State of Washington
Joint Legislative Audit and Review Committee (JLARC)

K-12 Employee Health Benefits: Legislature Should Direct Insurance Commissioner to Collect Data Needed to Analyze Health Care Purchasing

Project Update

January 7, 2014

Upon request, this document is available in alternative formats for persons with disabilities.

Joint Legislative Audit and Review Committee
1300 Quince St SE
PO Box 40910
Olympia, WA 98504
(360) 786-5171
(360) 786-5180 Fax
www.jlarc.leg.wa.gov

Committee Members

Audit Authority

The Joint Legislative Audit and Review Committee (JLARC) works to make state government operations more efficient and effective. The Committee is comprised of an equal number of House members and Senators, Democrats and Republicans.

JLARC's non-partisan staff auditors, under the direction of the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other analyses assigned by the Legislature and the Committee.

The statutory authority for JLARC, established in Chapter 44.28 RCW, requires the Legislative Auditor to ensure that JLARC studies are conducted in accordance with Generally Accepted Government Auditing Standards, as applicable to the scope of the audit. This study will be conducted in accordance with those applicable standards.

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K-12 EMPLOYEE HEALTH BENEFITS

PROJECT UPDATE

JANUARY 7, 2014

STATE OF WASHINGTON

JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

STUDY TEAM
John Bowden

PROJECT SUPERVISOR
John Woolley

LEGISLATIVE AUDITOR
Keenan Konopaski

Joint Legislative Audit & Review Committee
1300 Quince St SE
Olympia, WA 98504-0910
(360) 786-5171
(360) 786-5180 Fax

Website:
www.jlarc.leg.wa.gov
e-mail: JLARC@leg.wa.gov

In Brief

Health care premiums paid by K-12 employees vary within and between school districts. In 2012, to improve the equity and affordability of health care for school district employees, the Legislature established a number of goals for the provision of K-12 health care benefits. The Legislature gave the Health Care Authority (HCA) and Joint Legislative Audit and Review Committee (JLARC) specific roles in assessing the progress districts were making in meeting those goals and evaluating alternative approaches to providing coverage. The Office of the Insurance Commissioner (OIC) has a role in collecting key data from school districts and insurers for HCA and JLARC's analysis. OIC is collecting some, but not all, of the necessary data. Also, OIC is not providing all the data it has to HCA citing confidentiality concerns. Because of this, neither HCA nor JLARC will be able to complete all of the required analysis. This project update recommends the Legislature clearly direct OIC to collect the necessary data and provide the data to HCA and JLARC, and to make the data available to school districts so districts can make more informed purchasing decisions, as the Legislature intended.

LEGISLATURE PASSED MAJOR BILL ON K-12 EMPLOYEE HEALTH BENEFITS IN 2012

In calendar year 2012, $1 billion in public funds was spent to purchase health benefits for more than 104,000 school district employees and nearly 107,000 dependents.

The Legislature has appropriated funds for K-12 employee health benefits since 1969. Throughout the years, there have been major differences in the premium costs paid by different school districts and among employees. In 1990, the Legislature passed legislation intended to eliminate these differences. However, separately conducted studies by the Health Care Authority (HCA) and the State Auditor's Office in 2011 found these differences still persist.

In 2012, the Legislature passed a bill to ensure that school districts offer certain types of health benefit plans to their employees and limits the premiums that employees pay (see ESSB 5940, attached as Appendix B). The legislation established goals, such as improving "the transparency of health benefit plan claims and financial data…" and creating greater affordability and equity for full family coverage by having family coverage cost no more than three times as much as individual coverage. (For all of the legislative goals, see Sec. 1 (2) in ESSB 5940 in Appendix B).

Legislature Assigned Studies to HCA and JLARC

The 2012 legislation included study assignments for both the HCA and staff to the Joint Legislative Audit and Review Committee (JLARC):

1. The Legislature directed HCA to evaluate the 3:1 ratio for costs of family and individual coverage and to examine alternative approaches to purchasing health benefit coverage for school district employees. HCA must report to the Governor, the Legislature, and JLARC by June 1, 2015.
2. The Legislature directed JLARC staff to conduct an audit of the progress school districts are making in meeting the specified goals and to also analyze other possible arrangements for providing health benefit coverage for school district employees. JLARC staff intend to review and utilize the work of HCA to inform their analysis. The JLARC report is due December 31, 2015. JLARC is also mandated to select and allocate performance grants to some or all school districts that are meeting certain specified goals.

Legislature Tasked OIC with Data Collection

To implement the legislation and study mandates, school districts, HCA, and JLARC all need information about district health benefit purchases, especially district-level aggregate claims data. The Legislature directed the Office of the Insurance Commissioner (OIC) to collect data from school districts and their health insurance carriers so districts can "more effectively and competitively manage and procure health insurance plans for employees." OIC must report to the Governor, the Legislature, and HCA by December 1, 2013, and annually thereafter. The reports are to be available on OIC's website.

OIC Is Not Collecting Needed District-Level Claims Data

HCA, JLARC, and other legislative staff requested that OIC collect district-level claims data from carriers. However, when OIC adopted rules governing data collection, OIC decided not to require this requested district-level claims data. Data at this level is needed because each school district makes independent decisions about purchasing health care coverage. Each district needs claims data specific to that district in order to improve the information it has to competitively procure health coverage for its employees. OIC states that it believes the 2012 legislation does not explicitly authorize collection of district-level data. JLARC staff believe the statute does not prohibit collecting this information.

OIC Is Not Sharing All Data It Is Collecting with HCA

In addition to not collecting the needed district-level data, OIC has decided to only provide HCA with summarized versions of the data it is collecting. This severely impairs HCA's ability to conduct the analysis the Legislature expects HCA to provide. OIC believes statute prevents them from sharing carrier-specific information with HCA because HCA was not provided the statutory ability to protect the confidentiality of the data. JLARC staff do not believe the Legislature intended to impose this limitation on HCA's analysis.

Statute Does Not Require OIC to Share Data with School Districts

The Legislature intended to provide school districts with data that will allow more informed and competitive purchasing of employee health care coverage. For that to occur, districts need access to the aggregate claims data that OIC collected from carriers providing health care coverage in the district.

School Districts, HCA, and JLARC Are Severely Limited by OIC's Position on What Data It Can Collect and Provide

In the 2012 health benefits legislation, the Legislature stated that "the state, school districts, and employees need better information and data to make better health insurance purchasing decisions within the K-12 system…" For school districts to make better purchasing decisions, the districts need claims data specific to their districts. HCA and JLARC also need district-level data for the legislatively mandated studies. The purpose of these studies is to provide the Legislature with necessary information for policy decisions regarding health benefits purchasing for K-12 employees. Some state-wide analysis will be possible, but the impacts of OIC's interpretations are:

- School districts will not have district-specific information necessary for their competitive procurement of health benefits;
- HCA will be limited in its ability to conduct analysis and recommend purchasing alternatives, and the extent of the health care expertise HCA can provide is diminished; and
- Neither HCA nor JLARC will be able to provide the Legislature with any reliable information about individual districts or alternative approaches to purchasing health care coverage.

The Legislature Should Provide Clear Direction to OIC about Intentions and Expectations

The Legislature intended for school districts and the state to have data necessary to make informed decisions and "assure prudent and efficient use of taxpayers' funds at the state and local levels." The Legislature also intended for HCA and JLARC staff to be able to fully answer the Legislature's questions. Therefore, the Legislature should consider the following recommendations:

Recommendation 1: The Legislature should clarify its intent for the Office of the Insurance Commissioner to collect aggregate claims data at the school district level from carriers.

