Office of the Insurance Commissioner

ESSB 5940
K–12 School District Employee Health Benefits Data Collection Project

Year 4 Data Call Instructions — Carriers
Version 4.0

Contract: PS 2013.18

Description: Instructions for Year 4 — ESSB 5940 Data Call — Carriers

Version 4.1, January 28, 2016

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Overview

This document provides instructions for Year 4 of the Carrier Data Call, as authorized by ESSB 5940 ('the legislation'), which directs the Office of the Insurance Commissioner (OIC) to collect data from K-12 school districts and their carriers. Treinen Associates[1] is collecting the data on behalf of the OIC. The legislation requires reporting of K-12 school districts' health benefits, demographics, and financial data for district health plans[2]. However, carriers may include any vision exam benefit or cost embedded in the reported medical plans.

As in prior years, school districts are required to report premiums paid for dental and vision plans purchased separately from medical plans during the preceding School Fiscal Year; however, dental and vision data is not part of the Carrier Data Call.

Data should *not* be reported for Educational Service District (ESD) employees, retirees, charter schools, or COBRA participants.

Submission Process and Confirmations

Please acknowledge[3] receipt of the Data Call by sending an e-mail to this address: 5940survey@oic.wa.gov. The acknowledgement must include the contact person's name, e-mail address, and telephone number. Please copy OICDataCallTeam@Treinen.com on the acknowledgement e-mail.

Each carrier, when submitting data, must submit a Statement of Validity[4]. A template for this document is available on the OIC's web site.

Following initial submission, there will be only one opportunity for formal resubmission[5]. Formal resubmission does not include submission of minor corrections to previously submitted data. A formal resubmission is required within 30 days of receiving a Notice to Resubmit.

Please do not password-protect or encrypt your Data Collection Spreadsheet. Also, please do not hide rows or columns, or apply any filters to any Section within your spreadsheet; if you do so, the Treinen team will be unable to process your data.

To submit (or resubmit) data, carriers will again use ShareFile, a secure third-party 'DropBox'-type service.

Please send all submissions directly to ShareFile. Please do not send submissions to project team members or to the project team e-mail address.

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[1] Treinen Associates and its contractors

[2] See Health Plan definition under RCW 48.43.005 (26). Carriers must report plan design cost-sharing provisions for each plan for each plan year offered; report monthly premium rates by plan; and report other financial data including premiums, paid claims, and demographics information by "Benefit Package". A Benefit Package is one health plan, or an aggregation of health plans. Please refer to Section 5.

[3] Acknowledgement is required pursuant to WAC 284-198-010 and pursuant to WAC 284-198-050.

[4] Pursuant to WAC 284-109-035.

[5] Pursuant to WAC 284-198-030.

All e-mail communications from ShareFile to carriers will be from noreply@sf-notifications.com. Examples of such communications include:

- Notification that a carrier has successfully uploaded a data submission.
- Notification that the project team has uploaded a "return file" to the carrier's Sharefile account.
- Notification that submitted data was successfully processed.

When a carrier submits data, the project team will automatically validate and process the data using an application built for this purpose (the OIC K-12 Application). The process flow for acceptance or rejection of data submissions and the steps for required corrections are outlined below within the Section entitled "Process Flow — ShareFile".

Communication with the Project Team

In Year 4, the first point of contact for all matters related to carrier data collection in the OIC K-12 project is Joe Rueter at *OICDataCallTeam@Treinen.com*.

ShareFile Access

If you are a new user, please contact the project team to be set up with a ShareFile account, or have someone from your company who already has access do so. Note that all users have authority within a given carrier's account to add or delete other users, to upload or download files, and to configure the e-mail notifications that are automatically generated whenever files are uploaded or downloaded.

If you are an existing user of ShareFile (if you used ShareFile to submit data in Year 3 of the project) you can log on to ShareFile using the credentials that were set up previously. For security reasons you may want to consider changing your password. If you have forgotten your password, go to the login page, enter your e-mail address, and Click on "Forgot Password?" ShareFile then takes you to a screen where you can reset your password.

Process Flow — ShareFile

After a given carrier has submitted data, each ShareFile user (within that particular carrier) will receive an e-mail stating that the data has been:

- Accepted with no errors or warnings, or
- Accepted with warnings, or
- Rejected due to errors.

If processing of the submitted data results in errors and/or warnings, a "return file" is sent to the carrier's ShareFile account noting the reasons for the errors and/or warnings. Someone within the carrier should then log into ShareFile and retrieve (download) the "return file".

When the carrier retrieves the return file, ShareFile automatically sends an e-mail to the Treinen project team informing them that the carrier has done so.

Having made corrections to the Data Collection Spreadsheet, the carrier then uploads the corrected data file to ShareFile. Before resubmitting data, please rename the corrected file according to the version-naming convention described below.

The cycle continues until the data within the Data Collection Spreadsheet is accepted. When that happens,

the OIC's application automatically sends an e-mail indicating this to the submitting carrier.

ShareFile Administration

Individual users may add or delete other ShareFile contacts within their organization.

All users within a given carrier have exactly the same profile in terms of access rights and user privileges.

By default, ShareFile sends all communications to all contacts within a given carrier (although individual users may change their notification settings).

Any carrier contact can log onto their organization's ShareFile account in order to upload or download data.

If you encounter difficulties configuring or using ShareFile, or have questions about it, please send an e-mail to Joe Rueter at *OICDataCallTeam@Treinen.com*.

Data Submission Format

Please submit carrier data in a single Data Collection Spreadsheet, using the template provided with these instructions. The Data Collection Spreadsheet includes thirteen separate tabs:

- The first tab is labelled "Instructions". This contains two macros: one imports data into the spreadsheet from .CSV files, and the other is the Check My Spreadsheet utility, which must be run before the spreadsheet can be submitted.
- The last tab is labelled "Reference". It contains reference data needed by the Check My Spreadsheet macro. Please do not change any data within the Reference tab.
- The remaining tabs constitute the 11 Sections of the Data Call, each of which contains a different category of data.

Data File-Naming Convention

When saving the Excel spreadsheet that contains your carrier's data (The Data Collection Spreadsheet), please use the following naming convention: **Carrier-V*nn*.xlsm** where:

Carrier	is a shortened version of the carrier name
nn	is the version (reflecting the number of times you have previously submitted data); the first time you submit data, please use V01 and then increment the version number V02, V03, V04, and so on, with each of any subsequent resubmissions.

Required Values and Formats

1) Please do not alter column headings. If you do so, the data you submit will not load to the database and you will have to resubmit it.
2) Please do not alter worksheet names or change the sequence of worksheets within the workbook. If you do so, the data you submit will not load to the database and you will have to resubmit it.
3) Do not hide rows or apply any filters to the spreadsheet. If you do so, these will be removed by the "Check My Spreadsheet" macro.
4) Do not apply formulas to cells within the spreadsheet. If you do so, these will be removed by the "Check My Spreadsheet" macro.

