Office of the Insurance Commissioner

K-12 School District

Health Benefits Information and Data Collection Project

DELIVERABLE 7.5

Year 1 Final Report to the Legislature

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EXECUTIVE SUMMARY

This report to the Washington State Legislature represents the culmination of the data collection and reporting activities for Year 1 of the K-12 School District Health Benefits Data Collection Project. 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 duties as specified in Sections 4 and 5 of the law. The OIC competitively procured for technical consulting assistance in support of this project and selected Treinen Associates, Inc. (Treinen) in August 2012.

The project gathered employee census and benefit information from the 295 K-12 school districts and K-12 employee healthcare data (claim experience, benefit plan information, enrollment) from the eight carriers providing health insurance to the school districts, including self-insured plans. K-12 school district healthcare benefits cost the state approximately $1.04 billion in calendar year 2012.

The summary of the data collection efforts for Year 1 (for plan years in 2012) are contained in two major sections: the Report to the Legislature (this document) and the supporting exhibits summarizing the actual data collected (included as appendices).

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). That is, the legislation calls for the data to be collected by school district benefit packages and, and not by school district.

The supporting exhibits provide summary data, including aggregated demographic information, total claims and premiums paid by benefit package, and large claims for all K-12 carriers and administrators combined. Data reporting has been aggregated by benefit packages to protect the privacy of K-12 district members. However, certain data exhibits report district-specific information including information by health plan, health plan enrollments, premiums, and contributions.

All 295 K-12 school districts and eight carriers were mandated to participate in this project as stipulated by ESSB 5940. The project included formal Data Calls sent to all K-12 school districts and carriers requesting K-12 health plan data for a specific period of time to meet the requirements ESSB 5940. For Year 1, we received and processed data from 293 school districts and eight carriers within the timeframes requested.

This report presents data submitted by each entity that participated in the Health Benefits Data Collection Project. All data provided to Treinen was self-reported by the K-12 School districts, the carriers, or a third party administrator. The scope of our work was only to collect the required data—we were not charged with interpreting or evaluating the data. The data collected has not been audited or validated for accuracy; however, certain reasonableness checks were undertaken which required carriers and school districts to resubmit data. The data collected involved employee health benefit plans only and no other insurance benefits. Employee health plans include medical and pharmacy plans, but exclude separately purchased dental and vision plans and other types of insurance benefits.

Per ESSB 5940, the plan sponsor for the data collection effort is the OIC. Per the legislation, it is the responsibility of the Health Care Authority (HCA) to analyze and evaluate two years of the collected data and present its findings and results to the Governor, Legislature, and Joint Legislative Audit Review Committee (JLARC) by June 1, 2015.

The purpose and background section of this report outlines the purpose of ESSB 5940, scope of this report, authorized contractor, acknowledgements, and report contents (as specified under RCW 48.02.210 ***"School District Health Insurance Benefits–Annual Report").*** Further Legislative goals are summarized to address K-12 healthcare purchasing, affordability of family coverage, promotion of healthcare initiatives to control and reduce costs, and improving parity across employee groups and school districts.

Chapter 1 summarizes K-12 school districts current purchasing options, the carriers currently contracted to provide healthcare benefits, and the Data Call prepared to support the data collection efforts. In summary:

- 295 K-12 school districts purchase healthcare directly through insurers, through the Washington Education Association (WEA) plans, through the Public Employees Benefit Board (PEBB) program under the Health Care Authority (HCA), or self-fund their healthcare coverage
- 293 of 295 K-12 school districts submitted data; two school districts (Damman and Oakville) covering 46 employees did not supply the requested data
- Eight carriers provided data for 408 health plans covering 211,053 K-12 school district members (employees and dependents) and reported health premiums of $1.04 billion for calendar year 2012
- Post-data collection, the K-12 school districts data revealed unreported data for 5 districts representing 270 K-12 employees and accounting for $2.4 million in premiums
- This project did not entail a reconciliation of the self-reported data or information between carriers and school districts; although some reasonableness checks were undertaken, errors or inconsistencies in the source data may exist
- The data shows variations in the amounts reported by the carriers and school districts for the number of health plans, reported premiums, and enrollment numbers. These variations are expected when accounting for the timing of data being reported and do not constitute a data integrity issue.

Chapter 2 describes the data collection process and results of the data collection process. The major activities included:

- Early input from the HCA and carriers to clarify the statute and intent prior to the state rule-making process, allowing impacted stakeholders the opportunity for input
- Developing a formal engagement process including a pilot with seven school districts and five carriers to provide input on the Data Call approach; to validate and test the data collection instructions and processes
- Designing and constructing a database repository to hold the collected data; to allow the data to be reviewed, processed, and managed; and to provide a process for tracking school district and carrier data collection
- Clarifying the reporting period and definitions for reported data - the data required for Year 1 of the project, as specified in ESSB 5940, was calendar year 2012; the data collection process accommodated calendar year reporting, reporting for plan years ending in 2012 (for non-calendar year plans), and data based on a snapshot date (October 1, 2012)

- Capturing and leveraging school district data reported through a third party, namely the Washington School Information Processing Cooperative (WSIPC), which provides IT services for member school districts; WSIPC built and ran extract processes to produce the relevant health plan and employee census data
- Assessing the level of school district responsiveness to this data collection project; the results of Year 1 data collection are unprecedented compared to any previous study of this nature related to K-12 school district health benefits
- Performing limited data reasonableness checks. Though there was no programmatic validation or verification done on submitted data, the data was checked for reasonableness. Some corrections were necessary and documented with approval of the submitting entity. Variations in reported data are evident. The potential causes of the variations are largely due to the differences in the timeframe of the reported data and the source of the data (school district or carrier).
- Identifying the school district and carrier information required to meet legislative goals described in ESSB 5940.
- Documenting the data collected, which shows 104,431 employees and 211,053 members with combined premiums of $1.04 billion. Note: the differences in reporting across exhibits are attributable to the report period, and changes in enrollment, premiums, and so on, across different reporting periods.

Chapter 3 provides a summary of the reported school district data. The results show:

- Total premium dollars of $1.04 billion of which school districts contribute on average 80.2% towards premiums; employees contribute 19.8%
- Employee contributions, on average, as a percentage of premium for employee coverage, are 6% for full-time employees and 11.7% for part-time employees
- Employee contributions, on average, for employees with family coverage, are 28.9% for full-time employees and 34.7% for part-time employees
- The ratio of family to employee contributions is 7.3 for full-time employees and 4.6 for part-time employees
- The average reported premiums for all health plans combined, for employee and dependent coverage, as reported by the carriers for years ending in 2012, was $878.55 per month; the lowest school district premium was $427.52, the highest reported was $1,454.47 per month

Chapter 4 provides a summary of the reported carrier data. The results show:

- The carriers reported 408 separate health plans provided during 2012; one carrier reported 261 distinct plans
- Average monthly enrollment for calendar year 2012 was 104,431 employees and 211,053 members (members are defined as employees and dependents combined)
- Total premiums were $1.04 billion; claims paid during calendar year were $951,000,370, generating a paid claims loss ratio of 91.4% in 2012

- Administrative costs totaled $94.3 million (for the plan years ending in 2012) or approximately 9% of premiums reported; broker commissions were $7.08 million, state premium taxes and other assessments were $24.4 million, about 2.3%; carrier administration represented $61.7 million or 5.9% of premium
- Reserves for Incurred But Not Reported (IBNR) liabilities totaled $62.8 million (about 6% of reported premiums in 2012)
- Other reserves for claims stabilization or premium stabilization totaled $31.5 million (about 3% of reported premiums in 2012)
- Also presented were the actuarial values of the 408 plans offered in calendar year 2012. The range of values of school district plans was .67 to .97. This is the expected medical reimbursement of medical expenses (for example, a value of 0.97 would indicate a plan covers 97% of expected medical expenses); some individuals will see reimbursements more or less than the actuarial value.

