HEALTHCARE COST
CONTAINMENT COMMITTEE

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STATE OF CONNECTICUT
HEALTHCARE POLICY & BENEFIT SERVICES DIVISION
OFFICE OF THE STATE COMPTROLLER

HEALTHCARE COST CONTAINMENT COMMITTEE MEETING MINUTES
December 11, 2023

Meeting Called to Order by **Josh Wojcik**:

Attendance:

Labor	State Comptroller Administrative Staff
Carl Chisem – CEUI	Joshua Wojcik
Dan Livingston – SEBAC	Thomas Woodruff
	Presenters
	Bernie Slowik – OSC
	Rae-Ellen Roy – OSC
Management	Betsy Nosal -OSC
Gregory Messner	
Karen Nolen	
	Consultants
Dept. of Insurance	Terry DeMattie, Segal
Paul Lombardo	

Public Comment:

No public comment

Financials:

For the active appropriation, we're looking to close the year with about a $10.3 million surplus. Our active FAD accounts have a healthy IBNR of about $148 million, getting us very close to where we would like the reserve near the year's end. We're looking to have about a 45-day spend or claims cost value as our total IBNR.

The retiree health appropriation, considering the expected expenses for the 2024 Medicare reimbursements and the Medicare Advantage Premium, it appears that we will end the year with a surplus of approximately $2 million. We don't anticipate any sudden retirement expenses soon and are optimistic that we will maintain a balance of zero or above.

On the retiree health care OPEB FAD accounts, which are our spend accounts, we aim to close the year at $204 million, which is great news. We aim to spend down the reserve, which is currently higher than we need. This is mainly due to the changes made with our rx with Prudent RX and the addition of Aetna this past year.

Partnership:

As of December 1st, we have 153 groups enrolled in Partnership 2.0, which adds up to over 23,000 employees and approximately 50,000 members. One small group has confirmed their enrollment for 1/1/2024. We are promoting the plan through the Anthem retention campaign and on-site vendor events.

Partnership 1.0 still has five groups enrolled with approximately 2,400 employees and just under 3,400 members.

We are considering a recommendation to incorporate the changes regarding regional adjustments. This happened back in 2019, and it's time to review it. Per the contract, we can reassess the regional adjustment at each renewal. We suggest gradually implementing it from year five over two years for both the new and existing groups that match. Our next renewal is on 7/1/24, but we plan to inform our current partnership groups during the next quarterly update about the change that will commence on 7/1/25 and then complete on 7/1/26. Based on the adjustment factors as of today, the highest adjustment is a 2% increase, phased over two years, i.e., 1% per year. It is not a significant change; some may even receive a decrease. This is the proposal that we are considering.

High-Level Utilization:

This is our standard report on high-level utilization and our performance until the end of August. We are still doing well, with an annual trend of 2.7%. However, we can see some areas where we can improve. For instance, outpatient facilities are still at around 3.9% on the medical side, and professional services are still a little high. We mentioned in last month's meeting that we would take a closer look at professional services and will provide an update soon.

On the pharmacy side, we are seeing a slight increase in the trend. As mentioned earlier, this increase will occur over the course of the year because the Prudent RX savings are being phased into the base. As they become fully integrated into the base, we will see more of the actual pharmacy trend without those Prudent RX savings that were bringing it down. However, we are still getting the savings. We also received savings in the prior period, so this will not result in a negative trend on an ongoing basis.

Pharmacy Claims Breakout FY 2023:

To provide a more detailed review of our pharmacy performance, let's take a closer look at our data from fiscal year 2023, which has already been completed. Please note that the statistics we'll show you are from the state plan, which CVS manages. Although CVS runs the partnership and state plan independently, the utilization numbers from both plans are not significantly different. Therefore, this data can give you a good overall picture of our performance, even though it only represents the state plan.

We have been monitoring the compound annual growth rate every month. The rate has been limited since fiscal year 2021, with a significant impact from the Prudent RX savings. There was a notable increase in fiscal year 2022, but the introduction of the Prudent RX program brought the costs down close to the level of fiscal year 2021. Price inflation on non-specialty brands saw a 1.2% increase, while specialty brand inflation was at 3%. Generic saw almost no inflation at all. Utilization saw a 1.1% increase. However, the most significant change was the savings associated with Prudent RX, contributing to a 10.5% decrease. Although other factors are involved, the Prudent RX saving is the primary driver behind the large negative number.

One of the top five non-specialty categories that saw a significant increase in cost is antidiabetics. This is mainly driven by GLP-1, such as Ozempic, Mounjaro, Trulicity, and similar products. Other categories had limited increases in comparison. We implemented the Intellihealth program on July 1st to address this issue, and we will evaluate the performance in this category for the first quarter moving forward.

The following is a report on specialty costs. Even though specialty costs are generally increasing, in our case, they are decreasing. This same pattern continues to repeat itself. Prudent RX has helped to reduce specialty costs. The breakdown of costs shows that if we had not implemented Prudent RX, we would have seen an increase of $2.00 per member per month in specialty costs. However, we ended up with a decrease of about $13 in PMPM costs.

