# ILLUSTRATIVE ONLY

# State of Delaware - Cost Tracking System

## FY2016 Cost Analysis -- Paid Data Through Q4



August 2016

Willis Towers Watson

**State of Delaware**
Health Plan Cost Tracking Summary
FY2016 Cost Analysis -- Paid Data Through Q4
Executive Summary

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## Overall medical and prescription drug results

- Total active medical and prescription drug cost for the period of April 1, 2016 through June 30, 2016 is $xx.x which is approximately x.x% or $xx.x under budget.
  - Active total medical/Rx cost: $xx.x (x.x% below budget)
  - Non-Medicare Retiree total medical/Rx cost: $xx.x (x.x% above budget)
  - Medicare Retiree total medical/Rx cost: $xx.x million (x.x% below budget)

## Summary plan information

- Summary Plan Information through June 2016

| FY 2016 | Aetna | Highmark | Active | Non-Medicare Retiree | Medicare Retiree | Total |
|---|---|---|---|---|---|---|
| **Summary (total)** | | | | | | |
| Total cost ($m) | $xx.x | $xx.x | $xx.x | $xx.x | $xx.x | $xx.x |
| Budgeted cost ($m) | $xx.x | $xx.x | $xx.x | $xx.x | $xx.x | $xx.x |
| Loss ratio | xx% | xx% | xx% | xx% | xx% | xx% |
| PEPY | $xx | $xx | $xx | $xx | $xx | $xx |
| # of enrolled employees | x,xxx | x,xxx | x,xxx | x,xxx | x,xxx | x,xxx |

## Key medical and prescription drug cost drivers

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- High cost claimants (>$100k) represent xx% of the State's total spend, up from xx% in the prior 12 month period
- Emergency room visits per 1,000 members increased by xx% in the most recent 12 month period
- The State's generic dispensing rate increased from xx% to xx% in the most recent 12 month period, but still falls below benchmark

## Additional notes

- Claims and other expenses are reported on a paid basis
- Medical/Rx budget is based on FY16 budget rates developed by Segal Consulting. Costs include operating expenses.
- Paid claims and enrollment data based on reports from the Aetna, Highmark, and ESI. Costs include operating expenses.
- Expenses are broken down into two categories
  - ASO Fees: includes fees for vendor adminstration, COBRA administration, ACA-related (TRF & PCORI), Truven data analytics, and Segal and WTW consulting
  - Office Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
- No adjustments made to cost tracking for large claims as the State does not have stop loss insurance
- HRA dollars are assumed to be included in the reported claims
- Participating groups (such as University of DE) are included in the cost tracking, but are assumed to be 100% employer paid. As a result, reported net cost and cost share percentage may be skewed.

**State of Delaware**
Health Plan Cost Tracking Summary
FY2016 Cost Analysis -- Paid Data Through Q4
High Cost Claimant Summary

**ILLUSTRATIVE ONLY**

## High cost claimants (over $100K)

| Cumulative Medical/Rx Claims Total | | | | | |
|---|---|---|---|---|---|
| **Status** | **Vendor** | **Relationship** | **Age Range** | **Leading Diagnosis** | **Paid Claims** |
| Non-Medicare Retiree | Aetna | Wife | 60-69 | Diagnosis 1 | $xxx,xxx |
| Active | Aetna | Husband | 50-59 | Diagnosis 2 | $xxx,xxx |
| Termed | Highmark | Subscriber | 40-49 | Diagnosis 3 | $xxx,xxx |
| Active | Highmark | Subscriber | 40-49 | Diagnosis 4 | $xxx,xxx |
| Medicare Retiree | Aetna | Subscriber | 60-69 | Diagnosis 5 | $xxx,xxx |
| Non-Medicare Retiree | Aetna | Wife | 60-69 | Diagnosis 6 | $xxx,xxx |
| Active | Aetna | Husband | 50-59 | Diagnosis 7 | $xxx,xxx |
| Termed | Highmark | Subscriber | 50-59 | Diagnosis 8 | $xxx,xxx |
| Active | Aetna | Subscriber | 50-59 | Diagnosis 9 | $xxx,xxx |
| Medicare Retiree | Highmark | Subscriber | 60-69 | Diagnosis 10 | $xxx,xxx |
| Non-Medicare Retiree | Highmark | Wife | 60-69 | Diagnosis 11 | $xxx,xxx |
| Active | Aetna | Husband | 50-59 | Diagnosis 12 | $xxx,xxx |
| Termed | Highmark | Subscriber | 40-49 | Diagnosis 13 | $xxx,xxx |
| Active | Aetna | Subscriber | 50-59 | Diagnosis 14 | $xxx,xxx |
| Medicare Retiree | Highmark | Subscriber | 60-69 | Diagnosis 15 | $xxx,xxx |
| Non-Medicare Retiree | Aetna | Wife | 60-69 | Diagnosis 16 | $xxx,xxx |
| Active | Highmark | Husband | 50-59 | Diagnosis 17 | $xxx,xxx |
| Termed | Highmark | Subscriber | 50-59 | Diagnosis 18 | $xxx,xxx |
| Active | Highmark | Subscriber | 60-69 | Diagnosis 19 | $xxx,xxx |
| HCC's above $100k | | | | | $xxx,xxx |

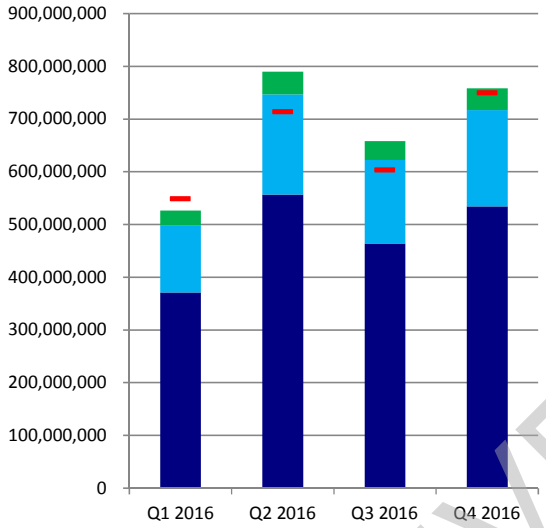
# State of Delaware

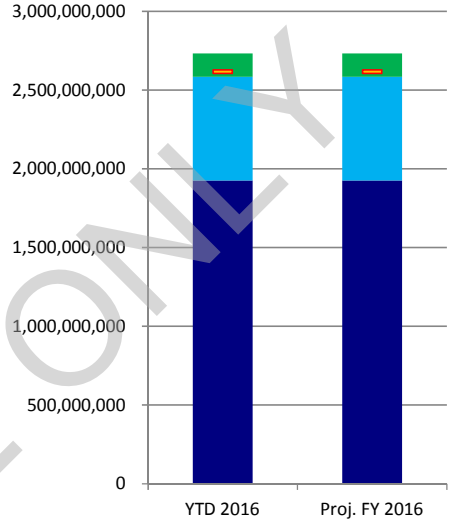
## Health and Welfare Financial Report

### Medical/Rx Specific Reporting

**ILLUSTRATIVE ONLY**

| | Drop-Down Choices |
|---|---|
| Status | Total |
| Vendor | Total |
| Plan | Total |




