Presentation for:

2020-21

MUNICIPAL TREND

Brown & Brown INSURANCE

State of Connecticut Partnership Plan 2.0

Claims, Demographics & Other Considerations

Presented by:

Robert FitzPatrick
Chuck Petruccione
Lew Panzo
Sonia Kaminsky
Jay Fiorello
Todd Goodall

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STATE PARTNERSHIP 2.0 SNAPSHOT

The State of Connecticut Partnership Plan 2.0 (SPP) is open to “Non-state public employers” which means a municipality or other political subdivision, including boards of education or quasi-public agencies such as public libraries or fire districts. The medical benefits on the plan are administered by Oxford Health Plans, a subsidiary of United HealthCare. The pharmacy benefits are administered by CVS Caremark. Dental and vision benefits are optional and are administered by Cigna.

2016

The second iteration of the State of CT Partnership Plan was rolled out on January 1, 2016.

124

As of January, 2020, there are 124 different entities enrolled in the Partnership Plan.

23,110

As of January, 2020, there are 23,110 employees enrolled in the Partnership Plan.

107%

From October 1, 2018 through September 30, 2019, the Partnership Plan paid out $1.07 in claims and fees for every $1 collected in premium.

CLAIMS HISTORY– JULY 2016 THROUGH JUNE 2018

CT State Partnership 2.0

											Loss Ratio	
Month	Total Contracts	Total Members	Fixed Cost	UHC Medical Claims	CVS/Caremark Pharmacy Claims	Total Paid Claims	Plan Cost	Anticipated Rebates	Plan Cost after Rebate	Medical & Pharmacy Budget	Plan Cost vs. Premium	Plan Cost after Rebate vs. Premium
Jan-2016	17	40	$680	$5,897	$4,734	$10,631	$11,311	$852	$10,459	$26,079	43.4%	40.1%
Feb-2016	17	43	$680	$4,986	$4,898	$9,884	$10,564	$882	$9,682	$28,229	37.4%	34.3%
Mar-2016	78	186	$3,120	$19,798	$23,213	$43,011	$46,131	$4,178	$41,953	$119,279	38.7%	35.2%
Apr-2016	195	475	$7,800	$111,399	$74,955	$186,354	$194,154	$13,492	$180,662	$298,499	65.0%	60.5%
May-2016	200	495	$8,000	$268,126	$53,993	$322,119	$330,119	$9,719	$320,400	$308,001	107.2%	104.0%
Jun-2016	199	494	$7,960	$271,343	$65,256	$336,599	$344,559	$11,746	$332,813	$322,733	106.8%	103.1%
Jul-2016	2,732	6,809	$109,280	$715,063	$867,362	$1,582,425	$1,691,705	$156,125	$1,535,580	$4,403,929	38.4%	34.9%
Aug-2016	2,855	7,120	$114,200	$2,778,006	$1,113,056	$3,891,062	$4,005,262	$200,350	$3,804,912	$4,594,815	87.2%	82.8%
Sep-2016	4,209	10,540	$168,360	$3,393,136	$1,430,194	$4,823,330	$4,991,690	$257,435	$4,734,255	$6,831,542	73.1%	69.3%
Oct-2016	4,234	10,608	$169,360	$3,742,112	$1,517,008	$5,259,120	$5,428,480	$273,061	$5,155,419	$6,861,261	79.1%	75.1%
Nov-2016	4,386	10,964	$175,440	$4,720,002	$1,620,077	$6,340,079	$6,515,519	$291,614	$6,223,905	$7,105,091	91.7%	87.6%
Dec-2016	4,390	10,976	$175,600	$5,709,561	$1,582,273	$7,291,834	$7,467,434	$284,809	$7,182,625	$7,075,404	105.5%	101.5%
Jan-2017	4,482	11,241	$179,280	$5,216,304	$1,932,549	$7,148,853	$7,328,133	$347,859	$6,980,274	$7,285,702	100.6%	95.8%
Feb-2017	4,476	11,241	$179,040	$5,212,550	$1,675,605	$6,888,155	$7,067,195	$301,609	$6,765,586	$7,252,521	97.4%	93.3%
Mar-2017	4,478	11,261	$179,120	$6,381,848	$1,856,142	$8,237,990	$8,417,110	$334,106	$8,083,004	$7,264,178	115.9%	111.3%
Apr-2017	4,561	11,396	$182,440	$5,371,795	$1,730,971	$7,102,766	$7,285,206	$311,575	$6,973,631	$7,261,258	100.3%	96.0%
May-2017	4,562	11,402	$182,480	$5,640,297	$1,945,786	$7,586,083	$7,768,563	$350,241	$7,418,322	$7,323,816	106.1%	101.3%
Jun-2017	4,549	11,367	$181,960	$5,848,904	$1,918,183	$7,767,087	$7,949,047	$345,273	$7,603,774	$7,346,366	108.2%	103.5%
Jul-2017	7,421	18,215	$278,288	$7,162,979	$2,711,689	$9,874,668	$10,152,956	$488,104	$9,664,851	$12,395,411	81.9%	78.0%
Aug-2017	7,450	18,271	$279,375	$10,395,594	$3,217,415	$13,613,009	$13,892,384	$579,135	$13,313,249	$12,357,900	112.4%	107.7%
Sep-2017	7,540	18,485	$282,750	$8,326,582	$2,648,442	$10,975,024	$11,257,774	$476,720	$10,781,054	$12,460,053	90.4%	86.5%
Oct-2017	8,935	21,745	$335,063	$9,284,158	$3,017,172	$12,301,330	$12,636,393	$543,091	$12,093,302	$15,035,383	84.0%	80.4%
Nov-2017	8,924	21,717	$334,650	$12,799,088	$3,017,064	$15,816,152	$16,150,802	$543,072	$15,607,730	$14,985,263	107.8%	104.2%
Dec-2017	8,936	21,721	$335,100	$9,986,473	$2,924,999	$12,911,472	$13,246,572	$526,500	$12,720,072	$12,436,824	106.5%	102.3%
Jan-2018	11,535	27,992	$432,563	$14,849,805	$4,119,578	$18,969,383	$19,401,946	$741,524	$18,660,421	$18,149,035	106.9%	102.8%
Feb-2018	11,667	28,386	$437,513	$15,141,408	$4,310,854	$19,452,262	$19,889,775	$775,954	$19,113,821	$18,745,589	106.1%	102.0%
Mar-2018	11,667	28,395	$437,513	$16,938,351	$4,018,762	$20,957,113	$21,394,626	$723,377	$20,671,248	$18,492,131	115.7%	111.8%
Apr-2018	11,664	28,405	$437,400	$14,174,813	$4,290,410	$18,465,223	$18,902,623	$772,274	$18,130,349	$18,531,561	102.0%	97.8%
May-2018	11,678	28,417	$437,925	$17,990,268	$4,746,549	$22,736,817	$23,174,742	$854,379	$22,320,363	$17,892,086	129.5%	124.7%
Jun-2018	11,681	28,418	$438,038	$14,969,072	$4,331,103	$19,300,175	$19,738,213	$779,599	$18,958,614	$18,503,287	106.7%	102.5%

