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
March 11, 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:

Our financial status is steady for fiscal year 2024, and we are on track with our projections from last month. However, we anticipate closing the year with a surplus of $10.5 million.

Our active healthcare FAD accounts currently hold a balance of $150 million, which is in line with our expectations. The retiree appropriation account is close to zero, but it is projected to close the year at around $2.8 million. Based on the current trend, we don't expect any significant changes in population or Medicare premium reimbursements for the remainder of the year.

The retiree OPEB FAD accounts for our healthcare payments are expected to close the year with a reserve of about $223.7 million, which is a substantial amount. We will continue to spend down this reserve as planned.

Rates:

We have completed the rates for fiscal year 2025. Per our contract, the basic and enhanced dental coverage plans will see a 2.75% increase. However, the DHMO and total care DHMO plans will remain unchanged with a zero percent increase in rates.

The rates for basic and enhanced members are mostly the same, which is less than a dollar difference, even with full family coverage on the employee side. On the active side, we are increasing the medical rate by 1.2% and the prescription rate by 10.9%. While the 10.9% increase may seem alarming, it's a small portion of the total premium. Therefore, the overall total premium increase for fiscal year 2025 on the active rates is only 2%, which is a great achievement. We have yet to see a renewal of this good in well pre-pandemic.

As for the retirees, they are a bit more expensive and high utilizers, so the overall total increase for retirees is 4.1% on the total rate. However, this is mostly due to general fund appropriation costs, as our retirees pay very little, if anything, for their coverage. New retirees will see a slight increase, but just a few dollars in their pension check deductions.

Moving on to the Medicare Advantage end, we have a $11.00 rate cap as part of our contract with Aetna as an annual increase value. However, the Inflation Reduction Act of 2022 is having a significant impact on our plan as well as on all other group Medicare Advantage plans. Therefore, we have conducted a deep dive analysis on the issue, and our best estimates today indicate that we will have an additional increase of $71.00 PMPM on the Medicare Advantage plan for 2025. We still need to test with Core CT to ensure the published rates match exactly what will come out of the checks. Once that is complete, I can share the payroll deduction rates that are coming out according to these rates with everyone.

Medicare Advantage:

The Federal Inflation Reduction Act of 2022 has certain provisions that impact Medicare Advantage plans. It changes the federal government's subsidies to these plans and the base structure of the base Medicare plans that apply to all individuals enrolled in Medicare. The changes are intended to help the individual market and individual users, particularly those using Part D.

The act eliminates the coverage gap, which is good news for those on individual plans who must pay a lot out of pocket for their prescriptions. However, it could be better for plans with very low

copays and high specialty utilizations like ours. This means that our plan will receive lower subsidies from the federal government, resulting in more drug costs applying to the plan itself.

Additionally, as part of the risk score adjustments for 2025, low income has been given more weight as a risk and a liability for members. Unfortunately, not all our members are low-income, so this increase in low-income subsidies on other plans has affected us by decreasing our subsidy. Overall, it's estimated that our plan will be affected by a $71.00 PMPM effect, which equates to $31.23 million for the six months of the year that would be covered in fiscal year 25. The governor's budget currently has sufficient funds for this hefty increase, but we will know the actual value in summer.

HEP Compliance Update:

Quantum Health has recently released the 2023 compliance updates for our plan. This update includes the total population of active state employees and active partnership as of 3/1. We made some of the changes discussed in this meeting, and it positively impacted the HEP compliance numbers. As of 3/7, our 2023 compliance percentage of the total population is 79% of households compliant, which is a good number compared to previous years. This is a great call out to Quantum Health about their work on the program.

The compliance percentage of individual participants is 88%. This feeds into the household level, also making it 88% compliant. Again, this is the total population. If you look at how the numbers have increased month over month, we are making a lot of progress with the communications being sent out to members in a non-compliant status.

Results of PBM RFP:

To give you a better understanding of the process, let me start by giving you a timeline. We began planning for this project in the spring and started working on it in the summer. Much effort went into it, and the outcome is satisfactory. In September, we conducted a bidders' conference, and we posted answers to the questions in October. The original closing date was set for November. However, due to interviews and multiple best and final offer rounds in a reverse auction style, the process continued till January and February.