Recommendation 2: The Legislature should provide specific statutory authority for:

- The Office of the Insurance Commissioner to share the district-level data with school districts and the Health Care Authority; and
- The Health Care Authority to receive and protect the confidentiality of the district-level data.

Recommendation 3: The Legislature should adjust the due dates for the HCA and the Joint Legislative Audit and Review Committee reports, consistent with the original bill. These dates would be two years from when the Office of the Insurance Commissioner first collects the necessary district-level data.

2nd JLARC Assignment: Contingent upon an Appropriation, JLARC Must Allocate Performance Grants

JLARC's second assignment in the 2012 legislation is to allocate $5 million in performance grants to school districts, based on their performance in meeting specific goals as well as the impact the grants will have on employees' copays and deductibles (see Sec. 7(4) of ESSB 5940 in Appendix B). Using analysis from JLARC staff, JLARC members will decide which school districts will receive performance grants during the 2015-16 school year, with the grants being allocated in the 2016-17 school year. The grants are contingent upon the Legislature appropriating $5 million for this purpose in either the 2015-17 Biennial Operating Budget or in the 2016 Supplemental Operating Budget.

JLARC staff will provide a detailed timeline and more information about decisions the Committee will need to make about the performance grants in a briefing report at the December 2014 JLARC meeting.

JLARC Staff Contact for the Study

John Bowden (360) 786-5298 john.bowden@leg.wa.gov

APPENDIX A – AGENCY RESPONSES

- Health Care Authority
- Office of the Insurance Commissioner

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

December 16, 2013

TO: Keenan Konopaski,
Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: Dorothy F. Teeter, MHA
Director

SUBJECT: Agency Response to JLARC's Project Update, "K-12 Employee Health Benefits"

Thank you for the opportunity to provide a formal response to JLARC's "K-12 Employee Health Benefits" project update, dated December 6, 2013. We understand the report is confidential and will not be released publicly until January 7, 2014.

We would like to take this opportunity to acknowledge the collective efforts of the Office of the Insurance Commissioner (OIC), the carriers, districts, and K-12 stakeholders, as a significant amount of resources were dedicated to reach this point in fulfilling the legislative mandates under ESSB 5940. We want to recognize OIC for their unprecedented data collection.

HCA's role under ESSB 5940 is to carry out the will of the Legislature by providing analysis on the equity and affordability of K-12 benefits for school district employees and provide recommendations on alternative approaches to purchasing K-12 health benefits. To complete the analysis and recommendations, the Health Care Authority (HCA) was allotted $837,000 in General Fund-State in the 2013-2015 biennium budget. To that end, we offer the following comments based on HCA's desire to maintain legislative fidelity to ESSB 5940 and utilize HCA's budget allocation responsibly.

Data Collection:
The report does not note that dental and vision data was not collected in year one. We are uncertain of the impact the missing data will have on HCA's analysis and recommendations. OIC has determined they will collect dental and vision data in year two for the upcoming OIC year two report.

Data Integrity:
The report describes data collection issues, but does not comment on data integrity concerns. HCA is unable to confirm the validity or accuracy of the summary data in OIC's reports which HCA will use in the actuarial analysis to make recommendations for how nearly $1.1 billion

dollars of health care should be purchased with public funds in Washington State. Milliman, our actuary, has "significant concerns with the data gaps."

Data Analysis:
We would like to clarify that HCA's analysis will be limited due to not having access to all of the data OIC collected. HCA is limited to using OIC's summarized and aggregated report tables, which do not provide the projected detail shared by OIC during technical reviews earlier this year and only cross two data dimensions at a time. We believe ESSB 5940 is directing HCA to provide a deeper analysis of affordability and transparency in K-12 benefit purchasing for the state, school districts, and district employees. This requires HCA to analyze multiple data dimensions at a time in order to make purchasing recommendations for full-time versus part-time employees, certificated versus classified employees, and single versus family coverage tiers.

Report Recommendations:
Again, HCA's role is to carry out the will of the Legislature under ESSB 5940. HCA is desirous of utilizing state funds responsibly by ensuring quality and accuracy in our analysis and recommendations. Therefore, HCA concurs with JLARC's recommendation.

HCA will be present and able to provide oral comments at the JLARC Committee meeting on January 7, 2014.

Thank you again for the opportunity to provide a formal response. Should you have any questions about our response, please contact Kari Leitch, Special Assistant, by telephone at 360-725-0858 or via email at kari.leitch@hca.wa.gov.

cc: Nathan Johnson, Division Director, HCP, HCA
Lou McDermott, Division Director, PEB, HCA
Mary Fliss, Deputy Division Director, PEB, HCA
Kari Leitch, Special Assistant, HCP, HCA
John Woolley, Audit Coordinator, JLARC
John Bowden, Research Analyst, JLARC

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone: (360) 725-7000
www.insurance.wa.gov

December 17, 2013

Keenan Konopaski, Legislative Auditor
Joint Legislative Audit & Review Committee
PO Box 40910
Olympia, WA 98504

RE: Response to the Joint Legislative Audit & Review Committee's Project Update, "K-12 Employee Health Benefits"

Dear Mr. Konopaski:

In 2012, to facilitate the conclusion of the 2012 first special session, Governor Gregoire asked if I would agree to have my office conduct a study of K-12 employee benefits. Engrossed Substitute Senate Bill 5940 was a major sticking point in negotiations between the House and Senate.

I agreed to do this, though the study fell outside of my office's regulatory responsibilities. Working with 295 school districts, three partner agencies (Health Care Authority (HCA), Joint Legislative Audit & Review Committee (JLARC), and the Office of the Superintendent of Public Instruction), a number of insurance carriers, school district employee's unions, and many other stakeholder groups, has been a considerable undertaking. However, I am pleased to report that the study was completed on time, within budget, and has collected an unprecedented amount of data that has eluded the five previous studies of this issue.

ESSB 5940 requires my office to annually gather this data and provide an annual report to the Legislature. The work for year one was completed, and work for year two has begun despite a 70% cut to the project's biennial budget.

My office disagrees with JLARC's assertions that we are obligated to collect district level claims data in every instance, and share the raw data collected from carriers with the HCA and school districts. Review of the JLARC update indicates that JLARC's interpretation of the legislation relies on understanding the "intent" of the legislation. Because my office does not have a historical reference with regard to K-12 issues or K-12 employee benefits, our approach to this project was based on the written legislation. With that in mind, JLARC's assertions appear inconsistent with the language chosen by the Legislature, and its report findings appear premature.

OFFICE OF INSURANCE COMMISSIONER

Keenan Konopaski, Legislative Auditor
Joint Legislative Audit & Review Committee
December 17, 2013
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Accompanying this letter, you will find my agency's written response to the JLARC project update. I believe our response demonstrates the collaborative and consistent approach that we've taken with this project.

If the Legislature's intent is to have my office collect district-level claims data, I would ask that the intent be more explicitly stated in the legislation. If the Legislature intends to allow the Health Care Authority and school districts access to this highly-sensitive data, I would ask that a public records exemption be extended to the HCA and the school districts. And lastly, if the Legislature intends these changes to be made to the legislation, I would request restoring appropriate funding to support this project.