5) All fields are required in all Sections, except where this document notes otherwise. Leave status columns blank. If the project team returns the data due to errors, the status columns will contain values showing errors or warnings for the appropriate rows.
6) Field Formats:
   a. Text, followed by maximum size. If no size is specified, the field can support pages of text (limited for reporting representation only).
   b. Integer (whole number, no decimals).
   c. Date — MM/DD/YYYY format (for example, 09/30/2015).
   d. Decimal (with number of places to the right of decimal specified).
   e. Currency (two decimal places to right of decimal).
   f. Enter 0 for numeric totals with zero values, or not applicable, "N/A", for text fields.

Year 4 Changes

Changes to the OIC K-12 Data Call in Year 4 follow are shown below.

Section	Changes
Global	• The "Check My Spreadsheet" macro within the Data Collection Spreadsheet will: – Unhide all rows and columns. – Remove all formulas. – Validate the number, names and sequence of all worksheets within the workbook.
Section 6 and Section 8	The following new validations have been implemented: • The sum of Total_MedPremiums (Section 6, Column H) by BP_Code/PY_Ending should equal or roughly correlate to the sum of Total_MedPremiums (Section 8, Column H) by Plan Code(s)/PY_Ending. • The average monthly Emp_Enrollment (Section 6 Col E) by BP_Code/PY_Ending should equal or roughly correlate to the sum of the Emp_Count (Section 8, Column E) by Plan_Code(s)/PY_Ending
Section 9	• In Year 4, the OIC will now accept ICD-10 Major Diagnosis Codes as well as the older ICD-9 codes. Carriers now have the option of reporting large claims with either ICD-9 or ICD-10 codes.

Data Validation

There are two levels of data validation. The first validations occur before data is submitted, by means of the Check My Spreadsheet macro within the Data Collection Spreadsheet. Additional, more complex, data validation occurs after data is submitted, by means of programs within the OIC K-12 Application, which is used to process and manage submitted data. The two levels of validation are described below.

Check My Spreadsheet Validations

Check My Spreadsheet performs 'Global Validations' – these are described below. Additionally, it performs validations of data within the individual Sections. The Section-specific CMS validations are described later in this document, within the individual Section descriptions.

Global CMS Validations

1. Unhide all rows
2. Unhide all columns
3. Remove all filters
4. Remove all formulas
5. Spreadsheet must contain 13 worksheets
6. Worksheet names and sequence:
    a. Instructions
    b. Section1
    c. Section2
    d. Section3
    e. Section4
    f. Section5
    g. Section6
    h. Section7
    i. Section8
    j. Section9
    k. Section10
    l. Section11
    m. Reference

Validations within the OIC K-12 Application

The validations described below are performed within the custom-built computer system, referred to as the 'OIC K-12 Application', that is used to process and manage submitted data.

All validations within the OIC K-12 Application may be enabled or disabled on a per carrier basis. Likewise, individual validations may be enabled or disabled for each carrier. These validations may also be set to generate an error or warning.

Each validation also has a variance, expressed as a percentage, which may be tailored for each validation. A condition which falls outside of the specified variance will generate an error or warning. Validation parameters are specified with guidance from the actuary and according to each carrier's specific circumstances.

Validations across Sections

Please review carefully and make note of validations of code values and balances between Sections:

1. Section 3 pool codes are unique and match pool codes referenced in Section 4.
2. Section 4 plan codes are unique for a given period.
3. Section 4 Benefit Package codes, which aggregate reporting of plans in Sections 5, 6, 7, and 8, are unique for a given period and are included for all plans. Benefit Package aggregations of plans follow rules that allow aggregating of plans with low enrollment or plans with similar actuarial values, for plans with the same plan periods in both cases.
4. Sections 5, 6, 7, and 8 include all Benefit Packages listed in Section 4 with the plan year ending in the current year. Total premiums, enrollments, and claims for each Benefit Package should be approximately the same across Sections.
5. Section 6 includes the validations in the preceding Sections and it includes those with a plan year ending in the next year.
6. Section 8 plan codes and periods match Section 4, district-county codes match OSPI lists, and validate that premium rates for all districts with enrollments separately for each group within the district.
7. Section 10 cost-share design codes are unique and match those referenced in Section 4.
8. Section 11 plan rate-set codes are unique and match those referenced in Section 8.

Validation Categories

Category 0	Perform basic edits like ensuring required fields are completed, the data types are correct (that is, numeric, currency, and so on,) and other data integrity checks. Category 0 validations are functionally identical to the Check My Spreadsheet validations.
Category 1	Specific validations on individual data elements — for example, ensure that the Plan Year Ending value is within a particular data range.
Category 2	Complex validations within a single submission — for example, ensure that 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, ensure that amounts do not vary more than a specified percentage between submissions.
Category 4	Comparisons between carrier and school district submissions within a project year —for example, ensure that enrollment counts and premiums do not vary more than a specified percentage between carriers and school districts.

Category 1, 2, 3, and 4 validations are described in detail below.

Category 1

1. Certain Sections must only contain plans or Benefit Packages that end in 2015. For these Sections, the presence of a Plan-Year Ending (PYE) value in any other year is an error condition.
2. Section 8 column D — SD_Code — district code must be valid.

Category 2

1. Plans must contain both a medical and prescription component.
2. Plan enrollment in Section 8 should roughly correlate to Benefit Package enrollment in Section 6.
3. Employee enrollment in Section 8 (summed by Plans within Rating Pools) should roughly correlate to Covered Employees in Section 3.

4. Compare employee enrollment totals across Sections 6 and 7.
5. Compare dependent enrollment totals across Sections 6 and 7.
6. Compare employee enrollment totals across Sections 7 and 8.
7. Compare dependent enrollment totals across Sections 7 and 8.
8. Compare premium-related totals across Sections 6 and 8.
9. Compare employee enrollment totals across Sections 6 and 8.
10. Compare claims-related totals across Sections 3 and 6.
11. Plan and Plan-Year-Ending combinations found in Section 8, but not defined in Section 4.
12. Benefit-Package and Plan-Year-Ending combinations found in Sections 6 and 7, but not defined in Section 5.
13. Inpatient admits higher number than inpatient days.
14. Inpatient average length-of-stay incorrect.
15. Sum of all claims types should equal the total claim amount reported.
16. Higher utilization of brand scripts than generic scripts.
17. The sum of the tier counts (EE, ES, EC, EF, and OD) must equal the employee count in Section 8.
18. Cost-share codes must be unique in Section 10.

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.

