CONNECTICUT 2.0 PARTNERSHIP PLAN

# REPORT ON THE STATUS *of the* CONNECTICUT PARTNERSHIP PLAN

FY22 | Prepared January 2023

PREPARED BY THE OFFICE *of the* STATE COMPTROLLER

OSC.CT.GOV/CTPARTNER


## *THE BASICS*

- **PLAN OPENED IN 2016**
- **24,605 EMPLOYEES**
- **58,502 MEMBERS**
- **160 ENROLLED GROUPS**

## EXECUTIVE SUMMARY

The Connecticut Partnership Plan offers non-state public employers the choice to participate in the state employee health plan. Participating groups rely on the same programs as the state health plan, and all claims from both plans are pooled to determine premium rates. All eligible groups that apply are admitted to the plan as long as they include all of their covered lives.

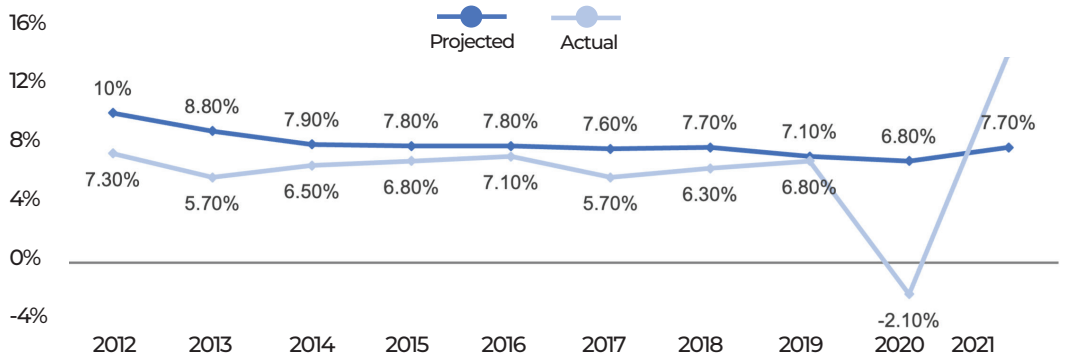
The Partnership Plan has allowed Connecticut cities and towns to obtain quality health insurance for their employees at affordable rates by accessing the contract terms and pricing available to the state as a large purchaser. In addition, participating groups get access to innovative programs, like the state's Health Enhancement Program (HEP), which provides lower premiums and cost share in exchange for members agreeing to receive preventive care and screenings. This program has shown significant positive impacts on preventive cancer screening rates and improvements in health equity.

Yet, like all private and public health plans, the last few years have been challenging due to the COVID-19 pandemic. Beginning in December of 2021, the Partnership Plan experienced a spike in claims due to delayed care from the COVID pandemic and increased hospitalizations specifically from the Omicron variant. The plan continues to see increased numbers of high-cost claimants, likely another impact of the COVID pandemic.

Nationwide increases in health care costs and a surge in health care utilization outdid actuarial projections affecting health plans across Connecticut and the country. The Partnership Plan was no exception. In Fiscal Year (FY) 2022, the plan collected less in premiums than it paid in claims for the first time in three years. In total, the plan took in approximately $622 million in premiums from enrolled members and paid out approximately $659 million in claims. The Medical Loss Ratio (MLR)–the percent of premiums the health plan spends on medical and pharmacy claims–was 106 percent. Independent actuaries currently project the MLR in FY23 to be 98 percent.

While health plans are generally conservative with health care cost projections, typically projecting higher cost increases than they actually experience, the opposite occurred in calendar year 2021. According to the actuarial firm Segal, forecasters' recent projections have not anticipated the magnitude of the rebound in health care utilization for medical plans. In calendar year 2021, actual Preferred Provider Organization (PPO) trends were 6.3 percentage points greater than projected as reported by commercial and self-insured health plans in a survey whose respondents cover 80% of the US market. As the graph below indicates, calendar year 2021 was the only year in the last decade in which actual health care plan cost growth outpaced projections for survey respondents.

## COMPARISON OF PROJECTION VS. ACTUAL PPO TRENDS




Source: 2023 Segal Health Plan Cost Trend Survey Report

Partnership Plan rates are calculated by an independent actuarial firm selected through a competitive bidding process. By statute, Partnership Plan rates are set based upon the combined health care claims experience of the State and Partnership Plans. Historically, the Partnership Plan has had similar utilization patterns to those seen in the State Plan. Thus, when adjusting for regional cost differences, the combined premium covered costs incurred by both groups. Recently, the Partnership Plan has experienced a greater spike in high-cost claimants than the State Plan.

The State Auditors of Public Accounts have oversight authority to audit the plan like all other programs of the Office of the State Comptroller. Each vendor payment made by the plan is updated in real-time to the state's nationally renowned transparency website, OpenConnecticut. The Comptroller's Office is also bound by Freedom of Information laws and has consistently provided data on the Partnership Plan to all requesters.

Despite the challenges the Partnership Plan and all public and private health plans have faced over the last two years, the Partnership Plan remains an indispensable benefit that can create savings for cities and towns, while offering quality and affordable health insurance to Connecticut's police officers, firefighters, teachers and other municipal workers.

As this report outlines, the Comptroller's office will be working with partners in municipal and state government to strengthen the health of the overall plan and offer an additional plan option for municipalities.

## ABOUT THE PARTNERSHIP PLAN

The Connecticut Partnership Plan is a point-of-service (POS) health plan available to non-state public employers and their employees. This includes municipalities, boards of education, quasi-public agencies, housing authorities, public libraries, and other public entities. The plan shares benefits, administration, and programs with the state health plan.

