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
February 13, 2024

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:

We anticipate having a surplus of around $9 million in our active health appropriation by the end of this fiscal year. We have observed a significant increase in overall enrollment, mainly due to the rehiring of vacated positions during the retirement surge. However, our financial situation is still healthy and stable. The active employee health FAD accounts indicate a healthy balance of

approximately $151.6 million, which is the required reserve and a bit more. This is also due to a lower-than-expected trend overall. Therefore, the overall trend is performing well even with more people enrolled.

Regarding the retiree appropriation, we have a roughly $2.8 million surplus. Although it's difficult to estimate with certainty, we can round this off to zero or even one. Nevertheless, we are on track to end the year positively. Our retiree and OPEB FAD accounts show a very healthy reserve level of about $216.2 million. This is because our retiree population is aging quickly and transitioning to the Medicare Advantage plan much faster than in previous years. In the past, it was a slow distribution throughout the year and rollover into the plan, but now we are seeing more and more retirees swiftly moving to the program as soon as they retire.

Health Accounts- Long-term financial sustainability:

This information pertains to our spending in the healthcare accounts for fiscal year 2023 and the general fund spend, considering what it was in fiscal year 2017. Fiscal year 2017 was the year before the implementation of the 2017 feedback agreement, which brought about many changes and adjustments in the plan. Since that agreement, this group has been active and has implemented many cost-containment measures to manage the health plans. The information presented showcases the results of those efforts. As the healthcare cost containment committee, we have played a vital role in all the significant activities carried out concerning cost containment and quality, and I wanted to share this information with everyone.

The healthcare spend from the general fund has been very active. If we calculate the compound annual growth rate between 2017 and 2023, we get about 1.8%. The retiree side has done even better at 0.7%. Combining the two, we have a compound annual growth rate of 1.2% over the past five to six fiscal years, which is significant. Furthermore, when we compare this growth to the general fund expenditures, which have only grown by 3.8% over the same period, the health accounts have outperformed the overall growth in the general fund.

In 2017, the health accounts accounted for 7.6% of total spending from the general fund, but by 2023, this had reduced by a whole percentage point to 6.6%. If the health accounts had grown at the same rate as the general fund expenditures, they would still account for 7.6% in 2023, requiring an additional spending of approximately $221 million.

To complete our analysis, let's talk about enrollment. Did the number of enrolled individuals increase or decrease during the period under review? If enrollment decreased, it could be due to a declining population, but that wasn't the case here. Overall, enrollment increased by 1% for both active employees and retirees. This increase was slightly slower than our spending growth rate. However, if you break down the general fund cost growth on a per-employee or per-retiree basis, the combined growth rate per year over this period was only 0.3%.

Partnership:

Partnership 2.0, as of February 1st, we have 154 groups enrolled, including over 23,000 employees and approximately 50,000 members. One small group is joining on 4/1/24, and one is already confirmed for 7/1/24. We have received much interest from potential new groups for 7/1/24, and one of them has recently reached out to us.

Last month, we had a quarterly update meeting with our administrators. During the meeting, we informed them about the updated 3% to 5% range for the 7/1/24 medical pharmacy renewal. Additionally, we plan to have the finalized rates ready by the first week of March, about a month earlier than in previous years.

Five groups remain, with approximately 2,400 employees and just under 3,400 members, in the Partnership 1.0 status quo.

High-Level Utilization:

The trend we have observed in the last few months is similar to the previous months. There has been moderate growth in medical and very limited growth in pharmacy. The total cost trend is still under 3%, which is reasonable and manageable. Outpatient surgery continues to increase, driving the growth in outpatient facility and professional services. In the previous meeting, we mentioned that the number seemed high and are working on analyzing it. We have Segal working on some analysis and hope to share it with you next month. Overall, the trend is still relatively moderate and manageable.

Here are more details about the breakdown of various utilizations and how they trend in some groupings. We have observed a slight decrease in-office visits and preventive care, while inpatient admissions have slightly increased. Emergency room visits have been consistently high, and the trend continues. Following the trend of ER visits, urgent care visits have decreased a little bit. Additionally, we have noticed a slight increase in the number of prescriptions, which is just based on utilization per 1000. We will continue to monitor these trends over the long term to see if they persist or are just temporary fluctuations.

Looking at preventive care for people with chronic conditions and that they receive the appropriate preventive services. Although there has been a slight decline in diabetes, we need to be vigilant about all other conditions trending upward. The one exception is hypertension, which has seen only a tiny increase. Diabetes is the main condition we must watch closely as we move forward. However, we may need a more thorough investigation if we continue to see these numbers.

We need to keep an eye on our high-cost claimants. Although the categories can be random, it's important to monitor them. The numbers fluctuate a lot, so it's good to check if we see a significant increase. We're currently experiencing a spike, which is something to note.

Compared to the prior year, most categories are similar, except for the 1 to $2,000,000 claimants, where we have seen an increase of about 12 more enrollees. However, this increase is not a significant concern in driving up our total trend numbers.

Q: Could you please clarify if the statistics for high-cost claimants include hospitalizations covered by Medicare Part A when an active employee or retiree makes a claim? Does that get included in the high-cost claimants, or does that get netted out?
A: This is incurred and paid. So, it would be netted out.