Chapter 5 is the Data Collection Project Year 1 conclusion:

- Summarizes the keys to success, acknowledgements of the participants, authors and contributors and introduction to the detailed data that is included in the appendices.
- Overall, the K-12 Health Benefits Data Collection Project met with an unprecedented level of participation, and gathered information that is very accurate and reliable. For these reasons, the project team believes that this report and its supporting exhibits contain data that will assist school districts and carriers in meeting the requirements of ESSB 5940.

PURPOSE AND BACKGROUND

Engrossed Substitute Senate Bill (ESSB) 5940[1]

In April 2012 ESSB 5940 was signed into law requiring every school district in the State of Washington and their ***"benefit providers[2]"*** (health insurers) to submit annually to the Office of the Insurance Commissioner (OIC) certain information, specified in detail below, with respect to each "health plan[3]" or "benefit package[4]" offered to district employees. 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.

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[5]"*** 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" included in the Data Call and referred to herein includes medical care and pharmacy services only.*

The data provided with this report relates to the 2012 calendar year. The data was submitted based an 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 data and other information[6]. 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.

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[1] 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

[2] "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

[3] "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

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

[5] ESSB 5940 Section 1 (1)(b); note, "health insurance benefits" includes medical and pharmacy benefits only

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

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. The due date for reporting the results to the governor, legislature, and Joint Legislative Audit Review Committee (JLARC) is June 1, 2015.

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

Limited Scope Review

This report does not attempt to evaluate the data or to 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 have been found in the data submitted although it may contain small errors and inconsistencies.

This report does not address areas of legislative or contractual compliance across carriers or school districts. However, of the eight carriers contacted, 100% submitted data as requested. Of the 295 school districts contacted, 293 school districts (99.3%) responded to the data request.

The Office of the Insurance Commissioner is required by ESSB 5940 to prepare a report and present a summary of each school district's health insurance benefit plans and each district's aggregated financial data. OIC contracted with Treinen Associates, Inc. as a technical consultant to prepare this report on behalf of the OIC for Year 1 of the project.

It is the responsibility of the Health Care Authority (HCA) to analyze the data and information collected by the OIC over a two-year period. The data herein represents Year 1 of the project (January 1, 2012 to December 31, 2012). By December 1, 2013, and December 1of each year thereafter, the OIC will submit a report to the Governor, the HCA and the Legislature on school district health insurance benefits. The report shall be made available to the public on the OIC's website.

Non-Disclosure

To maintain the confidentiality and privacy of information of school district employees and their dependents, ESSB 5940 does not require the reporting of Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI), as defined by HIPAA. In order to protect privacy further, data reporting has been 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 for similar actuarial values. The aggregated information is reported by carriers as "benefit packages," consisting of one or more health plans across multiple school districts.

In order to lessen the potential for public disclosure of proprietary carrier-provided information, certain data that was collected is not disclosed in this report. The de-identification of data for purposes of public disclosure or the elimination of confidential, proprietary information does not compromise the integrity of

the data presented in the report. The health plan information that ESSB 5940 requires is presented with 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"***[7] unless it contained an agreement ***"to abide by state laws relating to school district employee benefits."***

Any contract or agreement for employee benefits must 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 – Treinen Associates Inc.

ESSB 5940 authorized the OIC to enter into a Personal Services Agreement with a third-party contractor in order to fulfill the OIC's responsibilities under this act and to facilitate data collection efforts for year 1 of the project and beyond.

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 company based in Olympia, WA. Treinen was required under the contract to:

- Design and build a database to hold the collected data
- Design and build a computer application allowing collected data to be viewed, processed, and managed
- Design and build a suitable vehicle for data collection (this 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
- Conduct interviews with key stakeholders

[7] ESSB 5940 Section 4(1)

- Engage with school districts and their respective insurance carriers or plan administrators in order to collect the required data.

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

Data was collected for Year 1 and is summarized in this report.

Terms of Reference

Year 1 of the OIC K-12 Health Benefit Data Collection Project will be referred to throughout this document as "the project."

The team carrying out the project consists of employees and subcontractors of Treinen Associates Inc., a consulting company based in Olympia, WA. This team will be referred to throughout this document as "the project team."

Treinen Associates Inc. is frequently abbreviated within this document as "Treinen."

The "Data Call" referred to throughout this document is the act of broadcasting to school districts and to 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.

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

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

- The Office of the Insurance Commissioner (OIC)
- Treinen Associates, Inc.
- School districts Personnel (Superintendents, Office Managers, Financial Staff, etc.)
- All 9 Educational Service Districts
- The Washington School Information Processing Cooperative (WSIPC)
- The Office of the Superintendent of Public Instruction (OSPI)

- K-12 Insurance Carriers, HMOs, and Administrators: Group Health Cooperative, Kaiser Permanente, KPS Health Plans, Premera Blue Cross, Providence Health Plans, Regence BlueShield, United Healthcare, and the Public Employees Benefits Board (PEBB)[8]
- K-12 Benefit Insurance Brokers, Producers, and Consultants who supported the data collection process

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 1 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[9]

c. A description of the school district and carrier plan's use of innovative health plan features

d. Data to provide an understanding of employee health benefit plan coverage and costs

e. Data necessary for school districts to more effectively and competitively manage and procure health plans.

Following the main body of this report are a series of 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.

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

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

Project Sponsor and Stakeholders

This data collection project and report are sponsored by the Office of the Insurance Commissioner (OIC) of the State of Washington. Below is a list of the key stakeholders.

Initiators

- The Governor's Office
- State Legislators
- Active Participants and Data Contributors
- Carriers, including HMOs
- School Districts
- The Public Employees Benefits Board (PEBB)
- Benefit Insurance Brokers, Producers, and Consultants
- Washington School Information Processing Cooperative (WSIPC)

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 and Senate

Stakeholders with a Professional Interest

- Washington Association of School Business Officials (WASBO)
- 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[10]"

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

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."***

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

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, obtained either directly through insurers, or through the Washington Education Association (WEA) sponsored plans, or through the Public Employees Benefit Board (PEBB) program under the Health Care Authority, or by exercising the option to self-fund[11]. The vast majority of school districts purchase healthcare coverage through carrier-provided purchasing arrangements, such as the Washington Education Association, 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 293 school districts covering 109,327 employees and 212,930 members. Two school districts - Damman and Oakville - with approximately 46 employees, did not report their school district data; however, their carrier-related data was included in their respective carrier's data submission.