Claims from Partnership groups are pooled with those of the state health plan and used to establish rates.

The current Partnership Plan was established under Public Act 15-93 and began enrolling members on January 1, 2016. The Office of the State Comptroller administers the plan and contracts with private companies to manage benefits and claims processing, actuarial services, and health care programs.

Leveraging the size and negotiating power of the state employee health plan to benefit municipalities and other non-state public employers is a common practice across states, including Connecticut's neighbors: Massachusetts, Vermont and New Jersey.

### *Participating Groups*

As of January 1, 2023, the Partnership Plan has 58,502 enrolled employees and dependents representing 160 groups. By statute, the plan must admit all complete groups that apply.

Enrolled groups range in size from 8,016 total members (City of Bridgeport and Board of Education) to one (Cornwall Library, Deep River Housing Authority and Rocky Hill Housing Authority).

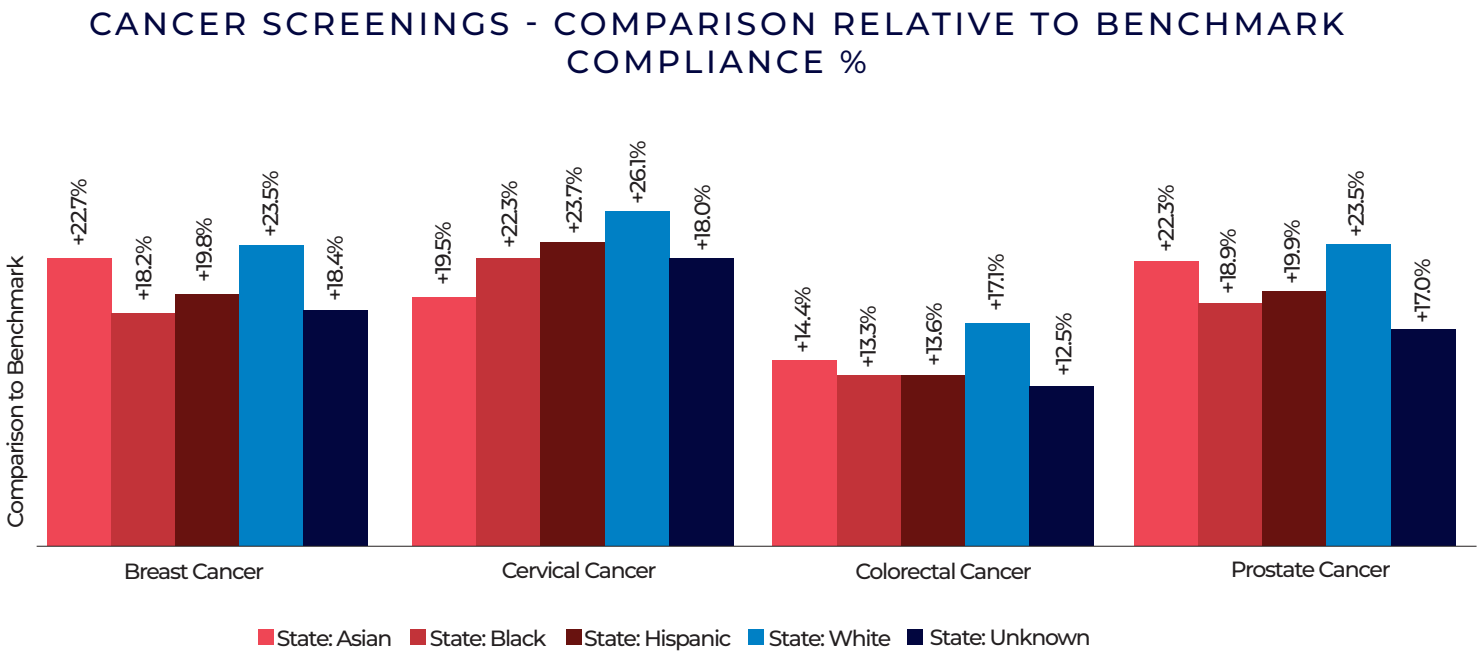
### *Offered Benefits*

Partnership Plan members have access to the same POS health plan as state employees. The plan has no- or low-deductibles for all services. Medical and pharmacy coverage are provided for all members, but individual groups may also decide to add dental coverage or a vision rider.

The cost-saving and wellness programs created by the state health plan are available to Partnership members as well. This includes:

- **Providers of Distinction**: a program that incentivizes members to use high quality, efficient providers for certain planned surgeries and services. Recent analysis indicates that the program saved the State and Partnership Plan as much as $28 million in FY22.
- **Diabetes Management Programs**: programs to prevent and manage diabetes including Livongo, which provides access to coaching, a free connected glucose meter and supplies. The plan also offers pre-diabetes programming to help members avoid becoming diabetic altogether.
- **Digital Orthopedic Services:** Upswing Health is an orthopedic resource that offers no-cost at home treatments to prevent surgery.

- **The Health Enhancement Program (HEP)**: a preventive health initiative that incentivizes members to receive several age-based services, such as physicals, dental cleanings, and cholesterol screenings, to maintain long-term health. The program is responsible for significantly improving cancer screening rates across all racial and ethnic groups. A recent Health Equity analysis of the State health plan found that the program was responsible for improving compliance with preventive cancer screenings well in excess of typical employer plans for all racial and ethnic groups.




