

State of Delaware - Quarterly Financial Reporting

FY17 Q1 Cost Analysis

January 2017

Willis Towers Watson 

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State of Delaware

Health Plan Quarterly Financial Reporting

FY17 Q1 Executive Summary

Overall medical and prescription drug results

- Total active and retiree medical and prescription drug cost for the period of July 1, 2016 through September 30, 2016 is \$190.5M which is approximately 96% of the \$199.3M budget (or 4.4% below budget), resulting in a surplus of \$8.8M
 - Active total medical/Rx cost: \$135.9M (8% below budget)
 - Non-Medicare eligible retiree total medical/Rx cost: \$27.3M (35% above budget)
 - Medicare eligible retiree total medical/Rx cost: \$27.4M (14% below budget)
- Overall medical and prescription drug costs per employee increased 3.6% over Q1 FY2016, and are projected to increase 5.4% over the full fiscal year

Summary plan information

- Summary Plan Information through September 2016

FY2017	Aetna	Highmark	Active	Non-Medicare Retiree	Medicare Retiree	Total
Summary (total)						
Total cost (\$M)	\$11.4	\$179.1	\$135.9	\$27.3	\$27.4	\$190.5
Budgeted cost (\$M)	\$12.7	\$186.6	\$147.2	\$20.2	\$31.8	\$199.3
Loss ratio	90%	96%	92%	135%	86%	96%
PEPY	\$13,079	\$11,012	\$14,532	\$17,171	\$4,412	\$11,117
# of enrolled employees	3,487	65,076	37,400	6,365	24,798	68,563

Key medical and prescription drug cost drivers - Actives

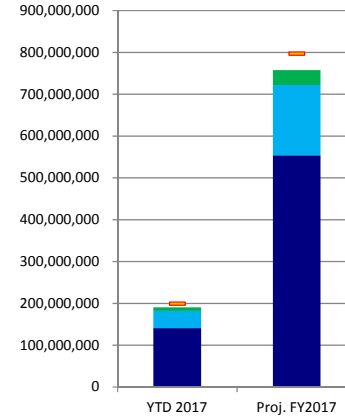
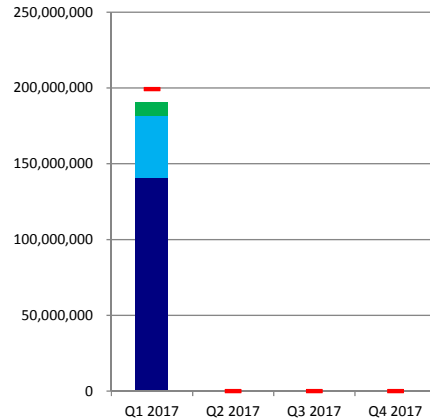
- Truven Executive Dashboard for October 2015-September 2016 (compared to October 2014-September 2015 prior period) details the following emerging trends and cost drivers:
 - Average payments per high cost patient (\geq \$100k in medical and Rx net payments) have increased 5%, while total payments for high cost patients increased 8% to \$105.7M
 - FY2016 (July 2015-June 2016) member risk score has increased 10% over FY2015 (July 2014-June 2015)
 - Allowed amounts for inpatient admit and outpatient service remain well above benchmarks; emergency room visits per 1,000 members also remain well above benchmark
 - Chronic condition prevalence continues to be significantly above benchmark for Asthma, Coronary Artery Disease, Diabetes, Hypertension, Osteoarthritis, Depression and Low Back Disorder
 - Generic drug dispensing rate has increased 4% over the prior period to 81%
 - The percentage of allowed drug costs for specialty prescriptions has increased 7% over the prior period to 29%

Additional notes

- Claims and other expenses are reported on a paid basis
- Medical/Rx budget is based on FY2017 budget rates developed by Segal Consulting.
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI. Costs include operating expenses.
- Expenses are broken down into two categories:
 - ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (TRF & PCORI), Truven data analytics, EAP and Segal and WTW consulting
 - Office Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
- Rx rebates and EGWP payments are shown based on the period to which the offsets are attributable, rather than the actual payment received in a given period. Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis.
- Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis
- 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% employee paid. As a result, reported net cost and cost share percentages may be skewed.

State of Delaware
Health Plan Quarterly Financial Reporting
FY17 Q1 High Cost Claims Analysis

Drop-Down Choices	
Status	Total
Vendor	Total
Plan	Total



Legend	
—	Medical/Rx Budget
■	Fees and Op. Expenses
■	Rx (incl. Rebates and EGWP)
■	Medical (incl. capitation)

	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total Program Cost	\$190,549,549	N/A	N/A	N/A
- Paid Claims	181,671,860	N/A	N/A	N/A
- Medical (includes capitation¹)	140,935,442	N/A	N/A	N/A
- Capitation	616,436	N/A	N/A	N/A
- Rx (including Rebates and EGWP)	40,736,418	N/A	N/A	N/A
- Rx Paid Claims	61,533,669	N/A	N/A	N/A
- EGWP	(9,555,483)	N/A	N/A	N/A
- Direct Subsidy	(1,995,813)	N/A	N/A	N/A
- CGDP	(4,738,898)	N/A	N/A	N/A
- Catastrophic Reinsurance	(2,820,773)	N/A	N/A	N/A
- Rx Rebates ²	(11,241,768)	N/A	N/A	N/A
- ASO Fees	8,195,098	N/A	N/A	N/A
- Operational Expenses	682,591	N/A	N/A	N/A
Medical/Rx Budget	\$199,286,480	N/A	N/A	N/A
- Surplus/(Deficit)	8,736,931	N/A	N/A	N/A
- Total Cost as % of Budget	96%	N/A	N/A	N/A
Current Year Per Capita				
- Medical per employee per year	8,652	N/A	N/A	N/A
- Rx per employee per year	2,425	N/A	N/A	N/A
- Total per employee per year ³	11,117	N/A	N/A	N/A
- Medical per member per year	4,811	N/A	N/A	N/A
- Rx per member per year	1,348	N/A	N/A	N/A
- Total per member per year ³	6,181	N/A	N/A	N/A
Prior Year Results				
- Total Program Cost ³	181,013,303	N/A	N/A	N/A
\$ change	9,536,246	N/A	N/A	N/A
- Total per employee per year ³	10,726	N/A	N/A	N/A
% change	3.6%	N/A	N/A	N/A
- Medical per employee per year	8,022	N/A	N/A	N/A
% change	7.9%	N/A	N/A	N/A
- Rx per employee per year	2,668	N/A	N/A	N/A
% change	-9.1%	N/A	N/A	N/A
EE Contributions	\$40,187,984	N/A	N/A	N/A
- Net SoD ⁴	150,361,566	N/A	N/A	N/A
- SoD Subsidy %	79%	N/A	N/A	N/A
Headcount				
- Enrolled Ees	68,563	N/A	N/A	N/A
- Enrolled Members	123,320	N/A	N/A	N/A
- Member/EE Ratio	1.8	N/A	N/A	N/A

	YTD 2017	Proj. FY2017 ⁴
Total Program Cost	\$190,549,549	\$757,329,116
- Paid Claims	181,671,860	721,792,751
- Medical (includes capitation¹)	140,935,442	553,797,113
- Capitation	616,436	2,363,256
- Rx (including Rebates and EGWP)	40,736,418	167,995,638
- Rx Paid Claims	61,533,669	248,352,837
- EGWP	(9,555,483)	(34,984,884)
- Direct Subsidy	(1,995,813)	(6,800,717)
- CGDP	(4,738,898)	(16,343,122)
- Catastrophic Reinsurance	(2,820,773)	(11,841,045)
- Rx Rebates ²	(11,241,768)	(45,372,315)
- ASO Fees	8,195,098	32,780,393
- Operational Expenses	682,591	2,755,973
Medical/Rx Budget	\$199,286,480	\$797,145,919
- Surplus/(Deficit)	8,736,931	39,816,802
- Total Cost as % of Budget	96%	95%
Current Year Per Capita		
- Medical per employee per year	8,652	8,436
- Rx per employee per year	2,425	2,499
- Total per employee per year ³	11,117	11,046
- Medical per member per year	4,811	4,690
- Rx per member per year	1,348	1,390
- Total per member per year ³	6,181	6,141
Prior Year Results		
- Total Program Cost ³	181,013,303	712,764,329
\$ change	9,536,246	44,564,787
- Total per employee per year ³	10,726	10,475
% change	3.6%	5.4%
- Medical per employee per year	8,022	8,003
% change	7.9%	5.4%
- Rx per employee per year	2,668	2,434
% change	-9.1%	2.7%
EE Contributions	\$40,187,984	\$160,751,934
- Net SoD ⁴	150,361,566	596,577,182
- SoD Subsidy %	79%	79%
Headcount		
- Enrolled Ees	68,563	68,563
- Enrolled Members	123,320	123,320
- Member/EE Ratio	1.8	1.8

¹ Capitation payments apply to HMO and POS plans only

² Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis

³ Includes Medical, Rx, and Operational Expenses

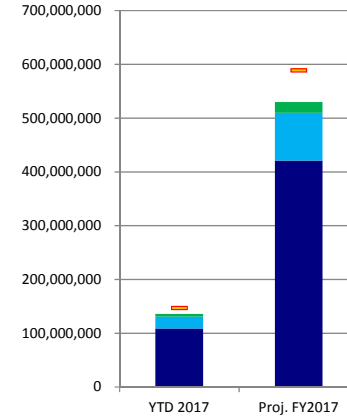
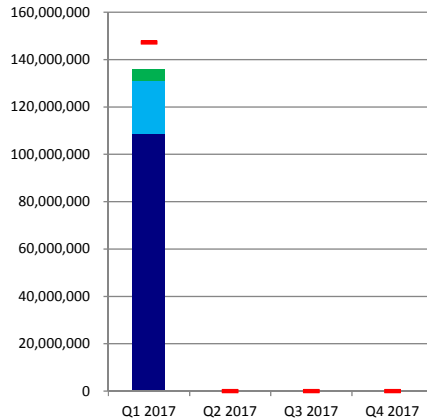
⁴ Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

⁵ Projections based on most recent 12 months of claims experience (10/1/2015 through 9/30/2016)

State of Delaware
Health Plan Quarterly Financial Reporting
FY17 Q1 High Cost Claims Analysis

	Drop-Down Choices
Status	Active
Vendor	Total
Plan	Total

Legend
— Medical/Rx Budget
■ Fees and Op. Expenses
■ Rx (incl. Rebates and EGWP)
■ Medical (incl. capitation)



