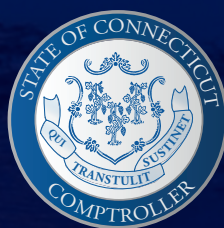


REPORT ON THE STATUS OF THE CONNECTICUT PARTNERSHIP PLAN

Prepared March 2021



PREPARED BY THE OFFICE OF THE STATE COMPTROLLER

REPORT ON THE STATUS OF THE CONNECTICUT PARTNERSHIP PLAN

EXECUTIVE SUMMARY

The Connecticut Partnership Plan offers non-state public employers the choice to buy-in to 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 full eligible groups that apply are admitted to the plan.

The Partnership Plan ended Fiscal Year 2020 in good financial standing, taking in more in premiums than it paid in claims with a Medical Loss Ratio (MLR) of 94 percent (medical loss ratio is the percent of premiums a health plan spends on claims and expenses). So far in FY 2021, the plan is repeating its positive performance with an MLR of 86.7 percent. While claims declined due to COVID-19, the plan's MLR was under 100 percent prior to the pandemic and continues to be as health care services have picked back up in frequency. Independent actuaries project the plan to maintain its positive financial status going forward. Initial FY 2022 estimates project an MLR of 96.6 percent.

A 2019 legislative change allowed the plan to set rates at a county level to account for regional differences in health care costs. The plan did have an MLR over 100 percent in FY 2018 and 2019 and with the new regional rates being phased in FY 2021 and fully applied in FY 2022 to all existing groups the plan projects to continue to maintain an MLR under 100%.

Partnership Plan rates are calculated by an independent actuarial firm selected through a competitive bidding process. The State Auditors have oversight authority to audit the plan as they can all other programs of the Office of the State Comptroller. Each vendor payment made by the plan is posted 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 always provided data on the Partnership Plan to all requesters.

The Partnership Plan provides municipal governments an opportunity to benefit from the market power of the state health plan and its programs, including a world-class preventive health initiative. Groups join to save on costs, improve benefits and reduce volatility. Since the Partnership Plan became fully pooled with the state plan, enrollment has consistently expanded without a single group choosing to exit the plan. The Partnership Plan is an indispensable resource protecting Connecticut teachers, first responders and other municipal workers.

CONNECTICUT
PARTNERSHIP PLAN 

The Basics

-  **PLAN OPENED IN 2016**
-  **59,500 MEMBERS**
-  **141 ENROLLED GROUPS**
-  **0 GROUPS LEFT PLAN**

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. Premium payments are deposited into a non-lapsing account and never co-mingled with funds associated with the state employee plan. All claims payments and expenses for the Partnership Plan are debited from the Partnership account. Since the plan began, it has been, and continues to be, self-sustaining.

The current Partnership Plan was established under PA 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.

Participating Groups

As of March 1, 2021, the Partnership Plan had 59,500 enrolled employees and dependents representing 141 groups. By statute, the plan must admit all complete groups that apply.

Enrolled groups range in size from 8,254 total members (Bridgeport city and Board of Education) to one (Cornwall Library).

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 the Health Enhancement Program (HEP), a preventive health initiative that incentivizes members to receive a number of age-based services, such as physicals, dental cleanings and cholesterol screenings, to maintain long-term health.

Other programs include the Network of Distinction, a collection of doctors and providers that meet specific quality metrics and have contracted to provide certain services and procedures at one bundled cost, from evaluation through recovery. Upswing Health is an orthopedic resource that offers no-cost at home treatments to members with the goal of surgical avoidance. Health Navigator is the plan's concierge customer service program to assist members with all aspects of their benefits.

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.

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.

Signify Health partners with the state to contract with hospitals and provider groups joining the Network of Distinction.

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

The Connecticut Partnership Plan is financially stable and projects to remain so into the future. In Fiscal Year 2020, the plan achieved a medical loss ratio (MLR) of 94 percent — meaning for every \$1 collected in premiums, \$0.94 was expended on claims.

Through the first six months of Fiscal Year 2021, the MLR stands at 86.7 percent. The amount spent on claims was lower than anticipated due to the onset of the COVID-19 pandemic and a corresponding delay in care for many members. However, from July 2019 through Feb. 2020, the plan was running a favorable MLR and has maintained that status as the frequency of claims has recovered in recent months.

Segal, the plan's independent actuarial contractor, currently projects Fiscal Year 2021 to have a year-end MLR of 91.5 percent and Fiscal Year 2022 to have an MLR of 96.6 percent. Administrative costs project to be 2.3 percent, leaving a projected 1.1 percent surplus.

Unlike private-sector plans that utilize low MLRs to generate profits, the balance of unused premium dollars paid by Partnership groups is exclusively held in reserve and utilized to reduce costs of premiums in future years.

