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Correspondence Memorandum

Date: July 30, 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 May Board meeting materials (Ref. GIB | 05.21.25 | 13F).

Dashboard Data

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

The Medicare retiree population has been excluded from the dashboard data this quarter due to a potential data quality issue affecting prescription drug financial reporting specific to this group. This step was taken to ensure the accuracy of the information presented while ETF investigates and resolves the issue. ETF expects to

Reviewed and approved by Renee Walk, Director, Office of Strategic Health Policy
Electronically Signed 07/24/2025

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incorporate the full GHIP population, including Medicare retirees, in future dashboard releases to the Board once the matter is resolved.

Notable Dashboard Highlights

Cost Trends by Benefit Types

- The current year-over-year (YoY) trend of 5.4% 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: 3.0%
    - Drug (Rx): 3.6%
    - Medical: 5.9%
- Active employees and their dependents (Actives) account for approximately 81% of the total GHIP membership. With Medicare retirees temporarily excluded from the dashboards, the actives represent 96% of the membership currently reflected in the data and continues to be the primary driver of the overall GHIP experience.
- Given that early retirees make up 4% of the members represented in this dashboard reporting period, the trends across all benefit categories are largely driven by the actives population (Data Warehouse Dashboards, p. 1).
- The current PMPM costs for dental benefits are $21.80 for actives and $22.60 for early retirees. Net dental payment trends show a slight difference between the groups, with a 2.9% increase for actives and a 5.6% increase for early retirees.
- PMPM drug cost for the actives group is $141.40, less than half of the early retirees cost of $292.20, and is trending lower at 3.2% compared to 15.6%. The overall drug trend is 3.6%.
- Actives also show lower medical costs at $552.90 PMPM, compared to $1,000.00 PMPM for early retirees. However, the medical trend is higher for actives at 6.8%, while early retirees remain flat.

Cost Trends by Service Categories

- Specialty drugs comprise the largest portion of prescription drug benefit costs, accounting for 61% of total spending in the current period. ETF will continue to manage specialty drug expenses by exploring the expansion of the successful clear bagging program and actively monitoring new drug approvals to identify 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.
- Monthly percentage changes reflect the overall annual trends and range from smaller variations of 3.0% in dental benefits to larger fluctuations in medical benefits, which drive an annual trend of 5.9%.
- Out-of-pocket costs paid by members 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 actives population, while the population represented here includes actives, early retirees, and Medicare retirees. While the norms for the actives 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 allowed amount PMPY is 5.3%, representing an annual increase of $465 per member. All key utilization and cost indicators show upward trends. The outpatient services segment continues to have the highest increases, with a 4.6% rise in allowed amount cost per outpatient member and a 4.7% increase in the number of outpatient events per 1,000 members. Inpatient service utilization shows the lowest increase at 0.4%, while prescription drugs have the smallest unit cost growth, with the allowed amount per prescription rising 1.2% (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 $334, followed by the inpatient price of $60.
- Breaking down cost drivers by actives and early retirees sub-populations reveals that outpatient service utilization is the largest contributor to positive cost trends for both groups, accounting for $337 and $621, respectively. However, the inpatient experience differs between the two groups. For actives, both utilization and price contribute positively, adding $11 and $93, respectively. In contrast, early retirees experience mitigating effects, with utilization and price reducing costs by $161 and $536, respectively.
- This difference reflects a broader shift in healthcare delivery. More complex procedures that once required inpatient stays are increasingly performed in outpatient settings. This shift leads to higher outpatient utilization alongside a reduction or stabilization in inpatient admissions.
- The prescription drug category also shows variation between the groups. Early retirees experience significant cost increases driven by price and utilization,

contributing $390 and $107, respectively. Actives have smaller positive contributions for price and utilization of $20 and $48, respectively (Data Warehouse Dashboards, p. 4).

High-Cost Claimant Trends

- Members with annual allowed amount costs of $50,000 or more are classified as high-cost claimants (HCC), as their expenses are significantly higher than the average.
- The proportion of members in this category has remained steady at 2.9% across both the previous and current periods. Despite representing a small segment of the population, these members account for just over 40% of the total GHIP allowed amount costs in both periods (Data Warehouse Dashboards, p. 5).

Member Risk Categories

- Members are grouped into risk bands using Truven by Merative 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 13.1% of the population but use 58% of the healthcare resources. This member risk categorization is useful for efficient resource allocation b 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 cost trends, but the combined trend reflects the aggregate of all health plans. In the current period, the three largest plan groups, representing nearly three-quarters (73.8%) of non-Medicare actives and early retiree members, experienced positive cost trends. When combined with trends from the remaining plan groups, these results contribute to the overall allowed amount PMPY medical and prescription drug cost trend of 5.3%. Table 1, which shows Allowed Amount PMPY Trends for Top Health Plans by Membership, illustrates these in greater detail.

Table 1: Allowed Amount PMPY Trends for Top Health Plans by Membership

Health Plan	Average Membership Count (% of Total)	Allowed Amount PMPY Cost Trends
Dean	47,343 (23.1%)	7.6%
Network Health Plan	27,344 (13.3%)	4.0%
Quartz	76,491 (37.3%)	4.0%

- 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 actives 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).
- Over the past two annual periods, enrollment for employees and contract holders rose by 2.1% while member enrollment grew by 1.7%. Family sizes remained nearly unchanged, decreasing slightly by 0.4%.
- Among all the member types, spouses have the highest current monthly net payment per member cost, at $936, up from $883. Employees and contract holders follow closely, with costs rising from $843 to $894. Both groups show a similar cost trend of approximately 6.0%. In contrast, child dependents have the lowest cost, at $439, and the smallest cost trend, at 3.8% (Data Warehouse Dashboards, p. 8).

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

Attachment A: GHIP Dashboards