The data collection project received carrier data from eight reporting carriers, inclusive of PEBB. The carriers reported total medical premiums of $1,040,579,047 and reported 408 health plans offered in 2012, including terminated plans and unused plans. Financial data (enrollment, premiums, and claims) was provided for 336 health plans covering 104,431 employees and 211,053 members for the 2012 calendar year. The carriers provided actuarial values on 408 plans.

Note: The 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 does not represent a data integrity issue. Carriers reported somewhat higher enrollment numbers in aggregate; while enrollments summarized from the plan-level data or from school districts are slightly lower.

A comparison of all reported school district and carrier data identified medical plans that were not reported. The unreported plans represent 270 employees across 5 school districts, which generated $2.4 million in medical premiums for plan years ending in 2012. The unreported plans are provided through various health insurance trusts, and were not included as part of the collection process in Year 1. *(Note: The Year 2 Data Call will require the carriers of these unreported plans to report Year 1 data).*

[11] 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) etc.

Reporting carriers include:

- Group Health Cooperative
- Kaiser Permanente
- KPS Health Plans
- 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 districts 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 PPO, HMO, and High-Deductible Health Plan (HDHP). The other reported plan types are unique and similar to HMO-type plans.

Table 1 School District Size Range	Number of School Districts	Percentage of Total
1 – 50	99	33.6%
50 – 100	46	15.6%
100 – 200	44	14.9%
200 – 300	23	7.8%
300 – 400	10	3.4%
400 – 500	19	6.4%
500 – 750	14	4.7%
750 – 1,000	10	3.4%
1,000 – 1,500	10	3.4%
1,500 – 2,000	11	3.7%
2,000+	9	3.1%
Total	295	100.0%

Table 1 – Size Ranking of School Districts

Table 2 Carrier	Employees	Members	% of Total Members
Carrier 1	68,000	131,536	61.8%
Carrier 2	20,021	39,921	18.7%
Carrier 3	13,303	24,484	11.5%
Carrier 4	3,668	7,578	3.6%
Carrier 5	354	649	0.3%
Carrier 6	1,103	2,232	1.0%
Carrier 7	1,694	3,592	1.7%
Carrier 8	1,184	2,938	1.4%
Total	109,327	212,930	100.0%

Table 2 – School District Enrollment by Carrier

Table 3 Plan Type	Employees	Percentage of Total
PPO	83,192	79.8%
HMO	16,698	16.0%
In-Network	3,677	3.5%
Closed Network	709	0.7%
Total	104,276	100.0%

Table 3 – Enrolled Employees by Plan Type

The combined total number of employees by plan type is lower than the combined total number of employees reported by carrier. The difference is due to the change in the reported health plans not included in the roll up of plans by benefit package. Not all carrier data defects discovered have been corrected; however, they are not material.

Note: This project did not entail a reconciliation of the data or information between carriers and school districts. In some cases, plans offered in 2012 (required by ESSB 5940 to be reported) are no longer active but are included with the Data Call. In addition, the data may show variations in the number of health plans, reported premiums, and enrollment numbers, which generally reflect a difference in timing of the reporting, and not a data issue per se.

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 carriers. The Data Call was comprised of detailed written instructions and a template Data Collection Spreadsheet to be used for data submission. The Data Collection Spreadsheet contained multiple separate Sections, each containing a different type of data, and was to be encrypted and password-protected before being transmitted to the project team.

The data collection process focused only on health benefit plans, not other forms of employee benefits such as vision, dental, life insurance, and disability insurance plans.

The initial stage of the data collection process identified only five carriers and 295 school districts for reporting data. No data was requested directly from any other third party or intermediary.

A pilot process included the initial group of five carriers and a sample group of school districts to validate and test the Data Collection Spreadsheets, the instructions, and the collection process. Feedback from the pilot process led to significant improvements in the design of the Data Call, the Data Collection Spreadsheets, the instructions, and the process. The underlying data structures were also enhanced by the pilot process. Points of contact at the carrier and school district level were collected throughout the process.

A very substantial portion of the total data collected originates from the carriers, which is to be expected, because ESSB 5940 requires more carrier-specific data. In addition, the carriers have the resources, internal systems, and capabilities to accommodate all the Data Call requirements, more so than most of the school districts. The final Data Call included only eight carrier submissions, including PEBB, whereas the school district data was derived from 293 school district submissions. Many school districts do not have the resources availability or capabilities to provide the data at the level of reporting required by ESSB 5940.

The school district data-collection process required reliance on independent multiple data sources and payroll systems, with unique tracking and reporting capabilities. This did not allow for consistent reporting across all school districts. The data extracts for school districts included, in some cases, non-medical information or non-reporting populations, and limited reporting of covered and non-covered dependents. For these reasons, the data collection process relied more heavily on carrier data for overall completeness.

There was no attempt to "audit" the veracity of the information from either the carriers or school districts; however, post-data collection, carriers were requested to review, validate, and verify certain data for reasonableness of the data. Resubmissions were required to correct certain errors in reporting.

Database Development and Data Traceability Matrix

The project database is a repository designed and built to hold the collected data; to allow data to be reviewed, processed, and managed; and to provide a process for school district and carrier data collection. Database development included identification of types of data to be captured with respect to school districts' health plans for their employees and dependents. In addition, the database was designed to allow for qualitative review of data submissions and to allow for linkages between data sets and data from different sources. The database allowed for systematic review of collected and processed data to assure quality was achieved. The data model itself was reviewed with the OIC and Subject Matter Experts for recommendations and feedback, and a "data dictionary[12]" was created.

Distinct stages of the project included development of the data requirements "Traceability Matrix" (included with this report), which traces the requirements outlined in ESSB 5940 to particular data elements and sources of information (carrier or school district). The Data Traceability Matrix provides an overview of, and the context for, the information collected in Year 1 of the project. In future years, the Traceability Matrix document will be revised based on changes in the Data Call.

The engagement process, described below, provided detailed instructions to school districts and carriers for submitting data. When submitted data was received, it was then loaded, using a software toolset designed and built by the project team, to the project database.

Engagement Model

Introduction

The Engagement Model document outlined how the contractor, Treinen, planned to engage with the entities submitting data, as well as the timelines, processes, and procedures for collection of the requisite data. Each phase of the data collection project involved a number of work products. The engagement process and production of initial work products commenced in September 2012.

As part of the engagement process, the OIC authorized the project team to collect the requisite data on its behalf, giving the team authority to approach contributing entities to request the data.

The Engagement Model activities are described below.

[12] This technical data dictionary is intended primarily for application development teams working on the project. The document illustrates the intended scope of data collection from various sources. While all the elements indicated will be collected as data, the collection method may vary (user interface fields, uploaded data files, etc.)

Initial Statements of Work (SOWs)

Initial phases included input from the Health Care Authority (HCA) and from the K-12 insurance carriers to address the legislative reporting requirements and to layout and describe which data elements would be included with the Data Call instructions.