Preventative Cancer Screenings
(Race and Ethnicity)

- **PrudentRx**: a specialty drug discount program that applies manufacturer assistance to reduce member and plan costs for high-cost specialty drugs. The program began July 1, 2022 and has saved the State Plan and Partnership Plan a combined $12 million through November 2022 and reduced member cost shares by approximately $600,000.

- **Primary Care Initiative**: a pilot program that gives primary care providers additional financial resources to invest in improved care management, coordination, and access for members to improve the care experience, improve outcomes and reduce total health care costs.

## *Public-Private Partnerships*

The Office of the State Comptroller has contractual agreements with a host of private companies to assist in administration of the Partnership Plan and provide programs for members.

**Anthem Blue Cross Blue Shield (Anthem)** is the plan's third-party administrator. Anthem manages eligibility and billing for medical and pharmacy coverage and offers its same POS plan design available to state employees.

**Cigna** provides fully insured dental and vision options to Partnership groups and manages the related eligibility and billing.

**CVS Caremark** is the pharmacy benefit manager for both the state health plan and the Partnership Plan. CVS utilizes a tiered prescription pricing plan and a maintenance drug network to allow members to receive maintenance drugs at local pharmacies at reduced costs.

**WellSpark** is the administrator for the Health Enhancement Program (HEP). WellSpark manages claims tracking for required preventive services and chronic disease management and related compliance. It also administers the virtual Diabetes Prevention Program.

**Upswing** provides telehealth orthopedic care to members with the goal of low-cost treatment and surgical avoidance. Upswing can diagnose injuries, connect members virtually with athletic trainers and recommend additional services as needed.

**Livongo** provides resources for members with diabetes including a free connected glucose monitor, supplies and access to health coaches.

**Health Advocate** operates the plan's "Health Navigator" program, a benefits concierge service to answer member questions about coverage and assist in connecting patients with the care they need.

**Segal** is an independent actuarial firm contracted to assist in monitoring financials and setting plan rates.

## FINANCIAL REPORT

| SPAN | PREMIUMS | CLAIMS | MLR |
|---|---|---|---|
| 7/1/17 – 6/30/18 | $140,669,124 | $150,040,021 | 106.7% |
| 7/1/18 – 6/30/19 | $358,398,841 | $380,547,450 | 106.2% |
| 7/1/19 – 6/30/20 | $512,762,495 | $484,097,446 | 94.4% |
| 7/1/20 – 12/31/20 | $272,319,765 | $236,120,985 | 86.7% |
| 7/1/20 – 6/30/21 | $557,177,149 | $508,175,960 | 91.2% |
| 7/1/21 – 6/30/22 | $622,034,873 | $659,088,796 | 106% |
| 7/1/22 – 6/30/23 | $633,431,524 | $620,970,349 | 98.0% |

The Partnership Plan experienced financial challenges in FY22, collecting less in premiums than it paid in claims. The plan ended FY22 with a MLR of 106 percent — meaning for every $1 collected in premiums, $1.06 was expended on medical and pharmacy claims. Segal, the plan's independent actuarial contractor, currently projects FY23 to have a year-end MLR of 98 percent.

The imbalance between claims costs and premiums was primarily the result of projected claims costs that were lower than actual experience, a trend experienced by health plans across the country this year. As noted above, there were unanticipated cost increases resulting from pent-up demand and an unforeseen additional spike in COVID hospitalizations due to the Omicron variant. The understated projection was not unique to the State and Partnership Plans and was a driving force behind large rate increases in the fully insured market and other self-insured plans this year.

The Partnership premium, by statute, is required to be equivalent to that of the State Plan. Recently Partnership claims have been higher than those of the State Plan. The variance between the Partnership Plan and the State Plan is driven in large part by high-cost claimants. High-cost claimant costs tend to be highly variable, even in large groups like the Partnership Plan or State Plan. Thus, it remains to be seen if the higher Partnership claims costs as compared to the State Plan is temporary or will prove to be consistent.

FY23 projections remain uncertain due to the potential impacts of inflation on the health care industry. Prices spiked nationally for goods and services across the board in calendar year 2022. According to the US Bureau of Labor Statistics, the Consumer Price Index peaked at an annual rate of 9 percent in June of 2022. The health care market experienced inflation for medical and hospital services, prescription drugs, and wages intensified by the COVID pandemic. According to the health care consulting firm Kaufman Hall, hospitals are struggling with escalating expenses due to widespread labor shortages and supply chain issues. Total expense per adjusted discharge was up 25 percent, and labor expense per adjusted discharge was up 28 percent year-to-date since 2019[1]. The US Department of Health and Human Services also reported that between July 2021 and 2022, the average price increase of over 1,200 prescription drugs was 31.6 percent, vastly outpacing the overall inflation rate[2]. Inflationary pressure remains a risk but is showing signs of slowing down in FY 2023.

[1]Swanson, Erik. "National Hospital Flash Report: November 2022." Kaufman Hall, 30 November, 2022.
https://www.kaufmanhall.com/insights/national-hospital-flash-report-november-2022

[2]Bosworth, A, Sheingold, S, Finegold K, De Lew, N, Sommers, B.D. "Price Increases for Prescription Drugs, 2016-2022." (Issue Brief No. HP-2022-27). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. 30 September, 2022. https://aspe.hhs.gov/sites/default/files/ documents/d850985c20de42de984942c2d8e24341/price-tracking-brief.pdf

In Fiscal Years 2018 and 2019, the Partnership Plan had a MLR greater than 100 percent. It was determined that geographic disparities in the cost of health care must be accounted for in rate setting, as is done in the commercial market.

