



Office of the Insurance Commissioner

K-12 School District

Health Benefits Information and Data Collection Project

Year 3 Report to the Washington State Legislature

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**K-12 School District Health Benefits Information and Data Collection Project
Final Report to the Washington State Legislature for Year 3**

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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 technical consulting assistance in support of this project and in August 2012 selected Treinen Associates, Inc. (Treinen) as the responsible contractor. This report to the Washington State Legislature represents the culmination of the data collection and reporting activities for Year 3 of the K-12 School District Health Benefits Data Collection Project.

In Year 3 of the project, the OIC is pleased to report that 100% of the 295 K-12 school districts (representing over 200,000 employees and dependents) and their ten medical insurance carriers (representing 438 health plans, and over 1 billion dollars in CY 2014 health premiums) submitted data in response to the collection effort.

Additionally, because of the Data Quality Assurance activities of the project team, data collection for Year 3 yielded information that is of measurably greater accuracy and reliability than in the prior two years. For example, prior to the team's Data Quality Assurance activities, the aggregate Year 3 discrepancy between carrier-reported data and district-reported data in terms of medical insurance premiums was approximately 7%. After these activities were concluded, the aggregate discrepancy was measured at 0.67%.

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

Data Collection

The legislation requires that OIC report a "summary of the benefit packages" offered by K-12 districts.¹ The law requires that data be summarized by school district benefit packages, not by school district. As required, Treinen gathered employee census and health benefit information from all 295 K-12 school districts. Additionally, from the ten carriers providing health care benefits to the K-12 employee school districts, Treinen gathered detailed health care data (claims experience, benefit plan information, and enrollment) for both insured and self-funded arrangements. 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 3, the required data was received and processed from all school districts and carriers within the timeframes requested.²

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.

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The data collected from carriers involved employee health care 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 the collected data was not formally audited for accuracy, Treinen applied many automated validations³ (for example, reasonableness checks and cross-validations) to the data. These data validations proved extremely valuable, as they caught innumerable errors and inconsistencies and resulted in data correction and resubmission by many carriers and school districts.

Report Organization and Content Highlights

Report results are presented in two major sections:

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

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, 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 school 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:

³ Described in detail below within the subsection entitled 'Data Validations', and in further detail within Appendices [23a](#) and [23b](#)).

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- K-12 school 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 school districts (100 percent) submitted data.
- Ten carriers provided data for 438 health plans covering 201,930 K-12 school district members (employees and dependents).
- Carriers reported health premiums of \$1.07 billion for calendar year 2014 (CY 2014).
- 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 in the amounts reported between the carriers versus school 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 School 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 report or maintain 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 reliable than carrier-reported dependent data. For this reason, in Year 3, some exhibits, which in prior years sourced membership data from district-reported data, now source it from carrier-reported data. Please see the descriptions of exhibits A6 and A12 within the [Appendices](#) 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 3 data collection process improvements; and developing statistical summaries.

[Chapter 3](#) summarizes the school district data. The results show:

- School Districts report total premium dollars of \$1.09 billion; school districts contributed (on average) 78.5% toward premiums, while employees contributed 21.5%.
- Average employee contribution, as a percentage of premiums for full family coverage, was 40.6% for full-time employees and 48.1% for part-time employees.
- Average employee contribution, as a percentage of premiums for employee-only coverage, was 9.0% for full-time employees and 15.0% for part-time employees.
- Average full-time employee contribution for employee plus dependent (ED) coverage (that is, any coverage other than employee-only) was \$331.84. In contrast, the average contribution for employee-only coverage was \$64.16. Hence, for full-time employees, the ratio for ED to employee-only coverage was 5.2 : 1.

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- For part-time employees, the average employee contribution for ED coverage was \$399.47. In contrast, the average contribution for employee-only coverage was \$100.26. Hence, for part-time employees, the ratio of ED to employee-only coverage was 4.0 : 1.
- For both full- and part-time employees, the average employee contribution ratio of full family coverage to employee-only coverage was 7.6 : 1.
- As reported by the carriers for the plan year ending in 2014, the average premium for all health plans combined for ED coverage was \$856.50 per month. The lowest reported premium was \$137.42 per month; the highest reported premium was \$1,409.85 per month.

[Chapter 4](#) summarizes the carrier data. The results show:

- Carriers reported that 438 separate health plans were provided that ended in CY 2014.
- Average monthly enrollment for calendar year 2014 was 105,776 employees. In total, the monthly average for employees and dependents combined was 201,930 members.
- Carriers report that total premiums paid during CY 2014 were \$1.07 billion.⁴
- Claims paid during CY 2014 were \$950.7 million, generating a paid claims loss ratio of 90.0% in 2014. The loss ratio is total paid claims divided by total premiums.⁵
- Administrative costs totaled \$118.3 million, or approximately 11.1% of the \$1.07 billion in reported premiums. Of the total administrative costs:
 - Broker commissions were \$7.2 million (about 0.7%).
 - State premium taxes and other assessments were \$52.1 million (about 4.9%).
 - Carrier administration was \$58.8 million (about 5.5%).
 - Network access fees of \$0.2 million comprise the remainder of the total administrative costs (<0.1%).
 - Reserves for incurred but not reported (IBNR) liabilities totaled \$55.8 million (about 5.3% of premium).
Note: IBNR is an estimate of the total amount owed by the insurer to all valid claimants who experienced a claim loss, but for which claims have not yet been 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 \$4.1 million (about 0.4% of premium).
Note: A Claims or Rate Stabilization Reserve (CSR or RSR) applies to a carrier rating pool. A CSR or RSR is used as a hedge against unexpectedly frequent or severe claims.

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. Some portion of those 15 dollars must pay all operating costs, and what is left is the net profit.

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- Chapter 4 also presents the actuarial values of the 438 plans that ended in CY 2014. The range of actuarial values of school district plans was 0.5538 to 0.9710. Note: Actuarial value is the plan's expected reimbursement of medical expenses. For example, a value of 0.97 would indicate that a plan, on average, pays 97% of expected medical expenses. Depending on specific circumstances, individuals may see reimbursements that are more or less than the actuarial value.

[Chapter 5](#) recaps the Year 3 Data Collection Project, summarizing keys to project success; acknowledging project participants, authors and contributors; and introducing the detailed data in the appendices.

Overall, Year 3 of the K-12 Health Benefits Data Collection Project attained the maximum possible participation by school 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) 5940⁶

In April 2012 ESSB 5940 was signed into law requiring every school district in the State of Washington and their "**benefit providers**"⁷ (health insurers) to annually submit certain information, specified in detail below, with respect to each "health plan"⁸ or "benefit package"⁹ offered to district employees. This information is submitted to the Office of the Insurance Commissioner (OIC). The data presented in this report is specified in Sections 4 and 5 of ESSB 5940, which authorizes 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 3 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 school districts. The basis for this data collection effort is that the legislature found that each year approximately \$1 billion in public funds are spent on the purchase of medical benefits for approximately 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.*

The data provided with this report relates to the 2014 calendar year. The data was submitted based on the overall plan summary and financial performance of each "health benefit plan" across carriers and school districts. This report includes a summary of each school district's health benefit plans and aggregated financial

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.

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data and other information¹¹. It does not include dental or vision information or employee-pay-all voluntary plans.

Educational Service Districts were specifically excluded within ESSB 5940 and thus were excluded from the Data Call.

ESSB 5940 also requires that the HCA establish targets to achieve greater equity between single and full-family premiums, to study consolidated school-district employee health benefits purchasing, to address purchasing for certificated and classified employees as separate groups, and to address alternatives and costs of existing programs.

By December 31, 2015, JLARC must review the report on school district health benefits submitted by the OIC and the HCA and report progress toward achieving legislative goals.

