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Correspondence Memorandum

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To: Group Insurance Board

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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 November Board meeting materials (Ref. GIB | 11.13.24 | 17D).

Dashboard Data

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

There is typically a gap between when services are provided and when they are paid. The three-month delay in reporting allows for billing and payment processing 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).

Notable Dashboard Highlights

Cost Trends by Benefit Types

- The current year-over-year (YoY) trend of 6.3% in net payments per member per month (PMPM) is a composite of three benefits offered to members. The net

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Electronically Signed 02/20/2025

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payment PMPM trends by benefit type are:
  - Dental: 4.1%
  - Drug (Rx): 6.4%
  - Medical: 6.3%.
- Active employees and their dependents make up about 81% of the GHIP membership and are the primary driver of the overall GHIP experience.
- The current PMPM costs for dental benefits range from $21.60 for actives to $25.00 for Medicare retirees, with early retirees falling in between at $22.10. The trends in net payments for dental benefits are similar across all three groups, ranging from 4.1% to 4.4%.
- The PMPM cost for prescription drugs is highest for early retirees at $267, which is approximately 80% higher than the $146 for the actives and several times greater than the $78 for Medicare retirees. The drug cost trends are highest among early retirees at 13.9% and lowest among Medicare retirees at 2.6%. The 6.7% trend for actives is more representative of the overall 6.4% cost trend for this category across all three groups.
- The 6.3% aggregate trend in PMPM medical benefit costs is similar to the trend for the actives and is roughly half of the 12.5% trend for Medicare retirees. The cost trend for medical benefits for early retirees declined by 0.9% YoY. Note that trends for this subgroup are more influenced by outliers due to its relatively small size, representing about 3% of the GHIP. The current net payment PMPM for the medical benefit for early retirees is $936, approximately 70% higher than the $551 for the actives (Data Warehouse Dashboards, p. 1).

Cost Trends by Service Categories

- The cost of specialty drugs represents the largest segment, at 57% of the total cost of drugs in the current period. This is a slight decrease from 60% in the previous period. This is due in part to the increased use of lower-cost alternatives to some expensive specialty drugs. For example, GHIP's utilization of Humira, a specialty drug with multiple uses, declined by about 40% YoY, and the related cost dropped by approximately 50% over the same period. This YoY reduction in Humira's cost totals around $24 million and represents about 10% of the total specialty drug expenses under the prescription drug benefit in the current period. ETF will continue managing specialty drug costs by exploring the expansion of the successful clear bagging program and proactively monitoring new drug approvals for lower-cost, equally effective alternatives. (Ref. GIB | 11.13.24 | 15; Data Warehouse Dashboards, p. 2).

Monthly Trends by Benefit Types and Cost Share

- Monthly trends for both the current and previous periods are shown.
- The monthly net payment PMPM in the current months are comparable to or greater than those in the previous period for all three benefits. The monthly percentage differences reflect the overall annual trends, ranging from smaller monthly percentage differences aggregating to 4.1% for the dental benefit, to 6.4% and 6.3% for the prescription drug and medical benefits, respectively.

- There is some monthly variation in overall net payments and allowed amount costs, with a general upward trend. However, the out-of-pocket costs paid by members follow a different pattern. These costs are highest at the start of the year, when members have not yet met their deductibles or out-of-pocket limits. As the year progresses and these limits are reached, out-of-pocket costs decrease, with more of the healthcare expenses being covered by the insurance plans (Data Warehouse Dashboards, p. 3).

Per Member Utilization and Cost Trends

- Annual per member costs (e.g., allowed amount per member per year/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 retirees. While the norms for the active subpopulation 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 change in the composite allowed amount PMPY for medical and prescription drug costs is $588, representing a 6.0% trend. The largest cost trend of 4.9% is for the allowed amount per script of prescription drug filled and is an indication of the relative increase in the unit cost of prescription drugs. There are only marginal increases of 2.9%, 1.7%, and 0.5% in the allowed amount costs for each office medical visit, admission, and emergency room (ER) visit, respectively (Data Warehouse Dashboards, p. 4).

Cost Drivers

- To determine their relative contribution to the change in overall cost, the impact of three benefit types — inpatient, outpatient, and prescription drugs — are further subdivided into price/cost and use/utilization.
- When aggregated for all members, each of the listed factors contributed positively to the overall cost trend, though with varying degrees. Outpatient utilization has the largest impact, adding $232, while inpatient use has the smallest impact at $11.
- Outpatient utilization is also the primary cost driver for actives, accounting for about 50% of their total increase, or $278 of $554. It also significantly contributes to cost increases for both early retirees and Medicare retirees.
- Rising prescription drug prices are a major factor in cost increases for early retirees, adding $356, and for Medicare retirees, adding $621 (Data Warehouse Dashboards, p. 4, bottom right).

High-Cost Claimant (HCC) Trends

- Members with annual allowed amount costs of at least $50,000 are classified as HCC.
- In the current period, HCC members make up 3.5% of the membership in the GHIP, up from 3.3% in the previous period. They account for a disproportionate amount of the GHIP spending, with the 3.5% in the current period accounting for 44% of the total GHIP spend. Some of the healthcare conditions and services resulting in high-cost members can benefit from proactive management. HCC membership and trends are monitored for opportunities to improve quality of services and manage costs (Data Warehouse Dashboards, p. 5).

Member Risk Categories

- Members are grouped into risk bands using Merative's risk methodology. These bands range from "Healthy," for those expected to require the fewest healthcare resources, to "In Crisis," for those expected to need the most. Higher-risk bands demand a disproportionate share of resources. For example, members in the "In Crisis" and "Struggling" categories make up about 24% of the population but use 62% of the healthcare resources. This member risk categorization is useful for efficient resource allocation by identifying the subpopulation where intervention will potentially result in the largest impact (Data Warehouse Dashboards, p. 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 size of the members covered under the health 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 y-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 about 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 6.0% in the allowed amount PMPY for medical and pharmacy drug costs.

Health Plan	Average Membership Count (% of Total)	Allowed Amount PMPY Cost Trends
Dean	54,064 (22.0%)	10.0%
Network Health Plan	28,271 (11.5%)	4.8%
Quartz	83,066 (33.8%)	5.3%

- In general, there is no guarantee of stable membership enrollment by plan group. The relatively small membership of some 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, p. 7).

Cost 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 and early retiree groups but only a secondary financial responsibility for employees/contract holders covered under Medicare programs. Separating financial reporting by these coverage types and demographics supports decisions specific to each of these groups (e.g., benefit design considerations).
- Compared to the previous period, overall enrollment has increased by 2.2% and 1.8% for employees/contracts and members, respectively. Enrollment by members for actives increased by 2.3%, compared to a drop of over 7% for early retirees. Enrollment for Medicare retirees remained mostly unchanged, with a 0.9% increase YoY. The average family size and ages of members remained stable at 2.2 members per family and 40 years old, respectively.
- The current monthly net payment per member cost is highest for spouses ($919) and lowest for child dependents ($425). Employees/contract holders have the highest cost trend of about 8% (from $757 to $819), compared to 5.5% for spouses (from $871 to $919) and the lowest trend of 2.6% for child dependents (from $414 to $425; Data Warehouse Dashboards, p. 8).

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

Attachment A: GHIP Dashboards