll deduction codes, accounts payable codes, and business entity names. WSIPC issues guidance to all its member districts in an effort to harmonize their payroll and deduction codes and to help the WSIPC extract to pull the relevant health-benefit data in a consistent way. However, myriad differences persist in the way districts configure and use payroll and accounting data, and this inevitably creates challenges in terms of achieving consistency in reporting across all districts.

[23] The Project Team internally performed System Testing. Testing with external entities such as districts, carriers, or WSIPC was out of scope in Year 4.

Note: WSIPC is an umbrella IT organization encompassing Information Service Centers co-located within the Educational Service Districts, as well as several Regional Data Centers. It offers integrated software solutions to member districts in the form of WESPaC, a robust, third-party suite of applications designed to support the data processing needs of districts. This data processing includes operations, financial management, accounts payable and receivable, and payroll, among other functions. Each member district runs their own version of WESPaC on their own "virtual machinery" within the IT infrastructure provided and operated by WSIPC. Each district has its own virtual database server and virtual file server, thus segregating each district's data from every other district's data, and providing security.

All Project Artifacts are on the OIC's Web Site

One may view and download all documents related to the project, for both districts and carriers from the K-12 Project-related web pages on the OIC's web site:

https://www.insurance.wa.gov/for-insurers/data-calls-reporting/special-data-calls/k-12-health-benefits-data-collection/

SOW 23 — Data Call Execution

Introduction

Under SOW 23, the Project Team engaged in the following activities:

- Sent a follow-up e-mail broadcast to districts and their carriers prior to the Year 4 Data Call
- Produced final versions of the documents required for the Year 4 Data Call:
  - District Data Call cover letter
  - District Instructions
  - Carrier Data Call Cover Letter
  - Carrier Instructions
  - Project Timelines
  - FAQs
  - Process Flow Diagrams

  Note that the Project Team internally performed final testing. Testing with external entities such as districts, carriers, or WSIPC was out of scope in Year 4.
- Executed the Data Call; in this activity, the Project Team sent the District Data Call to all 295 K-12 districts, and the Carrier Data Call to all 10 carriers.

District Data Call

The outcome of the District Data Call was that all 295 districts provided data in compliance with ESSB 5940. The districts reported 104,429 employees and 163,387 members, generating $1.1 billion in premiums.

Components

The District Data Call included an instructions document and a Data Collection Spreadsheet.

These documents, and additional documents, were (and still are) are available for viewing and download from the Year 4 district-related web page on the OIC's web site:

https://www.insurance.wa.gov/for-insurers/data-calls-reporting/special-data-calls/k-12-health-benefits-data-collection/schools/index4.html

The Data Collection Spreadsheet for district reporting has eight tabs. Each tab contained a different type of data referred to as a "Section," as detailed below.

Section 1: District Annual Reporting (Fiscal Year-End 2015)

This Section requested information about each district's health benefits such as:

- Total annual premiums paid to carriers for health benefits (calculated automatically based on input in Section 3).
- Insurance broker fees paid separately, not including broker commissions paid by the health plans.
- Dollar amounts paid for supplemental health services purchased from third parties, and a description of those supplemental health services, if any, purchased outside the medical health plan (for example, a wellness program, health risk assessments, or biometric screenings). This category of expenditure reporting also included employee-paid insurance against accidents, hospital stays, and certain specific conditions such as cancer.
- Internal and external administrative costs (exclusive of healthcare premiums) associated with health-plan administration.
- Dollar amounts paid to third parties, and a description of third-party costs excluding medical insurance and non-medical insurance. This field's principal purpose is to report the costs associated with the district retiree medical subsidy, also known as the "retiree carve-out."
- Confirmation that the district offers a high-deductible health plan (HDHP).
- Narratives describing various kinds of efforts, achievements, and progress towards:
  - affordability for full-family coverage
  - healthcare cost savings
  - reduced administrative costs
  - improvements in the management, delivery, and administration of health benefits
  - reducing the differential between employee-only and full-family coverage
  - protecting access to coverage for part-time employees
  - innovations to reduce health premium growth and the use of unnecessary health services

Section 2: Innovative Health Plan Features

- This Section provided a pre-defined list of "innovative features" which have the potential to reduce healthcare cost trends. The district selected which features are applicable to any health plan offered by the district.

Section 3: Carriers, Brokers, and Other Entities

- Each district identified various entities such as carriers, brokers, and other third parties that the district paid for services related to delivery, management, or administration of health benefits.
- For each entity, districts reported on premiums or fees paid for related services.

Section 4: Carrier Health-benefit Plans

- For each medical insurance carrier, the district listed all (medical) health plans offered and the name of each unique plan.

Section 5: Employee Groups by Category

- This Section requested identification of each employee group to which the district offered a distinct array of benefits. Districts had to categorize each employee group as being either for classified or certificated employees.
- The districts report here the health plans offered to each group of district employees (or in Section 6), thus allowing plans offered to be associated with employee groups.

Section 6: Medical Plans offered to Employee Groups

- This Section provided an alternate means of reporting the health plans offered to each group of employees.

Section 7: Employee Listing (Census Data)

- This Section requested census information — a list of the district's employees as of October 1, 2015. This section should list each district employee appearing on the district's OSPI S-275 report.
- For each employee, the following data was collected:
  - A unique employee identifier[24]
  - The group the employee belongs to
  - An indication as to whether the employee is classified or certificated
  - Gender
  - Date of birth (DOB)
  - Full-Time Employee (FTE) benefit status
  - A "Yes/No" indication as to whether, by the district's own local rules, the employee is benefits-eligible
- If an employee was eligible, and if a (medical) health-benefit plan selection was made, the following data were collected:
  - Plan selection
  - Monthly contributions paid by the reporting district
  - Monthly contributions paid by the employee
  - Total monthly premium (district contribution and employee premium combined)
  - Coverage tier selection: Employee only (EE), employee plus spouse (ES), employee plus child (EC), and employee plus family (EF)
- The districts could report eligible dependents here, or in Section 8.

Section 8: Dependent Listing

- This Section provided an alternate means of reporting data concerning each employee's eligible dependents.

[24] The Data Call specifically instructed districts not to provide the names or Social Security Numbers of district employees. However, in a few instances they did so. In such cases, the Project Team de-personalized the data before loading it to the project database.

Carrier Data Call

Introduction

The 2016 Carrier Data Call included 10 carriers, including PEBB (considered a "carrier" for the purposes of data collection). The 10 carriers in Year 4 include:

- Aetna
- Group Health Cooperative
- Kaiser
- KPS Health Plans
- MODA Health (new in Year 3)
- Premera
- Providence Health Plan
- Regence
- United Healthcare
- PEBB[25]

Carrier Data Call Components

The Carrier Data Call included an instructions document and a Data Collection Spreadsheet.

These documents, and additional documents, were (and still are) are available for viewing and download from the Year 4 carrier-related web page on the OIC's web site:

https://www.insurance.wa.gov/for-insurers/data-calls-reporting/special-data-calls/k-12-health-benefits-data-collection/carriers/index4.html

The Data Collection Spreadsheet for carrier reporting has eleven tabs. Each tab contains a different type of data, referred to as a "Section" as detailed below.

Section 1: Carrier Annual Reporting (for Calendar Year 2015)

This Section required reporting of narrative information related to each carrier's progress, efforts, and achievements towards healthcare cost savings, reduced administrative costs, mitigation of unnecessary health services, and improved management of K-12 health plans.

[25] *The Public Employees Benefit Board (PEBB) reported on a combined basis on behalf of their health plans Group Health Cooperative, Kaiser, and Regence*

Section 2: Innovative Health Plan Features (all K-12 Plans in 2015)

This Section provided a pre-defined list of "innovative" health plan features or programs that may (or may not) be offered by a given carrier to districts (for example, a high-risk maternity program). The section asks each carrier to identify those programs from the list that the carrier offered to one or more K-12 districts.

Section 3: Reserves by Rating Pool (Ending Reserves)

This Section required reporting of information related to reserves that are applicable to a carrier rating pool or purchasing pool. This Section also included enrollment and paid claims information by applicable pool.

The section requested information on two types of reserves:

1. Claim reserves for incurred but not reported (IBNR) claims, also referred to as claims incurred but not paid (IBNP).
2. Claim or Rate Stabilization Reserve (CSR or RSR), which is applicable to a carrier rating pool. A carrier uses a CSR or RSR as a hedge against claim fluctuations that occur during a reporting period.

Section 4: Health Plan Year Information (all Plan Years in 2015)

This Section required reporting of information on each unique health plan offered in 2015 by each K-12 carrier. The information requested included actuarial values,[26] plan type, and other key attributes.

This Section established the linkage between Plan Codes and Costshare Codes, used in Section 10 to report the cost-share design of (groups of) plans. Essentially, a Costshare Code identifies a group of plans that have the same cost-sharing features. The Project Team did not report the rates associated with individual plans in Year 4 reported in Section 4. Instead, the Project Team used a Rateset Code (see notes on Section 11, below). There may be a one-to-many relationship between Ratesets and Plans.

This section required identification of each unique plan as being part of a "benefit package." A benefit package can include one plan or multiple plans, depending on how a carrier chose to report their data. Carriers can aggregate district plan data for small district enrollments, or plans with similar actuarial values into a "benefit package" in order to maintain patient confidentiality of protected health information under HIPAA.

[26] Carriers determined the actuarial value using the "actuarial value calculator" applicable under the Affordable Care Act (ACA) to determine the percentage of the allowed costs of benefits. A value of 1.000 would indicate that a plan covers 100% of expected medical expenses, whereas a value of 0.900 would indicate that a plan, on average, covers 90% of expected medical expenses. One calculates these values for the total population of the plan, so some individuals may see reimbursement at more or less than the actuarial value.

