

## **State of Connecticut**

### **P.A. 11-58**

#### **Partnership Plan**

**February 21, 2012**

#### **Rules of Operations**

### **A. Background**

The State employee/retiree medical and pharmacy risk pool is large and experience is predictable. It presently has about \$1.3 billion of claims per year and covers over 200,000 persons. The State is able to achieve competitive administrative fees from its third party administrators (TPAs) and competitive pricing for its pharmacy benefits (i.e. discounts, dispensing fees, rebates). By allowing municipalities to join with the State in this risk pool, municipalities may achieve both lower costs for their benefits as well as longer term price stability.

The program must be established such that the State employee/retiree program's experience and rate levels are not significantly affected by the inclusion of municipalities in the risk pool. This will be achieved by:

1. Setting rates for each municipality based on its expected claims experience, providing medical and pharmacy coverage under a "guaranteed cost" basis, under which the municipality pays only the prescribed rates during the year and has no liability for the variation of their actual experience from what was assumed in the rate-setting during the policy year. (This approach applies to groups that are presently fully insured and those that are presently self-insured.)
2. Incorporating a "fluctuating reserve fee" (i.e. a risk charge) of, initially, 3.5% of expected claims to cover variances between actual and expected claims.
3. Requiring all the employees of a municipality or Board of Education (Note this makes language consistent with Public Act 11-58) to participate or else participation in the program will need to be approved by the Comptroller, SEBAC and OPM and the rates will be subject to a surcharge to cover uncertainties in the underlying experience of the portions of the group that will enroll.
4. Renewal rates for each group will be set based on their emerging experience, within minimum and maximum rate changes that may be promulgated.

### **B. Risk Management**

The use of the "fluctuating reserve fee" in setting the rates charged to participating municipalities creates a buffer that protects the State employee/retiree risk pool from variances in experience of participating municipalities. The hierarchy of funds that are

available to cover the claims of participating municipalities is: expected claim charge included in rates charged to the municipality, "fluctuating reserve fee" for the year that is added to the expected claims, accumulation of gains from the municipal pool from prior years (this will be \$0 in the first year), and then the State employee/retiree risk pool. Assuming that the rates are properly set for each participating municipality, the "fluctuating reserve fee" should accumulate over time to create a "surplus account" for the municipal pool to cover year to year fluctuations in experience. The combination of the "fluctuating reserve fee" and the renewal rate guarantees work together to ensure that the municipal pool, in total, is sufficient to fund its obligations without transferring risk to the State employee/retiree program.

PA 11-58 requires that the State employee pool cannot take on substantial risk related to the Partnership Plan. To keep the risk at a modest level, the rates for municipal groups participating in the Partnership Plan will include an explicit risk charge (i.e. "fluctuating reserve fee") of 3.5% of the expected claim costs for the group. This percentage may increase or decrease over time based on the experience of the program and any surplus that may accumulate from the program. Should surplus start to accumulate, amounts in excess of what is determined appropriate will be distributed to participating municipalities in the form of reduced "fluctuating reserve fees". Changes in the "fluctuating reserve fee", either upwards or downwards, need to be approved by the Comptroller, SEBAC and OPM. Decreases may only be considered once the program reaches its target surplus established by the HCCCC. Increases may be considered if the program's experience consistently runs worse than expected such that deficits are likely to arise.

The primary risks of the program are the same as the risks that any risk pool undertakes:

- Pricing risk – the risk that the rates set for a group are not representative of the group's true underlying experience
- Severity risk – the risk that several very large amount claims arise in a group during the year, more than would typically be expected (and reflected in the rating) for a comparable group
- Incidence risk – the risk that the general use of medical services exceeds what is typically expected. For example, a very bad flu season could generate many more physician visits, prescriptions, ER visits, etc. than would typically be expected
- Selection risk – the risk that less than 100% of the current risk pool for the municipality participates in the Partnership Plan, with the least healthy lives from the groups entering the Plan. (Note: the pricing is intended to reflect the health status of the participating members, but if the group does not have experience for the segment participating, there could be an additional pricing risk due to the selection factor.)