ESSB 5940 also requires that by December 1, 2013, and December 1 of each year thereafter, the OIC will submit a report on school district health insurance benefits, and that the report will be made available to the public on the OIC's web site (www.insurance.wa.gov). This document is the report for Year 3 of the project. In late November of 2015, it will be submitted to the Governor, the HCA, and the Legislature, and published 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. A limited scope review was undertaken to check for reasonableness and consistency of the data. No significant material defects were found in the submitted data.

This report does not address areas of legislative or contractual compliance across carriers or school districts. However, of the ten carriers contacted in Year 3 of the project, 100% submitted data as requested, as did all 295 school 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 school 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 further protect privacy, data reporting is aggregated by health plan. In addition, aggregation across multiple school districts and plans was permitted for smaller school districts or 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 school districts.

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

Contracts or Agreements with K-12 School Districts

ESSB 5940 requires that any contract or agreement for employee benefits executed after April 13, 1990 between a school 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 data required under ESSB 5940. School districts and the carriers must meet specific reporting requirements, including reporting progress by the school 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 school 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 by engaging in data collection efforts.

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

- Design and build a database to house the collected data.
- Design and build a computer application allowing collected data to be viewed, processed, and managed.

¹² ESSB 5940 Section 4(1)

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- Design and build a suitable vehicle for data collection (which became the school district and carrier Data Collection Spreadsheets).
- Prepare Data Call instructions for school districts and for carriers.
- Develop a formal engagement process, including preliminary pilots, to test the various components of the Data Calls.
- Engage with key stakeholders.
- Engage with school districts and their respective insurance 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.

The required data was collected for Year 3 and is summarized in this report and in the associated exhibits.

Definition of Terms

Year 3 of the OIC K-12 Health Benefit Data Collection Project is referred to throughout this document as “the project.”

The team carrying out the project consists of employees and subcontractors of Treinen. This team is referred to throughout this document as “the project team.”

Treinen Associates Inc. may be abbreviated within this document as “Treinen.”

The “Data Call” referred to throughout this document is the act of broadcasting to school districts and to their insurance 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.

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

The Year 3 Data Call, relating to the preceding calendar year, was issued on January 30, 2015.

The terms ‘health carrier’, ‘insurer’, ‘administrator’, or ‘entity’ are meant to describe any organization or third party, including HMOs, offering healthcare benefits to and contracts with K-12 school 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 school 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

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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 insurance 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)¹³
- K-12 benefit insurance brokers, producers, and consultants who supported the data collection process
- Stakeholders who 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)

¹³The 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. These plans are combined for reporting purposes in this report and PEBB is treated 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 3 healthcare data collected from K-12 school districts and their respective carriers.

The report includes:

- a. A summary of each school district's health insurance benefit plans for medical and pharmacy plans.
- b. Each school district's aggregated financial data, the overall performance of each health plan and other information.¹⁴
- c. Innovative features of school 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 school districts to more effectively and competitively manage and procure health plans.

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

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

¹⁴The 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."

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- 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 are stated as follows:

"The legislature finds that the legislature and school 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:¹⁵

- a. To improve transparency of K-12 purchasing by collecting key data across the K-12 school 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

¹⁵ Pursuant to ESSB 5940 Section 1(2)(a)(b)(c)(d)

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, school 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 Year 3 the project team greatly extended and refined the Year 2 data validations. These validations are categorized as follows:

- Category 0 — Basic edits like ensuring required fields are completed, the data types are correct (that is, numeric, currency, and so on) and other data integrity checks.
- Category 1 — Specific validations on individual data elements. For example, ensuring that the Plan Year Ending is in 2014.
- Category 2 — Complex validations within a single submission. For example, the sum of monthly premiums reported in a hypothetical Section X equals the total premiums reported in a hypothetical Section Y.
- Category 3 — Comparisons with prior submissions within a project year. For example, ensuring certain amounts (particularly premiums and enrollment numbers) do not vary more than a specified percentage between submissions.
- Category 4 — Comparisons between carrier and school 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 school district-reported data.

Category 0 validations are encapsulated within the “Check My Spreadsheet” macro of the carrier and district Data Collection Spreadsheets. This macro allows school 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 reliable, internally consistent, and free of obvious errors.

Additionally, a similar set of Category 0 data validations are performed by the OIC Application whenever submitted data is being processed and loaded into the project database. In other words, Category 0 validations are performed 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, are also performed both by Check My Spreadsheet and within the OIC Application as data is loaded.

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

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

Considerable flexibility has been built into Treinen's approach to data validation on the application side:

- Validations may be globally enabled or disabled on a per-carrier basis.
- Individual validations may be enabled or disabled for each individual carrier.
- Validations may be set to generate either an error or a warning.
- Each validation has a variance, expressed as a percentage, which may be tailored for each validation. A condition that falls outside of the specified variance generates an error or warning.
- Default validation parameters are specified with guidance from the project's actuary and adjusted according to each carrier's specific circumstances.

Please see Appendix 23 for a detailed description of the Year 3 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 school districts and carriers.

There are 295 school districts statewide with a wide variety of benefit plans that are 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-fund¹⁶.

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

The data collection project received school district data from all 295 school districts, covering 106,163 employees and 202,253 members (that is, employees plus covered dependents).

The data collection project received carrier data from ten carriers, inclusive of PEBB. The carriers reported total medical premiums of \$1,091,569,419 and reported 819 health plans offered in 2014, including terminated plans and unused plans. Financial data (enrollment, premiums, and claims) was provided for 438 health plans covering a monthly average of 104,455 employees and 198,952 members for CY 2014. The carriers provided actuarial values on 438 plans.

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. Due to the design of the Data Call¹⁷, carriers generally reported somewhat higher enrollment numbers, while enrollments summarized from the plan-level data or from school districts are slightly lower.

Note also that school 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 dependent and member counts.

¹⁶ 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.

¹⁷ In both Section 6 and Section 8 of the Carrier Data Call, carriers report enrollment on a yearly basis, whereas school districts, in Section 7 of the District Data Call, report enrollment based on a 'snapshot date', which in Year 3 of the project, was October 1, 2014.

The net outcome of this data collection design may be illustrated as follows: if, for District X, 100 employees switch at some point in 2014 from Carrier 1 to Carrier 2, then both carriers (quite correctly) report the 100 employees that switched, thus resulting in double-counting of those employees on the carrier side.

In the aggregate, this aspect of data collection design results in carrier reporting of enrollment that is approximately 5.6 % 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 practicable solution, and would place an undue burden on school districts.

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The ten carriers were:

- Aetna
- Group Health Cooperative
- Kaiser Permanente
- KPS Health Plans
- MODA Health (new in Year 3)
- 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

Below is a summation of the current K-12 school district data.

Table 1 shows all 295 K-12 school districts statewide by school district size.

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

Table 3 shows plan types by reporting carriers. 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.

School Districts by Size		
District Size Range	Number of Districts	Percentage of Total
1 – 50	99	33.6%
50 – 150	73	24.7%
150 – 300	37	12.5%
300 – 450	23	7.8%
450 – 600	14	4.7%
600 – 750	7	2.4%
750 – 1,000	12	4.1%
1,000 – 1,500	10	3.4%
1,500 – 2,000	9	3.1%
2,000+	11	3.7%
Total	295	100.0%

Table 1 —School Districts by Size

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School District Enrollment by Carrier			
Carrier	Employees	Members	% of Total Members
Carrier 01	62,110	119,466	59.1%
Carrier 02	22,942	42,766	21.1%
Carrier 03	9,795	18,374	9.1%
Carrier 04	3,451	6,532	3.2%
Carrier 05	1,181	2,115	1.0%
Carrier 06	1,043	1,923	1.0%
Carrier 07	2,869	5,197	2.6%
Carrier 08	1,524	3,727	1.8%
Carrier 09	509	839	0.4%
Carrier 10	739	1,314	0.6%
Total	106,163	202,253	100.0%

Table 2 — School District Enrollment by Carrier

Enrolled Employees by Plan Type		
Plan Type	Employees	Percentage of Total
PPO	82,165	77.7%
HMO	19,861	18.8%
Traditional	2,433	2.3%
High Deductible	669	0.6%
Closed Network	648	0.6%

Table 3 — Enrolled Employees by Plan Type

Note: As reported by the carriers, the combined total number of employees by plan type (105,776) as compared to the combined total number of employees by carrier (106,663). 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 per se. For example, some plans offered to school districts in 2014 were not carried over into 2015, but are nevertheless reported on by the carriers, 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 school districts in the State of Washington, and their medical carriers, involved sending a Data Call to all school districts and their medical insurance carriers. No data was requested directly from any other third party or intermediary.