Sincerely,

Mike Kreidler
Insurance Commissioner

Enclosure

Washington State
Office of the
Insurance Commissioner

December 17, 2013

To: Keenan Konopaski, Legislative Auditor
Joint Legislative Audit & Review Committee

From: Stacy Middleton, Project Manager
Office of the Insurance Commissioner

RE: Office of Insurance Commissioner's Response to JLARC's Project Update, "K-12 Employee Health Benefits"

On December 5, the Office of the Insurance Commissioner (OIC) submitted extensive technical edits to the Joint Legislative Audit & Review (JLARC) "K-12 Employee Health Benefits" briefing report. The majority of the requested edits were not included in JLARC's most recent update and because we believe that those edits are critical to a complete understanding of the JLARC report, we are again presenting the amendments to the report.

In our review of the JLARC briefing report, it appears that JLARC's interpretation of the legislation relies on understanding the "intent" of the legislation. The OIC does not have a historical reference with regard to K-12 issues or K-12 employee benefits, so our approach was based on the written legislation. Based on that approach, we believe the assertions in the report appear inconsistent with the language chosen by the legislature and that the report findings are premature.

The OIC does acknowledge and appreciate the following two corrections that JLARC made in its most recent project update to page 1, paragraph two:

1. Treinen identified $1.04B spent in 2012 for K-12 school district healthcare benefit costs as compared to $1.1B stated in the JLARC report.
2. Treinen identified for 2012, 104,431 employees and 106,622 dependents as compared to 109,000 employees and 94,000 dependents stated in the JLARC report.

In addition, the OIC requests that the following be included as the OIC's formal response to JLARC's project update:

1. In paragraph 1, sentence 4, the JLARC Report states that "OIC is collecting some, but not all, of the necessary data."
    a. OIC disputes the above statement because the OIC ***is*** collecting data in accordance with legislative requirements in ESSB 5940 and supporting state law.
        i. Per ESSB 5940, Section 4 (2)(c)(i)(A), "School districts and their benefit providers shall annually submit…the following information and data…to the Office of the Insurance Commissioner…an overall plan summary including the following:… total claims expenses." Per ESSB 5940, Section 4 (2)(c)(iv)(A)-(C), data must include "…a summary of benefit packages…total claim payments by benefit package."
        ii. The legislation requires a report be generated that includes a "summary of the benefit packages" offered by K-12 districts, per ESSB 5940, Section 4(2)(iv)(A). Because "benefit packages" was not defined in the legislation, it was necessary to clarify, as part of the OIC's rule making, what carriers and districts were required to submit to the OIC. The OIC conducted a series of stakeholder meetings with school district representatives, health carrier representatives, and HCA and JLARC prior to initiating its formal rulemaking. On July 18, 2012, the OIC initiated rulemaking regarding the submissions that would be required of carriers. The OIC also conducted a hearing on December 26, 2012 concerning its proposed rules. The OIC's rule was final and effective on March 10, 2013. Taking its definition from prior legislation (RCW

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48.43.005(26)), WAC 284-198-005(2) defined "benefit package" to be the same as "health plan."

iii. For plans that are provided at the district level, and provided to a single district, the OIC ***is*** collecting data at the plan level, which is also the district level. For districts that have small group plans that are required by statute to use pooled claims experience when setting premiums, the OIC is collecting information at the plan level, which is the level carriers must use in setting premiums. WAC 284-198-020(3) allowed for aggregation of data for benefit packages with small enrollment, which was how the data was reported.

iv. The report exhibits provide summary data, as called for in RCW 48.02.210(2)(b), including aggregated demographic information, total claims and premiums paid by benefit package, and large claims for all K-12 carriers and administrators combined.

v. Exhibits include: health plan options by district, enrollment by benefit package and health plan by district, health plan design comparison, total costs by district for district-specific health plans, average costs and contributions by district, financial plan structure and overall performance by benefit package—monthly claims, financial plan structure and overall performance by benefit package—loss ratios, experience reports by benefit package—claims paid per employee per month, and experience reports by benefit package—utilization.

b. The Concise Explanatory Statement (CES) issued January 2013 notes that ESSB 5940 does not require school district benefit providers [carriers] to report health benefit plan claims separately for the employees of each individual school district. Nothing in ESSB 5940 requires the reporting of claims information broken out separately for the employees of each school district.

c. In addition to the actual language of ESSB 5940 that the OIC used as a basis for the data collection, the <u>following were considered as supporting the legal requirements</u>:

i. Carriers often pool claims experience for employees of multiple school districts covered by a benefit plan, especially where a benefit plan has small enrollment within a school district.

ii. Over 27% (80) school districts fit the definition of a "small employer." Small school districts – those with fewer than 50 employees – would not be able to make use of the claims data in their procurement process since small group premiums are based on an adjusted community rating (RCW 48.44.023 and RCW 48.46.066). This means that insurers can not vary premium rates <u>except for</u>: geographic area, family size, age, or wellness activities--carriers cannot use claims experience to rate these groups but must pool the medical experience of all small groups purchasing coverage.

iii. There was concern that providing a list of large claims incurred by a school district's employees to the district (particularly small districts) could conflict with federal HIPAA privacy requirements. Given that 40% (118) of the school districts have fewer than 100 employees, and another 19% (56) have fewer than 200 employees, break out of data for these small entities would increase the possibility of associating specific data with a specific individual and result in possible HIPAA compliance violation. HIPAA concern aligned with OIC's responsibilities under ESSB 5940, Section 5 (2)(a) "...The confidentiality of personally identifiable district employee data shall be safeguarded consistent with the provisions of RCW 48.56.400(21)."

iv. Carriers voiced concern that the release of school district claims information could impact confidential proprietary and trade secret information provided to the commissioner under ESSB 5940 Sec. 8 (8).

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2. On page 2, paragraph 7, OIC requests that the following revised language (a through c) is added after, "More effectively and competitively manage and procure health insurance plans for employees."

    a. "ESSB 5940, Section 4(2)(c)(iv). The Legislature directed OIC to consult with school districts representatives to ensure that the data collected will give districts the ability to understand and seek more competitive insurance options for their employees. ESSB 5940, Section 5(4). The Legislature also authorized OIC to conduct rule making as necessary to clarify data submission requirements by districts and their carriers. ESSB 5940, Section 5(3). OIC must submit a report containing the summaries of district plans, and district level aggregate financial data to the Governor, the Legislature, and HCA by December 1, 2013, and annually thereafter. The reports are to be available on OIC's website. ESSB 5940, Section 5(2)(a). Except for the report provided to HCA, the governor, and the public, data collected by the OIC from any district or carrier under ESSB 5940 is exempt from public disclosure. ESSB 5940, Section 5(6), and Section 8(21).

    b. On July 18, 2012, the OIC initiated rulemaking regarding the submissions that would be required of carriers. The OIC also conducted a hearing on December 26, 2012 concerning its proposed rules. The OIC's rules were final and effective on March 10, 2013. The OIC has completed its data collection for 2014, and has shared the non-aggregated data it collected with JLARC. The OIC produced the first mandated aggregated report of district and carrier data on November 25, 2013, ahead of the December 1 deadline. As required by the Legislature, copies of the OIC's report were provided to the Legislature, HCA, the Governor, and online."

3. On page 2, in paragraphs 8 and 9, the OIC disputes the assertions that OIC is obligated to collect district level claims data in every instance, and share the raw data it has collected from carriers with both HCA and school districts. JLARC's interpretation of the the legislation appears to rely on understanding the "intent" of the legislation. Because OIC does not have a historical reference with regard to K-12 issues or K-12 employee benefits, the OIC based its approach to this project on the written legislation. OIC believes the JLARC assertions are inconsistent with the language chosen by the Legislature, and its report findings are premature.

