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Correspondence Memorandum

Date: July 19, 2024

To: Group Insurance Board

From: Jessica Rossner, Data and Compliance Unit Director
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Subject: Group Health Insurance Program Dashboards

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

Background

This memo provides the Group Insurance Board (Board) with the quarterly Group Health Insurance Program (GHIP) data warehouse dashboards and highlights. The previous quarter's dashboards and highlights can be found in the May Board meeting materials (Ref. GIB | 05.23.24 | 10H).

Dashboard Data

The dashboards include data for healthcare services (excluding wellness) provided from March 2023 through February 2024 (current period), compared to services provided from March 2022 through February 2023 (previous period). The reported data includes payments made for these services through May 2024.

There is typically a gap between when services are provided and when they are paid. The three-month delay in 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. Completion factors have been applied to all reported financial metrics. The completion factor adjustments are based on an estimate of claims that have been incurred but not yet reported (IBNR).

Reviewed and approved by Renee Walk, Director, Office of Strategic Health Policy
Electronically Signed 08/05/2024

Board	Mtg Date	Item #
GIB	08.14.24	13H

Notable Dashboard Highlights

Cost Trends by Benefit Types

- The current Year over Year (YoY) trend of 8.1% in net payments per member per month (PMPM) is a composite of three benefits offered to members. The net payment PMPM trends by benefit type are:
    - Dental: 4.2%
    - Drug (Rx): 12.6%
    - Medical: 7.1%
- The dashboard also shows these costs and trends by employee groups: active employees, early retirees, and Medicare retirees. This more detailed reporting by employee groups supports targeted monitoring and management of the different risk profiles represented in each group.
- The active employees and their dependents make up about 81% of the GHIP membership, and this group is the primary driver of the overall GHIP experience.
- In the current period, the PMPM dental costs are comparable for the active and early retiree groups ($21.2 vs $21.6), but the early retiree group is trending higher at 5.0% (vs 3.7%). The PMPM dental costs for the Medicare retirees are slightly higher than both other groups and also trend higher than both groups at 6.6%.
- The PMPM drug net payment for the early retiree group is about 70% more than the net payment for the active group in the current period ($245 vs $144), but trending at about half the rate (6.4% vs 13.1%). The PMPM drug net payments of the Medicare retiree group are lower than the other two groups but trending the fastest at 15.0%. The net payment for the Medicare retirees is only reflective of the GHIP's partial responsibility for that group. The aggregate drug cost trend of 12.6% is the highest of the three benefits.
- Similar to the drug costs, the current PMPM medical costs of the early retirees is about 79% higher than the active group ($960 vs $538) and trending at a faster rate of 6.7% (vs 5.4%). Both the previous and current reporting periods experienced minimal to no impact from the COVID pandemic disruption, so the medical cost trends for the active and early retiree groups are now closer to the typical, historical, single-digit trends resulting from a combination of inflation and medical cost increases [Data Warehouse Dashboards – Financial page 1].

Cost Trends by Service Categories

- The specialty drugs segment continues to represent a larger segment of the total cost of drugs when compared to the non-specialty segment, representing 60% in the current period. This relative distribution of the cost of drugs by segment is expected to continue to be of interest. In 2023 plan year, ETF implemented a

clear-bagging initiative to address these expected cost trends (Ref. GIB | 05.18.22 | 5C). The team has commenced the exploration of the data related to this program and plans to submit an assessment of the 2023 plan year at the November Board meeting [Data Warehouse Dashboards – Page 2].

Monthly Trends by Benefit Types and Cost Share

- Monthly trends for both the current and previous periods are shown.
- For all three benefits, the monthly net payment per member in the current months are equal to or greater than those in the previous. The monthly percentage differences reflect the overall annual trends, ranging from smaller differences, aggregating to a single digit of 4.2% for the dental benefit, to the largest for the prescription drug benefit. This resulted in the double-digit annual trend of 12.6%.
- As expected, the out-of-pocket amount paid for cost share by the members is highest at the beginning of the year, before members meet deductibles and out of pocket limits, and continues to decrease in the course of the year, as more of the healthcare costs are paid by the health insurance plans [Data Warehouse Dashboards – Page 3].

