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 9, 2024

Meeting Called to Order by **Josh Wojcik**

Attendance:

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

Public Comment:

No public comment.

Financials:

This is our monthly update on the status of our budget as of today. As you will see, our active health appropriation is projected to close the year with about a $33.2 million surplus. We have also seen an increase in the active health FAD accounts.

Over the past few months, claims spending has increased, slightly decreasing our balance; however, it remains in a healthy position. We continue to build our IBNR reserve and expect to close the year with approximately $91.3 million in that reserve.

We have discussed the retiree health appropriation and the rise in premiums for the Medicare Advantage plan due to the Inflation Reduction Act, as well as the overall plan size and utilization. The new Medicare premium rates released by CMS indicate an increase of just over 5%, closer to 6%. All these factors have been accounted for in our figures.

We anticipate closing the retiree health appropriation with a deficit of $35.3 million, including all these factors. Nonetheless, the retiree health FAD accounts still maintain a substantial surplus of about $243 million, which we continue to draw from to accommodate current claims payments.

Partnership:

As of December 1, 167 groups enrolled in Partnership 2.0, totaling just over 25,000 employees and over 60,000 members.

Last week, we published our Annual Partnership Report on our website, also announced in a press release from the Comptroller's office. Additionally, in mid-November, we conducted our quarterly partnership update meetings.

We shared our medical and pharmacy renewal projection for Partnership 2.0 during these meetings, effective July 1, 2025. The projection is between 8% and 10%, with a regional adjustment ranging from -3% to +2%, depending on the county.

This week, we are holding two meetings to attract potential new groups. These meetings will occur on Thursday the 12th at 1:00 PM and Friday the 13th at 10:00 AM.

The status of Partnership 1.0 remains the same, with five groups enrolled, totaling approximately 2,500 employees and 3,500 members.

Question: How many people are in the groups interested in joining?

Answer: We have a small number of groups in mind at this stage, but it's still early in the process. We have identified two categories: those who have reached out to us and those who completed the annual report but are outside the partnership plan. From our analysis, we have also pinpointed.

High-Level Utilization:

In reviewing our high-level utilization statistics, there are a few key points to note.

Firstly, the inpatient facility utilization remains elevated. While it has decreased slightly compared to the past few months, recent data still shows a trend higher than our historical averages. We will have Segal here today to discuss this further.

Another point I want to highlight is the pharmacy trend, which currently stands at 12.2%. This contributes significantly to our overall negative trend, and I want to emphasize that we are actively engaged with CVS to understand what's driving this problem. As many of you know, we have an updated pharmacy contract in place that was intended to lower our pharmacy trend. Still, unfortunately, it's moving in the wrong direction at the moment. We are working closely with CVS to explore what adjustments may be necessary.

Additionally, we are investigating some low-impact potential savings options. We plan to present these opportunities to all relevant parties in the coming weeks or months to reverse this trend.

Segal In-patient Analysis:

The prior report noted that the inpatient trend was 6.7%. For some context, this category encompasses all admissions, including those that come through the emergency room. Most of these admissions are for medical and surgical care. Still, they also include deliveries, inpatient maternity care, neonatal admissions (such as those in the NICU), and mental health or substance abuse admissions.

It's important to note that the data does not include physician bills when a physician is practicing in an inpatient setting; those would fall under professional services. Inpatient services account for about one-fifth of overall costs and tend to be more volatile, with higher dollar amounts but lower volumes, subjecting them to more significant fluctuations over time.

The first point is that the inpatient trends, while initially appearing high, were likely understated. Upon examining the claims lag pattern, we noticed unusually slow payments for high-dollar claims, particularly for July and August. This delay affected our standard completion factors.

We review these trends regularly, but our estimates may only be partially accurate if there is an anomaly in the claim's payment pattern during a given month. Upon closer inspection, we concluded that we had been understating the completion rates for those months.

Even though the trends have recently shown a slight decline, it's important to note that the figures were somewhat higher.

We also analyzed whether these patterns were concentrated in a specific area, possibly driven by a particular provider. While some fluctuations are evident, the trends are widespread across the state. The data shows how the situation escalated, especially in recent months. This is a rolling 12-

month trend, which allows us to see the previous months' figures with the corrected completion data, highlighting how the trend has evolved.