Section 5: Benefit Package Plan Year Performance (for Plan Years Ending in 2015)

This Section required reporting of performance data such as health-plan premiums[27] and total claims expenses or paid claims[28] for the plan year ending in 2015. For plans with low enrollment, which generally indicates fewer than 200 covered lives, the section permitted data aggregation. In some cases, carriers also aggregated plans with similar actuarial values (see related footnote 17). Carriers reported claims data by major benefit category (for example, hospitalization, professional services and pharmacy) using utilization metrics, such as hospitalization average length of stay and the number of professional services visits per 1,000 members.

The required data also includes carrier administrative costs, broker commissions, insurance taxes, and PPO network fees, if any.

Section 6: Benefit Package Performance by Month (all Plans in 2015)

This Section required monthly reporting of premiums, paid claims by major benefit category, and employee and dependent enrollment. The reporting period includes all months for the plan year ending in 2015, plus the remaining calendar months (within 2015) of the plan year that began in 2015 and ends in 2016.

Section 7: Benefit Package Demographics by Plan

This Section required reporting of enrollment data with demographic information (for employees and their dependents) such as gender, age, and plan enrollment. Carriers supplied this data based on pre-defined age bands (for example, 0 to 19, 20 to 24, 25 to 29, and so on). The section requested information for each benefit package associated with the plan year ending in 2015.

Section 8: Benefit Package by District by Plan (for Plan Years Ending in 2015)

This Section required reporting of enrollment (headcount) data for each health plan by district for the twelve-month period ending in December 2015. This allowed for the mapping of a district to a particular benefit package.

Section 9: Large Claims (for Plan Years Ending in 2015)

This Section required reporting of large claims. The large claims report represents aggregated large claims data for all K-12 districts for all carriers combined statewide. The design of this level of aggregated reporting protects the privacy of individually identifiable health information. A claim is "large" if the sum of all claims paid for an individual in the reporting period exceeds $100,000. The information by claimant included the primary diagnosis code associated with the highest-cost service related to the reported large claim.

[27] WAC 284.198.005 defined health-plan premiums as the amount agreed on as the health plan unit rate charged by the carrier for each plan participant for coverage. Further "actual earned premiums" as defined in RCW 48.43.005, includes rates credits and refunds. The Data Call requested that carriers report actual premium.

[28] WAC 284.198.005 defines paid claims as the dollar amount of claims recorded as paid during the reporting period.

Section 10: Cost-sharing Design (for Plan Years Ending in 2015)

In Year 1, the Project Team manually collated material supplied by the carriers in order to document the cost-sharing design of all plans offered to districts. However, in Year 2 the Project Team created an entirely new section to gather this information electronically from carriers. This new section worked well in Year 2 and the Project Team continues to use it. It gathers data on various types of deductibles, co-insurance, copays, and pharmacy-related plan attributes.

Section 11: Plan Rates by Rateset Code (for Plan Years Ending in 2015)

In Year 1, the carriers reported rates associated with plans in a single column within Section 4. In Year 2, the Project Team created Section 11 to focus explicitly on rates. It provides carriers with a mechanism to report rates by tier, and to group plans (which have identical rates) together by "rateset" code. This new Section worked well in Year 2 and the Project Team continues to use it.

SOW 24 — Data Collection

This Statement of Work requires the Project Team to perform the following activities:

- Collect district and carrier data
- Provide individualized support to districts and carriers
- Process and load collected data to the project database, which included applying robust, automated data validations to both district and carrier data
- Track and manage data collection efforts for each individual district and carrier, and the overall effort to collect, validate, and load all the required data
- Deliver status reports to the OIC on Data Collection efforts and follow-up activities

Data collection began in February of 2016, and continued until the official deadline, which was May 29, 2016. A small number of districts did not submit data by the deadline, so the Project Team followed up with each of them, and by June 16, the data collection was complete. Thus, the data collection achieved a 100% response rate and no districts or carriers were out of compliance.

Note, however, that because of Data Quality Assurance work performed by the Project Team from mid-June until mid-September, the Project Team requested many districts and carriers to make corrections to their data and to resubmit it. All of them complied fully, thus preserving the project's 100% success rate.

District Data Collection Results

The level of district responsiveness begun in Year 2 of the project is the highest compared to any previous study of this nature related to K-12 district health benefits. Beginning in Year 2, all 295 districts responded to the Data Call in each project year.

Districts provided census data as of the "snapshot date" of October 1, 2015. (For comparison, carriers provided financial data for the entire 2015 calendar year.) District reporting shows total enrollment of 103,236 employees and 161,822 members (please see the A12 series Exhibits attached to this report). Carriers provided financial data on 105,668 K-12 employees and 199,021 members (see Exhibit A9a). Districts reported combined contributions generating $1.111 billion in premiums, while carriers reported $1.139 billion in premiums. One expects to see these minor discrepancies due to differences in the reporting period.

The success of the district data-collection effort is due to:

- The high level of commitment from districts to this effort
- The role of WSIPC, including (i) centralized hosting of databases for the substantial majority of districts and (ii) provision of a universal data extract for participating districts
- A team member dedicated to working closely with the districts and to coaching individual districts as needed
- The OIC's active participation and management of all aspects of the project
- The support of all the Educational Service Districts throughout the state of Washington

Variations in District Data

Given the great variety of processes, information sources, information systems, and service providers used by districts, one expects variations in the reported data. However, please note:

(i) There was no verification of submitted data, although the Project Team validated it for internal consistency and manually checked it for reasonableness.

(ii) Some minor inconsistencies exist in the collected data, but they are statistically inconsequential. For example, district-reported enrollment and premiums do not match exactly with the corresponding carrier data.

A list of reasons for variations between district-reported data and carrier-reported data follows, specific to the districts:

1. There are large variations in district data-reporting capabilities and methods. Districts extract data from more than 200 different computer systems. Districts configure and manage computer applications and databases independently within each district, resulting in a wide variety of deduction and accounts payable coding schemes, configuration approaches, and data sources for extracting data. (This is true even for districts that use computing resources provided by WSIPC.) The result is that there is limited consistency across districts in terms of:
   - Use or reporting of plan codes or plan names
   - Configuration of WSIPC-provided district management software
   - Configuration of the WSIPC extract
2. Some districts reported certificated and classified populations in unified groups. In these cases, the Project Team had to ask the district to resubmit, and to segregate properly employee groups. Minor inaccuracies in the district data may persist with respect to certificated and classified employee groups.
3. Uncovered dependent information was available only from districts that surveyed their populations for this data; thus, data on uncovered dependents is neither comprehensive nor complete across districts. On a related note, while district reporting of employee enrollment appears to be accurate (because it closely matches carrier-reported employee enrollment), district-reported enrolled membership (employees plus dependents) varies greatly from the membership reported by carriers. Hence, the Project Team deems carrier-reported data concerning membership to be more accurate than district-reported data.
4. Improved District Data Call processes require districts to use a predefined list of carrier names, which subsequently allows matching, at the carrier level, between the district dataset and the carrier dataset. However, matching on plan name or plan code continues to be impossible due to huge variations in how districts identify plans within their accounts payable and payroll systems, and consequently in how they identify plans in their submitted data.
5. District data cannot perfectly align with carrier data because there are different periods for reporting data. Carriers were asked to report monthly, annually, or for the plan year ending in 2015; whereas districts were asked to report populations and premiums based on a single snapshot date of October 1, 2015, and total amounts paid (to each entity listed in Section 3) based on the full school fiscal year ending in 2015.
6. There is no universally accepted standard for reporting of administrative costs related to district benefit administration.

These factors, taken together, generate inevitable discrepancies between reporting of enrollment and premiums within individual districts, and across the entire district dataset compared to the entire carrier dataset. Given the wide variety of reporting periods and other factors, it is noteworthy that the Project Team achieved such a high level of concordance between district-reported and carrier-reported enrollment and premium data.

Carrier Data Collection Results

The data collection project received carrier data from 10 carriers including PEBB. For reporting purposes, the Project Team combined PEBB plans (underwritten by three carriers). A summary of the employee and member enrollment results reported by carrier for all K-12 health plans follows below in Table 4. Actual carrier-reported financial data included monthly averages of 105,668 employees and 199,021 members, and a total of $1,110,867,442 in premiums for calendar year 2015 (see Exhibit A9a). The difference in reporting may be attributable to the reporting period and expected changes in enrollment across different reporting periods.

Carrier Enrollment Summary			
Carrier	Employees	Members	% of Total Members
Carrier 01	56,739	108,021	53.8%
Carrier 02	27,238	49,763	24.8%
Carrier 03	8,584	15,939	7.9%
Carrier 04	3,432	6,219	3.1%
Carrier 05	3,218	6,138	3.1%
Carrier 06	979	1,768	0.9%
Carrier 07	2,724	4,707	2.3%
Carrier 08	1,933	4,624	2.3%
Carrier 09	348	630	0.3%
Carrier 10	1,437	2,902	1.4%
Total	106,632	200,711	100.0%

Table 4 — Carrier Enrollment Summary

Variations in Carrier Data

Note that there was no verification of submitted data, although the Project Team validated data for internal consistency using computer programs designed and build specifically for this purpose, and the Project Team manually checked the data for reasonableness.