	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total Program Cost	\$135,872,342	N/A	N/A	N/A
- Paid Claims	130,932,568	N/A	N/A	N/A
- Medical (includes capitation¹)	108,918,507	N/A	N/A	N/A
- Capitation	548,178	N/A	N/A	N/A
- Rx (including Rebates and EGWP)	22,014,061	N/A	N/A	N/A
- Rx Paid Claims	27,144,342	N/A	N/A	N/A
- EGWP	0	N/A	N/A	N/A
- Direct Subsidy	0	N/A	N/A	N/A
- CGDP	0	N/A	N/A	N/A
- Catastrophic Reinsurance	0	N/A	N/A	N/A
- Rx Rebates ²	(5,130,281)	N/A	N/A	N/A
- ASO Fees	4,567,427	N/A	N/A	N/A
- Operational Expenses	372,346	N/A	N/A	N/A
Medical/Rx Budget	\$147,227,156	N/A	N/A	N/A
- Surplus/(Deficit)	11,354,815	N/A	N/A	N/A
- Total Cost as % of Budget	92%	N/A	N/A	N/A
Current Year Per Capita				
- Medical per employee per year	12,090	N/A	N/A	N/A
- Rx per employee per year	2,402	N/A	N/A	N/A
- Total per employee per year ³	14,532	N/A	N/A	N/A
- Medical per member per year	5,094	N/A	N/A	N/A
- Rx per member per year	1,012	N/A	N/A	N/A
- Total per member per year ³	6,124	N/A	N/A	N/A
Prior Year Results				
- Total Program Cost ³	125,840,731	N/A	N/A	N/A
\$ change	10,031,611	N/A	N/A	N/A
- Total per employee per year ³	13,580	N/A	N/A	N/A
% change	7.0%	N/A	N/A	N/A
- Medical per employee per year	10,983	N/A	N/A	N/A
% change	10.1%	N/A	N/A	N/A
- Rx per employee per year	2,561	N/A	N/A	N/A
% change	-6.2%	N/A	N/A	N/A
EE Contributions	\$34,912,613	N/A	N/A	N/A
- Net SoD ⁴	100,959,728	N/A	N/A	N/A
- SoD Subsidy %	74%	N/A	N/A	N/A
Headcount				
- Enrolled Ees	37,400	N/A	N/A	N/A
- Enrolled Members	88,753	N/A	N/A	N/A
- Member/EE Ratio	2.4	N/A	N/A	N/A

YTD 2017	Proj. FY2017 ⁴
\$135,872,342	\$529,700,664
130,932,568	509,916,160
108,918,507	421,053,413
548,178	2,206,550
22,014,061	88,862,747
27,144,342	109,571,821
0	0
0	0
0	0
0	0
(5,130,281)	(20,709,074)
4,567,427	18,269,708
372,346	1,514,796
\$147,227,156	\$588,908,625
11,354,815	59,207,961
92%	90%
12,090	11,620
2,402	2,426
14,532	14,163
5,094	4,897
1,012	1,022
6,124	5,968
125,840,731	497,031,552
10,031,611	32,669,112
13,580	13,267
7.0%	6.8%
10,983	10,906
10.1%	6.6%
2,561	2,324
-6.2%	4.4%
\$34,912,613	\$139,650,453
100,959,728	390,050,211
74%	74%
37,400	37,400
88,753	88,753
2.4	2.4

¹ Capitation payments apply to HMO and POS plans only

² Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis

³ Includes Medical, Rx, and Operational Expenses

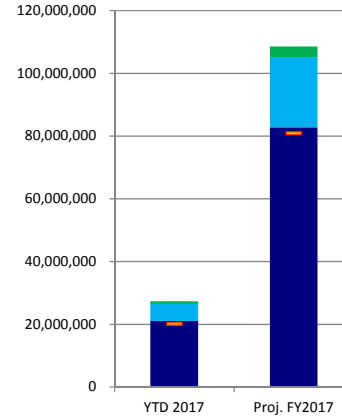
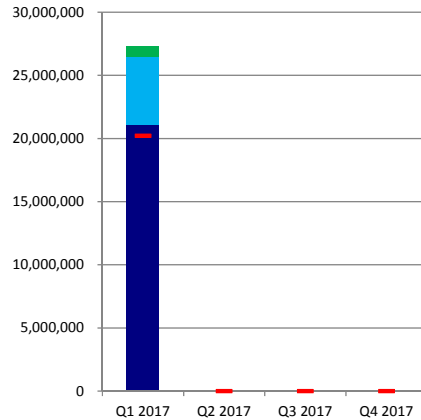
⁴ Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

⁵ Projections based on most recent 12 months of claims experience (10/1/2015 through 9/30/2016)

State of Delaware
Health Plan Quarterly Financial Reporting
FY17 Q1 High Cost Claims Analysis

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

Legend
— Medical/Rx Budget
■ Fees and Op. Expenses
■ Rx (incl. Rebates and EGWP)
■ Medical (incl. capitation)



	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total Program Cost	\$27,323,422	N/A	N/A	N/A
- Paid Claims	26,482,824	N/A	N/A	N/A
- Medical (includes capitation¹)	21,074,879	N/A	N/A	N/A
- Capitation	68,258	N/A	N/A	N/A
- Rx (including Rebates and EGWP)	5,407,945	N/A	N/A	N/A
- Rx Paid Claims	6,668,242	N/A	N/A	N/A
- EGWP	0	N/A	N/A	N/A
- Direct Subsidy	0	N/A	N/A	N/A
- CGDP	0	N/A	N/A	N/A
- Catastrophic Reinsurance	0	N/A	N/A	N/A
- Rx Rebates ²	(1,260,298)	N/A	N/A	N/A
- ASO Fees	777,236	N/A	N/A	N/A
- Operational Expenses	63,362	N/A	N/A	N/A
Medical/Rx Budget	\$20,219,435	N/A	N/A	N/A
- Surplus/(Deficit)	(7,103,986)	N/A	N/A	N/A
- Total Cost as % of Budget	135%	N/A	N/A	N/A
Current Year Per Capita				
- Medical per employee per year	13,685	N/A	N/A	N/A
- Rx per employee per year	3,447	N/A	N/A	N/A
- Total per employee per year ³	17,172	N/A	N/A	N/A
- Medical per member per year	8,916	N/A	N/A	N/A
- Rx per member per year	2,245	N/A	N/A	N/A
- Total per member per year ³	11,187	N/A	N/A	N/A
Prior Year Results				
- Total Program Cost ³	26,575,217	N/A	N/A	N/A
- \$ change	748,205	N/A	N/A	N/A
- Total per employee per year ³	16,648	N/A	N/A	N/A
- % change	3.1%	N/A	N/A	N/A
- Medical per employee per year	12,861	N/A	N/A	N/A
- % change	6.4%	N/A	N/A	N/A
- Rx per employee per year	3,751	N/A	N/A	N/A
- % change	-8.1%	N/A	N/A	N/A
EE Contributions	\$3,103,806	N/A	N/A	N/A
- Net SoD ⁴	24,219,616	N/A	N/A	N/A
- SoD Subsidy %	89%	N/A	N/A	N/A
Headcount				
- Enrolled Ees	6,365	N/A	N/A	N/A
- Enrolled Members	9,769	N/A	N/A	N/A
- Member/EE Ratio	1.5	N/A	N/A	N/A

YTD 2017	Proj. FY2017 ⁴
\$27,323,422	\$108,537,335
26,482,824	105,174,623
21,074,879	82,786,325
68,258	142,307
5,407,945	22,388,298
6,668,242	27,605,793
0	0
0	0
0	0
0	0
(1,260,298)	(5,217,495)
777,236	3,108,944
63,362	253,768
\$20,219,435	\$80,877,741
(7,103,986)	(27,659,595)
135%	134%
13,685	13,362
3,446	3,566
17,172	17,053
8,916	8,705
2,245	2,323
11,187	11,110
26,575,217	101,595,053
748,205	6,942,282
16,648	16,126
3.1%	5.7%
12,861	12,661
6.4%	5.5%
3,751	3,428
-8.1%	4.0%
\$3,103,806	\$12,415,223
24,219,616	96,122,112
89%	89%
6,365	6,365
9,769	9,769
1.5	1.5

¹ Capitation payments apply to HMO and POS plans only

² Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis

³ Includes Medical, Rx, and Operational Expenses

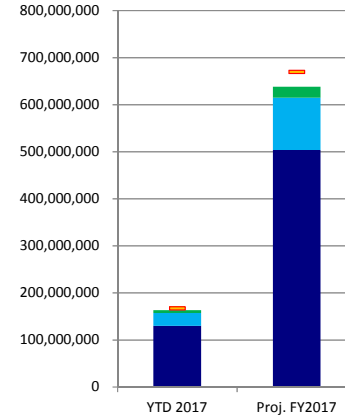
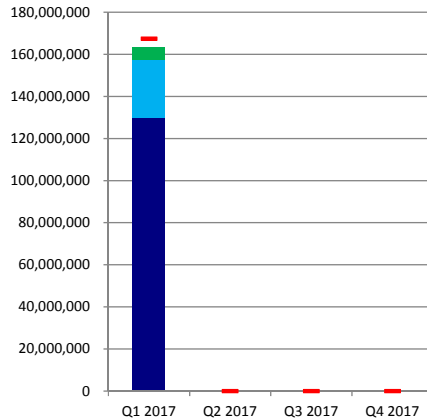
⁴ Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

⁵ Projections based on most recent 12 months of claims experience (10/1/2015 through 9/30/2016)

State of Delaware
Health Plan Quarterly Financial Reporting
FY17 Q1 High Cost Claims Analysis

Drop-Down Choices	
Status	Active & Non-Medicare Retiree
Vendor	Total
Plan	Total

Legend
— Medical/Rx Budget
■ Fees and Op. Expenses
■ Rx (incl. Rebates and EGWP)
■ Medical (incl. capitation)



