Office of the Insurance Commissioner

K-12 School District

Health Benefits Information and Data Collection Project

Year 2 Report to the Washington State 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 2 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 as specified in Sections 4 and 5 of the law. The OIC competitively procured technical consulting assistance in support of this project and in August 2012 selected Treinen Associates, Inc. (Treinen). ESSB 5940 provides for data collection over a three-year period; this report addresses Year 2 of the project.

The project requires Treinen to gather employee census and benefit information from the 295 K-12 school districts, as well as K-12 employee healthcare data (claim experience, benefit plan information, and enrollment) from the carriers that provide health insurance to the school districts, including self-insured plans. K-12 school district healthcare benefits cost the state approximately $1.03 billion in calendar year 2013.

Project outcomes for Year 2 are presented within two major components: the Report to the Legislature (this document) and the supporting exhibits summarizing the actual data collected (included as appendices).

The legislation requires a report 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, 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 employees and their family members. However, certain data exhibits report (aggregated) district-specific information including enrollment, premiums, and employee contributions by health plan.

In Year 2, all K-12 school districts and their medical insurance carriers submitted data as stipulated by ESSB 5940. The project included formal Data Calls sent to all K-12 school districts and carriers requesting data related to school district health benefits arrangements during 2013. (Please see point 2 within the subsection entitled “Variations in Carrier Data” within Chapter 2 for an explanation of the timespans involved in the project.) For Year 2, the required data was received and processed from all 295 school districts and nine carriers within the timeframes requested.

This report presents aggregated data derived from the substantial amount of raw data that was submitted by the school districts and carriers that participated in Year 2 of the K-12 Health Benefits Data Collection Project. All data provided by the participants (school districts and their carriers) was self-reported. The scope of work was only to collect the required data. The OIC was not charged with interpreting or evaluating the data.

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 collected data has not been audited for accuracy; however, many automated validations (described in detail below within the subsection entitled 'Data Validations', and in further detail within appendices 23a and 23b) were applied to the collected data. These validations caught innumerable errors and inconsistencies and resulted in many carriers and school districts correcting and resubmitting their data.

The data collected from carriers involved only employee health benefit plans. Data collection excluded other types of employee benefits such as life insurance and disability insurance. For the purposes of this project, employee health benefit plans include medical and pharmacy plans, but *exclude* separately purchased dental and vision plans and other types of insurance benefits.

The data collected from school districts involved employee health benefit plans, but districts were also required to report the aggregated cost of separately purchased dental and vision plans. (For further discussion of this topic please see the notes on the following pages concerning the contents of Chapter 2, as well as the sub-section entitled "Stakeholder Engagement – HCA" within Chapter 2).

The Purpose and Background section of this report outlines the purpose of ESSB 5940, describes the scope of this report, identifies the authorized contractor, acknowledges the contributions of stakeholders and participants, and describes the contents of the rest of the report (as specified under RCW 48.02.210 ***"School District Health Insurance Benefits–Annual Report").*** 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 that was executed in support of the data collection effort. 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.
- All 295 K-12 school districts submitted data.
- Nine carriers provided data for 764 health plans covering 200,785 K-12 school district members (employees and dependents) and reported health premiums of $1.02 billion for calendar year 2013.
- This project did not entail a detailed reconciliation of the self-reported data between carriers and school districts. Although some reasonableness checks and cross-validations across the two data sets were performed, errors or inconsistencies in the source data may persist.
- 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 were expected, and are due in large part to the timing of data being reported (this topic is discussed in detail within the subsections entitled 'Variations in District Data' and 'Variations in Carrier Data' within the section

relating to SOW 9 within Chapter 2). These variations do not constitute a data integrity issue.

It should also be noted that while districts accurately collect, maintain and report employee-level enrollment data, information about dependents (whether covered, or eligible but uncovered) is not consistently maintained or reported by districts. This is reflected in district-reported member counts (please see, for example, exhibit A6a) which vary substantially from carrier-reported member counts.

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

- Gathering early input from the HCA with respect to the collection of data about vision and dental insurance. In response to the HCA's request, the OIC instructed Treinen to collect additional summary data from school districts about their total spend on premiums for vision and dental insurance. (For further details, please see the sub-section entitled "Stakeholder Engagement – HCA" within Chapter 2).
- Substantially revising and improving the custom-built toolset that was used in Year 1 by districts and carriers to submit data to the project team. Toolset enhancements for Year 2 concerned:
    - The design of the database that was constructed in Year 1 to house the collected data;
    - The carrier Data Collection Spreadsheet and Carrier Instructions, and the district Data Collection Spreadsheet and District Instructions;
    - The data transport mechanism by which districts and carriers submitted their data and received detailed error notifications from the project team; and
    - The custom-built computer application that allows the project team to process and manage submitted data.

  Please see Chapter 2 for a detailed discussion of Year 2 project toolset improvements.
- Leveraging the information technology and data assets of the Washington Schools Information Processing Cooperative (WSIPC). This organization provides IT services and infrastructure, as well as integrated software solutions for the management of school districts, to member school districts. In Year 2, WSIPC made substantial improvements to the IT tools provided to member districts to produce the relevant health plan and employee census data.
- Designing, building and testing automated data validations. Programmatic validations were then performed on submitted data (these are described in detail later in this document, as well as in Appendices 23a and 23b). The data was also manually checked for reasonableness. Some corrections were necessary in order for the data to pass the validations and be loaded to the project database. All corrections were carefully documented, and approval was in all cases provided by the submitting entity.
- Refining our understanding of the school district and carrier information required to meet legislative goals described in ESSB 5940, and translating this into a better database design and a better data collection toolset.
- Collecting and processing carrier and district data.

- Building statistical summaries (i.e. exhibits) based upon the collected data, which shows 104,998 employees and 201,887 members with combined premiums of $1.03 billion. Note: differences in reporting across exhibits are attributable to the reporting period, and to changes in enrollment, premiums, etc., across different reporting periods.

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

- Total premium dollars of $1.03 billion, of which school districts contributed on average 77.6% toward premiums, while employees contributed 22.4%.
- Average employee contribution, as a percentage of premium for full family coverage, was 31.8% for full-time employees and 38% for part-time employees.
- Average employee contribution, as a percentage of premium for employee-only coverage, was 8.3% for full-time employees and 14.3% for part-time employees.
- For full-time employees, the average employee contribution for ED (employee plus dependent) coverage (i.e. any coverage other than employee-only) was $333.02, whereas the average employee contribution for employee-only coverage was $56.54. Hence, for full-time employees, the ratio (in terms of employee contribution) of ED coverage to employee-only coverage was 5.9 : 1.
- For part-time employees, the average employee contribution for ED (employee plus dependent) coverage (i.e. any coverage other than employee-only) was $372.27, whereas the average employee contribution for employee-only coverage was $89.87. Hence, for part-time employees, the ratio (in terms of employee contribution) of ED coverage to employee-only coverage was 4.1 : 1.
- For both full time and part time employees, the ratio (in terms of employee contribution) of full family coverage to employee-only coverage was 8.8 : 1.
- As reported by the carriers for plan-years ending in 2013, the average premium for all health plans combined, for employee and dependent coverage, was $814.27 per month. The lowest reported premium was $106.83 per month; the highest reported premium was $1,690.09 per month.

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

- Carriers reported 764 separate health plans provided during 2013.
- Average monthly enrollment for calendar year 2013 was 104,286 employees and 200,597 members (members are defined as employees and dependents combined).
- Total premiums paid during calendar year 2013 were $1.02 billion.
- Claims paid during calendar year 2013 were $939.8 million, generating a paid claims loss ratio of 92.2% in 2013. The loss ratio is based on total paid claims divided by the total premiums.
- Administrative costs totaled $96.7 million or approximately 9.5% of the $1.02 billion in reported premiums.
- Of the $96.7 million in administrative costs:
    - Broker commissions were $6.6 million (about 6.8% of administrative costs).