We were trying to achieve several goals through the process. Firstly, we aimed to retain the transparency provisions of our current contract. In our last contract with CVS, we made significant progress by shifting to a transparent contract. This allowed us to see all the fees and revenues, share them with the state, and get detailed information on our claims. We were able to represent the net cost of drugs net of the rebate, which was unique to our plan. We wanted to keep these aspects in our new contract. Secondly, we wanted to reduce total costs through a competitive bid process. However, we wanted to limit any disruptions for our members as much as possible. Lastly, we wanted to move our specialty pharmacy network to acquisition cost pricing. This means that we wanted to pay what the pharmacy pays for the drugs our members receive and then give them a transparent admin fee for filling the prescription. Doing this could improve our pricing as the pharmacy improves its pricing with its wholesalers. It also removes any incentive to increase spread pricing or prefer higher-cost drugs over lower-cost drugs. This

move was already in place with CVS, and we wanted to expand it to other participants of our pharmacy network, which includes hospital-based specialty pharmacies such as Hartford, Yale, and UConn.

We aimed to realign incentives with our plan and members. To achieve this, we wanted to switch to a per member per month (PMPM) guarantee on costs. This means that the pharmacy benefit manager would be mindful of the total costs involved in filling prescriptions, considering the plan and individual members, instead of just focusing on discounts and rebates. We aim to achieve several benefits by implementing a PMPM guarantee, such as encouraging the pharmacy benefit manager to opt for lower-cost drugs when multiple options exist in a therapeutic class. This approach will also make the pharmacy benefit manager more aware of waste, fraud, and abuse, which is not incentivized. However, under a PMPM guarantee, the pharmacy benefit manager will have an added incentive to be more mindful of these issues.

We want to implement a system that incentivizes our members to prefer drugs with higher clinical value, even if they are more expensive. This is achieved using a third-party formulary manager who can provide feedback on comparative effectiveness research. They can advise us on opportunities to prefer a drug that is either equally effective and lower cost or more effective and only slightly more expensive. This ensures that our members get the best possible outcomes without any undue influence from financial incentives.
Furthermore, we have ensured that the third-party formulary manager is not financially incentivized to save money. This ensures that their advice is based solely on clinical effectiveness and not financial considerations. To further improve our system, we also seek to implement unique contracting arrangements with manufacturers when we prefer a drug not on their formulary. This will ensure that we can retain any rebates for drugs that are preferred for our plan, even if we switch to a different drug. These significant changes represent a departure from the traditional way PBM contracts have been procured and contracted. However, they are necessary to ensure that our members get the best possible outcomes and are as healthy as possible. If we were to switch from a Novo Nordisk drug to an Eli Lilly drug, for example, we would lose the rebates. In this case, we need to ask CVS to negotiate a rebate on our behalf with Eli Lilly since it's our preferred drug. Since we are a large plan, we should be able to retain rebates for drugs that are preferred for our plan. This represents a significant departure from how PBM contracts are usually procured and contracted.

There were three sections in the RFP. The first section was for the Pharmacy Benefit Manager (PBM), which CVS currently manages. This section includes managing the pharmacy network, filling prescriptions, administering benefits, and negotiating rebates on behalf of the plan.
The second section is for the Specialty Pharmacy Network. This is open to any hospital-based specialty pharmacies that wish to participate in our network. They were able to submit a bid for this section. The third and final section is for the Formulary Third Party Formula Manager.

Four responses were received in the PBM category, five for specialty pharmacy, and two for formulary management.

After conducting a thorough evaluation process, including multiple rounds of clarifying questions and opportunities for pricing improvements, the committee has made the following

recommendations. CaremarkPCS (CVS), the current provider of PBM services in specialty pharmacy, will continue to serve as the incumbent. Although no additional in-state hospitals were proposed, each bidder submitted a reasonable and impressive bid. We have recommended TruDataRx, a Vermont-based company specializing in comparative effectiveness reviews for formulary management.