This is a breakdown of the top ten specialty drug classes. It is worth noting that the negative figures seen for the past year are due to the available manufacturer assistance. The more negative the figures are, the more assistance was provided. For instance, atopic dermatitis, which would have seen a 25% increase, only had a 2% decrease because of the manufacturer's assistance.

Medication adherence, how well are we performing regarding adherence metrics? As per our analysis, we usually exceed the market standards in this regard. The market in question consists of other government groups and CVS and government groups that also have CVS as a PBM. Even compared to other government groups, we still manage to outperform the market due to the significant role played by HEP. Our copay structure and incentives encourage people to stay adherent, and as you can see in each category, we are surpassing the peer group by a considerable margin.

Pharmacy Quarter 1 FY 2024:

The following information pertains to the pharmacy first quarter of fiscal year 2024. The current situation is different from the previous year because the Prudent RX savings are now included in the base. Therefore, we are comparing the first quarter of 2024 to the first quarter of 2023. We are experiencing rising pharmacy costs overall due to market impacts. The categories for the first quarter 2024 are the same as those in the fiscal year 2023. However, the last category, which is drug mix, marketplace factors, and rebates, has changed from highly negative to positive. This change is due to including the Prudent RX savings in the base. The overall cost growth for the first quarter of 2024 is about 10%, which is significant. In comparison to our peer group, we are slightly above them with a trend of 9.9%, while their trend is about 9.3%. There are a few items to call out in the full breakdown of categories. However, there is a significant increase of 22% in the specialty growth costs. When combined with the rebates, the overall specialty trend is 18.3%, which is a significant driver of the overall cost growth.

There is an increase in the cost of our top specialty categories or classes. This has caused our trend to rise above the peer group. The utilization of specialties has also increased to 14.4% compared to the prior period. We have found that a lot of the new specialty utilizers, up to a third of them, are new to the plan. These are people who have recently been hired, and this is driving some of our costs. Hiring new employees and adding new members to the plan is causing an increase in our costs.

We are falling behind the peer group in terms of specialty, costing us more. However, we are doing better in the non-specialty areas than the peer group. Upon analyzing the data, we found that we are performing well in the antidiabetic and obesity categories in the first quarter. We hope the adjustments we made on July 1st, such as implementing the Intellihealth program, will help control our costs and reduce the extreme cost growth we saw in the antidiabetic category. We want to continue providing people with the care they need but at a more affordable cost. We will have to wait and see how this plays out in the long term.

We achieved a total savings of around $30 million in the last fiscal year. We are experiencing slightly less savings in quarter one than the previous year. This is mainly due to ABV, the drug manufacturer, adjusting its manufacturer assistance program for drugs like Humira. As a result, less manufacturer assistance is available and flowing to the plan. This is having an impact on our overall savings as well as our specialty pharmacy trend.

Dental Plan Performance:

We met with Cigna to discuss our dental plan's performance during fiscal year 2023. In the meeting we received updates about some changes.

Last year, during the open enrollment period, we received complaints from many of our members about the network loss. Our recent contract included performance guarantees related to increased network size. Cigna has exceeded our expectations and added 457 access points with 150 providers. An access point refers to the number of offices, so we have 150 new providers on average, many of whom have more than one office. For the basic plan, we exceeded the

guarantee of 260 access points and 30 providers for year one. On the enhanced network, we increased the number of providers to 142, utilizing 443 access points, far exceeding the guarantee of 80. Overall, we've done very well in having Cigna exceed their goals.

The DHMO is close to achieving its goal of having 25 access points added to its network by the end of the year. They have already added 20 access points and are reaching out to the most frequently used providers first to bring them into the network. They have contacted all the providers currently using the network, and overall, we have seen an increase in our enrolled population compared to last year. Although our population is slightly smaller than the normal government population, we cover children up to age 26, which should have increased our population. However, we expect to see an increase in the next couple of years as more people reenroll their kids.

Most of our population is enrolled in the DPPO products, and dental care refers to DHMO. DPPO is our basic in-hand plan. This year, we have noticed a slight increase in DHMO in total care and general DHMO enrollment. It's great to see many new hires opting for lower-cost options initially. This is beneficial for the overall health behavior of our plan. We stand out in terms of behavior as our members are getting cleanings more frequently than the northeast New England government plans. Nearly 80% of our members receive at least one cleaning yearly. The good news is that most individuals still use an in-network provider, even on the basic plan that doesn't require in-network providers. This has resulted in a significant amount of plan savings. We have observed a 0.4% increase in overall savings, indicating that most members are starting to rely on in-network providers and services.

We have noticed a slight increase in savings due to some changes in our plan design. People are following the plan requirements and limits and seeking services within those limits, which is good news. For example, many people met their $1,500 orthodontia limit early in the year, so orthodontia services have decreased, and we have seen a rise in overall savings.