The Data Call comprised detailed written instructions and a Data Collection Spreadsheet to be used 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, each district was asked to report the aggregated cost of separately purchased dental and vision plans. Data collection 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, which is to be expected 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 Carrier Data Call was issued to only ten carriers, including PEBB, whereas the District Data Call was issued to 295 school districts.

School 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 school 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 school districts. However, in order to validate the internal consistency of collected data, five categories of automated validations were applied as the data was being loaded to the project database. Resubmissions were required from both districts and carriers to correct reporting errors that were uncovered by the run-time validations.

Additional Data Quality Assurance (DQA) activities were performed after all data had been collected and initially accepted. The DQA activities resulted in a large number of reporting errors being identified and corrected by carriers and districts. (For more information about data quality, please see the sub-sections below entitled "Data Validation" and "SOW 17").

When submitted or resubmitted data was received, it was processed using a computer application that was designed and built by the project team, referred to as the "OIC Application". 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 are automatically generated and sent to districts and carriers, and status reporting.

Period of the Information Collected

The language of ESSB 5940 specifies the "prior calendar year¹⁸" to be the period of data to be collected. For Year 3 of the project this means CY 2014. Most school 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 school district health benefit plans frequently straddled two plan years.

To obtain twelve months of data for CY 2014, carrier data reporting is for plan years ending in 2014 plus any remaining months of 2014 for those plans that begin in 2014, but end in 2015. For plans not aligned to a full calendar year, this required two different reporting periods in 2014. For example, for plan years ending September 30, this required the capture of 2014 data through September 30, 2014, plus data for the remaining months of October, November, and December 2014. The remaining three months of data represent data for the subsequent plan year ending in 2015.

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

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

Snapshot Date

In order to simplify the data collection process for the benefit of school districts, census data was collected from school districts based on a "snapshot date." The date selected was October 1, 2014, to align with the OSPI S-275 employee population reporting process.¹⁹ All school district personnel employed as of October 1 of each school district year are reported to the OSPI on the S-275 report. School district census information (population data), including employee and dependent head counts, demographics, full-time equivalent status, employee groups, enrollment information, and coverage elections were captured as of the "snapshot date" of October 1, 2014. Some districts may have reported all participants within the month of October 2014, rather than as of the snapshot date, which does not materially change the data.

Ideally, two sets of census results would have been gathered from school districts, one for each of the two school years within the calendar year to be reported per ESSB 5940. Even better would have been to collect monthly census data. However, both approaches were deemed too onerous, and they could have delayed data collection. Instead, a single set of census data was collected. This census data set had a date of October 1, 2014, near the beginning of the school year that was under way at the time of the data collection.

¹⁸ ESSB5940 Section 4(2)

¹⁹ The OSPI S-275 reporting process is an electronic personnel-reporting process that provides a record of certificated and classified employees of School Districts. Data collected by the S-275 reporting process are either mandated by state law, necessary for calculating state funding, or are needed for responding to requests from the federal government, the Legislature, or other organizations.

An additional benefit of the ‘snapshot’ approach is that census results from subsequent years of the project can easily and reliably be compared to those of a prior year.

The school 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 school district and employee contributions, which together comprise the monthly total premium rates. Unit rates were accepted 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, 2014), particularly to capture reserve balances for claim or rate stabilization reserves (CSR or RSR reserves) or reserves for claims incurred but not reported (IBNR²⁰ claim reserves). The snapshot date was used also to capture detailed demographics by plan.

Other information requested from school districts and carriers (for example, narratives, plans, performance measures, financial information, and so on) was reported by calendar year, plan year, or annually by month depending on the availability, type, and source of the data. For annual school district totals by expenditure category or payee, amounts for the school fiscal year ending in 2014 were requested.

Statements of Work (SOWs)

SOW 13 — Project Planning & 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 included:

- SOW Summary showing amounts and due dates associated with each workstream
- Project Budget
- Project Schedule
- SOW 13 — Word document describing the required foundational documents
- SOW 14 — Word document describing Data Call Preparation, Tooling & Engagement
- SOW 15 — Word document describing Data Collection
- SOW 16 — Word document describing Report Preparation
- SOW 17 — Word document describing Data Quality Assurance

SOW 14 — Data Call Preparation and Tooling & Engagement

Under SOW 14, revisions and improvements were made to the custom-built toolset that had been 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. The improvements in Year 3 were largely driven by feedback from districts and

²⁰ Sometimes called “Incurred But Not Paid (IBNP).” These are two names for the same reserve.

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carriers based on their experience while using the toolset provided in Year 2. Toolset enhancements for Year 3 concerned:

- **The Project Database**
Incremental improvements were made to the database design based on what the project team learned during Year 2, and as the project unfolded in Year 3.
- **The OIC Application**
Significant improvements were made in the area of automated data validations that are performed prior to loading district or carrier data.
- **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 major 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.

Initial Outreach

In early December 2014 the project team contacted all school districts and their medical insurance carriers to let them know that the Year 3 project was under way, to advise them of the project schedule, and to let them know what was going to be different about the Year 3 Project.

School District Data Call

Introduction

The Data Call was sent to all 295 K-12 school districts. All 295 school districts provided data in compliance with the Data Call. The school districts reported 106,163 employees and 202,253 members, generating \$1.09 billion in premiums.

Washington School Information Processing Cooperative (WSIPC)

School districts relied 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 school districts out of 295). WSIPC hosts databases for the substantial majority of school districts in Washington State, and routinely provides extract routines that allow member school 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 school districts comply with the reporting that is required under ESSB 5940. WSIPC provided software that allowed each district to extract much of the required data from their own independent database, which school districts then supplemented with additional information from other sources before submitting their data to the project team.

Each district has its own independent database, and is free to configure and use WSIPC-supplied software as it sees fit, or indeed to use WSIPC-supplied software in tandem with other software that is not supplied by WSIPC. Consequently, school districts use (and report) a wide variety of different payroll deduction codes,

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accounts payable codes, and business entity names. WSIPC issued guidance to all its member school 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.

(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 school districts in the form of WESPaC, a robust, third-party suite of applications designed to support the data processing needs of school districts, including operations, financial management, accounts payable and receivable, and payroll, among other functions. Each member school district runs their own version of WESPaC on their own virtual machinery within IT infrastructure that is provided and operated by WSIPC. Each school district has its own virtual database server and virtual file server, thus segregating each school district's data from every other school district's data, and providing security.)

School District Data Call — Methodology

The school district Data Call included an instructions document and a Data Collection Spreadsheet. The Data Collection Spreadsheet for school district reporting was divided into eight tabs. Each tab contained a different type of data and is referred to as a "Section" as detailed below.

Section 1: School District Annual Reporting (Fiscal Year-End 2014)

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

- Total annual premiums paid to carriers for health benefits (calculated automatically in Year 3, 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 was used principally to report the costs associated with the school district retiree medical subsidy, also known as the "retiree carve-out."
- Confirmation that the school 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

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- 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 school district was asked to check which features are applicable to any health plan offered by the school district.