We achieved our goals during the process, including retaining transparency from previous processes, adding drug labels and level rebate reporting components, and reducing total costs. Although we don't have the exact figures yet, we have a per-member-per-month guarantee lower than our current projected costs, which should help us reduce total costs relative to the pharmacy in the next fiscal year.
We also aimed to limit member disruption, and we accomplished that by accepting a strong bid from CVS, the incumbent. Additionally, we plan to move the specialty pharmacy network to acquisition cost pricing. Finally, we've developed a model that aligns incentives better with our pharmacy benefit manager, the plan, and members, and it includes appropriate oversight to ensure any gaps are filled.

Partnership:

Partnership 2.0 currently has 155 groups with over 23,000 employees and approximately 50,000 members enrolled. We have confirmed one small group for enrollment on 4/1/24 and another on 7/1/24. Several potential new groups are showing strong interest in enrolling on 7/1/24. We anticipate a busy open enrollment year but are unaware of any groups looking to leave the plan this year.

We released the renewal rates for existing groups on 7/1/24 and posted them on our website. The rates show an average increase of 2% for active members, and we have received positive feedback about them.

Additionally, we are holding a quarterly update meeting tomorrow and Thursday for current groups. We will also send out invitations for the following week to potential groups interested in learning more about the plan and whether it could be a good fit for them.

As of Partnership 1.0 status quo, five groups are still enrolled with 2,400 employees and just under 3,400 members.

High-Level Utilization:

The monthly utilization numbers, it's good to watch these and see how things are trending. The trend remains moderate, with the medical side at 2.7% and the patient side down, which has been a long-term trend. The outpatient facility continues to increase, although it's lower than we've seen in the last 6 to 9 months. Professional services are a little higher than we've historically seen, so we'll do a breakdown of that. On the pharmacy side, it is starting to bump up to positive. It's been 0 or negative in many of the previous months, reflecting the savings of the Prudent Rx program. More of that program will be in the baseline as we move further into this year. We anticipate it will continue to creep until we get onto our new pharmacy benefit management services contract

in July. At that time, we expect it to start going down again. We'll keep an eye on it throughout the rest of the year.

Professional Services:

Professional services have been a growing trend that has been overlooked by many. In the past, the industry has typically seen growth rates of only 1% to 2%. However, recently, there has been an upward trend, which is worth investigating.

To give you a quick overview of professional services. An inpatient facility includes the costs associated with someone admitted to the hospital. Outpatient facility, which covers the costs for someone who is not admitted. Finally, there are professional services, which include physician-focused services like office visits, lab tests, radiology services, and bills sent by physicians for work done in the hospital. These represent about one-third of the total cost and have been increasing lately. Therefore, we focus on a two-year change to allow for a longer-term perspective on trends. This will help us identify what's driving the trend and make more informed decisions.

This is a summary of various categories, including some I mentioned earlier and a few others. You'll notice a significant decrease in lab costs because we're coming out of the pandemic. Many tests were being done during the pandemic, so lab and pathology were at a very high level. Now, it's returning to a typical number, offsetting the trend in the current period. The categories pushing up the current period are preventive screenings, specialist visits, psychiatric care, and therapies. These are the main ones with the largest positive changes to your PMPM.

Specialist visits have increased by roughly 7% per year over the past two years. This change is primarily due to an increase in unit costs but also a shift in the types of services provided over time. It is not that the price of every service has increased, but rather the mix of services that people receive during specialist visits has trended towards higher-cost services. The most notable increase has been in respiratory, ear, nose, and throat diagnoses, such as sinus infections, ear infections, and acute bronchitis. There was also a period where the flu was elevated, and there has been a general increase in eye-related issues, such as pink eye or dryness, redness, and other sight-related diagnoses. It is uncertain if this trend towards higher-cost services will stay high or if it is just an acute situation that will moderate back to more typical levels.