CLAIMS HISTORY– JULY 2018 THROUGH SEPT 2019

CT State Partnership 2.0

Month	Total Contracts	Total Members	Fixed Cost	UHC Medical Claims	CVS/Caremark Pharmacy Claims	Total Paid Claims	Plan Cost	Anticipated Rebates	Plan Cost after Rebate	Medical & Pharmacy Budget	Loss Ratio: Plan Cost vs. Premium	Loss Ratio: Plan Cost after Rebate vs. Premium
Jul-2018	14,105	34,710	$528,938	$17,601,072	$5,030,941	$22,632,013	$23,160,951	$905,569	$22,255,381	$20,903,635	110.8%	106.5%
Aug-2018	14,192	34,928	$532,200	$20,830,928	$5,590,597	$26,421,525	$26,953,725	$1,006,307	$25,947,418	$26,371,243	102.2%	98.4%
Sep-2018	16,735	40,679	$627,563	$19,272,943	$5,112,371	$24,385,314	$25,012,877	$920,227	$24,092,650	$27,517,616	90.9%	87.6%
Oct-2018	17,471	42,412	$655,163	$23,175,093	$6,459,252	$29,634,345	$30,289,508	$1,162,665	$29,126,842	$29,558,109	102.5%	98.5%
Nov-2018	18,332	44,078	$687,450	$25,037,504	$6,460,198	$31,497,702	$32,185,152	$1,162,836	$31,022,316	$29,312,771	109.8%	105.8%
Dec-2018	18,388	44,179	$689,550	$25,284,812	$6,360,017	$31,644,829	$32,334,379	$1,144,803	$31,189,576	$31,904,462	101.3%	97.8%
Jan-2019	18,643	44,678	$699,113	$27,096,622	$7,198,175	$34,294,797	$34,993,910	$1,295,672	$33,698,238	$30,690,409	114.0%	109.8%
Feb-2019	19,244	45,826	$721,650	$27,193,547	$6,556,640	$33,750,187	$34,471,837	$1,180,195	$33,291,642	$31,188,391	110.5%	106.7%
Mar-2019	19,271	45,929	$722,663	$25,672,092	$6,839,734	$32,511,826	$33,234,489	$1,231,152	$32,003,336	$32,779,203	101.4%	97.6%
Apr-2019	19,660	46,893	$737,250	$30,798,330	$7,297,591	$38,095,921	$38,833,171	$1,313,566	$37,519,605	$32,003,512	121.3%	117.2%
May-2019	19,655	46,915	$737,063	$33,399,648	$7,227,033	$40,626,681	$41,363,744	$1,300,866	$40,062,878	$33,399,888	123.8%	119.9%
Jun-2019	19,653	46,947	$736,988	$28,108,645	$6,942,090	$35,050,735	$35,787,723	$1,249,576	$34,538,146	$32,769,603	109.2%	105.4%
Jul-2019	23,351	56,560	$875,663	$34,221,436	$6,322,029	$40,543,465	$41,419,128	$1,137,965	$40,281,162	$42,204,816	98.1%	95.4%
Aug-2019	23,445	56,796	$879,188	$37,383,475	$6,830,950	$44,214,425	$45,093,613	$1,229,571	$43,864,042	$42,456,025	106.2%	103.3%
Sep-2019	23,488	56,943	$880,800	$30,842,016	$6,009,190	$36,851,206	$37,732,006	$1,081,654	$36,650,352	$42,242,634	89.3%	86.8%