Section 3: Carriers, Brokers, and Other Entities

- Each school district was asked to identify various entities such as insurance 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 school district was asked to list 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 that was offered a distinct array of benefits. Districts had to categorize each employee group as being either for classified or certificated employees.
- The health plans offered to each group of school district employees were reported here (or in Section 6), thus allowing plans offered to be associated with employee groups.

Section 6: Medical Plans offered to Employee Groups

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

Section 7: Employee Listing (Census Data)

- This Section requested a list of employee or census information to reflect the school district's population as of October 1, 2014. Each school district employee appearing on the school district's OSPI S-275 report was to be listed.
- For each employee, the following data was collected:
 - The group the employee belonged to
 - An indication as to whether the employee was classified or certificated
 - Gender

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- Date of birth (DOB)
- Full-Time Employee (FTE) benefit status
- A ‘Yes/No’ indication as to whether, by the districts own local rules, the employee was 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 school district
 - Monthly contributions paid by the employee
 - Total monthly premium (school 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)
- Eligible dependents could be reported here, or in Section 8.

Section 8: Dependent Listing

- This Section presented an alternative means of reporting each employee's eligible dependents.

Carrier Data Call

Introduction

Ten carriers, including PEBB (considered a "carrier" for the purposes of data collection), were included in the 2015 Carrier Data Call. The ten carriers in Year 3 include:

- Aetna
- Group Health Cooperative
- Kaiser
- KPS Health Plans
- MODA Health (new in Year 3)
- Premera
- Providence Health Plan
- Regence
- United Healthcare
- PEBB²¹

²¹ *The Public Employees Benefit Board (PEBB) reported on a combined basis on behalf of their health plans Group Health Cooperative, Kaiser, and Regence*

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Carrier Data Call Methodology

The carrier Data Call included an instructions document and a Data Collection Spreadsheet. The Data Collection Spreadsheet for carrier reporting was divided into eleven tabs. Each tab contained a different type of data and is referred to as a "Section" as detailed below.

Section 1: Carrier Annual Reporting (for Calendar Year 2014)

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.

Section 2: Innovative Health Plan Features (all K-12 Plans in 2014)

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 school districts (for example, a high-risk maternity program). Each carrier was asked to identify those programs from the list that were offered to one or more K-12 school 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.

Two types of reserves were requested:

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 CSR or RSR is used as a hedge against claim fluctuations that occur during a reporting period.

Section 4: Health Plan Year Information (all Plan Years in 2014)

This Section required reporting of information on each unique health plan offered in 2014 by each K-12 carrier. The information requested included actuarial values²², plan type, and other key attributes.

This Section established the linkage between Plan Codes and Costshare Codes, which are used in Section 10 to report the costshare design of (groups of) plans. Essentially, a Costshare Code identifies a group of plans that have the same cost-sharing features. The rates associated with individual Plans were not, in Year 3, reported in

²²The actuarial value is determined by the "minimum value calculator" applicable under the Affordable Care Act (ACA) to determine the percentage of the allowed costs of benefits. A value of 1.00 would indicate that a plan covers 100% of expected medical expenses, whereas a value of 0.90 would indicate that a plan, on average, covers 90% of expected medical expenses. These values are calculated on a population basis so some individuals may see reimbursement at more or less than the actuarial value.

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Section 4. This was instead done by means of the Rateset Code (see notes on Section 11, below). There may be a one-to-many relationship between Ratesets and Plans.

This Section required that each unique plan be identified as being part of a “benefit package.” A benefit package could include one plan or multiple plans depending on how a carrier chose to report their data. Carriers had the opportunity to aggregate school district plan data for small school district enrollments, or plans with similar actuarial values into a “benefit package” in order to maintain patient confidentiality of protected health information under HIPAA.

Section 5: Benefit Package Plan Year Performance (for Plan Years Ending in 2014)

This Section required reporting of performance data such as health plan premiums²³ and total claims expenses or paid claims²⁴ for the plan year ending in 2014. For plans with low enrollments, which generally means fewer than 200 covered lives, data aggregation was permitted. In some cases, carriers also aggregated plans with similar actuarial values (see related footnote 17). Claims data by major benefit category (for example, hospitalization, professional services, and pharmacy) were reported by utilization metrics such as hospitalization average length of stay, and the number of professional services visits per 1,000 members.

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

Section 6: Benefit Package Performance by Month (all Plans in 2014)

This Section required monthly reporting of premiums, paid claims by major benefit category, and employee and dependent enrollment. The reporting period included all months for the plan year ending in 2014 plus the remaining calendar months (within 2014) of the plan year that began in 2014 and ended in 2015.

Section 7: Benefit Package Demographics by Plan

This Section required reporting of enrollment data by age tier (for employees and their dependents) such as gender, age, and 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 information was requested for each benefit package associated with the plan year ending in 2014.

²³ Health plan premiums are defined under WAC 284.198.005 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. Carriers are requested to report actual premium.

²⁴ Paid claims are defined under WAC 284.198.005 as the dollar amount of claims recorded as paid during the reporting period.

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Section 8: Benefit Package by School District by Plan (for Plan Years Ending in 2014)

This Section required reporting of enrollment (headcount) data for each health plan by school district for the twelve-month period ending in December 2014. This allowed for the mapping of a school district to a particular benefit package.

Section 9: Large Claims (for Plan Years Ending in 2014)

This Section required reporting of large claims. The large claims report represents aggregated large claims data for all K-12 school districts for all carriers combined statewide. This level of aggregated reporting is designed to protect the privacy of individually identifiable health information. A large claim was considered based on the aggregation of all claims paid per unique claimant in excess of \$100,000 during the reporting period. The information by claimant included the primary diagnosis code associated with the highest-cost service related to the reported large claim.

Section 10: Cost-sharing Design (for Plan Years Ending in 2014)

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 school districts. However, in Year 2 an entirely new Section was created to gather this information electronically from carriers. This new Section worked well in Year 2, and it was used again in Year 3. It gathers data on various types of deductibles, co-insurance, copays, and Rx-related plan attributes.

Section 11: Plan Rates by Rateset Code (for Plan Years Ending in 2014)

In Year 1, the rates associated with plans were reported in a single column within Section 4. In Year 2, Section 11 was created 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 was used again in Year 3.

SOW 15 — Data Collection

Under this Statement of Work, Treinen was required 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 effort for each individual school 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 2015, and continued until the official deadline, which was May 29, 2015. A small amount of ‘straggler management’ took place during June of 2015, and by June 16th the data collection was complete, meaning that data from all districts and carriers had by this point been submitted and (initially) accepted. 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, many districts and carriers were requested to make corrections to their data and resubmit. All of them complied fully, thus preserving the project team’s 100% success rate.

School District Data Collection Results

The level of school district responsiveness in Year 2 and Year 3 of the project is the highest compared to any previous study of this nature related to K-12 school district health benefits. In both Year 2 and Year 3, all 295 school districts responded to the Data Call.

School districts provided census data as of the ‘snapshot date’ of October 1, 2014. (For comparison, carriers provided financial data for the entire 2014 calendar year.) School district reporting shows total enrollment of 106,163 employees and 202,253 members (please see the A12 series Exhibits attached to this report). Carriers provided financial data on 104,455 K-12 employees and 198,952 members (see Exhibit A9a). School districts reported combined contributions generating \$1.09 billion in premiums, while carriers reported \$1.07 billion in premiums. Minor discrepancies such as these were expected due to differences in the reporting period.

The success of the school district data collection effort can be attributed to:

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

Variations in School District Data

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

- (i) There was no verification of submitted data, although it was validated for internal consistency and manually checked for reasonableness.
- (ii) Some minor inconsistencies exist in the collected data but are statistically inconsequential. For example, district-reported enrollment and premiums do not exactly match the corresponding carrier data.
- (iii) The variations are so small that they do not substantively affect the statistical validity of the information presented in the exhibits.