Therapies have been trending similarly over the past two years due to a reasonably consistent utilization mix. However, there has been a lot of shifting of services, and this increase is mostly due to the treatment of neurodevelopmental disorders, such as applied behavioral analysis for autism, which accounts for a significant portion of this trend. This is a common industry trend, and many clients have been experiencing it. These types of services have historically been underutilized, had limited coverage, provider shortages, and were often underdiagnosed. In the past five to ten years, a lot more attention has been given to these issues, and it takes time to address them and get them into the system. As coverage expands, more providers move into these areas, and there are fewer coverage limitations and provider shortages. This has been a long-term trend within the industry, and it remains to be seen whether it will continue or if we are reaching a new normal where the needs of these patients are better met, and the trend will level off.

There has been a significant increase in colorectal cancer screenings, which has led to a rise in the overall number of preventative screenings. This increase is mainly due to efforts to promote these screenings and ensure that people are getting checked. Although the unit cost of screenings has also increased steadily, the primary reason for the rise in costs is that more people who should be getting screened are doing so. This trend is expected and reflects a positive step towards better healthcare.

Psychiatric care has seen an increase of about 8% per year over the past two years, consistent with the industry's trend. During the pandemic, virtual settings became a popular option for psychiatric care instead of in-person visits. This made psychiatric care more accessible to people who had limited access to mental health professionals in their area. The convenience and reduced stigma of the virtual setting also made it a more attractive option to people. As a result, many new people started receiving this care. Even as things shift back to being primarily in-person, a lot of virtual utilization still occurs, leading to an overall increase in utilization. This increase is likely to continue as more people become comfortable with these services. Nationally, younger people are much more comfortable receiving mental health care, so as the population ages, this may continue to be a larger share of the population that receives mental health treatment. Common diagnoses include anxiety and major depressive disorder.

I looked at potential regional drivers that weren't less noticeable in the overall data, but they stood out when I focused on specific locations. The only noteworthy regional driver was the office surgery bucket. The office surgery wasn't out of the ordinary in the first slide. However, in Bridgeport specifically, there is a high cost of office-based surgery, primarily driven by sinus procedures. There are some codes for this type of surgery, such as balloon dilation and other types of office-based sinus procedures. I shared additional details with the state to investigate the providers and other relevant factors. There is an unusually high rate of these procedures being performed by a particular provider entity in the Bridgeport area. It needs to be looked into more closely as a potential driver.

Physicians are under significant pressure, including inflationary pressure. Unlike large hospitals or systems, they do not have enough margin to absorb these drivers. This trend is prevalent in professional services, and hopefully, some of these factors will reach a new normal and not continue at an elevated level. However, it may take some time before we can achieve that.

Communications Update:

We recently communicated with our members about several important topics. One is the partnership retention campaign, sent to all administrator's groups. We have scheduled an email to go out, along with a white paper that reflects on a Health Equity study done by the state. This study provided much insightful information, and we have developed a White Paper to show how our programs (especially HEP) and point solutions, along with our robust coverage, have gone above and beyond what is typical for the state of Connecticut. We will send weekly emails highlighting different parts of this campaign, starting with a kickoff email. We will also cover our clinical programs, point solutions, provider of distinction, and telehealth. We continue to advise and connect our admins groups to the members of the partnership groups. More information will

follow, and the campaign will wrap up with a final letter and printed mailer of the White Paper as a reminder. The letter will come from our Comptroller.

During a recent survey, we looked into the performance of our portal and care coordinators, customer call centers, and how our employees feel about their work. We received a good response from the survey, but we noticed that some people unsubscribed from our email list after we added access for spouses. Now that we're partnering with Quantum, we can access the spouses for the first time. In some cases, that would be a great benefit because they may be the ones who are looking at the benefits more than the actual employee. Though it could be an excellent benefit for spouses to have access, we understand that some may not recognize our brand of Care Compass. Therefore, we will soon inform them why they are receiving our emails and how they can benefit from it.

The clinical health programs received a positive response. We had a broad audience with high open rates for all our point solutions. Apart from that, our communications were standard.