4. On page 2, paragraph 8, the OIC requests that its stakeholder work prior to rule-making and the stakeholder's request for collection of dental and vision benefits are noted in the report. The OIC requests the following:

    a. Before the first sentence of the paragraph, the following should be inserted, "The OIC conducted a series of stakeholder meetings with school district representatives, health carrier representatives, and HCA and JLARC prior to initiating its formal rulemaking." OIC asks that the second sentence read, "HCA, JLARC, and other legislative staff requested that OIC collect district-level claims data from carriers and collect dental and vision benefits from school districts."

    b. Additionally, OIC disputes JLARC's following statement and asks for its removal, "However, when OIC adopted rules governing data collection, OIC decided not to require this requested district level claims data." This statement indicates that the OIC made an arbitrary decision, when in fact, the OIC was following the written legislation that did not require district level claims data.

    c. OIC makes this request because the OIC ***is*** collecting data in accordance with legislative requirements in ESSB 5940 and supporting state law.

        i. Per ESSB 5940, Section 4 (2)(c)(i)(A), "School districts and their benefit providers shall annually submit…the following information and data…to the Office of the Insurance Commissioner…an overall plan summary including the following:… total claims expenses." Per ESSB 5940, Section 4 (2)(c)(iv)(A)-(C), data must include "…a summary of benefit packages…total claim payments by benefit package."

        ii. The legislation requires a report be generated that includes a "summary of the benefit packages" offered by K-12 districts, per ESSB 5940, Section 4(2)(iv)(A). Because "benefit

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packages was not defined in the legislation, it was necessary to clarify, as part of the OIC's rule making, what carriers and districts were required to submit to the OIC. The OIC conducted a series of stakeholder meetings with school district representatives, health carrier representatives, and HCA and JLARC prior to initiating its formal rulemaking. On July 18, 2012, the OIC initiated rulemaking regarding the submissions that would be required of carriers. The OIC also conducted a hearing on December 26, 2012 concerning its proposed rules. The OIC's rule was final and effective on March 10, 2013. Taking its definition from prior legislation (RCW 48.43.005(26)), WAC 284-198-005(2) defined "benefit package" to be the same as "health plan." Prior to finalization of the rule, the OIC did not receive any comment or objection to its proposed rule or definition of "benefit package."

iii. For plans that are provided negotiated at the district level, and provided to a single district, the OIC ***is*** collecting data at the plan level, which is also the district level. For districts that have small group plans that are required by statute to use pooled claims experience when setting premiums, the OIC is collecting information at the plan level, which is the level carriers must use in setting premiums. WAC 284-198-020(3) allowed for aggregation of data for benefit packages with small enrollment, which was how the data was reported.

iv. The report exhibits provide summary data, as called for in ESSB 5940 including aggregated demographic information, total claims and premiums paid by benefit package, and large claims for all K-12 carriers and administrators combined.

v. Exhibits include: health plan options by district, enrollment by benefit package and health plan by district, health plan design comparison, total costs by district for district-specific health plans, average costs and contributions by district, financial plan structure and overall performance by benefit package—monthly claims, financial plan structure and overall performance by benefit package—loss ratios, experience reports by benefit package—claims paid per employee per month, and experience reports by benefit package—utilization.

d. Additionally, the Concise Explanatory Statement (CES) issued January 2013 notes that ESSB 5940 does not require school district benefit providers [carriers] to report health benefit plan claims separately for the employees of each individual school district. Nothing in ESSB 5940 requires the reporting of claims information broken out separately for the employees of each school district.

i. In addition to the actual language of ESSB 5940 that the OIC used as a basis for the data collection, the following were considered as supporting the legal requirements:

1. Carriers often pool claims experience for employees of multiple school districts covered by a benefit plan, especially where a benefit plan has small enrollment within a school district.

2. Over 27% (80) school districts fit the definition of a "small employer." Small school districts – those with fewer than 50 employees – would not be able to make use of the claims data in their procurement process since small group premiums are based on an adjusted community rating per state law (RCW 48.44.023 and RCW 48.46.066). This means that insurers can not vary premium rates except for: geographic area, family size, age, or wellness activities--carriers cannot use claims experience to rate these groups but must pool the medical experience of all small groups purchasing coverage.

3. There was concern that providing a list of large claims incurred by a school district's employees to the district (particularly small districts) could conflict with federal HIPAA privacy requirements. Given that 40% (118) of the school districts have fewer than 100 employees, and another 19% (56) have fewer than 200 employees, break out of data for these small entities would increase the possibility of associating specific data with a specific individual and result in possible HIPAA compliance violation. HIPAA concern aligned with OIC's responsibilities under ESSB 5940, Section 5 (2)(a) "...The

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confidentiality of personally identifiable district employee data shall be safeguarded consistent with the provisions of RCW 48.56.400(21)."

4. Carriers voiced concern that the release of school district claims information could impact confidential proprietary and trade secret information provided to the commissioner.

5. On page 2, paragraph 8, OIC disputes sentence 5 and requests that sentence 5 be revised with the following (a through b):

   a. "OIC does not believe the 2012 legislation explicitly authorizes collection of district-level claims data. Further, in conducting its stakeholder work prior to and during the rule making process, the OIC discovered that health carriers who have plans that cover more than one district, do not keep claims data at the district level. Nor do they track enrollees by district. Further, districts with fewer than 50 employees cannot use claims information to procure a competitive advantage, because the Legislature requires health carriers to pool all claims experience for small groups of 50 or less. Currently 27% (80) of the school districts have fewer than 50 employees. In addition, the OIC is concerned that forcing carriers to keep claims information at a district level would encourage rating practices that are explicitly prohibited by the Legislature (RCW 48.44.023 and RCW 48.46.066). For plans that are offered only to one district, (generally large group plans offered to large districts) the OIC is collecting claims data for plans at the district level. For plans that include more than one district, (generally small group plans offered to smaller districts), the OIC is collecting claims information at the plan level, not the district level.

   b. The OIC agreed, despite a 70% (-$900K) cut to its biennial budget, to include re-tooling necessary to implement the addition of vision and dental premium data in the year two data call for the school districts." This is because HCA, JLARC, and other legislative staff requested that OIC collect collect dental and vision benefits from school districts.

6. On page 2, paragraphs 7 and 8. Paragraph 7, sentence 1, states that school districts, HCA, and JLARC all need district level claims data. Sentence two states, "the Legislature directed the Office of the Insurance Commissioner (OIC) to collect data from school districts and their health insurance carriers so districts can more effectively and competitively manage and procure health insurance plans for employees.'" Because the OIC believes that these two sentences are not sufficient and that the following will provide additional supporting information to the committee, it requests that the following (a through e) be added at the beginning of paragraph 8:

   a. "In addition to the disagreement concerning the collection of some district-level claims data, there is a dispute between HCA and OIC regarding the type of data the OIC is required to provide to HCA. The Legislature directed HCA to provide its analysis and possible alternatives "based on two years of reports" provided by the OIC.

   b. Further, the Legislature exempted from public disclosure the raw data collected by the OIC. Reading this Public Records Act exemption narrowly, as is required by the Courts, the Legislature's exemption appears to be specific to the OIC. HCA has not produced a legal interpretation that extends this exemption to the HCA, nor have they been willing to enter into a data sharing agreement that requires HCA to maintain any non-aggregated data it receives from the OIC as confidential. The health carriers who provided information to the OIC have expressed significant concerns that the raw, non-aggregated data they have provided to the OIC might not remain confidential and exempt from disclosure. Because HCA has not demonstrated that it is authorized to keep confidential the raw data the Legislature has exempted from disclosure, the OIC believes producing the non-aggregated data it has collected would eviscerate the confidentiality the Legislature has afforded to this information.