A list of reasons for variations between school district-reported data and carrier-reported data is presented below.

1. There are large variations in school district data-reporting capabilities and methods. School district data is extracted from over 200 different computer systems. Computer applications and databases are configured and managed independently within each school 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 school districts that use computing resources provided by WSIPC.) The result is that there is limited consistency across school districts in terms of:
 - Use or reporting of plan codes or plan names
 - Configuration of WSIPC-provided school district management software
 - Configuration of the WSIPC extract
2. Some school 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 school district data may persist with respect to certificated and classified employee groups.
3. Uncovered dependent information was available only from selected school districts that surveyed their populations for this data; thus, data on uncovered dependents is neither comprehensive nor complete across school districts. On a related note, while district reporting of employee enrollment appears to be accurate (in that it closely matches carrier-reported employee enrollment), district-reported enrolled membership (employees plus dependents) varies greatly from the membership reported by carriers. Hence, carrier-reported data concerning membership is deemed by the project team to be more reliable than district-reported data concerning membership.
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 data set and the carrier data set. 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.

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5. School 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 2014; whereas school districts were asked to report populations and premiums based on a single snapshot date of October 1, 2014, and total amounts paid (to each entity listed in Section 3) on the basis of the full fiscal year ending in 2014.
6. There is no universally accepted standard for reporting of administrative costs related to school district benefit administration.

These factors, taken together, generate inevitable discrepancies between reporting of enrollment and premiums within individual school districts, and across the entire school district data set compared to the entire carrier data set. Given the wide variety of reporting periods and other factors, it is noteworthy that the project team was able to achieve 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 ten carriers including PEBB. For reporting purposes, PEBB plans (underwritten by three carriers) were combined. A summary of the employee and member enrollment results reported by carrier for all K-12 health plans is shown below. Actual carrier-reported financial data included monthly averages of 104,455 employees and 198,952 members, and a total of \$1,073,587,815 in premiums for CY 2014 (see Exhibits A8f and 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	62,110	119,466	59.1%
Carrier 02	22,942	42,766	21.1%
Carrier 03	9,795	18,374	9.1%
Carrier 04	3,451	6,532	3.2%
Carrier 05	1,181	2,115	1.0%
Carrier 06	1,043	1,923	1.0%
Carrier 07	2,869	5,197	2.6%
Carrier 08	1,524	3,727	1.8%
Carrier 09	509	839	0.4%

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Carrier Enrollment Summary			
Carrier	Employees	Members	% of Total Members
Carrier 10	739	1,314	0.6%
Total	106,163	202,253	100.0%

Table 4 – Carrier Enrollment Summary

Variations in Carrier Data

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

The factors listed below explain the small differences between district and carrier data:

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 CY 2014. However, school districts track data on a school fiscal-year basis, and most carriers track data on a school 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 school district reporting. Because of the different reporting periods between school districts and carriers, the data cannot perfectly align across these data sets.
4. Carriers were permitted to aggregate data by health plans, including aggregation of smaller school district plans and plans of similar benefit value. The purpose of aggregation was to avoid disclosure of individually identifiable health information or protected health information as defined by HIPAA.
5. Utilization metrics for medical and pharmacy data were not tracked on the same basis across all carriers, and in some cases were unavailable, all of which resulted in gaps in reporting. In addition, calculation of utilization metrics for small populations generated large variations in results, which would be expected 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 school districts. These minor discrepancies are mainly attributable to differences in reporting periods and to different sources of enrollment and premium information.

Run-Out Claims

These are claims against plans that are no longer offered, or have effectively ended (that is, 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 2013, and had run-out claims experience in 2014; or
- were active in 2013 and also in 2014, had no enrollment in 2014, and had run-out claims experience during 2014 from 2013 enrollment.

The question was raised, mid-project in Year 3, as to whether or not carriers could or should submit this type of run-out data. Based on instructions from the OIC, a decision was made that carriers could submit such 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 3 run-out claims data is probably incomplete.

SOW 16 — Exhibits and Report

The overall objectives of this SOW were to:

- a. Produce reporting as required by ESSB 5940 based on data collected from school districts and their health insurance carriers in the State of Washington.
- b. Produce related exhibits, which are statistical tables derived from the data collected from school districts and their health insurance carriers.
- c. Apply automated validations to collected data, and perform cross-validations between the carrier data set and the district data set.
- d. Create and submit Data Validation Reports; these identified apparent shortcomings in submitted data, as well as the steps taken to correct submitted data and/or request resubmission of corrected data.
- e. If submitted data needs to be changed, keep meticulous logs of what submitted data was changed and why, as well as separate pre-change and post-change versions of each set of submitted data.
- f. Request resubmission of data that was not found to be reasonable or credible, or that contradicted other collected data.
- g. Produce a Data Traceability Matrix, which traces the connections between data that must be reported under ESSB 5940, and the data design implemented and used by the project team.

The work specified in this SOW was duly performed and the deliverables produced were accepted by the OIC.

SOW 17 — Data Quality Assurance

The overall objectives of this SOW were 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 3 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.

The work specified in this SOW was duly performed and the deliverables produced were accepted by the OIC.

CHAPTER 3: SCHOOL DISTRICT-SPECIFIC DATA

295 school districts and 10 carriers participated in the K-12 Data Collection Project. School districts paid \$1.092 billion in annual premiums based on the snapshot date of October 1, 2014. The figures below are derived from school district enrollment as of the snapshot date, and the average reported premium and contributions were annualized. *Note: For source exhibits, refer to A7a, A7b, A16, and A17.*

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

Contributions by Tier		
Contributions as Reported by School Districts	Full-Time Employees	Part-Time Employees
Ratio of Family to Employee Contributions	8.6	6.5
Contributions as a Percentage of Premium Employee Coverage	9.0%	15.0%
Contributions as a Percentage of Premiums Employee & Family Coverage	40.6%	48.1%

Table 5 — Contributions by Tier

Table 6 below shows the average premiums and claims by health plan (Exhibit A14), as reported by the carriers, for all the plan year ending in 2014. 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 below (as per employee per month (PEPM)).

Employee Premium and Claims		
Category	Premium	Claims
Low	\$137.42	\$0.00
High	\$1,409.85	\$3,461.76
Average	\$856.50	\$758.49

Table 6 — Employee Premium and Claims

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

Note: Certain exhibits break down costs per employee per month (PEPM) and per member per month (PMPM). Exhibits A6a and A6b report 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 cost reporting.

CHAPTER 4: CARRIER-SPECIFIC DATA

In order to comply with requirements of ESSB 5940, carriers had to report all health plans provided in CY 2014. The carriers reported 819 separate health plans provided during 2014. This included plans ending in 2014 (plans offered in the 2013 – 2014 school year) and plans beginning in 2014 (plans offered for the 2014 – 2015 plan year). In other words, these plans straddled two years.

All 819 plans were presented with information related to benefit descriptions, financial data and plan actuarial values. The plans were combined benefit packages, which consists of one or more health plans across multiple school districts of similar size or aggregated health plans with similar actuarial value. There were 203 reported benefit packages with calendar-year data (see the A8 series of Exhibits). For the plan year ending in 2014 there were 203 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 2014 plans, and data reported for the plan year ending in 2014, is shown below. Not all data was available for the same reporting period, although both reporting periods are for twelve months.

The tables below show enrollments, premiums, administration costs, and reserves. For illustration, administration and reserves for the plan year ending in 2014 are compared to premiums paid for CY 2014. We would expect some variations in results if the data were presented for the same reporting periods; however, results are expected to be reasonably consistent.

In 2014, claims were running at 89.6% of premium. Administrative costs represent 11.1% of premium (\$118.3 million) of which carrier administration represents 5.5% of premium, considered below industry-targeted administration costs 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 some reserves were not reported by the carriers. This is informational only. There has been no assessment as to the appropriate level of the reserve levels by rating, purchasing pool or by benefit package.