Per Member Utilization and Cost Trends

- Annual per member costs (e.g., allowed amount PMPY for medical and prescription drug) and per member utilization rates (e.g., Admits Per 1000 Acute) for the previous and current periods are compared to determine YoY trends. Marked YoY trends in utilization or costs for specific service types can inform priorities for efficient resource management. These current values are also compared to benchmark “norms” to indicate deviation from expectations. Norms provide context for the general population. Note that the norms in the dashboard are for the typical active population, while the population represented here includes active, early retirees, and Medicare-eligible retirees. While the norms for the active sub-population only represent a subset of the membership, they still provide value as a basis for trending of differences from a general population over time.
- The YoY trend of the composite allowed amount PMPY for medical and prescription drug costs is 5.6%, representing an annual increase of $537. The largest cost trend of 9.4% is recorded for the allowed amount per script of prescription drug filled [Data Warehouse Dashboards – Page 4].

Cost Drivers

- To determine their relative contribution to the change in overall cost, the impact of the three benefit types: inpatient, outpatient, and prescription drugs are further subdivided into price/cost and use/utilization.

- When aggregated for all members, only the inpatient utilization has a mitigating impact on the overall cost trends, contributing -$114. The inpatient utilization also has mitigating impacts when the cost driver assessment is split by the active, early retirees, and Medicare retirees. For all the members, the inpatient price and both the outpatient and prescription drugs utilization and costs have a higher cost impact. The outpatient price impact ($300) and prescription drugs price impact ($251) are the biggest positive contributors to the total annual increase of $537. Price contributions for these two benefit segments are also substantial for each of the three subpopulations. The outpatient price as a substantial cost driver is generally in line with trends in the industry, with more complex procedures being performed in the outpatient setting. This also leads to a reduction in the utilization of inpatient services and positive contribution from the inpatient price as the fewer services still requiring inpatient stay are typically more expensive [Data Warehouse Dashboards – Financial page 4].

Member Risk Categories

- Member 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 the members expected to need the most resources for care. The higher risk bands require a disproportionate number of resources for care. For example, the combination of members in the “In Crisis” and “Struggling” risk bands make up about 24% of the membership, but account for 70% of the financial resources needed for care. This member risk categorization is useful for efficient resource allocation by identifying the subpopulation for which intervention may potentially result in the largest impact [Data Warehouse Dashboards – Page 6].

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 plan groups. The location on the vertical axis indicates the allowed amount for medical and prescription drug services in the current period, and the horizontal distances from the vertical axis show the YoY trend of the per member annual costs. This summary chart includes data for all members covered under the various programs. The bubbles representing the plan groups have been annotated with representative letters to facilitate identification.
- Typically, the largest plan groups by membership drive the 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 members (67%) in the current period, showed positive cost trends. These, combined with

trends from the other plan groups, result in the overall cost trend of 5.6% in the allowed amount PMPY for medical and Rx.

Health Plan	Average Membership Count (% of Total)	Allowed Amount PMPY Cost Trends
Dean	54,410 (22.5%)	16.5%
Network Health	27,832 (11.5%)	5.3%
Quartz	80,097 (33.1%)	8.8%

- In general, there is no guarantee of stable membership enrollment by plan group. The relatively small membership of some of the health plans makes them more susceptible to large swings in trends due to cost outliers and changes in membership.
- These trends are not risk adjusted to account for disparities in the risk pool of each health plan [Data Warehouse Dashboards – Page 7].

Costs by Eligibility Type

- The financial responsibility of the GHIP program varies by employee/contract type. The GHIP program has primary responsibility for the costs incurred for active employees but only a secondary financial responsibility for employees/contract holders covered under Medicare programs. Separating financial reporting by these coverage types and demographics supports informed decisions, specific to each of these groups (e.g., benefit design considerations).
- The overall enrollment and family sizes have remained relatively stable over the two annual periods under consideration, with only a marginal increase of 1.1% and 0.7% in employees/contracts and members, respectively.
- The current monthly net payment per member cost is highest for spouses ($893), but employees/contract holders have the highest cost trend at about 10.2% ($797 to $723). Both the current monthly net payment per member cost and cost trend is lowest for child dependents at $426 and 5.7%, respectively [Data Warehouse Dashboards – Page 8].

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

Attachment A: GHIP Dashboards