State of Delaware - Quarterly Financial Reporting

FY18 Q2 Cost Analysis

February 2018

Willis Towers Watson

State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q2 Executive Summary

Overall medical and prescription drug results

- Total active and retiree medical and prescription drug cost for the period of July 1, 2017 through December 31, 2017 is $366.8M which is approximately 90% of the $407.5M budget (or 10% below budget), resulting in a surplus of $40.7M
  - Combined Active and Non-Medicare eligible retiree population is running 8% below budget. Non-Medicare eligible retiree program costs are expected to exceed budget due to the combined active/retiree experience pool used to develop budget rates
  - FY18 overall medical and prescription drug costs through Q2 decreased 2.3% over the same period in FY17 on a per employee basis.

Summary plan information

- Summary Plan Information through December 2017

FY2018	Total	Aetna	Highmark	Active	Pre-65 Retiree	Medicare Retiree
Summary (total)						
Total cost ($M)	$366.8	$82.0	$284.8	$255.8	$53.0	$58.1
Budgeted cost ($M)	$407.5	$104.7	$302.8	$295.9	$40.0	$71.6
Loss ratio	90%	78%	94%	86%	133%	81%
PEPY	$10,492	$11,399	$10,257	$13,545	$16,892	$4,488
# of enrolled employees	69,923	14,391	55,533	37,768	6,271	25,884

Key medical and prescription drug cost drivers - Actives

- Truven Executive Dashboard for January 2017 - December 2017 (compared to January 2016 - December 2016) details the following trends and cost drivers:
  - Inpatient admits decreased 8% from prior period while allowed cost per admit increased 7%.
  - Specialty drug allowed cost increased 10% over prior period while utilization increased 9% over prior; percent of allowed drug cost attributable to specialty increased from 29% to 35%.
  - Breast cancer screening rates declined 11% from prior period (from 57% to 46%) and the percent with annual screenings is now 5% below benchmark.
  - Following a significant shift in enrollment into Aetna HMO for FY18, Aetna reported that inpatient and outpatient utilization levels decreased in Q1 FY18 for most key metrics compared to Q1 FY17, and anticipate that these metrics will return to expected levels as HMO plan matures with new membership. Q2 FY18 utilization appears to be closer in line with Q2 FY17.

Additional notes

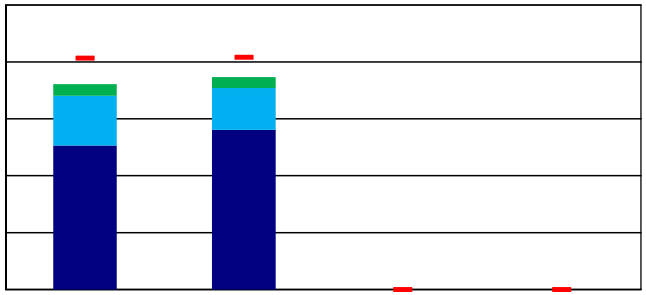
- Claims and other expenses are reported on a paid basis.
- Medical/Rx budget is based on FY18 budget rates, which were held flat from FY17.
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI. Costs include operating expenses.
- Expenses are broken down into two categories:
  - 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.
- 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.

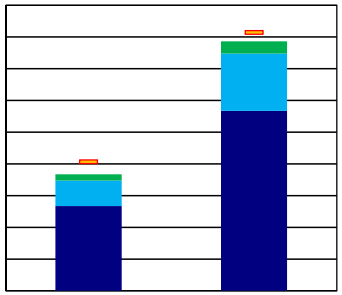
State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q2 Plan Cost Analysis

