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
July 14, 2025

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

Attendance:

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

Public Comment:

No public comment.

Financials:

Updated financial report for the fiscal year 2024-2025.

We closed the year with a surplus of $29.6 million in active appropriation, which has been redirected back into the general fund. Throughout the year, we discussed how claims for medical and pharmacy services were higher than anticipated.

In the active health FAD accounts, which are reserve accounts, we finished the year with a surplus of $30.6 million. Based on the rates developed for fiscal year 2026, this reserve will continue to grow.

Regarding the retiree health appropriation, we made a $30 million deposit into the account near the end of the year, bringing us out of the negative. We ended the year with an $8 million surplus, which we could transfer back to the general fund. For the retiree health accounts, we closed the year with approximately $202.7 million in reserves.

We plan to spend down these reserves faster in fiscal year 2026 than we have previously to lessen the impact on the appropriation general fund account.

At our next meeting, we will look at projections for fiscal year 2026.

Partnership:

As of July this year, we have enrolled 185 groups in Partnership 2.0, totaling approximately 29,000 employees and over 67,000 members. We have two quarterly update meetings scheduled: the 22nd at 9:00 AM and the 23rd at 2:00 PM. As usual, we will review the financials and discuss 2024 HEP compliance billing.

We have lost one group in Partnership 1.0, as they have switched to Partnership 2.0. This leaves us with approximately 2,300 employees and 3,000 members in that program.

High-Level Utilization:

There have been a few changes in the trends for the monthly utilization dashboard. This data reflects the end of March, marking the close of the first quarter, and does not include the recently completed fourth quarter.

One positive development is that inpatient facility utilization continues to decline, moving from well into double digits during much of the early part of last fiscal year down to single digits. On the other hand, the utilization of professional services is approaching nearly double digits, which is higher than our historical norms. Additionally, pharmacy utilization remains elevated at 14.5% during this period.

It's worth noting that the significant increase in pharmacy utilization occurred during July and August of 2024. Therefore, it will take a few months to compare year over year data accurately. We hope to see some moderation in these trends as we incorporate more recent utilization data in the coming months.

Those are the key highlights for now. We plan to take a deeper dive into the factors driving the increase in professional services further and will update the group in a future meeting.

Communications Update:

For communications, we continue to send out messages after open enrollment at a slightly less frantic pace, but they remain very effective. I'm happy to report that our follow-up emails have maintained an impressive open rate in the 50s and 60s, compared to the 30s and 40s we saw prior to open enrollment. This indicates high interest, and people are paying attention to Care Compass emails, especially as the new plan year began on July 1st.

We recently sent out an informational email regarding where to obtain ID cards, how to change plans, and where to access the portal. This is all aimed at preparing individuals for the upcoming year and ensuring they have access to all necessary resources.

We submitted a distribution request. Four or five individuals sent me revised emails, which I forwarded out on Friday. I hope this support continues to grow.

It's important to note that people often look to their groups for support, which fosters trust in Care Compass and healthcare information.

At the bottom, I want to mention a crossover with Quantum. In addition to our HEP communications, which will be reviewed in the next meeting, we are collaborating on an ongoing awareness campaign throughout the year.

An email was sent out in June and July. A postcard that serves as a general reminder about the importance of screenings will soon arrive in their mailboxes. This particular postcard focuses on cancer and highlights the significance of colorectal, breast, and cervical screening.

We are committed to driving home the importance of preventive care, which is why we send numerous reminders to ensure preventive visits are completed on time and routinely.

Behavioral Health:

Following the recent RFP process, Lyra Health has been selected as our new behavioral health vendor. We are targeting a go live date of November 1st, and implementation planning is underway.

A little about Lyra Health: They offer mental health programs that include therapy, mental health coaching, and digital self-care tools on their portal. They have a network of high quality providers, with services available virtually and in person in Connecticut. Their approach focuses on quick access to care and ensuring that the support provided is genuinely beneficial for our members, both of which are key priorities for us.