This analysis highlights recent trends in healthcare admissions and costs. We divide the data into two categories: utilization-based and unit cost-based metrics.

Utilization refers to the number of admissions—essentially, are more patients being admitted? In contrast, unit cost focuses on whether those admissions are becoming more expensive. We can observe a consistent pattern across all regions by reviewing the data.

The increase in admissions is driving this trend primarily. Interestingly, while the number of admissions has risen, the cost per admission consistently declines. This suggests that more admissions occur at a lower average price. In other words, while more patients are being admitted, they are less costly.

As a result, we see a high utilization trend coupled with a slightly negative trend in unit costs. This pattern is broadly evident throughout the state, although some areas may experience variations. Overall, the trend is primarily driven by increased utilization.

Here is a clear breakdown of the top diagnostic groups, including general insights into the significant changes observed between periods. By far, the most prevalent category is gastrointestinal conditions. This is not surprising, as it consistently ranks as a significant area of concern, encompassing infections, obstructions, biliary tract conditions, and hernias. We noticed a particular increase in hernia cases, which was somewhat atypical.

The second category relates to the urinary tract. We observed a significant rise in urinary tract infections (UTIs) and urinary tract calculi cases. Hypertension continues to be a common issue, generally exhibiting volatility, which isn't unexpected given its prevalence in driving trends. The focus was primarily on understanding the top two categories and uncovering the reasons behind these trends.

Unfortunately, we did not arrive at a straightforward narrative or a definitive explanation, which is usually our goal. We explored various avenues to seek explanations and even submitted a summary of top providers to the state for review. However, the broad findings did not mention a specific provider or initiative.

We examined rates of patients admitted through the emergency room to determine if hospitals admitted more patients than in the past, but the evidence did not support that. The rates appeared stable. Additionally, we looked into the usage of GLP-1 medications to see if there was any significant increase related to this population compared to the general population in the state. Our analysis did not yield compelling evidence, as both groups exhibited similar changes.

Nonetheless, the members not going through their benefits might receive the drug from a compounding pharmacy or pay out of pocket, making them unidentifiable in our data. This remains a circumstantial theory, as the types of diagnoses and the timing of the trends align well with the emergence of this business model associated with GLP-1 medications.

We cannot fully substantiate this working theory, but we will continue investigating it.

HEP Compliance Update 2024:

The 2023 compliance was not reviewed. The numbers for eligible households and participants in 2023 were nearly at the 100% mark.

However, if we look at compliance for 2024, we see that the compliance rate for eligible households is 67%, while the non-compliance rate for 2023 is 32.3%. For eligible participants, compliance is almost 80%, with a non-compliance rate of 20.4%, based on the state population.

Regarding partnerships, we have the compliance data for the HEP year program 2023, noted as of December 4th. For 2024, the compliance rate for eligible households is 63%, with a non-compliance rate of 37%. For eligible participants, compliance as of December 4th is 76%, while non-compliance is 23.8%.

We have compliance data for the requirement level regarding the totals for 2024. I won't go through all the details, but we're nearly at 100% for chronic conditions. Education is currently the lowest area but has seen a 10% increase since last month.

We will send chronic condition emails this week to help improve that percentage. The trends with the pods at Quantum remain consistent with last month. Many people are calling to check their compliance and inquire about their HEP bonuses to ensure they qualify for the 2024 HEP bonus.

As we close out the year, we're also preparing for the launch of the 25 HEP portal, which will go live on February 1st.

Communications Update:

We continue our monthly outreach efforts through routine emails, Care Compass emails, and well-being communications about chronic conditions. These initiatives include options for chronic HEP compliance education and provider distinction.

Our cornerstone is to educate and guide our members, especially with our new "Find a Provider" tool, which is particularly effective for accessing benefits in the state of Connecticut. This tool should help our employees and plan members quickly find the care they need while staying in-network.

We recently concluded our Benefit Spotlight series. In September, we hosted a session focused on Quantum Health and the HEP portal, which guided the navigation of these resources. This information is available on the Care Compass under the benefits enrollment page, where new hires can easily access it.