	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 2018	Q2 2018	Q3 2018	Q4 2018	YTD 2018	Proj. FY2018[6]
Total Program Cost[1]	**$180,343,366**	**$186,479,958**			**$366,823,324**	**$785,932,313**
- Paid Claims	170,156,510	177,054,281			347,210,791	747,213,691
- Medical (includes capitation[2])	126,441,323	140,283,995			266,725,317	567,237,527
- Capitation	2,758,791	2,772,018			5,530,809	11,415,461
- Rx (Including Rebates and EGWP)	43,715,188	36,770,286			80,485,474	179,976,164
- Rx Paid Claims	63,458,837	55,181,910			118,640,747	258,933,037
- EGWP	(7,802,622)	(8,035,595)			(15,838,217)	(30,203,447)
- Direct Subsidy	(1,406,523)	(1,286,724)			(2,693,247)	(4,949,876)
- CGDP	(4,110,986)	(4,448,707)			(8,559,692)	(13,939,892)
- Catastrophic Reinsurance	(2,285,113)	(2,300,165)			(4,585,278)	(11,313,678)
- Rx Rebates[3]	(11,941,027)	(10,376,029)			(22,317,056)	(48,753,426)
- ASO Fees	9,533,474	8,834,684			18,368,158	36,037,526
- Operational Expenses	653,382	590,993			1,244,375	2,681,096
Medical/Rx Budget	**$203,420,681**	**$204,084,021**			**$407,504,702**	**$815,009,403**
- Surplus/(Deficit)	23,077,315	17,604,063			40,681,378	29,077,090
- Total Cost as % of Budget	89%	91%			90%	96%
Current Year Per Capita						
- Total per employee per year[4]	10,340	10,643	N/A	N/A	10,492	11,227
- Total % change over prior	-7.9%	3.9%			-2.3%	1.9%
- Medical per employee per year	7,749	8,473	N/A	N/A	8,111	8,578
- Medical % change over prior	-11.2%	3.5%			-4.1%	0.4%
- Rx per employee per year	2,554	2,136	N/A	N/A	2,345	2,611
- Rx % change over prior	3.6%	5.9%			4.7%	7.2%
- Medical per member per year	4,350	4,761	N/A	N/A	4,556	4,819
- Rx per member per year	1,434	1,200	N/A	N/A	1,317	1,467
- Total per member per year[4]	5,805	5,980	N/A	N/A	5,893	6,307
Prior Year Results	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**		
- Total Program Cost[4]	192,489,481	177,399,275			369,888,756	762,939,276
- Total Program Cost $ Change	-12,146,115	9,080,683			(3,065,432)	22,993,038
- Total per employee per year[4]	11,231	10,248			10,739	11,017
- Medical per employee per year	8,725	8,190			8,458	8,540
- Rx per employee per year	2,465	2,017			2,241	2,436
EE Contributions	**$40,560,322**	**$39,856,517**			**$80,416,840**	**$160,833,679**
- Net SoD[5]	139,783,043	146,623,441			286,406,484	625,098,634
- SoD Subsidy %	78%	79%			78%	80%
Headcount						
- Enrolled Ees	69,762	70,083			69,923	70,003
- Enrolled Members	124,258	124,731			124,495	124,613
- Member/EE Ratio	1.8	1.8			1.8	1.8

[1] Aggregate totals includes run-off medical and pharmacy claims from Highmark BlueCare HMO ($9,046,782) and Highmark CDH Gold ($696,161) plans terminated 7/1/2017

[2] Capitation payments apply to HMO and POS plans only

[3] Reflects estimated rebates attributable to FY18, based on WTW analysis of expected rebates under new ESI contract and actual paid rebates attributable to FY17

[4] Program cost and PEPM values also include ASO fees and operational expenses

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

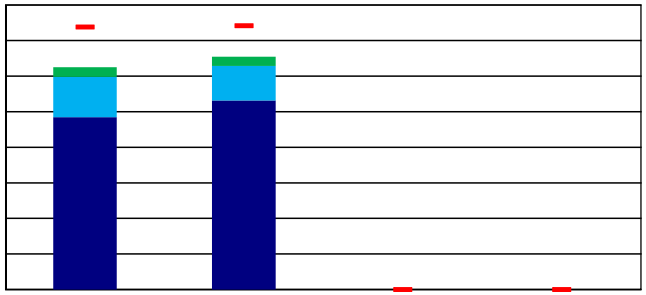
[6] Projections based on most recent 12 months of claims experience (1/1/2017 through 12/31/2017)

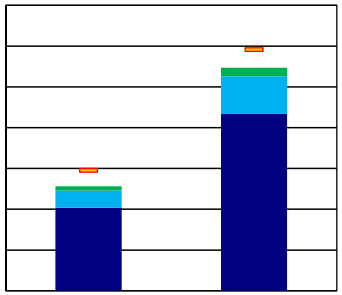
State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q2 Plan Cost Analysis