The Sections of the Carrier Data Call

Overview of Sections

The Data Collection Spreadsheet has eleven Sections, which are individual tabs or worksheets within the Data Collection Spreadsheet. We describe each Section in detail later in this document.

Section 1	Carrier Annual Reporting — For Calendar Year 2015
Section 2	Innovative Health Plan Features (For all K–12 Plans Combined in 2015)
Section 3	Reserves by Rating Pool (Ending Reserves)
Section 4	Health Plan-Year Information – All Plan Years, Beginning OR Ending in 2015
Section 5	Benefit Package Performance — For Plan Years Ending in 2015
Section 6	Benefit Package Performance by Month – All Plans, Beginning OR Ending in 2015
Section 7	Benefit Package Demographics — Plan Years Ending in 2015
Section 8	Plan Code Rates and Enrollments by District — All Plan Years, Beginning OR Ending in 2015
Section 9	Large Claims — For Plan Years Ending in 2015
Section 10	Plan Cost-Share Designs — All Plan Years, Beginning OR Ending in 2015
Section 11	Plan Rates — All Plans Offered, Beginning OR Ending in 2015

Section 1 — Carrier Annual Reporting — For Calendar Year 2015

This Section requests information by carrier with regard to health benefit plans offered to K–12 school districts within the State of Washington. Each carrier is requested to describe in the respective areas (fields below) its progress, efforts, and achievements during the calendar year 2015. Describe overall strategies towards healthcare cost savings, reduced administrative costs and unnecessary health services, and improved management of K–12 health programs.

Col	Column Name	Column Definition
A	Field_Name	From the field name below
B	Status	Status column (leave blank)
C	Carrier_Response	Enter carrier responses in this column
D	Field_Desc	Description from below

Row #	Column A Field Name	Description	Format
1		The first row has the column headings.	Do not change
2	Carrier_Name	Carrier Name	Text 60
3	PR_Beginning	Beginning date of performance reporting. This is the beginning date of the earliest reported plan year that ends in 2015.	Date
4	PR_Ending	Ending date of performance reporting. This is the ending date of the latest plan year that ends in 2016. This accounts for plans that begin in calendar year 2015 and end in calendar year 2016.	Date
5	Desc_CostSavings	Describe efforts and achievements toward healthcare cost savings.	Text
6	Desc_ReduceAdmin	Describe efforts and achievements toward significantly reducing administrative costs.	Text
7	Desc_Innovations	Describe other innovations designed to reduce health-benefit premium growth and to reduce the use of unnecessary health services. The next Section provides a checklist of specific pre-determined innovations. The intent of this narrative field is to capture innovations not listed in the next Section, or carrier comments with respect to innovations.	Text (optional)
8	Desc_DistrictManage	Describe efforts and achievements to help districts to manage their health benefit programs.	Text
9	Desc_DistrictProcure	Describe what information is needed for districts to procure health insurance with your company.	Text
10	Desc_CustService	Describe efforts and achievements to improve customer service.	Text
11	Desc_ProtectPT	Describe efforts and achievements to protect access to coverage for part-time employees.	Text
12	Submitted_By	The name of the person submitting the data.	Text 80
13	Submitted_E-mail	E-mail address of the submitter .	Text 80
14	Submitted_Date	Date of data submission.	Date
15	SpreadSheet_Check_ Date	System generated date of the last time “Check-My-Spreadsheet” was run.	Date

Section 1 — Check My Spreadsheet Validations

1. Column C (Carrier_Response) is required in rows 2 through 6 and 8 through 14.

2. Row 2 (Carrier Name) must be a valid carrier name from the dropdown list, which includes:
   - Aetna
   - Group Health
   - Kaiser
   - KPS Health Plans
   - Moda Health
   - PEBB
   - Premera
   - Providence
   - Regence
   - United Healthcare

3. Row 3 (PR_Beginning) is required, and must be a valid date. Beginning date of earliest reported plan year. Cannot be prior to January 1st of the previous calendar year nor can it be later than December 31st of the current calendar year. For year 4 this range is 1/1/2014 – 12/31/2015 inclusive.

4. Row 4 (PR_Ending) is required, and must be a valid date. Ending date of latest reported plan year. Cannot be prior to January 1st of the current calendar year, nor can it be later than December 31st of the next calendar year. For year 4 this range is 1/1/2015 – 12/31/2016.

Section 2 — Innovative Health Plan Features (for all K–12 Plans Combined in 2015)

Identify innovations available or offered to districts (across all plans offered to districts) from a pre-defined list. Enter "Y" if the feature is available in any plan offered to K–12 school districts in Washington during the calendar year 2015 (this can include prior or current plan years, which overlap calendar 2015). Enter "N" or leave the field blank if the feature is not offered to any district. Entries begin in row two, column B.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Used_YN	Is innovation used or offered (Y or N/blank)	Text 1
C	Innov_No	Number for the innovation (1–24 do not change)	Numeric 1–24
D	Innov_Desc	Description from below (do not change)	Text 200

Innovative Health Plan Features

1. PPO network
2. Centers of excellence for high-cost cases
3. Value-based plan designs
4. Case management; utilization management program
5. High-risk maternity program; maternity education program
6. Assessment of chronic diseases in a given population
7. Focused disease management program
8. Wellness program design and resources
9. Health-risk assessments
10. Coverage for treatment of obesity
11. Coverage for smoking cessation
12. Assessment of health risks within the district population
13. Reports to district on health-plan performance
14. Communication programs to support healthy behaviors
15. Information on medical trends and factors contributing to increasing claim trends within district populations (for example, high-cost cases, utilization of ER services, and hospital admissions)
16. Provide district clients with healthcare cost trends
17. District-specific claims data
18. Membership-specific feedback to plan participants/members on necessary medical services
19. Nurse line services
20. Website health tools and resources
21. Assessment of targeted chronic conditions, such as diabetes and depression, in the district population
22. Wellness newsletters and/or wellness messages on carrier website
23. Three-tier prescription drug program (generic, preferred brand, and non-preferred brand)
24. Four-tier prescription drug program (generic, preferred brand, non-preferred brand, and specialty)

Section 2 — Check My Spreadsheet Validations

1. Column B (Used_YN) is required in rows 2 through 25, and must be a value of “Y” or “N”.

2. Column C (Innov_No) must be a whole number value from 1 through 24 inclusive

Section 3 — Reserves by Rating Pool (Ending Reserves)

Report K–12 health plan reserves ending balances as of the plan year ending in 2015 — at the purchasing or rating pool level. Include K–12 health-plan reserves held by the carrier, trust, or other third-party pool. Include paid claims and enrolled employees and members by applicable rating or purchasing pool for the plan year ending in 2015. Do not include any non-K–12 health reserves. A code identifier identifies each pool, which Section 4 uses to link plans to applicable pools.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Pool_Code	Create a unique pool identifier to identify the plans covered by this reserve	Text 20
C	IBNR_Reserves	Plan-year-ending balance — Incurred but not reported (IBNR) reserve amount	Currency
D	Rate_Reserves	Plan-year-ending premium/rate-stabilization reserve amount, if one exists	Currency
E	Total_Claims	Plan-year total paid claims by applicable rating pool	Currency
F	Covered_Employees	Plan-year 2015 covered employees by rating pool	Integer
G	Covered_Members	Plan-year 2015 covered members by rating pool (members = employees plus dependents)	Integer

Notes on computations:

- Compute covered employees and covered members using either counts at the plan-year end, or average enrollments over the entire plan period. Average enrollment = the sum of monthly enrollments divided by the number of months in the plan year.
- You may associate a pool identified here with one or more plans in Section 4, but only associate each plan in Section 4 with one pool.

