QUESTION AND ANSWER ON OPEN ENROLLMENT AND MEDICAL/PRESCRIPTION PLAN CHOICES COMING THIS SEPTEMBER/OCTOBER, 2020

	Question	Answer
1.	Our open enrollment is usually in June of each year effective July 1. Why was it delayed until September with changes to be effective on October 1, 2020?	Because of the COVID-19 pandemic, it was impossible to complete all of the tasks necessary to make the process work by July 1, 2020.
2.	How does that affect employee premium shares? They normally go up on July 1 each year?	First, remember we are discussing only medical/prescription plans here. Our dental plan costs are actually going down about 15% this year. Sticking to medical/prescription plans, under the agreement, since employees' premium shares are a percentage of total costs, they go up each year as the plan's costs go up, just as the State's do. This usually happens on July 1st, and this July, since the underlying plan costs had increased 1.5% (far less than most plan's do because of the efficiency of our plan), employee costs were also scheduled to go up 1.5%. In addition, under the SEBAC 2017 Agreement, employee plans that were under 15% premium share were scheduled to go up 1% of total cost (but not to go over 15%). However, we had to suspend these increases, because they might have affected employee plan choice, and employees are not able to make effective plan choices until September (effective October).
3.	So, what will happen in October?	In October, all of the required increases will go into effect, but since there will be only 9 months to collect them instead of 12, the increases will temporarily be higher so that what the member pays will be what would have been paid over the full 12 months. So for instance, a member whose plan was already at the 15% rate (so would not have been affected by the 1% premium share increase) and who continues in the same plan will see a rate increase of 12/9ths (or 4/3rds) of the annual 1.5% increase. So, the member will pay 2% more for 9 months instead of 1.5% for 12 months, and thus pay the same total amount during the shorter period. Of course, a member may choose to lessen that impact by switching to a cheaper plan. *Remember that the specific effects of the increase will vary by whether the 1% premium share increase applies, and of course, whether the member stays in the same plan, vendor, and coverage class.*

	Question	Answer
4.	We understand that Anthem will be the sole provider for active and under 65 State Employee Health Insurance starting 10/1/2020.[1] How did this happen? Doesn't the plan require there to be two providers such as Anthem and United/Oxford Health Care?	The providers for the State's Health Plan are bid out through an RFP process every 3-5 years. Anthem was the winning bidder in the most recent RFP, and its bid to be the sole source provider was the winning bidder of all of the participants. While the plan allows there to be two winning bidders, it does not require that. In this case, Anthem's sole source bid beat out any of the options that allowed for two providers taking into account quality, plan requirements, and cost. United's bid lost out based upon cost, and also failed to meet certain plan requirements which are needed to expand the Centers of Excellence approach which benefits all plan members.
5.	But isn't this unfair to current United/Oxford participants? Now they will have to find providers within Anthem's network instead of United/Oxford's.	It is inherent in the RFP process that it is possible some plan members will need to change providers. That said, "disruption analysis" – how many participants might have to change providers – is one of the key factors considered in the RFP process. On core benefits, over 97% of United/Oxford providers are also in the Anthem network. For those few members who might have to switch, there are "continuation of care" options for those in the process of ongoing medical treatments. To check whether your provider is in the Anthem network, you can look here: Anthem Find Care. Note that your doctor doesn't need to be a "preferred provider" to be in network. They are also in network if they are listed under "Other Provider Types." Being under preferred provider in our current plan structure means only that the person has met Anthem's standards for quality and cost well enough so that members choosing those providers have their co-pays waived.
6.	I understand that. But many of United/Oxford's plans are cheaper for members than Anthem's. Isn't it unfair to remove some of the cheaper options?	Members' premium shares in all state plans are on a percentage of cost basis – members pay a percentage of the overall cost of claims in any given plans. United/Oxford's underlying plans are cheaper than Anthem's only because of what is known as "adverse selection." When making their plan choices over the years, because of Anthem's connection to the old Blue Cross/Blue Shield and its general reputation for higher quality service, older members or those with chronic health problems are more likely to choose Anthem. Younger members, if they happen to not have chronic health problems, are more likely to choose United/Oxford. This means that, on average, United/Oxford members have fewer and less expensive claims than Anthem members. This results in Anthem's cost to members rising and United/Oxford's lowering. This artificial cost difference is not required by the Plan and is inconsistent with the "all in this together" principles under which the health plan is meant to operate. There is nothing in our contract that requires this to continue.