Viewership for our on-demand content continues to rise. Quantum Health has surpassed 400 views, while the Cigna dental video has reached over 450 views. Additionally, the diabetes resource has garnered over 200 views thanks to a recent email that included a link to the diabetes information.

These short, informative pieces effectively highlight the tools and programs we offer for diabetes management. We have also uploaded slides to the benefits portal, where members can be reminded of the provider distinction program with a quick click. They are also directed to their HEP page for more information.

We are actively promoting these resources through emails and letters, contributing to increased compliance.

Our benefits enrollment page offers various planners. Our newest addition is the "Transition to Retirement" planner, which addresses the challenges of making that critical transition. We are nearly finished developing it and will post it as soon as it's ready.

We're contacting our agency HR teams to see if they would like to receive both a New Hire Overview Guide and a Transition to Retirement Guide. These new guides are designed to complement the two existing planners in the middle: the "Healthcare Options Planner" and the "Healthcare Options Plan for Retirees." We transitioned these planners to digital format several years ago and do not print and mail them, but we provide supplementary materials. For instance, rate charts and comparison charts can easily be printed for any of these planners.

The New Hire and Transition to Retirement guides are essential as they bridge the introduction materials and the more comprehensive planners. We are excited to distribute printed copies of these key resources to individuals in these roles.

Cigna Annual Report:

We recently met with Cigna to review our plan utilization and status over the past year. We want to share the results of that meeting with you.

From July 2023 to June 2024, we included several performance guarantees in our recent Cigna contract to ensure that the networks remained stable and continued to grow.

Regarding provider additions, our basic plan had a performance guarantee requiring adding 260 access points, which are locations for members to visit and receive care. We exceeded this requirement, adding a total of 1,100 access points.

For the enhanced plan, the performance guarantee was set at 80 access points, and we successfully added 812. The DHMO plan had a guarantee of 25 access points, and we achieved 114 access points.

As part of our nationwide network review and performance guarantees, we stipulated that at least 30 added access points should come from the top 100 utilized providers that had previously dropped out of the network. However, Cigna still needs to meet this guarantee, adding only 6

points throughout the year. They have been actively working to reach out and reconnect with these providers through phone calls and personal visits. Additionally, they have offered custom fee schedules and sign-on bonuses to encourage participation.

Unfortunately, about 80% of these offices indicated that they are in the process of terminating all insurance contracts. This is a growing trend among dental providers. Many offices are now willing to bill on behalf of their members but are reluctant to enter into contracts, leading them to consider balance billing where appropriate on enhanced plans.

Of the top 100 providers Cigna attempted to bring back into the network, 11 have either closed their offices or retired. As a result, we are currently working to onboard 30 of the remaining 89 top providers into the network.

To continue discussing the status of our current benefit year. We've conducted a full review of the past year, but we have requested that the work on improvements continue.

As for our current benefit year, we have added 284 basic plan providers, 264 enhanced plan providers, and 47 DMO provider offices and access points to our network. However, we still need to see an increase in the top 30 providers out of the 89 we monitor. I'm excluding the 100 providers added to the network, but they continue to reach out routinely to those members.

As noted, there's a significant trend in Connecticut. Approximately 40% of providers are dropping out of all PPO plans, whereas the national average is only 16%. This indicates a notable decision among dental providers in our state regarding their business protocols.

Regarding DMO plans, about 33% of providers are discontinuing participation instead of PPO plans. Conversely, nationally, more providers are leaving DMO networks than PPO networks. This could pose a long-term risk to our plan, and we should monitor it closely. The data comes from a national survey conducted by Cigna, which reveals similar trends in Connecticut, Massachusetts, and New York. Specifically, 40% of providers indicate that they plan to drop enrollment in dental networks in Connecticut over the next 24 months, which is relatively high.

One emerging trend involves dental consultants who analyze practices to identify opportunities for maximizing revenue. They often suggest that practices earn more by not participating in dental networks. The design of our basic plan plays a significant role in this situation, as we reimburse nearly 100% of the charges. Consultants note this as a potential opportunity since many of our members belong to these plans. I wanted to emphasize this as a possible risk that we need to monitor moving forward.

This sets the stage for what we expect to discuss in next month's meeting. We have requested a thorough analysis of our plans to identify potential risks and areas for enhancement. More information will be provided soon.