CLAIMS HISTORY SUMMARY– JULY 2016 THROUGH SEPT 2019

Month	Total Contracts	Total Members	Fixed Cost	UHC Medical Claims	CVS/Caremark Pharmacy Claims	Total Paid Claims	Gross Plan Cost	Anticipated Rebates	Total Medical & Pharmacy Plan Cost	Medical & Pharmacy Budget	Loss Ratio: Plan Cost vs. Premium	Loss Ratio: Plan Cost after Rebate vs. Premium
FY 2016	706	1,733	$28,240	$681,549	$227,049	$908,598	$936,838	$40,869	$895,969	$1,102,820	84.9%	81.2%
Jul 16 - Jun 17	49,914	124,925	$1,996,560	$54,729,578	$19,189,206	$73,918,784	$75,915,344	$3,454,057	$72,461,287	$80,605,883	94.2%	89.9%
Jul 17 - Jun 18	119,098	290,167	$4,466,175	$152,018,591	$43,354,037	$195,372,628	$199,838,803	$7,803,727	$192,035,076	$189,984,523	105.2%	101.1%
Jul 18 - Jun 19	215,349	518,174	$8,075,588	$303,471,236	$77,074,639	$380,545,875	$388,621,463	$13,873,435	$374,748,027	$358,398,842	108.4%	104.6%
Jul 19 - Sept 19	70,284	170,299	2,635,650	102,446,927	19,162,169	121,609,096	124,244,746	3,449,190	120,795,556	126,903,475	97.9%	95.2%
Prior Rolling 12	141,719	345,513	$5,314,463	$183,838,379	$50,510,400	$234,348,779	$239,663,242	$9,091,872	$230,571,370	$227,563,653	105.3%	101.3%
Rolling 12	240,601	578,156	$9,022,538	$348,213,220	$80,502,899	$428,716,119	$437,738,657	$14,490,522	$423,248,135	$410,509,823	106.6%	103.1%
CYTD to 09/30/2018	114,924	280,330	$1,084,320	$33,671,698	$11,059,236	$44,730,934	$45,815,254	$1,990,662	$43,824,592	$43,733,841	104.8%	100.2%
CYTD 09/30/2019	186,410	447,487	$2,620,950	$94,063,717	$25,817,256	$119,880,973	$122,501,923	$4,647,106	$117,854,817	$110,313,689	111.0%	106.8%
Cal Yr 2016	23,512	58,750	$940,480	$21,739,429	$8,357,019	$30,096,448	$31,036,928	$1,504,263	$29,532,665	$37,974,862	81.7%	77.8%
Cal Yr 2017	76,314	188,062	$2,929,545	$91,626,572	$28,596,017	$120,222,589	$123,152,134	$5,147,283	$118,004,851	$123,404,675	99.8%	95.6%
Cal Yr 2018	169,115	170,013	$2,620,950	$94,063,717	$25,817,256	$119,880,973	$122,501,923	$4,647,106	$117,854,817	$110,313,689	111.0%	106.8%
CYTD 9/30/2019	186,410	447,487	$6,990,375	$274,715,811	$61,223,432	$335,939,243	$342,929,618	$11,020,218	$331,909,400	$319,734,481	107.3%	103.8%
All	455,351	1,105,298	$17,202,213	$613,347,881	$159,007,100	$772,354,981	$789,557,194	$28,621,278	$760,935,916	$756,995,543	104.3%	100.5%

For the 3 months (Jul 19 – Sept 19), these claims are very preliminary and not necessarily an indication of how the 2019-2020 plan year will perform overall…..