SPAN	PREMIUMS	CLAIMS	MLR
Jul 1, 2017 - Jun 30, 2018	\$140,669,124	\$150,040,021	106.7%
Jul 1, 2018 - Jun 30, 2019	\$358,398,841	\$380,547,450	106.2%
Jul 1, 2019 - Jun 30, 2020	\$512,762,495	\$484,097,446	94.4%
Jul 1, 2020 - Dec 31, 2020 (ACTUAL)	\$272,319,765	\$236,120,985	86.7%
Jul 1, 2020 - Jun 30, 2021 (PROJECTED)	\$557,890,338	\$510,514,464	91.5%
Jul 1, 2021 - Jun 30, 2022 (PROJECTED)	\$587,606,000	\$567,853,000	96.6%

As a self-insured plan, premiums are established to meet projected claims plus administrative costs and appropriate reserve levels. Plan actuaries view the projected 1.1 percent surplus as a healthy margin. For reference, the state plan typically has an MLR of around 97-98 percent.

The recent financial success of the Partnership Plan, and its stable future projections, are due in part to a 2019 legislative change to the underlying statute. In Fiscal Years 2018 and 2019, the Partnership Plan had an 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 on the commercial market.

Legislation requested by the comptroller established county-based rates that would be phased-in over

three years. Regional rate adjustments were first applied to new groups in Fiscal Year 2020 and phased in (50%) for existing groups beginning in Fiscal Year 2021. Fiscal Year 2022 will be first year in which the regionally adjusted premiums will be fully applied across the entirety of Partnership Plan participants.

The change has had an immediate impact on the plan's finances, improving the MLR to under 100 percent in the first year of the phase-in and is a major factor in the favorable projections going forward.

Funding

The Partnership Plan is funded by premiums paid by enrolled groups. Premium payments are deposited into the Partnership Funds Awaiting Distribution (FAD) account.

The current Partnership FAD balance is approximately \$57.5 million. When accounting for invoices received and awaiting payment, the balance is \$22.7 million.

The Partnership FAD is funded only by premiums paid by enrolled groups. State funds have never been appropriated or transferred to the Partnership FAD account. In addition, the Partnership FAD account has always maintained a positive balance and does not have accounting authority to run a negative fund balance. Excess funds in the Partnership FAD account are held in reserve to guard against future claims spikes and keep premium increases low. The ending balances of the Partnership FAD account are reported annually in the comptroller's report on a budgetary basis since its inception and are displayed in the table to the right.

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 <i>(Year to date)</i>	\$57,521,541

Administrative Costs

Enrolled Partnership Plan groups have administrative costs included in their premiums. Those costs cover the state employees who support the program, fees for the vendors and consultants, and costs associated with the Health Enhancement Program (HEP) for data warehouse analytics, chronic condition management and member communications.

Segal projects the administrative cost in the Fiscal Year 2022 rates to be 2.3 percent. The administrative costs for the Partnership Plan have been around 2 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. The latest was submitted in Jan. 2021 and delivered to the Office of Policy and Management, as required by statute.

The state selected Segal to perform actuarial services for both the Partnership Plan and the state health 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 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 it is a public agency.

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

FUTURE OUTLOOK

The Partnership Plan's financial situation is projected to remain strong into the future. 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.

Anthem has expressed a strong desire to expand membership in the plan by increasing its outreach to eligible groups. In its history, no group has elected to leave the plan and as enrollment increases, the experience of the pool as a whole will grow more stable.

The state health plan is the largest plan in Connecticut and has notable market strength that results in favorable contractual terms and innovative programs within the health care sector. Enrolled Partnership groups will continue to benefit from being part of that larger pool.

Memorandum

To: State of Connecticut - Office of the State Comptroller

From: Mark Noonan, ASA, MAAA

Date: March 16, 2021

Re: Actuarial Certification

Segal has been retained to calculate preliminary rates for July 1, 2021 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 later in this report.

The projections in this report are estimates of future costs and are based on information provided to Segal by Anthem, CVS and Oxford 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 the 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.

The Coronavirus (COVID-19) pandemic continues to evolve, and will likely continue to impact the US economy and health plan claims projections for most Health Plan Sponsors. Segal has developed and applied plan cost adjustments factors to both our long-term and short-term financial projections such as those described in this report. However, projections of near-term income and claim expenses could be significantly altered by emerging events. At this point, it remains unclear what the ultimate income and cost impact will be for Health Plan Sponsors. Unless specifically noted, this current report does not include any adjustments such as changes in eligibility, income, increases in healthcare costs or decreased investment returns. Additionally, the potential for federal or state fiscal relief is also not contemplated in these projections. Given the high level of uncertainty and fluidity of the current events, some plans may seek periodic updated estimates throughout the year to closely monitor health plan budget projections this year.

The signing actuary is an Associate of the Society of Actuaries and member of the American Academy of Actuaries. He meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

A handwritten signature in black ink, reading "Mark J. Noonan". The signature is fluid and cursive, with the first name "Mark" and last name "Noonan" clearly legible.

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