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
October 15, 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	
Karen Nolen	
	Consultants
Dept. of Insurance	Terry DeMattie, Segal
Paul Lombardo	

Public Comment:

Public comment made by an active employee about the weight management program.

Financials:

You will notice an adjustment to the active appropriation.
Considering the funds that were moved from the active appropriation account, there has been a reduction of about $24 million in that account. However, we still show a surplus of approximately $14.3 million in the active health appropriation account. When we initially set this

budget, we were uncertain about the performance of our plan and the makeup of the plan itself. Fortunately, the plan has performed better than anticipated.

Now, regarding the active health FAD accounts, we currently have a surplus of $146.3 million in those accounts. These accounts function as our cash reserves from which we make our payments. We aim to continue building this reserve, which is getting close to the desired balance we hope to achieve in the coming years. Additionally, the IBNR rate, adjusted and included in our benefit plan rates each year, is expected to decrease gradually.

There has been a significant change to the overall renewal rates for Medicare Advantage. As a result, the updated appropriation balance is projected to close the year with a deficit of approximately $37.5 million. Last month, we estimated a deficit of about $9 million, but this adjustment has increased our expectations.

Regarding the OPEB FAD accounts, we currently have a surplus of $238.4 million. We are implementing a payroll deduction drawdown, intending to further reduce these account balances. When we initially transitioned to Medicare Advantage, the rates deducted from payroll were higher than necessary to cover the accounts. Consequently, we ended up with a substantial surplus. We will continue to draw from these funds to decrease the surplus.

MAPD Premium Adjustment:

The reason for this adjustment stems from our contract with Aetna, which includes a stipulation for population growth. Specifically, the contract states that if there is an increase or decrease of more than 10% in our overall population, Aetna has the right to re-rate our plan.

When we initially submitted our RFP and put the contract out to bid, we had approximately 56,000 members in the plan. Shortly after this, we experienced a surge in retirements. Many of the new retirees were older than we had anticipated, causing a significant increase in the population of the MAPD group. As a result, by the time we launched the plan on January 1, 2023, we were already serving around 60,000 lives.

Over the past couple of years, our plan has seen the addition of several new partnership groups, albeit small. Additionally, our population is aging quickly, with many individuals transitioning from our commercial plan to the Medicare Advantage plan. Currently, we have approximately 64,000 lives enrolled in the plan, representing a 14% increase over our initially rated value. This increase is why Aetna has indicated the need to re-rate the plan.

Several factors influenced their decision to re-rate. Notably, the influx of new members impacts our subsidies, as new members often present lower risk and have less historical data compared to established members. We've also discussed the effects of the Inflation Reduction Act of 2022, which has resulted in significant Medicare subsidies for carriers of Medicare Advantage plans.

Moreover, there have been market changes, particularly with Anthem ceasing the offering of its Medicare supplement plan, which currently serves about 3,500 municipal retirees in Connecticut.

Aetna expressed concern that this entire group could potentially transition to our plan, adding significant risk.

Lastly, the performance of our plan has been high, with utilization and overall costs exceeding what the carriers anticipated. This increase in costs is primarily driven by inpatient and outpatient care. Historically, our plan has demonstrated much higher emergency room utilization than any other available plans, partly due to a long-standing design that has not imposed cost-sharing for emergency room visits for many retirees.

Given all these factors, what does this mean for our plan moving forward? As of January 1, the new PMPM rate will be $339. The current rate through December 31 is $191.25. Initially, during our renewal discussions, we anticipated a $65 increase, which would have brought the rate to approximately $258. However, this adjustment represents a substantial increase on top of that.

In summary, these changes will lead to an estimated $28 million increase in our current fiscal year and an overall increase of $60 million in the coming fiscal year.

Question by Gregory Messner: Do we have any sense of how the $60 million change affects us? Can we break it down? Sort of. Does the reduction in the Medicare subsidy impact plan performance, or is it something else?

Answer by Rae-Ellen Roy and Josh Wojcik: We have received the overall rate. While it is not desegregated, I can request that Aetna provide us with this information.

Aetna was able to adjust in response to changes in CMS regulations and federal law, which they incorporated into the initial rating. The significant increase from $65 to $258 was primarily due to these changes. They had some flexibility within the contract regarding utilization, allowing them to adapt to the modifications brought about by CMS rules, reimbursements, and subsidies. We will follow up with further details, but this should give you a general understanding of the situation.

Partnership:

As of October 1st, we have enrolled 168 groups in Partnership 2.0, totaling just over 25,000 employees and more than 60,000 members. We reached out to the existing group leads regarding the recent increase in the Medicare Advantage plan rates. Groups had until last Friday to inform us if they planned to leave the plan, and we received notifications from two groups that decided to exit.

Partnership 1.0, there are five groups, which collectively have approximately 2,500 employees and 3,500 members.

High-Level Utilization:

During our monthly utilization review, we examined claims through August 2024, and most metrics appear consistent with what we have been observing. There are a few key points to discuss.