| | Q1 2016 | Q2 2016 | Q3 2016 | Q4 2016 | YTD 2016 | Proj. FY 2016 |
|---|---|---|---|---|---|---|
| **Total Program Cost** | **$528,373,217** | **$792,559,825** | **$660,466,521** | **$760,857,432** | **$2,742,256,994** | **$2,742,256,994** |
| - Paid Claims | 499,650,901 | 749,476,351 | 624,563,626 | 719,497,297 | 2,593,188,174 | 2,593,188,174 |
| **- Medical (includes capitation)** | 371,284,855 | 556,927,282 | 464,106,069 | 534,650,191 | 1,926,968,397 | 1,926,968,397 |
| *- Capitation* | 1,676,186 | 2,514,279 | 2,095,233 | 2,413,708 | 8,699,405 | 8,699,405 |
| **- Rx (Including Rebates and EGWP)** | 126,689,860 | 190,034,790 | 158,362,325 | 182,433,398 | 657,520,372 | 657,520,372 |
| *- EGWP* | (22,331,823) | (33,497,734) | (27,914,778) | (32,157,824) | (115,902,159) | (115,902,159) |
| - Direct Subsidy | (11,165,911) | (16,748,867) | (13,957,389) | (16,078,912) | (57,951,079) | (57,951,079) |
| - CGDP | (4,913,001) | (7,369,501) | (6,141,251) | (7,074,721) | (25,498,475) | (25,498,475) |
| - Catastrophic Reinsurance | (6,252,910) | (9,379,365) | (7,816,138) | (9,004,191) | (32,452,605) | (32,452,605) |
| *- Rx Rebates* | (29,878,023) | (44,817,034) | (37,347,529) | (43,024,353) | (155,066,939) | (155,066,939) |
| **- ASO Fees** | 20,796,545 | 31,194,817 | 25,995,681 | 29,947,024 | 107,934,067 | 107,934,067 |
| **- Operational Expenses** | 7,925,771 | 11,888,657 | 9,907,214 | 11,413,111 | 41,134,753 | 41,134,753 |
| **Medical/Rx Budget** | **$549,296,163** | **$714,085,011** | **$603,676,483** | **$749,789,262** | **$2,616,846,919** | **$2,616,846,919** |
| - Surplus/(Deficit) | 20,922,946 | (78,474,813) | (56,790,038) | (11,068,170) | (125,410,075) | (125,410,075) |
| - Total Cost as % of Budget | 96% | 111% | 109% | 101% | 105% | 105% |
| **Prior Year Results** | | | | | | |
| Program Cost | $517,805,752 | $808,411,021 | $660,459,916 | $715,205,986 | $2,701,882,676 | $2,701,882,676 |
| Change from Prior Period | $10,567,464 | ($15,851,196) | $6,605 | $45,651,446 | $40,374,318 | $40,374,318 |
| % Change from Prior Period | 2.0% | -2.0% | 0.0% | 6.4% | 1.5% | 1.5% |
| **EE Contributions** | **$15,352,844** | **$23,029,266** | **$19,191,055** | **$22,108,095** | **$79,681,261** | **$79,681,261** |
| - Net SoD[1] | 513,020,372 | 769,530,559 | 641,275,466 | 738,749,336 | 2,662,575,733 | 2,662,575,733 |
| - SoD Subsidy % | 97% | 97% | 97% | 97% | 97% | 97% |
| **Headcount** | | | | | | |
| - Enrolled Ees | 67,848 | 67,748 | 67,998 | 67,898 | 67,873 | 67,873 |
| - Enrolled Members | 122,470 | 122,289 | 122,741 | 122,560 | 122,515 | 122,515 |
| - Member/EE Ratio | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 |
| **Per Capita** | | | | | | |
| - Gross PEPM | $2,596 | $3,900 | $3,238 | $3,735 | $3,367 | $3,367 |
| - Net PEPM | $2,520 | $3,786 | $3,144 | $3,627 | $3,269 | $3,269 |
| - Gross PMPM | $1,438 | $2,160 | $1,794 | $2,069 | $1,865 | $1,865 |
| - Net PMPM | $1,396 | $2,098 | $1,742 | $2,009 | $1,811 | $1,811 |

[1] Participating groups are assumed to be 100% ER funded. This result may be skewed due to this assumption.

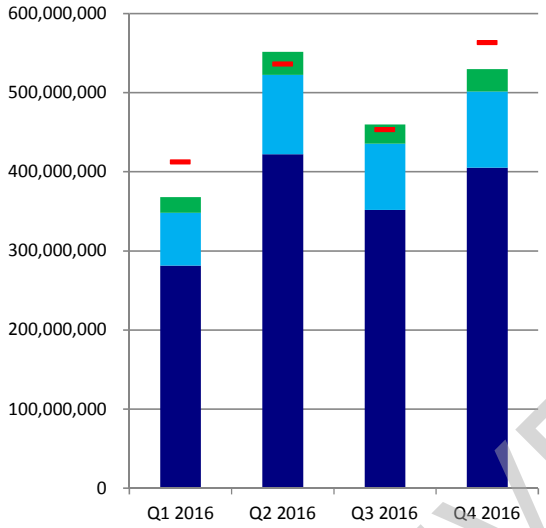
# State of Delaware

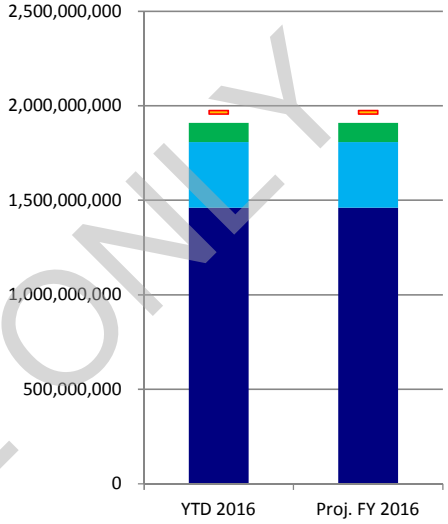
## Health and Welfare Financial Report

### Medical/Rx Specific Reporting

**ILLUSTRATIVE ONLY**

| | Drop-Down Choices |
|---|---|
| Status | Active |
| Vendor | Total |
| Plan | Total |