  - State premium taxes and other assessments were $25.4 million (about 26.2% of administrative costs).
  - Carrier administration was $64.6 million (about 66.8% of administrative costs)
  - Network access fees of $0.2 million comprise the remainder of the total administrative costs (0.2% of administrative costs)

- Reserves for Incurred But Not Reported (IBNR) liabilities totaled $52.4 million (about 5.1% of premium). *Note: IBNR reflects the total amount owed by the insurer to all valid claimants who have had a claim however the claims have not yet been reported. Since the insurer knows neither how many of these claim losses (the frequency) have occurred, nor the severity of each loss (the amount), the IBNR liability is an estimate.*
- Other reserves for claims and rate stabilization totaled $5.8 million (about 0.6% of premium). *Note: A Claims or Rate Stabilization Reserve (CSR or RSR) is applicable to a carrier rating pool. A CSR or RSR is used as a hedge against unexpectedly frequent or severe claims.*
- Also presented are the actuarial values of the 764 plans offered in calendar year 2013. The range of actuarial values of school district plans was 0.5495 to 0.9571. *Note: Actuarial value is the expected reimbursement by a plan of medical expenses. For example, a value of 0.97 would indicate that a plan, on average, covers 97% of expected medical expenses; some individuals see reimbursements that are more or less than the actuarial value.*

Chapter 5 recaps the Year 2 Data Collection Project:

- Summarizes the keys to project success, acknowledges the project participants, authors and contributors and provides an introduction to the detailed data in the appendices.
- Overall, the K-12 Health Benefits Data Collection Project met with an unprecedented level of participation and gathered accurate and reliable information. For these reasons the project team believes that this report and supporting exhibits 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 annually submit certain information, specified in detail below, with respect to each "health plan[3]" or "benefit package[4]" offered to district employees. This information is submitted to the Office of the Insurance Commissioner (OIC). The data presented in this report is specified in Sections 4 and 5 of ESSB 5940, which authorizes the OIC to collect the required data and produce an annual report to the Legislature.

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

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" as described in the Data Call and referred to herein, includes medical care and pharmacy services only.*

The data provided with this report relates to the 2013 calendar year. The data was submitted based on the overall plan summary and financial performance of each "health benefit plan" across carriers and school districts. This report includes a summary of each school district's health benefit plans and aggregated financial data and other information[6]. It does not include dental or vision information or employee-pay-all voluntary plans.

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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

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

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

ESSB 5940 also requires that by December 1st, 2013, and December 1st of 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 (www.insurance.wa.gov).

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 were found in the submitted data.

This report does not address areas of legislative or contractual compliance across carriers or school districts. However, of the nine carriers contacted, 100% submitted data as requested. All 295 school districts contacted responded to the data request.

The OIC 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. (Treinen) as a technical consultant to prepare this report on behalf of the OIC for Year 2 of the project.

HCA is responsible for analyzing the data and information collected by the OIC over a two-year period.

This report to the Washington State Legislature, together with the associated exhibits, constitutes the outcome of the data collection and reporting activities for Year 2 of the K-12 School District Health Benefits Data Collection Project.

Non-Disclosure

To maintain the confidentiality and privacy of information of school district employees and their dependents, ESSB 5940 does not require reporting of Individually Identifiable Health Information (IIHI) or Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA). To further protect privacy, data reporting is aggregated by health plan. In addition, aggregation across multiple school districts and plans was permitted for smaller school districts or plans with similar

benefits or similar actuarial values. Aggregated information is reported by carriers as "benefit packages" consisting of one or more health plans across multiple school districts.

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

Contracts or Agreements with K-12 School Districts

ESSB 5940 requires that any contract or agreement for employee benefits executed after April 13, 1990 between a school district and their health insurer or employee bargaining unit would be ***"null and void"***[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

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

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

- Design and build a database to house the collected data.
- Design and build a computer application allowing collected data to be viewed, processed, and managed.
- Design and build a suitable vehicle for data collection (which became the school district and carrier Data Collection Spreadsheets).

[7] ESSB 5940 Section 4(1)

- Prepare Data Call instructions for school districts and for carriers.
- Develop a formal engagement process including preliminary pilots to test the various components of the Data Calls.
- Engage with key stakeholders.
- Engage with school districts and their respective insurance carriers or plan administrators in order to collect the required data.

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 2 and is summarized in this report.

Definition of Terms

Year 2 of the OIC K-12 Health Benefit Data Collection Project is referred to throughout this document as "the project."

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

Treinen Associates Inc. may be abbreviated within this document as "Treinen."

The "Data Call" referred to throughout this document is the act of broadcasting to school districts and to their insurance carriers, including HMOs, a request for data relating to health benefits for K-12 employees. The Data Call consisted of a Data Collection Spreadsheet, a set of instructions, and a cover letter. The Year 2 Data Call was issued on January 30, 2014.

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)
- School districts Personnel (Superintendents, Office Managers, Financial Staff, etc.)
- All nine Educational Service Districts (ESDs)

- The Washington School Information Processing Cooperative (WSIPC)
- The Office of the Superintendent of Public Instruction (OSPI)
- K-12 Insurance Carriers, HMOs, and Administrators: Aetna, 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 2 health care 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; and

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

Attached to 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

[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".

all exhibits is summarized to protect school district employee Protected Health Information (PHI), as defined by HIPAA.

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:

- 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; and

d. To provide greater parity in state allocations for state employee and K-12 employee health benefits.

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

Data Validation

For Year 2 the project team designed, built, tested and implemented a series of data validations to ensure data quality. These validations are categorized as follows:

- Category 0 – These validations perform basic edits like ensuring required fields are completed, the data types are correct (i.e. numeric, currency, etc.) and other data integrity checks.

- Category 1 – Specific validations on individual data elements – for example: Ensuring Plan Year Ending is in 2013.

- Category 2 – Complex validations within a single submission – for example: The sum of monthly premiums reported in Section X equals the total premiums reported in Section Y.

- Category 3 – Comparisons with prior submissions within a project year – for example: Ensuring amounts do not vary more than a specified percentage between submissions.

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

- Category 4 – Comparisons between carrier and school district submissions within a project year – for example: Ensuring enrollment counts and premiums do not vary more than a specified percentage between carriers and school districts.

The vast majority of the Category 0 validations are encapsulated within the "Check My Spreadsheet" macro of the carrier and district Data Collection Spreadsheets. After the Data Call was issued (including the Data Collection Spreadsheets containing the "Check My Spreadsheet" macro) the project team identified additional Category 0 validations. Since the Data Call had already been issued, these additional Category 0 validations were performed within the OIC application itself. Note: In Year 3 of the Data Collection project the additional Category 0 validations will be included in the "Check My Spreadsheet" macro.

Category 1, 2, 3 and 4 validations are all contained within the OIC application. Considerable flexibility has been built into our approach to data validation on the application side:

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

Please see Appendix 23 for a detailed description of the Year 2 data validations.

CHAPTER 1: K-12 CURRENT HEALTH PURCHASING OPTIONS

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

There are 295 school districts statewide with a wide variety of benefit plans, obtained directly through insurers, or through the Washington Education Association (WEA), or through the Public Employees Benefits 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 WEA, or as part of community-rated plans, and risk or rating pools established exclusively for K-12 school districts.

The data collection project received school district data from all 295 school districts covering 104,998 employees and 201,887 members.

The data collection project received carrier data from nine reporting carriers, inclusive of PEBB. The carriers reported total medical premiums of $1,019,002,441 and reported 764 health plans offered in 2013, including terminated plans and unused plans. Financial data (enrollment, premiums, and claims) was provided for 764 health plans covering 104,286 employees and 200,597 members for the 2013 calendar year. The carriers provided actuarial values on 764 plans.

Note: Small differences in the premium and enrollment numbers as reported by the carriers, as opposed to those reported by the districts, is generally due to the timing of the counts and do not represent a data integrity issue. Carriers reported somewhat higher enrollment numbers in aggregate; while enrollments summarized from the plan-level data or from school districts are slightly lower. Note that school districts accurately maintain (and report) employee member data, but do not consistently maintain (or report) dependent member information. As a result, carrier-reported data may be considered as more accurate than district-reported data with respect to member counts.

The nine reporting carriers include:

- Aetna
- Group Health Cooperative
- Kaiser Permanente
- KPS Health Plans

[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.

- Premera Blue Cross
- Providence Health Plans
- Regence BlueShield
- United Healthcare
- The Public Employees Benefits Board (PEBB), which sponsors plans administered by Group Health, Kaiser and Regence

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

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

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

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

School Districts by Size		
District Size Range	**Number of Plans**	**Percentage of Total**
1 – 50	99	33.6%
50 – 150	74	25.1%
150 – 300	37	12.5%
300 – 450	24	8.1%
450 – 600	13	4.4%
600 – 750	9	3.1%
750 – 1,000	10	3.4%
1,000 – 1,500	10	3.4%
1,500 – 2,000	7	2.4%
2,000+	12	4.1%
Total	**295**	**100.0%**

Table 1 –School Districts by Size

School District Enrollment by Carrier			
Table 2 Carrier	Employees	Members	% of Total Members
Carrier 1	65,244	124,937	61.9%
Carrier 2	20,309	39,496	19.6%
Carrier 3	11,388	21,026	10.4%
Carrier 4	3,629	7,225	3.6%
Carrier 5	330	607	0.3%
Carrier 6	1,132	2,214	1.1%
Carrier 7	1,556	3,082	1.5%
Carrier 8	1,217	3,037	1.5%
Carrier 9	193	263	.1%
Total	104,998	201,887	100.0%

Table 2 – School District Enrollment by Carrier

Enrolled Employees by Plan Type		
Plan Type	Employees	Percentage of Total
PPO	82,036	78.5%
HMO	19,695	18.8%
Traditional	2,076	2.0%
Closed Network	712	0.7%
Total	104,519	100.0%

Table 3 – Enrolled Employees by Plan Type

Note: As reported by the carriers, the combined total number of employees by plan type (104,519) is lower than the combined total number of employees by carrier (104,998). The collected data shows variations in the number of health plans, reported premiums, and enrollment numbers, which generally reflect differences in the timing of the reporting, and do not constitute a data quality issue per se. For example, some plans offered to school districts in 2013 were not carried over into 2014, but are nevertheless reported on by the carriers, as required by ESSB 5940.

