Office of the State Comptroller

Healthcare Policy and Benefits Services Division
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CONNECTICUT PARTNERSHIP PLAN 2.0 POLICY

Section 1: Introduction and Overview

The Connecticut Partnership Plan 2.0 is a health insurance program offered by the State of Connecticut through the Office of the State Comptroller (OSC). Established under Connecticut General Statutes § 3-123aaa et seq. and § 5-259, the Partnership Plan enables non-state public employers—including municipalities, boards of education, quasi-public agencies, and public libraries—to provide high-quality, affordable health care coverage to their employees, retirees, and eligible dependents.

The Partnership Plan 2.0 is based on the benefit offerings and purchasing power of the State Employee Health Plan and utilizes the same medical, pharmacy, dental, and Medicare Advantage plans provided to state employees and retirees. By joining the Partnership Plan, participating employers gain access to comprehensive benefits, stable premium rates, and the administrative oversight of the OSC.

The objective of this policy manual is to define the rules and requirements for participation in Partnership Plan 2.0 and provide a reference for participating employers on plan features, benefit coverage, compliance expectations, and administrative procedures.

Section 2: Benefits Overview

2.1 Medical and Pharmacy Benefits

The Partnership Plan 2.0 offers a Point of Service (POS) medical plan administered by Anthem Blue Cross and Blue Shield. Plan participants have access to the State BlueCare POS network in Connecticut and national coverage through the BlueCard® program. Features include:

- $15 in-network copays for office visits and urgent care
- $0 copays for preventive care and screenings
- $5 or $10 generic drug copays for maintenance medications
- Access to out-of-network care (at a higher cost share)
- Coordination of benefits through Quantum Health, including Care Compass and personal Care Coordinators

The pharmacy benefit is administered by CVS/Caremark. Mandatory 90-day fills are required for maintenance medications, available via mail order or at retail pharmacies in the State Maintenance Drug Network. Brand-name drugs are tiered into preferred and non-preferred categories, and exceptions require formal approval.

2.2 Health Enhancement Program (HEP)

HEP is an integral component of the plan, incentivizing preventive care and chronic disease management. Compliance includes:

- Routine wellness exams and screenings by age and gender
- Dental cleanings
- Additional disease education requirements for individuals with diabetes, asthma/COPD, heart disease, hyperlipidemia, or hypertension

Non-compliance results in a $100 monthly premium surcharge and the imposition of an annual in-network deductible ($350 individual/$1,400 family).

2.3 Dental and Vision Benefits

Dental and vision coverage are offered through Cigna and are available as separate, fully insured options. Employers may opt in either or both. Selecting a Cigna dental plan may support HEP compliance by facilitating monitoring of annual dental cleanings.

2.4 Medicare Retiree Coverage

Eligible Medicare retirees may enroll in the fully insured Medicare Advantage with Prescription Drug (MA-PD) plan administered by Aetna. Rates are developed annually by the insurer, and coverage aligns with federal Medicare requirements.

Section 3: Eligibility and Enrollment

Participation in the Partnership Plan 2.0 is open to all non-state public employers in Connecticut. Eligible individuals include active employees, non-Medicare eligible retirees, Medicare eligible retirees, and their dependents as defined by the participating employer's eligibility rules.

3.1 Employer Enrollment

- Employers submit an application to the Office of the State Comptroller.
- Full group participation is generally required; partial group participation is subject to additional review.
- Upon acceptance, employers must enter into a three-year Participation Agreement.

3.2 Member Enrollment

- Employers are responsible for enrolling all eligible members.
- Eligibility data must be provided 30 days prior to the effective date.
- Ongoing updates to eligibility must be submitted to the carriers to ensure accurate coverage and billing.

3.3 ACA Reporting Responsibilities

- Employers with fewer than 50 full-time employees: the State issues IRS Forms 1095-C.
- Employers with 50 or more full-time employees: responsible for IRS reporting (Forms 1094-C and 1095-C).

Section 4: Premiums and Rate Development

4.1 Rate Setting Methodology

- Rates are developed using a combination of the State Employee Plan and Partnership Plan 2.0 claims experience.
- Adjustments are applied based on the county in which the majority of employees work.
- Pharmacy rebates and ACA-related fees are incorporated into the rate.
- The formula weights employee tiers as follows:
    - Single = 1
    - Employee + 1 = 2.2
    - Family = 2.7

4.2 Premium Rate Schedules

- Rates are updated annually on July 1.
- Rates are posted by county and are uniform for all non-state public employers.
- Quarterly rates are available for new groups joining mid-year.