Legislation requested by the Comptroller's office established county-based rates that would be phased-in over three years. Regional rate adjustments were first applied to new groups in FY20 and phased in (50 percent) for existing groups in FY21. FY22 was the first year in which the regionally adjusted premiums were fully applied across the entirety of Partnership Plan participants.

## *Funding*

The Partnership Plan is funded by premiums paid by enrolled groups. Premium payments are deposited into the Partnership account. The Partnership account balance as of January 4, 2023, is approximately $30 million.

At the close of calendar year 2021, expiring federal COVID relief funds were used to offset COVID related costs in both the Partnership and State health plans. The Partnership Plan received approximately $39 million in reimbursements which helped increase the plan's reserve fund account balance. No other state or federal funds have been transferred to the Partnership account.

| FISCAL YEAR | FAD YEAR-END BALANCE |
|---|---|
| FY 2016 | $384,269 |
| FY 2017 | $8,831,813 |
| FY 2018 | $2,230,584 |
| FY 2019 | $8,040,047 |
| FY 2020 | $23,668,462 |
| FY 2021 | $31,575,411 |
| FY 2022 | $58,486,561 |
| **FY 2023** | **$29,801,478** |

## *Administrative Costs*

Enrolled Partnership Plan groups have administrative costs included in their premiums. Those costs cover the state employees who support the program, as well as fees for the vendors and consultants.

In FY22, administrative costs were approximately 2.4 percent.

Segal projects the administrative cost in the FY23 rates to be 2.6percent. The administrative costs for the Partnership Plan have been around 2.5 percent each year, well below typical costs in the private market.

## OVERSIGHT & REPORTING

The Office of the State Comptroller is required to submit annual reports on the Partnership Plan to the Health Care Cost Containment Committee (HCCCC), the Office of Policy and Management (OPM) and the legislature's Appropriations Committee.

The state selected Segal to perform actuarial services for both the Partnership Plan and the State Plan after a competitive bidding process. Segal provides independent financial analysis to determine the fiscal state of the plan and calculates all premium rates for Partnership groups.

The State Auditors of Public Accounts maintain oversight authority into all functions of the Office of the State Comptroller, including the Partnership Plan. Additionally, the Comptroller must provide legal statements of fact on the financial status of the agency and the office, and its employees must comply with all Freedom of Information laws as a public agency.

Each vendor payment made on behalf of the Partnership Plan is also updated to OpenConnecticut, the Comptroller's transparency website that updates checkbook-level payment information on a nightly basis.

## FUTURE OUTLOOK

The Partnership Plan provides top-quality health care benefits at reasonable rates to 160 groups including municipal, boards of education, and other non-state public employers in Connecticut. It allows smaller public groups to access the state's low administrative costs and aggressive discounts as well as innovative programming like the Health Enhancement Plan, Provider of Distinction Program and PrudentRx.

The full implementation of county level rates has corrected regional imbalances, and the cost-saving measures aimed at reducing long-term costs through surgery avoidance, preventive care, chronic disease management and lowering emergency room use will all grow more impactful over time.

The Plan's Medical Loss Ratio (MLR) is expected to improve with independent actuaries projecting the MLR for FY23 to be 98 percent. While the predictability of the post-COVID healthcare market has proved challenging, the Comptroller's Office will continue to monitor and report on costs from Partnership Plan enrollees versus State Health plan enrollees to ensure the long term strength and sustainability of the program.

The Partnership Plan remains a significant benefit to municipal and board of education employees and their dependents, including police, firefighters, teachers and other essential workers. Combined, the State Plan and Partnership Plan is the largest group plan in Connecticut and has notable market strength that results in favorable contractual terms and innovative programs for enrollees. Enrolled Partnership groups will continue to benefit from being part of that larger pool.

## ADDENDUM

Sec. 3-123yyy of the Connecticut General Statutes requires the Comptroller's Office to "include a plan to ensure the fiscal adequacy of the premium rate structure" for participants in the Partnership Plan, when "the profit loss ratio demonstrates inadequacy in premium payments." As reported above, the Partnership Plan incurred losses in FY22. The Comptroller's Office recommends taking a deliberative approach to addressing the reported financial deficiencies.

Over the long-term, the combined State and Partnership Plans will cover their costs as understated projections in a given year are covered by the plan's reserve funds. The resultant lower reserve fund balances are incorporated into future year rate increases to replenish the reserve funds.

The real risk to the long-term financial stability of the Partnership Plan is if the Partnership Plan's per member health care costs are consistently higher than those of the State Plan after regional cost adjustments are applied. Should this occur, the Partnership Plan premiums, as applied under current statute, would be consistently too low to cover the plan's costs.

The primary factor driving losses in FY22 was an understated claims cost projection by the plan's actuary due to the unpredictable environment created by the COVID pandemic. The losses in FY22 have been accounted for in developing the rates for FY23. While unfortunate, this loss does not indicate long-term challenges to the financial stability of the Partnership Plan. Moreover, higher than projected claims costs were an issue faced by many health plans across the state and nation.

Over the first 8 months of calendar year 2022, the Partnership Plan had higher per member costs than the State Plan, even after adjusting for regional cost differences due to a higher percentage of high-cost claimants in the Partnership Plan.