Utilization management is another aspect of the plan design. We have set a limit on the frequency of certain services, such as cleanings or fillings on a single tooth. If an individual tries to have a filling on a tooth within three years of having one, the plan will not cover it. This way, we can avoid unnecessary costs and increase savings. The planned and paid services trend is around 0.6%, which is well within our objectives and rate cap.

Quantum Call Center Reporting:

This month, we have divided the data we collected between the core and partnership groups. This is the engagement rates for the core group. As you can see, employees remain the most engaged group overall. We contacted people via phone and contacted a little over 41% of them. Our success rate was just over 40%. As for the core group again, focusing on the overall engagement success, the members strongly prefer using the member portal. The phone calls are the second most popular way of engagement. This trend has remained consistent over the months.

On the partnership groups, their behavior seems very similar to that of the core group. The employees in the partnership groups are the most engaged, just like in the core group. We are also seeing similar levels of attempted and successful engagement. Whenever members call us, we reach out to them, and we have been successful almost every time.

Based on the overall engagement data, the member portal is the most frequently used platform by members to find information and resolve their queries. Following the portal, phone calls and reaching out to care coordinators are the next preferred modes of communication. This indicates that members utilize different channels on both the core and the partnership platforms, which is a positive sign. The overall usage of the member portal and registration process. About 40% of the membership has registered, consistent with other groups that joined at the same time as you, with just over 61,000 registered memberships. Different months show varying levels of activity, such as April, which significantly increased registrations when you first joined, and October, when communication was sent out. Many members use the member portal to view their claims and track their status. They also use the portal to find healthcare providers or doctors. The tools available on the portal help members to keep track of their authorizations and approved memberships.

Communications Update:

We are continuing our monthly well-being and Upswing seminars for all users. But we recently had a diabetes awareness month where we highlighted all the resources available to our members. These resources include a health reversal program, the Virta Health diabetes management, HEP chronic disease for diabetes seminars, and a diabetes prevention program. We want to remind our employees that these resources are available if they have diabetes or want to prevent it. Our open rates for personal emails, state emails, and partnership emails are strong, indicating that employees are interested in their benefits. However, diabetes awareness wasn't for everyone; those interested clicked through and got involved. We also posted similar information on our Care Compass Facebook page so employees can access the information from different sources. Additionally, we are working with Quantum Health on the portal and introducing sliders to correspond, ensuring consistency across all access points for our members' benefits.

As mentioned last month, we have started to automate our monthly new hire email. This is proving effective in providing new employees with necessary information about their benefits, where to go for assistance, and how to use the Care Compass care coordinators portal. We sent out a bulk email to 662 new employees in September and October. In November, we sent out 278 emails. This has helped us build relationships with new employees and establish our brand. However, I still receive questions from new employees and provide them with assistance. We are committed to helping new employees from the start of their employment in the state. In addition to the clinical health flyer introduced last month, we will conduct a two-part campaign in the early year.

We have various vendors and point solutions available and plan to make them printable for anyone who needs them. We have many great member testimonials from Virta and Upswing, the diabetes prevention program, and Flyte. Using those and linking to the information will help drive the utilization as it applies to our members, making it more accessible.

We are still going forward feedback with more planned member feedback as we prepare for open enrollment and upcoming outreach activities in January. Our focus groups are about to begin, and we are planning an interactive, all-employee live event that will last 30 minutes. Even if someone misses the live event, they can still access the link to participate in an interactive survey, which is a step up from our traditional fall survey.

In January, we will use the feedback received to ask our agency benefits specialists for their opinions. These specialists are usually the first point of contact for new hires and long-term employees, so their feedback is crucial to us. We will combine this feedback with the members' feedback to better understand our agency's needs.

Additionally, we are working on creating a shorter survey, 5-10 questions, to gather feedback from specific agencies that are not easily accessible digitally. This survey will be aimed at employees who may not have the time or inclination to participate in an online survey.

We are working with Quantum on a brief survey for portal and care coordinators. The objective is to gather feedback to prepare and work toward open enrollment. As we approach the initially planned launch in April, we need to identify areas for improvement and make necessary changes before waiting for an entire year.

Primary Care Initiative:

We are about to finish our first year of work with the Primary Care Initiative. We have 11 groups and 12 patient panels. One of the larger groups has a pediatric and adult panel, and we meet with them every two weeks. We are currently holding our final meetings for all groups for the calendar year 2023. We have been working with the groups on attribution, which means that if you primarily see one of their primary care doctors, you will be attributed to that group. We evaluate their performance based on how well they care for their attributed populations.

This year, we benefit from Quantum Health's work, where they gather primary care information when speaking with our members. For the calendar year 2024, we are working with Anthem to incorporate some of Quantum's work to enhance attribution accuracy. This will make our PMPM payments to the groups more precise, and they will know which members they are attributed to sooner so they can do a better job. We are also currently negotiating with three smaller groups, and we hope to bring them on board by January 1, 2024**.**

Josh Wojcik – Invited other questions or comments from committee members and the public. There were no additional questions or comments, call for motion to adjourn.

Motion to Adjourn was made by Dan Livingston, seconded by Gregory Messner.

Meeting was adjourned.