The factors listed below explain the small differences between district and carrier data, specific to the carriers:

1. A variety of different data reporting sources within individual carriers led to variations in reported enrollment, premiums, and claim totals across different Sections of the Carrier Data Call.
2. Each carrier has a unique database design and its own programming staff. Although the Carrier Instructions were clear as to the desired result (that is, the target data definitions and layouts), no guidance was provided on how to achieve the desired result. Inevitably, therefore, there were differences in the approaches and methodologies used by carriers to extract the requisite data.
3. The period of data collection that is required under ESSB 5940 is calendar year 2015. However, districts track data on a school fiscal-year basis, and most carriers track data on a district's plan-year basis. Thus, enrollments, premiums, contributions, and other data may not align between calendar-year reporting, plan-year reporting, and the snapshot date used for district reporting. Because of the different reporting periods between districts and carriers, the data cannot perfectly align across these datasets.
4. Carriers may aggregate data by health plan, including aggregation of smaller district plans and plans of similar benefit value. The purpose of aggregation is to avoid disclosure of individually identifiable health information or protected health information as defined by HIPAA.
5. The Project Team does not track utilization metrics for medical and pharmacy data on the same basis across all carriers, and in some cases, they are unavailable, all of which results in gaps in reporting. In addition, calculation of utilization metrics for small populations generated large variations in results, which one would expect for smaller health plans.
6. There are measurable, but statistically insignificant, variations in total premiums by benefit package reported by carriers compared to the total premiums reported by districts. These minor discrepancies are mainly attributable to differences in reporting periods and to different sources of enrollment and premium information.

Run-Out Claims

Run-out claims are claims against plans that are no longer offered, or that have effectively ended (that is, they have no enrollment or premiums), but for which claims from prior plan years are still trickling in.

The Data Call did not specifically request or exclude run-out claims data for plans that:

- Ended in 2014, and had run-out claims experience in 2015; or
- Were active in 2014 and 2015, had no enrollment in 2015, and had run-out claims experience during 2015 resulting from claimants in 2014.

Based on instructions from the OIC, the Project Team made a decision that carriers could submit run-out claims data if they chose to do so. In the end, some carriers chose to submit run-out claims data, and the Project Team accepted it and loaded it to the project database. Some carriers did not submit any run-out data.

The Project Team did not design the Carrier Data Call to collect such data, and hence the Year 4 run-out claims data is probably incomplete.

SOW 25 — Data Quality Assurance

Early in the Year 4 project, the Project Team agreed with the OIC that the Project Team would include the work of SOW 25 within SOW 26. In Year 4, the Project Team performed the Data Quality Assurance work under SOW 26.

SOW 26 — Exhibits and Year 4 Report

The overall objectives of this SOW are to:

a. Perform detailed analysis on data anomalies between carrier-reported data and district-reported data, and between district data reported in different project years.

b. Take reasonable steps to resolve anomalies that are discovered through the analysis referred to above, by following up with WSIPC and with individual districts, about serious variances between Year 4 district data and carrier data in terms of enrollment and/or premiums, or striking variances in terms of district-reported premiums and enrollment across multiple project years. Apply automated validations to collected data, and perform cross-validations between the carrier dataset and the district dataset.

c. Create and submit a Data Validation Report; this identified, at a summary level, apparent shortcomings in submitted data, as well as the steps taken to correct submitted data and/or request resubmission of corrected data.

d. Keep logs of what, if any, submitted data that the Project Team changed and why, as well as separate pre-change and post-change versions of each set of submitted data.

e. Request resubmission of data that was not reasonable or credible, or that contradicted other collected data.

f. Produce reporting as required by ESSB 5940 based on data collected from districts and their health carriers in the state of Washington.

g. Produce related exhibits derived from the data collected from districts and their health carriers.

h. Produce a Data Traceability Matrix, which traces the connections between data on which ESSB 5940 requires reporting, and the data design implemented and used by the Project Team.

The Project Team duly performed the work specified in this SOW, and OIC accepted the deliverables produced.

CHAPTER 3: DISTRICT-SPECIFIC DATA

All 295 school districts and 10 carriers participated in the K-12 Data Collection Project. Districts paid $1.1 billion in annual premiums based on the snapshot date of October 1, 2015. The figures below derive from district enrollment as of the snapshot date, and report annualized average premium and contributions.

Note: For source exhibits, refer to A7a, A7b, A16, and A17.

Table 5 below shows the average contributions as reported by districts as of the snapshot date.

Contributions by Tier		
Contributions as Reported by Districts	**Full-Time Employees**	**Part-Time Employees**
Ratio of Family to Employee Contributions	8.1	7.1
Contributions as a Percentage of Premium Employee Coverage	9.1%	12.1%
Contributions as a Percentage of Premiums Employee & Family Coverage	38.2%	41.2%

Table 5 — Contributions by Tier

Table 6 shows the average premiums and claims by health plan (Exhibit A14), as reported by the carriers, for the plan year ending in 2015. These are employee composite monthly rates derived from premiums by coverage tier, weighted by the enrollment in each coverage tier to calculate the composite rates. They are shown on a "per employee per month" (PEPM) basis.

Employee Premium and Claims		
Category	**Premium**	**Claims**
Low	$389.81	$19.38
High	$1,570.72	$3,444.71
Average	$876.07	$784.91

Table 6 — Employee Premium and Claims

A detailed description of exhibits is included in the appendix of this report.

Note: Certain exhibits break down costs per employee per month (PEPM) and per member per month (PMPM). Exhibits A6a and A6b show only the medical portion of premium costs, exclusive of carrier administration. Exhibits A7a and A7b break down premiums and contributions by full-time and part-time employees. Some exhibits provide low, high, and average costs.

CHAPTER 4: CARRIER-SPECIFIC DATA

To comply with the requirements of ESSB 5940, carriers had to report all health plans provided in calendar year 2015. The carriers reported 554 separate health plans provided during 2015. This included plans ending in 2015 (plans offered in the 2014 – 2015 school year) and plans beginning in 2015 (plans offered for the 2015 – 2016 plan year). In other words, these plans straddled two school years.

The carriers presented all 554 plans with information related to benefit descriptions, financial data, and plan actuarial values. The plans presented by the carriers were, in actuality, combined benefit packages, which consists of one or more health plans across multiple districts of similar size, or aggregated health plans with similar actuarial value. There were 226 reported benefit packages with calendar-year data (see the A8 series of Exhibits). For the plan year ending in 2015 there were 157 benefit packages reported with utilization data, demographics, and carrier administration fees. This is consistent with the required data reporting requirements.

The summary of the Data Call results for carrier-reported information for calendar year 2015 plans, and data reported for the plan year ending in 2015, is in Table 7. Not all data was available for the same reporting period, although both reporting periods are for twelve months.

The tables below show enrollment, premium, administration cost, and reserves. For illustration, Table 7 and Table 8 compare administration fees and reserves for the plan year ending in 2015 with the premium paid for calendar year 2015. One would expect some variations in results if the data covered the same reporting periods; however, one expects the results to be reasonably consistent.

In 2015, claims were 89.6% of premiums. Administrative costs represent 10.8% of premium ($119.5 million) of which carrier administration represents 5.1% of premium, considered below industry-targeted administration fees and within the expected range for the K-12 population health-plan size.

Total reserve levels approximate about one month's claim liability, which is lower than expected. It is possible that carriers did not report some reserves. The Project Team did not make an assessment as to the appropriate level of the reserve levels by rating, purchasing pool, or by benefit package.

Enrollment, Premium, and Paid Claims	
Category (Calendar Year 2015)	**Amount**
Average Monthly Employees (A9a)	105,668
Average Monthly Members (A9a)	199,021
Premium (A8d)	$1,110,867,442
Claims Paid (A8c)	$995,275,719
Loss Ratio	89.6%

Table 7 — Enrollment, Premiums, and Paid Claims

Administrative Fees and Reserves		
Category	Amount	Percentage of Total Premium
Administrative Fees for Plan Years Ending in 2015		
Taxes	$56,385,469	5.1%
Agent Payments	$6,572,945	0.6%
TPA Payments	$32,613	0.0%
PPO Access Fees	$348,868	0.0%
Carrier Admin	$56,165,740	5.1%
Total Administration	$119,505,635	10.8%
Reserve Reported for Plan Years Ending in 2015		
IBNR Reserves	$60,314,642	5.4%
Other Reserves	$3,464,806	0.3%
Total Reserves	$63,779,448	5.7%

Table 8 — Administrative Fees and Reserves

The following table shows district enrollment by types of plans offered. Note that enrollment uses carrier data for the plan year ending in 2015.

Enrollment by Plan Type		
Plan Type	Employees	Percentage of Total
PPO	81,604	77.3%
HMO	19,160	18.1%
Traditional	2,063	2.0%
Point of Service	1,101	1.0%
High Deductible	728	0.7%
Closed Network	554	0.5%
Open Network	425	0.4%
Total	105,635	100.0%

Table 9 — Enrollment by Plan Type

The number of K-12 district plans in relationship to the values associated with healthcare plans under the Health Care Act, also known as the Affordable Care Act (ACA), follows in Table 10.

Metal Level	Actuarial Values	Number of Plans	Percentage of Total
Catastrophic	0.00 – 0.57	1	0.2%
Bronze	0.58 – 0.67	2	0.4%
Silver	0.68 – 0.77	48	10.0%
Gold	0.78 – 0.87	186	38.6%
Platinum	0.88 – 1.00	245	50.8%
Total		482	100.0%

Table 10 — Benefit Plans as Compared to ACA Levels

Please refer to the appendix for further details.

CHAPTER 5: CONCLUSIONS

The purpose of the K-12 School District Health Benefits Data Collection Project was to meet the requirements of ESSB 5940 by gathering the information specified in ESSB 5940. This legislation requires collection of K-12 district and carrier health-benefit plan data in order to:

- Improve transparency of K-12 purchasing.
- Create greater affordability and equity regarding the cost of coverage for single employees as compared to full family coverage.
- Promote healthcare innovations and cost savings.
- Reduce administrative expenses.
- Provide greater parity of state allocations for K-12 employee health benefits.