	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total Program Cost	\$163,195,763	N/A	N/A	N/A
- Paid Claims	157,415,392	N/A	N/A	N/A
- Medical (includes capitation¹)	129,993,386	N/A	N/A	N/A
- Capitation	616,436	N/A	N/A	N/A
- Rx (including Rebates and EGWP)	27,422,006	N/A	N/A	N/A
- Rx Paid Claims	33,812,584	N/A	N/A	N/A
- EGWP	0	N/A	N/A	N/A
- Direct Subsidy	0	N/A	N/A	N/A
- CGDP	0	N/A	N/A	N/A
- Catastrophic Reinsurance	0	N/A	N/A	N/A
- Rx Rebates ²	(6,390,578)	N/A	N/A	N/A
- ASO Fees	5,344,663	N/A	N/A	N/A
- Operational Expenses	435,708	N/A	N/A	N/A
Medical/Rx Budget	\$167,446,591	N/A	N/A	N/A
- Surplus/(Deficit)	4,250,828	N/A	N/A	N/A
- Total Cost as % of Budget	97%	N/A	N/A	N/A
Current Year Per Capita				
- Medical per employee per year	12,322	N/A	N/A	N/A
- Rx per employee per year	2,554	N/A	N/A	N/A
- Total per employee per year ³	14,916	N/A	N/A	N/A
- Medical per member per year	5,473	N/A	N/A	N/A
- Rx per member per year	1,135	N/A	N/A	N/A
- Total per member per year ³	6,626	N/A	N/A	N/A
Prior Year Results				
- Total Program Cost ³	152,415,947	N/A	N/A	N/A
\$ change	10,779,816	N/A	N/A	N/A
- Total per employee per year ³	14,031	N/A	N/A	N/A
% change	6.3%	N/A	N/A	N/A
- Medical per employee per year	11,259	N/A	N/A	N/A
% change	9.4%	N/A	N/A	N/A
- Rx per employee per year	2,736	N/A	N/A	N/A
% change	-6.6%	N/A	N/A	N/A
EE Contributions	\$38,016,419	N/A	N/A	N/A
- Net SoD ⁴	125,179,344	N/A	N/A	N/A
- SoD Subsidy %	77%	N/A	N/A	N/A
Headcount				
- Enrolled Ees	43,765	N/A	N/A	N/A
- Enrolled Members	98,522	N/A	N/A	N/A
- Member/EE Ratio	2.3	N/A	N/A	N/A

	YTD 2017	Proj. FY2017 ⁴
Total Program Cost	\$163,195,763	\$638,008,083
- Paid Claims	157,415,392	614,860,867
- Medical (includes capitation¹)	129,993,386	503,703,338
- Capitation	616,436	2,351,286
- Rx (including Rebates and EGWP)	27,422,006	111,157,529
- Rx Paid Claims	33,812,584	137,062,305
- EGWP	0	0
- Direct Subsidy	0	0
- CGDP	0	0
- Catastrophic Reinsurance	0	0
- Rx Rebates ²	(6,390,578)	(25,904,776)
- ASO Fees	5,344,663	21,378,653
- Operational Expenses	435,708	1,768,564
Medical/Rx Budget	\$167,446,591	\$669,786,366
- Surplus/(Deficit)	4,250,828	31,778,283
- Total Cost as % of Budget	97%	95%
Current Year Per Capita		
- Medical per employee per year	12,322	11,871
- Rx per employee per year	2,554	2,589
- Total per employee per year ³	14,916	14,578
- Medical per member per year	5,473	5,273
- Rx per member per year	1,135	1,150
- Total per member per year ³	6,626	6,476
Prior Year Results		
- Total Program Cost ³	152,415,947	598,626,605
\$ change	10,779,816	39,381,477
- Total per employee per year ³	14,031	13,679
% change	6.3%	6.6%
- Medical per employee per year	11,259	11,159
% change	9.4%	6.4%
- Rx per employee per year	2,736	2,483
% change	-6.6%	4.3%
EE Contributions	\$38,016,419	\$152,065,676
- Net SoD ⁴	125,179,344	485,942,407
- SoD Subsidy %	77%	76%
Headcount		
- Enrolled Ees	43,765	43,765
- Enrolled Members	98,522	98,522
- Member/EE Ratio	2.3	2.3

¹ Capitation payments apply to HMO and POS plans only

² Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis

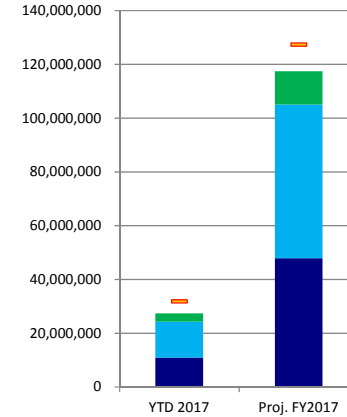
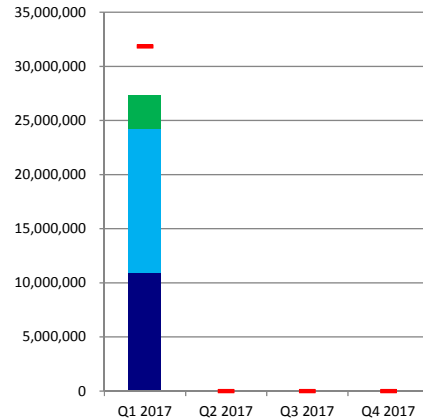
³ Includes Medical, Rx, and Operational Expenses

⁴ Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

⁵ Projections based on most recent 12 months of claims experience (10/1/2015 through 9/30/2016)

State of Delaware
Health Plan Quarterly Financial Reporting
FY17 Q1 High Cost Claims Analysis

	Drop-Down Choices
Status	Medicare Retiree
Vendor	Total
Plan	Total



	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total Program Cost	\$27,353,786	N/A	N/A	N/A
- Paid Claims	24,256,468	N/A	N/A	N/A
- Medical (includes capitation¹)	10,942,056	N/A	N/A	N/A
- Capitation	0	N/A	N/A	N/A
- Rx (including Rebates and EGWP)	13,314,412	N/A	N/A	N/A
- Rx Paid Claims	27,721,084	N/A	N/A	N/A
- EGWP	(9,555,483)	N/A	N/A	N/A
- Direct Subsidy	(1,995,813)	N/A	N/A	N/A
- CGDP	(4,738,898)	N/A	N/A	N/A
- Catastrophic Reinsurance	(2,820,773)	N/A	N/A	N/A
- Rx Rebates ²	(4,851,190)	N/A	N/A	N/A
- ASO Fees	2,850,435	N/A	N/A	N/A
- Operational Expenses	246,883	N/A	N/A	N/A
Medical/Rx Budget	\$31,839,888	N/A	N/A	N/A
- Surplus/(Deficit)	4,486,102	N/A	N/A	N/A
- Total Cost as % of Budget	86%	N/A	N/A	N/A
Current Year Per Capita				
- Medical per employee per year	2,177	N/A	N/A	N/A
- Rx per employee per year	2,196	N/A	N/A	N/A
- Total per employee per year ³	4,412	N/A	N/A	N/A
- Medical per member per year	2,177	N/A	N/A	N/A
- Rx per member per year	2,196	N/A	N/A	N/A
- Total per member per year ³	4,412	N/A	N/A	N/A
Prior Year Results				
- Total Program Cost ³	28,597,356	N/A	N/A	N/A
- \$ change	(1,243,570)	N/A	N/A	N/A
- Total per employee per year ³	4,756	N/A	N/A	N/A
- % change	-7.2%	N/A	N/A	N/A
- Medical per employee per year	2,174	N/A	N/A	N/A
- % change	0.1%	N/A	N/A	N/A
- Rx per employee per year	2,546	N/A	N/A	N/A
- % change	-13.8%	N/A	N/A	N/A
EE Contributions	\$2,171,565	N/A	N/A	N/A
- Net SoD ⁴	25,182,221	N/A	N/A	N/A
- SoD Subsidy %	92%	N/A	N/A	N/A
Headcount				
- Enrolled Ees	24,798	N/A	N/A	N/A
- Enrolled Members	24,798	N/A	N/A	N/A
- Member/EE Ratio	1.0	N/A	N/A	N/A

YTD 2017	Proj. FY2017 ⁴
\$27,353,786	\$117,408,755
24,256,468	105,019,606
10,942,056	47,917,915
0	0
13,314,412	57,101,691
27,721,084	111,620,090
(9,555,483)	(34,984,884)
(1,995,813)	(6,800,717)
(4,738,898)	(16,343,122)
(2,820,773)	(11,841,045)
(4,851,190)	(19,533,516)
2,850,435	11,401,740
246,883	987,409
\$31,839,888	\$127,359,553
4,486,102	9,950,798
86%	92%
2,177	2,286
2,196	2,351
4,412	4,735
2,177	2,286
2,196	2,351
4,412	4,735
28,597,356	114,137,724
(1,243,570)	3,271,031
4,756	4,701
-7.2%	0.7%
2,174	2,316
0.1%	-1.3%
2,546	2,347
-13.8%	0.2%
\$2,171,565	\$8,686,259
25,182,221	108,722,497
92%	93%
24,798	24,798
24,798	24,798
1.0	1.0

¹ Capitation payments apply to HMO and POS plans only

² Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis

³ Includes Medical, Rx, and Operational Expenses

⁴ Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

⁵ Projections based on most recent 12 months of claims experience (10/1/2015 through 9/30/2016)

