

Partnership Plan 2.0 Operating Rules – Exhibit A

Premium Rate Development Description

Active & Non-Medicare Retiree Plans

Partnership plan 2.0 base rates are developed using a combination of the state's overall claims experience and Partnership 2.0 claims experience. The base rate is combined with a regional rate adjustment based on the county in which the majority of the non-state public employer's employees work. The rates are established in the following manner:

1. The medical and pharmacy claims experience are evaluated separately for actives and non-Medicare retirees. The claims include all plans consisting of state and Partnership 2.0 employees and non-Medicare retirees to produce the experience-based total incurred claim amount for the experience period.
2. The experience-based total incurred claim amount is trended forward to the plan year.
3. ASO fees, fees required by the Affordable Care Act, and Administrative fees are added to the claims cost. Pharmacy rebates are included with the Rx claims cost.
4. This amount is divided by the average number of employees by tier during the experience period in which the claims were extracted.

The formula for Actives is:

Single Employees + 2.2 x (Employee + 1 family) + 2.7 x Family Employees.

The formula for Non-Medicare Retirees is:

Single Employees + 2.2 x (Employee + 1 family) + 2.7 x Family Employees.

Post-65 Retirees Not Eligible for Medicare rates are based on (pre-65) non-Medicare Retiree rate actions for medical claims, pharmacy claims, ASO fees, fees required by the Affordable Care Act, and administrative fees.

5. The result of this calculation is a premium amount for each tier (i.e. active employees, non-Medicare Retirees under 65 and Non-Medicare Retirees over 65). The premium rates to be charged for each tier were then established by the Office of the State Comptroller to comply with the SEBAC (State Employees Bargaining Agent Coalition) agreement.
6. Regional adjustments are made to the rates based on a review of the Anthem area factors by county as well as the State and Partnership 2.0 per member per month costs by county.
7. Premium rates for non-state public employers are reset on July 1 and will be based on the entire pool's experience combined with the regional rate adjustment by county. The monthly premium rates are posted by county and are guaranteed from the original date of coverage to the end of the current fiscal year. For existing groups during the 2020/2021 plan year, the current rates for fiscal year ending June 30, 2020 will be charged for July 2020 through September 2020. Then, 9-month rates billed from October 2020 through June 2021 will incorporate the full needed rate adjustment for the 12-month period of July 1, 2020 through

June 30, 2021. New groups joining on or after July 1st: Quarterly rates are posted for new groups to accommodate effective dates other than July 1st. Non-state public employers pay the same calculated premium by county regardless of the employer's specific experience.¹

Medicare Retiree Plans

Medicare retirees enrolled in Partnership 2.0 are offered a fully insured Medicare Advantage plan with Prescription Drug coverage (MA-PD). The insurance carrier develops rates for each calendar year on a per member basis.

Considerations for Enrollment Acceptance

If the non-state public employer's application to the State Comptroller's office indicates the entire group will be enrolled, the employer may join the state pool in accordance with the current premium rate and benefit offering.

The application is not subject to traditional underwriting procedures whereby the premium rates are adjusted based on the characteristics of the group.

If the non-state public employer's application to the state indicates that a portion of the group will be enrolled (less than the entire board, town or other non-state public employer's covered employees or retirees) the application will be forwarded to the Health Care Cost Containment Committee (HCCCC) for review. The following are considerations in the HCCCC review, but are not exhaustive:

1. If the intention is to shift a high risk or high cost population to the state plan for budget purposes, the application will be denied.
2. If the state plan is offered in conjunction with plans offering less generous benefits and lower costs, the application will generally be denied due to the likelihood that the state plan would attract a higher risk population than the competing option.
3. If the population is segmented by division, HCCCC may review the application to determine whether the segmentation will shift a significant portion of the high cost claims to the state while leaving more favorable populations in the employer's control. The Comptroller's office will supply any required analysis and a recommendation for the HCCCC to consider.

¹ Premium rates do not include the excise tax, which will apply to certain health plans under the Affordable Care Act, in its current form, beginning in 2022. To the extent that the excise tax applies to premiums for non-state public employers under the Partnership Plan 2.0, the non-state public employer will be responsible for paying such costs. Rates will be developed annually based on actual experience. Applicants may request information regarding the state historical trends to assist in determining the potential impact, if any, of the excise tax provision on the Partnership Plan 2.0. The HCCCC is continually working to constrain health care costs through our HEP program, and other initiatives.

The excise tax is assessed on only the premium amounts in excess of the statutory thresholds.

(Please note that final regulations concerning the excise tax are not complete; some of the proposed regulations provide for higher thresholds for certain plans based upon occupation, age and/or gender, and rules for combining different plans for purposes of calculating the tax have not been finalized.)

Once the application has been accepted, the non-state public employer will work with the state's third-party administrator to enroll.

Benefit Plan Offerings

The state's current benefit plans for non-state public employers are:²

- Anthem POS Plan
- CVS/Caremark Pharmacy Plan
- United Healthcare MA-PD Plan for Medicare Retirees
- Cigna Dental Plan (Separate fully insured plan with varying premium rates)
- Cigna Vision (Separate rider, not included in the calculated premium rates)

The plan will be administered according to the POS benefit design, including medical management and case management administration. A participating non-state public employer must enroll in the health care and pharmacy plans in order to participate in the state's benefit plan. Participation in dental plan or the vision rider is not required; however, selecting one of the dental plans offered will facilitate compliance monitoring of the HEP requirement for annual dental cleanings by participating members.