The intent of the detailed information provided in this report and in the accompanying exhibits is to support the achievement of these goals.

Year 4 of the K-12 School District Health Benefits Data Collection Project was successful, as it was in prior project years, due to the participation of all 295 districts, and because 100% of the carriers reported the required data. The Project Team's approach to gathering information and data to meet the requirements of ESSB 5940 included:

- Developing a formal Data Call with two separate instructions and Data Collection Spreadsheet documents specific to the districts and carriers. The carriers used the two versions of the Data Collection Spreadsheet for reporting the data required by ESSB 5940.
- Engaging with districts and their respective carriers to collect the required data.
- Redesigning the database housing the collected data and the computer application that allows the viewing, processing, and managing of the data.
- Providing ongoing feedback to, and obtaining feedback from, key stakeholders, carriers, and the OIC.
- Presenting illustrative data — report "mock-ups" and interim exhibits — throughout the exhibit-generation and report-writing process with the OIC as precursors to final report content and exhibits.

The appendix summarizes the data provided by districts and carriers in a series of exhibits. The appendix provides an explanation of each exhibit.

This report describes variations and minor inconsistencies in the reported data. Nevertheless, the integrity of the data is solid. Some information is not useful, for example, district-reported administrative costs (A12e, A12f, A12g, and A12h). This is due to the lack of uniformity across districts in their reporting of administrative costs.

Reviewers should exercise caution in comparing data across exhibits in this report. There are differences in results, enrollment, premiums, plans, and other data. This is attributable to:

- Different data sources (carrier versus district).
- Differences in reporting periods, including calendar year 2015, plans ending in 2015, data from both plans ending in 2015 and beginning in 2015, and reporting data based on a snapshot date of October 1, 2015 for district reporting.
- Carriers are required to report all plans in effect in 2015; thus, they reported active and inactive plans. Therefore, carrier reporting will not align perfectly with district plan reporting.
- District plan names and carrier plan names do not match, since plan names across districts and carriers are not consistent. Thus, the Project Team assigned numeric plan identifiers separately for district plans and carrier plans. For purposes of summarizing cost-share designs, the Project Team used carrier naming conventions and carrier-provided plan summaries to complete the cost-share exhibits of this report.

Overall, Year 4 of the K-12 School District Health Benefits Data Collection Project experienced an excellent level of participation, and gathered accurate and reliable information. We believe that this report and supporting exhibits contain data that meets the requirements of ESSB 5940.

Further, by providing useful data and information, these results should support legislative efforts and goals for health-benefit purchasing across all 295 K-12 districts.

APPENDIX (Exhibits)

The purpose of this section is to identify and explain each exhibit in the appendix, comprising a set of numbered exhibits. The exhibit number identifier is included in the exhibit title. The exhibits present the results of the Data Collection Project.

The period presented in the exhibits varies. Some exhibits show data reported for calendar year 2015, for the plan year ending in 2015, for all plans in existence in 2015, or for a snapshot date (October 1, 2015). As such, information across exhibits may vary.

Throughout the exhibits, the Project Team replaced the health plan names with numeric code identifiers to maintain the confidentiality of information. It is important to note that the Project Team assigned district health-plan codes and carrier health-plan codes separately. One set of codes does not match to the other. This was necessary because health-plan names for the districts and for the carriers are not consistent and easily discernible.

The Project Team relied on the data supplied by the districts and the K-12 carriers, including HMOs. While the Project Team performed extensive automated validations on the data to ensure its internal consistency, and manually reviewed the data for reasonableness overall, it has, nevertheless, not been audited.

Note that when carriers or districts did not report all required data, or did not report exactly per the instructions in the Data Call, the outcome is that some exhibits have fields with no data. In addition, fields within exhibits are occasionally blank because there is no applicable data to report.

The Project Team has been very diligent in identifying and correcting defects in the reported data. As a rule, however, the Project Team cannot change any carrier or district submission, or retroactively modify the project database to make corrections without express consent or agreement by the submitting entity[29].

[29] There are some exceptions to this rule, noted here. For a handful of smaller districts, the classifying group name for a group of employees (such as “Certificated”, “Classified”, “Salaried”, “Teaching”, “Janitorial”, and so on), the group name supplied by the district was the name of an individual employee. In these cases, the Project Team assigned a generic name to that group, such as “Group 001”. This occurred with fourteen groups. Another issue occurred for three districts that did not report demographic and plan information for a district’s employees. Loon Lake, North River, and Roosevelt School District had this issue. Loon Lake School District had 26 employees lacking information, North River School District had 20, and Roosevelt School District had 8. The Project Team matched the employees to information in the Year 3 report, where possible. Where the information for an employee was not available, we assigned the employee to the employee-only tier, and to the most-common plan for that district. Note that to address this particular error, the Project Team will implement a new data validation in Year 5 of the project to ensure that districts supply complete census and enrollment data.

The carriers and districts made many corrections to the data and re-submitted the corrected data. Thus, the collected data shows a high degree of internal consistency, and holds up well to the complex validations that the Project Team executed against it. However, despite the Project Team's best efforts and due diligence, small errors may persist in the reported data. The Project Team did not correct spelling, grammatical, or typographical errors in the submitted data.

Exhibit A1 — ESSB 5940 Data Requirements

This exhibit summarizes the legislation (ESSB 5940) that requires specific information from K-12 districts and carriers. Section 4 of ESSB 5940 amends RCW 28A.400.275 to require mandatory reporting and annual submission of information for the prior calendar year. Specific rules described by rule-making order CR103 further details the requirements.

Exhibit A2a — Health Plan Options by District

This exhibit lists all plans offered in 2015 by each district as reported by the carriers. Districts and carrier plan names are not consistent; as such, the Project Team used carrier plan names and the Project Team assigned unique numeric identifiers to each plan. The carriers reported 554 plans offered in 2015. Some of the plans offered begin in 2015 but were not in existence prior to 2015, which is why this number is higher than the count of 462 plans that end in 2015, referenced elsewhere in the report. Not all plans are necessarily unique; however, they appear unique as reported by the carriers based on their plan code and plan name.

Exhibit A2b — Health Plan Coverage Periods

This exhibit shows the health plan options (from Exhibit A2a) by reporting period for all plans offered in calendar year 2015. The list of plans includes those plans ending in 2015 and those that begin in 2015. The legislation requires reporting of all data for calendar year 2015. The list shows that there are 554 K-12 health plans reported by carriers in 2015. In addition to showing plans that begin in 2015 but that were not in existence prior to 2015, like Exhibit A2a above, this exhibit also includes plans offered by the carriers but in which no district participates. For the specific health-plan design for each plan, refer to the A5 series of exhibits.

Exhibit 3a — Enrollment by Benefit Package and Health Plan

This exhibit ties each health plan to a benefit package listed by district for the plan year ending in 2015. The exhibit shows employee, dependent, and total member enrollment. Total enrollment reported for all benefit packages is 105,635 employees and 199,007 members.

Exhibit A3b — Number of Plans and Employee Enrollment by Metal Tier

This exhibit summarizes the number of plans and total enrollment in each metal tier (bronze, silver, gold, and platinum). The bronze category includes any plans that may fall in the "catastrophic" category.

Exhibits A4a – A4c — Employee and Dependent Counts

Exhibit A4a reports employee and dependent counts and total members by district for all plans combined. Average family size reported was 1.884 members per family. The carriers reported data for the plan year ending in 2015.

Exhibit A4b shows data by coverage tier (EE, ES, EC, and EF) for the enrolled population. The report indicates the employee status, either certificated or classified. The basis for this exhibit is information from the districts, which report 133,153 employees. This is higher than enrolled employee counts, as reported by carriers, at 105,635 (Exhibit A3). One expects discrepancies due to differences in the reporting period or the date and the source of the data. The date for the districts' data is censuses as of the snapshot date of October 1, 2015.

Exhibit A4c reports enrollment by district, by employee group, for district-reported health plans. Districts reported different plans than carriers, thus this exhibit does not tie to other exhibits with plans reported by carriers. Districts reported 163,387 members, whereas carriers reported 199,007 members (Exhibit A3). Districts do not track dependent members consistently, resulting in the lower value as compared to the carrier member total. Thus, the Project Team considers carrier member counts to be more accurate.

Exhibits A5a – A5g — Health Plan Design Comparison

The A5-series exhibits provide health-plan design information and the actuarial value of each plan for all plans offered during calendar year 2015 (that is, plans ending and beginning in 2015). Exhibit A5a provides a one-page summary of each health plan design offered in the plan year beginning and ending in 2015. The remaining A5 exhibits report the following:

- A5b — plan actuarial values
- A5c — plan deductibles
- A5d — coinsurance
- A5e — copayments
- A5f — out-of-pocket maximums
- A5g — pharmacy

Exhibits A6a & A6b — Total Costs by District for District-Specific Health Plans Combined

Exhibits A6a and A6b show carrier-reported premiums, exclusive of plan administration fees. Exhibit A6a lists districts in alphabetical order, whereas Exhibit A6b sorts the results by total cost PMPM in descending order. Reported employees total 104,456, and members total 163,426 for all districts combined. The average PMPM cost was $581.59. The highest-cost district has a PMPM of $3,776.17], compared to the lowest cost at $1.32 PMPM. Carrier-reported medical premiums, exclusive of administration fees, totaled $1,140,554,691, for the plan year ending in 2015.

One may attribute the differences in premium costs between this exhibit and other exhibits to differences in plan design, pricing, and enrollment as reported by K-12 carriers, and to the fact that the source for other exhibits are from data supplied in different sections within the Carrier Data Call.

The data in Exhibits A6a and A6b is for the plan year ending in 2015.