4.3 Regional Rate Adjustments

- Each county of the state has its own regional premium rates. Regional premium rates reflect the variation in the underlying cost of care across regions in the state.
- Regional rate adjustments are updated every 5 years to reflect changes that may occur over the intervening time period related to regional cost of care.
- Applicable adjustments, positive and negative, are phased in over a two year period. For example if it is determined the regional rate adjustment of a specific county needs to increase by 2%, the adjustment will be applied as 1% in the first year and 1% in the second year, the next 3 years will have no additional regional adjustments, and the process will begin again with another evaluation in year 5.

4.4 HEP Surcharges

- Non-compliant members will trigger a $100 monthly surcharge per individual and an in-network deductible.
- Employers are billed directly and must collect reimbursement from non-compliant employees or retirees.

4.5 Premium Payment Requirements

- Premiums are due on the first day of each month, and bills are sent approximately on the 10th of the month prior.
- Groups have a 60-day payment window before being classified as delinquent.
    - Anthem to reach out to groups that are 45 days past due
    - Anthem to report on delinquencies on our weekly calls
- Late payments accrue interest at 8% annually after 90 days of delinquency.
- Non-payment may result in claim holds or termination (120 days past due)
- Claims are the responsibility of the State only from the effective enrollment date forward. Employers are responsible for run-out claims incurred prior to entry.

4.6 Early Termination Penalty

- Groups existing in year 1: pay the lesser of excess costs or 5% of prior year premiums.
- Year 2: the lesser of excess or 3%.
- Year 3 or later: no fee, but groups must notify at least 30 days prior to renewal to avoid automatic re-enrollment.

Section 5: Participation Rules

5.1 Full Group Participation A "full group" includes all eligible employees and retirees from a given employer (e.g., an entire town or board of education). Full group applications are automatically accepted upon review of eligibility and submission of required enrollment data.

5.2 Partial Group Participation Partial group applications undergo a more detailed evaluation process depending on the percentage of the overall eligible population included:

- **≥75% of total group**: Treated as a full group. No special evaluation is required.
- **50%–74.9% of the total group**: Must submit a completed application, census data for both the applying and total group (including demographics by age, gender, and coverage tier) and indicate whether all bargaining units in current negotiations are participating.
- **<50% of total group**: Must submit all information above, as well as current plan designs and rates for both the partial group and the full group.

5.3 Review Process

- Applications are reviewed by OSC staff.
- Demographic data and plan designs are evaluated.
- A recommendation is sent to the Health Care Cost Containment Committee (HCCCC), which has five business days to respond.
- In the absence of a response, OSC proceeds based on its recommendation.

5.4 Evaluation Thresholds

- If **all bargaining units in negotiations** are included: up to 15% demographic disparity is permitted.
- If **only some bargaining units** are included: up to 7.5% disparity is permitted.
- Applications designed to offload high-cost populations or that offer the state plan alongside less generous options are likely to be denied.

5.5 Approval Timeline

- Applicants receive a decision within 30 days of submitting all required materials.
- Employers must be prepared to work with the state's third-party administrator upon acceptance.

5.6 Terminated Groups

- Groups are to provide a 60-day notice, if leaving the plan
- If a group leaves within their 3-year initial period, will be assessed the fee described in section 4.5 Exit Fees (unless rate calculation or benefits change during this time)
- All groups that leave are responsible for run-out claims fees 60 days after termination
    - *The fee for Claims Runout Services will be equal to the product of the following calculation: the Base Administrative Services Fees (currently **$xx.xx**)in effect at the time of termination of this Agreement multiplied by (the greater of (1) the total of the last 3 months of Subscriber enrollment; or (2) the average of the last 6 months of Subscriber enrollment) multiplied by 3.*
- If a group is also enrolled in dental and/or vision under the state plan, those plans will term at the same time as the medical/rx
- If a group is enrolled in the MAPD plan, those retirees may remain on the plan until the end of the calendar year in which the commercial plan terms
- There is no waiting period for a termed group to re-join the Partnership Plan 2.0

6.0 Open Enrollment participation and requests

Open enrollment occurs each year between April and June for existing Partnership groups. We typically host a table at the group's benefits fair, and we're usually joined by Quantum Health. Requests for an OE meeting are emailed to the Partnership team, and we ask existing groups to give us a two-week notice for scheduling purposes.

New group open enrollment occurs 60-90 days before their effective date. The State team provides a one-hour presentation covering each section of the plan; medical, pharmacy, HEP, Quantum Health, and if applicable, Cigna will present on dental & vision. Requests for OE meetings are emailed to the Partnership team, and we again ask for two weeks' notice for scheduling purposes.

7.0 Contact information

- SPP 2.0 & 1.0 have their own contact lists, which are manually updated by the Partnership team
- Groups initially provide their contact information through the Partnership application
    - Lead Contact
    - Billing Contact
    - Broker Contact, if applicable
- Any updates to the contact list are emailed to the Partnership Team
    - Each election season, our team reaches out to any group that could be affected by a change in leadership to ensure our contact list is the most up-to-date.