The pricing methodology discussed above addresses these risks as follows:

- Pricing risk – rates are set based on each municipality's actual historical experience, along with reference to current and historical rate levels.
- Severity risk – the "fluctuating reserve fee" provides some protection against large amount claims. Also, the pooling of the experience of the participating municipalities

allows a balancing between groups with more than expected large amount claims against those with fewer than expected

- Incidence risk – the “fluctuating reserve fee” provides protection from such variances
- Selection risk – the surcharge added to the rates when less than a full group participates provides some protection.

### **C. Surplus in the Municipal Pool**

The fact that the rates being charged to the participating municipalities will include a “fluctuating reserve fee” implies that, on average and over time, there should be more than sufficient funds collected from the municipalities to cover the claims and expenses of their benefits programs. At the outset of the program, this surplus is zero, since no funds have been set aside for such a purpose. Assuming that the groups are priced appropriately, such that the rates cover their claims, then the surplus will begin to accumulate. It is appropriate to develop a policy to determine the appropriate amount of surplus that will be allowed to accumulate, when and how to manage the level of that surplus, and to determine when and how certain amounts of that surplus may be returned to the municipalities participating in the Partnership Program.

- A. “Fluctuating Reserve Fee” – presently, illustrations of rate levels have assumed that a fee of 3.5% of the expected claims will be added to the rates for participating municipalities. This is the “fluctuating reserve fee”. This amount can be increased or decreased from year to year based on the performance of the program and in accordance with the provisions of Part B of these rules of operation. The higher the fee, the less attractive the rates in the Partnership Plan will be; the lower the fee, the greater the likelihood that the municipal pool may have a loss during the year. Hence, it is essential to monitor and manage this fee at a level that balances the stand-alone solvency of the municipal pool with the competitiveness of the program.
- B. Surplus in the Municipal Pool – Rules must be established to set the target surplus level in the pool. The level should be commensurate with the size of the pool, the stability of the members from year to year, and the State’s tolerance for the likelihood and amount of any charge to the State employee/retiree risk pool. Other municipal risk pools have established target surplus levels; these are typically tied to a percent of a year’s premiums or claims or a Risk-Based Capital (RBC) threshold. RBC is the measure used by the insurance industry to monitor the solvency position of insurance companies. We have seen target surplus amounts ranging from as low as 5-7% of premium to over 20% of premium. Presently, 15% of premium is the target surplus amount.
- C. “Ownership” of Surplus by participating municipalities – Surplus is accumulated by the groups that are in the program each year. There are two primary ways to manage the level of the surplus; they affect participating groups in different ways. One approach is to increase or decrease the “fluctuating reserve fee”. This approach puts the increase or decrease on the groups that are participating in the next year, which is not necessarily the groups that gave risk to the favorable or unfavorable experience. Unless a provision is made to require a retrospective additional premium contribution from groups (which is not recommended), this may be the only way to replenish a deficiency due to poor experience. The other approach for decreasing the surplus if it exceeds its target value is to issue a “dividend” to participating municipalities. Which groups are entitled to how

much must be established now before any real dollars arise. Possible approaches are to use membership, premium, and/or length of time in the program.

#### **D. Deficit in the Municipal Pool**

Consideration should be given to repaying the State pool with any gains that arise under the municipal pool starting in the year following the original charge against the State pool. Assuming that the municipal pool is properly priced, there should be a gain in the year following a loss. This puts the repayment of the State pool as the top priority of the municipal pool. It does defer the replenishment of the surplus in the municipal pool, which increases the risk that additional charges against the State employee/retiree pool may arise, but it also minimizes the total amount of the charge against the State employee/retiree pool. The two main elements of such a policy are the priority of repaying any charges against the State pool and any charges (e.g. interest and/or risk charge) that must be made in addition to the amount that the municipal pool utilized.