| | Q1 2016 | Q2 2016 | Q3 2016 | Q4 2016 | YTD 2016 | Proj. FY 2016 |
|---|---|---|---|---|---|---|
| **Total Program Cost** | **$369,525,991** | **$554,288,986** | **$461,907,489** | **$532,117,427** | **$1,917,839,893** | **$1,917,839,893** |
| - Paid Claims | 350,010,465 | 525,015,698 | 437,513,082 | 504,015,070 | 1,816,554,315 | 1,816,554,315 |
| **- Medical (includes capitation)** | 281,479,181 | 422,218,772 | 351,848,977 | 405,330,021 | 1,460,876,951 | 1,460,876,951 |
| *- Capitation* | 1,487,618 | 2,231,427 | 1,859,523 | 2,142,170 | 7,720,737 | 7,720,737 |
| **- Rx (Including Rebates and EGWP)** | 67,043,666 | 100,565,499 | 83,804,582 | 96,542,879 | 347,956,626 | 347,956,626 |
| *- EGWP* | 0 | 0 | 0 | 0 | 0 | 0 |
| - Direct Subsidy | 0 | 0 | 0 | 0 | 0 | 0 |
| - CGDP | 0 | 0 | 0 | 0 | 0 | 0 |
| - Catastrophic Reinsurance | 0 | 0 | 0 | 0 | 0 | 0 |
| *- Rx Rebates* | (12,735,818) | (19,103,727) | (15,919,773) | (18,339,578) | (66,098,896) | (66,098,896) |
| **- ASO Fees** | 14,353,853 | 21,530,780 | 17,942,317 | 20,669,549 | 74,496,499 | 74,496,499 |
| **- Operational Expenses** | 5,161,672 | 7,742,508 | 6,452,090 | 7,432,808 | 26,789,079 | 26,789,079 |
| **Medical/Rx Budget** | **$412,740,579** | **$536,562,752** | **$453,601,896** | **$563,390,890** | **$1,966,296,117** | **$1,966,296,117** |
| - Surplus/(Deficit) | 43,214,588 | (17,726,234) | (8,305,593) | 31,273,463 | 48,456,223 | 48,456,223 |
| - Total Cost as % of Budget | 90% | 103% | 102% | 94% | 98% | 98% |
| **Prior Year Results** | | | | | | |
| Program Cost | $362,135,471 | $565,374,766 | $461,902,870 | $500,190,381 | $1,889,603,488 | $1,889,603,488 |
| Change from Prior Period | $7,390,520 | ($11,085,780) | $4,619 | $31,927,046 | $28,236,405 | $28,236,405 |
| % Change from Prior Period | 2.0% | -2.0% | 0.0% | 6.4% | 1.5% | 1.5% |
| **EE Contributions** | **$15,352,844** | **$23,029,266** | **$19,191,055** | **$22,108,095** | **$79,681,261** | **$79,681,261** |
| - Net SoD[1] | 354,173,147 | 531,259,720 | 442,716,434 | 510,009,332 | 1,838,158,632 | 1,838,158,632 |
| - SoD Subsidy % | 96% | 96% | 96% | 96% | 96% | 96% |
| **Headcount** | | | | | | |
| - Enrolled Ees | 37,369 | 37,269 | 37,519 | 37,419 | 37,394 | 37,394 |
| - Enrolled Members | 88,584 | 88,347 | 88,940 | 88,703 | 88,643 | 88,643 |
| - Member/EE Ratio | 2.4 | 2.4 | 2.4 | 2.4 | 2.4 | 2.4 |
| **Per Capita** | | | | | | |
| - Gross PEPM | $3,296 | $4,958 | $4,104 | $4,740 | $4,274 | $4,274 |
| - Net PEPM | $3,159 | $4,752 | $3,933 | $4,543 | $4,096 | $4,096 |
| - Gross PMPM | $1,390 | $2,091 | $1,731 | $2,000 | $1,803 | $1,803 |
| - Net PMPM | $1,333 | $2,004 | $1,659 | $1,917 | $1,728 | $1,728 |

[1] Participating groups are assumed to be 100% ER funded. This result may be skewed due to this assumption.

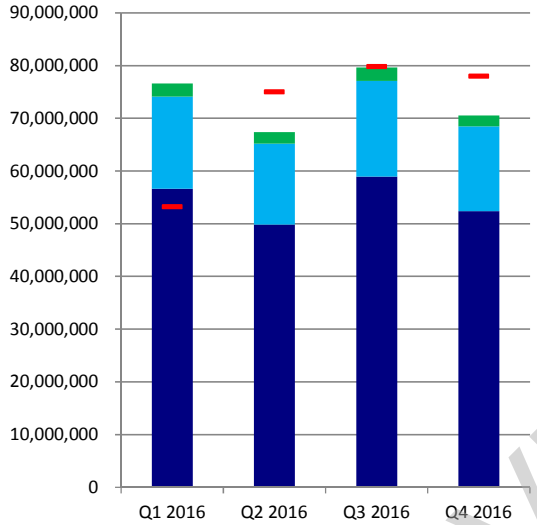
# State of Delaware

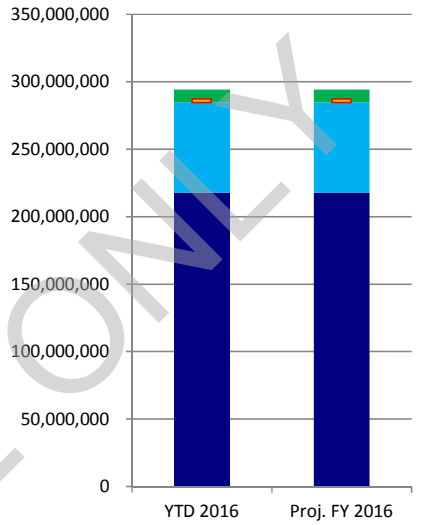
## Health and Welfare Financial Report

### Medical/Rx Specific Reporting

**ILLUSTRATIVE ONLY**

| | Drop-Down Choices |
|---|---|
| Status | Non-Medicare Retiree |
| Vendor | Total |
| Plan | Total |