SOW 1–"K-12 HCA Discovery"

This phase included a memorandum to the OIC in response to HCA's request that certain data elements be included in the data collection. SOW 1 identified the provisions in ESSB 5940 that authorized the OIC to require the reporting of the HCA data elements, identified any HCA requested data elements that may not have been required by ESSB 5940, and included Treinen's recommendations whether or not the OIC should require the reporting of the HCA requested data elements.

SOW 1 was delivered to the OIC in October 2012.

SOW 2–"K-12 Carrier Discovery"

The OIC provided initial regulatory compliance contacts within Group Health Cooperative, Kaiser, Premera, Regence, and United Healthcare, all of which provide health benefit coverage for K-12 school district employees. SOW 2 required soliciting input from these carriers. The carrier input included their comments with regard to the data elements required from carriers pursuant to ESSB 5940 Sections 4 and 5 as well as those data elements proposed by the HCA, as documented in SOW1.

The output of SOW2 included a summary of carrier survey responses. This was delivered to the OIC in October 2012.

The Rulemaking Process

Following input from the HCA and carriers, the OIC drafted and finalized rules implementing the new reporting requirements.

The carrier engagement process included working with the OIC to support the drafting of rulemaking[13] provisions. The proposed rules established and implemented the data requirements under RCW 28A.400.275 for carriers that provide health benefit plans for school district employees. The rules apply to carriers, not to school districts. Proposed rulemaking form (CR102), allows stakeholders and interested parties the opportunity to submit formal comment to the regulatory authority (in this case, the OIC) before

[13] The rule-making process is used to create, change, or delete existing rules. When the state legislature passes a bill that is signed into law by the Governor, it is coded into state law known as the Revised Code of Washington (RCW). In order to clarify, apply, or enforce state laws, state agencies may propose and adopt a rule, sometimes referred to as a regulation, known as the Washington Administrative Code (WAC)

a final decision to adopt rules. The CR102 provides for a public comment period and all comments are considered.

The adopted rule language is filed with the publication of the Rulemaking Order form (CR103), which provides final rule language, effective date, and typically requires compliance within 31 days after the rule language is adopted. The rule adoption consists of the final rule (CR103), along with the Code Reviser. The Code Reviser filed and published the final rule order in the state's register in February 2013.

School District and Carrier Engagement Model – Roll Out

Introduction

The engagement process included creating and working with a small pilot group of school districts before the full rollout to all K-12 school districts. For carriers, the pilot process began subsequent to the publication of the rulemaking document (CR103). There were seven school districts and five carriers in the initial sampling to validate and test the data collection process. The goal of the pilot process was to streamline and minimize the effort to comply with the data collection process.

School district data files were not altered or corrected to preserve the data from school districts exactly as submitted.

Carrier data files were returned to each carrier, as needed, for corrections, or to affirm changes made to the data file.

ESSB 5940 provides for certain sanctions, specified in ESSB 5940, against non-compliant school districts. Carriers are fully compliant in providing school district data since they are required to do so under the law.

Period of the Information Collected

The language of ESSB 5940 specifies the "prior calendar year[14]"to be the period of data to be collected, or for the initial reporting period, calendar year 2012. Most school districts and their carriers align health benefit plans with an enrollment election date - typically effective October 1 - for the current school year. As such, data reporting for most school district health plans often straddled two plan years.

To obtain 12 months of data for 2012, carrier data reporting was for plan-year data ending in 2012 plus the remaining months in 2012 through December 31, 2012. For plans not on a calendar year, this required reporting of two different reporting periods in 2012. For example, for plan years ending September 30, this required the capture of 2012 data through September 30, 2012, plus data for the remaining months of

[14] ESSB5940 Section 4(2)

October, November, and December 2012. The remaining three-months of data represented data for the subsequent plan year ending in 2013.

In addition to calendar year and plan-year reporting, some carrier data is based on a single "snapshot" date for a given reporting period. For school districts, 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 imposed by the requirements of the collection process and data sources.

Snapshot Date

For the purposes of simplifying the data collection process from school districts, data was collected from school districts based on a "snapshot date". The date selected was October 1, 2012, to correspond to the OSPI S-275 employee population reporting process.[15] *(Note: 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, 2012. Census data extracted for the month may have reported all participants within the month 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. However, that was deemed too onerous and could have delayed data collection. Instead, a single year-end census was collected. It was based on census as of October, 2012, and corresponded to the school year currently under way at the time of the data collection. An additional benefit of this approach is that census results from subsequent years can easily be compared to those of a prior year.

The school district census data captures the monthly unit rates by coverage tier, (Employee only (EE), EE and spouse (ES), EE and children (EC), and EE and family (EF)), including 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 will be the plan year ending date, typically the end of the school plan year (September 30, 2012), particularly to capture reserve balances for rate or premium stabilization

[15] 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

reserves (RSR or PSR reserves) or reserves for claims incurred but not reported (IBNR[16] claim reserves). The snapshot date was also used 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) may be 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 category, payee, or fiscal year ending 2012 was requested.

School District Data Call

Introduction

The Data Call was sent to all 295 K-12 school districts. The following organizations served key roles in support of the data collection process for school districts. As a result, 293 school districts provided data in compliance with the Data Call request. The school districts reported 103,116 employees and 132,688 members, generating $1.044 billion in premiums.

Role of Washington School Information Processing Cooperative (WSIPC)

School district reporting required a high degree of reliance on third-party reporting through the Washington School Information Processing Cooperative (WSIPC), which provides a variety IT and other support services, including the hosting of databases for the substantial majority of school districts in Washington State. WSIPC routinely provides software services to all school districts, including extract routines that allow the school districts to comply with the continually evolving reporting requirements of the Office of Superintendent of Public Instruction (OSPI).

Throughout the pilot process and data collection phases, WSIPC was instrumental in helping school districts with reporting compliance. WSIPC provided school districts with extracts from each school district's independent database which school districts then supplemented with additional information from other sources before submitting their data to the project team.

As each school district's database is independent, and uses different payroll deduction codes, account payable codes, business entity names, and programming packages, WSIPC instructed all its member school districts to harmonize their code descriptions in order to help WSIPC extract to pull the relevant medical data. In some cases the programming required educated guesses, and while the process was accurate, in the vast majority of cases, in some cases data was pulled that was not related to medical benefit plans. Based on a wide variety of entity names and school district data scenarios, data received from school

[16] Sometimes called "Incurred But Not Paid (IBNP)." These are two names for the same reserve.

districts was then processed using automated and manual steps to help separate medical from non-medical data.

After the WSIPC extract was developed and tested, it was run on behalf of each of the approximately 282 school districts (out of 295) that use WSIPC for their information processing needs. In so doing WSIPC made a huge contribution to the success in Year 1 of the OIC School District Health Benefit Information Data Collection Project, and enabled many school districts to comply with the Data Call, which may not have been possible otherwise.

(Note: WSIPC is an umbrella IT organization encompassing nine Information Service Centers co-located within the nine Educational Service Districts, as well as several Regional Data Centers. It offers an integrated software solution 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 provided and operated by WSIPC. Each school district has their 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).

Role of the Office of Superintendent of Public Instruction (OSPI)

The Office of the Superintendent of Public Instruction (OSPI) is a key project stakeholder that provided dissemination of project information and guidance to the school districts, and was identified in ESSB 5940 as the entity that would address any non-responding school districts. OSPI regulates and manages the public education enterprise statewide.