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c. The OIC believes that the information contained within the report and its supporting exhibits provide the information necessary for HCA to meet its legislative goals. The first OIC report was released on November 25, 2013, and the JLARC's report was drafted on November 22. Neither JLARC nor HCA, nor the districts, have had sufficient time to review or work with the data in the OIC's report to clearly explain how the data is insufficient for their analysis. Therefore the OIC believes the JLARC findings to be premature.

d. The OIC believes that the information contained within the report and its supporting exhibits provide the information necessary for the school districts to meet its goals.

e. Per the December 12, 2012 HCA feedback to Senate staff to OIC comments on data collection issues, HCA noted that not collecting claims data at the individual school district level was "not specifically an obstacle to HCA in completing its 2015 reporting responsibilities."

7. On page 2, paragraph 9 the JLARC report states that "OIC has decided to only provide HCA with summarized versions of the data it is collecting." The OIC disputes this statement because:

a. The OIC believes that ESSB 5940 and state law mandate protection of this data. Per ESSB 5940 Section 5(6), "Data, information, and documents other than those described in subsection (2) of this section, that are provided by a school district or an entity providing coverage pursuant to this section are exempt from public inspection and copying under this act and chapters 42.17A and 42.56 RCW." In addition the OIC believes it has responsibilities to protect the data under ESSB 5940, Section 5 (2)(a) "...The confidentiality of personally identifiable district employee data shall be safeguarded consistent with the provisions of RCW 48.56.400(21)."

b. The OIC considered the above noted legislation and state law when considering release of confidential data to HCA, per HCA's requests for raw data. Nothing in ESSB 5940 requires the OIC to share underlying confidential data with HCA.

i. Both HCA and JLARC requested that OIC enter into data share agreements with OIC to access the confidential raw data underlying the summary tables contained within the Legislative Report.

ii. Because JLARC has statutory authority allowing its access to program/project data for which it reviews and has an exemption from public disclosure, the OIC agreed to a data share agreement. This agreement was finalized and forwarded on October 19.

iii. HCA has not agreed to enter into the proposed data sharing agreement. In a September 20 e-mail shared by HCA, HCA's Assistant Attorney General advised HCA that its proposals carried significant PRA legal risks, and thus a high chance the raw data would be subject to public disclosure. OIC has suggested that HCA to pursue an exemption from public disclosure so that OIC could provide the data to HCA. HCA has indicated it does not intend to do so.

iv. On October 25, HCA proposed an interagency agreement for OIC to contract with HCA's contractor, Milliman, for creation of new summary data tables of the "raw data" collected by OIC's contractor, Treinen. Under this proposal, HCA-Milliman's aggregated report, and not the aggregated report produced by the OIC on November 25, would be considered the "starting point" for HCA's report. This request was denied in part because HCA does not have statutory authority to receive the data and we were advised by our AAG that contracting with Milliman would not offer the confidentiality required by ESSB 5940. Further,

1. OIC does not have an existing contract with Milliman, and the HCA proposal would require OIC to engage in a competitive contracting process.

2. This would require the use of additional project or agency resources. Project funding cut of -70% in this biennium would not allow the project to fund additional

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contracting; and budget proviso language establishes that OIC may not use funds otherwise appropriated for the general functions of the OIC for this data collection project.

3. The proposal would entail the state paying for two sets of summarized reports, (1) legislatively mandated via OIC, and (2) not legislatively mandated, with OIC acting as an agent of HCA. The second set may subject the underlying data to public disclosure requests and would replace the OIC summary reports as starting point for HCA, which appears counter to the direction in ESSB 5940.

8. On page 3, paragraph 10, the OIC requests the following be added after the last sentence.
    a. "Districts have already voiced intention to make public records requests to the OIC for carrier claims data. The OIC has refused to provide records obtained from the carriers citing the Legislature's exemption from public disclosure in ESSB 5940, Section 5(6), and Section 8(21)."

9. OIC has sought JLARC and HCA input in every major decision concerning collection and reporting of data. One example of this collaborative work was the OIC's August 7, 2013, meeting with HCA, JLARC, and Milliman for a technical discussion regarding the legislative report exhibits. When OIC requested agenda items for the meeting, HCA only asked that the following be discussed:
    i. How OIC would address the budget cuts in Years 2 and 3;
    ii. Discussion of what could be accomplished given the 70% budget cut from Year 1 to Year 2;
    iii. How to incorporate vision and dental into the Year 2 data call; and,
    iv. What would be the downstream impacts for the HCA and JLARC reports?

    At that meeting Milliman expressed that they were 95% in agreement with the OIC report exhibits, and asked only that OIC include a request for the school districts to provide vision and dental premium information in the year two data collection submission. OIC agreed and, with a -$900,000 cut to its biennial budget, included re-tooling to implement the addition of vision and dental premium in the year two data request for the school districts.

    v. It should be noted that in an August 19 follow-up e-mail forwarded to OIC by HCA from Milliman, HCA-Milliman responded to the review of the legislative report exhibits—only noting a few requests, which did not include provision of school district level claims data.
    vi. The OIC addressed the HCA-Milliman concerns and reconfigured the tables to align with its concerns, where possible.

10. The OIC has gone to great lengths to work collaboratively with this project's many stakeholders, including the Governor's office, JLARC, legislative staff, HCA, OSPI, 8 carriers, WSIPC, 9 ESDs, 295 school districts, school administrators and superintendents, and the school district employees' unions. The OIC's work has yielded unprecedented success, which should be highlighted.
    a. There have been 5 studies since 1989 on WA K-12 employee health benefits. Most recent include:
        i. 2010 State Auditor's Office (SAO) HayGroup report, to analyze alternative health care coverage models.
        ii. 2011 Health Care Authority (HCA) Milliman report, to develop plan for consolidated public school employees benefit program.
        iii. The data collection under ESSB 5940 is the 6th study on K-12 employee health benefits in 25 years.

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b. Per Project Charter, Success Measurements:
   i. SDs meet reporting requirements.
   ii. SDs and benefit providers submit data in timely manner.
   iii. OIC meets annual December 1 reporting requirement.
   iv. Complete project on time and within budget.

c. Data Collection ended June 30—2 months ahead of schedule, within budget, and with unprecedented response.
   i. ***293 (99.3%)*** SDs data received, loaded and accepted (passed critical edits). As compared to:
      1. *117 (39.6%)* SDs in 2010 SAO Study (Hay);
      2. *175* (59.3%) SDs in 2011 HCA Study (Milliman).
   ii. ***2 (0.7%)*** SDs "non-responsive," Damman and Oakville.
   iii. ***All 8 (100%)*** carrier's data was loaded and accepted. As compared to:
      1. 2 carriers in 2011 HCA study (not GHC or Premera).

d. The Legislative Report for Year One was completed prior to the December 1 deadline and within budget. The report contains approximately 1,950 pages of data from an unprecedented 293 SDs and 8 carriers.