State of Delaware
FY2017 Financial Analysis of Health/Rx Plans - Paid Basis
Year to Date July 1, 2016 - September 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	\$1,531,415	\$1,704,045	\$62,340,693	\$11,643,932	\$2,765,946	\$312,932	\$10,942,056	\$33,780,446	\$6,098,327	\$1,110,238	\$132,230,030	\$5,707,335	\$1,162,502	\$1,134,256	\$84,883	\$8,088,976	\$140,319,006
Capitation	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$548,178	\$68,258	\$0	\$0	\$0	\$616,436
Administration	\$111,500	\$11,969	\$2,142,476	\$402,641	\$160,587	\$10,463	\$2,553,305	\$1,345,674	\$221,936	\$28,931	\$6,989,482	\$278,548	\$50,775	\$51,583	\$3,194	\$384,101	\$7,373,582
Total Medical Program Cost	\$1,642,915	\$1,716,014	\$64,483,169	\$12,046,573	\$2,926,533	\$323,395	\$13,495,361	\$35,126,120	\$6,320,263	\$1,139,169	\$139,219,512	\$6,534,061	\$1,281,535	\$1,185,839	\$88,077	\$9,089,513	\$148,309,024
Average Number of Employees	1,012	109	19,452	3,656	1,458	95	24,798	12,218	2,015	263	65,076	2,529	461	468	29	3,487	68,563
Program Cost/Employee/Yr.	\$6,494	\$62,973	\$13,260	\$13,180	\$8,029	\$13,617	\$2,177	\$11,500	\$12,546	\$17,326	\$8,557	\$10,335	\$11,120	\$10,135	\$12,149	\$10,427	\$8,652
Change from prior period (pepy)	0.8%	372.8%	9.6%	7.6%	24.2%	-8.1%	-6.0%	12.6%	-2.8%	28.1%	8.3%	8.8%	-23.4%	47.2%	48.1%	5.8%	8.1%
Average Number of Members	1,842	144	46,134	5,460	3,099	160	24,798	30,151	3,203	508	115,499	6,091	762	928	41	7,822	123,321
Program Cost/Member/Yr.	\$3,568	\$47,667	\$5,591	\$8,825	\$3,777	\$8,085	\$2,177	\$4,660	\$7,893	\$8,970	\$4,821	\$4,291	\$6,727	\$5,111	\$8,593	\$4,648	\$4,811
Change from prior period (pmpy)	-0.6%	399.6%	8.8%	8.2%	22.6%	-13.5%	-6.0%	12.4%	-3.4%	29.7%	8.4%	8.6%	-22.8%	48.2%	42.1%	6.0%	8.2%
Express Scripts, Inc.																	
Paid Claims	\$262,201	\$53,681	\$15,804,760	\$3,854,170	\$595,684	\$65,348	\$27,721,084	\$8,327,620	\$1,946,727	\$145,464	\$58,776,738	\$1,629,303	\$737,788	\$379,311	\$10,528	\$2,756,930	\$61,533,669
Administration	\$12,130	\$1,302	\$233,074	\$43,802	\$17,470	\$1,138	\$297,130	\$146,392	\$24,144	\$3,147	\$779,730	\$30,303	\$5,524	\$5,612	\$347	\$41,785	\$821,516
Estimated EGWP Savings	\$0	\$0	\$0	\$0	\$0	\$0	(\$9,555,483)	\$0	\$0	\$0	(\$9,555,483)	\$0	\$0	\$0	\$0	\$0	(\$9,555,483)
Estimated Rebates ¹	(\$49,556)	(\$10,146)	(\$2,987,100)	(\$728,438)	(\$112,584)	(\$12,351)	(\$4,851,190)	(\$1,573,920)	(\$367,931)	(\$27,493)	(\$10,720,708)	(\$307,930)	(\$139,442)	(\$71,690)	(\$1,990)	(\$521,060)	(\$11,241,768)
Total Rx Program Cost	\$224,775	\$44,837	\$13,050,735	\$3,169,534	\$500,569	\$54,135	\$13,611,542	\$6,900,092	\$1,602,940	\$121,118	\$39,280,277	\$1,351,667	\$603,870	\$313,233	\$8,886	\$2,277,656	\$41,557,933
Average Number of Employees	1,012	109	19,452	3,656	1,458	95	24,798	12,218	2,015	263	65,076	2,529	461	468	29	3,487	68,563
Program Cost/Employee/Yr.	\$888	\$1,645	\$2,684	\$3,468	\$1,373	\$2,279	\$2,196	\$2,259	\$3,182	\$1,842	\$2,414	\$2,138	\$5,240	\$2,677	\$1,226	\$2,613	\$2,425
Change from prior period (pepy)	3.7%	-1.1%	3.3%	-5.6%	0.3%	11.1%	-6.5%	4.4%	3.4%	1.9%	-1.0%	-1.9%	37.8%	53.6%	4.2%	11.7%	-0.4%
Average Number of Members	1,842	144	46,134	5,460	3,099	160	24,798	30,151	3,203	508	115,499	6,091	762	928	41	7,822	123,321
Program Cost/Member/Yr.	\$488	\$1,245	\$1,132	\$2,322	\$646	\$1,353	\$2,196	\$915	\$2,002	\$954	\$1,360	\$888	\$3,170	\$1,350	\$867	\$1,165	\$1,348
Change from prior period (pmpy)	2.2%	4.5%	2.5%	-5.0%	-1.0%	4.6%	-6.5%	4.2%	2.7%	3.2%	-0.9%	-2.0%	38.8%	54.7%	0.0%	11.9%	-0.3%
Total Medical and Rx																	
Premium	\$3,018,046	\$276,349	\$80,236,508	\$11,907,863	\$5,046,384	\$308,582	\$31,839,888	\$47,035,782	\$6,204,922	\$759,902	\$186,634,225	\$9,587,645	\$1,439,287	\$1,542,890	\$82,433	\$12,652,255	\$199,286,480
Program Cost (prior to operational)	\$1,867,690	\$1,760,851	\$77,533,904	\$15,216,108	\$3,427,102	\$377,531	\$27,106,903	\$42,026,213	\$7,923,202	\$1,260,287	\$178,499,789	\$7,885,729	\$1,885,405	\$1,499,072	\$96,963	\$11,367,169	\$189,866,958
Operational Expenses	\$10,079	\$1,082	\$193,660	\$36,395	\$14,516	\$946	\$246,883	\$121,636	\$20,061	\$2,615	\$647,872	\$25,178	\$4,590	\$4,663	\$289	\$34,719	\$682,591
Total Program Cost	\$1,877,768	\$1,761,933	\$77,727,564	\$15,252,503	\$3,441,617	\$378,477	\$27,353,786	\$42,147,849	\$7,943,263	\$1,262,902	\$179,147,661	\$7,910,907	\$1,889,995	\$1,503,735	\$97,251	\$11,401,888	\$190,549,549
Surplus / (Deficit)	\$1,140,277	(\$1,485,584)	\$2,508,944	(\$3,344,639)	\$1,604,766	(\$69,895)	\$4,486,102	\$4,887,933	(\$1,738,341)	(\$503,000)	\$7,486,563	\$1,676,739	(\$450,708)	\$39,155	(\$14,819)	\$1,250,367	\$8,736,931
Total Cost as % of Budget	62.2%	637.6%	96.9%	128.1%	68.2%	122.7%	85.9%	89.6%	128.0%	166.2%	96.0%	82.5%	131.3%	97.5%	118.0%	90.1%	95.6%
Average Number of Employees	1,012	109	19,452	3,656	1,458	95	24,798	12,218	2,015	263	65,076	2,529	461	468	29	3,487	68,563
Program Cost/Employee/Yr.	\$7,422	\$64,658	\$15,983	\$16,688	\$9,442	\$15,936	\$4,412	\$13,799	\$15,768	\$19,208	\$11,012	\$12,512	\$16,399	\$12,852	\$13,414	\$13,079	\$11,117
Change from prior period (pepy)	1.2%	330.5%	8.5%	4.6%	20.0%	-5.8%	-6.1%	11.2%	-1.6%	25.0%	6.1%	6.8%	-10.7%	48.3%	42.4%	6.9%	6.1%
Average Number of Members	1,842	144	46,134	5,460	3,099	160	24,798	30,151	3,203	508	115,499	6,091	762	928	41	7,822	123,321
Program Cost/Member/Yr.	\$4,078	\$48,943	\$6,739	\$11,174	\$4,442	\$9,462	\$4,412	\$5,592	\$9,920	\$9,944	\$6,204	\$5,195	\$9,921	\$6,482	\$9,488	\$5,831	\$6,181
Change from prior period (pmpy)	-0.3%	354.9%	7.7%	5.2%	18.4%	-11.2%	-6.1%	10.9%	-2.2%	26.5%	6.2%	6.6%	-10.0%	49.4%	36.7%	7.1%	6.2%
Prior Period Program Cost																	
Per Employee Per Year																	
Medical	\$6,442	\$13,318	\$12,098	\$12,248	\$6,463	\$14,821	\$2,316	\$10,210	\$12,903	\$13,522	\$7,903	\$9,502	\$14,518	\$6,888	\$8,205	\$9,857	\$8,003
Rx	\$857	\$1,663	\$2,598	\$3,673	\$1,369	\$2,052	\$2,347	\$2,164	\$3,077	\$1,807	\$2,439	\$2,180	\$3,803	\$1,743	\$1,177	\$2,339	\$2,434
Total ²	\$7,337	\$15,019	\$14,734	\$15,959	\$7,869	\$16,910	\$4,701	\$12,411	\$16,018	\$15,366	\$10,380	\$11,719	\$18,358	\$8,669	\$9,419	\$12,234	\$10,475
Per Member Per Year																	
Medical	\$3,590	\$9,540	\$5,140	\$8,154	\$3,081	\$9,343	\$2,316	\$4,147	\$8,170	\$6,917	\$4,449	\$3,950	\$8,718	\$3,448	\$6,046	\$4,385	\$4,445
Rx	\$477	\$1,191	\$1,104	\$2,445	\$653	\$1,293	\$2,347	\$879	\$1,948	\$924	\$1,373	\$906	\$2,284	\$873	\$867	\$1,041	\$1,352
Total ²	\$4,088	\$10,759	\$6,260	\$10,624	\$3,752	\$10,661	\$4,701	\$5,041	\$10,142	\$7,861	\$5,844	\$4,871	\$11,024	\$4,340	\$6,941	\$5,442	\$5,818

¹ Rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis

² Includes Medical, Rx, and Operational Expenses

State of Delaware
Health Plan Quarterly Financial Reporting
FY17 Q1 High Cost Claims Analysis

Summary

- Through September 2016, there are 103 members with claims over \$100k for a total of \$18.8M
- 50% of high claimants have been engaged with care management; 41 previously (40%) and 11 currently (10%)
- The top 20 claimants by paid claims are summarized in the table below:

Cumulative Medical Claims Total										
Status	Vendor	Relationship	Gender	Age	Leading Diagnosis	HCC Last Year	Previously Engaged	Currently Engaged	Reason Not Engaged	Q1 Paid
Inactive	Highmark	Employee	F	50-59	ACUTE KIDNEY FAILURE WITH TUBULAR NECROSIS	Y	Y	N		\$1,485,954
Inactive	Highmark	Spouse	M	60-69	MYELOID LEUKEMIA	Y	Y	N		\$651,398
Inactive	Highmark	Child	F	0-9	SINGLE LIVEBORN INFANT, DELIVERED BY CESAREAN	N	N	N	Coverage Terminated	\$502,473
Active	Highmark	Employee	M	40-49	ANTINEOPLASTIC CHEMOTHERAPY	N	N	N	Member Declined	\$402,845
Active	Highmark	Child	F	10-19	SPASTIC QUADRIPLLEGIC CEREBRAL PALSY	Y	Y	N		\$397,639
Active	Highmark	Employee	M	60-69	CHRONIC MYELOPROLIFERATIVE DISEASE	N	Y	N		\$367,484
Active	Highmark	Spouse	M	60-69	ACUTE MONOBLASTIC/MONOCYTIC LEUKEMIA	N	Y	N		\$325,758
Retiree	Highmark	Employee	F	50-59	BENIGN NEOPLASM OF CEREBRAL MENINGES	N	N	Y		\$316,228
Active	Highmark	Child	M	20-29	CLOSED FRACTURE OF BASE OF SKULL WITH CEREBRAL LACERATION AND CONTUSION	Y	N	N	Unable to Reach	\$311,353
Active	Highmark	Child	M	0-9	SINGLE LIVEBORN INFANT, DELIVERED VAGINALLY	N	Y	N		\$275,575
Active	Highmark	Child	M	20-29	ACUTE RESPIRATORY FAILURE WITH HYPOXIA	N	Y	N		\$273,152
Active	Highmark	Child	M	10-19	MELENA	N	Y	N		\$263,196
Active	Highmark	Employee	M	60-69	MALIGNANT NEOPLASM OF RECTOSIGMOID JUNCTION	N	Y	N		\$256,995
Retiree	Highmark	Child	F	20-29	GUILLAIN-BARRE SYNDROME	N	N	N	Unable to Reach	\$248,746
Active	Highmark	Employee	M	50-59	ANTINEOPLASTIC CHEMOTHERAPY	Y	Y	N		\$246,850
Active	Highmark	Spouse	F	50-59	MALIGNANT NEOPLASM OF THYROID GLAND	N	N	N	Unable to Reach	\$239,853
Active	Highmark	Spouse	M	60-69	INTRACRANIAL ABSCESS AND GRANULOMA	N	N	N	Phone Number Invalid	\$238,850
Retiree	Highmark	Child	F	30-39	FOREIGN BODY IN STOMACH, INITIAL ENCOUNTER	Y	Y	N		\$226,571
Active	Highmark	Child	F	0-9	SYMPTOMATIC EPILEPSY AND EPILEPTIC SYNDROMES WITH COMPLEX PARTIAL SEIZURES	N	N	N	Unable to Reach	\$224,779
Active	Highmark	Employee	M	60-69	SECONDARY MALIGNANT NEOPLASM OF CEREBRAL MENINGE	N	N	N	Hospice Enrolled	\$221,615
Top 20 HCC's above \$100k										\$7,477,314
Total HCC's above \$100k										\$18,810,978

State of Delaware
Health Plan Quarterly Financial Reporting
Assumptions and Caveats

Claim basis and timing

- 1 All reporting provided on a paid basis within this document.
- 2 FY2017 represents the time period July 1, 2016 through June 30, 2017 for all statuses; note Medicaid plan for Medicare eligible retirees runs from January 1, 2017 through December 31, 2017. Therefore, FY2017 financial results span two plan years for the Medicare eligible population.

Enrollment

- 3 Medical and Rx enrollment based on quarterly tiered enrollment data from Highmark and Aetna.
- 4 Highmark quarterly reports do not provide enrollment data split by State and Participating. For FY2017 Q1: we assumed State / Participating split follows the same ratio as the monthly September Highmark enrollment report. The ratio is calculated by status (Active, non-Medicare eligible retiree, and Medicare eligible retiree), by plan and by contracts/members. This assumption will be updated quarterly.
- 5 All Medicare eligible retirees are assumed to be enrolled in medical and Rx coverage.

Benefit costs/fees

- 6 Medical quarterly paid claims from Highmark and Aetna; Rx quarterly paid claims from ESI; EGWP subsidies and Rx rebates (Active, non-Medicare eligible retiree, and Medicare eligible retiree) from OMB; Rx rebates include assumed formulary true-ups.
- 7 Administration fees and operational expenses from OMB-provided September FY2017 monthly fund equity report, as PEPM values were not provided; total quarterly fees are assigned to each plan on a contract count basis.
 - a. ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (TRF & PCORI), Truven data analytics, EAP and Segal and WTW consulting fees.
 - b. Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
- 8 Pharmacy drug rebates are shown based on the period to which rebates are attributable and reflect estimated payments based on prior quarters as a percentage of paid claims; active/non-Medicare eligible retiree rebates assigned to each plan on a contract count basis. May differ from actual payments received during FY2017 due to payment timing lag; these rebates do not reflect updated ESI contract effective 7/1/2016, pending WTW independent contract analysis
- 9 EGWP payments based on actual and expected payments attributable to the period July 1, 2016 through June 30, 2017; reflects actual direct subsidy reimbursements received, estimated coverage gap discount payments, projected Calendar Year 2016 catastrophic reinsurance payments from ESI, and estimated Calendar Year 2017 catastrophic reinsurance payment (calculated by WTW). May differ from actual payments received during FY2017 due to payment timing lag.
- 10 Prior year costs calculated from WTW's FY16 Q4 Financial Reporting.
- 11 FY17 costs projected based on the most recent 12 months of data (10/1/2015 – 9/30/2016) using trend assumptions of 10.0% prescription drug, 6.5% medical for active/non-Medicare eligible retiree, 3.0% medical for Medicare eligible retiree

Budget/contributions

- 12 Active and non-Medicare eligible retiree budget rates and contributions reflect rates effective July 1, 2016. Medicare eligible retiree budget rates reflect rates effective January 1, 2016 for FY17 Q1 and Q2, and rates effective January 1, 2017 for FY17 Q3 and Q4. Budget rates include FY17 risk fees for Participating groups (excludes \$2.70 PEPM charge). All rates developed by Segal.
- 13 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors.
- 14 Highmark quarterly reports do not provide enrollment data split by retirement date. All Medicare eligible retirees are assumed to have retired prior to July 1, 2012, and therefore do not contribute towards the cost of premiums. As a result of this conservative assumption, the healthcare program's net cost to the State may be overstated.
- 15 Participating groups are assumed to be 100% employee paid in order to estimate the healthcare program's net cost to the State; actual employee contributions vary and are difficult to capture since each group pays premiums at different times.
- 16 While COBRA enrollment and claims are reflected in the expenses, all medical/Rx participants are assumed to pay active contributions since COBRA participants make up less than 0.1% of the total population.
- 17 HRA funding for CDH plans are included in the paid claims reported in this document.

State of Delaware

Health Plan Quarterly Financial Reporting

Glossary of Important Health Care Terms

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.
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 <i>bundled payments</i> or other <i>value-based payments</i> .
Consumer Driven Health Plan	CDHP	Allows members to use health savings accounts (HSA), health reimbursement accounts (<i>HRA</i>), or other similar medical payment products to pay routine health care expenses directly. GHIP currently offers a CDHP with <i>HRA</i> .
Coverage Gap Discount Program	CGDP	One of the funding components of an <i>EGWP</i> . Manufacturers provide discounts on covered Part D brand prescription drugs to Medicare beneficiaries while in the coverage gap.
Employee	EE	A person employed for wages or salary.
Employer Group Waiver Plans	EGWP	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. GHIP currently contracts with ESI as the TPA and includes a “wrapper,” which is referred to as an enhanced benefit.
Fiscal Year	FY	A year as reckoned for taxing or accounting purposes. GHIP fiscal year runs from July 1st through June 30th.
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. 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. GHIP only offers HRA to employees and non-Medicare eligible retirees who enroll in the CDH Gold plan.
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.
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.

State of Delaware

Health Plan Quarterly Financial Reporting

Glossary of Important Health Care Terms

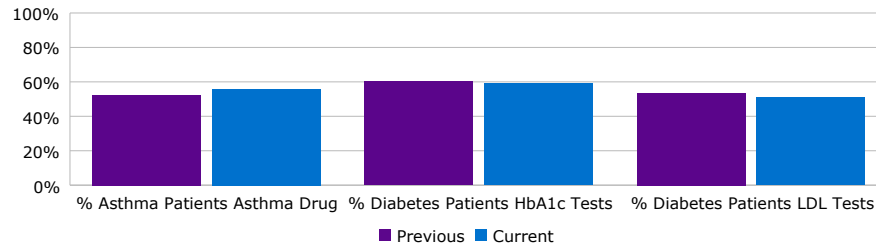
Point-of-Service	POS	A type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. GHIP only offers this type of plan to Port of Wilmington employees.
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. For this financial reporting document, YTD refers to the time period of July 1, 2016 to September 30, 2016

State of Delaware Medical and Prescription Drug Dashboard - Actives

Previous Period: Oct 2014 - Sep 2015 (Paid)

Current Period: Oct 2015 - Sep 2016 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	383.2	283.3	-26.1%
Visits Per 1000 Well Child	832.8	815.9	-2.0%
Visits Per 1000 Prevent Adult	356.6	366.3	2.7%

4. Medical Plan Eligibility

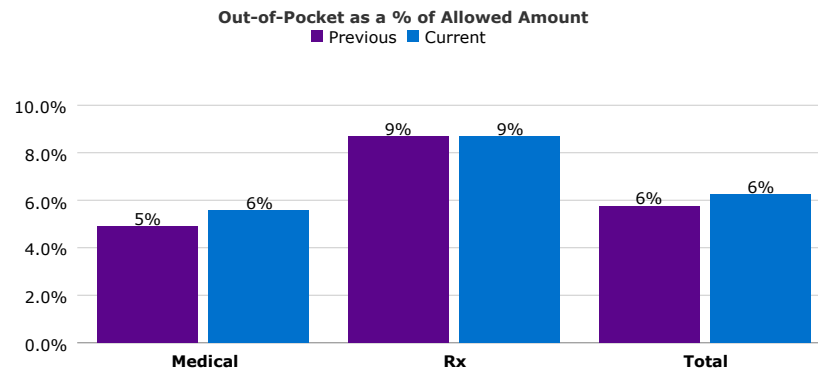
	Previous	Current	Trend
Average Employees	37,288	37,395	0%
Average Members	87,955	88,289	0%
Family Size	2.4	2.4	0%
Member Age	33.1	33.1	0%
Members % Male	47%	47%	0% pts

5. Risk Score

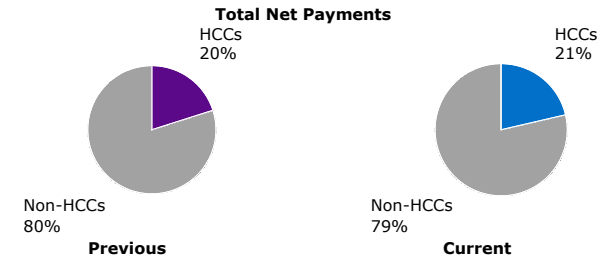
	Previous*	Current**	Trend
Member Risk Score	133	146	10%

Risk score is based on the following time periods: *Previous: July 2014 to June 2015, **Current: July 2015 to June 2016

7. Cost Sharing



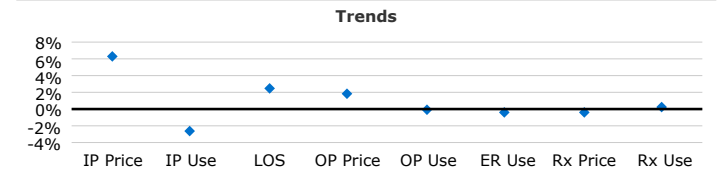
2. High Cost Claimants*



*Members with >=\$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	565	582	3%
Patients per 1,000	5.8	6	3%
Payments (in millions)	\$97.5	\$105.7	8%
Payment per Patient	\$172,480	\$181,654	5%