Section 3 — Check My Spreadsheet Validations

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

Section 4 — Health Plan-Year Information – All Plan Years (Beginning or Ending) in 2015

List one record for each health-plan design offered in the 2015 calendar year. List each plan-year period separately, but use the same plan code for each record with the same plan/cost-share design. In other words, if the same plan design spans multiple periods, use the same plan code for each record regardless of the period. If the cost-share design for a plan changes, assign a new plan code to that plan. We recommend adding a suffix to the original plan code to indicate that it is a related plan that changed cost-share design from one period to the next.

Multiple plans can have the same cost-share design; for example:

Plan	Cost-Share Design
A	X
B	Y
C	X
D	Z

A carrier might offer Plan A to district one and Plan C to district two. The rates may be different, but the cost-share design is the same. Carriers could theoretically share the same cost-share design, although this is most unlikely.

Include plan design information in the narratives below. Include all plans beginning or ending in 2015 (if a plan ends before 2015 or starts after 2015, do not include it).

For plans that follow the calendar year, list each plan once per cost-share level. For plans which span multiple calendar years, list each plan period which covers a portion of calendar-year 2015 separately (for example, 2014 – 2015 and 2015 – 2016 are listed separately). Do not include plans which end prior to, or begin after, 2015. Do not include plans that do not include a portion of the 2015 calendar year.

Year 4 notes — Plans and Benefit Package codes used in the Year 4 submission for 2015. Plans for 2015 must be consistent with Year 3 submissions. For a plan design continuing into the next year, do not change the plan code or Benefit Package code; instead, please use the same plan codes and Benefit Package code. Aggregation of plans (into a Benefit Package) should not change unless the plan design changes.

Definitions

Benefit Package: Benefit Packages were invented for the purposes of this project in response to carriers' concerns about publishing proprietary data in the yearly report and exhibits. “Benefit Package” is not a standard industry term. Carriers had a very strong desire not to publish plan design, enrollment, performance, and other measures at the plan level. So Benefit Packages were invented to create a level of abstraction in terms of publishing information about plans.

There are rules around how plans should be aggregated into Benefit Packages. These rules allow aggregation of plans with low enrollment and with similar actuarial values. Aggregated plans must have the same plan periods (start and end dates).

Report all plans in a Benefit Package, although a Benefit Package may consist of only a single plan. The reporting in Sections 5, 6, and 7 must be done at the Benefit Package level, and cannot be done at the plan level. If a plan is not aggregated with other plan(s) into a Benefit Package, the un-aggregated plan should nevertheless be reported as a Benefit Package (consisting of one plan). Carriers may use the same code for Plan_Code and BP_Code.

Costshare Code: A Costshare Code identifies a plan design that may be used by one plan or shared across multiple plans. This Section establishes the linkage between Plan_Codes and Costshare_Codes, which are used in Section 10 to report plan designs (cost-sharing features).

Rateset Code: The rates associated with individual plans are not reported directly. This is instead done indirectly by means of the Rateset Code. There may be a one-to-many relationship between Ratesets and Plans. A Plan must belong to only one Rateset, and each Rateset may apply to one or many Plans.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Plan_Name	Health benefit plan name	Text 60
C	Plan_Code	Plan identifier. List one record for each plan/cost-share design/plan year. Each plan code/period combination must be unique. The same code for a different period indicates the same plan design continues into the next period. Section 8 references plan codes for reporting district enrollments by plan.	Text 20

Col	Column Name	Column Definition	Format
D	BP_Code	Benefit Package (BP) identifier. The project team uses this value to associate a plan design reported here with the reporting of the plan's performance data in Sections 5, 6, and 7. There should be one BP Code for each plan code, with some exceptions. You may aggregate plans with less than 200 employees into a BP Code. If the aggregation of these "small" plans does not produce 200 employees or more in total, one may add a "large" plan to the BP aggregation to bring the total employees to 200 or more. "Large" plans are those plans with 200 or more employees. Do not aggregate two or more large plans. You may also aggregate plans with similar actuarial values. We recommend that the plans have, at a minimum level of similarity, the same "metal" level. Metal levels are platinum, gold, silver, and bronze, as defined in the ACA. Do not change BP Codes for plans and aggregations used for Year 3 data. Apply the above rules only to plans new to Year 4 data that have new plan codes. Apply BP aggregations consistently in Sections 5, 6, and 7. See the Section 5 for more details on reporting performance in a BP aggregation.	Text 20
E	Pool_Code	Pool code from Section 3 used to identify reserves used for this plan.	Text 20
F	HDHP_YN	Is this a high-deductible health plan?	Y or N
G	Plan_Type	Choose a Plan Type code from this list: • HMO — licensed as an HMO • PPO — In-network and out-of-network benefits, includes POS and "Open Access" HMO plans • Closed Network — Similar to HMO with in-network only benefits	Text 20
H	PY_Beginning	Plan-year-beginning date	Date
I	PY_Ending	Plan-year-ending date	Date

Col	Column Name	Column Definition	Format
J	Desc_CoveredBenefits	Plan summaries are not required. Complete Section 10 and provide appropriate plan design information including deductible levels, co-insurance, copays, and other cost-share features. The CostShare_Code in Section 10 should match the CostShare_Code in this Section 4.	Leave this field blank
K	Desc_Supplemental	Describe separate supplemental services offered that are not built into premiums. These include programs that are not part of the medical plan billed separately. Examples include wellness programs, weight management programs, and others.	Text
L	CostShare_Code	Cost-share Code for this plan design. Section 10 specifies cost-share codes and identifies deductible levels, co-insurance, copays, and other cost-share features.	Text 20
M	Plan_Act_Value	Plan actuarial value (0.00 – 1.00), as published in the federal regulations implementing the Affordable Care Act[6].	Value between 0.00 – 1.00
N	Ded_FollowCalendar	Deductibles reset on calendar year	Y or N

[6] The Minimum Value Calculator will return values as a decimal between 0.00 – 1.00 for each plan's actuarial value. A value of 1.00 would indicate that a plan covers 100% of expected medical expenses for an average population. A value of 0.90 would indicate that a plan covers 90% of expected medical expenses for an average population. Some individuals, in this example, might see more than 90% of their expenses covered, whereas others would see less.