| | Q1 2016 | Q2 2016 | Q3 2016 | Q4 2016 | YTD 2016 | Proj. FY 2016 |
|---|---|---|---|---|---|---|
| **Total Program Cost** | **$77,477,933** | **$68,180,581** | **$80,577,050** | **$71,339,497** | **$297,575,061** | **$297,575,061** |
| - Paid Claims | 74,319,938 | 65,401,545 | 77,292,735 | 68,671,622 | 285,685,841 | 285,685,841 |
| **- Medical (includes capitation)** | 56,689,200 | 49,886,496 | 58,956,768 | 52,380,821 | 217,913,285 | 217,913,285 |
| *- Capitation* | 188,568 | 165,940 | 196,111 | 174,237 | 724,855 | 724,855 |
| **- Rx (Including Rebates and EGWP)** | 17,442,170 | 15,349,109 | 18,139,856 | 16,116,565 | 67,047,700 | 67,047,700 |
| *- EGWP* | 0 | 0 | 0 | 0 | 0 | 0 |
| - Direct Subsidy | 0 | 0 | 0 | 0 | 0 | 0 |
| - CGDP | 0 | 0 | 0 | 0 | 0 | 0 |
| - Catastrophic Reinsurance | 0 | 0 | 0 | 0 | 0 | 0 |
| *- Rx Rebates* | (2,838,438) | (2,497,826) | (2,951,976) | (2,622,717) | (10,910,957) | (10,910,957) |
| **- ASO Fees** | 2,478,698 | 2,181,254 | 2,577,846 | 2,094,004 | 9,331,801 | 9,331,801 |
| **- Operational Expenses** | 679,297 | 597,782 | 706,469 | 573,871 | 2,557,419 | 2,557,419 |
| **Medical/Rx Budget** | **$53,157,286** | **$74,951,774** | **$79,735,930** | **$77,949,845** | **$285,794,835** | **$285,794,835** |
| - Surplus/(Deficit) | (23,641,349) | 6,771,193 | (841,121) | 6,610,348 | (11,780,227) | (11,780,227) |
| - Total Cost as % of Budget | 144% | 91% | 101% | 92% | 104% | 104% |
| **Prior Year Results** | | | | | | |
| Program Cost | $75,262,663 | $69,544,193 | $83,800,132 | $68,485,917 | $297,092,905 | $297,092,905 |
| Change from Prior Period | $1,535,973 | ($1,363,612) | ($3,223,082) | $2,853,580 | $482,156 | $482,156 |
| % Change from Prior Period | 2.0% | -2.0% | -3.8% | 4.2% | 0.2% | 0.2% |
| **EE Contributions** | **$15,352,844** | **$13,510,503** | **$15,966,958** | **$14,186,028** | **$59,016,333** | **$59,016,333** |
| - Net SoD1 | 61,445,791 | 54,670,078 | 64,610,092 | 57,153,469 | 238,558,729 | 238,558,729 |
| - SoD Subsidy % | 80% | 80% | 80% | 80% | 80% | 80% |
| **Headcount** | | | | | | |
| - Enrolled Ees | 6,370 | 6,270 | 6,520 | 6,420 | 6,395 | 6,395 |
| - Enrolled Members | 9,777 | 9,624 | 10,007 | 9,854 | 9,815 | 9,815 |
| - Member/EE Ratio | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 |
| **Per Capita** | | | | | | |
| - Gross PEPM | $4,019 | $3,625 | $4,119 | $3,704 | $3,878 | $3,878 |
| - Net PEPM | $3,215 | $2,906 | $3,303 | $2,967 | $3,109 | $3,109 |
| - Gross PMPM | $2,618 | $2,362 | $2,684 | $2,413 | $2,526 | $2,526 |
| - Net PMPM | $2,095 | $1,894 | $2,152 | $1,933 | $2,025 | $2,025 |

1 Participating groups are assumed to be 100% ER funded. This result may be skewed due to this assumption.

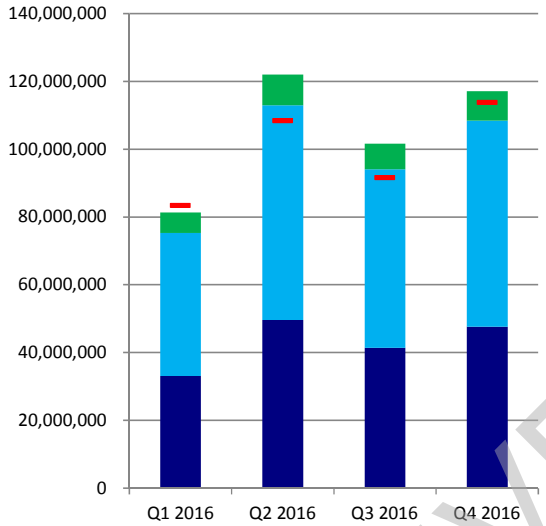
# State of Delaware

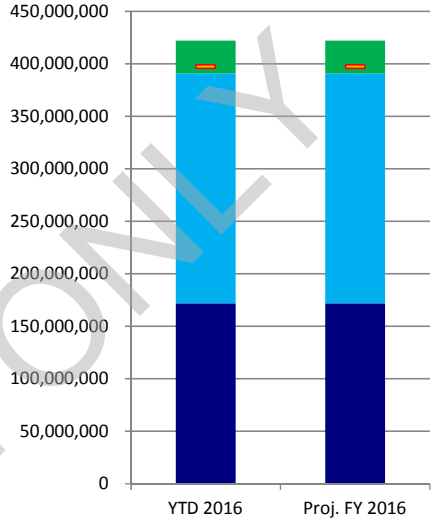
## Health and Welfare Financial Report

### Medical/Rx Specific Reporting

**ILLUSTRATIVE ONLY**

| | Drop-Down Choices |
|---|---|
| Status | Medicare Retiree |
| Vendor | Total |
| Plan | Total |




