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Correspondence Memorandum

Date: May 14, 2025

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 March Board meeting materials (Ref. GIB | 03.12.25 | 5D).

Dashboard Data

The dashboards include data for healthcare services provided from January to December 2024 (current period), compared to services provided from January to December 2023 (previous period). The reported data also includes payments made for these services through March 2025.

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).

Well Wisconsin program data has been newly added to the data warehouse. It includes health assessment results, biometrics, and participation in well-being activities like coaching, condition management, and wellness challenges to support healthy lifestyles.

Reviewed and approved by Renee Walk, Director, Office of Strategic Health Policy
Electronically Signed 05/14/2025

Board	Mtg Date	Item #
GIB	05.21.25	13F

New dashboards on the Well Wisconsin program have been added to the Board's dashboard packet. These dashboards will be provided annually rather than quarterly, as incentive payments are issued only once per year after all requirements are met. Additionally, most metrics are best assessed on a yearly basis to reflect meaningful trends.

The new dashboards include data for GHIP members eligible to receive the $150 incentive. This group is divided into incentive recipients and nonrecipients for the purpose of comparing demographics, utilization rates, costs, and risk categories across the two groups. Currently, Medicare Advantage members are excluded from the Well Wisconsin dashboards since they are not eligible for the incentive, therefore, making their experience different from the non-Medicare Advantage population. They will be included in the dashboards starting with the 2026 program, when they will be eligible for the incentive.

Notable Dashboard Highlights

Cost Trends by Benefit Types

- The current year-over-year (YoY) trend of 6.7% 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: 3.6%
  - Drug (Rx): 2.4%
  - Medical: 7.9%
- 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 are $21.70 for actives, $22.50 for early retiree, and $25.40 for Medicare retirees. Trends of dental net payments vary slightly across groups, with actives at 3.4%, early retirees at 5.0%, and Medicare retirees at 4.5%. The overall trend of 3.6% aligns closely with the annual rate observed when comparing 2022 plan year to 2023 plan year experience (Ref. GIB | 05.23.24 | 10H).
- The overall drug cost trend is 2.4% which is much lower than the 13.5% trend observed when comparing the 2022 plan year to the 2023 plan year experience (Ref. GIB | 05.23.24 | 10H). The reduction in cost trends for the specialty drug category from a double-digit YoY increase to a slightly negative decrease in more recent period is largely driven by the increased availability of biosimilars and other lower cost alternatives to typically very expensive specialty drugs. The PMPM net payment cost for prescription drugs is highest for early retirees at $274, about $127 higher than the $147 PMPM cost for actives. Early retirees are also experiencing a higher trend at 13.7%, compared to 3.2% for actives. Because actives represent the largest share of membership, they have the greatest influence on the overall trend. The reported prescription drug costs and rates do not reflect rebates subsequently passed along to GHIP by Navitus, the board's pharmacy benefit manager. The level of rebates can vary over time,

resulting in impact on actual costs and trends.

- The overall medical cost trend is 7.9%, which is slightly higher than the 6.1% trend observed when comparing the 2022 plan year to the 2023 plan year experience (Ref. GIB | 05.23.24 | 10H). Similar to the pattern seen in drug costs, the PMPM medical cost for early retirees is $970, almost $400 higher than the $572 cost for actives. However, medical costs for actives trend higher at 8%, compared to 4.7% for early retirees.
- In general, the reported annual cost trends no longer reflect the effects of COVID-related disruptions to healthcare delivery. The trends now accurately reflect inflation and other factors influencing healthcare utilization and costs in the GHIP (Data Warehouse Dashboards, p. 1).

Cost Trends by Service Categories

- The cost of specialty drugs represents the larger segment, at 58% of the total cost of drugs in the current period. This is a slight decrease from 60% in the previous period. This decline is due in part to reduced use of certain high-cost specialty drugs, as lower-cost alternatives become available. For example, the use of Humira, a specialty drug, dropped by about 38%, and the related costs fell by 76% YoY. This is the result of members switching from the drug to similarly effective but lower cost biosimilars and other alternatives. 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 2.4% for the pharmacy benefit to 7.9% the medical benefit.
- 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 trend for the combined medical and prescription drug costs shows a 6.9% increase, which equals about $689 more per member annually. Outpatient services play the largest role in that increase, with a 5.6% rise in the average cost per visit and a 7.1% increase in the number of outpatient events per 1,000 members. The prescription drug category has the smallest impact on overall cost increases, with a 3.2% rise in the average allowed amount cost per prescription and a 1.2% increase in the number or prescriptions filled per 1,000 members (Data Warehouse Dashboards, p. 4).