The cost variation between the State Plan and the Partnership Plan was also impacted by a small number of groups leaving the Partnership Plan this calendar year. On average, the groups leaving had better medical loss ratios, which resulted in slightly increased average costs of approximately one percent for remaining Partnership Plan members.

It is not yet clear that higher average costs for the Partnership Plan will be consistent into the future. Already, Partnership claims data from the most recent months have begun to show some moderation in overall costs.

In the short-term, the Comptroller's Office will take steps within its existing authority to strengthen the plan. This includes the introduction of an additional lower-cost plan option. A lower-cost plan option will make the Partnership Plan financially accessible to more municipal groups and boards of education, allowing more non-state public employers and employees to enjoy the benefits of the plan and potentially attracting more diverse risk profiles.

The Comptroller's Office will continue to monitor the cost variation between the plans. Should cost differentials prove persistent overtime, with the Partnership Plan consistently more costly than the State Plan, the Comptroller's Office will require additional flexibility in order to avoid long-term financial losses in the Partnership Plan.

Any changes to the premium calculation for Partnership would require a statutory change. The current statute requires premiums to "*be the same as those paid by the state inclusive of any premiums paid by state employees*" with allowable adjustments for regional cost differentials or differences in covered benefits. The current law provides no allowance to adjust the Partnership Plan's premium due to differences in the underlying claims costs of the Partnership Plan relative to the State Plan, thus a consistent cost differential will result in an imbalance between Partnership premiums and plan costs.

The existing premium development requirements have certain benefits and are not unique to Connecticut. Many other states, including New Jersey, Massachusetts and Vermont, allow non-state public employers to buy into their state employee health care plan, and many offer a single combined premium, just like the state of Connecticut. The current design for premium calculations has real and meaningful benefits. First, it creates a simple premium that prospective groups and unions can use to assess the potential financial benefit of joining the plan. Second, it provides increased year to year stability for Partnership groups as premiums are based on a 220,000-member group, which in general will have more moderate year to year premium fluctuations

than a single small or medium sized group. Third, the plan provides predictable annual premium costs as the premium is fixed for the year, making annual health care budgeting predictable for participating groups.

Any modifications to the premium calculation in the future should retain, as best as possible, the benefits of the current process. Potential options that could address long-term imbalances between claims costs and premiums for the Partnership Plan include:

1. Creating a limited number of additional premium tiers. For example, a high, medium and low premium tier. Groups would pay the premium amount that corresponds with their historic claims costs. Higher cost groups would pay higher rates than the State Plan, while lower cost groups would pay less. This type of structure should use multiple years of experience to place groups in each tier and limit the overall premium differential between each tier. Creating premium tiers would allow the Partnership Plan to better attract and retain lower risk groups because they would get a relatively lower premium rate than available today. In addition, it would allow the Partnership Plan to collect more in premiums when the membership, on average, is more costly than the State Plan. This is because a higher percentage of the participating groups would fall into the higher cost premium tier, increasing the premium amount collected and keeping premiums in line with total projected claims costs.

2. Allowing the Comptroller to set independent reserve fund adjustments for the Partnership and State Plans. A reserve fund adjustment is an adjustment to the premium calculation to account for the current reserve fund balance of a health plan. If the reserve fund has more funds than necessary to cover claims runout (claims incurred but not yet paid) and reasonable claims fluctuations, then the reserve fund adjustment will result in a reduction in the premium. Alternatively, if the reserve fund is too low, then the adjustment will result in an increase in the premium. Currently, the Partnership Plan premiums are calculated using the combined reserve fund balance of the State Plan and Partnership Plan accounts. Should the plans continue to have divergent claims experience, with the State Plan less costly than the Partnership Plan, then the combined adjustment will result in a persistent and growing surplus in the State Plan reserve fund and a consistently growing deficit in the Partnership Plan reserve fund. Allowing the Comptroller to make independent reserve fund adjustments for each plan would avoid this issue, as any annual losses in the Partnership Plan would be accounted for in the following year's premium through the reserve fund adjustment. This would prevent continuous and growing deficits in the Partnership Plan account regardless of differentials in the claims experience between the Partnership Plan and the State Plan.

Both above options retain the core elements of the current Partnership Plan—predictable annual premiums, stable year to year premium fluctuations and simple pooled premium rates. Should the Partnership Plan continue to see higher average costs than the State Plan, it will be necessary to consider plan improvements in order to avoid long-term financial losses.

In closing, the Partnership Plan remains a significant and meaningful benefit for tens of thousands of first responders, teachers and other public servants and their families. The plan provides contractual terms and innovative programing that would not otherwise be available to individual municipalities or boards of education. Consistent with the statutory requirement in Sec. 3-123yyy this report offers possible options to resolve financial deficits in the Partnership Plan, however the current state of the Partnership Plan does not necessitate immediate legislative action. The existing rate development structure has worked well in other states over long periods of time. Moreover, the primary driver of the financial challenges to the Partnership Plan in FY22 was the instability of health care costs caused by direct impacts from the Covid-19 pandemic. Most recent claims data is showing some return to normalcy; however, some uncertainty persists related to the impacts inflationary forces on the health care industry. The Comptroller's Office will continue to monitor the financial performance of the Partnership Plan to determine if additional action is required to strengthen its financial stability. In the meantime, the Comptroller will continue to promote the benefits of the plan to enrolled and eligible groups to sustain and grow the Plan.

