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Correspondence Memorandum

Date: October 18, 2023

To: Group Insurance Board

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Subject: Claims Expenditures in the Group Health Insurance Program (GHIP)

This memo is for informational purposes only. No Board Action is required.

Background

This memo provides the Group Insurance Board (Board) with the quarterly data warehouse dashboard and highlights. The previous quarter's dashboards and highlights can be found in the May 2023 Board meeting materials (GIB | 08.16.23 | 9D).

Dashboard Data

The dashboards include data for healthcare services (excluding wellness) provided from June 2022 through May 2023 (current period), compared to services provided from June 2021 through May 2022 (previous period). The reported data includes payments made for these services through August 2023. To provide the most current data as frequently as possible, the data is presented on a "rolling year" basis, meaning it could span from one mid-year month to another. There is typically a gap in time between when services are provided and when they are paid. The three-month delay in dashboard reporting allows for the billing and payment process to be completed for most of the services rendered. The length of this process varies, depending on the nature of the service. It is typically shorter for prescription drug services and longer for more complex services like inpatient hospital stays.

Notable Dashboard Highlights

Total Net Payment Trend

- The current Year over Year (YoY) trend of 2.8% is a composite of three benefits offered to Group Health Insurance Program (GHIP) members. The trends by benefit type are:
  - Medical: 0.4%
  - Pharmacy (Drug or Rx): 14.2%
  - Dental: 2.5%

Reviewed and approved by Eileen Mallow, Director, Office of Strategic Health Policy
Electronically Signed 10/26/2023

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- The double-digit trend in prescription drug costs is driven primarily by the specialty drug sub-category of this benefit.
- The nearly flat trend in the costs for medical services is lower than typical historical annual trends. This is explained in part by lingering impact of the COVID pandemic on services. Note that the "previous" reporting span (June 2021 - May 2022) includes a period of a rebound in healthcare service utilization immediately after the most marked disruption due to the COVID pandemic. When compared to the "current" more normalized period, the transient, higher-than-usual utilization in the "previous" period results in a lower YoY trend, as currently recorded. An increase in the annual trend is expected as both the previous and current reporting periods move further away from the effects of the COVID pandemic. [Data Warehouse Dashboards – Financial page 1, top]

Service Categories

- The shift in relative costs by service category under the medical benefits is in line with the current trends in the healthcare industry where advances in technology now allows for the rendering of services typically offered at inpatient locations at outpatient facilities. The relative costs of facility outpatient services now represent 39.0% of all medical costs for the members, compared to 37.4% in the previous period. The relative cost for facility inpatient services has decreased by a similar 1.6% over the same period. The Department of Employee Trust Funds (ETF) is monitoring the relevant metrics closely and has started discussions to ensure that the members are obtaining the best value from this rapidly growing service segment.
- The rapid increase in the relative cost of the specialty drug subcategory of prescription drugs is also consistent with trends in the industry. This is due to the development of specialized and typically more expensive drugs. Specialty drugs account for 59.8% of all prescription drug costs in the current period. This is compared to 57.4% for the same category in the previous period and complemented by a smaller and consistently shrinking relative cost of 40.2% for the non-specialty drug category in the same current period. The rapid growth in the cost of specialty drugs is already being addressed by ETF through a clear-bagging program (GIB | 05.18.22 | 5C). [Data Warehouse Dashboards – Financial page 1, middle]

Monthly Trends

- The monthly trends shown for net payment per member and the cost share across stakeholders is for the current year period.
- The largest portion of the total net payment goes toward the medical benefits. The monthly variations in net payments are expected and are due to cyclical factors e.g., higher incidence of influenza in the colder months, members having more cost share in the first quarter as they meet their deductibles, among other factors.
- The total monthly Allowed Amount cost is dominated by the net payment made by the health plans on behalf of the GHIP. All the cost share categories are also

subject to cyclical and other factors similar to the per member net payments. In general, the member out of pocket cost share decreases as the calendar year progresses as members accumulate more costs for services and meet their out-of-pocket limits. [Data Warehouse Dashboards – Financial page 1, bottom]

Utilization, Costs, and Cost Drivers

- Member Utilization and Cost Rates
  - The annual per member costs, such as, Allowed Amount Per Member Per Year (PMPY) Med (Medical) and Rx, and per member utilization rates, such as Admits Per 1000 Acute for the previous and current periods are compared to determine YoY trends. These current values are also compared to benchmark "Norms" to indicate deviation from expectations. Marked YoY trends in utilization or costs for specific service categories can provide insight into areas requiring attention to ensure efficient use of resources. Comparisons to "Norms" inform efforts for adjustment to the general population when appropriate. Note that the "Norms" in the dashboard are for the typical "Active" population while the GHIP population represented here includes both the "Active," "Early Retirees," and "Medicare Eligible Retirees." The use of the norm for the "Active" population is a compromise that allows for comparison in a single chart. This will result in further deviation from the norms, but these extra differences should be consistent, and the comparison is still valuable when trended over time.
  - The YoY trend of the composite Allowed Amount PMPY Med and Rx is 3.3%. The utilization of emergency room (ER) services, represented by the "Visits Per 1000 ER" rate has a YoY positive trend of 4.4%. ETF and the health plans continue efforts to reduce the utilization of ER services when avoidable (GIB | 5.13.20 | 7B). [Data Warehouse Dashboards – Page 2]