6. Price and Use



	Current	Benchmark	Trend
Inpatient			
Allowed per Admit	\$22,546	\$20,290	6%
Admits per 1,000	64.8	54.6	-3%
Days LOS	4.5	3.7	3%
Outpatient			
Allowed per Service	\$129	\$110	2%
Services PMPY	28.0	28.1	0%
Emergency Room Visits per 1,000	273	217	-1%
Prescription Drug			
Allowed/Days Supply	\$3.44	\$3.30	-1%
Days Supply PMPY	383	315	0%

● Represents a lower than -3% comparison to the benchmark

◆ Represents a comparison to the benchmark within +/-3%

■ Represents a higher than 3% comparison to the benchmark

Nov 16, 2016

Confidential - Prepared by Truven Health Analytics, an IBM Company

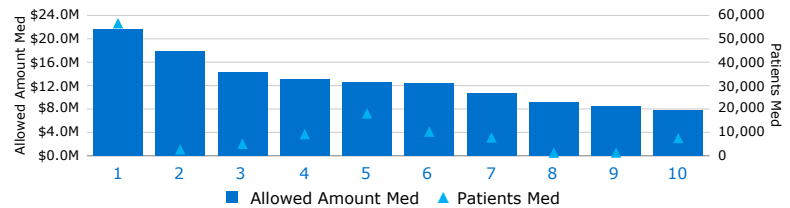
1 of 3

State of Delaware Medical and Prescription Drug Dashboard - Actives

Previous Period: Oct 2014 - Sep 2015 (Paid)

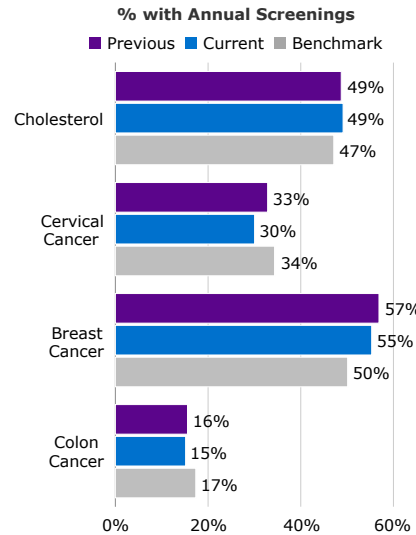
Current Period: Oct 2015 - Sep 2016 (Paid)

8. Top Medical Conditions (by cost)

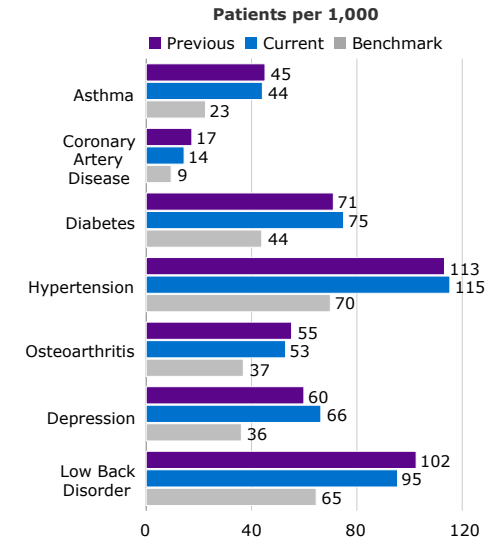


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1 Prevent/Admin Hlth Encounters	\$21,678,664	56,687	\$382
2 Pregnancy without Delivery	\$17,957,512	2,715	\$6,614
3 Osteoarthritis	\$14,362,778	5,138	\$2,795
4 Spinal/Back Disord, Low Back	\$13,022,959	9,269	\$1,405
5 Arthropathies/Joint Disord NEC	\$12,520,749	18,130	\$691
6 Gastroint Disord, NEC	\$12,433,701	10,333	\$1,203
7 Respiratory Disord, NEC	\$10,777,942	7,853	\$1,372
8 Newborns, w/wo Complication	\$9,190,516	1,334	\$6,889
9 Coronary Artery Disease	\$8,514,900	1,397	\$6,095
10 Spinal/Back Disord, Ex Low	\$7,702,507	7,581	\$1,016

9. Screening Rates

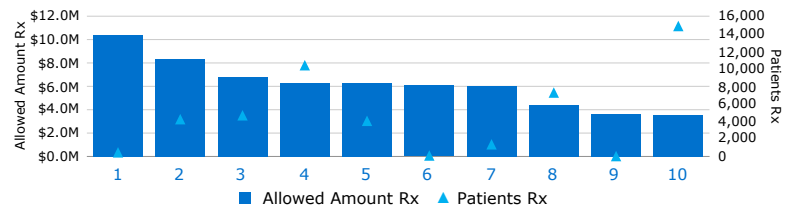


10. Chronic Condition Prevalence

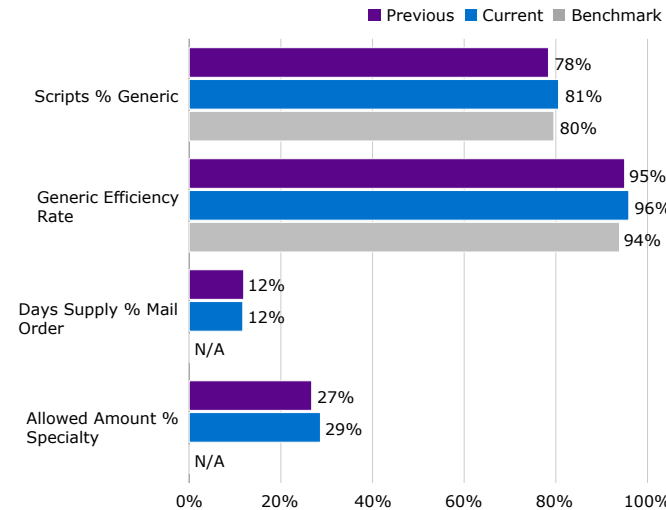


11. Prescription Drug Metrics

Top 10 Therapeutic Classes (by cost)



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1 Immunosuppressants, NEC	\$10,401,780	470	\$22,131
2 Antidiabetic Agents, Misc	\$8,319,538	4,255	\$1,955
3 Stimulant, Amphetamine Type	\$6,772,061	4,697	\$1,442
4 Antihyperlipidemic Drugs, NEC	\$6,311,627	10,408	\$606
5 Antivirals, NEC	\$6,273,420	4,066	\$1,543
6 Biological Response Modifiers	\$6,073,565	110	\$55,214
7 Antidiabetic Agents, Insulins	\$6,051,001	1,386	\$4,366
8 Gastrointestinal Drug Misc, NEC	\$4,426,987	7,291	\$607
9 Molecular Targeted Therapy	\$3,627,823	46	\$78,866
10 Adrenals & Comb, NEC	\$3,533,242	14,882	\$237



State of Delaware Medical and Prescription Drug Dashboard - Actives

Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2014 U.S. Total MarketScan norms that are age, gender, geographic, and/or severity adjusted as appropriate
- **PMPY** stands for Per Member Per Year and is weighted based on the number of months a member was enrolled in medical benefits
- **Allowed Amount (Allowed)** is the amount of submitted charges eligible for payment for medical and prescription drug claims; it is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts
- **Net Payment (Payment)** is the net amount paid by the company for medical and prescription drug claims; it represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted
- **Inpatient (IP)** represents claims for services provided under medical coverage in an acute inpatient setting; acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities
- **Outpatient (OP)** represents claims for medical services provided in any non-inpatient setting
- **Prescription Drug (Rx)** represents any claim paid under the pharmacy benefit
- **Patients** represents any member with a claim for the service (e.g., medical or prescription drug) being reported during the time period

1. Well Care and Preventive Visits

2. High Cost Claimants

- High Cost Claimants (HCCs) are members with \$100,000 or more in medical and prescription drug net payments incurred during the year
- Non-High Cost Claimants (HCCs) are members with less than \$100,000 in medical and prescription drug net payments incurred during the year

3. Quality Metrics

4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

- The Member Risk Score is produced using the Verisk DCG® model
- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
- **Benchmark** represents the U.S. Total MarketScan norm for the Price or Use rate
- The **Symbol** next to the Benchmark represents your Current rate compared to the Norm
- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests [source for age and gender criteria: US Preventive Services Task Force]
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services [source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services [source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services [source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

11. Prescription Drug Metrics

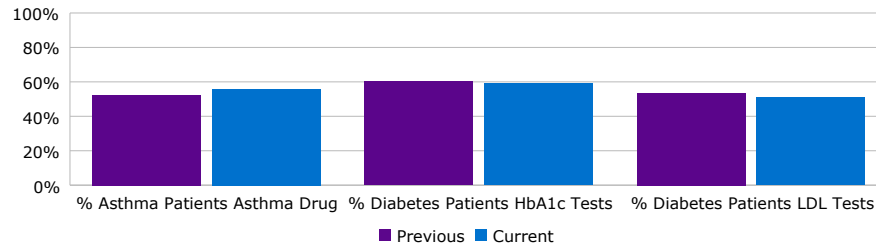
- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)

State of Delaware Medical and Prescription Drug Dashboard - Early Retirees

Previous Period: Oct 2014 - Sep 2015 (Paid)

Current Period: Oct 2015 - Sep 2016 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	383.2	283.3	-26.1%
Visits Per 1000 Well Child	832.8	815.9	-2.0%
Visits Per 1000 Prevent Adult	356.6	366.3	2.7%

4. Medical Plan Eligibility

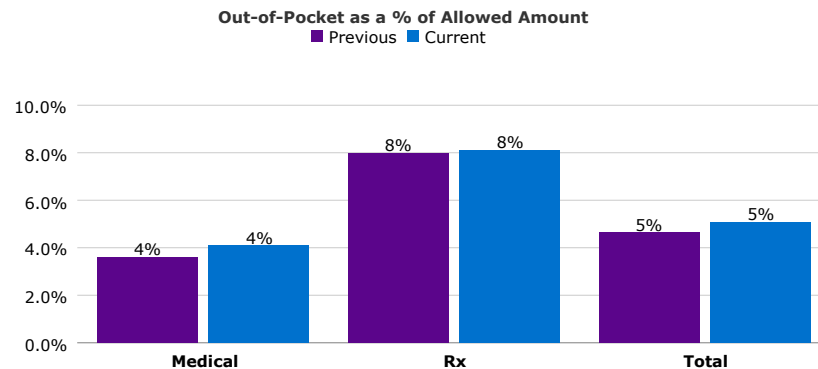
	Previous	Current	Trend
Average Employees	6,078	6,034	-1%
Average Members	9,301	9,287	0%
Family Size	1.5	1.5	1%
Member Age	51.3	51.1	0%
Members % Male	41%	41%	0% pts