In the next few months, we have a lot going on in our care compass communication plans. May is open enrollment, so we're preparing a lot of resources to get out to our agencies, whether it be through mail or live events. We're also continuing our care compass revision redesign, based on feedback from our members, to make it more user-friendly as we continue to grow. We're also working on point solutions and outreaches to primary care providers through their primary care initiative. We have added many new pages, including a revamped medical page that highlights our point solutions and vendors. We also have a new care coordinator page going live soon. This page will help our spouses and employees understand how the care coordinators can help them. Additionally, we have a new form for HEP, and as of March 1st, it is now an opt-out option instead of an opt-in option. Everyone is now opted in and can choose to opt-out. The agencies are all aware of this change. We have a lot going on, but we are trying to keep things simple.

With Quantum Health, we recently announced changes to HEP, and that announcement was sent out to all employees via email and mail. We will start sending non-compliance reminders this month, which they will receive by April. This year, the number of non-compliant employees is lower, which is excellent news. We are excited to get the word out to all of our employees and see its positive impact. One important thing to note is that we are sending out a special letter about benefits reinstatement. This letter is for employees affected by changes to HEP, specifically the removal of vision coverage. If an employee was non-compliant with vision coverage in 2022, they will receive this letter confirming their compliance. Over 1,000 employees will receive this letter in the next few weeks.

There are some updates regarding HEP chronic conditions. The process of finding non-compliant individuals and sending out emails to help them become compliant through the available channels will continue. Also, two new initiatives are related to cancer screening and preventive care reminders. This year, we are partnering with Quantum to educate all eligible employees through postcards and emails on the importance of these screenings and care.

Point Solutions 6-month Results:

Flyte:

We have received some results from the Flyte program, which was implemented for the Obesity management in July. Although we are a little past the six-month mark, we are looking back to review the claims delays and other aspects. I will walk you through the high-level results of the Flyte program.

When you sign up for Flyte, you can access an application that will assist you with lifestyle changes. One of the program's features is a cellular connected scale and blood pressure monitors, automatically logged into the app. Additionally, there are health assessment questionnaires that you can complete, and you can log your meals to track your calories. The data shows that most people use the scale and log their weight, which is great. However, some people find logging their food very useful, while others do not use this feature. Overall, there is significant utilization of the program features.

There are some scenarios in which the specialists at Flyte, who are fellowship-trained obesity specialists, as well as other obesity specialists who focus on this area of medicine, have uncovered inappropriate prescriptions or safety concerns for their patients. This slide provides a few examples of the positive outcomes of having a group that specializes in this area of medicine take care of its members. The examples are available for those who wish to review them later in the slide.

To give you more information about prescribed medications, there have been almost 2,400 unique prescriptions. These prescriptions can be categorized into two types: GLP-1 and non-GLP-1. There are slightly more non-GLP-1 prescriptions, making up a higher percentage of the total prescriptions. About 46% of the total scripts are GLP-1, but a reasonable amount of that percentage was from people already on a GLP-1 before joining the program. Generally, if a patient is doing well on a medication, the physicians at the Flyte would want to continue the medication that works for the patient.

The average weight at enrollment is for everyone who completed enrollment between July 1st and January 1st. During these six months, almost 1,250 members enrolled, with an average starting weight of about 230 pounds. However, for weight change over time, we're only looking at those who have completed a full six months in the program. This group includes those who enrolled in the program in the first month or month and a half. The average starting weight for this group of about 182 patients was 217 pounds. After six months in the program, the same group has an average weight of about 195 pounds, a 10% change in their overall average weight. Although the BMI hasn't dropped as much as the average rate, it still shows an 8.2% reduction.

It is important to monitor the difference in weight loss between those on GLP-1 and those not. Generally, those prescribed GLP-1 are likely at a higher risk and, therefore, have a higher starting weight. However, we have observed that people on GLP-1 experience a more significant weight reduction of 12.2% compared to those not on GLP-1, who experience only a 4.3% reduction in weight. We will keep an eye on this trend over time to ensure that all members are making progress within the program.

We currently have around 60 patients on this timeline, and we can see a significant reduction in blood pressure for both types being tracked. The numbers indicate a drop from 12% to 9% on one side and from 6% to 7% on the other. These are positive initial outcomes for blood pressure.