Here is some demographic information about the plan. Currently, 90% of our population is enrolled in PPO plans—both the basic and enhanced options—compared to 10% who are in traditional and total care DHMO plans.

We have a higher prevalence of female enrollees, which aligns with our overall employment and health benefits enrollment. Employees cover 50% of all insured lives, while the remaining 50% is split evenly between spouses and dependents.

The basic and enhanced plans have slightly larger family sizes than the DHMO plans. This suggests that more single individuals looking for lower-cost options may be opting for the DHMO plan.

Regarding membership by age bracket, the group aged 65 and over—primarily retirees—shows a high enrollment and utilization of the PPO plan. This is likely due to the coverage for dentures, braces, and bridges offered by the PPO plan, which many find easier to navigate than the DHMO plan.

Spending patterns generally follow enrollment trends. Our utilization rates are high compared to many other plans. While we have a robust membership, all members actively use the plan. It's important to note that higher-cost utilization predominantly comes from the 65 and over age group.

Regarding the basic and enhanced plans, the overall total spend has increased by approximately 2.6%, leading to a per-member-per-month (PMPM) cost of just under $800. This figure surpasses the industry norm of about $690. Our health enhancement program has played a significant role in this increase, notably as it is closely correlated with the number of cleanings.

This year, utilization has increased by 0.7%, with 0.3% of that increase attributed explicitly to cleanings. We have also seen improved compliance rates, which are promising indicators regarding utilization.

One interesting aspect of our program is the virtual care initiative called Teledentics. This innovative service allows patients to attend a dental appointment virtually and have a dentist examine their mouth using their phone's camera. This feature helps determine if the patient needs to be seen urgently for issues such as an abscess. So far, we have recorded 30 visits using this tool, available through our My Cigna Tools, and communicated via different Cigna programs.

As a direct result, we've observed a 0.4% reduction in plan non-users, which indicates that more individuals are engaging in preventive care through their dental coverage, which is encouraging.

The services utilized are predominantly diagnostic and preventive, which we want to see. The next highest categories of utilization are basic restorative and major restorative services. Basic restorative services include fillings, while major restorative services involve crowns, root canals, and similar procedures.

Interestingly, we have noticed a 7.1% decrease in orthodontic coverage and utilization within our PPO plans. Although there is a decline in other plans, the drop is less significant. Given the inquiries we received during open enrollment, I initially expected a sharp rise in orthodontic utilization.

On a positive note, we have seen an increase in periodontal services. This suggests that individuals not previously attending for their routine cleanings are now seeking care, improving their overall dental health.

In summary, we observe a 2.7% increase in overall costs, while overall services have increased by 0.7%. The discrepancy between the rise in cost and services is attributed to Cigna's efforts to recontract providers who had fallen out of network. They are offering incentives and are willing to pay these providers more than their traditional rates to incentivize them to come back into the network while still achieving savings for our plan.

Moving on to the DHMO, we're noticing another trend reversal. Individuals previously enrolled in the traditional DHMO co-pay plan have shifted to the total care plan, particularly concerning enrollment and utilization of orthodontic services. This is quite unusual, as all users from orthodontia have left the traditional DHMO and transitioned to the total care DHMO. The total care plan offers slightly better overall benefits to its members.

In contrast to the PPO plan, we are observing a reduction in the utilization of periodontal services. However, there is an increase in the use of major restorative and basic restorative services. This aligns with previous data showing that the over-65 population on the DHMO is utilizing more services for crowns and root canals, which are higher-cost services overall.

For a quick update on the Oral Health Integration Program, we initiated automatic enrollment for individuals with certain chronic conditions. As of the end of October/beginning of November, 17,400 participants have been auto enrolled in the program. Each participant received communication notifying them of their enrollment and informing them about their eligibility for additional cleanings and service reimbursements to assist with their conditions.

These members still have more to learn. In the previous planning year, 129 individuals utilized the program for a total of 140 services. We've seen a slight increase in the current year, with 152 users accessing 173 services. Communication remains ongoing with these members, and Cigna is collaborating with Anthem to identify their medical providers and ensure they are aware of this benefit for these individuals.

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

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

The meeting was adjourned.