5. Risk Score

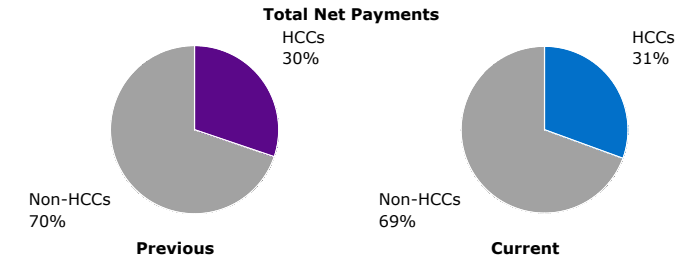
	Previous*	Current**	Trend
Member Risk Score	263	277	5%

Risk score is based on the following time periods: *Previous: July 2014 to June 2015, **Current: July 2015 to June 2016

7. Cost Sharing



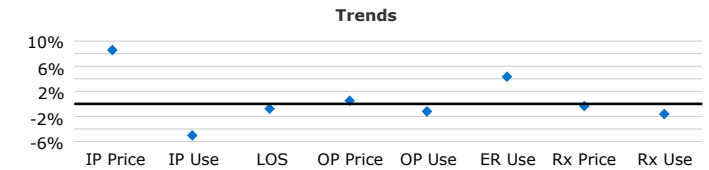
2. High Cost Claimants*



*Members with >=\$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	182	195	7%
Patients per 1,000	15.8	17.1	8%
Payments (in millions)	\$29.4	\$29.7	1%
Payment per Patient	\$161,761	\$152,344	-6%

6. Price and Use



	Current	Benchmark	Trend
Inpatient			
Allowed per Admit	\$31,366	\$26,167	9%
Admits per 1,000	94.4	69.2	-5%
Days LOS	5.5	4.1	-1%
Outpatient			
Allowed per Service	\$139	\$109	1%
Services PMPY	45.2	40.8	-1%
Emergency Room Visits per 1,000	355	220	4%
Prescription Drug			
Allowed/Days Supply	\$3.42	\$2.89	0%
Days Supply PMPY	818	657	-2%

● Represents a lower than -3% comparison to the benchmark

◆ Represents a comparison to the benchmark within +/-3%

■ Represents a higher than 3% comparison to the benchmark

Nov 18, 2016

Confidential - Prepared by Truven Health Analytics, an IBM Company

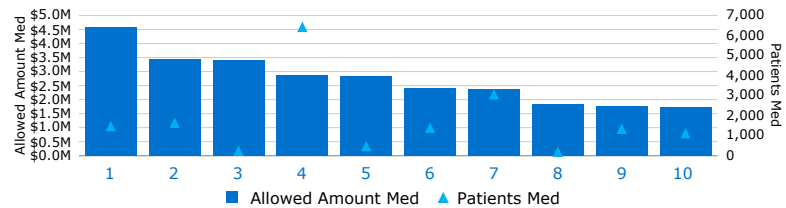
1 of 3

State of Delaware Medical and Prescription Drug Dashboard - Early Retirees

Previous Period: Oct 2014 - Sep 2015 (Paid)

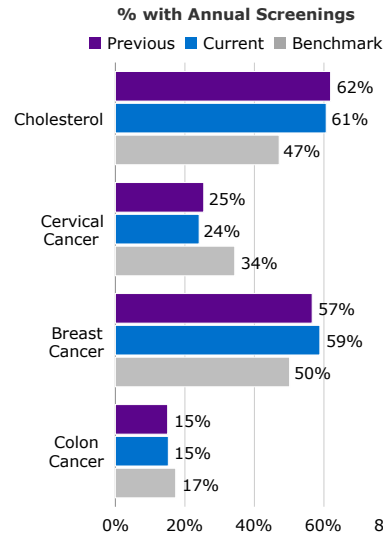
Current Period: Oct 2015 - Sep 2016 (Paid)

8. Top Medical Conditions (by cost)

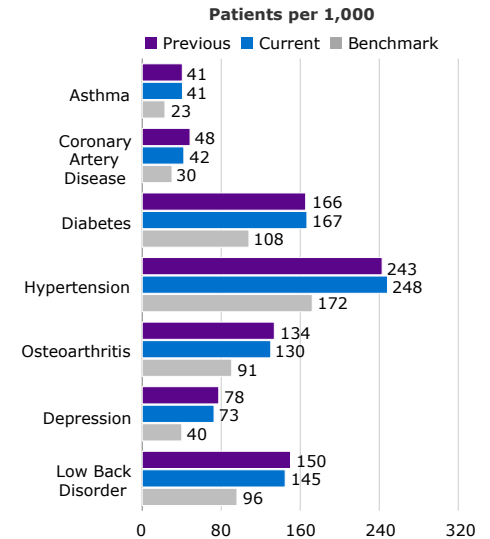


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1 Osteoarthritis	\$4,578,861	1,482	\$3,090
2 Spinal/Back Disord, Low Back	\$3,436,669	1,648	\$2,085
3 Renal Function Failure	\$3,388,562	252	\$13,447
4 Prevent/Admin Hlth Encounters	\$2,859,582	6,432	\$445
5 Coronary Artery Disease	\$2,824,042	480	\$5,883
6 Gastroint Disord, NEC	\$2,409,035	1,401	\$1,720
7 Arthropathies/Joint Disord NEC	\$2,387,279	3,071	\$777
8 Cancer - Breast	\$1,826,192	196	\$9,317
9 Respiratory Disord, NEC	\$1,777,385	1,351	\$1,316
10 Spinal/Back Disord, Ex Low	\$1,729,659	1,129	\$1,532

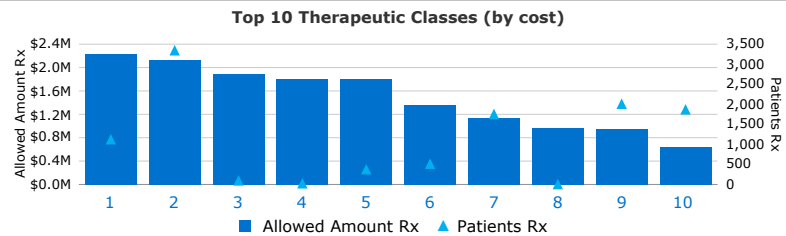
9. Screening Rates



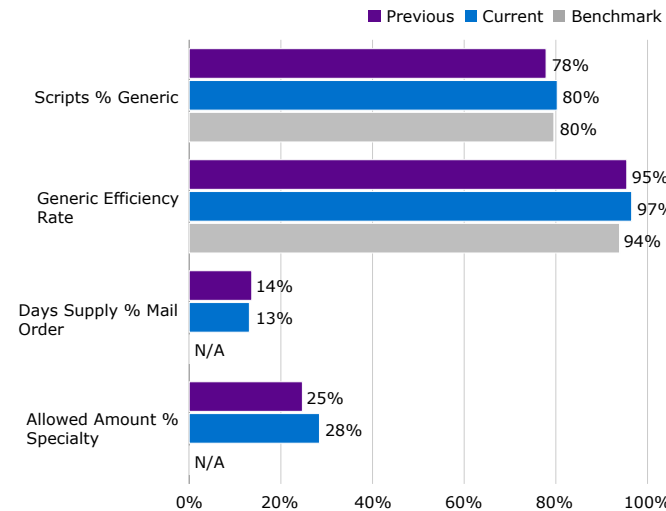
10. Chronic Condition Prevalence



11. Prescription Drug Metrics



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1 Antidiabetic Agents, Misc	\$2,232,277	1,128	\$1,979
2 Antihyperlipidemic Drugs, NEC	\$2,127,238	3,349	\$635
3 Immunosuppressants, NEC	\$1,897,524	102	\$18,603
4 Biological Response Modifiers	\$1,803,744	30	\$60,125
5 Antidiabetic Agents, Insulins	\$1,801,449	381	\$4,728
6 Antivirals, NEC	\$1,353,795	518	\$2,614
7 Gastrointestinal Drug Misc, NEC	\$1,143,218	1,759	\$650
8 Molecular Targeted Therapy	\$967,292	10	\$96,729
9 Analg/Antipyr, Opiate Agonists	\$943,355	2,015	\$468
10 Adrenals & Comb, NEC	\$634,277	1,875	\$338



State of Delaware Medical and Prescription Drug Dashboard - Early Retirees

Dashboard Glossary

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- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests [source for age and gender criteria: US Preventive Services Task Force]
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services [source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services [source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]
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10. Chronic Condition Prevalence

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- Chronic conditions identified based on medical claims

11. Prescription Drug Metrics

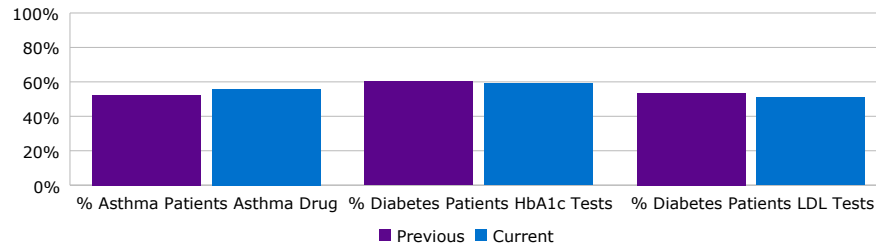
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- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)

State of Delaware Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Oct 2014 - Sep 2015 (Paid)

Current Period: Oct 2015 - Sep 2016 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	383.2	283.3	-26.1%
Visits Per 1000 Well Child	832.8	815.9	-2.0%
Visits Per 1000 Prevent Adult	356.6	366.3	2.7%