Below is an example that lists plan codes, plan periods, actuarial values, Benefit Package codes, and a note indicating in which subsequent Sections to list that Benefit Package for the stated plan-year-ending date.

Row	Plan Code	Plan Year Beginning and Ending	Actuarial Value	BP Code	BP Plan-Year-Ending Date is Included in Following Sections
A	Plan1-200	10/1/2014 – 9/30/2015	0.90	BP1	9/30/2015 in Sections 5, 6, 7, 8
B	Plan1-200	10/1/2015 – 9/30/2015	0.90	BP1	9/30/2015 in Sections 6 and 8
C	Plan2-500	10/1/2014 – 9/30/2015	0.85	BP2	9/30/2015 in Sections 5, 6, 7, 8
D	Plan2-500	10/1/2014 – 9/30/2015	0.85	BP2	9/30/2015 in Section 6 and 8
E	Plan3-200	9/30/2014 – 9/30/2015	0.90	BP1	Included in **A**
F	Plan3-200	10/1/2014 – 9/30/2015	0.90	BP1	Included in **B**
F	Plan4-250	1/1/2015 – 12/31/2015	0.90	BP3	12/31/2015 in Sections 5,6,7,8
G	Plan4-1000	1/1/2015 – 12/31/2015	0.77	BP4	12/31/2015 in Sections 5,6,7,8

The above example shows:

- Typical plan-year-beginning and ending periods
- Plan codes with different cost-share designs are listed using separate codes
- Plan1-200 and Plan3-200 are aggregated into BP1 for the given periods, PYE 9/30/2015 and PYE 9/30/2015
- BP codes do not combine plans with different actuarial values or mixed periods
- Plans that begin, but do not end, in 2015 are reported in Section 6 (monthly) and Section 8 (by district), but not in Section 5 (plan-year-ending) or Section 7 (demographics at plan-year-ending)

Section 8 includes each plan code and plan-year-ending combination with a breakdown of district enrollments by employee groups for the given plan, with premium rates shown separately for each group.

Once plans are included in a given Benefit Package, the aggregation should be consistent across Sections. Total premiums/claims for each Benefit Package/period should be similar across Sections. Annual enrollments also should be similar; that is, Section 6 shown by month and each month should be similar to the annual total, with monthly variations expected.

Section 4 — Check My Spreadsheet Validations

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

Section 5 — Benefit Package Performance — Plan Years Ending in 2015

Report Benefit Package performance for plan years ending in 2015. For school district plan years, this is typically 10/1/2014–9/30/2015. Performance data includes enrollment, premiums, and claims. Annual performance includes utilization, administration, supplemental fees, and other expenses. Report on performance for plan years ending in the calendar year 2015 only.

For plans with less than 200 employees, you may create Benefit Packages that are an aggregation of such smaller plans. You may also aggregate plans with similar actuarial values into a Benefit Package when reporting plan performance, including small and large plans. Report the aggregated plans as instructed below. Please report aggregated plans in Year 4 on the same basis as Year 3. Aggregated plans must have consistent plan-year-beginning and plan-year-ending dates.

You may calculate actuarial values according to publicly available tools such as the "Minimum Value Calculator" published in federal regulations implementing the Affordable Care Act. Plan aggregations must be consistent across all Sections. The same rules of consolidation by Benefit Package apply to performance reporting in Sections 6, 7, and 8; please apply the rules consistently across Sections.

For non-aggregated plans, the Plan_Code and BP_Code may be the same.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	BP_Code	Benefit Package code from Section 4	Text 20
C	PY_Ending[7]	Plan-year-ending date	Date
D	Total_Supplemental	Plan-year total fees for supplemental services	Currency
E	Exp_Comm	Plan-year total commissions paid	Currency
F	Exp_Taxes	Plan-year total taxes and WSHIP, or other assessments paid	Currency
G	Exp_PPO	Plan-year total Preferred Provider Organization access fees	Currency
H	Exp_Fees3rdP	Plan-year total fees paid to associations, trusts, and other third parties, including benefit administration and marketing-related compensation	Currency
I	Exp_OtherAdmin	Plan-year total carrier admin fees not reported above. This represents the carrier's administration expense component of premium[8].	Currency
J	Capitation_Payments	Plan-year total capitation payments	Currency

[7] Use the plan-year-ending date for the plan associated with the Benefit Package code. If the Benefit Package code is an aggregate of plans, all of the plans in that aggregation should have the same plan-year-ending dates.

[8] This field cannot be zero. It is the carrier's component share of premiums or the carrier's administration fees, administration expense or retention. This represents the carrier's cost of doing business exclusive of state premium taxes, PPO access fees, commissions, or other payments to third parties.

Col	Column Name	Column Definition	Format
K	Inpatient_AvgLOS	Plan-year inpatient-facility average lengths-of-stay. This should equal Inpatient_D/Inpatient_A Average length of stay (LOS) is not measured on a per 1,000 basis. It is the total inpatient days divided by the total admissions. Or total inpatient days per 1,000 divided by total admissions per 1,000. Either way the answer is the same.	Decimal 1[d]
L	Inpatient_A	Plan-year inpatient facility admits per 1,000 members	Decimal 3
M	Inpatient_D	Plan-year inpatient days per 1,000 members	Decimal 3
N	Outpatient_V	Plan-year outpatient facility visits per 1,000 members **without ER visits**	Decimal 3
O	Outpatient_ER_V	Plan-year outpatient **ER visits only** per 1,000 members	Decimal 3
P	Professional_V	Plan-year professional services visits per 1,000 members	Decimal 3
Q	OtherMed_V	Plan-year other medical visits per 1,000 members	Decimal 3
R	Pharmacy_GS	Plan-year pharmacy generic scripts (30-day fills) per 1,000 members	Decimal 3
S	Pharmacy_BS	Plan-year pharmacy brand scripts (30-day fills) per 1,000 members	Decimal 3

Notes on Utilization Computations

1. Compute plan-year enrollments as either snapshot values at plan-year-ending, or average enrollments (average = total of monthly enrollments ÷ number of months).

2. Utilization columns L through S are per 1,000 members. A value of 1,000.000 = an average of one occurrence per member per plan year. Scripts are per 30-day fills. A value of 12,000.000 = an average of one script per member per month.

3. Prescriptions offered for longer than 30-day fills should be adjusted to correspond to 30-day fills as follows: Divide the number of days actually given by 30. So a 34-day fill would be reported as 1.133 prescriptions.