| | Q1 2016 | Q2 2016 | Q3 2016 | Q4 2016 | YTD 2016 | Proj. FY 2016 |
|---|---|---|---|---|---|---|
| **Total Program Cost** | **$81,369,293** | **$122,053,939** | **$101,711,616** | **$117,171,781** | **$422,306,628** | **$422,306,628** |
| - Paid Claims | 75,320,498 | 112,980,746 | 94,150,622 | 108,461,517 | 390,913,383 | 390,913,383 |
| **- Medical (includes capitation)** | 33,116,473 | 49,674,710 | 41,395,592 | 47,687,722 | 171,874,497 | 171,874,497 |
| *- Capitation* | 0 | 0 | 0 | 0 | 0 | 0 |
| **- Rx (Including Rebates and EGWP)** | 42,204,024 | 63,306,036 | 52,755,030 | 60,773,795 | 219,038,885 | 219,038,885 |
| *- EGWP* | (22,331,823) | (33,497,734) | (27,914,778) | (32,157,824) | (115,902,159) | (115,902,159) |
| - Direct Subsidy | (11,165,911) | (16,748,867) | (13,957,389) | (16,078,912) | (57,951,079) | (57,951,079) |
| - CGDP | (4,913,001) | (7,369,501) | (6,141,251) | (7,074,721) | (25,498,475) | (25,498,475) |
| - Catastrophic Reinsurance | (6,252,910) | (9,379,365) | (7,816,138) | (9,004,191) | (32,452,605) | (32,452,605) |
| *- Rx Rebates* | (14,303,767) | (21,455,650) | (17,879,708) | (20,597,424) | (74,236,549) | (74,236,549) |
| **- ASO Fees** | 3,963,994 | 5,945,990 | 4,954,992 | 5,708,151 | 20,573,127 | 20,573,127 |
| **- Operational Expenses** | 2,084,801 | 3,127,202 | 2,606,002 | 3,002,114 | 10,820,119 | 10,820,119 |
| **Medical/Rx Budget** | **$83,398,298** | **$108,417,787** | **$91,654,729** | **$113,838,676** | **$397,309,490** | **$397,309,490** |
| - Surplus/(Deficit) | 2,029,005 | (13,636,152) | (10,056,887) | (3,333,105) | (24,997,139) | (24,997,139) |
| - Total Cost as % of Budget | 98% | 113% | 111% | 103% | 106% | 106% |
| **Prior Year Results** | | | | | | |
| Program Cost | $79,741,907 | $124,495,018 | $101,710,599 | $110,141,474 | $416,088,997 | $416,088,997 |
| Change from Prior Period | $1,627,386 | ($2,441,079) | $1,017 | $7,030,307 | $6,217,631 | $6,217,631 |
| % Change from Prior Period | 2.0% | -2.0% | 0.0% | 6.4% | 1.5% | 1.5% |
| **EE Contributions** | **$15,352,844** | **$23,029,266** | **$19,191,055** | **$22,108,095** | **$79,681,261** | **$79,681,261** |
| - Net SoD[1] | 66,016,448 | 99,024,673 | 82,520,561 | 95,063,686 | 342,625,368 | 342,625,368 |
| - SoD Subsidy % | 81% | 81% | 81% | 81% | 81% | 81% |
| **Headcount** | | | | | | |
| - Enrolled Ees | 24,109 | 24,009 | 24,259 | 24,159 | 24,134 | 24,134 |
| - Enrolled Members | 24,109 | 24,009 | 24,259 | 24,159 | 24,134 | 24,134 |
| - Member/EE Ratio | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| **Per Capita** | | | | | | |
| - Gross PEPM | $1,125 | $1,695 | $1,398 | $1,617 | $1,458 | $1,458 |
| - Net PEPM | $913 | $1,375 | $1,134 | $1,312 | $1,183 | $1,183 |
| - Gross PMPM | $1,125 | $1,695 | $1,398 | $1,617 | $1,458 | $1,458 |
| - Net PMPM | $913 | $1,375 | $1,134 | $1,312 | $1,183 | $1,183 |

[1] Participating groups are assumed to be 100% ER funded. This result may be skewed due to this assumption.

# State of Delaware
## FY2016 Financial Analysis of Health/Rx Plans - Paid Basis
## Year to Date July 1, 2015 - June 30, 2016