Note that in Year 3 and beyond, Exhibits A6a and A6b derive from carrier-submitted data. The reason for the change is that with respect to membership counts, the Project Team considers carrier-reported data to be more accurate than district-submitted data.

Exhibits A7a & A7b — Average Costs and Contributions by District

This exhibit shows the average costs and contributions by district as well as the differential by employee and family contributions for full-time employees (Exhibit A7a) and part-time employees (Exhibit A7b).

For full-time employees, the results show that contributions for ED (employee-plus-dependent) coverage are on average 4.9 times the contribution for EE (employee-only) coverage; for part-time employees, contributions for ED coverage are, on average, 4.5 times the contribution for employee-only coverage.

On average, full-time and part-time employees contribute 9.1% and 12.1%, respectively, to the average cost of EE premiums, as compared to ED, which are at 29.1% and 33.9% respectively. The basis of this data is district census data that has a snapshot date of October 1, 2015.

Note that in the context of Exhibits A7a and A7b, one should interpret the term "ED" as **E**mployee plus **D**ependent coverage. In other words, the term as used here encompasses all of the following: ES (employee and spouse), EC (employee and one or more children), and EF (full-family coverage for employee, spouse, and one or more children).

An important enhancement that began in Year 3 and has continued into year 4 is the addition, for both exhibits in this series, of columns that indicate the ratio of EF to EE premiums, and the ratio of EF to EE employee contributions. For example, in terms of premiums, a value of 1.500 would mean that in a particular district, the average premium for employees that purchase the EF tier of coverage is 1.500 times higher than the average premium for employees that purchase the EE tier of coverage. Similarly, in terms of employee contributions, a value of 3.000 would mean that in a particular district, the average contribution of employees that purchase the EF tier of coverage is 3.000 times higher than the average contribution of employees that purchase the EE tier of coverage.

Exhibits A8a & A8b — Financial Plan Structure and Overall Performance by Benefit Package

The A8 series exhibits provide financial performance for the calendar year 2015 by month. The data includes employee counts (Exhibit A8a), dependent counts (Exhibit A8b), monthly paid claims (Exhibit A8c), monthly premiums (Exhibit A8d), and loss ratios (Exhibit A8e). Exhibit A8f represents the consolidation of all the prior A8 exhibits. All A8-series exhibits are by benefit package. Total premiums for calendar year 2015 are $1,110.9 million for all benefit packages combined, compared to total paid claims of $995.3 million. This generated a paid claims loss ratio, which is a comparison of claims to premiums, of 89.6% for calendar year 2015.

Exhibits A9a – A9h — Experience Reports by Benefit Package

The A9 series exhibits show financial data for calendar year 2015, as well as utilization metrics for the plan year ending in 2015. A summary of each exhibit follows.

Exhibit A9a shows premiums and claims paid by major benefit category (for example inpatient, outpatient, emergency room (ER), professional services, and pharmacy claims). Inpatient hospitalizations represent 20.7% of total paid claims, outpatient 20.2%, ER 3.7%, professional services 29.3%, pharmacy 19.2%, and other services 6.9%. Total claims were $995.3 million for the period.

Exhibit A9b shows claims paid PEPM. Total average employee enrollment during the calendar year was 105,668 employees; premiums averaged $876.07 PEPM and, total claims averaged $784.91 PEPM.

Exhibit A9c shows claims paid PMPM. Total average member enrollment during the calendar year was 199,021 members; premiums averaged $465.14 PMPM and, total claims averaged $416.74 PMPM.

The remaining exhibits provide a breakdown of utilization metrics for the plan year ending in 2015, including:

- Exhibit A9d — Utilization by Hospitalization, Outpatient Visits, ER Visits, Professional Services, and Pharmacy Scripts
- Exhibit A9e — Utilization per Unit Measures (for example, average length of stay (LOS), utilization per 1,000 members for professional visits, and so on)
- Exhibit A9f — Monthly Financial Measures for Calendar Year 2015,
- Exhibit A9g — Monthly PEPM Measurements
- Exhibit A9h — Monthly PMPM Measurements.

Exhibit A10 — List of Large Claimants by Major Diagnostic Categories

This is a list of 861 large cases defined as the total of aggregated claims per unique claimant with aggregated claims in excess of $100,000 for the plan year ending in 2015. Average large cases were approximately $200,226 per claimant and represent about 17.3% of all paid claims, which are $995,275,719, as reported in Exhibit A19a. The exhibit categorizes claims by major diagnostic categories including diseases, injuries, and other conditions.

Exhibit A11 — Demographics by Benefit Package

This exhibit reports member demographic information associated with each benefit package for the plan year ending in 2015. Demographic information includes coverage tier, age, and sex. There were 156 benefit packages reported.

Exhibits A12a & A12b — Administrative Cost Breakdown - Carrier Data Call

Each carrier reported administrative fees for the plan year ending in 2015. Fees were broken down into several component parts. Data requested included premium taxes payable for insured plans; Washington State Health Insurance Pool (WSHIP) assessments; other government taxes or assessments; commissions paid to agents, brokers, or consultants; other third-party administrative (TPA) fees; PPO access fees; and carrier administration fees. Results show total administration was $98.00 PEPM (Exhibit A12a) and $52.02 PMPM (Exhibit A12b) for the reporting period. Total premium is $1,110,867,442, as reported in Exhibit A9a. Total administration fees of $119.5 million represented 10.758% of total premium for the plan year ending in 2015. Of this amount, 0.592% ($6.6 million) was payable to agents, brokers, or consultants; 5.076% ($56.4 million) was payable for premium taxes and other assessments; and 5.056% ($56.2 million) was for administrative expenses charged by carriers.

Exhibits A12c & A12d — Supplemental Services and Costs

Exhibit A12c shows other supplemental services and associated costs reported by districts. The supplemental services are generally for employee-paid cancer or accident policies. The Project Team requested similar information from the carriers. However, all carriers reported no supplemental services were purchased separately by the districts, therefore Exhibit A12d reports no data except for the total employee and member enrollment by carrier. Carriers reported 104,456 employees and 163,426 members.

Exhibits A12e – A12h — Other Administrative Costs Not Paid Through Carrier Insurance Premiums

Additional exhibits in this Section show results of district-reported external and internal administration fees not paid through carrier insurance premiums. One should use caution when drawing conclusions from this information due to inconsistent reporting. Exhibit A12e reports total administrative costs, Exhibit A12f reports this information on a PEPM basis, and Exhibit A12g reports it on a PMPM basis. The Data Call asked districts to report internal administrative expenses allocated to employee benefits (Exhibit 12h). The exhibit is incomplete. Most districts were unable to provide this information.

Note that beginning in Year 3 the following exhibits switched partially to a carrier source, resulting in a mixed-source exhibit:

- A12c — Supplemental Services Financial Summary by District
- A12e — District Administrative Costs by District Not Paid Through Carrier Insurance Premiums
- A12h — District Staff Costs by District

In these exhibits, member enrollment comes from carrier-reported data, whereas employee enrollment comes from district-reported data. The reason for the change is that with respect to membership counts, the Project Team considers carrier-reported data to be more accurate than district-submitted data.

Exhibit A13 — Paid Claims and Rate Reserves by Carrier Rating Pool

The Data Call asked carriers to report K-12 health-plan reserves with ending balances for the plan year ending in 2015. One reserve identified was the reserve liability for claims incurred but not reported (IBNR reserves). IBNR reserves cover the liability of claims incurred in one reporting period but paid in another period. IBNR levels typically range from one to three months of claims. It would be necessary to report paid claims on an incurred basis and a paid basis in order to determine the appropriate level of IBNR reserves. The Data Call did not require incurred-basis reporting.

Other reserves required include claim or rate stabilization reserves (CSR or RSR reserves). Insured plans often build a margin factor into the premium rates, or establish these types of reserves to help mitigate the impact of claim fluctuations during a reporting period.

In addition, the Data Call asked districts to report plan-year enrollment and paid claims for the reporting period to allow comparative assessments across rating pools.

For the plan year ending in 2015, paid claims were $1,004.6 million and total IBNR reserve liabilities were $60.3 million. IBNR reserves are about 6.0% of paid claims, less than one month's paid claims. CSR/RSR reserves were $3.5 million, about 0.3% of paid claims. The reserve levels are within expected ranges.

Exhibit A14 — Summary of Monthly Premium Rates with Composite Cost by Health Plan

This exhibit reports premium by health plan by coverage tier (EE, ES, EC, and EF) for the plan year ending in 2015. Enrollment data shown on the exhibit includes employee counts only; the database includes enrollment by tiers. The results show that the premium costs for all K-12 health plans for all employees and dependents combined averaged $1,044.42 per month. The lowest and highest composite premiums across districts are $56.18 and $3,389.87 respectively. Carriers provided the information for this exhibit.

Exhibits A15a – A15e— Summary of Total Monthly Premium Rates with Composite Cost by District

This series of exhibits reports information by district as of October 1, 2015, the snapshot date, and shows the average total monthly rates by coverage tier. They also show the total monthly premiums by district. Districts provided the information for these exhibits. Individual reports identify employee classifications, including full-time, part-time, certificated, and classified.

Exhibits A16a – A16e — Summary of Monthly Payroll Rates with Composite Cost by District

This exhibit series shows the employee contributions through payroll deductions for each coverage tier for all district employees. The reported monthly composite contributions for employee and family coverage combined was $187.81, or $235,417,128 in total for the year, based on 104,456 employees as of the snapshot date of October 1, 2015. The districts provided information for these exhibits. Individual reports identify employee classifications, including full-time, part-time, certificated, and classified.