The plan is subject to HEP (Health Enhancement Program) compliance, which is administered by Care Management Solutions, Inc., a division of WellSpark.

After the first year of enrollment, members who are non-compliant with HEP will be moved to a non-compliant status in the POS plan, which includes additional copays and deductibles. If a member is in a non-compliant status, there is an additional premium of \$100 per month that will be billed to the non-state public employer.

Participating non-state public employers are required to accept the State plan design without modification.

Run-out Claims

The state will be responsible only for claims that are incurred on and after the effective date of enrollment. The self-insured non-state public employer is responsible for payment of all claims incurred prior to the date of its enrollment. Non-state public employers moving from fully insured plans generally do not incur run-out costs, as they are the responsibility of the insurer.

If a non-state public employer leaves the Partnership Plan 2.0, the state will pay those claims that were incurred prior to the group's termination under the Plan.³ The non-state public employer will be responsible for paying an administration fee for the processing of the run-out claims upon leaving the program.

² Vendors are subject to change, the State engages in a competitive bidding process on a regular basis to ensure the best possible price and service from vendors.

³ In the event of a multi-day confinement, the start date of the claim must occur during the group's enrollment period.

Premium Payments

Premiums are due on the first day of each month for that month's coverage. Once remitted, refunds are not permitted. There may be retroactive adjustments to premiums based on retroactive adjustments to the eligibility files. The Partnership plan rates are uniform across all non-state public employers by county regardless of group size.

If premium payment by the non-state public employer is not paid by the date such payment is due, a non-state public employer will be assessed interest retroactive to the date such payment was due, at the prevailing rate of interest as determined by the Comptroller.

If a non-state public employer fails to make premium payments, the Comptroller may direct the State Treasurer, or any other officer of the state who is the custodian of any moneys made available by grant, allocation or appropriation payable to such non-state public employer at any time subsequent to such failure, to withhold the payment of such moneys until the amount of the premium or interest due has been paid to the Comptroller, or until the State Treasurer or such custodial officer determines that arrangements have been made, to the satisfaction of the State Treasurer, for the payment of such premium and interest. Such moneys shall not be withheld if such withholding will adversely affect the receipt of any federal grant or aid in connection with such moneys.

In the event of non-payment by a non-state public employer, the Comptroller may direct the carriers to suspend payment of claims incurred by the non-state public employer's members until satisfactory arrangements have been made to satisfy outstanding premium payments plus any accrued interest.

Catastrophic Claims

Premium rates are developed using all claims experience, including large claims. High cost claims are pooled into the entire Plan experience. There will be no premium rate adjustments for any individual non-state public employers based on the existence or absence of high cost claims experience. Premium rate increases will be based upon the experience of the entire population covered under the state employee plan and Partnership Plan 2.0. Stop loss insurance is not necessary for plan participants.

Group Size

All non-state public employers will receive the same premium rates by county regardless of group size.

Exiting the Partnership Plan 2.0.

A non-state public employer enrolled in the state Partnership plan 2.0 that chooses to leave the plan before the initial required three-year enrollment period must be current on all premiums and any interest assessed and may be subject to an assessment as set forth below. In no event will a withdrawing non-state public employer be entitled to a refund of premium payments due to differences in premiums paid and claims experience.

If an exiting group's actual experience since inception has been worse than the Partnership Plan 2.0 rates that have been established for that group, the group will be assessed a fee as follows:

- Exit after 1 year: Lesser of the excess of the group's total costs over the rates they were charged since joining the plan or 5% of the total premium paid by the group in the most recent Plan year.
- Exit after 2 years: Lesser of the excess of the group's total costs over the rates charged since joining the plan or 3% of the total premium paid by the group in the most recent Plan year.
- Exit after 3 years or later: no assessment.

Groups continuing in the plan after the first 3 years will be required to sign an additional 3-year commitment; however no exit fee will apply if a group leaves prior to the end of the extension period.

Affordable Care Act Compliance (ACA)

Fees for the Patient-Centered Outcomes Research Institute ("PCORI") under the ACA are included in the rates, and the Partnership Plan's members will be included in the State's reporting for this purpose. These fees are built into the premium calculations based on Segal's understanding of the ACA laws as they exist in May, 2020.

As an entity sponsoring a self-funded health plan, the State of Connecticut will report to the Internal Revenue Service (IRS) health benefit coverage that it provides to its employees and non-employee individuals covered under its plan. The size of the Partnership Plan group will determine whether the reporting will be done by the State or will be the responsibility of the non-state public employer.

Groups with Less than 50 Full-Time Employees

For Partnership Plan groups with less than 50 full-time employees, the State will complete and mail the 1095-C forms directly to the enrolled members, using enrollment data obtained from the medical carrier.

Groups with More than 50 Full-Time Employees.

Partnership Plan groups with 50 or more full-time employees are obligated to provide the IRS Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage* to covered individuals and to file Form 1094-C *Transmittal of Employer-Provided Health Insurance Offer* with the IRS.

A non-state public employer may consult with the state or the state's Partnership Plan 2.0 administrators for alternatives to assist it in meeting its ACA compliance requirements. However, any fees or penalties assessed by the IRS against a non-state public employer for failure to make affordable healthcare coverage available to its employees are to be paid by the non-state public employer.