| Vendor | Highmark | | | | | | | | | | | Aetna | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | Basic Active | Basic Non Medicare Retirees | PPO Active | PPO Non Medicare Retirees | CDH Active | CDH Non Medicare Retirees | Medicare Primary Retirees | Blue Care HMO Active | Blue Care HMO Non Medicare Retirees | POS | Total Highmark | Aetna HMO Active | Aetna HMO Non Medicare Retirees | Aetna CDH Active | Aetna CDH Non Medicare Retirees | Total Aetna | Total |
| **Medical** | | | | | | | | | | | | | | | | | |
| Paid Claims | $4,199,663 | $769,563 | $162,244,650 | $31,261,780 | $5,924,394 | $991,644 | $33,116,473 | $88,312,946 | $18,313,794 | $2,280,299 | $347,415,206 | $15,319,001 | $5,036,666 | $1,710,610 | $127,186 | $22,193,463 | $369,608,669 |
| Capitation | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,487,618 | $188,568 | $0 | $0 | $1,676,186 | $1,676,186 |
| Administration | $314,625 | $36,571 | $7,054,392 | $1,327,551 | $490,315 | $32,485 | $3,324,149 | $4,310,513 | $695,841 | $95,639 | $17,682,080 | $1,147,492 | $212,945 | $173,167 | $11,663 | $1,545,267 | $19,227,347 |
| Total Medical Program Cost | $4,514,288 | $806,134 | $169,299,042 | $32,589,330 | $6,414,709 | $1,024,129 | $36,440,622 | $92,623,459 | $19,009,635 | $2,375,937 | $365,097,285 | $17,954,111 | $5,438,179 | $1,883,777 | $138,849 | $25,414,916 | $390,512,202 |
| Average Number of Employees | 872 | 101 | 19,547 | 3,678 | 1,325 | 88 | 24,109 | 12,389 | 2,000 | 265 | 64,374 | 2,560 | 475 | 411 | 28 | 3,474 | 67,848 |
| Program Cost/Employee/Yr. | $6,903 | $59,595 | $308 | $1,637 | $4,543 | $68,398 | $250 | $486 | $3,010 | $22,713 | $94 | $2,351 | $12,672 | $14,645 | $214,966 | $1,733 | $89 |
| Change from prior period (pepy) | 54.1% | 494.7% | -97.4% | -86.9% | -26.6% | 591.2% | -87.2% | -95.2% | -74.7% | 98.3% | -98.8% | -76.8% | 27.3% | 200.7% | 3987.1% | -81.9% | -98.9% |
| Average Number of Members | 1,583 | 141 | 46,115 | 5,516 | 2,810 | 137 | 24,109 | 30,566 | 3,152 | 522 | 114,651 | 6,165 | 794 | 823 | 37 | 7,819 | 122,470 |
| Program Cost/Member/Yr. | $3,802 | $42,688 | $131 | $1,091 | $2,142 | $43,935 | $250 | $197 | $1,910 | $11,531 | $52 | $976 | $7,581 | $7,314 | $162,677 | $770 | $49 |
| Change from prior period (pmpy) | 53.1% | 490.3% | -97.4% | -87.0% | -27.2% | 569.0% | -87.2% | -95.1% | -74.8% | 101.9% | -98.8% | -76.9% | 26.6% | 193.6% | 4532.2% | -81.9% | -98.8% |
| **Express Scripts, Inc.** | | | | | | | | | | | | | | | | | |
| Paid Claims | $643,467 | $150,711 | $46,794,645 | $12,658,776 | $1,661,632 | $165,553 | $78,839,613 | $24,484,027 | $5,633,642 | $467,817 | $171,499,884 | $5,129,679 | $1,642,125 | $598,217 | $29,800 | $7,399,821 | $178,899,705 |
| Administration | $8,038 | $1,821 | $428,991 | $95,906 | $18,916 | $1,459 | $639,845 | $255,511 | $50,190 | $5,259 | $1,505,936 | $45,794 | $11,853 | $5,202 | $412 | $63,262 | $1,569,198 |
| Estimated EGWP Savings | | | | | | | ($22,331,823) | | | | ($22,331,823) | | | | | | ($22,331,823) |
| Estimated Rebates | ($125,479) | ($31,180) | ($7,311,502) | ($1,718,889) | ($301,473) | ($25,153) | ($14,303,767) | ($4,098,129) | ($857,892) | ($86,593) | ($28,860,058) | ($730,768) | ($198,118) | ($81,873) | ($7,206) | ($1,017,965) | ($29,878,023) |
| Total Rx Program Cost | $526,027 | $121,353 | $39,912,134 | $11,035,792 | $1,379,075 | $141,859 | $42,843,869 | $20,641,409 | $4,825,940 | $386,483 | $121,813,939 | $4,444,705 | $1,455,861 | $521,546 | $23,007 | $6,445,119 | $128,259,058 |
| Average Number of Employees | 872 | 101 | 19,547 | 3,678 | 1,325 | 88 | 24,109 | 12,389 | 2,000 | 265 | 64,374 | 2,560 | 475 | 411 | 28 | 3,474 | 67,848 |
| Program Cost/Employee/Yr. | $804 | $1,602 | $2,722 | $4,001 | $1,388 | $2,149 | $2,369 | $2,221 | $3,217 | $1,945 | $2,523 | $2,315 | $4,087 | $1,692 | $1,096 | $2,474 | $2,521 |
| Change from prior period (pepy) | 9.2% | 66.8% | -1.7% | 7.6% | -20.0% | -28.2% | -38.0% | -3.8% | -0.1% | -41.6% | -18.3% | 0.1% | -2.7% | 25.7% | -14.1% | -0.5% | -17.6% |
| Average Number of Members | 1,583 | 141 | 46,115 | 5,516 | 2,810 | 137 | 24,109 | 30,566 | 3,152 | 522 | 114,651 | 6,165 | 794 | 823 | 37 | 7,819 | 122,470 |
| Program Cost/Member/Yr. | $443 | $1,148 | $1,154 | $2,668 | $654 | $1,381 | $2,369 | $900 | $2,041 | $987 | $1,417 | $961 | $2,445 | $845 | $829 | $1,099 | $1,396 |
| Change from prior period (pmpy) | 8.5% | 65.6% | -2.3% | 6.5% | -20.7% | -30.5% | -38.0% | -3.7% | -0.5% | -40.5% | -18.0% | -0.1% | -3.2% | 22.8% | -2.6% | -0.7% | -17.3% |
| **Total Medical and Rx** | | | | | | | | | | | | | | | | | |
| Premium | $7,267,931 | $734,183 | $223,944,819 | $31,173,472 | $12,838,180 | $720,133 | $83,398,298 | $135,567,511 | $16,330,723 | $2,023,471 | $513,998,720 | $27,282,550 | $4,004,918 | $3,816,117 | $193,857 | $35,297,443 | $549,296,163 |
| Program Cost (prior to other admin) | $5,040,315 | $942,592 | $212,287,856 | $43,449,854 | $7,502,004 | $1,146,426 | $81,885,894 | $114,707,096 | $24,153,191 | $2,782,120 | $494,256,542 | $22,613,436 | $7,173,554 | $2,528,287 | $167,250 | $32,482,527 | $526,739,069 |
| Total Program Cost | $5,040,315 | $942,592 | $212,287,856 | $43,449,854 | $7,502,004 | $1,146,426 | $81,885,894 | $114,707,096 | $24,153,191 | $2,782,120 | $494,256,542 | $22,613,436 | $7,173,554 | $2,528,287 | $167,250 | $32,482,527 | $526,739,069 |
| Surplus / (Deficit) | $2,227,616 | ($208,408) | $11,656,963 | ($12,276,382) | $5,336,175 | ($426,293) | $1,512,403 | $20,860,415 | ($7,822,468) | ($758,649) | $19,742,177 | $4,669,114 | ($3,168,636) | $1,287,830 | $26,608 | $2,814,916 | $22,557,094 |
| **Total Cost as % of Budget** | **30.6%** | **-28.4%** | **5.2%** | **-39.4%** | **41.6%** | **-59.2%** | **1.8%** | **15.4%** | **-47.9%** | **-37.5%** | **3.8%** | **17.1%** | **-79.1%** | **33.7%** | **13.7%** | **8.0%** | **4.1%** |
| Average Number of Employees | 872 | 101 | 19,547 | 3,678 | 1,325 | 88 | 24,109 | 12,389 | 2,000 | 265 | 64,374 | 2,560 | 475 | 411 | 28 | 3,474 | 67,848 |
| Program Cost/Employee/Yr. | $7,707 | $12,443 | $14,481 | $15,751 | $7,549 | $17,370 | $4,529 | $12,345 | $16,102 | $13,998 | $10,237 | $11,778 | $20,136 | $8,202 | $7,964 | $12,467 | $10,351 |
| Change from prior period (pepy) | 46.0% | 12.7% | -0.2% | -3.1% | -5.4% | 34.1% | -22.3% | -0.4% | 6.0% | -5.7% | -5.1% | -5.9% | 41.6% | 30.6% | 20.7% | 2.9% | -4.7% |
| Average Number of Members | 1,583 | 141 | 46,115 | 5,516 | 2,810 | 137 | 24,109 | 30,566 | 3,152 | 522 | 114,651 | 6,165 | 794 | 823 | 37 | 7,819 | 122,470 |
| Program Cost/Member/Yr. | $4,245 | $8,913 | $6,138 | $10,503 | $3,560 | $11,157 | $4,529 | $5,004 | $10,217 | $7,106 | $5,748 | $4,891 | $12,046 | $4,096 | $6,027 | $5,539 | $5,735 |
| Change from prior period (pmpy) | 45.0% | 11.8% | -0.8% | -4.1% | -6.2% | 29.8% | -22.3% | -0.3% | 5.6% | -4.0% | -4.8% | -6.1% | 40.9% | 27.6% | 36.8% | 2.6% | -4.4% |
| **Prior Period Program Cost** | | | | | | | | | | | | | | | | | |
| ***Per Employee Per Year*** | | | | | | | | | | | | | | | | | |
| Medical | $4,479 | $10,021 | $11,678 | $12,480 | $6,185 | $9,896 | $1,944 | $10,021 | $11,913 | $11,454 | $7,640 | $10,143 | $9,957 | $4,871 | $5,260 | $9,571 | $7,740 |
| Rx | $736 | $960 | $2,770 | $3,720 | $1,734 | $2,993 | $3,823 | $2,309 | $3,220 | $3,328 | $3,089 | $2,312 | $4,201 | $1,346 | $1,275 | $2,486 | $3,058 |
| Total | $5,277 | $11,043 | $14,511 | $16,262 | $7,981 | $12,951 | $5,829 | $12,393 | $15,196 | $14,844 | $10,791 | $12,517 | $14,219 | $6,279 | $6,597 | $12,119 | $10,860 |
| ***Per Member Per Year*** | | | | | | | | | | | | | | | | | |
| Medical | $2,484 | $7,231 | $4,977 | $8,405 | $2,941 | $6,567 | $1,944 | $4,058 | $7,587 | $5,712 | $4,274 | $4,222 | $5,988 | $2,491 | $3,512 | $4,263 | $4,273 |
| Rx | $408 | $693 | $1,181 | $2,505 | $825 | $1,986 | $3,823 | $935 | $2,051 | $1,660 | $1,728 | $962 | $2,526 | $688 | $852 | $1,107 | $1,688 |
| Total | $2,927 | $7,969 | $6,184 | $10,952 | $3,796 | $8,594 | $5,829 | $5,019 | $9,678 | $7,402 | $6,037 | $5,210 | $8,552 | $3,211 | $4,405 | $5,398 | $5,996 |