11. The OIC is striving to do its best to accomplish the tasks it has been given by the Legislature. We again note that OIC does not have historical reference with regard to K-12 issues or K-12 employee benefits and that our approach was not based on "intent," but was based on the written legislation. If the OIC has misunderstood the Legislature's instructions, we are happy for any guidance this committee can offer, and would request the following if a change to the OIC approach is considered:

    a. That "intent" is more explicitly stated within the legislation. Include language in the legislation that states that for those plans where claims experience is currently aggregated, carriers must begin collecting and preserving information at the district level and include a strong admonition that collection of data at this level in no way permits carriers to use it contrary to the small group pooling requirements in RCW 48.44.023 and RCW 48.46.066.

    b. In addition, the OIC would ask that if changes are made to the legislation, that funding be restored to the project so that the contractor can re-tool to accommodate new requirements. It should be noted that year two of the contract and re-tooling for year two began September 2013. Year two re-tooling is now complete (to include school district vision and dental premium request) and the year two data call is scheduled to be released to carriers and school districts by January 30, 2014. Therefore, additional re-tooling due to legislative changes could not occur until year two's data collection is completed in August 2014.

    c. If it is the legislature's intent is to allow HCA and districts to access all the data collected by the OIC, the OIC also believes that intent needs to be more explicitly stated in the legislation, either by eliminating the public records exemption from the legislation, or by extending the exemption to HCA and districts. This will not alleviate the significant concerns carriers have expressed concerning the dissemination of their confidential and proprietary data, but it would address JLARC staff's concern that HCA and districts need access to this data.

APPENDIX B – STATUTE

- Engrossed Substitute Senate Bill 5940

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 5940

Chapter 3, Laws of 2012

62nd Legislature
2012 2nd Special Session

SCHOOL EMPLOYEE BENEFITS

EFFECTIVE DATE: 07/11/12

Passed by the Senate April 11, 2012
YEAS 25 NAYS 20

BRAD OWEN

President of the Senate

Passed by the House April 11, 2012
YEAS 53 NAYS 45

FRANK CHOPP

Speaker of the House of Representatives

Approved May 2, 2012, 1:53 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5940** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

May 2, 2012

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE SENATE BILL 5940

Passed Legislature - 2012 2nd Special Session

State of Washington 62nd Legislature 2012 2nd Special Session

By Senate Ways & Means (originally sponsored by Senators Hobbs, Ericksen, Keiser, Tom, Kastama, and Zarelli)

READ FIRST TIME 04/06/12.

AN ACT Relating to public school employees' insurance benefits; amending 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.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) Each year, nearly one billion dollars in public funds are spent on the purchase of employee insurance benefits for more than two hundred thousand public school employees and their dependents;

(b) The legislature and school districts and their employees need better information to improve current practices and inform future decisions with regard to health insurance benefits;

(c) Recent work by the state auditor's office and the state health care authority have advanced discussions throughout the state on opportunities to improve the current system; and

(d) Two major themes have emerged: (i) The state, school districts, and employees need better information and data to make better health insurance purchasing decisions within the K-12 system;

(ii) affordability is a significant concern for all employees, especially for employees seeking full family insurance coverage and for the lowest-paid and part-time employees.

(2) The legislature establishes the following goals:

(a) Improve the transparency of health benefit plan claims and financial data to assure prudent and efficient use of taxpayers' funds at the state and local levels;

(b) Create greater affordability for full family coverage and greater equity between premium costs for full family coverage and for employee only coverage for the same health benefit plan;

(c) Promote health care innovations and cost savings, and significantly reduce administrative costs; and

(d) Provide greater parity in state allocations for state employee and K-12 employee health benefits.

(3) The legislature intends to retain current collective bargaining for benefits, and retain state, school district, and employee contributions to benefits.

Sec. 2. RCW 28A.400.280 and 2011 c 269 s 1 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, school districts may provide employer fringe benefit contributions after October 1, 1990, only for basic benefits. However, school districts may continue payments under contracts with employees or benefit providers in effect on April 13, 1990, until the contract expires.

(2) School districts may provide employer contributions after October 1, 1990, for optional benefit plans, in addition to basic benefits, only for employees included in pooling arrangements under this subsection. Optional benefits may include direct agreements as defined in chapter 48.150 RCW, but may not include employee beneficiary accounts that can be liquidated by the employee on termination of employment. Optional benefit plans may be offered only if:

(a) The school district pools benefit allocations among employees using a pooling arrangement that includes at least one employee bargaining unit and/or all nonbargaining group employees;

(b) Each full-time employee included in the pooling arrangement is offered basic benefits, including coverage for dependents((~~, without a payroll deduction for premium charges~~));

(c) Each employee included in the pooling arrangement who elects medical benefit coverage pays a minimum premium charge subject to collective bargaining under chapter 41.59 or 41.56 RCW;

(d) The employee premiums are structured to ensure employees selecting richer benefit plans pay the higher premium;

(e) Each full-time employee included in the pooling arrangement, regardless of the number of dependents receiving basic coverage, receives the same additional employer contribution for other coverage or optional benefits; and

((~~(d)~~)) (f) For part-time employees included in the pooling arrangement, participation in optional benefit plans shall be governed by the same eligibility criteria and/or proration of employer contributions used for allocations for basic benefits.

(3) Savings accruing to school districts due to limitations on benefit options under this section shall be pooled and made available by the districts to reduce out-of-pocket premium expenses for employees needing basic coverage for dependents. School districts are not intended to divert state benefit allocations for other purposes.

Sec. 3. RCW 28A.400.350 and 2011 c 269 s 2 are each amended to read as follows:

(1) The board of directors of any of the state's school districts or educational service districts may make available liability, life, health, health care, accident, disability, and salary protection or insurance, direct agreements as defined in chapter 48.150 RCW, or any one of, or a combination of the types of employee benefits enumerated in this subsection, or any other type of insurance or protection, for the members of the boards of directors, the students, and employees of the school district or educational service district, and their dependents. Such coverage may be provided by contracts or agreements with private carriers, with the state health care authority after July 1, 1990, pursuant to the approval of the authority administrator, or through self-insurance or self-funding pursuant to chapter 48.62 RCW, or in any other manner authorized by law. Any direct agreement must comply with RCW 48.150.050.

(2) Whenever funds are available for these purposes the board of directors of the school district or educational service district may contribute all or a part of the cost of such protection or insurance

for the employees of their respective school districts or educational service districts and their dependents. The premiums on such liability insurance shall be borne by the school district or educational service district.

After October 1, 1990, school districts may not contribute to any employee protection or insurance other than liability insurance unless the district's employee benefit plan conforms to RCW 28A.400.275 and 28A.400.280.

(3) For school board members, educational service district board members, and students, the premiums due on such protection or insurance shall be borne by the assenting school board member, educational service district board member, or student. The school district or educational service district may contribute all or part of the costs, including the premiums, of life, health, health care, accident or disability insurance which shall be offered to all students participating in interschool activities on the behalf of or as representative of their school, school district, or educational service district. The school district board of directors and the educational service district board may require any student participating in extracurricular interschool activities to, as a condition of participation, document evidence of insurance or purchase insurance that will provide adequate coverage, as determined by the school district board of directors or the educational service district board, for medical expenses incurred as a result of injury sustained while participating in the extracurricular activity. In establishing such a requirement, the district shall adopt regulations for waiving or reducing the premiums of such coverage as may be offered through the school district or educational service district to students participating in extracurricular activities, for those students whose families, by reason of their low income, would have difficulty paying the entire amount of such insurance premiums. The district board shall adopt regulations for waiving or reducing the insurance coverage requirements for low-income students in order to assure such students are not prohibited from participating in extracurricular interschool activities.

(4) All contracts <u>or agreements</u> for insurance or protection written to take advantage of the provisions of this section shall provide that

the beneficiaries of such contracts may utilize on an equal participation basis the services of those practitioners licensed pursuant to chapters 18.22, 18.25, 18.53, 18.57, and 18.71 RCW.