Again, the Partnership Plan remains a significant benefit to municipal and board of education employees and their dependents, including police, firefighters, teachers and other essential workers. Combined, the State Plan and Partnership Plan is the largest group plan in Connecticut and has notable market strength that results in favorable contractual terms and innovative programs for enrollees. Enrolled Partnership groups will continue to benefit from being part of that larger pool.

## Medical/Pharmacy
## July 01, 2021 through June 30, 2022

| Month | Subscribers | Members | Premium | Medical Claims | Pharmacy Claims | Total Claims | Loss Ratio |
|---|---|---|---|---|---|---|---|
| Jul-21 | 26,472 | 63,788 | $51,722,669 | $41,696,913 | $7,678,167 | $49,375,079 | 95.5% |
| Aug-21 | 26,651 | 64,210 | $52,056,003 | $44,574,949 | $8,295,429 | $52,870,378 | 101.6% |
| Sep-21 | 26,714 | 64,396 | $51,265,844 | $42,122,406 | $8,141,301 | $50,263,708 | 98.0% |
| Oct-21 | 26,720 | 64,401 | $52,431,061 | $45,952,160 | $8,370,895 | $54,323,055 | 103.6% |
| Nov-21 | 26,754 | 64,448 | $52,266,059 | $49,525,254 | $8,900,648 | $58,425,902 | 111.8% |
| Dec-21 | 26,756 | 64,446 | $52,286,185 | $55,983,856 | $8,698,660 | $64,682,515 | 123.7% |
| Jan-22 | 26,789 | 63,806 | $51,674,845 | $44,879,271 | $8,728,544 | $53,607,815 | 103.7% |
| Feb-22 | 26,763 | 63,847 | $52,349,290 | $43,291,454 | $8,288,412 | $51,579,866 | 98.5% |
| Mar-22 | 26,756 | 63,875 | $51,740,985 | $46,085,924 | $8,982,618 | $55,068,542 | 106.4% |
| Apr-22 | 26,670 | 63,803 | $51,890,374 | $44,764,845 | $8,444,477 | $53,209,322 | 102.5% |
| May-22 | 26,626 | 63,726 | $51,349,917 | $46,634,706 | $8,289,057 | $54,923,762 | 107.0% |
| Jun-22 | 26,554 | 63,630 | $51,001,641 | $52,151,989 | $8,716,862 | $60,868,851 | 119.3% |
| **Total** | **26,685** | **64,031** | **$622,034,873** | **$557,663,726** | **$101,535,070** | **$659,198,796** | **106.0%** |

**Data Sources**

1. Segal's SHAPE Claims Database from Anthem and CVS: Subscribers, Members, Medical Claims and Pharmacy Claims on paid basis.
2. Pharmacy claims reflect Point of Sale Rebates.
3. Premium: Anthem billed premium
4. This report is subject to change in the future as enrollment and claims are restated with the State's data aggregator.

## Medical/Pharmacy
## July 01, 2022 through June 30, 2023

| Month | Subscribers | Members | Premium | Medical Claims | Pharmacy Claims | Total Claims | Loss Ratio |
|---|---|---|---|---|---|---|---|
| Jul-22 | 26,149 | 62,643 | $55,460,830 | $44,204,500 | $6,645,848 | $50,850,348 | 91.7% |
| Aug-22 | 26,225 | 62,852 | $55,491,265 | $47,305,267 | $8,007,324 | $55,312,591 | 99.7% |
| Sep-22 | 25,335 | 60,579 | $53,747,597 | $41,541,218 | $6,841,863 | $48,383,081 | 90.0% |
| Oct-22 | 24,878 | 59,305 | $53,364,104 | $43,629,796 | $7,174,239 | $50,804,035 | 95.2% |
| Nov-22 | 24,658 | 58,723 | $52,471,657 | $42,740,989 | $7,369,305 | $50,110,295 | 95.5% |
| Dec-22 | 24,572 | 58,502 | $51,842,296 | $44,750,000 | $7,620,000 | $52,370,000 | 101.0% |
| Jan-23 | 24,572 | 58,502 | $51,842,296 | $44,590,000 | $7,620,000 | $52,190,000 | 100.7% |
| Feb-23 | 24,572 | 58,502 | $51,842,296 | $44,590,000 | $7,620,000 | $52,190,000 | 100.7% |
| Mar-23 | 24,572 | 58,502 | $51,842,296 | $44,590,000 | $7,620,000 | $52,190,000 | 100.7% |
| Apr-23 | 24,572 | 58,502 | $51,842,296 | $44,590,000 | $7,620,000 | $52,190,000 | 100.7% |
| May-23 | 24,572 | 58,502 | $51,842,296 | $44,590,000 | $7,620,000 | $52,190,000 | 100.7% |
| Jun-23 | 24,572 | 58,502 | $51,842,296 | $44,590,000 | $7,620,000 | $52,190,000 | 100.7% |
| **Total** | **24,937** | **59,468** | **$633,431,524** | **$531,711,770** | **$89,258,580** | **$620,970,349** | **98.0%** |

### Data Sources

1. Jul22-Nov22: Segal's SHAPE Claims Database from Anthem and CVS: Subscribers, Members, Medical Claims and Pharmacy Claims on paid basis.
2. Dec22-Jun23 (Projection): Subscribers and Members are adjusted for groups that terminated effective December 1, 2022 and reflect no further change. Claims are based on Segal projected FYE2023 PEPM costs and expected subscribers. Claims for Dec22 also include projected runout for groups that terminated December 1st.
3. Jul22-Dec22: Premium reflects OSC billed premium.
4. Jan23-Jun23 (Projection): Premium reflects the Dec22 OSC billed premium.
5. Pharmacy claims reflect Point of Sale Rebates.
6. This report is subject to change in the future as enrollment and claims are restated with the State's data aggregator.