A summary of the support provided by OSPI for Year 1 of the OIC K-12 Data Collection Project is below:

- Provided consultancy to the project team on various aspects of the project, particularly in the design and execution of the school district engagement
- Reviewed and made recommendations on the various mass communications sent to the school districts
- Posted and published various materials and Q&As on their website, including links to further information on OIC's website
- The OSPI was included on school district communications

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 2012)

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

- Total annual premiums paid to carriers for health benefits.
- 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 plan (for example, a wellness program, health risk assessments, or biometric screenings).
- Internal and external administrative costs paid to third parties (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 principally used to report the costs associated with the school district retiree medical subsidy, aka 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
  - ✓ reduced administrative costs
  - ✓ improvements in the management, delivery, and administration of health benefits
  - ✓ reducing the differential between employee-only and family health benefits coverage
  - ✓ protecting access to coverage for part-time employees
  - ✓ innovations to reduce health premium growth and 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 or lower healthcare or medical 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 Third Party Entities

- Each school district was asked to identify services provided by various entities such as insurance carriers, brokers, and other third parties for delivery, management, or administration of the school district's health benefit plans.
- For each entity, this section requested a description of the type of services as well as premiums or fees paid for related services.
- Each school district was asked to report the dollar amount of all medical insurance premiums paid in fiscal year ending 2012 exclusive of COBRA.

Section 4: Carrier Health Benefit Plans

- For each carrier, the school district was asked to list all health plans offered and the name of each unique plan.

Section 5: Employee Groups by Classification

- The section requested identification of each employee groups; in particular, classified and certificated employees for the 2011–2012 school year and the 2012–2013 school year.
- The plans offered to each group of school district employees, could be reported here (or in Section 6), thus allowing plans offered to be associated with employee groups.
- For each group, the school district was to provide rate sheets identifying plans offered and their respective costs or premium rates.

Section 6: Medical Plans offered to Employee Groups

- This section presented an alternative means of reporting health plans offered to each group of employees for the 2011–2012 and 2012–2013 school years.

Section 7: Employee Listing (Census)

- This section requested a list of employee or census information to reflect the school district's population as of October 1, 2012. Each school district employee appearing on the school district's OSPI S-275 report was requested to be listed. For each person, monthly premiums and contributions, and coverage tier election (Employee only (EE), employee plus spouse (ES), employee plus child (EC), and employee plus family (EF)) were requested including:
  - ✓ Monthly contributions paid by the reporting school district
  - ✓ Monthly contributions paid by the employee
  - ✓ Total monthly premium (school district contribution and employee premium combined)
- Also required was census information on the employee population including benefit full-time employee (FTE) status, gender, and age of each person on the census, classified and certificated employees, and enrollments by coverage tier; covered and 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 covered and eligible dependents.

School District Data Collection Results

The level of school district responsiveness to this data collection project is the highest compared to any previous study of this nature related to K-12 school districts benefit plans. 293 out of 295 school districts responded to the Data Call. The two school districts not reporting provide health benefits to 46 employees.

The reporting school districts provided census as of October 1, 2012; carriers provided financial data for the 2012 calendar year. K-12 school district reporting shows total enrollment of 103,116 employees and 132,688 members (see A12 series Exhibits). Carriers provided financial data on 104,431 K-12 employees and 211,053 members (Exhibit A9a). School districts reported combined contributions generating $1.044 billion in premiums; while carriers reported $1.040 billion in premiums. Minor discrepancies such as these were expected due to differences in the period of reporting.

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

- The pilot process and 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
- The role of OSPI in providing support and resources around communication with districts
- A Treinen team member dedicated to working with the pilot school districts and to coaching and meeting with individual non-pilot 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. Below is an explanation of variations in the school district-reported data that may affect the information in the exhibits. Note: there was no validation or verification of submitted data, although the data was checked for reasonableness. Some minor errors exist in the Data Call results but are inconsequential (e.g. enrollment or premium reporting may not exactly match carrier data; in such cases, carrier data has been relied upon for consistency).

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 account payable coding schemes, applications, and data sources for extracting data. (This is true even for school districts that share computing resources, such as those offered by WSIPC.) The result is that there is little or no consistency across school districts in the use or reporting of medical entity names, plan codes, or plan names.
2. Many non-medical entities were reported by school districts – about one-third of the entities reported were non-medical. This required the project team to build data filters to remove the extraneous and irrelevant entities.
3. Some school district employees, who may be included in the final results, should not have been reported by school districts because they were not on the OSPI S-275 report (for example, retirees, volunteers, ESD personnel, shared employees, and so on). Some school districts did not report the appropriate medical coverage tiers for their employee populations. As such, the project team had to

extrapolate the tiered rates from premium rates. This may have resulted in some inaccuracies in the school district data with respect to tiers of coverage.

4. Some school districts included certificated and classified population in unified groups. In these cases, the project team had to extrapolate employee groups and ask the school district to confirm. This manual process was largely accurate but inaccuracies in the school district data may persist with respect to certificated and classified employee groups.
5. 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.
6. There are large variations in school district coding for carriers and plans. Consequently, plans identified by school districts cannot be directly linked to plans identified by carriers. (Note: For Year 2 of the Data Collection Project, some Data Call redesign may allow for better matching of carrier plan codes to school district plan codes).
7. School district data does not align with carrier data because there are different periods for reporting data. Carriers were asked to report monthly, annually, or for plan years ending in 2012; whereas school districts were asked to report populations and premiums based on a single snapshot date of October 1, 2012.
8. Some information is not particularly useful, for instance, school district-reported administration (see Exhibits A12e, f, g, h). This may be because there was no adequate guidance or standardization for uniform reporting of school district administration data and the information was incomplete.

These factors, taken together, generate discrepancies between reporting of enrollments and premiums within the school district data set, across the school district data set, and compared to the carrier data set.

Carrier Data Call

Introduction

Eight carriers, including PEBB (considered a "carrier" for the purposes of data collection), were identified as K-12 carriers and included in the 2012 Data Call. Carriers reported that they provide health coverage to 109,327 school district employees, 212,930 members for plan years ending in 2012 (see Exhibit A12d). Actual carrier-reported financial data included 104,431 employees, 211,053 members generating $1,040,579,047 in premiums for the 2012 calendar year (see Exhibits A8f, and A9a). Note: The actual carrier-reported financial data information will vary from the information reported on all plans because some plans were inactive or terminated during the reporting period and were not included in actual results.

The carriers reporting data include:

- Group Health Cooperative
- Kaiser
- KPS Health Plans
- Premera
- Providence Health Plan
- Regence
- United Healthcare
- PEBB*

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

Subsequent to the data collection effort, a review of the school district data submissions disclosed unreported plans representing 270 employees across 5 school districts, which accounted for $2.4 million in medical premiums for plan years ending in 2012.

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 nine tabs. Each tab contained a different type of data and is referred to as a "Section" detailed below.