**ILLUSTRATIVE ONLY**

## Terms directly tied to cost tracking

| Terminology | Acronym | Definition |
|---|---|---|
| Administrative Services Only | ASO | When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as "self-funded". Currently, the GHIP has ASO contracts with Aetna, Highmark and Express Scripts. |
| Consumer Driven Health Plan | CDHP | Allows members to use health savings accounts, health reimbursement accounts, or other similar medical payment products to pay routine health care expenses directly. |
| Coverage Gap Discount Program | CGDP | One of the funding components of an *EGWP* . Manufacturers provide discounts on covered Part D prescription drugs to Medicare beneficiaries while in the coverage gap. |
| Employee | EE | A person employed for wages or salary, especially at nonexecutive level |
| Employer Group Waiver Plans | EGWP | Also known as a Series 800 Plan and is a Center for Medicare Service (CMS) approved program for both employers and unions. An employer may contract directly with CMS or go through an approved TPA such as ESI to establish the plan. They are usually Self Funded, are integrated with Medicare Part D, and sometimes include a fully insured "wrapper" around the plan to cover non-Medicare Part D prescription drugs. |
| Fiscal Year | FY | A year as reckoned for taxing or accounting purposes |
| Health Maintenance Organization | HMO | A form of health insurance combining a range of coverages in a group basis. A group of doctors and other medical professionals offer care through the HMO for a flat monthly rate with no deductibles. However, only visits to professionals within the HMO network are covered by the policy. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary physician within the HMO handles referrals. |
| Health Reimbursement Account | HRA | Employer-funded account that reimburses employees for out-of-pocket medical expenses. Employees can choose how to use their HRA funds to pay for medical expenses, but the employer can determine what expenses are reimbursable by the HRA (e.g., employers often designate prescription drug expenses as ineligible for reimbursement by an HRA). Funds are owned by the employer and are tax-deductible to the employee. |
| High Cost Claimant | HCC | An insured who incurs claims over a catastrophic claim limit during the plan year. For purposes of cost tracking, this threshold is $100K. |
| Human Resources | HR | A department within an organization that deals with the people who work for that organization |
| Per Employee Per Month | PEPM | A monthly cost basis measured on an employee/contract/subscriber level |
| Per Employee Per Year | PEPY | A yearly cost basis measured on an employee/contract/subscriber level |
| Per Member Per Month | PMPM | A monthly cost basis measured on a member level |
| Per Member Per Year | PMPY | A yearly cost basis measured on a member level |
| Patient-Centered Outcomes Research Trust Fund Fee | PCORI | The Patient-Centered Outcomes Research Trust Fund fee is a fee on plan sponsors of self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings. This fee is part of the Affordable Care Act legislation. |
| Point-of-Service | POS | A type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. |

| | | |
|---|---|---|
| Preferred Provider Organization | PPO | A health care organization composed of physicians, hospitals, or other providers which provides health care services at a reduced fee. A PPO is similar to an HMO, but care is paid for as it is received instead of in advance in the form of a scheduled fee. PPOs may also offer more flexibility by allowing for visits to out-of-network professionals at a greater expense to the policy holder. Visits within the network require only the payment of a small fee. There is often a deductible for out-of-network expenses and a higher co-payment. |
| Transitional Reinsurance Fee | TRF | Fee collected by the transitional reinsurance program to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years. This fee is part of the Affordable Care Act legislation, and ends after the 2016 benefit year. |
| Year to Date | YTD | A period, starting from the beginning of the current year (either the calendar year or fiscal year) and continuing up to the present day |