CHAPTER 2: DATA COLLECTION PROCESS AND RESULTS

Introduction

As authorized under ESSB 5940, the data collection process for K-12 school districts in the State of Washington, and their medical carriers, involved sending a Data Call to all school districts and their medical insurance carriers. No data was requested directly from any other third party or intermediary.

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

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

A substantial portion of the total data collected originates from the carriers, which is to be expected because (a) ESSB 5940 requires more carrier-specific data, and (b) carriers generally have resources, systems, processes, and reporting capabilities that exceed those of most school districts.

The carrier Data Call was issued to only nine carriers, including PEBB, whereas the school district Data Call was issued to 295 school districts.

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

There was no attempt to "audit" the completeness or veracity of the data that was collected from either the carriers or school districts. However, in order to validate the internal consistency of collected data, five categories of automated validations were applied (please see the sub-section below entitled “Data Validation”), and the data was manually reviewed for reasonableness.

Resubmissions were required from both districts and carriers to correct reporting errors that were uncovered by the validations.

When submitted or resubmitted data was received, it was then loaded, using a toolset designed and built by the project team, to the project database.

Period of the Information Collected

The language of ESSB 5940 specifies the "prior calendar year[12]" to be the period of data to be collected. For Year 2 of the project this means calendar year 2013. 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 benefit plans frequently straddled two plan-years.

To obtain 12 months of data for 2013, carrier data reporting was for plan-year data ending in 2013 plus the remaining months in 2013 through December 31, 2013. For plans not aligned to a full calendar year, this required two different reporting periods in 2013. For example, for plan-years ending September 30, this required the capture of 2013 data through September 30, 2013, plus data for the remaining months of October, November, and December 2013. The remaining three-months of data represent data for the subsequent plan-year ending in 2014.

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 for the benefit of school districts, census data was collected from school districts based on a "snapshot date". The date selected was October 1, 2013, to correspond to the OSPI S-275 employee population reporting process.[13] 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, 2013. Some districts may have reported all participants within the month of October 2013, rather than as of the snapshot date, which does not materially change the data.

[12] ESSB5940 Section 4(2)

[13] 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.

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 1, 2013, 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 of the project 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), employee and spouse (ES), employee and children (EC), and employee and family (EF) – as well as school district and employee contributions, which together comprise the monthly total premium rates. Unit rates were accepted as of the snapshot date.

For some carrier data, the snapshot date is the plan-year ending date, typically the end of the school plan-year (September 30, 2013), particularly to capture reserve balances for rate or premium stabilization reserves (RSR or PSR reserves) or reserves for claims incurred but not reported (IBNR[14] 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) was reported by calendar year, plan-year, or annually by month depending on the availability, type, and source of the data. For annual school district totals by expenditure category or payee, amounts for the school fiscal year ending in 2013 were requested.

Statements of Work (SOWs)

SOW 8 – Data Call Preparation and Tooling

Under SOW 8, substantial revisions and improvements were made to the custom-built toolset that had been used in Year 1 by districts and carriers to submit data to the project team, and by the project team to process and store submitted data. The improvements in Year 2 were, in a spirit of continuous improvement, largely driven by feedback from districts and carriers based on their experience while using the toolset provided in Year 1. Toolset enhancements for Year 2 concerned:

- The Project Database.
  This was designed and built to house the data that would be collected in the course of the project. Significant improvements were made to the database design in Year 2, based on what the project team learned during Year 1.

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

- The Data Traceability Matrix *(included with this report).*
  This document traces the requirements (with respect to carrier and school district data) that are outlined in ESSB 5940 to tables and data elements within the project database. This document was updated in Year 2 to reflect all changes to our database design. (In future years of the project, the Data Traceability Matrix will again be revised based on any subsequent changes to our database design.)

- The OIC Application.
  In Year 1, the project team designed, built and implemented a custom-built application (referred to elsewhere in this document as "the OIC Application") that allows submitted data to be reviewed, processed, and loaded to the project database; and provides a means of tracking school district and carrier data submissions and re-submissions. In Year 2, major improvements were made. The tool was made much more streamlined, efficient and automated, and far easier to use. One particularly invaluable set of enhancements allows the tool to 'harvest' submitted data and process it in a fully automated way, and to send confirmations and requests for corrections back to submitters of data with minimal human intervention.

- The Carrier Data Collection Spreadsheet and Carrier Instructions, and the District Data Collection Spreadsheet and District Instructions.
  Improvements included:
  i) Much clearer and more precise instructions;
  ii) Major enhancements in terms of ease-of-use;
  iii) The addition of two completely new Sections in the carrier Data Collection Spreadsheet (to capture cost sharing design and plan rates in a consistent, accurate and automated way);
  iv) The introduction of a tool within the Data Collection Spreadsheets named "Check My Spreadsheet"; this, as the name suggests, allowed users to perform pre-validations and get instant feedback on their data before submission, thus improving data integrity and shortening the submission/correction cycle; and
  v) The introduction of an 'authorized carrier list' that was enforced by the "Check My Spreadsheet" utility on the district side. This caused districts to identify their carriers in a consistent way, and ultimately allowed the project team to more easily cross-reference district data with carrier data.

- The Data Transport Mechanism.
  This was the technology used by districts and carriers to submit their data and receive confirmations and detailed error notifications from the project team. In Year 1 of the project we used e-mail with encrypted and password-protected attachments, whereas in Year 2 we used a very secure and reliable, third-party, web-based 'dropbox'-type service.

SOW 9 – Engagement

Engagement Model

The project planning document describes how the contractor intended to engage with stakeholders, and with entities that were to submit data, as well as the timelines, processes, and procedures for collection of the requisite data. Production of the Engagement Model commenced in September 2013.

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.

Activities related to the Engagement Model are described below.

Stakeholder Engagement - HCA

Early in the project the project team gathered input from the HCA with respect to the collection of data about vision and dental insurance. In response to HCA's request, the OIC subsequently instructed Treinen to collect additional summary data from school districts about their total spend on premiums for these types of insurance. The OIC also determined that:

- Districts need not submit detailed data about vision or dental carriers or plans, or about district employee enrollment in dental or vision plans.
- Districts need not submit detailed data about premiums, paid by or on behalf of individual employees, that are related to vision or dental insurance; only aggregated data would be collected from districts indicating the total district spend (including district and employee contributions) on vision and dental insurance.
- Carriers would not be required to submit any data concerning vision or dental insurance.
- This report would not be modified to include new exhibits concerning vision and dental insurance; instead, the vision and dental data would be included in the district data that would in due course be made available by the OIC to HCA.

Stakeholder Engagement - Office of Superintendent of Public Instruction (OSPI)

The Office of the Superintendent of Public Instruction (OSPI) is a key project stakeholder that in Year 2 (just as in Year 1) provided project-related information and guidance to the school districts. OSPI 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. In Year 2 no such action was necessary, as 100% of school districts responded to the Data Call and submitted compliant data within acceptable time frames.

In Year 2 of the OIC K-12 Data Collection Project, OSPI:

- Provided consultancy on the design and execution of the school district engagement.
- Published various materials and Q&As on their website, including links to information on OIC's website.

OSPI was included on all mass communications by the project team to the school districts.

Initial Outreach

In early December 2013 the project team contacted all school districts and their medical insurance carriers to let them know that the Year 2 project was under way, to advise them of the project schedule, and to let them know what was going to be different about the Year 2 Project.

District Dry Run Testing

The process included testing with a small subset of districts, as well as with WSIPC, prior to issuing the Data Call to all districts. The purpose of the testing was to examine the Data Call process, as well as the components of the Data Call. Feedback from the districts that participated in testing was incorporated into final versions of the artifacts that comprise the Data Call, and into the Data Call process.

School District Data Call

Introduction

The Data Call was sent to all 295 K-12 school districts. All 295 school districts provided data in compliance with the Data Call. The school districts reported 104,998 employees and 201,887 members, generating $1.03 billion in premiums.

