



CT Partnership Plan

Frequently Asked Questions

For your convenience this document is organized into three categories: Administration; Coverage; and Rates, Premiums and Fees

Administration

What happens to my agent/broker?

Broker fees are NOT built into the Partnership premium. We understand your agent may provide valuable services to your group. Participants wishing to keep their consultants and brokers can sign an independent service contract with them or work with the Partnership Plan to build broker or consultant fees into Partnership Premiums. If you have a broker, they may need to apply for a consulting license through the Department of Insurance in order to offer their services as a contracted consultant.

Who will process any eligibility changes to our group?

UnitedHealthcare will administer the medical, dental and vision plan in conjunction with CVS Caremark. As plan administrators they will process your eligibility changes.

Will there be a plan change in the benefit plan design?

The Partnership Plan benefit design is modeled after the State Employees Health Plan. Any changes to the plan design would require approval from the Health Care Cost Containment Committee (HCCCC) made up of leaders of SEBAC and the Office of Policy and Management.

Is the Partnership Plan fully insured or self funded?

The Partnership program as a whole is self funded, however the plan will work like a fully insured plan for any individual member. Each member's annual costs are fixed at the premium rates they were quoted upon entry. Monthly premiums are inclusive of all costs normally associated with a traditional self-insured plan like administrative fees, network access fees, rebates, and stop loss insurance. Any additional costs incurred by an individual group will be covered first by the "fluctuating reserve fund."

Who manages the Partnership Plan and will they administer COBRA?

UnitedHealthcare/Oxford is the third-party administrator for the Partnership Plan. COBRA is administered as part of the program.

Who is responsible for providing the ASO document?

A standard ASO document will be made available to all groups. Modifications regarding eligibility are on a case by case basis.

Coverage

What is the Health Enhancement Program (HEP)?

It is a program designed to promote routine health and wellness care for employees and, as a result, save money on health care in the long term by focusing health care dollars on prevention. New groups will be given a one year waiver to enroll in the HEP program.

Do we have to enroll in the Health Enhancement Program?

No, rates may be adjusted to those groups who do not wish to enroll in the Health Enhancement Program.

What is the Chronic Disease Management Program?

The Chronic Disease Management Program under HEP may require enrollees with one or more of five identified chronic conditions to participate in a disease education and counseling program for that particular condition. To assist enrollees with their disease management the program offers free office visits and reduced pharmacy co-pays for treatments related to their condition. The five chronic diseases covered by the Disease Management Program are: 1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension(high blood pressure).

What is the Maintenance Drug Network?

The Maintenance Drug Network provides members with two options to obtain 90-day supplies of their maintenance medications:

- 1. Obtain maintenance drugs through mail order; or*
- 2. Pick up maintenance drugs in person at any local pharmacy participating in the Maintenance Drug Network.*

You can find a list of participating pharmacies on the Comptroller's Website at (www.osc.ct.gov)

Is the dental program mandatory?

The dental plan is mandatory for groups participating in the Health Enhancement Program. As a part of the HEP program participants are required to receive two dental cleanings each year. Participating in the dental program ensures coverage for the required cleanings is available.

Does our entire group have to choose the same dental plan?

No, groups may choose more than one dental plan option.

Is the vision rider mandatory?

No, the vision rider is not a mandatory requirement in the Partnership Plan. Vision exams are built into the medical benefits. The vision rider supplies additional vision hardware benefits.

What if a provider isn't in the Network?

The plan offers out-of-network benefits. Should a provider not currently be in the national network, UnitedHealthcare will contact the provider directly to try to bring them in-network on behalf of your group.

Does the plan follow all Connecticut state mandates?

Yes, the plan adheres to all Connecticut mandates.

Do the Medicare-eligible retirees have to join the plan?

It is not mandatory that retirees join the Partnership Plan.

Rates, Premiums and Fees

What is the exit penalty?

After two years participants have the option to leave the Partnership Plan. If a participant chooses to leave the Plan after two years and benefited from paying lower premiums than their claims costs should have dictated, then the participant will be charged an exit fee upon leaving. The exit fee is equal to the excess of the group's total claims costs over the rates they were charged since joining the Plan with a cap of 5% of the premiums paid by the participant in the most recent year (Example: Should you leave with \$1,000 more in claims costs than you paid in premiums you would reimburse the state \$1,000, assuming \$1,000 is less than 5% of the total premiums paid in the most recent year). The exit fee cap reduces with each additional year of participation until after 5 years there is no exit fee for leaving regardless of experience.

If we are fully insured when enrolling into the plan, are we responsible for any claim "runout"?

If you were fully insured upon entering the program, the state will absorb any claim "runout" upon leaving the program.

How does the fluctuating reserve fee work?

The fluctuating reserve fee is a charge of 3.5% of your premium designed to cover any claim costs over and above a group's standard premiums. The reserve fees of all participants are pooled into a "fluctuating reserve fund." The fund works very similarly to stop loss insurance, protecting individual members from incurring additional costs when they have negative claims experience. The fee can be reviewed on an annual basis and be adjusted to cover incurred claims.

How are plan rates determined?

Rates are based on claim experience provided by the group. For those groups under 50, actual experience may not be available. These groups will be rated based on census data.

For more details on rating methodologies see the plan rules on the Partnership Plan website: www.osc.ct.gov/ctpartner/index.html

How does the annual renewal process work?

Claims are reviewed the same as in the commercial market on an annual basis. Each group's rate is based on their own experience. Changes in renewal rates are limited to three percentage points higher or lower than the State Employee Plan renewal.

What has been the trend for the State Employees Health Plan over the past several years?

Over the last five years the State Employee Health Plan has performed extremely well compared to the broader insurance market, with per-enrollee rate increases averaging under 4.5% over the last five years and no increase in 2012.