(5) School districts offering medical, vision, and dental benefits shall:

(a) Offer a high deductible health plan option with a health savings account that conforms to section 223, part VII of subchapter 1 of the internal revenue code of 1986. School districts shall comply with all applicable federal standards related to the establishment of health savings accounts;

(b) Make progress toward employee premiums that are established to ensure that full family coverage premiums are not more than three times the premiums for employees purchasing single coverage for the same coverage plan, unless a subsequent premium differential target is defined as a result of the review and subsequent actions described in section 6 of this act;

(c) Offer employees at least one health benefit plan that is not a high deductible health plan offered in conjunction with a health savings account in which the employee share of the premium cost for a full-time employee, regardless of whether the employee chooses employee-only coverage or coverage that includes dependents, does not exceed the share of premium cost paid by state employees during the state employee benefits year that started immediately prior to the school year.

(6) All contracts or agreements for employee benefits must be held to responsible contracting standards, meaning a fair, prudent, and accountable competitive procedure for procuring services that includes an open competitive process, except where an open process would compromise cost-effective purchasing, with documentation justifying the approach.

(7) School districts offering medical, vision, and dental benefits shall also make progress on promoting health care innovations and cost savings and significantly reduce administrative costs.

(8) All contracts or agreements for insurance or protection described in this section shall be in compliance with this act.

(9) Upon notification from the office of the insurance commissioner of a school district's substantial noncompliance with the data reporting requirements of RCW 28A.400.275, and the failure is due to

the action or inaction of the school district, and if the noncompliance has occurred for two reporting periods, the superintendent is authorized and required to limit the school district's authority provided in subsection (1) of this section regarding employee health benefits to the provision of health benefit coverage provided by the state health care authority.

Sec. 4. RCW 28A.400.275 and 1990 1st ex.s. c 11 s 5 are each amended to read as follows:

(1) Any contract or agreement for employee benefits executed after April 13, 1990, between a school district and a benefit provider or employee bargaining unit is null and void unless it contains an agreement to abide by state laws relating to school district employee benefits. The term of the contract or agreement may not exceed one year.

(2) School districts and their benefit providers shall annually submit, by a date determined by the office of the insurance commissioner, the following information and data for the prior calendar year to the ((~~Washington state health care authority a summary descriptions of all benefits offered under the district's employee benefit plan. The districts shall also submit data to the health care authority specifying the total number of employees and, for each employee, types of coverage or benefits received including numbers of covered dependents, the number of eligible dependents, the amount of the district's contribution, additional premium costs paid by the employee through payroll deductions, and the age and sex of the employee and each dependent.~~)) office of the insurance commissioner:

(a) Progress by the district and its benefit providers toward greater affordability for full family coverage, health care cost savings, and significantly reduced administrative costs;

(b) Compliance with the requirement to provide a high deductible health plan option with a health savings account;

(c) An overall plan summary including the following:

(i) The financial plan structure and overall performance of each health plan including:

(A) Total premium expenses;

(B) Total claims expenses;

(C) Claims reserves; and

(D) Plan administration expenses, including compensation paid to brokers;

(ii) A description of the plan's use of innovative health plan features designed to reduce health benefit premium growth and reduce utilization of unnecessary health services including but not limited to the use of enrollee health assessments or health coach services, care management for high cost or high-risk enrollees, medical or health home payment mechanisms, and plan features designed to create incentives for improved personal health behaviors;

(iii) Data to provide an understanding of employee health benefit plan coverage and costs, including: The total number of employees and, for each employee, the employee's full-time equivalent status, types of coverage or benefits received including numbers of covered dependents, the number of eligible dependents, the amount of the district's contribution to premium, additional premium costs paid by the employee through payroll deductions, and the age and sex of the employee and each dependent;

(iv) Data necessary for school districts to more effectively and competitively manage and procure health insurance plans for employees. The data must include, but not be limited to, the following:

(A) A summary of the benefit packages offered to each group of district employees, including covered benefits, employee deductibles, coinsurance, and copayments, and the number of employees and their dependents in each benefit package;

(B) Aggregated employee and dependent demographic information, including age band and gender, by insurance tier and by benefit package;

(C) Total claim payments by benefit package, including premiums paid, inpatient facility claims paid, outpatient facility claims paid, physician claims paid, pharmacy claims paid, capitation amounts paid, and other claims paid;

(D) Total premiums paid by benefit package;

(E) A listing of large claims defined as annual amounts paid in excess of one hundred thousand dollars including the amount paid, the member enrollment status, and the primary diagnosis.

(3) Annually, school districts and their benefit providers shall jointly report to the office of the insurance commissioner on their health insurance-related efforts and achievements to:

(a) Significantly reduce administrative costs for school districts;

(b) Improve customer service;

(c) Reduce differential plan premium rates between employee only and family health benefit premiums;

(d) Protect access to coverage for part-time K-12 employees.

(4) The ((~~plan descriptions and the~~)) information and data shall be submitted in a format and according to a schedule established by the ((~~health care authority~~)) office of the insurance commissioner under section 5 of this act to enable the commissioner to meet the reporting obligations under that section.

((~~(3)~~)) (5) Any benefit provider offering a benefit plan by contract or agreement with a school district under subsection (1) of this section shall ((~~agree to~~)) make available to the school district the benefit plan descriptions and, where available, the demographic information on plan subscribers that the district ((~~is~~)) and benefit provider are required to report to the ((~~Washington state health care authority~~)) office of the insurance commissioner under this section.

((~~(4)~~)) (6) This section shall not apply to benefit plans offered in the 1989-90 school year.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.02 RCW to read as follows:

(1) For purposes of this section, "benefit provider" has the same meaning as provided in RCW 28A.400.270.

(2)(a) By December 1, 2013, and December 1st of each year thereafter, the commissioner shall submit a report to the governor, the health care authority, and the legislature on school district health insurance benefits. The report shall be available to the public on the commissioner's web site. The confidentiality of personally identifiable district employee data shall be safeguarded consistent with the provisions of RCW 42.56.400(21).

(b) The report shall include a summary of each school district's health insurance benefit plans and each district's aggregated financial data and other information as required in RCW 28A.400.275.

(3) The commissioner shall collect data from school districts or their benefit providers to fulfill the requirements of this section. The commissioner may adopt rules necessary to implement the data submission requirements under this section and RCW 28A.400.275,

including, but not limited to, the format, timing of data reporting, data elements, data standards, instructions, definitions, and data sources.

(4) In fulfilling the duties under this act, the commissioner shall consult with school district representatives to ensure that the data and reports from benefit providers will give individual school districts sufficient information to enhance districts' ability to understand, manage, and seek competitive alternatives for health insurance coverage for their employees.

(5) If the commissioner determines that a school district has not substantially complied with the reporting requirements of RCW 28A.400.275, and the failure is due to the action or inaction of the school district, the commissioner will inform the superintendent of public instruction of the noncompliance.

(6) Data, information, and documents, other than those described in subsection (2) of this section, that are provided by a school district or an entity providing coverage pursuant to this section are exempt from public inspection and copying under this act and chapters 42.17A and 42.56 RCW.

(7) If a school district or benefit provider does not comply with the data reporting requirements of this section or RCW 28A.400.275, and the failure is due to the actions of an entity providing coverage authorized under Title 48 RCW, the commissioner may take enforcement actions under this chapter.

(8) The commissioner may enter into one or more personal services contracts with third-party contractors to provide services necessary to accomplish the commissioner's responsibilities under this act.

NEW SECTION. **Sec. 6.** A new section is added to chapter 41.05 RCW to read as follows:

By June 1, 2015, the health care authority must report to the governor, legislature, and joint legislative audit and review committee the following duties and analyses, based on two years of reports on school district health benefits submitted to it by the office of the insurance commissioner:

(1) The director shall establish a specific target to realize the goal of greater equity between premium costs for full family coverage and employee only coverage for the same health benefit plan. In

developing this target, the director shall consider the appropriateness of the three-to-one ratio of employee premium costs between full family coverage and employee only coverage, and consider alternatives based on the data and information received from the office of the insurance commissioner.