Washington School Information Processing Cooperative (WSIPC)

School districts relied heavily on third-party reporting through the Washington School Information Processing Cooperative (WSIPC), which provides integrated software solutions as well as IT infrastructure and support to member districts (276 school districts out of 295). WSIPC hosts databases for the substantial majority of school districts in Washington State. WSIPC routinely provides extract routines that allow member school districts to comply with the reporting requirements of the Office of Superintendent of Public Instruction (OSPI).

Throughout the testing and data collection phases, WSIPC was instrumental in helping school districts comply with the reporting that is required under ESSB 5940. WSIPC provided software that allowed each district to extract much of the required data from their own independent database, which school districts then supplemented with additional information from other sources before submitting their data to the project team.

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

After the WSIPC extract was developed and tested, it was rolled out to member districts, which were able to run the extract on demand. In so doing WSIPC made a huge contribution to the success in Year 2 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 otherwise have been possible.

(Note: WSIPC is an umbrella IT organization encompassing Information Service Centers co-located within the Educational Service Districts, as well as several Regional Data Centers. It offers integrated software

solutions to member school districts in the form of WESPaC, a robust, third-party suite of applications designed to support the data processing needs of school districts, including operations, financial management, accounts payable and receivable, and payroll, among other functions. Each member school district runs their own version of WESPaC on their own virtual machinery within IT infrastructure that is provided and operated by WSIPC. Each school district has 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).

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 2013)

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 health 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 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 reporting on 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 2013, exclusive of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage.

Section 4: Carrier Health Benefit Plans

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

Section 5: Employee Groups by Classification

- This Section requested identification of each employee groups; in particular, classified and certificated employees for the 2012–2013 school year and the 2013–2014 school year.
- The health plans offered to each group of school district employees must be reported here (or in Section 6), thus allowing plans offered to be associated with employee groups.

Section 6: Medical Plans offered to Employee Groups

- This Section presented an alternative means of reporting health plans offered to each group of employees for the 2012–2013 and 2013–2014 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, 2013. Each school district employee appearing on the school district's OSPI S-275 report was to be listed.
- For each employee, the following data were collected:
  - The group the employee belonged to
  - An indication as whether the employee was classified or certificated
  - Gender
  - Date of birth (DOB)
  - FTE benefit status

- A 'Yes/No' indication as to whether, by the districts own local rules, the employee was benefits-eligible

- If an employee was eligible, and if a (medical) health benefit plan selection was made, the following data were collected:
  - Plan selection
  - Monthly contributions paid by the reporting school district
  - Monthly contributions paid by the employee
  - Total monthly premium (school district contribution and employee premium combined)
  - Coverage tier selection (Employee only (EE), employee plus spouse (ES), employee plus child (EC), and employee plus family (EF))
- Eligible dependents could be reported here, or in Section 8.

Section 8: Dependent Listing

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

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. All 295 school districts responded to the Data Call.

The reporting school districts provided census data as of the 'snapshot date' of October 1, 2013; carriers provided financial data for the 2013 calendar year. School district reporting shows total enrollment of 104,998 employees and 201,887 members (please see the A12 series Exhibits attached to this report). Carriers provided financial data on 104,286 K-12 employees and 200,597 members (see Exhibit A9a). School districts reported combined contributions generating $1.03 billion in premiums, while carriers reported $1.02 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 be attributed to:

- The high level of commitment from school districts to this effort;
- The role of WSIPC including (i) centralized hosting of databases for the substantial majority of school districts and (ii) provision of a universal data extract for participating districts;
- A team member dedicated to working closely with the school districts and to coaching individual non-pilot school districts as needed;
- The OIC's active participation and management of all aspects of the project; and
- 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 verification of submitted data, although the data was validated for internal consistency and manually checked for reasonableness. Some minor inconsistencies exist in the collected data but are statistically inconsequential. For example, district-reported enrollment and premiums do not exactly match the corresponding carrier data.

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 consistency across school districts in the use or reporting of plan codes or plan names.
2. 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).
3. Some school districts reported certificated and classified populations in unified groups. In these cases, the project team had to ask the district to resubmit, and to properly segregate employee groups. Minor inaccuracies in the school district data may persist with respect to certificated and classified employee groups.
4. Uncovered dependent information was available only from selected school districts that surveyed their populations for this data; thus, data on uncovered dependents is neither comprehensive nor complete across school districts. On a related note, while district reporting of employee enrollment appears to be accurate (in that it closely matches carrier-reported employee enrollment), district-reported enrolled membership (employees plus dependents) varies greatly from membership as reported by carriers. Hence, carrier-reported data concerning membership is deemed by the project team to be more reliable than district-reported data concerning membership.
5. Improved district Data Call processes require districts to use a predefined list of carrier names, which subsequently allows matching, at the carrier level, between the district data set and the carrier data set. However, matching on plan name or plan code continues to be impossible due to huge variations in how districts identify plans within their accounts payable and payroll systems, and consequently in how they identify plans in their submitted data.
6. School district data cannot perfectly align with carrier data because there are different periods for reporting data. Carriers were asked to report monthly, annually, or for plan-years ending in 2013;

whereas school districts were asked to report populations and premiums based on a single snapshot date of October 1, 2013.

7. Some information is not particularly useful; for instance, school district-reported administration (see Exhibits A12e, f, g, h). This may be because there is no standardization for uniform reporting of school district administration data.

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

Carrier Data Call

Introduction

Nine carriers, including PEBB (considered a "carrier" for the purposes of data collection), were identified as K-12 carriers and included in the 2013 Data Call. Carriers reported that they provide health coverage to 104,998 school district employees, 201,887 members for plan-years ending in 2013 (see Exhibit A12d). Actual carrier-reported financial data included 104,519 employees, 200,785 members generating $1.02 billion in premiums for the 2013 calendar year (see Exhibits A8f, and A9a).

Note: The actual carrier-reported financial data information varies 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 nine carriers reporting data in Year 2 include:

- Aetna
- 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.*

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" as detailed below.

Section 1: Carrier Annual Reporting (For Calendar Year 2013)

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 2013)

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 2013)

This Section required reporting of information on each unique health plan offered in 2013 by each K-12 carrier. The information requested included actuarial values[15], plan type, and other key attributes.

This Section established the linkage between Plan Codes and Costshare Codes, which are used in Section 10 to report the costshare design of (groups of) plans. Essentially, a Costshare Code identifies a group of plans that have the same cost sharing features.

The rates associated with individual Plans were not, in Year 2, reported in Section 4. This was instead done by means of the Rateset Code (see notes on Section 11, below). There may be a one-to-many relationship between Ratesets and Plans.

[15] 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 that a plan, on average, covers 90% of expected medical expenses. These values are calculated on a population basis so some individuals may see reimbursement at more or less than the actuarial value.

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

Section 5: Benefit Package Plan Year Performance (For Plan Year Ending in 2013)

This Section required reporting of performance data such as health plan premiums[16] and total claims expenses or paid claims[17] for the plan-year ending in 2013. 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 2013)

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 2013 plus the remaining calendar months (within 2013) of plan-years that began in 2013 and ended in 2014.

Section 7: Benefit Package Demographics by Plan

This Section required reporting of enrollment data by age tier (for employees and their dependents) such as gender, age, and enrollment. Carriers supplied this data based on pre-defined age-bands (for example, 0 to 19, 20 to 24, 25 to 29, and so on). The information was requested for each benefit package associated with plan-years ending in 2013.

[16] 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.

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

Section 8: Benefit Package by School District by Plan (For Plan Year Ending in 2013)

This Section required reporting of enrollment (headcount) data for each health plan by school district for the 12-month period ending in December 2013. This allowed for the mapping of a school district to a particular benefit package.

Section 9: Large Claims (For Plan Year Ending in 2013)

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

Section 10: Cost-sharing Design (New in Year 2)

In Year 1 the project team manually collated material supplied by the carriers in order to document the cost-sharing design of all plans offered to school districts. However, in Year 2 an entirely new Section was created to gather this information electronically from carriers. This Section gathers data on various types of deductibles, co-insurance, copays, and Rx-related plan attributes.

Section 11: Plan Rates by Rateset Code (New in Year 2)

In Year 1 the rates associated with plans were reported in a single column within Section 4. In Year 2, an entirely new Section was created that focuses explicitly on rates, and provides carriers with a mechanism to report rates by tier, and to group plans (which have identical rates) together by rateset code.