4. Prescriptions offered for less than 30-day fills should be reported as follows: Divide the number of days actually given by 30. So, report a 7-day fill as 0.233 prescriptions for 1 and 0.0467 for 2.

5. Compute and round utilization values to three places after the decimal.

Section 5 — Check My Spreadsheet Validations

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

Section 6 — Benefit Package Performance by Month – All Plans (Beginning or Ending) in 2015

You must report monthly data for all months for plans with plan years ending in 2015. If a plan ends before the end of calendar year 2015 (12/31/2015) and the SAME plan is continued into calendar year 2016, then you must report the plan months in calendar year 2015. This may require reporting more than 12 months of data. For example:

Plan	Plan Year	Report Months
XYZ	10/1/2014 – 9/30/2015	Oct 2014, Nov 2014, Dec 2014, Jan 2015, Feb 2015, Mar 2015, Apr 2015, May 2015, Jun 2015, Jul 2015, Aug 2015, Sep 2015
XYZ	10/1/2015 – 9/30/2016	Oct 2015, Nov 2015, Dec 2015

It is important to ensure all months of calendar year 2015 are reported if a plan spans more than one calendar year.

Please list each Benefit Package with enrollment, premiums, and paid claims for each calendar month within the plan years starting or ending in 2015.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	BP_Code	Benefit Package code from Section 4	Text 20
C	PY_Ending[9]	Plan-year-ending date	Date
D	Calendar_Month	The year and calendar month of 2015 for which the data is applicable in the form YYYYMM. Example: February 2015 = 201502.	Text 6
E	Emp_Enrollment	Enrolled employees headcount	Integer
F	Dep_Enrollment	Enrolled dependent headcount	Integer
G	Total_MedPremiums	Medical portion of premiums; include Rx, exclude vision and dental	Currency
H	Total_Claims	Total claims	Currency
I	Inpatient_Claims	Inpatient facility claims	Currency
J	Outpatient_Claims	Outpatient facility claims without ER claims	Currency
K	Outpatient_ER_Claims	ER claims only	Currency
L	Professional_Claims	Professional services claims	Currency
M	OtherMed_Claims	Other medical claims	Currency
N	Pharmacy_Claims	Pharmacy claims	Currency

[9] Use the plan-year-ending date for the plan associated with the Benefit Package code. If the Benefit Package code is an aggregate of plans, all of the plans in that aggregation should have the same plan-year-ending dates.

Notes/Examples:

1. For a plan beginning 10/1/2014 and ending 9/30/2015, and then continuing into 2016, report all 12 plan months (October 2014 through September 2015) for the plan year ending 9/30/2015, and the first three months of the plan year ending 9/30/2016 (October – December of 2015). Report 15 months of data.
2. For a plan beginning 1/1/2015 and ending 12/31/2015, report 12 months of data.
3. Do not include plans ending before calendar year 2015 or beginning after calendar year 2015. Report all data for calendar year 2015.

Section 6 — Check My Spreadsheet Validations

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

Section 7 — Benefit Package Demographics — Plan Years Ending in 2015

For each Benefit Package, report employee and dependent demographics by gender, age, and coverage tier, as required by the legislation. Base tier-reporting of dependents on the coverage tier of the covered employee.

The demographic reporting record contains three indicators:

1. **Emp_Dep** indicator:
    a. **E** = Employee
    b. **D** = Dependent
2. **M_F** gender:
    a. **M** = Male
    b. **F** = Female
3. **Tier_Code** is one of five values:
    a. **EE** = Employee Only
    b. **ES** = Employee + Spouse
    c. **EC** = Employee + Child
    d. **EF** = Employee + Spouse + Child(ren)
    e. **OD** = Other Dependent.
4. For plans with additional tiers for multiple children, report using corresponding EC or EF tiers.

Each record holds 11 fields, each corresponding to an age bracket (documented below) to hold counts of members in the age bracket.

Detailed Processing Rules:

- For each employee, add 1 to the age bucket corresponding to the employee age, in the record Emp_Dep = E (Employee), M_F = the employee gender, and Tier_Code = the employee's coverage tier.
- For each employee dependent, add 1 to the age bucket corresponding to the dependent age, in the record Emp_Dep = D (Dependent), M_F = the dependent Gender, and Tier_Code = the corresponding employee's coverage tier. Tier "EE" should have no dependent record, and tier "OD" should have no employee records.
- A four-tier program design (without "OD") requires up to 14 records (EE-only tier has no male or female dependents). You may record a "0" for all ages, or omit the enrollment, for records with all counts equal to zero, or where selected tiers have no enrollments, or that you do not offer.
- The sum of all age counts in employee records and all age counts in dependent records should match reported head count totals by employee and dependents reported in the plan-year- ending data in Section 5, and in totals across all districts in Section 7.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	BP_Code	Benefit Package code from Section 4	Text 20
C	PY_Ending[10]	Plan-year-ending date	Date
D	Emp_Dep	**E** = Employee or **D** = Dependent	Text 1
E	M_F	**M** = Male or **F** = Female	Text 1
F	Tier_Code	Tier Code where **EE** = Employee Only, **ES** = Employee + Spouse, **EC** = Employee + Child, **EF** = Employee + Family or **OD** = Other Dependent	Text 2
G	Age_Tier1	Headcount Age Band 0–19	Integer
H	Age_Tier2	Headcount Age Band 20–24	Integer
I	Age_Tier3	Headcount Age Band 25–29	Integer
J	Age_Tier4	Headcount Age Band 30–34	Integer
K	Age_Tier5	Headcount Age Band 35–39	Integer
L	Age_Tier6	Headcount Age Band 40–44	Integer
M	Age_Tier7	Headcount Age Band 45–49	Integer
N	Age_Tier8	Headcount Age Band 50–54	Integer
O	Age_Tier9	Headcount Age Band 55–59	Integer
P	Age_Tier10	Headcount Age Band 60–64	Integer
Q	Age_Tier11	Headcount Age Band 65+	Integer

Section 7 — Check My Spreadsheet Validations

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

[10] Use the plan-year-ending date for the plan associated with the Benefit Package code. If the Benefit Package code is an aggregate of plans, all of the plans in that aggregation should have the same plan-year-ending dates.

15. Column P (Age_Tier10) is required, must be numeric and greater than or equal to 0, default is 0.
16. Column Q (Age_Tier11) is required, must be numeric and greater than or equal to 0, default is 0.

Section 8 — Plan Code Rates and Enrollment by District — All Plan Years (Ending or Beginning) in 2015

For each health plan, this Section requires reporting of information for each school district. Please list district total premiums for a twelve calendar-month period (January 2015 – December 2015) for plans which end and resume within 2015, and employee and dependent headcounts and rates at the end of the plan year. For districts with multiple groups of employees with different rates for the same plan, separate the enrollments and identify each group with a corresponding rate-set code, identified in Section 11 (plan rates).