Notwithstanding any other provisions of these rules, if, in any year, there is an actual or projected deficit in the reserve fund for non-state public employers, as a group, equal to one quarter of one percent or more of the total claim amount for State employees and retirees, the Comptroller shall, in establishing the upcoming annual rate for each of these employers, add surcharges on such rates in an amount necessary to eliminate the deficit during the year to which these rates apply. The surcharge amounts shall be in addition to the rate or premium established in accordance with the rate setting methodology established for these employers.

#### **E. Glossary of Terms**

Entire Group: the collection of employees, and possibly retirees, that comprise the risk pool used for current rate-setting.

Segments of a group: a portion of an entire group, representing some of the persons whose experience is combined at the entire group level for purposes of current rate-setting.

HEP: Health Enhancement Plan, an arrangement that exists in the State of Connecticut Employee plan under which participants must comply with scheduled preventive screening and participants with certain medical conditions must comply with physician orders with respect to management of those conditions.

“Fluctuating Reserves Fee”: a term defined in P.A. 11-58 that represents a “margin” or “risk charge” that is added to the expected cost of benefits for a group participating in the Partnership Plan to reduce the risk of loss to the State Employee health plan’s experience.

#### **F. Plan Design(s)**

The State of Connecticut POS Plan, including HEP, is the standard plan design to be made available to participating municipal groups. Groups may choose to implement the

Partnership Plan with the option to be in HEP or to not be in HEP. The charges for employee classes of coverage that opt out of HEP shall be set by the Comptroller.

For groups that do not wish to participate in HEP, the State "Standard" plan version of the POS plan will be made available at a rate that reflects the expected additional costs due to exclusion of HEP.

*Dental benefits need to be addressed – not yet evaluated*

## **G. Underwriting Criteria**

Municipalities or Boards of Education that enroll all of their employees will be eligible to participate in the Partnership Plan.

Municipalities or Boards of Education that enroll only certain segments of their group (e.g. police and fire only) will be eligible to participate in the Partnership Plan so long as 100% of that segment participates and rates will be established to recognize the expected costs of that segment of the total group. Participation in the plan of less than all of the employees of a municipality or Board of Education will require approval by the Comptroller, SEBAC and OPM and the rates will be subject to a surcharge to cover the uncertainties in the underlying experience of the portions of the group that will enroll. . Only retirees of participating groups can join the Partnership Plan.

## **H. Rating of Groups**

A municipality or Board of Education that enrolls all of its employees will be charged a rate that covers the group's expected costs of medical and pharmacy benefits together with administrative fees that are equal to the State employee administrative fees and any other costs that will be incurred to manage the Partnership Plan, plus a "fluctuating reserve fee" that is initially set at 3.5% of the group's expected claim costs.

## **I. Rating Methodology**

The following approach will be used to compute the rates for an eligible group:

1. Obtain current rates and recent experience (to the extent available) from the group. Also obtain census information showing number of employees covered by each plan of benefits currently offered by rating tier by plan. If any segment of the group is to be excluded from the Partnership Plan, group must provide rates and experience (if available) for the excluded group along with demographic composition of the excluded group and the entire group.
2. Using the information from #1 above, estimate the group's expected claim costs under their current benefit plans. Standard underwriting and actuarial practices will be used to develop these claim costs.
3. Using CORAL or Milliman Health Cost Guidelines, adjust the group's claim costs to be reflective of the State employee POS plan. Include adjustments for change of carrier if necessary.
4. Adjust the claim costs to reflect any excluded groups.
5. Adjust the claim costs to reflect non-acceptance of HEP, if required.

6. Increase the claim costs to incorporate the 3.5% "fluctuating reserve fee".
7. Add the administrative costs of the State employee program to produce the required rates.

## **J. Rate Guarantees**

Annual renewals: rate change will be no more than three points higher or three points lower than the rate change for the State employee plan.

Each group will be re-rated at its fifth anniversary; the rate increases/decreases at that time may vary from the percentages above based on the group's actual historical experience.

These rate increase guarantees can be modified by the management of the Partnership Plan if the financial integrity of the Plan would be compromised by continuing such rate increase guarantees.