On the communication side, we will be rolling out various materials for our members. This will include emails, updates on Care Compass, web updates, and printed materials. We are also working closely with the executive team to coordinate the communication rollout.

Our goal is to ensure that members are aware of the available services and understand how to start the program when it launches in November.

We want to highlight some statistics showing how Lyra is a good fit for our health plan and how it can significantly benefit employees seeking mental health care.

Finding a provider or securing an appointment in a timely manner can often be challenging, especially during a mental health crisis. Lyra aims to simplify this process for our members, often helping them schedule appointments within a day. Most users of the service report substantial improvements in their satisfaction rates.

Additionally, using Lyra will cost less than traditional therapy options, which is beneficial for both the health plan and the members seeking support. This will represent a significant change for our members.

Lyra's standout features include 24/7 access to Lyra's care navigator. Members can call any time, day or night, to talk with a person who can help them find the right provider. The care navigators are licensed clinicians who remain involved throughout the member's journey. They can assist with members' cases, connect individuals to additional state benefits if applicable, and coordinate services for those needing various support, such as neurodiversity or social services.

Overall, Lyra presents an excellent option for our members to utilize.

Question: *One thing to consider regarding the communication strategy: could you also think about how we should communicate this to primary care doctors? We are holding them accountable for implementing integrated behavioral health services, and they have been looking forward to this. That would be helpful.*

Answer: *Yes, for sure. That's a good point. As we approach November, we will work with the PCI team.*

Question: *Do you have an estimated arrival time for when the first member communication might go out, considering the go-live date is November 1st? Would it be in September, or what are you thinking?*

Answer: *It will probably be closer to November. There will also be a related press conference, so we want to ensure all our efforts are coordinated. We want to be ready with everything on Care Compass before any communication goes out. Therefore, we're considering a timeline closer to the launch to ensure everything is aligned.*

MAPD RFP:

As you know, we initiated this process due to the end of our contract with Aetna. By the end of this calendar year, we need to implement our updated vendor, effective January 1st.

In rolling out the RFP, we received bids from Aetna, Humana, Optum RX, and United Healthcare. After reviewing all the options, the committee decided that continuing with Aetna is the best choice for us from a financial, logistical, and member benefit perspective.

Here are some highlights from the RFP process and the recontracting with Aetna:

- Aetna submitted the lowest cost and received the highest CMS rating among all the bids.
- By unbundling medical and prescription services, we project nearly $316 million in savings over three years compared to our current fully integrated product.

Our members have a single card for medical and prescription coverage. With the unbundling, they will likely receive two separate cards: one for medical services and another for pharmacy services. Aetna will manage all medical benefits, while SilverScript will handle pharmacy benefits.

Unbundling allows us to take advantage of split risk scoring for each member. Instead of one combined risk score for CMS subsidies, we will now have two per individual, enabling us to obtain a higher risk score based on pharmacy utilization.

Overall, we expect savings of about $43 million compared to Aetna's last best offer before we went out to bid. We explored the possibility of negotiating one or two one-year extensions with Aetna, but those options were not lucrative, which is why we moved forward with the bidding process.

The accepted bid from Aetna is less expensive than their previous best offer, with rates of $42.9 million for the first year and $30.2 million for the second year. Additionally, we have included performance guarantees that will benefit everyone involved. Aetna will audit 200 denied prior authorizations each quarter, and we will work closely with them to review the results and identify improvement opportunities to minimize both member and provider disruptions.

Lastly, by continuing our services with our current vendor, the implementation is largely limited to re-contracting. There will be a separate contracting effort for Silver Script, but we won't need a full re-implementation or reintroduction to our members. We will, however, hold education sessions for our members to help them understand the changes, including whether they will need two cards and how that process will work. Further details will be provided on this soon.

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

Motion to Adjourn was made by Dan Livingston, seconded by Karen Nolen.

The meeting was adjourned.