(2) The director shall also study and report the advantages and disadvantages to the state, local school districts, and district employees:

(a) Whether better progress on the legislative goals could be achieved through consolidation of school district health insurance purchasing through a single consolidated school employee health benefits purchasing plan;

(b) Whether better progress on the legislative goals could be achieved by consolidating K-12 health insurance purchasing through the public employees' benefits board program, and whether consolidation into the public employees' benefits board program would be preferable to the creation of a consolidated school employee health benefits purchasing plan;

(c) Whether certificated or classified employees, as separate groups, would be better served by purchasing health insurance through a single consolidated school employee health benefits purchasing plan or through participation in the public employees' benefits board program; and

(d) Analyses shall include implications of taking any of the actions described in (a) through (c) of this subsection to include, at a minimum, the following: The costs for the state and school employees, impacts for existing purchasing programs, a proposed timeline for the implementation of any recommended actions.

NEW SECTION. **Sec. 7.** A new section is added to chapter 44.28 RCW to read as follows:

(1) By December 31, 2015, the joint committee must review the reports on school district health benefits submitted to it by the office of the insurance commissioner and the health care authority and report to the legislature on the progress by school districts and their benefit providers in meeting the following legislative goals to:

(a) Improve the transparency of health benefit plan claims and

financial data to assure prudent and efficient use of taxpayers' funds at the state and local levels;

(b) Create greater affordability for full family coverage and greater equity between premium costs for full family coverage and employee only coverage for the same health benefit plan;

(c) Promote health care innovations and cost savings and significantly reduce administrative costs.

(2) The joint committee shall also make a recommendation regarding a specific target to realize the goal in subsection (1)(b) of this section.

(3) The joint committee shall report on the status of individual school districts' progress in achieving the goals in subsection (1) of this section.

(4)(a) In the 2015-2016 school year, the joint committee shall determine which school districts have met the requirements of RCW 28A.400.350 (5) and (6), and shall rank order these districts from highest to lowest in term of their performance in meeting the requirements.

(b) The joint committee shall then allocate performance grants to the highest performing districts from a performance fund of five million dollars appropriated by the legislature for this purpose. Performance grants shall be used by school districts only to reduce employee health insurance copayments and deductibles. In determining the number of school districts to receive awards, the joint committee must consider the impact of the award on district employee copayments and deductibles in such a manner that the award amounts have a meaningful impact.

(5) If the joint committee determines that districts and their benefit providers have not made adequate progress, in the judgment of the joint committee, in achieving one or more of the legislative goals in subsection (1) of this section, the joint committee report to the legislature must contain advantages, disadvantages, and recommendations on the following:

(a) Why adequate progress has not been made, to the extent the joint committee is able to determine the reason or reasons for the insufficient progress;

(b) What legislative or agency actions would help remove barriers to improvement;

(c) Whether school district health insurance purchasing should be accomplished through a single consolidated school employee health benefits purchasing plan;

(d) Whether school district health insurance purchasing should be accomplished through the public employees' benefits board program, and whether consolidation into the public employees' benefits board program would be preferable to the creation of a consolidated school employee health benefits purchasing plan; and

(e) Whether certificated or classified employees, as separate groups, would be better served by purchasing health insurance through a single consolidated school employee health benefits purchasing plan or through participation in the public employees' benefits board program.

(6) The report shall contain any legislation necessary to implement the recommendations of the joint committee.

(7) The legislature shall take all steps necessary to implement the recommendations of the joint committee unless the legislature adopts alternative strategies to meet its goals during the 2016 session.

Sec. 8. RCW 42.56.400 and 2012 c 222 s 2 are each amended to read as follows:

The following information relating to insurance and financial institutions is exempt from disclosure under this chapter:

(1) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110;

(2) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW;

(3) The names and individual identification data of either all owners or all insureds, or both, received by the insurance commissioner under chapter 48.102 RCW;

(4) Information provided under RCW 48.30A.045 through 48.30A.060;

(5) Information provided under RCW 48.05.510 through 48.05.535, 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and 48.46.600 through 48.46.625;

(6) Examination reports and information obtained by the department of financial institutions from banks under RCW 30.04.075, from savings banks under RCW 32.04.220, from savings and loan associations under RCW 33.04.110, from credit unions under RCW 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and from securities brokers and investment advisers under RCW 21.20.100, all of which is confidential and privileged information;

(7) Information provided to the insurance commissioner under RCW 48.110.040(3);

(8) Documents, materials, or information obtained by the insurance commissioner under RCW 48.02.065, all of which are confidential and privileged;

(9) Confidential proprietary and trade secret information provided to the commissioner under RCW 48.31C.020 through 48.31C.050 and 48.31C.070;

(10) Data filed under RCW 48.140.020, 48.140.030, 48.140.050, and 7.70.140 that, alone or in combination with any other data, may reveal the identity of a claimant, health care provider, health care facility, insuring entity, or self-insurer involved in a particular claim or a collection of claims. For the purposes of this subsection:

(a) "Claimant" has the same meaning as in RCW 48.140.010(2).

(b) "Health care facility" has the same meaning as in RCW 48.140.010(6).

(c) "Health care provider" has the same meaning as in RCW 48.140.010(7).

(d) "Insuring entity" has the same meaning as in RCW 48.140.010(8).

(e) "Self-insurer" has the same meaning as in RCW 48.140.010(11);

(11) Documents, materials, or information obtained by the insurance commissioner under RCW 48.135.060;

(12) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.060;

(13) Confidential and privileged documents obtained or produced by the insurance commissioner and identified in RCW 48.37.080;

(14) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.140;

(15) Documents, materials, or information obtained by the insurance commissioner under RCW 48.17.595;

(16) Documents, materials, or information obtained by the insurance commissioner under RCW 48.102.051(1) and 48.102.140 (3) and (7)(a)(ii);

(17) Documents, materials, or information obtained by the insurance commissioner in the commissioner's capacity as receiver under RCW 48.31.025 and 48.99.017, which are records under the jurisdiction and control of the receivership court. The commissioner is not required to search for, log, produce, or otherwise comply with the public records act for any records that the commissioner obtains under chapters 48.31 and 48.99 RCW in the commissioner's capacity as a receiver, except as directed by the receivership court;

(18) Documents, materials, or information obtained by the insurance commissioner under RCW 48.13.151;

(19) Data, information, and documents provided by a carrier pursuant to section 1, chapter 172, Laws of 2010; ((~~and~~))

(20) Information in a filing of usage-based insurance about the usage-based component of the rate pursuant to RCW 48.19.040(5)(b)<u>; and</u>

<u>(21) Data, information, and documents, other than those described in section 5(2) of this act, that are submitted to the office of the insurance commissioner by an entity providing health care coverage pursuant to RCW 28A.400.275 and section 5 of this act</u>.

<u>NEW SECTION.</u> **Sec. 9.** A new section is added to chapter 48.62 RCW to read as follows:

If an individual or joint local government self-insured health and welfare benefits program formed by a school district or educational service district does not comply with the data reporting requirements of RCW 28A.400.275 and section 5 of this act, the self-insured health and welfare benefits program is no longer authorized to operate in the state. The state risk manager shall notify the state auditor and the attorney general of the violation and the attorney general, on behalf of the state risk manager, must take all necessary action to terminate the operation of the self-insured health and welfare benefits program.

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