RENEWAL INCREASES

One of the major selling points of the SPP has been its historically low annual increases. In a time when the medical and pharmacy trend has fluctuated between 8% and 12%, the SPP has generally had low single-digit increases. The chart below tracks the SPP's increases back to the original inception of the Partnership Plan. From 2011 through 2015, the plan analyzed each prospective group's claims and demographic information, issuing each group their own renewal. Since 2016, the 2.0 version has instead posted just one set of rates on its Web site each year, which is the same for all groups.

Plan Year	Budgetary Increase
2020-2021	3.0% (preliminary)
2019-2020	8.0%
2018-2019	8.0%
2017-2018	5.0%
2016-2017	5.0%
2015-2016	4.0%
2014-2015	4.9%
2013-2014	4.9%
2012-2013	0.0%
2011-2012	2.0%

Area	Approximate Rate Change
1-Fairfield	6.5%
2-Hartford	0.5%
3-Litchfield	1.0%
4-Middlesex	3.5%
5-New Haven	5.5%
6-New London	4.5%
7-Tolland	-1.0%
8-Windham	3.5%

UNDERWRITING PROJECTION

The SPP's overall trend has been climbing slightly faster than the renewal increases being issued by the State. That raises some concerns regarding the adequacy of the premiums being collected versus the claims being paid. Brown & Brown took the data we collected and did the same type of renewal analysis we would perform for any of our self-funded clients.

2020-2021 Premium Requirements	
2019 - 2020 Estimated Premium	$506,911,608
2020 - 2021 Suggested Premium	$594,538,058
Increase	**$87,626,450**
	17.29%
Additional Funding of IBNR	$47,458,366
2020-2021 Adjused Premium	$641,996,424
Increase	**$135,084,816**
	26.65%

Based on the known membership and rates, this is the premium expected to be collected by the plan in 2019-20.

Expected premium needed to cover claims and fixed fees for the plan in the 2020-21 year, using the current membership.

Projected increase needed to cover the base costs of the plan in 2020-21.

All self-funded plans being budgeted for properly should have a reserve accounted for to cover claims for the point in time when the plan ceases to exist. This is Brown & Brown's estimate of the plan's current shortfall.

Projected increase needed to cover the base costs of the plan in 2020-21 and account for the reserve needed to cover runout claims.

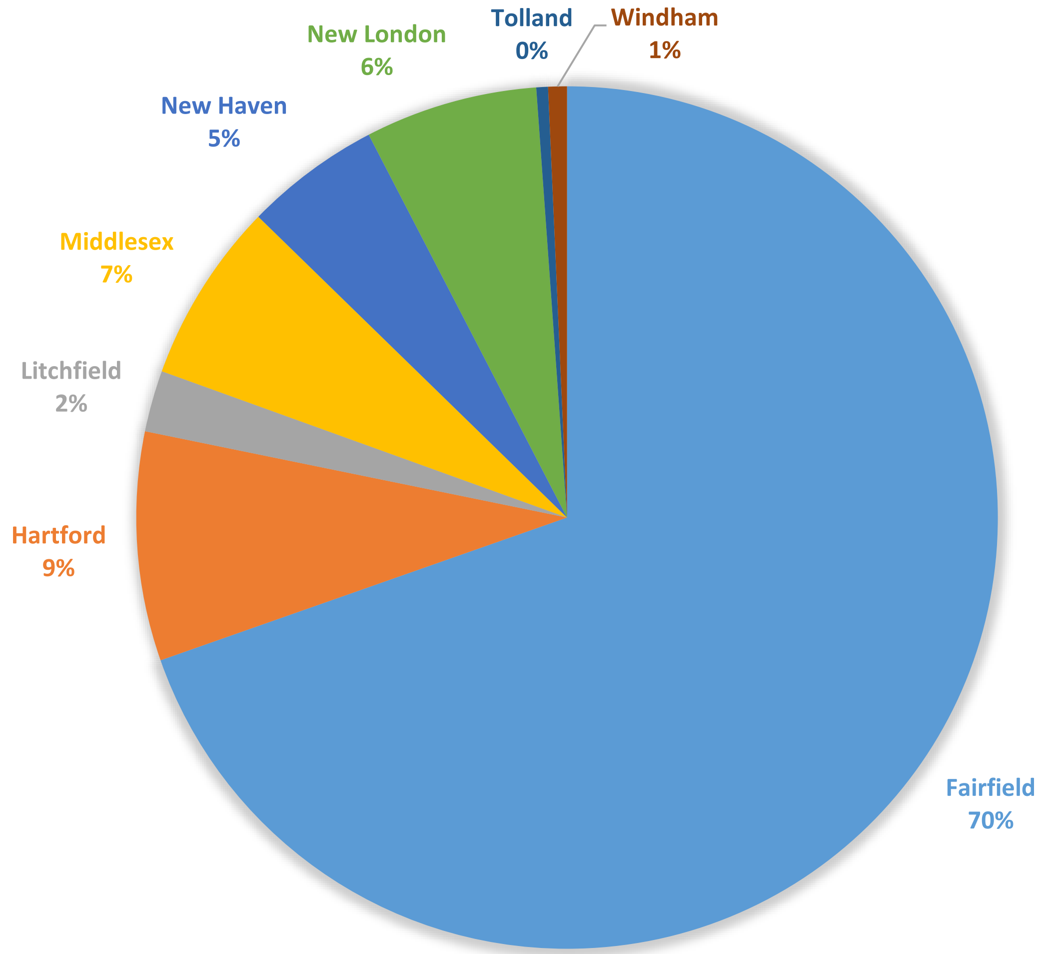
The State has released a preliminary +3.0% increase for the 2020-21 year, but we don't expect that number to be finalized until mid-April. IMPORTANT – effective 7/1/2020, the SPP is changing carriers from United Healthcare to Anthem BCBS of Connecticut.