	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 2018	Q2 2018	Q3 2018	Q4 2018	YTD 2018	Proj. FY2018[6]
Total Program Cost[1]	**$124,968,474**	**$130,813,667**			**$255,782,141**	**$546,442,590**
- Paid Claims	119,473,038	125,716,111			245,189,150	525,514,682
- Medical (includes capitation[2])	96,896,568	106,204,470			203,101,037	432,879,122
- Capitation	2,460,705	2,473,884			4,934,589	10,184,877
- Rx (Including Rebates and EGWP)	22,576,471	19,511,642			42,088,112	92,635,560
- Rx Paid Claims	28,185,357	24,359,103			52,544,460	115,649,888
- EGWP	0	0			0	0
- Direct Subsidy	0	0			0	0
- CGDP	0	0			0	0
- Catastrophic Reinsurance	0	0			0	0
- Rx Rebates[3]	(5,608,886)	(4,847,462)			(10,456,347)	(23,014,328)
- ASO Fees	5,142,960	4,777,938			9,920,897	19,476,773
- Operational Expenses	352,475	319,618			672,094	1,451,135
Medical/Rx Budget	**$147,602,446**	**$148,334,074**			**$295,936,521**	**$591,873,041**
- Surplus/(Deficit)	22,633,973	17,520,407			40,154,380	45,430,452
- Total Cost as % of Budget	85%	88%			86%	92%
Current Year Per Capita						
- Total per employee per year[4]	13,283	13,805	N/A	N/A	13,544	14,443
- Total % change over prior	-9.2%	6.4%			-1.9%	2.2%
- Medical per employee per year	10,798	11,675	N/A	N/A	11,236	11,916
- Medical % change over prior	-11.1%	5.7%			-3.1%	1.5%
- Rx per employee per year	2,447	2,097	N/A	N/A	2,272	2,488
- Rx % change over prior	0.5%	10.6%			4.9%	6.0%
- Medical per member per year	4,580	4,963	N/A	N/A	4,772	5,063
- Rx per member per year	1,038	891	N/A	N/A	965	1,057
- Total per member per year[4]	5,634	5,869	N/A	N/A	5,752	6,137
Prior Year Results	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**		
- Total Program Cost[4]	136,761,585	123,070,044			259,831,629	534,352,624
- Total Program Cost $ Change	-11,793,111	7,743,623			(4,049,488)	12,089,966
- Total per employee per year[4]	14,628	12,980			13,804	14,132
- Medical per employee per year	12,152	11,044			11,598	11,743
- Rx per employee per year	2,435	1,896			2,165	2,348
EE Contributions	**$36,497,076**	**$36,772,347**			**$73,269,423**	**$146,538,846**
- Net SoD[5]	88,471,397	94,041,321			182,512,718	399,903,743
- SoD Subsidy %	71%	72%			71%	73%
Headcount						
- Enrolled Ees	37,634	37,902			37,768	37,835
- Enrolled Members	88,722	89,155			88,939	89,047
- Member/EE Ratio	2.4	2.4			2.4	2.4

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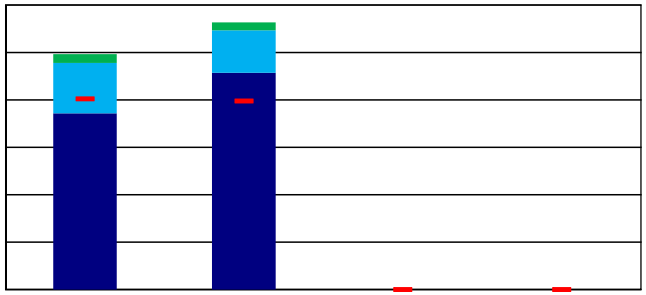
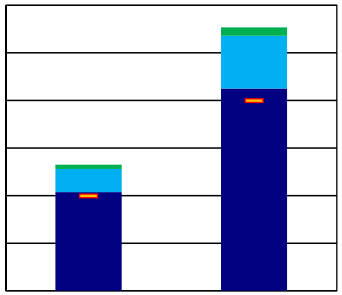
State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q2 Plan Cost Analysis