First, regarding inpatient facilities, we have seen significant fluctuations over the past three months. For most of last year, our trend for inpatient services was consistently around zero or negative. Looking back over the last four to five years, this has remained the standard trend. However, two months ago, we experienced a jump of 5%. Last month, we were back down to around zero, but now we're seeing another increase of 6.7%. We plan to investigate this further, as we have encountered some delays with our carrier in the payment of claims. I am unsure whether these payment issues are influencing this inconsistent trend, but we will look into it as we prepare for next month and may provide a more detailed analysis.

The second point is about pharmacy utilization, which has been gradually increasing. As we know, it currently has minimal utilization under our new contract with CVS. Since we only have one month of data from this contract, we expect the trend in pharmacy costs to decline as we gather more data over the fiscal year. Therefore, we are not overly concerned about pharmacy utilization currently, as we believe we have measures in place to improve the situation.

Finally, while our total cost of 5.7% is higher than we would like, I want to highlight that we are trending better than the market in two ways that we can track against benchmarks: Anthem's book of business and Segal's book of business. We are a few percentage points below both benchmarks, indicating that, relative to the market, we are still performing well.

Communications Update:

This fall has been a busy time for our communications efforts.
We enhanced our all-user emails with consistent engagement across each campaign. We began with our monthly email that highlighted the schedules for well-being and chronic condition seminars. This email also promoted a webinar hosted by Upswing Health, which took place last week.

In September, we held the first session of our Benefit Spotlight Webinar series. The initial schedule was sent out on September 10th and 11th, with a reminder sent on the 19th. The webinar occurred on September 26th and provided an overview of how to log into or register for the Quantum Health benefits portal and the resources it offers. It also covered the HEP portion of the portal, including how to check your HEP status and more.

The webinar included answers to frequently asked questions and guidance on how to connect with a care coordinator. We received a solid response, with 656 members registering and 317 attending live. As of this morning, the recording on YouTube had about 225 views. The recording was sent out to all registrants and is also available on Care Compass, where it will be featured in future emails for anyone who missed it or wants to register for upcoming sessions.

Looking ahead, we have the next Benefit Spotlight session on Cigna Dental scheduled for this Thursday, which currently has 442 registrants.

We also sent out an all-user email reminding members that it is the time of year to think about getting a flu shot, including resources on where to find participating pharmacies. To reinforce this message, we added a flu shot slider on the Quantum Health benefits portal and a banner on the Care Compass homepage. Both link to our Care Compass flu shot page, which provides more information and a database of participating pharmacies.

Additionally, we sent out a registration email for a Diabetes Prevention Program class this fall, which included instructions on how to register and a link to the Care Compass Diabetes page for more information and testimonials.

As part of our overall outreach strategy, we accompanied each all-user email with a boosted Facebook ad to ensure that if members miss an email, they'll still see the same information on Facebook or the benefits portal. In addition to the flu shot slider on the portal, there's also a reminder for the Find Provider Tool and a HEP reminder, both of which serve as easy bookmarks for members to quickly navigate to those sections of the portal, especially since these are key priorities right now.

12-month data for Intellihealth:

These are some results from our Flyte Weight Management Program. Approximately six months ago, we reviewed some preliminary results that were trending positively. Now, we have the 12-month results for participants who have been in the program for a full year.

First, the baseline characteristics of the participants. The average age of our members enrolled in the program is 47 years. There is a significant gender distribution, with nearly 70% of participants identifying as female, compared to 18% identifying as male and 13% who did not respond.

In terms of initial metrics, the average baseline weight is 223 pounds, and the average baseline BMI is 36.4. After one year, we had 6,700 participants who expressed interest in engaging with the program. Out of these, 6,400 created an account within 30 days and began their journey. Approximately 5,000 participants started the onboarding tasks, and nearly 5,000 have had their initial appointment.

Now, regarding current medication utilization among participants: our chart indicates that a little over 50% of participants are using GLP-1 medications. The Flyte program also incorporates non-GLP-1 medications, which consist of a series of generic drugs that have been shown to aid in weight loss. It's important to note that a substantial portion of those on GLP-1 medications were already using them before joining the program, particularly since our initial outreach targeted individuals who were already using GLP-1 medications. This distribution is expected to evolve.

How are we performing in terms of our objective, which is to reduce weight, and the comorbidities associated with obesity? At the one-year mark, we have data from about 500

individuals, and we have observed approximately a 16% reduction in weight for this population. This is an improvement from the 10% reduction we noted at the six-month mark.

We can break this down into two groups: those who were prescribed GLP-1 and those who were not. Not surprisingly, individuals on GLP-1 initially had a higher weight. These higher-risk members, who are the most likely to benefit from GLP-1, have lost almost 17% of their total body weight. Meanwhile, those not on GLP-1 have also performed well, with a weight loss of about 13%. These results are very positive and align with the goals of this program, indicating that we can achieve favorable outcomes for both individuals who need GLP-1 and those who may do well without it.

In terms of blood pressure, we are seeing a similar trend, with a 14% reduction in blood pressure overall and a positive change in diastolic blood pressure as well. This serves as a very promising indicator.

We also have other metrics that are generally measured through lab results, such as A1C levels. However, we are not sharing those numbers yet, as the sample sizes are quite small. Nevertheless, they are trending in the right direction. We would like to see larger sample sizes before we report on these figures to ensure that what we share is meaningful. These other metrics will have much larger numbers at both the beginning and end of the evaluation, which will help us measure outcomes more effectively.

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.