PARTNERSHIP PLAN: BUDGETARY CONCERNS

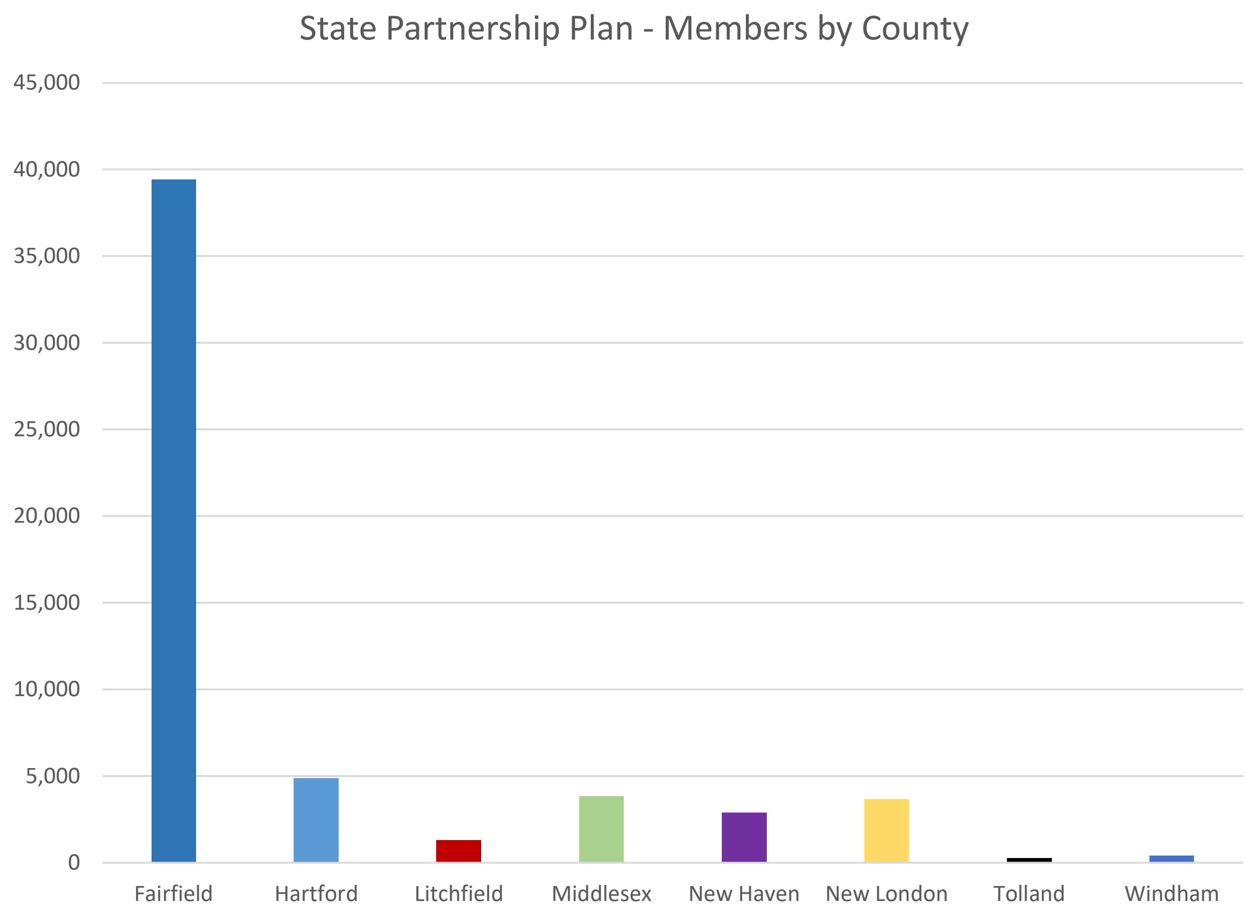
- Adverse Selection
  - *By not underwriting each potential group and simply posting rates, only groups whose costs are currently higher will join*
- Deteriorating Experience
  - *The claims experience shows the 2.0 Plan had the following medical loss ratios:*
    - *85% loss ratio in 2016*
    - *94% in 2017*
    - *105% in 2017-18*
    - *108% in 2018-19.*
- Demographics
  - *In addition to adverse selection, claims for the plan are increasing due in large part to an influx of membership from Fairfield County.*