Auditing RFP Update:

We submitted an RFP for various auditing services in late summer. We initially had nine different scopes of service under that one umbrella RFP, but we ended up with only eight because we didn't receive any eligible bidders for one of the scopes. For the remaining eight scopes, we had between two and six candidates each, and we conducted interviews with the finalists via Zoom. We asked many questions and reviewed a comparison document prepared by Segal. We also met with all the members of the RFP committee and made some initial recommendations to the Comptroller. He decided to go with our recommendations, which resulted in the awarding of contracts to four different consulting vendor types. We were hoping to start these contracts on February 1st, but we will likely get them into effect in the next few weeks due to some delays. Altogether, the total cost of these services will be more than $4 million**,** but we expect to see lots of savings that will pay for themselves.

Quantum Call Center Reporting:

The State of Connecticut members, the most frequently used methods of contacting Quantum are phone calls and the Member portal. This trend is consistent throughout our entire book of business.

Looking at the engagement for the state of Connecticut members overall, we see a 33% engagement rate. We also measured provider and member interactions. Providers have about 4.2 interactions per member, while members have about 1.9 engagements per member. On average, 1.4 topics are discussed during these phone calls. Our Care Coordinators are trained to ask in-depth questions and provide helpful answers without being timed to get off the phone quickly.

We have touched 75% of your members or 75% of claims managed by Quantum Health. For claims under $10,000, we have connected 41%. For higher claims over $100,000**,** we help guide members through the complex healthcare journey with an 89% touch rate. The Net Promoter score for the state of Connecticut Plan members is 69, based on 656 surveys.

Looking at the partnership plan, the most frequently used modes of engagement are phone calls and the Member portal. The overall engagement rate for the membership is 30%. Out of this, 1.4 is dedicated to providers and members. To ensure that we cater to the needs of our members, we focus on topics that are relevant to them. Quantum Health managed 75% of the healthcare claims for the partnership plan. In addition, the partnership plan's member participation score is higher at 76%, with 200 surveys submitted.

The following is an explanation of our real-time intercept model. The model aims to intervene before a claim is available to improve outcomes and drive savings for the plan. We conducted

research with the help of an independent actuary to compare the outcomes of members with and without real-time intercept. The results showed that the humanistic approach and healthcare journey are better with real-time intercept, and the plan can save money.

Here's how the model works: Quantum Health gets in front of the member when a provider calls in to request authorization for a diagnostic mammogram. Since it could be a cancer diagnosis, our care coordinators refer the member to a nurse care coordinator. The next day, the care coordinator reaches out to the member and helps guide them through staying in-network and ensuring the authorizations go through quickly. This early intervention can make a massive difference in the member's healthcare journey, rather than waiting until day 106, when a regular carrier would flag the member for a cancer journey. In summary, the real-time intercept model is a way to intervene early and improve outcomes for members while saving money for the plan.

We intervened and helped 72% of your members with claims over $10,000. This saved you $7.42 million. The actuary separated the members into different groups based on the amount of their claims. For example, members with claims between $10,000 and $25,000 were put into a group that saved $500.00 for each member. There are 3,650 members in this group, which adds up to a total savings of $1.8 million. This report is usually shown at the end of the year, but we understand that you are eager to see what the actual real-time intercept was looking at.

Communications Update:

We sent reminders about flu vaccinations, stress management, and monthly Upswing and well-being seminar updates in December. However, we covered some special topics in January, including the diabetes prevention program. We've had the highest number of registered participants to date, with 127 members currently enrolled. The success results are from our collaborative efforts with Quantum Health, their slider, and the portal. Our members are receiving information about the diabetes prevention program through various channels, and I'm thrilled to see its positive impact.

We had a focus group with 90 participants, which may seem small compared to our large numbers, but it was effective for our purposes. The focus group was conducted asynchronously for two weeks after the live event, during which participants could interact and see the results of others as they replied. We will receive the report this week, and I'm excited to review it and share it with others to gather more feedback.

The Comptroller has announced the HEP changes for 2024. These changes have been well received, as evidenced by the open rates. We have also mailed a letter to educate people about the changes. Quantum Health has sent a letter or mailer to support the new grid and the announcement. We have communicated much about this, and these changes will be visible to the members by March 1st. We are ahead of the game with our communication efforts.

Primary Care Initiative:

In 2024, we have 14 groups who are contracted for the primary care initiative. These groups represent over 23,000 providers located throughout the state. Most providers in the state are now participating, including providers in each group, specialists, and support staff for the organizations that can bill. This also includes people who are still in the Anthem network as providers.

We are collaborating with CVS and Anthem to obtain pharmacy data for provider groups. Additionally, we will contact CVS to ensure they appoint someone to the primary care initiative. This is important because some groups have recently added pharmacists to their teams, and we want to have someone on our end who can work with them regarding pharmacy expenses.

Our office and Anthem are organizing a town hall meeting where all provider groups are invited to discuss attribution. Attribution refers to the members who are attributed or belong to certain provider groups and the care they receive. We have decided on an attribution model that gives more time in the calendar year to determine the population each group is managing. With the new model, groups coming on in July will have until the end of September, the end of the quarter, to include the individuals they will be managing. Also, during the town hall, we will discuss our quality metrics and which ones to include in 2024.

Quantum has met with all provider groups and is helping with care coordination, especially during care transitions. Each provider group handles care coordination differently, but Quantum coordinates with them to avoid duplicating efforts. For example, when someone is discharged from the emergency room, they need follow-up within a week. Quantum is working with the provider groups to determine who will make the initial outreach to ensure the patient receives one call. I'd like to acknowledge this coordination effort by Quantum.

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.