Carrier Data Collection Results

The data collection project received carrier data from nine 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 104,286 employees, and 200,597 members, generating $1,019,002,441 in premiums for the 2013 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 Enrollment Summary			
Carrier	**Employees**	**Members**	**% of Total Members**
Carrier 1	65,244	124,937	61.9%
Carrier 2	20,309	39,496	19.6%
Carrier 3	11,388	21,026	10.4%

Carrier Enrollment Summary			
Carrier	**Employees**	**Members**	**% of Total Members**
Carrier 4	3,629	7,225	3.6%
Carrier 5	330	607	0.3%
Carrier 6	1,132	2,214	1.1%
Carrier 7	1,556	3,082	1.5%
Carrier 8	1,217	3,037	1.5%
Carrier 9	193	263	0.1%
Total	104,998	201,887	100.0%

Table 4 – Carrier Enrollment Summary

Variations in Carrier Data

Variations may exist in the reported data. An explanation follows of variations in the carrier-reported data that may affect the information reported on the exhibits. Note that there was no verification of submitted data, although the data was validated for internal consistency and manually checked for reasonableness. Data is as reported and has been validated wherever possible. However, there may be some differences between district and carrier data for the following reasons:

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 2013. However, school districts track data on a school fiscal-year basis, and most carriers track data on a school district's plan-year basis. Thus, enrollments, premiums, contributions, and other data may not align between calendar year reporting, plan-year reporting, and the snapshot date used for school district reporting. Because of the different reporting periods between school districts and carriers, the data cannot perfectly align across these data sets.
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, subsequent 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

295 school districts and 9 carriers participated in the K-12 Data Collection Project. School districts paid $1.025 billion in annual premiums, as reported as of the snapshot date of October 1, 2013. 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.*

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

Contributions by Tier		
Contributions as Reported by School Districts	**Full-Time Employees**	**Part-Time Employees**
Ratio of Family to Employee Contributions	5.89%	4.14%
Contributions as a Percentage of Premium Employee Coverage	8.3%	14.3%
Contributions as a Percentage of Premiums Employee & Family Coverage	31.8%	38%

Table 5 – Contributions by Tier

The table below shows the average premiums and claims by health plan (Exhibit A14), as reported by the carriers, for all plan-years ending in 2013. These are employee composite monthly rates derived from premiums by coverage tier, weighted by the enrollment in each coverage tier to calculate the composite rates below (as Per Employee Per Month (PEPM)).

Employee Premium and Claims		
Category	**Premium**	**Claims**
Low	$106.83	$0.00
High	$1,690.09	$4,281.28
Average	$814.27	$750.94

Table 6 – Employee Premium and Claims

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

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

CHAPTER 4: CARRIER-SPECIFIC DATA

In order to comply with requirements of ESSB 5940, carriers had to report all health plans provided in calendar year 2013. The carriers reported 764 separate health plans provided during 2013. This included plans ending in 2013 (plans offered in the 2012–2013 school year) and plans beginning in 2013 (plans offered for the 2013–2014 plan-year). In other words, these plans straddled two years.

All 764 plans were presented with information related to benefit descriptions, financial data and plan actuarial values. 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 169 reported benefit packages with calendar year data (see the A8 series of Exhibits). For plan-years ending in 2013 there were 169 benefit packages reported with utilization data, demographics, and carrier administration fees. This is consistent with the required data reporting requirements.

The summary of the Data Call results for carrier reported information for calendar year 2013 plans and data reported for plan-years ending in 2013 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 2013 are compared to premiums paid for calendar year 2013. We would expect some variations in results if the data were presented for the same reporting periods; however, results are expected to be reasonably consistent.

In 2013, claims were running at 92.7% of premium. Administration costs represent 9.9% of premium ($96.7 million) of which carrier administration represents 6.6% 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.

Enrollment, Premiums, and Paid Claims	
Category (CY 2013)	**Amount**
Average Monthly Employees (A9a)	104,286
Average Monthly Members (A9a)	200,597
Premiums (A8d)	1,019,002,441
Claims Paid (A8c)	$939,751,642
Loss Ratio	92.2%

Table 7 – Enrollment, Premiums, and Paid Claims

Administration Fees and Reserves		
Category	**Amount**	**Percentage of Total Premium**
Administration Fees for Plan Years Ending in 2013		
Taxes	$25,351,606	2.5%
Agent Payments	$6,593,803	0.6%
TPA Payments	$0	0.0%
PPO Access Fees	$166,315	0.0%
Carrier Administration	$64,604,570	6.3%
Total Administration (A12a, A12b)	$96,716,294	9.5%
Reserve Reported for Plan Years Ending in 2013		
IBNR Reserves	$52,352,001	5.1%
Other Reserves	$5,767,950	0.6%
Total Reserves (A13)	$58,119,951	5.7%

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 2013. The school district enrollment by types of plans offered is shown in the following table.

Enrollment by Plan Type		
Plan Type	**Employees**	**Percentage of Total**
PPO	82,036	78.5%
HMO	19,695	18.8%
In-Network	2,076	2.0%
Closed Network	712	0.7%
Total	104,519	100.0%

Table 9 – Enrollment by Plan Type

The following table indicates the actuarial values of reported school district plans for all plans in calendar year 2013. Of the 764 reported, 91 (11.9%) have a reimbursement value less than 80%; 479 plans (62.7%) show a value of 80% or greater but less than 90%, and 194 plans (25.4%) show a value equal to or greater than 90%.

Actuarial Values of Benefit Plans		
Actuarial Value	**Number of Plans**	**Percentage of Total**
0.55	**2**	**0.3%**
0.57	1	0.1%
0.61	**2**	**0.3%**
0.65	16	2.1%
0.68	**2**	**0.3%**
0.69	7	0.9%
0.71	**1**	**0.1%**
0.72	1	0.1%
0.73	**6**	**0.8%**
0.74	2	0.3%
0.75	**14**	**1.8%**
0.76	7	0.9%
0.77	**7**	**0.9%**
0.78	17	2.2%
0.79	**6**	**0.8%**
0.80	52	6.8%
0.81	**6**	**0.8%**
0.82	20	2.6%
0.83	**31**	**4.1%**
0.84	14	1.8%
0.85	**49**	**6.4%**
0.86	142	18.6%
0.87	**75**	**9.8%**
0.88	17	2.2%

Actuarial Values of Benefit Plans		
Actuarial Value	**Number of Plans**	**Percentage of Total**
0.89	**73**	**9.6%**
0.90	18	2.4%
0.91	**90**	**11.8%**
0.92	18	2.4%
0.93	**12**	**1.6%**
0.94	10	1.3%
0.95	**45**	**5.9%**
0.96	1	0.1%
Total	**764**	**100.0%**

Table 10 – Actuarial Values of Benefit Plans

For comparison, below is the number of K-12 school district plans in relationship to the values associated with healthcare plans under the Health Care Act, also known as the Affordable Care Act (ACA). The relationship revealed that 37.2% of school districts (277) have "Platinum"–level benefits, 53.9% of plans (374) have "Gold"– level benefits, 6.2% (85) school districts have "Silver"–level benefits, 2.7% (21) school districts have "Bronze"–level benefits.

Benefit Plans as Compared to ACA Levels			
Metal Level	**AV Range**	**Number of Plans**	**Percentage of Total**
Bronze or Below[18]	0.00 – 0.67	21	2.7%
Silver	0.68 – 0.77	47	6.2%
Gold	0.78 – 0.87	412	53.9%
Platinum	0.88 – 1.00	284	37.2%
Total		764	100.0%

Table 11 – Benefit Plans as Compared to ACA Levels

Please refer to the appendices and corresponding exhibits for further details.

[18] There are three plans with actuarial values, as reported by the carriers, which are below 0.58, the minimum value for consideration as a Bronze plan. Two of the plans have actuarial values of 0.55 and the third plan has an actuarial value of 0.57.

CHAPTER 5: CONCLUSIONS

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

- improve transparency of K-12 purchasing
- create greater affordability and equity with regard to the cost of coverage for single employees as compared to full family coverage
- promote healthcare innovations and cost savings
- reduce administrative expenses; and
- provide greater parity of state allocations for K-12 employee health benefits.

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

Year 2 of the K-12 School District Health Benefits Data Collection Project was successful due to an unprecedented level of school district participation (all 295 school districts), and because 100% of carriers that received the Data Call reported the required data.

Treinen's approach to gathering information and data to meet the requirements of ESSB 5940 included:

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

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

This report describes variations and minor inconsistencies in the reported data. Nevertheless, the integrity of the data appears solid. Some information is not useful, for example, school district-reported administrative costs (A12e, f, g and h). This may be due to the lack of uniform data reporting and incomplete information provided by school districts regarding administrative costs.