Enrollment, Premiums, and Paid Claims	
Category (CY2014)	Amount
Average Monthly Employees (A9a)	104,455
Average Monthly Members (A9a)	198,952
Premiums (A8d)	1,073,587,815
Claims Paid (A8c)	\$950,739,745
Loss Ratio	88.6%

Table 7 — Enrollment, Premiums, and Paid Claims

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Administrative Fees and Reserves		
Category	Amount	Percentage of Total Premium
Administrative Fees for Plan Years Ending in 2014		
Taxes	\$52,074,090	4.9%
Agent Payments	\$7,195,392	0.7%
TPA Payments	\$0	0.0%
PPO Access Fees	\$245,846	0.0%
Carrier Admin	\$58,767,743	5.5%
Total Administration	\$118,283,071	11.1%
Reserve Reported for Plan Years Ending in 2014		
IBNR Reserves	\$55,839,443	5.3%
Other Reserves	\$4,118,028	0.4%
Total Reserves	\$59,957,471	5.6%

Table 8 — Administrative Fees and Reserves

Additional information regarding the distribution of plan enrollment by type of plan is shown below. Note that enrollment is based on carrier data for the plan year ending in 2014. The school district enrollment by types of plans offered is shown in the following table.

Enrollment by Plan Type		
Plan Type	Employees	Percentage of Total
PPO	82,165	77.7%
HMO	19,861	18.8%
Traditional	2,433	2.3%
High Deductible	669	0.6%
Closed Network	648	0.6%
Total	105,776	100.0%

Table 9 — Enrollment by Plan Type

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The following table indicates the actuarial values of reported school district plans for all plans ending in CY 2014. Of the 438 reported, 180 (41.1%) have a reimbursement value less than 80%; 163 plans (37.2%) show a value of 80% or greater, but less than 90%; and 95 plans (21.7%) show a value equal to or greater than 90%.

Actuarial Value	Number of Plans	Percentage of Total
0.55	1	0.2%
0.57	1	0.2%
0.61	2	0.5%
0.68	2	0.5%
0.69	24	5.5%
0.71	1	0.2%
0.72	1	0.2%
0.73	3	0.7%
0.74	11	2.5%
0.75	6	1.4%
0.76	5	1.1%
0.77	14	3.2%
0.78	23	5.3%
0.79	45	10.3%
0.80	89	20.3%
0.81	7	1.6%
0.82	8	1.8%
0.83	10	2.3%
0.84	10	2.3%
0.85	17	3.9%
0.86	11	2.5%
0.87	28	6.4%
0.88	9	2.1%
0.89	8	1.8%
0.90	11	2.5%

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Actuarial Value	Number of Plans	Percentage of Total
0.91	19	4.3%
0.92	27	6.2%
0.93	23	5.3%
0.94	10	2.3%
0.95	9	2.1%
0.96	2	0.5%
0.97	1	0.2%
Total	438	100.0%

Table 10 — Actuarial Values of Benefit Plans

For comparison, below is the number of K-12 school district plans in relationship to the values associated with healthcare plans under the Health Care Act, also known as the Affordable Care Act (ACA). The relationship revealed that 26.3% of school districts (115) have "Platinum"-level benefits; 56.2% of plans (246) have "Gold"-level benefits; 16.2% (71) school districts have "Silver"-level benefits; 0.9% (4) school districts have "Bronze"-level benefits; and 0.5% (2) school districts have "Catastrophic"-level benefits.

Metal Level	Number of Plans	Percentage of Total
Bronze or Below	6	1.4%
Silver	71	16.2%
Gold	246	56.2%
Platinum	115	26.3%
Total	438	100.0%

Table 11 — Benefit Plans as Compared to ACA Levels

Please refer to the appendices and corresponding exhibits 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 school district and carrier health benefit plan data in order to:

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

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

Year 3 of the K-12 School District Health Benefits Data Collection Project was successful, as it was in Year 2, due to the participation of all 295 school districts, and because 100% of carriers that received the Data Call reported the required data. Treinen'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 that are specific to the districts and carriers, respectively. The two versions of the Data Collection Spreadsheet were used for reporting the data required by ESSB 5940.
- Engaging with school districts and their respective insurance carriers to collect the required data.
- Redesigning the database housing the collected data and the computer application that allows the data to be viewed, processed, and managed.
- 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 data provided by school districts and carriers are summarized in the appendices, which are presented as a series of statistical exhibits. An explanation of each exhibit is provided in the Appendix.

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

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- Different data sources (carrier versus school district).
- Differences in reporting periods, including CY 2014, plans ending in 2014, data from both plans ending in 2014 and beginning in 2014, and reporting data based on a snapshot date of October 1, 2014 for school district reporting.
- Carriers are required to report all plans in effect in 2014; thus, they reported active and inactive plans. Therefore, carrier reporting cannot perfectly align with school district plan reporting.
- School district plan names and carrier plan names do not match, since plan names across school districts and carriers were not consistent. Thus, the project team assigned numeric plan identifiers separately for school 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 3 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 will assist school districts and carriers in meeting 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 school districts.

APPENDICES (Exhibits)

The purpose of this section is to identify and explain each appendix, included as numbered exhibits. The exhibit number identifier is included in the exhibit title. The exhibits represent the results of the Data Collection Project and are summarized and explained below.

Some exhibits show data that has been reported for CY 2014, other exhibits are presented with data for the plan year ending in 2014, or for all plan years in 2014, or a snapshot date (October 1, 2014). As such, information across exhibits may vary.

Throughout the exhibits, the actual health plan names have been replaced by numeric code identifiers to maintain the confidentiality of information. It is important to note that school district health plan codes and carrier health plan codes have been separately assigned. One set of codes does not match to the other. This was necessary because health plan names across school districts and between school districts and carriers were not consistent and easily discernible.

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

Note that when data was not reported, or not reported exactly according to the Data Call instructions, the outcome is that some exhibits have fields with no data. In addition, fields within exhibits are occasionally blank because there was no applicable data to report.

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

Many corrections and re-submissions were made by schools districts and carriers, and, as a result, the collected data shows a high degree of internal consistency, and holds up well to the complex validations that have been executed against it. However, despite the project team's best efforts and due diligence, small errors may persist in the reported data. Spelling, grammatical, or typographical errors in the submitted data have not been corrected.

Summary of New Exhibits and Changes to Existing Exhibits

1. Modified Exhibits.

Exhibits A15, A16 and A17:

- Added a column that shows the ratio between the “monthly payroll rate” for EE and EF.
- Amended the title of the exhibits to clearly state that it shows the amount contributed by all employees.

Exhibit A5b:

- Statewide enrollment included in each plan.

2. New Exhibits.

Additional exhibit that summarizes the number of plans and total enrollment in each metal tier (bronze, silver, gold, or platinum):

- A3(b)

Additional exhibits equivalent to A15, A16, and A17 for full-time employees:

- A15(b) — Full-time
- A16(b) — Full-time
- A17(b) — Full-time

Additional exhibits equivalent to A15, A16, and A17 for part-time employees:

- A15(c) — Part-time
- A16(c) — Part-time
- A17(c) — Part-time

Additional exhibits equivalent to A15, A16, and A17 for certificated employees:

- A15(d) — Certificated
- A16(d) — Certificated
- A17(d) — Certificated

Additional exhibits equivalent to A15, A16, and A17 for classified employees.

- A15(e) — Classified
- A16(e) — Classified
- A17(e) — Classified

Appendix 1 — ESSB 5940 Data Requirements

This exhibit summarizes the legislation (ESSB 5940) that requires specific information from K-12 school 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. A description of the requirements is further described through specific rules described by rule-making order CR103.