COUNTY DEMOGRAPHICS

STATE PARTNERSHIP PLAN - MEMBERSHIP PERCENTAGE BY COUNTY

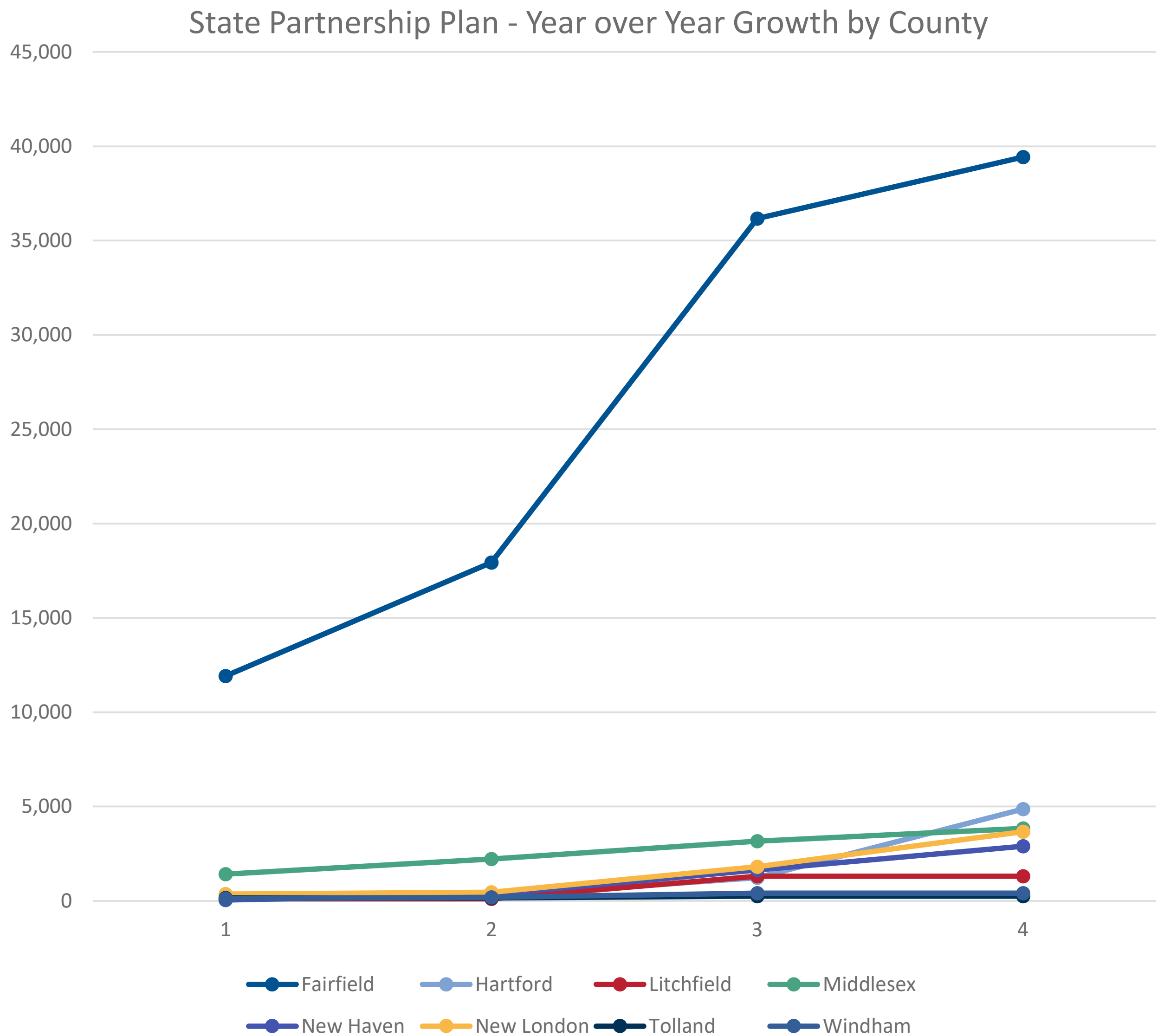


COUNTY DEMOGRAPHICS (Continued)



Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham
39,424	4,858	1,302	3,837	2,888	3,665	248	398

COUNTY DEMOGRAPHICS (Continued)



WHY DO DEMOGRAPHICS MATTER?