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

- Different data sources (carrier versus school district);
- Differences in reporting time periods, including calendar year 2013, plans ending in 2013, data from both plans ending in 2013 and beginning in 2013, and reporting data based on a snapshot date of October 1, 2013 for school district reporting;
- Carriers are required to report all plans in effect in 2013; thus, they reported active and inactive plans. Therefore, carrier reporting cannot perfectly align with school district plan reporting;
- School district plan names and carrier plan names do not match, since plan names across school districts and carriers were not consistent. Thus, the project team assigned numeric plan identifiers separately for school district plans and carrier plans. For purposes of summarizing cost-share designs, the project team used carrier naming conventions and carrier-provided plan summaries to complete the cost-share exhibits of this report.

Overall, Year 2 of the K-12 School District Health Benefits Data Collection Project experienced an unprecedented level of participation, and gathered accurate and reliable information. We believe that this report and supporting exhibits contain data that will assist school districts and carriers in meeting the requirements of ESSB 5940.

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

APPENDICES (Exhibits)

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

Some exhibits show data that has been reported for the 2013 calendar year, other exhibits are presented with data for plan-years ending in 2013, or for all plan-years in 2013, or a snapshot date (October 1, 2013). 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 project team relied on the data supplied by the school districts and the K-12 carriers, including HMOs. While the project team 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, fields shown in exhibits are occasionally blank because there was no applicable data to report. The project team has been very diligent in identifying and correcting defects in reported data. As a rule, however, the project team cannot change any carrier or school district submission or retroactively modify the project database to make corrections without express consent or agreement by the submitting entity. This being so, small errors may persist in the reported data. Spelling errors in the submitted data have not been corrected.

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 2013 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 764 plans in their plan information for all plans offered in 2013. 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 2013. The list of plans includes those plans ending in 2013 and all that begin in 2013. The legislation requires reporting of all data for calendar year 2013. The list shows that there are 764 K-12 health plans reported by carriers in 2013. 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 2013. The exhibit shows employee, dependent and total member enrollment. Total enrollment reported for all benefit packages is 104,519 employees and 200,785 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 1.921 members per family. The carriers reported data for plan-years ending in 2013.

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 101,092 employees, which is higher than enrolled employees as reported by carriers at 104,519 (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, 2013.

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 138,093 members whereas carriers reported 200,785 members (Exhibit A3). School districts do not track dependent members consistently, resulting in the lower value as compared to the carrier member total. As a result, carrier member counts are believed to be more accurate.

Appendix 5 – Health Plan Design Comparison

The A5 series exhibits provide health plan design information and the actuarial value of each plan for all plans offered during the 2013 calendar year (that is, plans ending and beginning in 2013). 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 2013. The remaining A5 exhibits report the following; A5b plan actuarial values, A5c plan deductibles, A5d coinsurance, A5e co-payments, A5f out-of-pocket maximums, and A5g prescription drugs.

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

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 101,348 and members total 138,349 for all school districts combined. The average PMPM cost was $594.43. The highest cost school district is shown at $2,051.86 PMPM, compared to the lowest cost at $0.00 PMPM. Carrier reported medical premiums, exclusive of administration fees, totaled $986,862,941 for plan-years ending in 2013. 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 2013.

Appendix 7 – Average Costs and Contributions by School District

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

For full-time employees, the results show that contributions for ED (employee plus dependent) coverage are on average 5.9 times the contribution for employee-only coverage; for part-time employees, contributions for employee plus dependent coverage are on average are 4.1 times the contribution for employee-only coverage.

On average, full-time and part-time employees contribute 8.3% and 14.3% respectively to the average cost of employee-only premiums, as compared to employee plus dependent contributions which are at 31.8% and 38.0% respectively. This data is based on the school district census as of the snapshot date of October 1, 2013.

Note that in the context of Exhibits A7a and A7b, the term ED should be interpreted as employee plus dependent coverage, in other words the term as used here encompasses ES – employee and spouse, EC – employee and one or more children, and EF – full family coverage for employee and spouse and one or more children.

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

The A8 series exhibits provide financial performance for the calendar year 2013 by month. The data includes employee counts (Exhibit A8a), dependent counts (Exhibit A8b), monthly paid claims (Exhibit A8c), monthly premiums (Exhibit A8d), and loss ratios (Exhibit A8e). Exhibit A8f represents the consolidation of all prior A8 exhibits. All A8-series exhibits are presented by benefit package. Total premiums for calendar year 2013 are reported at $1.019 billion for all benefit packages combined, compared to total paid claims of $939.8k. This generated a paid claims loss ratio, which is a comparison of claims to premiums, of 92.2% for calendar year 2013.

Appendix 9 – Experience Reports by Benefit Package

The A9 series exhibits show financial data for calendar year 2013, as well as utilization metrics for plan-years ending in 2013. 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 20.6% of total paid claims, outpatient 20.4%, ER 3.5%, professional services 31.6%, and pharmacy 6.6%. Total claims were $939.8k for the period.

Exhibit A9b shows claims paid per employee per month (PEPM). Total average employee enrollment during the calendar year was 104,286 employees; premiums averaged $814.27 PEPM and, total claims averaged $750.94 PEPM.

Exhibit A9c shows claims paid per member per month (PMPM). Total average member enrollment during the calendar year was 200,597 members; premiums averaged $423.32 PMPM and, total claims averaged $390.40 PMPM.

The remaining exhibits provide a breakdown of utilization metrics for the plan-years ending in 2013, including Exhibit A9d - utilization by hospitalization, outpatient visits, ER visits, professional services, and pharmacy scripts, Exhibit A9e - utilization per unit measures (for example, average length of stay (LOS), utilization per 1,000 members for professional visits and so on), Exhibit A9f - monthly financial measures for calendar year 2013, Exhibit A9g - monthly PEPM measurements, and Exhibit A9h - monthly PMPM measurements.

Appendix 10 – List of Large Claimants by Major Diagnostic Categories

This is a list of 766 large cases defined as aggregated claims per unique claimant in excess of $100,000 for plan-years ending in 2013. Average large cases were approximately $200,625 per claimant and represent about 16% of all paid claims. The claims are reported by major diagnostic categories including diseases, injuries, and other conditions. The reporting period is for plan-years ending in 2013.

Appendix 11 – Demographics by Benefit Package

This exhibit reports member demographic information associated with each benefit package for plan-years ending in 2013. Demographic information included coverage tier, age and sex. There were 119 benefit packages reported.

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

Each carrier reported administrative fees for plan-years ending in 2013. Fees were broken down into several component parts. Data requested included premium taxes payable for insured plans, WSHIP assessments, other government taxes or assessments, commissions paid to agents, brokers or consultants, other third-party administrative (TPA) fees, PPO access fees, and carrier administration fees. Results show total administration was $77.24 PEPM (Exhibit A12a) and $40.11 PMPM (Exhibit A12b) for the reporting period. Total administration fees of $96.7 million were reported and they represented 9.49% of total

premium for plan-years ending in 2013. Of this amount, 6.82% ($6.6 million) was payable to agents, brokers, or consultants; 26.21% (25.4 million) was payable for premium taxes and other assessments; and 66.8% ($64.6 million) was for administrative expenses charged by carriers.

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

Exhibit A12c shows other supplemental services and associated costs reported by school districts. The supplemental services are generally for employee-paid cancer or accident policies. Similar information was requested from the K-12 carriers. However, all carriers reported no supplemental services were purchased separately by the school districts, therefore Exhibit A12d reports no data except total employee and member enrollment by carrier. Carriers reported 104,998 employees and 201,887 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 report internal administrative expenses 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 2013. 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 reported on an incurred basis to determine the appropriate level of IBNR reserves. Incurred basis reporting was not required with the Data Call.

Other reserves that were required to be reported include 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 2013, paid claims were reported at $943.9k and, total IBNR reserve liabilities were reported at $52.4 million. IBNR reserves are about 5.5% of paid claims, less than one month's paid claims. PSR/RSR reserves were reported at $5.8 million, about 0.61% 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 2013. 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 $856.16 per month for plan-years ending in 2013. The lowest and highest composite premiums across school districts are also reported at $0 and $2,740.30 respectively. Information for this exhibit was provided by the carriers.

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

This exhibit reports information by school district as of October 1, 2013, the snapshot date, and shows the average total monthly rates by coverage tier. Also shown are the total monthly premiums by school district. Information for this exhibit 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 $188.96, or $19,136,546.08, based on 101,273 employees as of the snapshot date of October 1, 2013. Information for this exhibit was provided by the school districts.

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

This exhibit shows the school district contributions for each coverage tier. The reported monthly composite contributions for employee and family coverage combined was $654.70, or $66,303,433.10, based on 101,273 employees as of the snapshot date of October 1, 2013. Information for this exhibit was provided by the school districts.