Exhibits A17a – A17e — Summary of District Monthly Contributions with Composite Cost by District

This series of exhibits shows the district contributions for each coverage tier. The reported monthly composite contributions for employee and family coverage combined was $719.87, or $902,332,043 in total for the year, based on 104,456 employees as of the snapshot date of October 1, 2015. Districts provided the information for these exhibits. Individual reports identify employee classifications, including full-time, part-time, certificated, and classified.

Exhibits A18a & A18b — Summary of Innovative Plan Features All Plans Combined

Exhibit A18a — Carrier Responses

Exhibit A18b — District Responses

These exhibits show pre-defined lists of the various categories of "innovative features" available from carriers and implemented by districts. The innovative features are measures taken by carriers or districts to improve the overall health of employees, as well as to manage or control healthcare costs.

Exhibits A19a & A19b — Efforts and Achievements

Exhibit A19a — By Carrier

Exhibit A19b — By District

These exhibits are narratives provided by carriers and districts describing efforts and achievements during calendar year 2015 to reduce administrative costs, to achieve cost savings, to improve customer service, to manage health plans, and to assure coverage for part-time employees.

The Project Team did not correct nor edit the narratives, however the Project Team reformatted some narratives in order to display better in the exhibit.

Exhibit A20 — Glossary of Acronyms

Acronyms used throughout these exhibits.

Exhibits A21a – A21c — Data Traceability Matrix

Exhibit A21a — Carriers

Exhibit A21b — Districts

Exhibit A21c — Definitions

The Data Traceability Matrix traces the requirements outlined in ESSB 5940 to particular data elements collected from districts and their carriers, thus providing the context for the information collected. The Data Traceability Matrix was revised based on improvements to the design of the Data Call in Year 2, and will continue to evolve over successive project years.

Exhibit A22 — Report Contributors

This Exhibit includes a list of the Treinen employees and consultants who participated in the Year 4 project and who contributed to the creation of this report.

Exhibit A23a — Data Validations — Carriers

Carrier Validations — "Check My Spreadsheet" (CMS)

Section 1

1. Column C (Carrier_Response) Rows 2 through 6 and 8 through 14: required
2. Row 2 (Carrier Name) must be a valid carrier name from the dropdown list:
   - Aetna
   - Group Health
   - Kaiser
   - KPS Health Plans
   - Moda Health
   - PEBB
   - Premera
   - Providence
   - Regence
   - United Healthcare
3. Row 3 (PR_Beginning) required, must be a valid date. Beginning date of earliest reported plan year cannot be prior to January 1 of the previous reporting calendar year nor can it be later than December 31 of the current reporting calendar year. For Year 4 this range is 1/1/2014 – 12/31/2015 inclusive.
4. Row 4 (PR_Ending) required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.

Section 2

1. Column B (Used_YN) Rows 2 through 25 is required and must be a value of "Y" or "N".
2. Column C (Innov_No) must be a whole number value from 1 through 24 inclusive

Section 3

1. Column B (Pool_Code) required, must be unique within worksheet
2. Column C (IBNR_Reserves) required, numeric, greater than or equal to zero, 0 default
3. Column D (Rate_Reserves) required, numeric, greater than or equal to zero, 0 default
4. Column E (Total_Claims) required, numeric, greater than or equal to zero, 0 default
5. Column F (Covered_Employees) required, numeric, greater than or equal to zero, 0 default
6. Column G (Covered_Members) required, numeric, greater than or equal to zero, 0 default, must be greater than or equal to Column F (Covered_Employees) value

Section 4

1. Column B (Plan_Name) required
2. Column C (Plan_Code) required, Plan_Code/PY_Ending must be unique within worksheet
3. Column D (BP_Code) required
4. Column E (Pool_Code) required, must match a Pool Code defined in Section 3 Column B
5. Column F (HDHP_YN) required, must be a value of “Y” or “N”
6. Column G (Plan_Type) required
7. Column H (PY_Beginning) required, must be a valid date. Beginning date of earliest reported plan year cannot be prior to January 1 of the previous reporting calendar year nor can it be later than December 31 of the current reporting calendar year. For Year 4 this range is 1/1/2014 – 12/31/2015 inclusive.
8. Column I (PY_Ending) required, must be a valid date, must be later than PY_Beginning. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.
9. Column L (CostShare_Code) required
10. Column M (Plan_Act_Value) required, numeric, must be a value greater than 0 and less than or equal to 1
11. Column N (Ded_FollowCalendar) required, must be a value of “Y” or “N”

Section 5

1. Column B (BP_Code) required, must match a BP Code defined in Section 4 Column D, BP_Code/PY_Ending must be unique within worksheet
2. Column C (PY_Ending) required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.
3. Column D (Total_Supplemental) required, numeric, greater than or equal to zero, 0 default
4. Column E (Exp_Comm) required, numeric, greater than or equal to zero, 0 default
5. Column F (Exp_Taxes) required, numeric, greater than or equal to zero, 0 default
6. Column G (Exp_PPO) required, numeric, greater than or equal to zero, 0 default
7. Column H (Exp_Fees3rdP) required, numeric, greater than or equal to zero, 0 default
8. Column I (Exp_OtherAdmin) required, numeric, greater than or equal to zero, 0 default
9. Column J (Capitation_Payments) required, numeric, 0 default
10. Column K (Inpatient_AvgLOS) required, numeric, greater than or equal to zero, 0 default
11. Column L (Inpatient_A) required, numeric, greater than or equal to zero, 0 default
12. Column M (Inpatient_D) required, numeric, greater than or equal to zero, 0 default
13. Column N (Outpatient_V) required, numeric, greater than or equal to zero, 0 default
14. Column O (Outpatient_ER_V) required, numeric, greater than or equal to zero, 0 default
15. Column P (Professional_V) required, numeric, greater than or equal to zero, 0 default
16. Column Q (OtherMed_V) required, numeric, greater than or equal to zero, 0 default
17. Column R (Pharmacy_GS) required, numeric, greater than or equal to zero, 0 default
18. Column S (Pharmacy_BS) required, numeric, greater than or equal to zero, 0 default

Section 6

1. Column B (BP_Code) required, must match a BP Code defined in Section 4 Column D, BP_Code/PY_Ending/Calendar_Month must be unique within worksheet
2. Column C (PY_Ending) required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.
3. Column D (Calendar_Month) required, YYYYMM format
4. Column E (Emp_Enrollment) required, numeric, greater than or equal to zero, 0 default
5. Column F (Dep_Enrollment) required, numeric, greater than or equal to zero, 0 default
6. Column G (Total_MedPremiums) required, numeric, greater than or equal to zero, 0 default
7. Column H (Total_Claims) required, numeric, 0 default
8. Column I (Inpatient_Claims) required, numeric, 0 default
9. Column J (Outpatient_Claims) required, numeric, 0 default
10. Column K (Outpatient_ER_Claims) required, numeric, 0 default
11. Column L (Professional_Claims) required, numeric, 0 default
12. Column M (OtherMed_Claims) required, numeric, 0 default
13. Column N (Pharmacy_Claims) required, numeric, 0 default

Section 7

1. Column B (BP_Code) required, must match a BP Code defined in Section 4 Column D, BP_Code/PY_Ending/Emp_Dep/M_F must be unique within worksheet
2. Column C (PY_Ending) required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.
3. Column D (Emp_Dep) required, must be a value of “E” or “D”
4. Column E (M_F) required, must be a value of “M” or “F”
5. Column F (Tier_Code) required must be a value of “EE”, “ES”, “EC”, “EF” or “OD”
6. Column G (Age_Tier1) required, numeric, greater than or equal to zero, 0 default
7. Column H (Age_Tier2) required, numeric, greater than or equal to zero, 0 default
8. Column I (Age_Tier3) required, numeric, greater than or equal to zero, 0 default
9. Column J (Age_Tier4) required, numeric, greater than or equal to zero, 0 default
10. Column K (Age_Tier5) required, numeric, greater than or equal to zero, 0 default
11. Column L (Age_Tier6) required, numeric, greater than or equal to zero, 0 default
12. Column M (Age_Tier7) required, numeric, greater than or equal to zero, 0 default
13. Column N (Age_Tier8) required, numeric, greater than or equal to zero, 0 default
14. Column O (Age_Tier9) required, numeric, greater than or equal to zero, 0 default
15. Column P (Age_Tier10) required, numeric, greater than or equal to zero, 0 default
16. Column Q (Age_Tier11) required, numeric, greater than or equal to zero, 0 default

Section 8

1. Column B (Plan_Code) required, Plan_Code/PY_Ending must match a Plan_Code/PY_Ending defined in Section 4 Columns C and I
2. Column C (PY_Ending) required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.
3. Column D (SD_Code) required, numeric, 5 digits including leading 0, must be a valid County/District code
4. Column E (Emp_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number
5. Column F (Dep_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number
6. Column G (Total_MedPremiums) required, numeric, greater than 0, 0 default
7. Column H (District_Name) required, must be a valid District Name, SD Code/District Name combination must be valid
8. Column I (RateSet_Code) required
9. Column J (RateSet_Desc) required
10. Column K (EE_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number
11. Column L (ES_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number
12. Column M (EC_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number
13. Column N (EF_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number
14. Column O (OD_Count) required, numeric, greater than or equal to zero, 0 default, must be a whole number

Section 9

1. Column B (Claim_Amount) required, numeric, greater than or equal to zero
2. Column C (Claim_Status) required, E = Employee, S = Spouse, or C = Child
3. Column D (Diagnosis_Code) required, numeric, value between 1 and 19 inclusive
4. Column E (PY_Ending) required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1 of the current reporting calendar year, nor can it be later than December 31 of the next reporting calendar year. For Year 4 this range is 1/1/2015 – 12/31/2016.