Section 1: Carrier Annual Reporting (For Calendar Year 2012)

- 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 2012)

- 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. Premium or Rate Stabilization Reserve (PSR or RSR), which is applicable to a carrier rating pool. A PSR 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 2012)

- This section required reporting of information on each unique health plan offered in 2012 by each K-12 carrier. The information requested included plan design or cost-sharing provisions, actuarial values[17], and monthly rates. In Year 1 only, carriers provided plan summaries with cost-share data that was manually loaded to the database by Treinen. *(Note: the Year 2 Data Call will include cost-share fields in a separate section).*

  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.

[17] The 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 a plan that 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.

Section 5: Benefit Package Plan Year Performance (For Plan Year Ending in 2012)

- This section required reporting of performance data such as health-plan premiums[18] and total claims expenses or paid claims[19] for the plan year ending in 2012. For plans with low enrollments, which generally represent fewer than 200 covered lives, data aggregation was permitted. In some cases, carriers also aggregated plans with similar actuarial value (see related footnote 17). Claims data by major benefit category (e.g. hospitalization, professional services, and pharmacy) were reported by utilization metrics such as hospitalization average length of stays, and 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 2012)

- 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 plan years ending in 2012 plus the remaining calendar months (within 2012) of plan years that began in 2012 and ended in 2013.

Section 7: Benefit Package Demographics by Plan (Snapshot Plan Year Ending in 2012)

- This section required reporting of demographics data (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 plan years ending in 2012.

Section 8: Benefit Package by School District by Plan (For Plan Year Ending in 2012)

- This section required reporting of enrollment (headcount) data for each health plan by school district for the 12-month period ending in December 2012. This allowed for the mapping of a school district to a particular benefit package.

Section 9: Large Claims (For Plan Year Ending in 2012)

- 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

[18] 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.

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

reporting is designed to protect the privacy of individually identifiable health information. A large claim was considered the aggregation of all claims paid per 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.

Carrier Data Collection Results

The data collection project received carrier data from eight reporting carriers inclusive of 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 104,431 employees, and 211,053 members, generating $1,040,579,047 in premiums for the 2012 calendar year (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	Employees	Members	% of Total Members
Carrier 1	68,000	131,536	61.8%
Carrier 2	20,021	39,921	18.7%
Carrier 3	13,303	24,484	11.5%
Carrier 4	3,668	7,578	3.6%
Carrier 5	354	649	0.3%
Carrier 6	1,103	2,232	1.0%
Carrier 7	1,694	3,592	1.7%
Carrier 8	1,184	2,938	1.4%
Total	109,327	212,930	100.0%

A comparison of all reported school district and carrier data identified other medical plans. These were not initially discovered because they were reported (by school districts) as payments to various trusts. As previously mentioned, the unreported plans represent 270 employees across 5 school districts, which accounted for $2.4 million in medical premiums for plan years ending in 2012.

Variations in Carrier Data

Variations may exist in the reported data. An explanation of variations in the carrier-reported data that may affect the information reported on the exhibits is below. Note, that there was no validation or verification of submitted data, although data was checked for reasonableness. Some minor errors exist in the Data Call results; however, they are inconsequential.

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. As a result, the data reported by carriers may not have been reported consistently.
2. The period of data collection that is required under ESSB 5940 is calendar year 2012. However, school districts track data on a 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-specific reporting. Further, because of the different reporting periods between school districts and carriers, the data will not align across these data sets.
3. 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. In some cases, aggregation introduced errors in carrier reporting.
4. Utilization metrics for medical and pharmacy data were not tracked on the same basis across all carriers, and in some cases was 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.
5. 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 attributable to differences in reporting periods, and to different sources of enrollment and premium information.
6. Carriers resubmitting data to correct reporting errors created new plan codes or plan names that did not match the plan names they had reported previously, thereby generating additional plans with no corresponding cost-share designs. However, carrier resubmissions allowed for correction of these errors.
7. Enrollment for various tiers of coverage (that is, Employee Only (EE), Employee & Spouse (ES), Employee & Children (EC), and Employee & Family (EF)) was not reported consistently across carriers. Errors in reporting of tier enrollment were observed by the project team, and corrections were recommended whenever carriers were requested to resubmit data.

CHAPTER 3: SCHOOL DISTRICT-SPECIFIC DATA

293 school districts and 8 carriers participated in the K-12 Data Collection Project. School districts paid $1.044 billion in annual premiums, as reported as of the snapshot date of October 1, 2012. 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.*

Total Premiums as Reported by School Districts	Total Dollars	Percentage of Total
Total Premium	$1,044,700,331	100.0%
Total School District Contribution	$838,077,886	80.2%
Total Employee Contribution	$206,622,445	19.8%

Table 4 – Total Premiums reported by School Districts

The table below shows the average contributions as reported by school districts as of the snapshot date.

Contributions as Reported by School Districts	Full-Time Employees	Part-Time Employees
Ratio of Family to Employee Contributions	7.3	4.6
Contributions as a Percentage of Premium Employee Coverage	6.0%	11.7%
Contributions as a Percentage of Premiums Employee & Family Coverage	28.9%	34.7%

Table 5 – Contributions by Tier

Note: 20 school districts have negative contributions that appear to be a submission error; 91 employee records are affected. The impact is not material; however, this error has not been corrected as of the writing of this report.

The table below shows the average premiums by health plan (Exhibit A14), as reported by the carriers, for all plan years ending in 2012. 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)).

Category	Premium (PEPM)
Low	$427.52
High	$1,454.47
Average	$878.55

Table 6 – Employee Premiums

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 breakdown 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 calendar year 2012. The carriers reported 408 separate health plans provided during 2012. One carrier reported 261 distinct plans. These include plans for plan years ending in 2012 (plans offered in the 2011–2012 school year) and plans beginning in 2012 (plans offered for the 2012–2013 plan year). In other words, these plans straddled two years.

Of the total plans reported 408 were presented with benefit descriptions, 336 were reported with financial information (that is, enrollment, premiums, claims data, and so on), and 408 provided the requested plan actuarial values. In some cases, when resubmitting their data, carriers presented new plan code data without cost-share information, or plans without any enrollment, creating the disparity in the number of plans. The timing of the reporting may also create differences in reported numbers.

The plans were combined under 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 138 reported benefit packages with calendar year data (see A8 series Exhibits). For plan years ending in 2012 there were 134 benefit packages reported with utilization data, demographics, and carrier administration fees. This is consistent with the required data reporting requirements.

The summary of the report Data Call results for carrier reported information for calendar year 2012 plans and data reported for plan years ending in 2012 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 2012 are compared to premiums paid for calendar year 2012. We would expect some variations in results if the data was presented for the same reporting periods, results are expected to be reasonably consistent.

In 2012, claims were running at 91.4% of premium. Administration costs represent 9% of premium ($93.4 million) of which carrier administration represents 5.9% 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 would be expected. 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.