## Terms indirectly tied to cost tracking

| Terminology | Acronym | Definition |
|---|---|---|
| Accountable Care Organization | ACO | Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. |
| Actuarial Value | AV | Percentage of total average costs for covered benefits that a plan will cover. Bronze, silver, gold, and platinum are plans according to the Affordable Care Act that cover an increasingly greater share of enrollees' medical expenses. |
| Bundled Payment | n/a | Lump sum payment covering all health care services related to a specific procedure, episode of care, or population. Bundle is usually based on an acute event plus some specified time period following the event. Payments may be risk adjusted based on the severity of illness/injury or complexity of the procedure(s) covered. |
| Center of Excellence | COE | Provider that has been identified as delivering high quality services and superior outcomes for specific procedures and/or conditions. May incorporate separate contracting arrangements for a predetermined set of services (e.g., see *bundled payment*). |
| Diagnosis Related Group | DRG | A statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Payments may be risk adjusted based on the severity of illness/injury or complexity of the procedure(s) covered. |
| Electronic Medical Record | EMR | A digital version of a paper medical chart that contains all of a patient's medical history from one medical practice. An EMR is primarily used by doctors for diagnosis and treatment. |
| Evidence-Based Medicine | EBM | An approach to medical practice intended to help providers make decisions about the best possible care for individual patients by using the best evidence available from well-designed, scientifically tested research. |
| Fee-for-service | FFS | A traditional method for reimbursing medical providers for the services they administer to patients, in which a provider is allowed to charge a fee for each service rendered to a patient. Fees for providers who participate in a third-party administrator's network are typically determined as a percentage discount off of the provider's billed charge. |
| Flexible Spending Account, Full Use | FSA | A tax-advantaged financial account. Allows an employee to set aside a portion of earnings to pay for qualified medical, dental, and vision expenses. The IRS limit is $2,550, but can be set lower if the employer chooses. |
| Flexible Spending Account, Limited Purpose | FSA | A tax-advantaged financial account. Allows an employee to set aside a portion of earnings to pay for qualified dental and vision expenses only. The IRS limit is $2,550, but can be set lower if the employer chooses. May be used if a member is enrolled in an HSA. |
| Global Capitation | n/a | Fixed payment amount (per member) to a physician or group of physicians for a defined set of services for a defined set of members. Fixed or "capitated" payment per member provides physician with an incentive for meeting quality and cost efficiency outcomes, since the physician is responsible for any costs incurred above the capitated amount. May be risk adjusted based on the demographics of the member population or changes in the member population. Often used for *bundled payments* or other *value-based payments*. |
| Health Savings Account | HSA | Tax-advantaged savings account available to tax payers who are enrolled in an IRS-qualified *high deductible health plan* (i.e., an *account based health plan* that meets IRS guidelines for tax-advantaged status). Can be funded by the employer and/or the employee, up to certain annual limits specified by the IRS. An HSA is a "triple tax advantaged" account, meaning that an individual can deposit money into the account on a pre-tax basis (Federal tax free; the following states assess income tax on HSA deposits: AL, CA, NJ). Funds in an HSA grow at a tax-free rate, and distributions from an HSA are tax free if HSA funds are spent on medical expenses defined by the IRS as being "qualified" or eligible for reimbursement using the HSA. Funds used for non-qualified expenses are subject to taxation. Funds roll over from year to year if they are not spent. The HSA is owned by the individual accountholder and is theirs to keep even if they leave their employer or retire. |
| High Deductible Health Plan | HDHP | An *account based health plan* that meets IRS guidelines for tax-advantaged status and includes an *HSA*. |

| | | |
|---|---|---|
| High Performance Network | HPN | Typically found in heavily concentrated employer locations. Network provider selection is based on a provider's ability to meet certain cost/quality targets. Often requires provider agreement to accept *value based payments* in lieu of traditional *fee-for-service* arrangements. |
| Metric-Based Pricing | n/a | See *Reference-Based Pricing* |
| Minimum Value | MV | The minimum threshold for the *actuarial value* of a health plan under the Affordable Care Act. A plan with MV should cover at least 60% of the cost of all benefits, i.e., for every $1 spent on medical procedures and treatments, at least $0.60 will be covered by the plan. |
| Narrow Network | n/a | A smaller panel of providers that have agreed to deliver medical services at a reduced unit cost in exchange for a higher volume of patients that have been directed to the network through plan design incentives. |
| Partial Capitation | n/a | See above *Global Capitation* , for a defined set of services rendered by a physician or facility, rather than all services rendered by that provider. |
| Patient-Centered Medical Home | PCMH | A primary care physician who coordinates a team of clinicians providing a holistic approach to caring for a patient. Requires coordination across all elements of the health care system, including specialty care, hospitals, home health care, and community services. Often includes some sort of *value-based payment* to encourage favorable cost and quality outcomes. Also requires consistent and continual use of technology and data sharing to promote *evidence-based medicine* and provide an enhanced patient experience. |
| Pay-for-Performance | P4P | See *Value-Based Payment* |
| Pay-for-Value | n/a | See *Value-Based Payment* |
| Personal Health Record | PHR | An electronic portal, usually a website or an app, used by patients to track and manage their health information in a private, secure, and confidential environment. |
| Reference-Based Pricing | n/a | Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, and health plan members must pay the difference in price if they select a more costly health care provider or service. |
| Self-Funded | SF | See *Administrative Services Only* |
| Self-Insured | SI | See *Administrative Services Only* |
| Shared Risk, Upside/Downside | n/a | See *Value-Based Payment* |
| Shared Savings, Upside/Downside | n/a | See *Value-Based Payment* |
| Value-Based Network | n/a | See *High Performance Network* |
| Value-Based Payment | n/a | Paying a medical provider for meeting a predetermined set of performance goal, including quality, cost efficiency and/or referral/prescribing patterns of care. The payment structure and performance goals will vary based on the provider's willingness to accept responsibility for meeting the goals (i.e., "upside" risk may include a bonus payment if goals are met, "downside" risk may require the provider to pay a penalty to the third-party administrator if goals are not met). |