Section 10

1. Column B (CostShare_Code) required, must exist in Section 4 Column L, must be unique within spreadsheet
2. Column C (Ded_Individual_In) required, numeric, 0 default
3. Column D (Ded_Individual_Out) required, numeric, 0 default
4. Column E (Ded_Family_In) required, numeric, 0 default
5. Column F (Ded_Family_Out) required, numeric, 0 default
6. Column G (Coins_Prevent_In) required, numeric, 0 default
7. Column H (Coins_Prevent_Out) required, numeric, 0 default
8. Column I (Coins_Other_In) required, numeric, 0 default
9. Column J (Coins_Other_Out) required, numeric, 0 default
10. Column K (Copay_Office_In) required, numeric, 0 default
11. Column L (Copay_Office_Out) required, numeric, 0 default
12. Column M (Copay_Inpatient_In) required
13. Column N (Copay_Inpatient_Out) required
14. Column O (Copay_Outpatient_In) required, numeric, 0 default
15. Column P (Copay_Outpatient_Out) required, numeric, 0 default
16. Column Q (Copay_ER_In) required, numeric, 0 default
17. Column R (Copay_ER_Out) required, numeric, 0 default
18. Column S (OOPM_Individual_In) required, numeric, 0 default
19. Column T (OOPM_Individual_Out) required, numeric, 0 default
20. Column U (OOPM_Family_In) required, numeric, 0 default
21. Column V (OOPM_Family_Out) required, numeric, 0 default
22. Column W (Rx_Deductible_In) is required, cannot exceed 20 characters
23. Column X (Rx_Retail_CostShare) is required, cannot exceed 30 characters
24. Column Y (Rx_Retail_Days_Supply) required, numeric, 0 default
25. Column Z (Rx_MailOrder_CostShare) is required, cannot exceed 30 characters
26. Column AA (Rx_MailOrder_Days_Supply) required, numeric, 0 default
27. Column AB (Rx_Speciality_CostShare) is required, cannot exceed 30 characters
28. Column AC (Rx_Specialty_Days_Supply) required, numeric, 0 default

Section 11

1. Column B (RateSet_Code) is required, must match a Rate Set Code defined in Section 8 Column I
2. Column C (EE_Rate) required, numeric, greater than or equal to zero, 0 default
3. Column D (ES_Rate) required, numeric, greater than or equal to zero, 0 default
4. Column E (EC_Rate) required, numeric, greater than or equal to zero, 0 default
5. Column F (EF_Rate) required, numeric, greater than or equal to zero, 0 default
6. Column G (OD_Rate) required, numeric, greater than or equal to zero, 0 default

Category 0 — OIC Application

Section 1	Carrier_Name	Error if missing
	PR_Beginning	Valid date, error if missing
	PR_Ending	Valid date, error if missing
	Desc_CostSavings	Warning if missing
	Desc_ReduceAdmin	Warning if missing
	Desc_Innovations	Warning if missing
	Desc_DistrictManage	Warning if missing
	Desc_DistrictProcure	Warning if missing
	Desc_CustService	Warning if missing
	Desc_ProtectPT	Warning if missing
	Submitted_By	Error if missing
	Submitter_Email	Error if missing
Section 2	Used_YN	Y or N
	Innov_No	Numeric, warning if missing
	Innov_Desc	Warning if missing
Section 3	Pool_Code	Must be unique in worksheet, error if missing
	IBNR_Reserves	Numeric, warning if missing
	Rate_Reserves	Numeric, warning if missing
	Total_Claims	Numeric, error if missing
	Covered_Employees	Numeric, warning if missing
	Covered_Members	Numeric, warning if missing
Section 4	Plan_Name	Error if missing
	Plan_Code	Must be unique is worksheet, error if missing
	BP_Code	Must be unique is worksheet, error if missing
	Pool_Code	Must exist in section 3, error if missing
	HDHP_YN	Y or N, error if missing
	Plan_Type	Error if missing
	PY_Beginning	Valid date, error if missing
	PY_Ending	Valid date, error if missing
	Desc_Supplemental	Warning if missing
	CostShare_Code	Error if missing
	Plan_Act_Value	Numeric, warning if missing
	Ded_FollowCalendar	“Y” or “N”

Section 5	BP_Code	Must exist in section 4, error if missing
	PY_Ending	Valid date, error if missing
	Total_Supplemental	Numeric, default 0
	Exp_Comm	Numeric, warning if missing
	Exp_Taxes	Numeric, warning if missing
	Exp_PPO	Numeric, warning if missing
	Exp_Fees3rdP	Numeric, default 0
	Exp_OtherAdmin	Numeric, warning if missing
	Capitation_Payments	Numeric, default 0
	Inpatient_AvgLOS	Numeric, warning if missing
	Inpatient_A	Numeric, warning if missing
	Inpatient_D	Numeric, warning if missing
	Outpatient_V	Numeric, warning if missing
	Outpatient_ER_V	Numeric, warning if missing
	Professional_V	Numeric, warning if missing
	OtherMed_V	Numeric, warning if missing
	Pharmacy_GS	Numeric, warning if missing
	Pharmacy_BS	Numeric, warning if missing
Section 6	BP_Code	Must exist in section 4, error if missing
	PY_Ending	Valid date, error if missing
	Calendar_Month	Numeric, between 1 and 12 inclusive, error if missing
	Emp_Enrollment	Numeric, warning if missing
	Dep_Enrollment	Numeric, warning if missing
	Total_Premiums	Numeric, warning if missing
	Total_MedPremiums	Numeric, warning if missing
	Total_Claims	Numeric, warning if missing
	Inpatient_Claims	Numeric, warning if missing
	Outpatient_Claims	Numeric, warning if missing
	Outpatient_ER_Claims	Numeric, warning if missing
	Professional_Claims	Numeric, warning if missing
	OtherMed_Claims	Numeric, warning if missing
	Pharmacy_Claims	Numeric, warning if missing

Section 7	BP_Code	Must exist in section 4, error if missing
	PY_Ending	Valid date, error if missing
	Emp_Dep	E or D, error if missing
	M_F	M or F, error if missing
	Tier_Code	EE, ES, EC, EF, E2, or F2, error if missing
	Age_Tier1	Numeric, default 0
	Age_Tier2	Numeric, default 0
	Age_Tier3	Numeric, default 0
	Age_Tier4	Numeric, default 0
	Age_Tier5	Numeric, default 0
	Age_Tier6	Numeric, default 0
	Age_Tier7	Numeric, default 0
	Age_Tier8	Numeric, default 0
	Age_Tier9	Numeric, default 0
	Age_Tier10	Numeric, default 0
	Age_Tier11	Numeric, default 0
Section 8	Plan_Code	Must exist in section 4
	PY_Ending	Valid date, error if missing
	SD_Code	Valid County-District code, error if missing
	Emp_Count	Numeric, warning if missing
	Dep_Count	Numeric, warning if missing
	Total_Premiums	Numeric, warning if missing
	Total_MedPremiums	Numeric, warning if missing
	District_Name	No validation on this field
	RateSet_Code	No validation on this field
	RateSet_Desc	No validation on this field
	EE_Count	Numeric, default 0
	ES_Count	Numeric, default 0
	EC_Count	Numeric, default 0
	EF_Count	Numeric, default 0
	OD_Count	Numeric, default 0
Section 9	Claim_Amount	Numeric, error if missing
	Claimant_Status	E, S, C, error if missing
	Diagnosis_Code	Numeric, between 1 and 19 inclusive, error if missing
	PY_Ending	Valid date, warning if missing

Section 10	CostShare_Code	Error if missing
	Ded_Individual_In	Error if missing
	Ded_Individual_Out	Error if missing
	Ded_Family_In	Error if missing
	Ded_Family_Out	Error if missing
	CoIns_Prevent_In	Error if missing
	CoIns_Prevent_Out	Error if missing
	Coins_Other_In	Error if missing
	Coins_Other_Out	Error if missing
	Copay_Office_In	Error if missing
	Copay_Office_Out	Error if missing
	Copay_Inpatient_In	Error if missing
	Copay_Inpatient_Out	Error if missing
	Copay_Outpatient_In	Error if missing
	Copay_Outpatient_Out	Error if missing
	Copay_ER_In	Error if missing
	Copay_ER_Out	Error if missing
	OOPM_Individual_in	Error if missing
	OOPM_Individual_out	Error if missing
	OOPM_Family_in	Error if missing
	OOPM_Family_out	Error if missing
	Rx_Deductible_In	Error if missing
	Rx_Retail_CostShare	Error if missing
	Rx_Retail_Days_Supply	Error if missing
	Rx_MailOrder_CostShare	Error if missing
	Rx_MailOrder_Days_Supply	Error if missing
	Rx_Specialty_CostShare	Error if missing
	Rx_Specialty_Days_Supply	Error if missing
	Plan_Comments	Error if missing
Section 11	RateSet_Code	Error if missing
	EE_Rate	Error if missing
	ES_Rate	Error if missing
	EC_Rate	Error if missing
	EF_Rate	Error if missing
	OD_Rate	Error if missing

Category 1 — OIC Application

1. Certain sections must contain only plans or benefit packages that end in 2015. For these sections, the presence of a plan year ending in 2016 or any other year is an error condition.
2. Section 8 column D — SD_Code — district code must be valid.

Category 2 — OIC Application

1. Plans must contain both a medical and prescription component.
2. Plan enrollment in section 8 should roughly correlate to Benefit Package enrollment in section 6.
3. Employee enrollment in section 8 (summed by Plans within Rating Pools) should roughly correlate to Covered Employees in section 3.
4. Compare employee enrollment totals across sections 6 and 7.
5. Compare dependent enrollment totals across sections 6 and 7.
6. Compare employee enrollment totals across sections 7 and 8.
7. Compare dependent enrollment totals across sections 7 and 8.
8. Compare premium-related totals across sections 6 and 8.
9. Compare claims-related totals across sections 3 and 6.
10. Plan and Plan Year Ending combination found in section 8 but not defined in section 4.
11. Benefit Package and Plan Year Ending combination found in sections 6 and 7, but not defined in section 5
12. Inpatient admits higher number than inpatient days.
13. Inpatient average length-of-stay populated and greater than or equal to zero.
14. Sum of all claims types should equal the total claim amount reported.
15. Higher utilization of brand scripts than generic scripts.