Appendix 2a — Health Plan Options by School District

This exhibit lists all plans offered in 2014 by each school district as reported by the carriers. School districts and carrier plan names were not consistent; as such, carrier plans were used and unique numeric identifiers were assigned to each reported plan. The carriers reported 506 plans in their plan information for all plans offered in 2014. Some of the plans offered begin in 2014 but were not in existence prior to 2014, which is why this number is higher than the count of 438 plans that end in 2014, 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.

Appendix 2b — Health Plan Coverage Periods

This exhibit shows the health plan options (from Exhibit A2a) by reporting period for all plans offered in CY 2014. The list of plans includes those plans ending in 2014 and all that begin in 2014. The legislation requires reporting of all data for CY 2014. The list shows that there are 515 K-12 health plans reported by carriers in 2014. In addition to showing plans that begin in 2014 but were not in existence prior to 2014, like Appendix A2a above, this exhibit also includes plans offered by the carriers but in which no school district participates. For the specific health plan design for each plan, refer to the A5 series exhibits.

Appendix 3 — Enrollment by Benefit Package and Health Plan

This exhibit ties each health plan to a benefit package listed by school district for the plan year ending in 2014. The exhibit shows employee, dependent and total member enrollment. Total enrollment reported for all benefit packages is 105,776 employees and 201,930 members.

Please note the addition in Year 3 of a new exhibit in this series, namely A3b. This exhibit is described above, within the section entitled “Summary of New Exhibits and Changes to Existing Exhibits”.

Appendix 3b — Number of Plans and Employee Enrollment by Metal Tier

Appendix 3b is new for Year 3. This exhibit summarizes the number of plans and total enrollment in each metal tier (bronze, silver, gold, and platinum).

Appendix 4 — Employee and Dependent Counts

Exhibit A4a reports employee and dependent counts and total members by school district for all plans combined. Average family size reported was 1.909 members per family. The carriers reported data for the plan year ending in 2014.

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Exhibit A4b shows data by coverage tier (EE, ES, EC, and EF) for the enrolled population. The report indicates the employee status, whether certificated or classified. This exhibit is based on information from reporting school districts and reports 102,739 employees, which is lower than enrolled employees as reported by carriers at 105,776 (Exhibit A3). Discrepancies are expected due to differences in reporting period or date and the source of the data. This data was reported by school districts based on census as of the snapshot date October 1, 2014.

Exhibit A4c reports enrollment by school district, by employee group, for school district-reported health plans. School districts reported different plans than carriers, thus this exhibit does not tie to other exhibits with plans reported by carriers. School districts reported 166,204 members, whereas carriers reported 201,930 members (Exhibit A3). School districts do not track dependent members consistently, resulting in the lower value as compared to the carrier member total. As a result, carrier member counts are believed to be more accurate.

Appendix 5 — 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 CY 2014 (that is, plans ending and beginning in 2014). Exhibit A5a provides a one-page summary of each health plan design offered in the plan year beginning and ending in 2014. The remaining A5 exhibits report the following; A5b, plan actuarial values, A5c, plan deductibles, A5d, coinsurance, A5e, co-payments, A5f, out-of-pocket maximums, and A5g, prescription drugs.

Appendix 6 — Total Costs by School District for School District-Specific Health Plans Combined

Exhibits A6a and A6b show carrier-reported premiums, exclusive of plan administration costs. Exhibit A6a lists school districts in alphabetical order, whereas Exhibit A6b sorts the results by total cost PMPM in descending order. Reported employees total 102,739, and members total 166,204 for all school districts combined. The average PMPM cost was \$556.81. The highest-cost school district has a PMPM of \$3,176.51, compared to the lowest cost at \$200.00 PMPM. Carrier-reported medical premiums, exclusive of administration fees, totaled \$1,110,537,899 for the plan year ending in 2014.

The differences in premium costs between this exhibit and other exhibits may be attributed to differences in plan design, pricing, and enrollment mix as reported by K-12 carriers, and to the fact that other exhibits are sourced 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 2014.

A6 — Changed in Year 3 to Carrier-Sourced

Note that in Year 3, unlike in prior project years, A6a and A6b were sourced from carrier-submitted data. The reason for the change is that with respect to membership counts, carrier-reported data is considered by the project team to be more reliable than district-submitted data.

Appendix 7 — Average Costs and Contributions by School District

This exhibit shows the average costs and contributions by school 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 5.2 times the contribution for EE (employee only) coverage; for part-time employees, contributions for employee plus dependent coverage are on average are 4.0 times the contribution for employee-only coverage.

On average, full-time and part-time employees contribute 9.0% and 15.0%, respectively, to the average cost of employee-only premiums, as compared to employee plus dependent contributions, which are at 30.2% and 37.9% respectively. This data is based on school district census data as of the snapshot date of October 1, 2014.

Note that in the context of Exhibits A7a and A7b, the term ED should be interpreted 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 and spouse and one or more children.

An important enhancement in Year 3 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 1.543 would mean that in a particular district, the average premium for employees that purchase the EF tier of coverage is 1.543 times higher than the average premium for employees that purchase the EE tier of coverage. Similarly, in terms of employee contributions, a value of 2.987 would mean that in a particular district, the average contribution of employees that purchase the EF tier of coverage is 2.987 times higher than the average contribution of employees that purchase the EE tier of coverage.

Appendix 8 — Financial Plan Structure and Overall Performance by Benefit Package

The A8 series exhibits provide financial performance for the CY 2014 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 prior A8 exhibits. All A8-series exhibits are presented by benefit package. Total premiums for CY 2014 are reported at \$1.074 billion for all benefit packages combined, compared to total paid claims of \$950.7. This generated a paid claims loss ratio, which is a comparison of claims to premiums, of 88.6% for CY 2014.

Appendix 9 — Experience Reports by Benefit Package

The A9 series exhibits show financial data for CY 2014, as well as utilization metrics for the plan year ending in 2014. A summary of each exhibit is described below.

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 21.0%

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of total paid claims, outpatient 20.0%, ER 3.7%, professional services 30.3%, and pharmacy 18.5%. Total claims were \$950.7k for the period.

Exhibit A9b shows claims paid per employee per month (PEPM). Total average employee enrollment during the calendar year was 104,455 employees; premiums averaged \$856.50 PEPM and, total claims averaged \$758.49 PEPM.

Exhibit A9c shows claims paid per member per month (PMPM). Total average member enrollment during the calendar year was 198,952 members; premiums averaged \$449.68 PMPM and, total claims averaged \$398.23 PMPM.

The remaining exhibits provide a breakdown of utilization metrics for the plan year ending in 2014, 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 2014, Exhibit A9g — Monthly PEPM Measurements, and Exhibit A9h — Monthly PMPM Measurements.

Appendix 10 — List of Large Claimants by Major Diagnostic Categories

This is a list of 841 large cases defined as the total of aggregated claims per unique claimant in excess of \$100,000 for the plan year ending in 2014. Average large cases were approximately \$200,777 per claimant and represent about 17.8% of all paid claims. The claims are reported by major diagnostic categories including diseases, injuries, and other conditions. The reporting period is for the plan year ending in 2014.

Appendix 11 — Demographics by Benefit Package

This exhibit reports member demographic information associated with each benefit package for the plan year ending in 2014. Demographic information included coverage tier, age, and sex. There were 203 benefit packages reported.

Appendix 12 (a & b) — Administrative Cost Breakdown - Carrier Data Call

Each carrier reported administrative fees for the plan year ending in 2014. 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 \$95.68 PEPM (Exhibit A12a) and \$50.12 PMPM (Exhibit A12b) for the reporting period. Total administration fees of \$118.3 million were reported and they represented 11.14% of total premium for the plan year ending in 2014. Of this amount, 0.007% (\$7.2 million) was payable to agents, brokers, or consultants; 0.49% (\$52.3 million) was payable for premium taxes and other assessments; and 5.53% (\$58.8 million) was for administrative expenses charged by carriers.