## Experience by Group (part 1 of 2)
## Medical/Pharmacy
## July 01, 2021 through June 30, 2022

| Group Name | Average Subscribers | Average Members | Annual Premium | Annual Medical Claims | Annual Pharmacy Claims Net of Rebates | Annual Total Claims | Loss Ratio |
|---|---|---|---|---|---|---|---|
| Ansonia City | 72 | 177 | $1,841,234 | $1,484,341 | $207,810 | $1,692,151 | 91.9% |
| Bethel BOE | 360 | 985 | $9,123,145 | $6,832,102 | $1,089,623 | $7,921,726 | 86.8% |
| Bethel Town | 126 | 306 | $3,076,217 | $2,149,886 | $446,347 | $2,596,233 | 84.4% |
| Bolton Town & BOE | 137 | 324 | $2,855,486 | $2,230,831 | $462,331 | $2,693,162 | 94.3% |
| Bridgeport BOE | 2,595 | 5,169 | $58,927,689 | $48,330,749 | $8,185,223 | $56,515,972 | 95.9% |
| Bridgeport City | 1,511 | 3,170 | $36,460,664 | $31,740,972 | $6,736,297 | $38,477,270 | 105.5% |
| Bridgeport Housing Authority/Park City Communities | 117 | 236 | $2,711,692 | $2,900,064 | $587,636 | $3,487,700 | 128.6% |
| Brookfield BOE | 330 | 856 | $7,913,277 | $6,261,383 | $898,180 | $7,159,563 | 90.5% |
| Brookfield Town | 112 | 276 | $2,725,317 | $2,281,731 | $344,691 | $2,626,422 | 96.4% |
| Canterbury Public Schools | 65 | 147 | $1,359,701 | $713,493 | $152,514 | $866,007 | 63.7% |
| Charter Oak/Stamford Housing | 64 | 140 | $1,428,455 | $1,340,263 | $167,933 | $1,508,196 | 105.6% |
| Clinton Public Schools | 244 | 676 | $5,972,925 | $7,114,613 | $1,121,384 | $8,235,997 | 137.9% |
| Clinton Town | 62 | 144 | $1,366,861 | $1,666,359 | $122,471 | $1,788,830 | 130.9% |
| Columbia Town & BOE | 87 | 207 | $1,690,672 | $1,308,345 | $244,515 | $1,552,860 | 91.8% |
| East Hampton BOE | 233 | 619 | $5,442,300 | $4,638,200 | $1,210,945 | $5,849,145 | 107.5% |
| East Hampton Town | 68 | 187 | $1,662,828 | $1,683,652 | $336,160 | $2,019,812 | 121.5% |
| East Lyme BOE | 450 | 1,121 | $7,742,774 | $8,394,880 | $1,405,570 | $9,800,450 | 126.6% |
| East Windsor BOE | 179 | 368 | $3,250,313 | $2,812,828 | $502,938 | $3,315,766 | 102.0% |
| East Windsor Town (Anthem) | 63 | 154 | $1,383,412 | $1,083,985 | $1,384,511 | $2,468,496 | 178.4% |
| Easton Town | 52 | 128 | $1,273,915 | $1,035,691 | $230,178 | $1,265,869 | 99.4% |
| Fairfield PS | 1,338 | 3,598 | $33,674,800 | $29,073,363 | $5,926,242 | $34,999,605 | 103.9% |
| Greater Bridgeport Transit (GBTD) | 123 | 228 | $2,433,728 | $2,179,051 | $818,969 | $2,998,020 | 123.2% |
| Greater New Haven Transit | 87 | 175 | $1,796,389 | $1,649,722 | $200,682 | $1,850,403 | 103.0% |
| Greenwich Town & BOE | 2,205 | 5,439 | $53,956,845 | $53,471,208 | $9,013,104 | $62,484,313 | 115.8% |
| Housatonic Area Transit Auth | 63 | 112 | $1,201,618 | $941,613 | $112,310 | $1,053,923 | 87.7% |
| Lebanon BOE | 146 | 377 | $3,512,027 | $1,926,942 | $409,022 | $2,335,964 | 66.5% |
| Ledyard BOE | 292 | 704 | $5,898,437 | $5,213,534 | $1,203,966 | $6,417,500 | 108.8% |
| Middletown BOE | 518 | 1,242 | $11,300,984 | $9,829,805 | $1,716,989 | $11,546,793 | 102.2% |
| Monroe BOE | 389 | 1,078 | $9,955,137 | $6,488,804 | $1,540,669 | $8,029,474 | 80.7% |
| Monroe Town | 109 | 267 | $2,638,185 | $1,564,691 | $458,103 | $2,022,794 | 76.7% |
| New Haven Housing Authority | 107 | 265 | $2,487,934 | $2,415,914 | $312,024 | $2,727,938 | 109.6% |
| New London Public Schools | 393 | 832 | $8,625,204 | $10,906,499 | $1,834,781 | $12,741,280 | 147.7% |
| New Milford BOE | 582 | 1,387 | $8,752,122 | $10,440,499 | $2,281,116 | $12,721,615 | 145.4% |
| North Branford BOE | 178 | 426 | $4,115,670 | $5,034,945 | $686,170 | $5,721,115 | 139.0% |