Category (CY 2012)	Amount
Average Monthly Employees (A9a)	104,431
Average Monthly Members (A9a)	211,053
Premiums (A8d)	$1,040,579,047
Claims Paid (A8c)	$951,000,370
Loss Ratio	91.4%

Table 7 – Enrollment, Premiums, and Paid Claims

Category	Amount	Percentage of Total Premium
Administration Fees for Plan Years Ending in 2012		
Taxes	$24,448,411	2.3%
Agent Payments	$7,082,151	0.7%
TPA Payments	$11,697	0.0%
PPO Access Fees	$228,728	0.0%
Carrier Administration	$61,694,300	5.9%
Total Administration (A12a, A12b)	$93,465,287	9.0%
Reserve Reported for Plan Years Ending in 2012		
IBNR Reserves	$62,857,719	6.0%
Other Reserves	$31,479,976	3.0%
Total Reserves (A13)	$94,337,695	9.1%

Table 8 – Administration Fees and Reserves

Below is additional information with regard to the distribution of plan enrollment by type of plan. Note that enrollment is based on carrier data for plan years ending in 2012. The school district enrollment by types of plans offered is shown in the following table.

Plan Type	Employees	Percentage of Total
PPO	83,192	79.8%
HMO	16,698	16.0%
In-Network	3,677	3.5%
Closed Network	709	0.7%
Total	104,276	100.0%

Table 9 – Enrollment by Plan Type

The following table indicates the actuarial value of reported school district plans for all plans in calendar year 2012. Of the 408 reported, 29 (7.1%) have a reimbursement value less than 80%; 254 plans (62.3%) show a value of 80% or greater but less than 90%, and 125 plans (30.6%) show a value greater than 90%.

Actuarial Value	Number of Plans	Percentage of Total
0.67	1	0.2%
0.69	3	0.7%
0.72	1	0.2%
0.73	1	0.2%
0.74	1	0.2%
0.75	6	1.5%
0.76	3	0.7%
0.77	2	0.5%
0.78	7	1.7%
0.79	4	1.0%
0.80	30	7.4%
0.81	1	0.2%
0.82	6	1.5%
0.83	19	4.7%
0.84	8	2.0%
0.85	21	5.1%
0.86	70	17.2%
0.87	38	9.3%
0.88	15	3.7%
0.89	46	11.3%
0.90	11	2.7%
0.91	47	11.5%
0.92	11	2.7%
0.93	8	2.0%
0.94	11	2.7%

Actuarial Value	Number of Plans	Percentage of Total
0.95	33	8.1%
0.96	3	0.7%
0.97	1	0.2%
Total	408	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 of K-12 school district plan values to the values associated with healthcare plans defined under the Health Care Act, also known as the, Affordable Care Act (ACA), revealed that 77.2% of school districts (315) have "Platinum"–level benefits, 21.1% of plans (86) have "Gold"– level benefits, and the remainder of plans 1.7% (7 school districts) have "Silver"–level benefits. No plans had "Bronze"–level benefits.

Metal Level	AV Range	Number of Plans	Percentage of Total
Bronze	0.55 – 0.65	0	0.0%
Silver	0.65 – 0.75	7	1.7%
Gold	0.75 – 0.85	86	21.1%
Platinum	0.85 – 1.00	315	77.2%
Total		408	100.0%

Table 11 – K-12 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 K-12 school district and carrier health benefit plan data to be collected 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 the cost of 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. These goals can only be achieved based on access to the type of highly detailed information that this report and its exhibits provide.

The success of the Data Collection project has been described in this report: there was an unprecedented level of school district participation (293 out of 295 school districts), and 100% of carriers that received the Data Call reported the required data.

This report has summarized Treinen's engagement approach to gathering information and data to meet the requirements of ESSB 5940. The approach included:

- Gathering of initial input from key stakeholders, the HCA and JLARC, and carriers with regard to healthcare reporting requirements of ESSB 5940 prior to publication of the state's rule-making document
- Development of a formal engagement process including preliminary pilots to test the various components of the Data Calls
- Development of a formal Data Call with instructions document and a Data Collection Spreadsheet. The Data Collection Spreadsheet was used for reporting the data required by ESSB 5940
- Engagement with school districts and their respective insurance carriers to collect the required data
- Design and development of a database to hold the collected data, and of a computer application that would allow collected data to be viewed, processed and managed
- Ongoing feedback provided to, and obtained from, key stakeholders, carriers, and the OIC
- Presentation of illustrative data—the legislative report "mock-up" exhibits were used throughout the collection process to gain acceptance and agreement with the OIC and key stakeholders, and to develop the final data report content and Data Call exhibits

The data provided by school districts and carriers are detailed in the appendices, and are presented as a series of exhibits. An explanation of each exhibit follows.

This report includes a description of variations in the data, and of potential errors and defects that may have been mitigated or may still exist. Nevertheless the integrity of the data appears very good. Some information is not useful, for instance, school district-reported administrative costs (A12e, f, g, h). This may be because there was no uniform reporting of school district administration data, and the information provided by school districts in reference to school district administrative costs was incomplete.

Caution should be exercised in attempting to compare data across exhibits of this report. There are differences in results, enrollment, premiums, plans, and other data. This is attributable to:

- Different data sources (carrier versus school district);
- Reporting time period of the data including calendar year 2012, plans ending in 2012, data from both plans ending in 2012 and beginning in 2012, and reporting data based on a snapshot date of October 1, 2012 for school district reporting;
- Carriers are required to report all plans in effect in 2012; thus, they reported active and inactive plans; this reporting therefore cannot perfectly align with school district plan reporting;
- School district plan names and carrier plan names are not matched 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, the K-12 Health Benefits Data Collection Project met with an unprecedented level of participation, and gathered information that is very accurate and reliable. For these reasons, the project team believes that this report and its supporting exhibits contain data that will assist school districts and carriers in meeting the requirements of ESSB 5940.

Further, the data collection results are intended to support decision-making, legislative efforts and goals to affect K-12 purchasing by providing improved access to health information across 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 the 2012 calendar year, other exhibits are presented with data for plan years ending in 2012, or for all plan years in 2012, or a snapshot date (October 1, 2012). 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 and carrier health-plan numeric codes have been separately assigned. One 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 data presented herein relied primarily on carrier source data. Further, all carrier health-plan names and/or codes were initially matched to the cost-share plan summaries submitted by each carrier to Treinen outside the formal Data Call.

Treinen relied on the data supplied by the school districts and the K-12 carriers, including HMOs. While Treinen has reviewed the data for reasonableness overall, it has not been audited. Some exhibits have fields with no data or the data is not reported according to the Data Call instructions. There has been no attempt to investigate why some fields are blank. In some cases, no data was submitted or the data may have been allocated to a different field within the same exhibit and not available separately.

In addition, occasionally, the fields shown in exhibits are blank because there was no applicable data to report. Attempts have been made to correct defects from carriers or school districts. As a rule however, Treinen cannot change any carrier or school district submissions or modify the database to make corrections without express consent or agreement. As such, reporting errors may exist in the data and they may not have been corrected. Text formatting or spelling errors submitted have not been edited.

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 2012 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 408 plans in their plan information for all plans offered in 2012. 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 calendar year 2012. This list of plans includes plans ending in 2012 and beginning in 2012. The legislation requires reporting of data for calendar year 2012. This list shows that there are 408 K-12 health plans reported by carriers in 2012. 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 plan years ending in 2012. The exhibit shows employee, dependent and total member enrollment. Total enrollment reported for benefit packages combined is 104,276 employees and 210,644 members.