[1] This was originally scheduled for 7/1/2020 but was delayed because open enrollment was delayed due to the pandemic.

	Question	Answer
7.	But now as a United/Oxford member switching to Anthem, I'm going to have no choice but to pay significantly more for my insurance. Won't there be anything I can do about that?	The good news is that the Comptroller, through the joint Health Care Cost Containment Committee, has required that Anthem offer a high quality, lower cost alternative to all members, whether they are young and healthy or otherwise. This voluntary plan choice will reward members for making provider choices that have been demonstrated to be highest in quality and fair in cost. This plan option will be available for selection in the new open enrollment period (but Answer 11 for the problem with Hartford Health Care's participation). The new option is called the State BlueCare Prime Plus POS.
8.	Tell us more about this new plan choice.	For all plans, there will be a Health Navigator support system available by phone, web, and live online messenger chat to assist employees with any questions they may have at any time during the year. To understand the new plan choice, we need to start with the current plan choices and explain the difference.
9.	Okay. Let's start there. What are the key components of the current choices?	In general, state employees right now choose between two types of plan. Most employees choose a POS plan. These are the more expensive choices, because even though they had a network of providers employees are encouraged to choose, they also have out of network coverage (although members pay a portion of the cost). The alternatives are the POE plans. These are cheaper because even though they have the same in network coverage and the same networks, they have no out of network coverage. If you see an out of network provider, you have no coverage at all. Both types of plan have in common a preferred provider group within the covered network, which has been selected for quality and overall value. Members who use preferred providers have their $15 co-pays waived but otherwise get the same coverage.
10.	So how does the new plan option differ?	The new plan option is a narrower network than the current plans have, but it has full out of network coverage (with higher member costs if you choose to go out of network). With one important exception, the narrower network includes all of the preferred providers and all of the specialists they recommend. Because these are all the higher quality and value providers, the overall costs are lower, and both the member and the State saves money. In addition, it should produce better health outcome for the members which is good for everyone.

	Question	Answer
11.	What is the important exception on participation in the narrow network?	So far, Hartford Health Care has refused to participate in the narrow network. This is very disappointing and makes this an unfavorable choice for members who use Hartford HealthCare. For those members, their lowest cost choice would be one of the POE plans, all of which include Hartford Health Care (although these don't include out of network coverage). The Comptroller's office and the HCCC are working to try to remedy this situation by the next open enrollment on July 1, 2021 if not before but as of now there is no guarantee.
12.	How will member premium shares for the narrow network compare to current plans?	Premium shares for the new plan will be 10% for single coverage, 11.5% for single plus 1, 12.5% for families, and 10% for FLES (families less employed spouse). Because overall costs are lower, the bi-weekly payroll deductions will be lower than all of the current Anthem choices using October 1 rates, and lower than all of the current Oxford choices (using what 10/1/20 rates would have been) except the Oxford POE plans. Although they will be higher than those POE plans, they will offer out of network coverage not available under the current Oxford POE plans.
13.	Why couldn't we match the lower costs of the current Oxford POE plans?	As answer 6 above explains, Oxford costs were kept artificially low by what's called "adverse selection" which also kept Anthem's cost artificially high. This was not an intentional aspect of the plan, nor was it required by our contract or consistent with our plan values and philosophy. However, the new narrow network plan will go a long way toward preserving low cost choices, based not upon adverse selection, but on high quality and value providers producing better health outcomes for employees and the plan.
14.	Where do I look to see if my provider is part of the narrow network?	You use the same link as above --Anthem Find Care -- and click on "State BlueCare Prime Plus POS."