Appendix 18 – Summary of Innovative Plan Features All Plans Combined

Exhibit A18a **–** Carrier Responses

Exhibit A18b **–** School District Responses

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

Appendix 19 – Efforts and Achievements

Exhibit A19a **–** By Carrier

Exhibit A19b **–** By School District

These exhibits are narratives provided by carriers and school districts describing efforts and achievements during calendar year 2013 to reduce administrative costs, to achieve cost savings, to improve customer service, to manage health plans, and to assure coverage for part-time employees.

The narratives have not been corrected or edited, however some have been reformatted in order to be presented as exhibits.

Appendix 20 – Glossary of Acronyms

Acronyms used throughout these exhibits are explained herein.

Appendix 21 – Data Traceability Matrix

Exhibit A21a **–** Carriers

Exhibit A21b **–** School Districts

Exhibit A21c **–** Definitions

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

Appendix 22 – Report Contributors

This Exhibit includes a list of the Treinen employees and consultants who participated in the Year 2 project and contributed to the creation of this report.

Appendix 23a – Data Validations – Carriers

Category 0 – 'Check My Spreadsheet'

Section 1	Carrier_Name	Required
	Submitted_By	Required
	Submitter_Email	Required
	PR_Beginning	Required, valid date, between 01/01/2012 and 12/31/2013 inclusive
	PR_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
Section 2	Used_YN (All rows)	Required, Y or N
	Innov_No (All Rows)	Required, must be a whole number between 1 and 24 inclusive

Section 3	Pool_Code	Required
	IBNR_Reserves	Required, numeric, 0 is default, > or = 0
	Rate_Reserves	Required, numeric, 0 is default, > or = 0
	Total_Claims	Required, numeric, 0 is default, > or = 0
	Covered_Employees	Required, numeric, 0 is default, > or = 0
	Covered_Members	Required, numeric, 0 is default, > or = 0, Covered Members value must be > or = number of Covered Employees
Section 4	Plan_Name	Required if Plan_Code is specified
	Plan_Code	Required if Plan_Name is specified
	BP_Code	Required
	PY_Beginning	Required, valid date, between 01/01/2012 and 12/31/2013 inclusive
	PY_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
	Pool_Code	Required
	Plan_Type	Required
	CostShare_Code	Required
	Plan_Act_Value	Required, decimal, > or = 0.00 and < or = 1.00
	Ded_FollowCalendar	Required, Y or N
	HDHP_YN	Required, Y or N
Section 5	BP_Code	Required if PY_Ending is specified
	PY_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
	Total_Supplemental	Required, numeric, 0 is default, > or = 0
	Exp_Comm	Required, numeric, 0 is default, > or = 0
	Exp_Taxes	Required, numeric, 0 is default, > or = 0
	Exp_PPO	Required, numeric, 0 is default, > or = 0
	Exp_Fees3rdP	Required, numeric, 0 is default, > or = 0
	Exp_OtherAdmin	Required, numeric, 0 is default, > or = 0
	Capitation_Payments	Required, numeric, 0 (default)
	Inpatient_AvgLOS	Required, numeric, 0 is default, > or = 0
	Inpatient_A	Required, numeric, 0 is default, > or = 0
	Inpatient_D	Required, numeric, 0 is default, > or = 0
	Outpatient_V	Required, numeric, 0 is default, > or = 0
	Outpatient_ER_V	Required, numeric, 0 is default, > or = 0
	Professional_V	Required, numeric, 0 is default, > or = 0
	OtherMed_V	Required, numeric, 0 is default, > or = 0
	Pharmacy_GS	Required, numeric, 0 is default, > or = 0

	Pharmacy_BS	Required, numeric, 0 is default, > or = 0
Section 6	BP_Code	Required if PY_Ending is specified
	PY_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
	Calendar_Month	Required, numeric, between 1 and 12 inclusive
	Emp_Enrollment	Required, numeric, 0 is default, > or equal to 0
	Dep_Enrollment	
	Total_Premiums	Required, numeric, 0 is default, > or = 0
	Total_MedPremiums	Required, numeric, 0 is default, > or = 0
	Total_Claims	Required, numeric, 0 is default, > or = 0
	Inpatient_Claims	Required, numeric, 0 is default, > or = 0
	Outpatient_Claims	Required, numeric, 0 is default, > or = 0
	Outpatient_ER_Claims	Required, numeric, 0 is default, > or = 0
	Professional_Claims	Required, numeric, 0 is default, > or = 0
	OtherMed_Claims	Required, numeric, 0 is default, > or = 0
	Pharmacy_Claims	Required, numeric, 0 is default, > or = 0
Section 7	BP_Code	Required
	PY_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
	Emp_Dep	Required, E or D
	M_F	Required, M or F
	Tier_Code	Required, EE, ES, EC, EF, or OD
	Age_Tier1	Required, numeric, 0 is default, > or = 0
	Age_Tier2	Required, numeric, 0 is default, > or = 0
	Age_Tier3	Required, numeric, 0 is default, > or = 0
	Age_Tier4	Required, numeric, 0 is default, > or = 0
	Age_Tier5	Required, numeric, 0 is default, > or = 0
	Age_Tier6	Required, numeric, 0 is default, > or = 0
	Age_Tier7	Required, numeric, 0 is default, > or = 0
	Age_Tier8	Required, numeric, 0 is default, > or = 0
	Age_Tier9	Required, numeric, 0 is default, > or = 0
	Age_Tier10	Required, numeric, 0 is default, > or = 0
	Age_Tier11	Required, numeric, 0 is default, > or = 0
Section 8	Plan_Code	Required
	PY_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
	SD_Code	Required, numeric, 0 is default
	Emp_Count	Required, numeric, 0 is default, > or = 0

	Dep_Count	Required, numeric, 0 is default, > or = 0
	Total_Premiums	Required, numeric, 0 is default, > or = 0
	Total_MedPremiums	Required, numeric, 0 is default, > or = 0
	EE_Count	Required, numeric, 0 is default, > or = 0
	ES_Count	Required, numeric, 0 is default, > or = 0
	EC_Count	Required, numeric, 0 is default, > or = 0
	EF_Count	Required, numeric, 0 is default, > or = 0
	OD_Count	Required, numeric, 0 is default, > or = 0
Section 9	Claim_Amount	Required, numeric, > or = 0
	Claimant_Status	Required
	Diagnosis_Code	Required, numeric, between 1 and 19 inclusive
	PY_Ending	Required, valid date, between 01/01/2013 and 12/31/2014 inclusive
Section 10	CostShare_Code	Required if Ded_Individual_in is specified, must be a value specified in Section 4-L
	Ded_Individual_In	Required, numeric, 0 is default
	Ded_Individual_Out	Required, numeric, 0 is default
	Ded_Family_In	Required, numeric, 0 is default
	Ded_Family_Out	Required, numeric, 0 is default
	CoIns_Prevent_In	Required, numeric, 0 is default
	CoIns_Prevent_Out	Required, numeric, 0 is default
	Coins_Other_In	Required, numeric, 0 is default
	Coins_Other_Out	Required, numeric, 0 is default
	Copay_Office_In	Required, numeric, 0 is default
	Copay_Office_Out	Required, numeric, 0 is default
	Copay_Inpatient_In	Required
	Copay_Inpatient_Out	Required
	Copay_Outpatient_In	Required, numeric, 0 is default
	Copay_Outpatient_Out	Required, numeric, 0 is default
	Copay_ER_In	Required, numeric, 0 is default
	Copay_ER_Out	Required, numeric, 0 is default
	OOPM_Individual_in	Required, numeric, 0 is default
	OOPM_Individual_out	Required, numeric, 0 is default
	OOPM_Family_in	Required, numeric, 0 is default
	OOPM_Family_out	Required, numeric, 0 is default
	Rx_Deductible_In	Required
	Rx_Retail_CostShare	Required
	Rx_Retail_Days_Supply	Required, numeric
	Rx_MailOrder_CostShare	Required

	Rx_MailOrder_Days_Supply	Required, numeric
	Rx_Specialty_CostShare	Required
	Rx_Specialty_Days_Supply	Required, numeric
	Plan_Comments	Required
Section 11	RateSet_Code	Required if EF_Rate is specified
	EE_Rate	Required, numeric, 0 is default, > or = 0
	ES_Rate	Required, numeric, 0 is default, > or = 0
	EC_Rate	Required, numeric, 0 is default, > or = 0
	EF_Rate	Required, numeric, 0 is default, > or = 0
	OD_Rate	Required, numeric, 0 is default, > or = 0