	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 2018	Q2 2018	Q3 2018	Q4 2018	YTD 2018	Proj. FY2018[6]
Total Program Cost[1]	**$24,801,278**	**$28,163,700**			**$52,964,978**	**$110,626,606**
- Paid Claims	23,881,916	27,323,656			51,205,573	107,163,694
- Medical (includes capitation[2])	18,565,869	22,832,177			41,398,045	84,984,416
- Capitation	298,086	298,134			596,220	1,230,584
- Rx (Including Rebates and EGWP)	5,316,048	4,491,480			9,807,528	22,179,278
- Rx Paid Claims	6,636,764	5,607,341			12,244,104	27,689,486
- EGWP	0	0			0	0
- Direct Subsidy	0	0			0	0
- CGDP	0	0			0	0
- Catastrophic Reinsurance	0	0			0	0
- Rx Rebates[3]	(1,320,716)	(1,115,861)			(2,436,577)	(5,510,208)
- ASO Fees	860,394	787,373			1,647,767	3,222,512
- Operational Expenses	58,968	52,671			111,639	240,400
Medical/Rx Budget	**$20,102,537**	**$19,887,574**			**$39,990,111**	**$79,980,223**
- Surplus/(Deficit)	(4,698,741)	(8,276,126)			(12,974,867)	(30,646,383)
- Total Cost as % of Budget	123%	142%			132%	138%
Current Year Per Capita						
- Total per employee per year[4]	15,757	18,036	N/A	N/A	16,897	17,676
- Total % change over prior	-8.9%	3.0%			-2.9%	2.5%
- Medical per employee per year	12,294	15,089	N/A	N/A	13,691	14,054
- Medical % change over prior	-10.6%	2.7%			-3.7%	1.2%
- Rx per employee per year	3,425	2,914	N/A	N/A	3,170	3,584
- Rx % change over prior	-2.1%	5.3%			1.2%	7.9%
- Medical per member per year	7,976	9,775	N/A	N/A	8,876	9,108
- Rx per member per year	2,222	1,888	N/A	N/A	2,055	2,323
- Total per member per year[4]	10,223	11,685	N/A	N/A	10,954	11,456
Prior Year Results	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**		
- Total Program Cost[4]	27,505,375	27,269,512			54,774,887	107,926,430
- Total Program Cost $ Change	-2,704,096	894,188			(1,809,909)	2,700,176
- Total per employee per year[4]	17,291	17,506			17,398	17,246
- Medical per employee per year	13,751	14,698			14,224	13,883
- Rx per employee per year	3,499	2,767			3,133	3,323
EE Contributions	**$3,941,766**	**$2,957,843**			**$6,899,610**	**$13,799,219**
- Net SoD[5]	20,859,512	25,205,857			46,065,369	96,827,386
- SoD Subsidy %	84%	89%			87%	88%
Headcount						
- Enrolled Ees	6,296	6,246			6,271	6,259
- Enrolled Members	9,704	9,641			9,673	9,657
- Member/EE Ratio	1.5	1.5			1.5	1.5

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[3] Reflects estimated rebates attributable to FY18, based on WTW analysis of expected rebates under new ESI contract and actual paid rebates attributable to FY17

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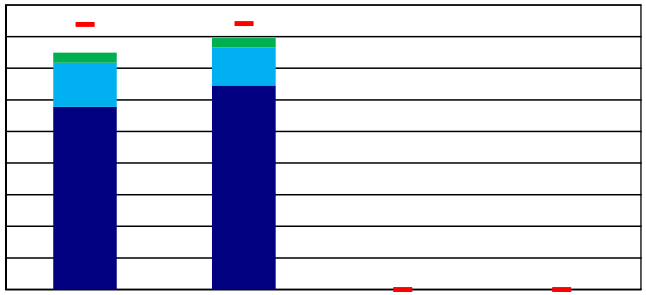
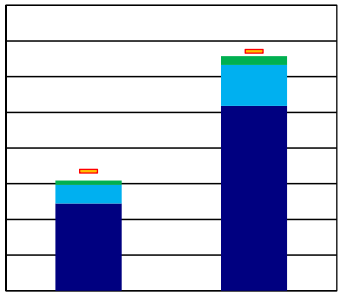
Health Plan Quarterly Financial Reporting
FY18 Q2 Plan Cost Analysis