Appendix 12 (c & d) — Supplemental Services and Costs

Exhibit A12c shows other supplemental services and associated costs reported by school districts. The supplemental services are generally for employee-paid cancer or accident policies. Similar information was

requested from the K-12 carriers. However, all carriers reported no supplemental services were purchased separately by the school districts, therefore Exhibit A12d reports no data except total employee and member enrollment by carrier. Carriers reported 106,163 employees and 202,253 members.

Appendix 12 (e to h) — Other Administrative Costs Not Paid Through Carrier Insurance Premiums

Additional exhibits in this Section show results of school district-reported external and internal administration costs 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. School districts were asked to report internal administrative expenses allocated to employee benefits (Exhibit 12h). The exhibit is incomplete. Most school districts were unable to provide this information.

Some A12x Exhibits Changed in Year 3 to Being of Mixed-Source

Note that in Year 3, unlike in prior project years, 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 is sourced from carrier-reported data, whereas employee enrollment is sourced from district-reported data. The reason for the change is that with respect to membership counts, carrier-reported data is considered by the project team to be more reliable than district-submitted data.

Appendix 13 — Paid Claims and Rate Reserves by Carrier Rating Pool

Carriers were asked to report K-12 health plan reserves with ending balances for the plan year ending in 2014. 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. Paid claims would need to be reported on an incurred basis to determine the appropriate level of IBNR reserves. Incurred-basis reporting was not required with the Data Call.

Other reserves that were required to be reported 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, school districts were asked 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 2014, paid claims were reported at \$974.6k and total IBNR reserve liabilities were reported at \$55.8 million. IBNR reserves are about 5.7% of paid claims, less than one month's paid claims. CSR/RSR reserves were reported at \$4.1 million, about 0.004% of paid claims. The reserve levels are within expected ranges.

Appendix 14 — 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 2014. 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 \$999.29 per month for the plan year ending in 2014. The lowest and highest composite premiums across school districts are also reported at \$55.09 and \$1,729.34 respectively. Information for this exhibit was provided by the carriers.

Appendix 15 — Summary of Total Monthly Premium Rates with Composite Cost by School District

This series of exhibits reports information by school district as of October 1, 2014, the snapshot date, and shows the average total monthly rates by coverage tier. Also shown are the total monthly premiums by school district. Information for these exhibits was provided by the school districts. Individual reports identify employee classifications including full-time, part-time, certified, and classified.

Please note the addition in Year 3 of new exhibits in this series, namely A15b, A15c, A15d, and A15e. These are described above, within the section entitled “Summary of New Exhibits and Changes to Existing Exhibits”.

Another enhancement in Year 3 is the addition, for all exhibits in this series, of a column that indicates the ratio of EF to EE premiums. For example, a value of 1.885 would mean that in a particular district the average premium for employees that purchase the EF tier of coverage is 1.885 times higher than the average premium for employees that purchase the EE tier of coverage.

Appendix 16 — Summary of Monthly Payroll Rates with Composite Cost by School District

This exhibit series shows the employee contributions through payroll deductions for each coverage tier for all school district employees. The reported monthly composite contributions for employee and family coverage combined was \$190.01, or \$19,521,437.39 in total for the year, based on 102,739 employees as of the snapshot date of October 1, 2014. Information for these exhibits was provided by the school districts. Individual reports identify employee classifications including full-time, part-time, certified, and classified.

Please note the addition in Year 3 of new exhibits in this series, namely A16b, A16c, A16d, and A16e. These are described above within the section entitled “Summary of New Exhibits and Changes to Existing Exhibits”.

Another enhancement in Year 3 is the addition, for all exhibits in this series, of a column that indicates the ratio of EF to EE employee contributions. For example, a value of 2.516 would mean that in a particular district the average contribution paid by employees that purchase the EF tier of coverage is 2.516 times higher than the average contribution paid by employees that purchase the EE tier of coverage.

Appendix 17 — Summary of District Monthly Contributions with Composite Cost by District

This series of exhibits shows the school district contributions for each coverage tier. The reported monthly composite contributions for employee and family coverage combined was \$695.38, or \$71,442,645.82 in total for the year, based on 102,739 employees as of the snapshot date of October 1, 2014. Information for these exhibits was provided by the school districts. Individual reports identify employee classifications including full-time, part-time, certified, and classified.

Please note the addition in Year 3 of new exhibits in this series, namely A17b, A17c, A17d, and A17e. These are described above, within the section entitled “Summary of New Exhibits and Changes to Existing Exhibits

Another enhancement in Year 3 is the addition, for all exhibits in this series, of a column that indicates the ratio of EF to EE district contributions. For example, a value of 1.9525 would mean that in a particular district the average district contribution for employees that purchase the EF tier of coverage is 1.9525 times higher than the average district contribution for employees that purchase the EE tier of coverage.

Appendix 18 — Summary of Innovative Plan Features All Plans Combined

Exhibit A18a — Carrier Responses

Exhibit A18b — School District Responses

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

Appendix 19 — Efforts and Achievements

Exhibit A19a — By Carrier

Exhibit A19b — By School District

These exhibits are narratives provided by carriers and school districts describing efforts and achievements during CY 2014 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 narratives have not been corrected or edited, however some have been reformatted in order to be display better in the exhibit.

Appendix 20 — Glossary of Acronyms

Acronyms used throughout these exhibits are explained herein.

Appendix 21 — Data Traceability Matrix

Exhibit A21a — Carriers

Exhibit A21b — School Districts

Exhibit A21c — Definitions

The Data Traceability Matrix traces the requirements outlined in ESSB 5940 to particular data elements collected from school 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.

Appendix 22 — Report Contributors

This Exhibit includes a list of the Treinen employees and consultants who participated in the Year 3 project and contributed to the creation of this report.

Appendix 23a — Data Validations — Carriers

Carrier Validations — “Check My Spreadsheet” (CMS)

Section 1

1. Column C (Carrier_Response) Rows 2 through 6 and 8 through 14 are 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 3 this range is 1/1/2013 – 12/31/2014 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 3 this range is 1/1/2014 – 12/31/2015.

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

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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 3 this range is 1/1/2013 – 12/31/2014 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 3 this range is 1/1/2014 – 12/31/2015.
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 3 this range is 1/1/2014 – 12/31/2015.
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

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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 3 this range is 1/1/2014 – 12/31/2015.
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 3 this range is 1/1/2014 – 12/31/2015.
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

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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 3 this range is 1/1/2014 – 12/31/2015.
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 3 this range is 1/1/2014 – 12/31/2015.

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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

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Category 0 — OIC Application

<u>Section 1</u>	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
<u>Section 2</u>	Used_YN	Y or N
	Innov_No	Numeric, warning if missing
	Innov_Desc	Warning if missing
<u>Section 3</u>	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
<u>Section 4</u>	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”
<u>Section 5</u>	BP_Code	Must exist in section 4, error if missing
	PY_Ending	Valid date, error if missing

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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

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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
Colns_Prevent_In	Error if missing
Colns_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

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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

<u>Section 11</u>	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 only contain plans or benefit packages that end within 2014. For these sections, the presence of a PYE in 2015 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 incorrect.
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

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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

Appendix 23b — Data Validations — School Districts

School District Validations — “Check My Spreadsheet” (CMS)

Section 1

1. Column C (District_Response) Rows 2 through 20, 22, 23 and 24 are 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

1. 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", amount is reported in Column E (Premiums_Paid) and column G (Non_Premium_Fees_Paid) must be 0.

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12. If Column D (Entity_Role_Type) does not contain "Carrier", amount is reported 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) is 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

1. All plans listed in Section 4 Column D must be accounted for 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"

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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 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"

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.

Appendix 24 — LEAP Reports

This Exhibit consists of reports prepared for the LEAP team within the Budget Office. These will be delivered to the LEAP team separately from the main body of the exhibits.

End of Report