Use the same Plan_Code when a plan ends in calendar year 2015 and that same plan resumes and continues into calendar year 2016. Be mindful of spelling and format — for example: The OIC K-12 Application considers "PlanCode3" and "Plan Code 3" to be different plans. When a plan ends, discontinue use of that Plan_Code.

You must report plans ending OR beginning in 2015. If a plan ends before the end of calendar year 2015 (12/31/2015) and the SAME plan is continued into calendar year 2016, then you must report the plan data for the period within calendar year 2015. It is important to ensure all months of calendar year 2015 are reported if a plan spans more than one calendar year.

The tier counts are expressed as a whole number and represent the count of employees or sponsors of the plan, NOT dependents/beneficiaries. The sum of the Tier counts (EE, ES, EC, EF, and OD) must equal the Emp_Count.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Plan_Code	Plan code from Section 4	Text 20
C	PY_Ending	Plan-year-ending date	Date
D	SD_Code	District county code from OSPI Lists[11]	Text 5
E	Emp_Count	Plan-year employee headcount	Integer
F	Dep_Count	Plan-year dependent headcount	Integer
G	Total_MedPremiums	Plan-year total medical portion of premiums	Currency
H	District_Name	District Name	Text 60
I	RateSet_Code	Code to match to the set of rates in Section 11	Text 20
J	RateSet_Desc	This describes to which employee group the rates tie	Text 40
K	EE_Count	Plan-year employee enrollment count at EE	Integer
L	ES_Count	Plan-year employee enrollment count at ES	Integer
M	EC_Count	Plan-year employee enrollment count at EC	Integer
N	EF_Count	Plan-year employee enrollment count at EF	Integer
O	OD_Count	Plan-year employee enrollment count at OD	Integer

[11] SD_Code is the district-county code from the OSPI listing of districts at https://eds.ospi.k12.wa.us/schoollist.aspx

Note: Section 8 column J is the Rateset Code, which ties to the Rateset Code in Section 11. It is the rate-set matching for the plan (and employee group) in Section 8. Section 8 may have multiple instances of a plan code if there are multiple employee groups. Section 8 column K is the Rateset Description, which describes to which employee group the rates tie. Below is an example, using made-up values:

Plan Code	Rateset Code	Rateset Description	Notes
A	1	Certificated	This might be District 1's certificated employees
A	2	Classified	This might be District 1's classified employees
A	3	Certificated	This might be District 2's certificated
B	4	Certificated	This might be District 1's certificated
C	1	Certificated	Two different plans may have same rates, although this is highly unlikely

Rateset Code 1: $400 EE, $800 ES, $700 EC, $1,100 EF

Rateset Code 2: $500 EE, $1,000 ES, $900 EC, $1,400 EF

… and so on.

Section 8 — Check My Spreadsheet Validations

1. Column B (Plan_Code) is required; Plan_Code/PY_Ending must match a Plan_Code/PY_Ending defined in Section 4 Columns C and I.
2. Column C (PY_Ending) is required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1st of the current calendar year, nor can it be later than December 31st of the next calendar year. For year 4 this range is 1/1/2015 – 12/31/2016.
3. Column D (SD_Code) is required, numeric, 5 digits including leading 0, must be a valid County/District code.
4. Column E (Emp_Count) is required, must be numeric and greater than or equal to 0, default is 0, must be a whole number.
5. Column F (Dep_Count) is required, must be numeric and greater than or equal to 0, default is 0, must be a whole number.
6. Column G (Total_MedPremiums) is required, must be numeric and greater than 0, default is 0.

Section 9 — Large Claims — For Plan Years Ending in 2015

For all plans combined, offered to all K–12 districts statewide — list **aggregated** claims by **claimant** with an aggregated total in excess of $100,000 for the plan year ending in 2015. Include claimant status (Employee, Spouse, or Child) and major diagnosis code.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Claim_Amount	Amount in Dollars	Currency
C	Claimant_Status	Indicate Claimant: **E** = Employee, **S** = Spouse, or **C** = Child	Text 1
D	Diagnosis _Code*	If ICD 9 — Input a numeric value of 1 to 19, according to the list of Major Diagnosis Codes shown below. If ICD 10 — input the three-digit diagnosis code in the letter-number-number format.	Free-form text
E	PY_Ending	Plan-year-ending date	Date

* In Year 4 of the OIC Data Call, carriers may report large claims using either an ICD-9 or an ICD-10 diagnosis code — please see below for more detailed instructions about this.

ICD-9 Major Diagnosis Codes (MDC)

If you choose to report a large claim using the applicable ICD-9 diagnosis code, then please use one of the following codes to identify the primary diagnosis code associated with the most services and/or expense:

1	Infectious and Parasitic Diseases (001–139)
2	Neoplasms (140–239)
3	Endocrine, Nutritional, and Metabolic Diseases, and Immunity Disorders (240–279)
4	Diseases of the Blood and Blood-Forming Organs (280–289)
5	Mental Disorders (290–319)
6	Diseases of the Nervous System and Sense Organs (320–389)
7	Diseases of the Circulatory System (390–459)
8	Diseases of the Respiratory System (460–519)
9	Diseases of the Digestive System (520–579)
10	Diseases of the Genitourinary System (580–629)
11	Complications of Pregnancy, Childbirth, and the Puerperium (630–679)
12	Diseases of the Skin and Subcutaneous Tissue (680–709)
13	Diseases of the Musculoskeletal System and Connective Tissue (710–739)
14	Congenital Anomalies (740–759)
15	Certain Conditions Originating in the Perinatal Period (760–779)
16	Symptoms, Signs, and Ill-Defined Conditions (780–799)

17	Injury and Poisoning (800–999)
18	V01–V91 — Supplementary Classification of Factors Influencing Health Status
19	e000–e999 — Supplementary Classification of External Causes of Injury and Poisoning

ICD-10 Major Diagnosis Codes (MDC)

If you choose to report a large claim using the applicable ICD-10 diagnosis code, then please enter the three-digit Major Diagnosis Code associated with the most services and/or expense. The MDC should be in the ICD-10 letter-number-number format, for example, A00, K95, and so on.

Section 9 — Check My Spreadsheet Validations

1. Column B (Claim_Amount) is required, must be numeric and greater than or equal to 0.
2. Column C (Claim_Status) is required, E = Employee, S = Spouse, or C = Child.
3. Column D (Diagnosis_Code) required, 2 or 3 characters in length:

   ICD-9 Format: 1 or 2 characters, numeric, value between 1 and 19 inclusive.