## **K. Exit Rules**

One of the objectives of the Plan is the desire to keep groups in the Partnership Plan as long as possible. PA 11-58 requires participation for a minimum of two years. Setting the renewal rate increases to be no more than three points higher than the State employee rate change was one tactic considered to encourage groups to remain in the Plan for a long period of time. Another approach that has been raised is to create a set of exit rules that may cost groups if they leave the Plan after less than five years of continuous participation. The following presents some rules for consideration:

- If an exiting group's actual experience since inception has been worse than the rates that have been established for that group (e.g. their rate increase(s) should have been higher than the State rate increase plus three points), the group is assessed a fee as follows:
  - Exit after 2 years: lesser of the excess of the group's total costs over the rates they were charged since joining the Plan and 5% of the most recent year's Plan premium.
  - Exit after 3 years: lesser of the excess of the group's total costs over the rates they were charged since joining the Plan and 3% of the most recent year's Plan premium.
  - Exit after 4 years: lesser of the excess of the group's total costs over the rates they were charged since joining the Plan and 2% of the most recent year's Plan premium.
  - Exit after 5 years or later: no assessment.
- Groups do not benefit from any reductions in the "fluctuating reserve fee" that may take place (due to favorable experience in the Plan) until after they have participated for five years and they are presently in the Plan.

- Groups are not eligible to participate in any distributions of “surplus” in excess of the target surplus (presently we’re using 15% of annual premium as the reference point for target surplus) until after they have completed four years of continuous participation in the Plan and they are presently in the Plan.

#### **L. Current Self-Insured Groups**

Groups that are currently self-insured will have a different structure under the Partnership Plan in that they will have rates that are guaranteed for the policy period. That is, the program will look like a fully insured program, though each group is part of the self-insurance pool. Self-insured groups will have had an obligation to pay all claims incurred during the years prior to participating in the Partnership Plan. This includes claims that were incurred during such prior year(s) but that are paid during the period when the group is participating in the Partnership Plan. Since the group will also be paying a monthly “premium” to the Partnership Plan, there will be a period during the first few months of participation when the group will experience cash flows in excess of a typical month’s worth of self-insured claims and fees. The Partnership Plan can address this situation in either of two ways, depending on the group’s preference.

- A. If the group has established an IBNR reserve or comparable funds to cover the “runout” of claims from the prior year, the group can use that fund to cover the claims that are paid during the first few months of participation in the Partnership Plan but that were incurred prior to participating in the Partnership Plan. In that case, the rates for the Partnership Plan will be set to cover the claims incurred during the contract year, regardless of their payment date.
- B. If the group has not established an IBNR reserve or comparable funds to cover the “runout” of claims from the prior year, or if the group does not wish to tap into that fund to pay such claims, the rates for the Partnership Plan can be set to cover the claims that become payable during the contract year, regardless of their incurred date. The Partnership Plan will pay the runout claims from the prior contract year, meaning that the group will not be paying more than twelve months of cost during the contract year. However, the group will be responsible for the runout claims at the end of their participation in the Partnership Plan.
- C. Related to any “runout” claims to be paid by the Partnership Plan, the Comptroller’s Office and the HCCCC may impose requirements upon the municipality as may be needed to protect the State plan from extraordinary level of claims related to the runout period. In addition, municipalities shall keep any stop-loss coverage they had in place for claims associated with prior periods.

**M. Other Operating Guidance** Each year, HCCCC, in consultation with Non-state Public Health Care Advisory Committee, shall review and make adjustments, as needed, in structure.

1. Each year, a report will be provided to HCCCC, SEBAC and OPM of actual or projected losses for municipalities as a group and individually; annual and cumulative since inception.

2. Office of The State Comptroller and The Health Care Cost Containment Committee retain the right to change administrators or funding arrangement for plan.
3. Non-state employers participating in plan acknowledge that the plan may change from time to time upon action by the Comptroller, the HCCCC, Sebac and OPM.