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 2.02 members per family. This data was reported by the carriers for plan years ending in 2012.

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 100,748 employees, which is somewhat lower than report by carriers at 104,276 (Exhibit A3). Discrepancies are expected due to differences in reporting period or date and source data. This data was reported by school districts based on census as of the snapshot date October 1, 2012.

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 132,688 members whereas carriers reported 210,644 members (Exhibit A3).

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 the 2012 calendar year (that is, plans ending and beginning in 2012). Exhibit A5a provides a one-page summary of each health-plan design for the plan years with beginning and ending coverage periods for plans offered in 2012. Exhibit A5b shows each plan's actuarial value, 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

The 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 per member per month (PMPM) in descending order. Reported employees total 104,276, and members total 210,644 for all school districts combined. The average PMPM cost was $364.65. The highest cost school district is shown at $822.56 PMPM, compared to the lowest cost at $216.89 PMPM. Carrier reported

medical premiums, exclusive of administration fees, totaled $921,736,603 for plan years ending in 2012. There has been no review of the data to determine the basis for the differences in premium costs other than expected differences attributable to plan design, pricing, and enrollment mix reported by K-12 carriers. The data is for all plan years ending in 2012.

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 family contributions on average are 7.3 times the contribution of employees; for part-time employees, family contributions on average are 4.6 times the contribution of employees. On average, full-time and part-time employees contribute 6.0% and 11.7% respectively to the average cost of premiums compared to family contributions at 28.9% and 34.7% respectively. This data is based on the school district census as of the snapshot date October 1, 2012.

Note: 20 school districts have negative contributions for one or more employees in their populations. This affects 91 employees. This negative contribution is a data submission error and has not been corrected as of the writing of this report.

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

The A8 series exhibits provide financial performance for the calendar year 2012 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 exhibits. All the A8-series exhibits are presented by benefit package. Total premiums for calendar year 2012 are reported at $1,040,579,047 for all benefit packages combined, compared to total paid claims of $951,000,370. This generated a paid claims loss ratio, which is a comparison of claims to premiums, of 91.4% for calendar year 2012.

Appendix 9—Experience Reports by Benefit Package

The A9 series exhibits show financial data for calendar year 2012, as well as utilization metrics for plan years ending in 2012. 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 22.1% of total paid claims, outpatient 18.3%, ER 3.4%%, professional services 34.3%, and pharmacy 16.6%. Total claims were $951,000,370 for the period.

Exhibit A9b shows claims paid per employee per month (PEPM). Total average employee enrollment during the calendar year was 104,431 employees; premiums averaged $830.35 PEPM and, total claims averaged $758.87 PEPM.

Exhibit A9c shows claims paid per member per month (PMPM). Total average member enrollment during the calendar year was 211,053 members; premiums averaged $410.87 PMPM and, total claims averaged $375.50 PMPM.

The remaining exhibits provide a breakdown of utilization metrics for the plan years ending in 2012, 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, financial measures monthly for calendar year 2012, Exhibit A9g, and the monthly measures reported PEPM, and Exhibit A9h PMPM.

Appendix 10—List of Large Claimants by Major Diagnostic Categories

This is a list of 830 large cases defined as aggregated claims per claimant in excess of $100,000 for plan years ending in 2012. The large cases average about $196,601 per claimant and represented about 17% of paid claims. The claims are reported by major diagnosis categories for diseases, injuries, and other conditions. The reporting period is for plan years ending in 2012.

Appendix 11—Demographics by Benefit Package

This exhibit reports the corresponding demographics associated with each benefit package for plan years ending in 2012. There were 134 benefit packages reported.

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

Each carrier reported its administrative fees for plan years ending in 2012. These fees were broken down into several component parts. Data requested included premium taxes payable for insured plans, any WSHIP assessments, or any other government taxes or assessments; commissions paid to agents, brokers or consultants; any other third-party administrative (TPA) fee; PPO access fees, if any; and carrier administration fees. Results show total administration was $74.69 PEPM (Exhibit A12a) and $36.99 PMPM (Exhibit A12b) for the reporting period. Total administration fees of $93.4 million were reported and they represented 8.98% of total premium for plan years ending in 2012. Of this amount, 0.68% ($7 million) was payable to agents, brokers, or consultants; 2.35% was payable for premium taxes and other assessments; and 5.93% ($61.7 million) was 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 purchased separately by school districts; therefore Exhibit A12d reports no data except total employee and member enrollment by carrier. Carriers reported 109,327 employees and 212,930 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. The Data Call instructions did not include instructions as to how school districts should report this information. Exhibit A12e reports total administration, Exhibit A12f reports this information on a PEPM basis, and Exhibit A12g reports it on a PMPM basis. School districts were asked to include a description of internal administrative expenses and

school district staff costs allocated to employee benefits (Exhibit 12h). The exhibit is incomplete. Most school districts were unable to provide this information.

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 plan years ending in 2012. One reserve to identify 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 adjusted to an incurred basis to determine the appropriate level of IBNR reserves, which is not required with the Data Call.

The other reserves required to be reported include premium or rate stabilization reserves (PSR/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 plan years ending in 2012, paid claims were reported at $920,491,200 and, total IBNR reserve liabilities were reported at $62.8 million. IBNR reserves are about 6.8% of paid claims, less than one month's paid claims. PSR/RSR reserves were reported at $31.5 million, about 3.4% 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, EF) for plan years ending in 2012. 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 $878.55 per month for plan years ending in 2012. The lowest and highest composite premiums across school districts are also reported at $427.52 and $1,454.47 respectively. This information was provided by the carriers.

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

This exhibit reports information by school district as of October 1, 2012, the snapshot date, and shows the average total monthly rates by coverage tier. Also shown are the total monthly premiums by school district. This was provided by the school districts.

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

This exhibit 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 $166.98, or $206,622,445, based on 103,116 employees as of the snapshot date of October 1, 2012. Some school districts showed negative payroll deductions, which is due to errors in reporting. At the writing of this report those contributions have not been validated or corrected. This information was provided by the school districts.

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

This exhibit shows the school district contributions for each coverage tier. The reported monthly composite contributions for employee and family coverage combined was $677.29, or $838,077,886, based on 103,116 employees as of the snapshot date of October 1, 2012. This information was provided by the school districts.

Appendix 18—Summary of Innovative Plan Features All Plans Combined — Exhibit A18a Carrier Responses and 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 calendar year 2012 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 text responses have not been formatted, corrected, or edited.

Appendix 20—Glossary of Acronyms

Acronyms used throughout these exhibits are explained herein.

Appendix 21—Traceability Matrix Crosswalk: Exhibit A21a Carriers, Exhibit A21b School Districts, and Exhibit A21c Definitions

The "Traceability Matrix" traces the requirements outlined in ESSB 5940 to particular data elements and sources of information (carrier or school district). The traceability document provides an overview and the context for the information collected. The traceability document will be revised periodically based on changes in the Data Call instructions over time.

Appendix 22—Report Contributors

This Exhibit includes a list of the Treinen Associates consultants who contributed to the creation of this report.