4. Medical Plan Eligibility

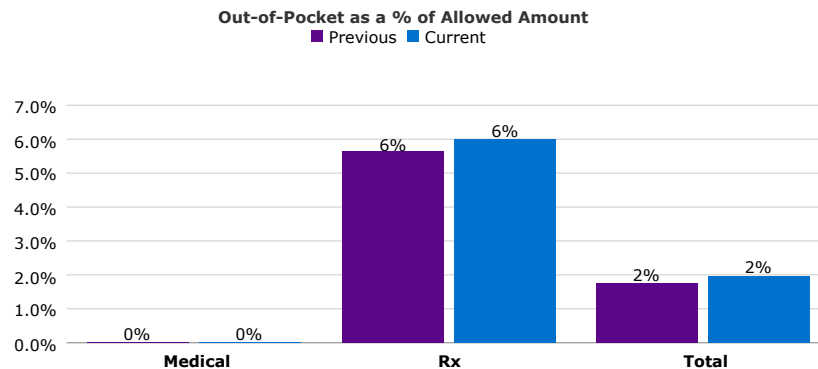
	Previous	Current	Trend
Average Employees	21,540	22,418	4%
Average Members	21,552	22,428	4%
Family Size	1.0	1.0	0%
Member Age	73.1	73.2	0%
Members % Male	42%	42%	0% pts

5. Risk Score

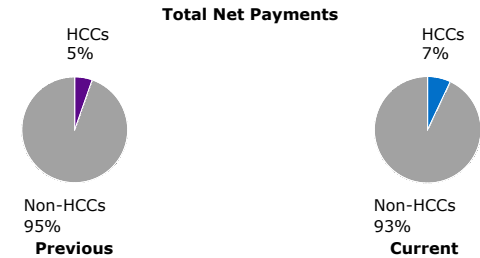
	Previous*	Current**	Trend
Member Risk Score	660	686	4%

Risk score is based on the following time periods: *Previous: July 2014 to June 2015, **Current: July 2015 to June 2016

7. Cost Sharing



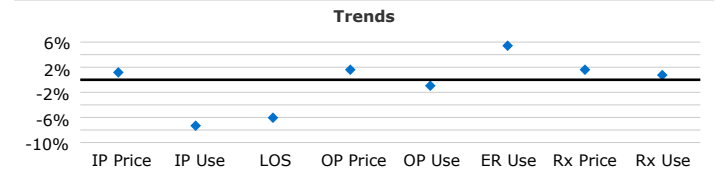
2. High Cost Claimants*



*Members with >=\$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	64	81	27%
Patients per 1,000	2.8	3.4	22%
Payments (in millions)	\$7.1	\$9.7	35%
Payment per Patient	\$111,590	\$119,277	7%

6. Price and Use



	Current	Benchmark	Trend
Inpatient			
Allowed per Admit	\$15,561	\$26,231	1%
Admits per 1,000	181.6	56.4	-7%
Days LOS	5.2	3.7	-6%
Outpatient			
Allowed per Service	\$102	\$110	2%
Services PMPY	71.3	29.6	-1%
Emergency Room Visits per 1,000	555	216	5%
Prescription Drug			
Allowed/Days Supply	\$3.17	\$3.22	1%
Days Supply PMPY	1,522	359	1%

● Represents a lower than -3% comparison to the benchmark

◆ Represents a comparison to the benchmark within +/-3%

■ Represents a higher than 3% comparison to the benchmark

Nov 18, 2016

Confidential - Prepared by Truven Health Analytics, an IBM Company

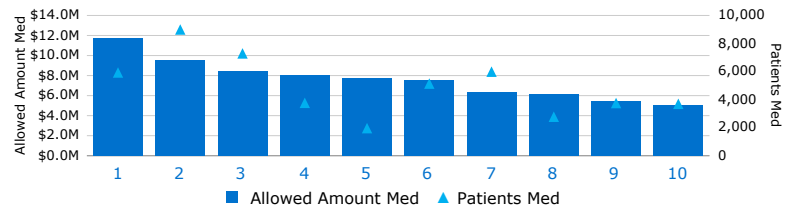
1 of 3

State of Delaware Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Oct 2014 - Sep 2015 (Paid)

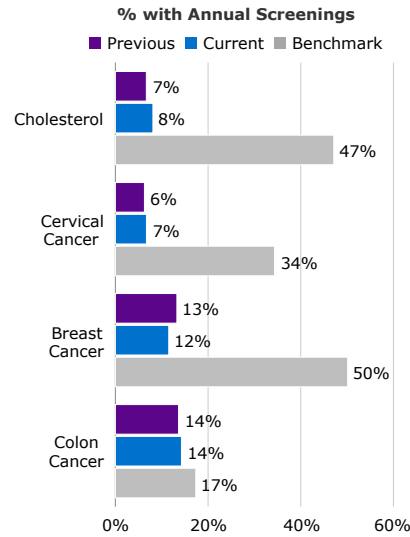
Current Period: Oct 2015 - Sep 2016 (Paid)

8. Top Medical Conditions (by cost)

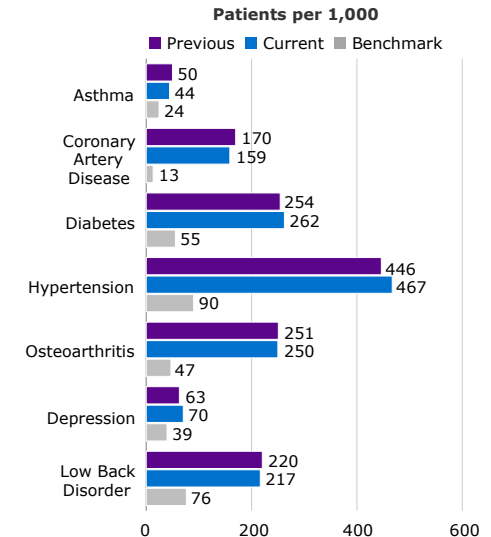


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1 Osteoarthritis	\$11,756,853	5,935	\$1,981
2 Arthropathies/Joint Disord NEC	\$9,523,497	8,999	\$1,058
3 Eye Disorders, Degenerative	\$8,455,736	7,295	\$1,159
4 Coronary Artery Disease	\$8,076,046	3,771	\$2,142
5 Renal Function Failure	\$7,774,983	1,967	\$3,953
6 Spinal/Back Disord, Low Back	\$7,501,108	5,143	\$1,459
7 Respiratory Disord, NEC	\$6,312,776	5,993	\$1,053
8 Cerebrovascular Disease	\$6,141,701	2,782	\$2,208
9 Cardiac Arrhythmias	\$5,399,269	3,756	\$1,438
10 Infections, NEC	\$5,015,195	3,701	\$1,355

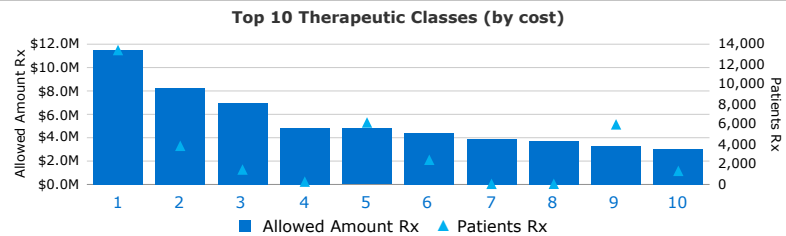
9. Screening Rates



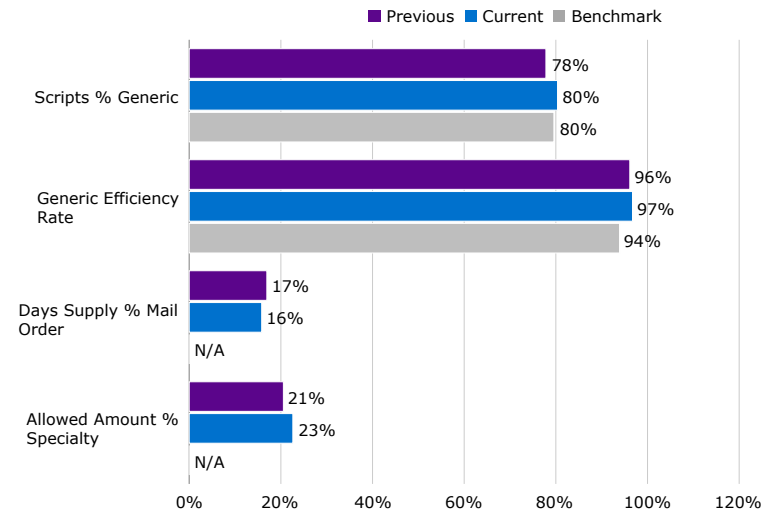
10. Chronic Condition Prevalence



11. Prescription Drug Metrics



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1 Antihyperlipidemic Drugs, NEC	\$11,538,330	13,417	\$860
2 Antidiabetic Agents, Misc	\$8,240,462	3,858	\$2,136
3 Antidiabetic Agents, Insulins	\$6,986,801	1,491	\$4,686
4 Immunosuppressants, NEC	\$4,817,615	284	\$16,963
5 Gastrointestinal Drug Misc, NEC	\$4,788,798	6,188	\$774
6 Coag/Anticoag, Anticoagulants	\$4,425,065	2,464	\$1,796
7 Biological Response Modifiers	\$3,926,102	66	\$59,486
8 Molecular Targeted Therapy	\$3,709,894	69	\$53,767
9 Adrenals & Comb, NEC	\$3,269,137	5,998	\$545
10 CNS Agents, Misc.	\$3,009,736	1,360	\$2,213



State of Delaware Medical and Prescription Drug Dashboard - Medicare Retirees

Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2014 U.S. Total MarketScan norms that are age, gender, geographic, and/or severity adjusted as appropriate
- **PMPY** stands for Per Member Per Year and is weighted based on the number of months a member was enrolled in medical benefits
- **Allowed Amount (Allowed)** is the amount of submitted charges eligible for payment for medical and prescription drug claims; it is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts
- **Net Payment (Payment)** is the net amount paid by the company for medical and prescription drug claims; it represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted
- **Inpatient (IP)** represents claims for services provided under medical coverage in an acute inpatient setting; acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities
- **Outpatient (OP)** represents claims for medical services provided in any non-inpatient setting
- **Prescription Drug (Rx)** represents any claim paid under the pharmacy benefit
- **Patients** represents any member with a claim for the service (e.g., medical or prescription drug) being reported during the time period

1. Well Care and Preventive Visits

2. High Cost Claimants

- High Cost Claimants (HCCs) are members with \$100,000 or more in medical and prescription drug net payments incurred during the year
- Non-High Cost Claimants (HCCs) are members with less than \$100,000 in medical and prescription drug net payments incurred during the year

3. Quality Metrics

4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

- The Member Risk Score is produced using the Verisk DCG® model
- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
- **Benchmark** represents the U.S. Total MarketScan norm for the Price or Use rate
- The **Symbol** next to the Benchmark represents your Current rate compared to the Norm
- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests [source for age and gender criteria: US Preventive Services Task Force]
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services [source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services [source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services [source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

11. Prescription Drug Metrics

- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)