- Cost Drivers
  - In order to determine their relative contribution to the change in overall cost, the impact of the three broad service categories: inpatient, outpatient, and prescription drugs are further subdivided into price/cost and use/utilization.
  - The outpatient and prescription drug prices are the largest positive contributors to the overall YoY cost trend, accounting for $343 and $243, respectively. The prescription drug contribution is mostly driven by the cost of specialty drugs. The increase in utilization had a net cost impact of $35, bringing the relative impact of prescription drugs to $278. The outpatient utilization had a cost mitigation impact of -$156, so the total cost and utilization impact of the outpatient services is $187. Both the inpatient utilization and cost had mitigating impacts on the total cost change at -$43 and -$110 respectively, for a total impact of -$153. All these relative impacts total to the YoY Allowed Amount increase of $312,

with the prescription drug category being the largest contributor to the increase. [Data Warehouse Dashboards – Financial page 2]

Top Clinical Conditions

- Identifying the top conditions by overall costs can inform efficient allocation of resources to disease or condition specific initiatives.
- Preventive health encounters, such as annual physical check-ups, consistently the top costs for services received by members. This is a desirable pattern since such encounters help identify more serious conditions early, and generally lead to the best outcomes for members.
- Some of the top encounters, such as chemotherapy, are for treating serious conditions, like cancers. The primary focus for these types of encounters should be early detection through recommended screenings and preventive visits to improve the probability of better prognosis for the member while reducing the high cost of more complex care typically associated with later detection.
- Other top conditions by cost, such as osteoarthritis, are manageable and efforts could be geared toward ensuring the best outcome for members at competitive costs. [Data Warehouse Dashboards – Page 3]

High-Cost Claimants (HCCs)

- Usually represent a small percentage of total membership but account for a relative cost that is much larger than their representation. The threshold to be included in this group has been set at members receiving services that cost $50,000 or greater in Allowed Amount in the year of consideration.
- 3.1% and 3.2% of the GHIP population meet this cost criteria in the previous and current year, respectively, but these account for 58.1% and 57.9% in relative costs in the same periods.
- Members meeting the HCC criteria over multiple years usually have chronic conditions that are amenable to management. These members will benefit from proactive management to ensure that resources are efficiently targeted at the best evidence-based treatment for their conditions. [Data Warehouse Dashboards – Page 3]

Member Risk Categories

- Members are categorized into risk bands based on Merative's risk methodology. The bands range from "Healthy", representing members expected to need the least resources for care to "In Crisis", representing members expected to need the most resources for care. The higher risk bands require a disproportionate number of resources for care — e.g., members in the "In Crisis" risk band only make up about 5% of the membership but account for 33% of the financial resources for care. This member risk categorization is useful for efficient resource allocation by identifying the sub-population for which intervention may potentially result in the largest impact. [Data Warehouse Dashboards – Page 4]

Cost by Plan Groups

- An illustration of the relative sizes of membership of each medical health plan and per member cost trends is useful for providing a quick but valuable summary of the membership distribution and financial status of the GHIP program. The size of the bubbles indicates the relative number of members covered under the health plan groups. The location on the vertical axis indicates the allowed amount costs for medical and prescription drug services in the current period. The horizontal distances from the y-axis shows the YoY trend of the per member annual costs. This summary chart includes data for all members covered under the various GHIP programs.
- Typically, the largest plan groups by membership drive the general overall trend, but the combined trend effect is an aggregate of cost trends for all the health plans. The largest three plan groups, accounting for almost two of every three GHIP members (65%) in the current period, show positive cost trends higher than the overall trend. However, a number of the mid-sized health plans show negative trends, resulting in the lower but still positive overall cost trend of approximately 2.6% in the Allowed Amount PMPY Med and Rx.

Health Plan	Average Membership Count (% of Total)	Allowed Amount PMPY Cost Trends
Dean	46,931 (19.3%)	6.3%
Quartz	78,504 (32.4%)	6.6%
WEA Trust	32,362 (13.3%)	7.4%

- Please note that only partial data are used for the trend calculations for the WEA Trust and Aspirus because these health plans did not have members for all of the time spanning the “previous” and “current” periods. The relative representation of the top three plans by membership is dropping because of the exit of the WEA Trust plan at the end of 2022. In general, the stability of membership enrollment by health plan is not guaranteed.
- For health plans with relatively small membership (membership size is indicated by the smaller circles), this makes them more susceptible to large swings in trends due to outliers.
- These trends are not risk-adjusted to account for disparities in the risk pool of each health plan. [Attachment: Data Warehouse Dashboards – Financial page 5]

Cost by Eligibility Type

- The overall enrollment and family sizes have remained relatively stable over the past two annual rolling periods.
- The per member net payment trend for spouses is highest at about 4.4% ($809 to $845), compared to about 2.7% for Employees/Contract holders, and nearly flat at 0.5% for child dependents.
- The per member net payment trend for the "Active" population is the lowest at 2.0% ($643 to $656), compared to about 5.5% ($1,095 to $1,155) for the "Early

Retirees" and 8.8% ($475 to $517) for the "Medicare Retirees. [Attachment: Data Warehouse Dashboards – Financial page 6]

Staff will be at the Board meeting to answer any questions.

Attachment A: Data Warehouse Dashboards