	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 2018	Q2 2018	Q3 2018	Q4 2018	YTD 2018	Proj. FY2018[6]
Total Program Cost[1]	**$149,769,752**	**$158,977,367**			**$308,747,119**	**$657,069,195**
- Paid Claims	143,354,955	153,039,768			296,394,722	632,678,376
- Medical (includes capitation[2])	115,462,436	129,036,646			244,499,083	517,863,538
- Capitation	2,758,791	2,772,018			5,530,809	11,415,461
- Rx (Including Rebates and EGWP)	27,892,518	24,003,121			51,895,640	114,814,838
- Rx Paid Claims	34,822,120	29,966,444			64,788,564	143,339,373
- EGWP	0	0			0	0
- Direct Subsidy	0	0			0	0
- CGDP	0	0			0	0
- Catastrophic Reinsurance	0	0			0	0
- Rx Rebates[3]	(6,929,602)	(5,963,322)			(12,892,924)	(28,524,535)
- ASO Fees	6,003,354	5,565,310			11,568,664	22,699,285
- Operational Expenses	411,443	372,289			783,732	1,691,535
Medical/Rx Budget	**$167,704,984**	**$168,221,648**			**$335,926,632**	**$671,853,264**
- Surplus/(Deficit)	17,935,232	9,244,281			27,179,513	14,784,069
- Total Cost as % of Budget	89%	95%			92%	98%
Current Year Per Capita						
- Total per employee per year[4]	13,637	14,404	N/A	N/A	14,021	14,902
- Total % change over prior	-9.2%	5.8%			-2.1%	2.2%
- Medical per employee per year	11,012	12,158	N/A	N/A	11,585	12,219
- Medical % change over prior	-11.1%	5.2%			-3.2%	1.4%
- Rx per employee per year	2,588	2,212	N/A	N/A	2,400	2,644
- Rx % change over prior	-0.1%	9.6%			4.2%	6.3%
- Medical per member per year	4,915	5,433	N/A	N/A	5,174	5,459
- Rx per member per year	1,155	989	N/A	N/A	1,072	1,181
- Total per member per year[4]	6,087	6,437	N/A	N/A	6,262	6,657
Prior Year Results	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**		
- Total Program Cost[4]	164,266,959	150,339,557			314,606,516	642,279,054
- Total Program Cost $ Change	-14,497,208	8,637,811			(5,859,397)	14,790,142
- Total per employee per year[4]	15,015	13,619			14,317	14,574
- Medical per employee per year	12,384	11,559			11,972	12,047
- Rx per employee per year	2,590	2,019			2,304	2,487
EE Contributions	**$40,438,843**	**$39,730,190**			**$80,169,033**	**$160,338,066**
- Net SoD[5]	109,330,909	119,247,177			228,578,086	496,731,130
- SoD Subsidy %	73%	75%			74%	76%
Headcount						
- Enrolled Ees	43,930	44,148			44,039	44,094
- Enrolled Members	98,426	98,796			98,611	98,704
- Member/EE Ratio	2.2	2.2			2.2	2.2

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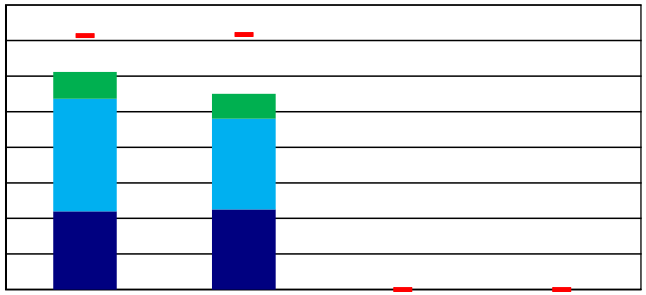
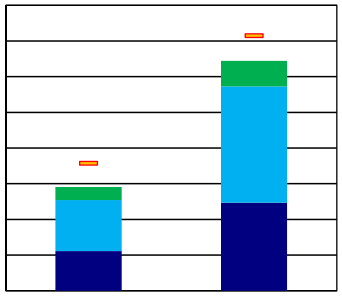
FY18 Q2 Plan Cost Analysis

	Drop-Down Choices
Status	Medicare Retiree
Vendor	Total
Plan	Total

Legend

- **Medical/Rx Budget**
- **Fees and Op. Expenses**
- **Rx (incl. Rebates and EGWP)**
- **Medical (incl. capitation)**