   ICD-10 Format: 3 characters.
   Character 1 — alpha, value between A through Z inclusive;
   Characters 2 and 3 — numeric, value between 00 and 99 inclusive.

3. Column E (PY_Ending) is required, must be a valid date. Ending date of latest reported plan year cannot be prior to January 1st of the current calendar year, nor can it be later than December 31st of the next calendar year. For year 4 this range is 1/1/2015 – 12/31/2016.

Section 10 — Plan Cost-Share Designs — All Plan Years (Beginning or Ending) in 2015

For all plans combined, offered to all K–12 districts statewide — list each unique plan cost-share design.

NOTE: Report Coinsurance values (Columns G – J) as the portion that the Employee pays, not the carrier.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	CostShare_Code	This is the unique code for the cost-share design, referenced in Section 4 (one or more plans can reference the same cost-share code); there is no standard for the CostShare_Code. It can be a numeric, alpha, or alphanumeric field that represents each unique set of plan benefits. If each plan is different and does not share cost-sharing values with other plans, then each plan should have a unique CostShare_Code. You could use "1" for first unique benefit design, "2" for the second one, and so on. Alternatively, you could give them names that describe plan benefits, as long as the code is 20 characters or less in length.	Text 20
C	Ded_Individual_In	Deductible, individual, per calendar year, in-network	Numeric
D	Ded_Individual_Out	Deductible, individual, per calendar year, out-of-network. Enter: **0** (for none), A numeric value (dollars), **–1** if not covered, or **–2** if the out-of-network services are included in the in-network individual deductible	Numeric
E	Ded_Family_In	Deductible, family, per calendar year, in-network	Numeric
F	Ded_Family_Out	Deductible, family, per calendar year, out-of-network. Enter: **0** (for none), A numeric value (dollars), **–1** if not covered, or **–2** if the out-of-network services are included in the in-network family deductible	Numeric
G	Coins_Prevent_In	Coinsurance percentage, preventive services, in-network. This is the portion the employee pays. Enter: **0** (for none), or a numeric value between 0 and 100 (do not include the "%" sign) or **–1** if not covered.	Numeric

Col	Column Name	Column Definition	Format
H	Coins_Prevent_Out	Coinsurance percentage, preventive services, out-of-network. This is the portion the employee pays. Enter: **0** (for none), A numeric value between 0 and 100, do not include the "%" sign; or −**1** if not covered	Numeric
I	Coins_Other_In	Coinsurance percentage, other services, in-network. This is the portion the employee pays. Enter a numeric value between 0 and 100. Do not include the "%" sign.	Numeric
J	Coins_Other_Out	Coinsurance percentage, other services, out-of-network. This is the portion the employee pays. Enter: **0** (for none), A numeric value between 0 and 100, do not include the "%" sign; or −**1** if not covered.	Numeric
K	Copay_Office_In	Copay, office visit, in-network. Enter a numeric amount	Numeric
L	Copay_Office_Out	Copay, office visit, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **−1** if not covered	Numeric

M	Copay_Inpatient_In	Copay, inpatient visit, in-network. Enter:
		0 (for none),
		A numeric dollar amount,
		$ per day, or
		$ per day and the maximum number of copays
			Text 30

N	Copay_Inpatient_Out	Copay, inpatient visit, out-of-network. Enter:
		0 if none,
		$ per day,
		$ per day and the maximum number of copays
		$ per admit, or
		−1 if not covered
			Text 20

O	Copay_Outpatient_In	Copay, outpatient visit, in-network. Enter a numeric amount.	Numeric
P	Copay_Outpatient_Out	Copay, outpatient visit, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **−1** if not covered	Numeric

Q	Copay_ER_In	Copay, ER visit, in-network. Enter a numeric amount.	Numeric
R	Copay_ER_Out	Copay, ER, out-of-network: **0** (for none), A numeric dollar amount, or **–1** if not covered	Numeric
S	OOPM_Individual_In	Out-of-pocket maximum, individual, in-network	Numeric

Col	Column Name	Column Definition	Format
T	OOPM_Individual_Out	Out-of-pocket maximum, individual, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **–2** if included in in-network OOPM	Numeric
U	OOPM_Family_In	Out-of-pocket maximum, family, in-network. Enter a numeric value.	Numeric
V	OOPM_Family_Out	Out-of-pocket maximum, family, out-of-network. Enter: **0** (for none), A numeric dollar amount, or **–2** if included in in-network OOPM	Numeric
W	Rx_Deductible_In	Prescription deductible. Enter: **0** (if none), or A numeric dollar amount per person, or **–1 if included in the medical deductible**	Text 20
X	Rx_Retail_CostShare	Retail cost share in three classes — per days' supply shown in column Y: Generic/Brand/Non-Formulary Brand Enter: No coverage, Cost-share $ per prescription per tier, Cost-share % per tier, Minimum or maximum $ cost share per tier Examples: $10/$20/Not covered $10/$20/50% (Max $100) $5/$15/50% (Max $35)	Text 30
Y	Rx_Retail_Days_Supply	Retail days' supply (for example, 30 or 34)	Numeric
Z	Rx_MailOrder_CostShare	Mail-order cost share (same format as Retail)	Text 30
AA	Rx_MailOrder_Days_Supply	Mail Order days' supply (for example: 90)	Numeric
AB	Rx_Specialty_CostShare	Specialty cost share	Text 30
AC	Rx_Specialty_Days_Supply	Specialty days' supply	Numeric
AD	Plan_Comments	Other plan comments/footnotes	Text Memo

Numeric code values for descriptions in numeric fields:

–1 = Not covered

–2 = Included in In-Network (for example, if in-network deductibles included out-of-network services)

Section 10 — Check My Spreadsheet Validations

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

Section 11 — Plan Rates — All Plans Offered (Beginning or Ending) in 2015

Table of plan rates — for all plans combined offered to all K–12 districts statewide — list each unique set of plan rates by tier.

Section 8 references plan rates by district. Identify each group of employees with different rates, with their corresponding enrollments by using a reference to a rate-set code corresponding to this table. Any plans/districts/groups with identical rates may reference the same Rateset in this table.

Col	Column Name	Column Definition	Format
A	Status	Value is set for a return error, if an error is found	Leave blank
B	Rate_Set_Code	Rate-set code from Section 8	Text 20
C	EE_Rate	Employee-only rate	Currency
D	ES_Rate	Employee and spouse rate	Currency
E	EC_Rate	Employee and child(ren) rate	Currency
F	EF_Rate	Employee, spouse, and child(ren) rate	Currency
G	OD_Rate	Other dependent rate (if used)	Currency

Section 11 — Check My Spreadsheet Validations

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

Questions?

Please contact Joe Rueter at OCDataCallTeam@Treinen.com.