Category 0 – Application

Section 1	Carrier_Name	Error if missing
	PR_Beginning	Valid date, error if missing
	PR_Ending	Valid date, error if missing
	Desc_CostSavings	Warning if missing
	Desc_ReduceAdmin	Warning if missing
	Desc_Innovations	Warning if missing
	Desc_DistrictManage	Warning if missing
	Desc_DistrictProcure	Warning if missing
	Desc_CustService	Warning if missing
	Desc_ProtectPT	Warning if missing
	Submitted_By	Error if missing
	Submitter_Email	Error if missing
Section 2	Used_YN	Y or N
	Innov_No	Numeric, warning if missing
	Innov_Desc	Warning if missing
Section 3	Pool_Code	Must be unique in worksheet, error if missing
	IBNR_Reserves	Numeric, warning if missing
	Rate_Reserves	Numeric, warning if missing
	Total_Claims	Numeric, error if missing
	Covered_Employees	Numeric, warning if missing
	Covered_Members	Numeric, warning if missing
Section 4	Plan_Name	Error if missing
	Plan_Code	Must be unique in worksheet, error if missing
	BP_Code	Must be unique in worksheet, error if missing

	Pool_Code	Must exist in Section 3, error if missing
	HDHP_YN	Y or N, error if missing
	Plan_Type	Error if missing
	PY_Beginning	Valid date, error if missing
	PY_Ending	Valid date, error if missing
	Desc_Supplemental	Warning if missing
	CostShare_Code	Error if missing
	Plan_Act_Value	Numeric, warning if missing
	Ded_FollowCalendar	Y or N
Section 5	BP_Code	Must exist in Section 4, error if missing
	PY_Ending	Valid date, error if missing
	Total_Supplemental	Numeric, default is 0
	Exp_Comm	Numeric, warning if missing
	Exp_Taxes	Numeric, warning if missing
	Exp_PPO	Numeric, warning if missing
	Exp_Fees3rdP	Numeric, default is 0
	Exp_OtherAdmin	Numeric, warning if missing
	Capitation_Payments	Numeric, default is 0
	Inpatient_AvgLOS	Numeric, warning if missing
	Inpatient_A	Numeric, warning if missing
	Inpatient_D	Numeric, warning if missing
	Outpatient_V	Numeric, warning if missing
	Outpatient_ER_V	Numeric, warning if missing
	Professional_V	Numeric, warning if missing
	OtherMed_V	Numeric, warning if missing
	Pharmacy_GS	Numeric, warning if missing
	Pharmacy_BS	Numeric, warning if missing
Section 6	BP_Code	Must exist in Section 4, error if missing
	PY_Ending	Valid date, error if missing
	Calendar_Month	Numeric, between 1 and 12 inclusive, error if missing
	Emp_Enrollment	Numeric, warning if missing
	Dep_Enrollment	Numeric, warning if missing
	Total_Premiums	Numeric, warning if missing
	Total_MedPremiums	Numeric, warning if missing
	Total_Claims	Numeric, warning if missing
	Inpatient_Claims	Numeric, warning if missing
	Outpatient_Claims	Numeric, warning if missing
	Outpatient_ER_Claims	Numeric, warning if missing
	Professional_Claims	Numeric, warning if missing

	OtherMed_Claims	Numeric, warning if missing
	Pharmacy_Claims	Numeric, warning if missing
Section 7	BP_Code	Must exist in Section 4, error if missing
	PY_Ending	Valid date, error if missing
	Emp_Dep	E or D, error if missing
	M_F	M or F, error if missing
	Tier_Code	EE or ES or EC or EF or E2 or F2, error if missing
	Age_Tier1	Numeric, default is 0
	Age_Tier2	Numeric, default is 0
	Age_Tier3	Numeric, default is 0
	Age_Tier4	Numeric, default is 0
	Age_Tier5	Numeric, default is 0
	Age_Tier6	Numeric, default is 0
	Age_Tier7	Numeric, default is 0
	Age_Tier8	Numeric, default is 0
	Age_Tier9	Numeric, default is 0
	Age_Tier10	Numeric, default is 0
	Age_Tier11	Numeric, default is 0
Section 8	Plan_Code	Must exist in Section 4
	PY_Ending	Valid date, error if missing
	SD_Code	Valid County-District Code, error if missing
	Emp_Count	Numeric, warning if missing
	Dep_Count	Numeric, warning if missing
	Total_Premiums	Numeric, warning if missing
	Total_MedPremiums	Numeric, warning if missing
	District_Name	
	RateSet_Code	
	RateSet_Desc	
	EE_Count	Numeric, default is 0
	ES_Count	Numeric, default is 0
	EC_Count	Numeric, default is 0
	EF_Count	Numeric, default is 0
	OD_Count	Numeric, default is 0
Section 9	Claim_Amount	Numeric, error if missing
	Claimant_Status	E or S or C, error if missing
	Diagnosis_Code	Numeric, between 1 and 19 inclusive, error if missing
	PY_Ending	Valid date, warning if missing

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

Category 1

1. Total_Premiums in both Sections 6 and 8 are obsolete. Should be blank or 0, anything else is an error.

2. Certain Sections must contain only plans or benefit packages that end within 2013. For these Sections the presence of a PYE in 2014 or any other year is an error condition.

3. Section 8, column D – SD_Code – school district code must be valid.

Category 2

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

Category 3

1. Total number of Pool Codes in Section 3
2. New or missing Pool Codes in Section 3
3. IBNR Reserves amount by Pool Code in Section 3
4. Rate Reserves amount by Pool Code in Section 3
5. Total Claims by Pool Code in Section 3
6. Covered Employees count in Section 3

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

Category 4

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

Appendix 23b – Data Validations – School Districts

'Check My Spreadsheet'

Section 1	SD_Code	Required
	District_Name	Required
	Report_Year_Ending	Required
	Desc_Affordability	Required
	Desc_CostSavings	Required
	Desc_ReducedAdmin	Required
	Desc_CustService	Required
	Desc_ReduceDiff	Required
	Desc_PTCoverage	Required
	Desc_Innovations	Required
	HDHP_Offered	Required, Y or N
	Total_Premiums_Med	Required, numeric
	Total_Premiums_Dental	Required, numeric
	Total_Premiums_Vision	Required, numeric
	Total_Broker	Required, numeric
	Total_ExternalAdmin	Required, numeric
	Total_Supplemental	Required, numeric
	Total_Retire_Carveout	Required, numeric
	Total_InternalAdmin	Required, numeric
	Desc_InternalAdmin	Required
	Total_Other	Required
	Submitted_By	Required
	Submitter_Email	Required
	Submission_Date	Required
	Spreadsheet_Check_Date	
Section 2	Used_YND (all fields)	Required, Y, N or D
Section 3	Entity_Code	Required, must be unique
	Entity_Name	Required
	Entity_Type_Role	Required, must be a valid role
	Premiums_Paid	Numeric, 0 is default
	Premium_Type	Required, must be a valid type
	Non_Premium_Fees_Paid	Numeric, 0 is default
	C_Name	Optional
	C_Phone	Optional
	C_Email	Optional

Section 4	Carrier_Code	Required, carrier code must match Entity_Code from Section 3
	Carrier_Name	Required, must be a valid name
	Plan_Code	Required, must be unique
	Plan_Name	Required
Section 5	Group_Code	Required
	Group_Name	Optional
	Group_CT	Required
	Plan_Codes_Offered	Optional, Codes within Plan_Codes_Offered must match Plan_Codes in Section 4
Section 6	Group_Code	Required, must match Group_Code in Section 5
	Group_Name	Optional
	Plan_Code	Required, must match Plan_Code in Section 4
	Plan_Name	Optional
Section 7	Emp_Code	Required
	Group_Code	Required, must match Group_Code in Section 5
	Emp_CT	Required, C or T
	Gender	Required, M or F
	DOB	Required, valid date
	Calculated_FTE	Required, > or = 0 and < or = 1
	Benefit_FTE	Required, > or = 0 and < or = 1
	Benefit_Elig_YN	Required, Y or N
	Plan_Code	Optional, must match Plan_Code in Section 4
	Plan_Tier	Required if Plan_Code is provided, must be listed in references section
	SD_Contrib	Required if Plan_Code is provided, numeric, cannot be negative
	Emp_Contrib	Required if Plan_Code is provided, numeric, cannot be negative
	Total_Premium	Required if Plan_Code is provided, numeric, cannot be negative
	Dep_YN	Required Y or N
	Cov_MaleDep_Ages	Numeric, < or = 80
	Cov_FemaleDep_Ages	Numeric, < or = 80
	Elig_MaleDep_Ages	Numeric, < or = 80
	Elig_FemaleDep_Ages	Numeric, < or = 80

Section 8	Emp_Code	Required, must match Emp_Code in Section 7
	Gender	Required, M or F
	DOB	Required, valid date
	Benefits_YN	Required, Y or N