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Memorandum

To: Sam Watts

From: Jason Jossie, Kenneth Vieira

Date: October 14, 2024

Re: **Synopsis of Actionable Items from the Population Risk Report**

Segal was retained by the North Carolina State Health Plan (the Plan) to prepare the 2023 Population Risk Report. Our risk analysis for the Plan encompasses five years of data and brings the current financial status of the Plan into sharp relief. Specifically, the data show that per capita healthcare costs have increased by 28.5% from 2019 – 2023 (6.5% effective annual increase). This breaks down into a 27.1% for medical (6.2% effective annual increase) and 33.1% for prescription drugs net of rebates (7.4% effective annual increase). This has partly been driven by an increase in population morbidity of 15.2% over the 5-year period (as determined by the medical and prescription drug risk scores).

Both medical and prescription drug costs are trending higher than our SHAPE book-of-business for public sector clients (the Benchmark). If the State followed the expected trend from the Benchmark, healthcare costs over the 5-year period would've been $407.9 million lower than actual ($170.7 million for medical and $237.2 million for prescription drugs). The difference was mainly driven during the height of the pandemic in 2020. The Plan experienced a 1.8% increase in medical expenses during 2020, compared to a 4.8% reduction for the Benchmark. This difference alone is valued at $125.4 million in additional costs for the Plan.

Meanwhile, per capita Legislative funding for actives has increased by only 21.2% over that time, or a 4.9% effective annual increase. Given that medical and prescription drug expenses have been increasing at an effective annual rate of 6.5%, it should be no surprise that the Plan's financial status has declined.

Note that in 2023, net prescription drug costs for the Plan were approximately $94.3 million more than expected, which was mainly due to high utilization of GLP-1 medications used for weight-loss. The amount the Plan paid for GLP-1 drugs used for weight-loss increased by an estimated $90.3 million from 2022 to 2023. The Board has already taken action on this issue as coverage for weight-loss drugs was rescinded in 2024. Although the difference between actual and expected prescription drug trend is expected to improve, the Plan should continue to monitor this area as more indications are approved for GLP-1 medications.

Although there is a wealth of information in this report, we have identified seven strategic actionable items within the framework of our risk analysis:

1) Improving the Plan's oversight mechanisms for medical and prescription drug costs are an obvious focus. Initiatives to improve management of benefits, oversight of vendors, and accuracy of claims would all provide value for the members and could reduce costs.

2) Since 82% of the State's medical costs and 85% of the State's prescription drug costs are attributable to eight chronic conditions those need to be an area of focus for the Plan. Those conditions are Asthma; Coronary Artery Disease; Congestive Heart Failure; Chronic Obstructive Pulmonary Disease; Diabetes; Hypertension; Mental Health; and Substance Abuse Disorder. The Plan could improve the health of members and reduce its risk by exploring a range of options from communication strategies to disease management programs.
3) The Plan should continue to promote screenings for early detection of Cancer as the State's risk scores for Cancer are consistently higher than our benchmarks. Additionally, the Plan should review cancer care strategies available through Aetna (e.g., second opinion services, access to and identification of Centers of Excellence, treatment guidelines, nutritional counseling, virtual and in-home care, etc.).
4) The tobacco premium credit no longer seems to be accomplishing its intended purpose of reducing tobacco use and could reasonably be replaced by a more focused approach of promoting cessation programs and respiratory cancer screenings. The majority of the premium penalty is due to no action taken by member vs. actual attestation.
5) The Plan should continue to promote access to mental health services and refine steerage to incentivize use of high-quality providers. The number of utilizers in this category has grown over 32% during the last 5 years.
6) The Plan should also take steps to favor use of biosimilar medications over the original biologics when this can be done safely and responsibly. This can be done by utilizing prior authorization that directs provides and members towards biosimilars if available and appropriate, as well as by implementing step therapy so members can start with lower-cost biosimilars before becoming eligible for more expensive originator biologics.
7) The Wilmington Health pilot project is still too new to determine conclusively that the model in use there is optimal. However, the Plan's efforts to promote regular usage of primary care should be continued and enhanced using strategies that hold providers accountable for high quality care.

The full report attached to this memorandum includes more key findings, actionable insights, and details on the above areas as well as other areas of potential concern. This report continues to evolve over time and can continue to be tailored to be meet your needs while highlighting emerging trends.