When insurance carriers create quotes for potential groups, they take several factors in to account. Age and gender of the employees and their dependents are considered, as well as where the group is located. The cost of services in one area of the state can vary greatly from another area. In the large group market, carriers are often willing to manipulate their quotes to gain business. They often refer to this as "making an investment." However, in the small group market, quotes are generated blindly – taking only age, gender and county in to consideration.

To see how different counties are rated by the various carriers in the small group market, we took an identical sample small group census and ran it through the quoting tools of each carrier in the small group marketplace. You can see from the ratios below that all of the carriers would require a group in Fairfield County to pay anywhere from 11% to 17% more than the rest of the state.

CT Small Group Rating Differential by County

Using Rates as of 1/1/2019

	Anthem Blue Cross	ConnectiCare	Harvard Pilgrim	UnitedHealthcare
Fairfield	1.12	1.09	1.17	1.05
Hartford	1.00	0.98	1.02	1.00
Litchfield	1.00	0.98	1.02	0.96
Middlesex	1.04	1.07	1.07	1.07
New Haven	1.04	1.00	1.07	1.02
New London	1.00	1.08	1.02	0.99
Tolland	1.00	1.00	1.00	0.99
Windham	1.00	1.00	1.00	1.00

Quoted rates from carriers available on small group quoting tool

SEBAC Agreement Savings for FY 2018 and FY 2019

In a report presented by the State Employees Bargaining Agent Coalition (SEBAC) to Gov. Lamont and the General Assembly on Dec. 10, 2019, several aspects of proposed money-savings programs from previous years were analyzed. 10 programs were outlined in the "Employee Health Care" section. Three of those either had no firm data available or no initial savings projection to compare to. The other seven are outlined on the following slides, taken directly from the report, found at: https://www.osc.ct.gov/reports/sebacsavings/SEBACSavingsReport2019.pdf

Note that Fiscal Year 2018 health care savings projections related to benefit design changes anticipated a September 1, 2017 implementation date. The benefit design changes were implemented as soon as administratively feasible but not until October 1, 2017 in most cases and March 1, 2018 in others. Actual implementation dates of each provision related to health care benefits is identified below. The delayed implementation impacted the savings achieved.

Financial incentive to utilize urgent care *(implemented October 1, 2017)*

- The agreement increased Emergency Room copays from $35 to $250, with the goal of decreasing unnecessary ER visits and encouraging the use of Urgent Care.

	FY 2018	*FY 2019*	*Total*
Projected Savings	*$13.3 million*	*$15.9 million*	*$29.2 million*
Actual Savings	*$6.6 million*	*$13.0 million*	*$19.6 million*

SEBAC Agreement Savings for FY 2018 and FY 2019 cont.

***Utilization management** on physical and occupational therapy services (implemented October 1, 2017).*

- The agreement requires the state employee health plan's consistent application of utilization management requirements for physical and occupational therapy.

	FY 2018	FY 2019	Total
Projected Savings	$2.7 million	$3.2 million	$5.9 million
Actual Savings	$1.5 million	$2.0 million	$3.5 million

***Incentives to utilize lower cost imaging**, and lab providers (implemented March 1, 2018)*

- The agreement created a new tiered benefit design for imaging and lab services in which the $0 copay for lab and imaging services would continue for certain preferred low cost lab and imaging providers, a 20% co-insurance would apply to in-network non-preferred higher cost providers, and a 40% co-insurance would apply to out of network providers for plans that include an out of network benefit.

	FY 2018	FY 2019	Total
Projected Savings	$6.3 million	$7.5 million	$13.8 million
Actual Savings	$3.2 million	$3.6 million	$6.8 million

The original savings estimates assumed that all lab and radiology services would be covered by the program. However, in order to ensure appropriate patient care, certain labs and radiology services were exempted including services associated with pregnancy, cancer treatment and pediatrics.

SEBAC Agreement Savings for FY 2018 and FY 2019 cont.

Member incentive based program (SmartShopper) *(implemented March 1, 2018)*

- The agreement allows for a new financial incentive program to encourage plan participants to seek care from high quality, low cost providers in order to improve patient outcomes while reducing overall plan costs.

	FY 2018	FY 2019	Total
Projected Savings	$2.80 million	$3.70 million	$6.5 million
Actual Savings	$0.47 million	$0.97 million	$1.4 million

Increased co-pays for certain prescription drugs *(implemented October 1, 2017)*

- The agreement creates a 4-tier co-pay schedule. $5 and $10 co-pays will be assigned to clinically equivalent generic drugs, with $5 co-pays corresponding to the lower cost generics within the therapeutic class. Preferred brand drug copays increased from $10 to $25 and non-preferred drugs copays increased from $25 to $40. Any drug indicated to treat one the five chronic diseases covered by the state's Health Enhancement Program are exempt from the copay adjustments.