Category 3 — OIC Application

1. Total number of Pool Codes in section 3
2. New or missing Pool Codes in section 3
3. IBNR Reserves amount by Pool Code in section 3
4. Rate Reserves amount by Pool Code in section 3
5. Total Claims by Pool Code in section 3
6. Covered Employees count in section 3
7. Covered Members count in section 3
8. Number of Benefit Packages
9. New or missing Benefit Packages
10. Number of Plans
11. New or missing Plan Codes
12. Plans cannot switch from one Benefit Package to another
13. Section 5 utilization per Benefit Package — Inpatient_AvgLOS
14. Section 5 utilization per Benefit Package — Inpatient_Admits
15. Section 5 utilization per Benefit Package — Inpatient_Days
16. Section 5 utilization per Benefit Package — Outpatient_Visits
17. Section 5 utilization per Benefit Package — Outpatient_ER_Visits
18. Section 5 utilization per Benefit Package — Prof_Svcs_Visits
19. Section 5 utilization per Benefit Package — Other_Medical_Visits
20. Section 5 utilization per Benefit Package — Pharmacy_Generic_Scripts
21. Section 5 utilization per Benefit Package — Pharmacy_Brand_Scripts
22. Section 6 Average enrollment by Benefit Package — Employees
23. Section 6 Average enrollment by Benefit Package — Dependents
24. Section 6 Total premiums by Benefit Package — Sum of months
25. Section 6 Total claims by Benefit Package — Sum of months
26. Section 6 Total all claim types by Benefit Package — Sum of months
27. Section 7 Employee count — Total across tiers
28. Section 7 Dependent count — Total across tiers
29. Section 8 Enrollment by plan — Employees
30. Section 8 Enrollment by plan — Dependents
31. Section 8 Total Premiums by Plan
32. Section 9 Number of Claims — Row count

Category 4 — OIC Application

1. Total enrollment by carrier by district
2. Total premiums by carrier by district

Exhibit A23b — Data Validations — Districts

District Validations — "Check My Spreadsheet" (CMS)

Section 1

1. Column C (District_Response) Rows 2 through 20, 22, 23, and 24: required
2. Column C (District_Response) Rows 13 through 20 must be numeric values
3. Column C (District_Response) Row 21 (Desc_InternalAdmin) is required when Column C Row 20 (Total_InternalAdmin) is greater than 0
4. Column C (District_Response) Row 12 (HDHP_Offered) must be a value of "Y" or "N"
5. Column C (SD_Code) must match an entry in the Reference section
6. Column C (District_Name) must match an entry in the Reference section
7. Column C (SD_Code)/ (District_Name) combination must match an entry in the Reference section

Section 2

Column B (Used_YND) Rows 2 through 34 are required and must be a value of "Y", "N", or "D"

Section 3

1. Column B (Entity_Code) required, must be unique within spreadsheet
2. Column C (Entity_Name) required, must be valid carrier name if Column D (Entity_Type_Role) is "Medical Ins. Carrier"
3. Column D (Entity_Type_Role) required, must be value from dropdown list
4. Column E (Premiums_Paid) required if Column D (Entity_Type_Role) contains "Carrier", numeric, must be greater than 0
5. Column F (Premium_Type) required, must be a value from dropdown list, default "N/A" when Column E (Premiums_Paid) column is 0
6. Column G (Non_Premium_Fees_Paid) required if Column D (Entity_Type_Role) does not contain "Carrier", numeric, must be greater than 0
7. When Column D (Entity_Role_Type) has a value of "Medical Ins. Carrier" then Column F (Premium_Type) must contain "Medical".
8. When Column D (Entity_Role_Type) has a value of "Dental Ins. Carrier" then Column F (Premium_Type) must contain "Dental" or "Vision" and must not contain "Medical".
9. When Column D (Entity_Role_Type) has a value of "Vision Ins. Carrier" then Column F (Premium_Type) must contain "Vision" and must not contain "Medical" or "Dental".
10. When Column D (Entity_Role_Type) does not contain "Carrier" then Column F (Premium_Type) must be "N/A"
11. If Column D (Entity_Role_Type) contains "Carrier", report amount in Column E (Premiums_Paid) and column G (Non_Premium_Fees_Paid) must be 0.
12. If Column D (Entity_Role_Type) does not contain "Carrier", report amount in Column G (Non_Premium_Fees_Paid) and Column E (Premiums_Paid) must be 0.

Section 4

1. Column B (Carrier_Code) required, must match an Entity Code defined in Section 3 Column B when Column C (Carrier_Name) is not "Other"
2. Column B (Carrier_Code) required, must not match an Entity Code defined in Section 3 Column B when Column C (Carrier_Name) is "Other"
3. Column C (Carrier_Name) required, must be value from dropdown list
4. Column D (Plan_Code) required, must be unique within worksheet
5. Column E (Plan_Name) required

Section 5

1. Column B (Group_Code) required, must be unique within worksheet
2. Column C (Group_Name) required
3. Column D (Group_CT) required, must be a value of "C" or "T"
4. Column E (Plan_Codes_Offered) optional when Section 6 Column D (Plan_Code) used to define plans. Must be blank when Column B (Group_Code) is "NBO-Cert" or "NBO-Class" otherwise the plan codes must match those defined in Section 4 Column D.

Section 6

1. Column B (Group_Code) required, must match those defined in Section 5 Column (B)
2. Column C (Group_Name) optional
3. Column D (Plan_Code) must be blank when Column B (Group_Code) is "NBO-Cert" or "NBO-Class" otherwise the plan codes must match those defined in Section 4 Column D
4. Column E (Plan_Name) must be blank when Column B (Group_Code) is "NBO-Cert" or "NBO-Class" otherwise it is optional
5. Column B (Group_Code)/Column D (Plan_Code) combination must be unique within the worksheet

Section 5 and Section 6

Must list all plans listed in Section 4 Column D in either Section 5 or Section 6

Section 7

1. Column B (Emp_Code) required, must be unique within worksheet
2. Column C (Group_Code) required, must match those defined in Section 5 Column B
3. Column D (Emp_CT) required, value must be “C” or “T”
4. Column E (Gender) required, value must be “M” or “F”
5. Column F (DOB) required, must be a valid date, not in the future
6. Column G (Calculated_FTE) required, numeric, greater than or equal to zero and less than or equal to 1
7. Column H (Benefit_FTE) required, numeric, greater than or equal to zero and less than or equal to 1
8. Column I (Benefit_Elig_YN) required, value must be “Y” or “N”, must be “N” when Column H (Benefit_FTE) is 0, must be “Y” when Column J (Plan_Code) is populated
9. Column J (Plan_Code) must be blank when Column C (Group_Code) is “NBO-Cert” or “NBO-Class” or Column I (Benefit_Elig_YN) is “N”, plan codes must match those defined in Section 4 Column D
10. Column K (Plan_Tier) required when Column J (Plan_Code) is populated, must be a value of “EE”, “ES”, “EF”, “EC”, “E2”, or “F2”, must be blank when Column I (Benefit_Elig_YN) is “N”, must be blank when Column J (Plan_Code) is blank
11. Column L (SD_Contrib) required when Column J (Plan_Code) is populated, numeric, must be greater than or equal to zero, blank when Column I (Benefit_Elig_YN) is “N”, must be blank when Column J (Plan_Code) is blank
12. Column M (Emp_Contrib) required when Column J (Plan_Code) is populated, numeric, must be greater than or equal to zero, blank when Column I (Benefit_Elig_YN) is “N”, must be blank when Column J (Plan_Code) is blank
13. Column N (Total_Premium) required when Column J (Plan_Code) is populated, numeric, must be greater than 0, blank when Column I (Benefit_Elig_YN) is “N”, must be blank when Column J (Plan_Code) is blank
14. Column O (Dep_YN) required, must be "Y" or "N", must be “N” when Column I (Benefit_Elig_YN) is “N”
15. Column P (Cov_MaleDep_Ages) optional, must be numeric, ages must be between 1 and 100 inclusive
16. Column Q (Cov_FemaleDep_Ages) optional, must be numeric, ages must be between 1 and 100 inclusive
17. Column R (Elig_MaleDep_Ages) optional, must be numeric, ages must be between 1 and 100 inclusive
18. Column S (Elig_FemaleDep_Ages) optional, must be numeric, ages must be between 1 and 100 inclusive

Section 7 and Section 8

If Section 7 Column O (Dep_YN) is “Y” then Section 7 Column P (Cov_MaleDep_Ages) or Column Q (Cov_FemaleDep_Ages) or Column R (Elig_MaleDep_Ages) or Column S (Elig_FemaleDep_Ages) is required or a row with a matching Emp_Code must exist in Section 8.

Section 8

1. Column B (Emp_Code) required, must match a value from Section 7 Column B (Emp_Code)
2. Column C (Gender) required, value must be “M” or “F”
3. Column D (DOB) required, must be a valid date, not in the future
4. Column E (Benefits_YN) required, value must be “Y” or “N”

Exhibits B1 – B3 — LEAP Reports

These Exhibits consist of reports prepared for the LEAP team within the Budget Office. The Project Team will deliver the exhibits to the LEAP team separately from the main body of the exhibits. These exhibits include Exhibits B1, B2a, B2b, and B3a through B3h.

End of Report