## Experience by Group (part 2 of 2)
## Medical/Pharmacy
## July 01, 2021 through June 30, 2022

| Group Name | Average Subscribers | Average Members | Annual Premium | Annual Medical Claims | Annual Pharmacy Claims Net of Rebates | Annual Total Claims | Loss Ratio |
|---|---|---|---|---|---|---|---|
| Norwalk City | 802 | 1,977 | $20,650,467 | $15,039,984 | $2,992,600 | $18,032,584 | 87.3% |
| Norwalk Public Schools | 1,650 | 3,834 | $37,310,665 | $33,323,844 | $5,478,397 | $38,802,241 | 104.0% |
| Norwalk Transit | 74 | 170 | $1,719,555 | $1,309,308 | $278,070 | $1,587,378 | 92.3% |
| Oxford Public Schools | 205 | 540 | $5,047,837 | $4,408,265 | $531,834 | $4,940,099 | 97.9% |
| Plainville BOE | 316 | 781 | $6,672,756 | $6,760,418 | $1,164,504 | $7,924,922 | 118.8% |
| Plainville Town | 103 | 241 | $2,155,707 | $2,223,721 | $432,054 | $2,655,775 | 123.2% |
| Plymouth BOE | 178 | 429 | $3,856,535 | $3,036,326 | $665,315 | $3,701,641 | 96.0% |
| Preston BOE | 86 | 210 | $1,673,289 | $1,290,305 | $244,476 | $1,534,781 | 91.7% |
| Region One BOE | 121 | 296 | $2,655,955 | $1,991,641 | $359,760 | $2,351,401 | 88.5% |
| Regional School District #17 | 308 | 861 | $7,510,914 | $7,036,000 | $1,217,049 | $8,253,048 | 109.9% |
| Ridgefield Town | 192 | 505 | $4,871,094 | $4,607,193 | $1,143,917 | $5,751,110 | 118.1% |
| Southeast Area Transit (SEAT) | 57 | 104 | $1,090,738 | $1,002,814 | $133,303 | $1,136,117 | 104.2% |
| Stafford Town | 51 | 141 | $1,128,237 | $1,150,916 | $90,596 | $1,241,512 | 110.0% |
| Stamford City | 916 | 2,222 | $21,964,301 | $21,161,873 | $3,937,686 | $25,099,559 | 114.3% |
| Stamford Public Schools | 1,692 | 3,944 | $38,721,948 | $39,078,706 | $5,971,132 | $45,049,837 | 116.3% |
| Thompson BOE | 124 | 313 | $2,820,966 | $1,327,865 | $745,220 | $2,073,086 | 73.5% |
| Trumbull BOE | 784 | 2,114 | $19,911,131 | $16,678,250 | $4,080,105 | $20,758,355 | 104.3% |
| Trumbull Town | 253 | 645 | $6,221,672 | $5,798,559 | $1,366,546 | $7,165,105 | 115.2% |
| West Hartford BOE | 1,323 | 3,465 | $29,289,983 | $27,208,835 | $4,744,864 | $31,953,700 | 109.1% |
| West Hartford Town | 278 | 773 | $6,287,922 | $5,020,157 | $745,849 | $5,766,006 | 91.7% |
| West Haven BOE | 615 | 1,338 | $13,050,004 | $11,083,584 | $1,841,660 | $12,925,244 | 99.0% |
| West Haven City | 258 | 606 | $5,907,437 | $10,919,537 | $1,053,824 | $11,973,361 | 202.7% |
| Weston PS | 320 | 908 | $8,377,367 | $6,648,866 | $1,677,318 | $8,326,185 | 99.4% |
| Westport BOE | 798 | 2,120 | $19,546,328 | $18,215,930 | $2,584,146 | $20,800,076 | 106.4% |
| Wilton Town | 127 | 317 | $3,139,584 | $4,449,822 | $253,311 | $4,703,133 | 149.8% |
| Woodstock BOE | 102 | 225 | $2,168,320 | $2,357,890 | $237,647 | $2,595,537 | 119.7% |
| Small Groups Combined (<50 Subscribers) | 1,503 | 3,434 | $39,726,205 | $27,392,158 | $5,212,482 | $32,604,640 | 82.1% |
| **Total** | **26,693** | **64,033** | **$622,034,873** | **$557,663,726** | **$101,535,070** | **$659,198,796** | **106.0%** |

### Data Sources

1. Segal's SHAPE Claims Database from Anthem and CVS: Subscribers, Members, Medical Claims and Pharmacy Claims on paid basis.
2. Pharmacy claims reflect Point of Sale Rebates.
3. Premium: Anthem billed premium
4. This report is subject to change in the future as enrollment and claims are restated with the State's data aggregator.

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# Memorandum

**To:** State of Connecticut - Office of the State Comptroller (OSC)

**From:** Mark Noonan, ASA, MAAA

**Date:** January 3, 2023

**Re:** Actuarial Certification

Segal has been retained to calculate preliminary rates for July 1, 2023 and projected loss ratios on behalf of the State of Connecticut for the Partnership 2.0 plan. The calculations in this report were completed in accordance with generally accepted actuarial principles and practices, consistently applied, based on the data described in this report.

The projections in this report are estimates of future costs and are based on information provided to Segal by OSC, Anthem and CVS at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from new health care reform legislation or other recently passed state or federal regulations.

Projections of retiree costs take into account only the dollar value of providing benefits for retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection.

I am an Associate of the Society of Actuaries and member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

Mark J. Noonan, ASA, MAAA
Vice President and Consulting Actuary