	FY 2018	FY 2019	Total
Projected Savings	$7.5 million	$4.5 million	$12.0 million
Actual Savings	$1.4 million	$1.3 million	$2.7 million

SEBAC Agreement Savings for FY 2018 and FY 2019 cont.

Adopting the CVS standard formulary *(implemented October 1, 2017)*

- The agreement requires the adoption of a standard drug formulary offered through the state's contracted pharmacy benefit manger to encourage utilization of lower cost and more effective prescriptions.

	FY 2018	*FY 2019*	*Total*
Projected Savings	*$25.4 million*	*$27.0 million*	*$52.4 million*
Actual Savings	*$16.0 million*	*$21.7 million*	*$37.7 million*

Implementation Cost

- Certain aspects of the changes to health benefits required by the agreement resulted in implementation costs for the state plan health carriers, which was charged back to the plan.

	FY 2018	*FY 2019*	*Total*
Projected Savings	*($0.10 million)*	*N/A*	*($0.10 million)*
Actual Savings	*($0.30 million)*	*N/A*	*($0.30 million)*

Miscalculated Savings Opportunities for FY 2018 and FY 2019

Financial incentive to utilize urgent care	**$9.6M**
Utilization management - on physical and occupational therapy services	**$2.4M**
Incentives to utilize lower cost imaging	**$5.0M**
Member incentive based program (SmartShopper)	**$5.1M**
Increased co-pays for certain prescription drugs	**$9.3M**
Adopting the CVS Standard Formulary	**$14.7M**
TOTAL	**$46.1M**

PLAN BENEFITS

The most enticing aspect of the plan for most people are the rich benefits. While the majority of the groups in the public sector have moved to High Deductible Health Plans in recent years, the SPP's benefits are closer to what members would have last had well over a decade ago. However, there's no guarantee those benefits will remain in tact. In 2017, as a result of concessions from the state's unions, the partnership plan passed the following benefit changes along to its members:

- Preferred tier doctors visits go from $15 co-pay to $0
- "Site of Service" for outpatient lab work – use a preferred lab or you pay 20% coinsurance
- Narrower drug formulary
- Rx co-pays from $5/$20/$35 to $5/$10/$25/$40
- PT/OT services added to prior authorization list

The State also made a recent change to the language on its Web site regarding state mandated benefits. Instead of agreeing to cover all state mandates, the site now reads:

Does the plan follow all Connecticut state mandates?

The Partnership plan is self-insured and therefore is not required to follow all Connecticut state mandates. However, we try to follow state mandates as best we can. There are certain instances where there are union agreements or other mitigating circumstances that take precedent.

PLAN BENEFITS (Continued)

Despite the generally rich benefits, there have been some unions in the state who have expressed concern about the managed care elements of the SPP. Here are the benefits listed in the SPP's plan documents as requiring prior authorization:

Medical Services Requiring Prior Authorization	
Air ambulance	Kidney dialysis
Bariatric surgery	Oral surgery
Chemotherapy	Organ transplant
Colonoscopy	Orthoptic exercises
Durable medical equipment over $500	Sleep studies
Gender reassignment surgery	Outpatient occupational therapy
Hearing aids (bone-anchored)	Outpatient physical therapy
High cost diagnostic imaging (MRI, MRA, CAT, CTA, PET, SPECT scans)	Outpatient surgery
Infertility treatments	Private duty nursing
Inpatient non-emergency care (includes childbirth)	Skilled nursing facility admission
Inpatient hospice	Speech therapy
Inpatient mental health	Specialized infant formula
Inpatient substance abuse treatment	Specialty hospital admission
Internal & external prosthetic devices	Substance abuse residential treatment

POTENTIAL LEGISLATIVE IMPACT

PA 15-93, which created the SPP and was amended to allow for the change to the 2.0 plan at the end of 2015, includes language noting that the funds for the SPP shall be held separately. So while the State may say they aren't concerned about the plan's finances because they are in a shared risk pool with the much larger body of all state employees, they are certainly tracking it.

In 2016, the state's Office of Policy and Management proposed legislation that would have tacked the highlighted language on to the end of PA 15-93:

The Comptroller may charge each nonstate public employer participating in the state employee plan an administrative fee calculated on a per member, per month basis. Such administrative fees shall include an amount deemed necessary by the Comptroller to ensure that the state employee plan premium account established in accordance with Section 4 of this Act will maintain a positive balance.

That proposal was ultimately shot down, but there's nothing to say it couldn't be raised again at any time. If that did happen, groups could see a surcharge added on to their invoices from the state to offset the losses the plan is experiencing.

Questions?

THANK YOU