Cost Drivers

- To determine their relative contribution to the change in overall cost, the impact of three benefit types—namely 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 $387, while outpatient price had the smallest effect at $31.
- Breaking down the cost driver impacts for active, early retiree, and Medicare retiree shows that the effect of inpatient services varies across these groups. Utilization and prices for all groups contribute to the overall increase in costs, with two exceptions: the outpatient price for actives (-$9) and the inpatient price for early retirees (- $332).
- Outpatient utilization makes the largest contribution to cost increases for actives ($397) and early retirees ($652), with the second-highest contribution from Medicare retirees ($419). Outpatient utilization is the primary cost driver for actives, accounting for approximately 67% of their total cost increase, $397 out of $596. (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 represent 3.6% of the GHIP membership, up from 3.4% in the previous period. Despite making up a small portion of the membership, HCC account for a disproportionate share of the GHIP spending. HCC members in the current period are responsible for 43.9% of total GHIP expenditures, up from 43.3% in the previous period (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 25% of the population but use 73% 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).

Well Wisconsin Member Risk Categories

- Proportionately, the Well Wisconsin program is supporting more participating members who are considered “stable” and “at risk” (51.3% of incentive recipients) than the nonrecipient population (43% of nonrecipients). This indicates better relative participation in the program by members in risk categories that can benefit the most from wellness programs aimed at maintaining good health and preventing decline.
- A smaller proportion of incentive recipients are categorized as “in crisis” (4.5%) compared to the nonrecipient population (7.9%). Members in the “in crisis” risk category typically require more support than what is offered by the Well Wisconsin program.
- The “healthy” risk category representation for the incentive recipients (21.7%) is lower than for the nonrecipients (25.8%). While this group can benefit from the Well Wisconsin program, the impact on their health outcomes may not be as substantial as for members in the higher risk categories.
- The representation of those in the “struggling” risk category is comparable for both the incentive recipient and nonrecipients populations (Data Warehouse Dashboards, p.7).

Well Wisconsin Participation, Demographics and Costs

- Participation in the program increased steadily throughout the year, with the largest uptick in the months prior to the incentive deadline in October, after which point the growth flattens for both the actives and retirees. Participation for both the active and retiree groups was slightly lower in 2024 compared to 2023.
- For actives, the demographics of incentive recipients is comparable to nonrecipients, with a gender lean – fewer males for incentive recipients (41.5%) compared to 49.7% for the nonrecipients. Active incentive recipients have better healthcare utilization than nonrecipients with higher preventive visits, and lower potentially avoidable emergency room visit, and hospital admission rates compared to nonrecipients. The allowed amount PMPM is comparable for active recipients and nonrecipients.
- Retiree incentive recipients are younger (average age of 66.8 years) than nonrecipients (72.1 years). Retiree incentive recipients also have a lower percentage of males represented (39.2% vs 43.9%). Retiree incentive recipients have slightly lower preventive visit rates. They also have lower potentially

avoidable ER and hospital admission rates. Retiree recipients have 14% lower allowed amount PMPM compared to nonrecipients (Data Warehouse Dashboards, p. 8).

Cost by Plan Groups

- 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 6.9% in the allowed amount PMPY for medical and pharmacy drug costs.

Health Plan	Average Membership Count (% of Total)	Allowed Amount PMPY Cost Trends
Dean	53,910 (21.8%)	9.3%
Network Health Plan	28,488 (11.5%)	4.7%
Quartz	84,406 (34.2%)	3.6%

- 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. 9).

Cost by Eligibility Type

- Compared to the previous period, overall enrollment has increased by 2.5% and 2.1% for employees/contracts and members, respectively. The average family size and ages of members remained relatively stable at 2.1 members per family and 40 years old, respectively.
- The current monthly net payment per member cost is highest for spouses ($946). Employees/contract holders have the highest cost trend of about 7.7% (from $779 to $839). Both the current monthly net payment per member cost and cost trend is lowest for child dependents at $438 and 3.8%, respectively (Data Warehouse Dashboards, p. 10).

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

Attachment A: GHIP Dashboards