We are seeing some early indicators of success at the six-month mark of the pilot program. We're observing a decrease in BMI and blood pressure, which is a good sign. We will continue to review and gather more detailed data as we move forward. We plan to present some pre- and post-claims data in April or May, which will help us decide whether to extend this program beyond the pilot phase. The program has a one-year contract, which can be extended to a three-year term with two one-year renewals based on the performance and outcome. We will also compare the claims experience of those who enrolled in the program with those who did not to see if there is a positive effect on participants' health. These are a few additional things that we will present when we re-evaluate the program in a few months and decide whether to extend it.

Virta:

A few years back, we started a diabetes management program using Livongo. The program monitored blood sugar levels in real time and provided alerts, text messages, and even emergency phone calls to help people manage their blood sugar better. However, we shifted to a new company called Virta on July 1st. Virta also offers diabetes management services, but their program is more intense and focuses on diet and behavior change. Clinicians oversee the program and can rapidly reduce blood sugar levels. Some people have even been able to reduce their medication and achieve remission. In this report, we'll be discussing the Virta diabetes reversal program and its results.

There were 283 participants in this particular group, all of whom signed up in the first month or so of the program. It's important to note that this program was initially only advertised to individuals already in the Livongo program, meaning their A1c levels were already relatively well managed. The starting A1c was 7.1%, but over the first six months of the program, it was reduced to 6.4%. Approximately 39% of individuals were able to reduce their diabetes medication as a result of the program. Additionally, there was a 7% reduction in weight for those in the program.

This is a breakdown of the reduction in diabetes medications and what it looked like. At the end of six months, only 18 out of 32 people who started on insulin were still on it, and most of them were on reduced levels. There was also a significant reduction in people taking SGLT2, a medication with more risks and side effects than others. This reduction is an area of focus for deprescribing. Although it's too early to make long-term conclusions about potential medical savings, there are clear hard savings from deprescribing. We can calculate the cost of medications and compare it to what we are paying now. This program is unique in that we have a hard savings number that we can define. Going forward, we will bring those savings numbers forward and show what impact they have had. We will also compare this population to similarly situated people and see how they are doing on the medical side in terms of receiving fewer ER visits and patient visits. Early indications show movement relative to this program, and we will continue to review as we move forward.

Primary Care Initiative:

We now have 14 groups contracted for our Primary Care Initiative. We are in the process of finalizing our PBM contract, and one of the factors we negotiated was to ensure that they provide resources for the Initiative. Six of the groups have assigned pharmacists to work with us, and we will work together to manage pharmacy spend within those groups.

We recently had a town hall meeting to discuss the quality measures that we will be holding our providers accountable for and the attribution of our members to them. During the meeting, we received constructive feedback. Regarding attribution, we have decided to engage with providers early in the year to ensure that we have accurate numbers of our members attributed to them. This is important since we make per-member, per-month payments to them. Knowing the attribution will also give providers an idea of who to engage in exams and screenings.
Regarding quality measures, we considered dropping breast cancer screening and colonoscopies from the measures we hold providers accountable for because we already provide these services to our members. However, after receiving feedback from providers who felt these measures were important, we looked at our claims and compliance data. We noticed that there is still room for improvement in compliance within 12 months (January to December). As previously mentioned, we would like to get people into compliance within 12 months and not have a sudden end-of-year rush or have to push a compliance screening into the spring of the following year. Therefore, we have decided to retain these two measures in our quality review and work with providers to encourage our members to get their screenings earlier in the year. This way, we can avoid the end-of-year rush and have a smoother six-month compliance process for these screenings.

We have made significant progress in acquiring and utilizing data. In the past, some quality measures were based on claims. But now, we are working with Anthem to include more clinical-based data. We are also collaborating with Connie, our statewide health information exchange, to acquire lab results data. This will help us close data gaps in quality measures such as A1c results, blood pressure, etc. We are optimistic about the potential impact of the Connie connection as they take in a lot of clinical data. This work will continue throughout this year and beyond; we are eager to see the results.

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 Gregory Messner, seconded by Dan Livingston.

Meeting was adjourned.