	Q1 2018	Q2 2018	Q3 2018	Q4 2018	YTD 2018	Proj. FY2018[6]
Total Program Cost[1]	**$30,573,614**	**$27,502,591**			**$58,076,205**	**$128,863,118**
- Paid Claims	26,801,555	24,014,513			50,816,069	114,535,315
- Medical (includes capitation[2])	10,978,886	11,247,349			22,226,235	49,373,989
- Capitation	0	0			0	0
- Rx (Including Rebates and EGWP)	15,822,669	12,767,165			28,589,834	65,161,326
- Rx Paid Claims	28,636,717	25,215,467			53,852,183	115,593,664
- EGWP	(7,802,622)	(8,035,595)			(15,838,217)	(30,203,447)
- Direct Subsidy	(1,406,523)	(1,286,724)			(2,693,247)	(4,949,876)
- CGDP	(4,110,986)	(4,448,707)			(8,559,692)	(13,939,892)
- Catastrophic Reinsurance	(2,285,113)	(2,300,165)			(4,585,278)	(11,313,678)
- Rx Rebates[3]	(5,011,425)	(4,412,707)			(9,424,132)	(20,228,891)
- ASO Fees	3,530,120	3,269,374			6,799,494	13,338,242
- Operational Expenses	241,939	218,704			460,642	989,561
Medical/Rx Budget	**$35,715,697**	**$35,862,373**			**$71,578,070**	**$143,156,139**
- Surplus/(Deficit)	5,142,083	8,359,782			13,501,865	14,293,021
- Total Cost as % of Budget	86%	77%			81%	90%
Current Year Per Capita						
- Total per employee per year[4]	4,734	4,242	N/A	N/A	4,488	4,974
- Total % change over prior	4.0%	-1.7%			1.2%	3.8%
- Medical per employee per year	2,199	2,201	N/A	N/A	2,200	2,380
- Medical % change over prior	-3.0%	-2.6%			-2.8%	-0.9%
- Rx per employee per year	2,498	2,007	N/A	N/A	2,252	2,555
- Rx % change over prior	11.3%	-0.4%			5.8%	8.8%
- Medical per member per year	2,199	2,201	N/A	N/A	2,200	2,380
- Rx per member per year	2,498	2,007	N/A	N/A	2,252	2,555
- Total per member per year[4]	4,734	4,242	N/A	N/A	4,488	4,974
Prior Year Results	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**		
- Total Program Cost[4]	28,222,521	27,059,719			55,282,240	120,660,222
- Total Program Cost $ Change	2,351,092	442,872			2,793,965	8,202,896
- Total per employee per year[4]	4,552	4,315			4,434	4,792
- Medical per employee per year	2,267	2,260			2,264	2,403
- Rx per employee per year	2,244	2,014			2,129	2,348
EE Contributions	**$121,480**	**$126,327**			**$247,807**	**$495,614**
- Net SoD[5]	30,452,134	27,376,264			57,828,398	128,367,504
- SoD Subsidy %	100%	100%			100%	100%
Headcount						
- Enrolled Ees	25,832	25,935			25,884	25,909
- Enrolled Members	25,832	25,935			25,884	25,909
- Member/EE Ratio	1.0	1.0			1.0	1.0

[1] Aggregate totals includes run-off medical and pharmacy claims from Highmark BlueCare HMO ($9,046,782) and Highmark CDH Gold ($696,161) plans terminated 7/1/2017

[2] Capitation payments apply to HMO and POS plans only

[3] Reflects estimated rebates attributable to FY18, based on WTW analysis of expected rebates under new ESI contract and actual paid rebates attributable to FY17

[4] Program cost and PEPM values also include ASO fees and operational expenses

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

[6] Projections based on most recent 12 months of claims experience (1/1/2017 through 12/31/2017)

State of Delaware
FY2018 Financial Analysis of Health/Rx Plans - Paid Basis
Year to Date July 1, 2017 - December 30, 2017

Vendor	Highmark											Aetna					Total
Plan	**Basic Active**	**Basic Non Medicare Retirees**	**PPO Active**	**PPO Non Medicare Retirees**	**CDH Active (termed 7/1/2017)**	**CDH Non Medicare Retirees (termed 7/1/2017)**	**Medicare Primary Retirees**	**Blue Care HMO Active (termed 7/1/2017)**	**Blue Care HMO Non Medicare Retirees (termed 7/1/2017)**	**POS**	**Total Highmark[3]**	**Aetna HMO Active**	**Aetna HMO Non Medicare Retirees**	**Aetna CDH Active**	**Aetna CDH Non Medicare Retirees**	**Total Aetna[3]**	**Total**
Medical																	
Paid Claims	$6,744,742	$789,414	$138,656,569	$30,532,207	$632,412	$42,253	$22,226,235	$7,466,460	$1,398,419	$1,221,537	$203,059,144	$39,019,002	$7,705,475	$4,425,726	$334,058	$58,135,365	$261,194,508
Capitation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,934,589	$596,220	$0	$0	$5,530,809	$5,530,809
Administration	$517,595	$55,299	$5,563,081	$957,792	$0	$0	$6,247,237	$0	$0	$61,326	$13,402,329	$2,450,479	$459,978	$522,741	$40,801	$3,473,999	$16,876,327
Total Medical Program Cost	$7,262,337	$844,713	$144,219,650	$31,489,999	$632,412	$42,253	$28,473,471	$7,466,460	$1,398,419	$1,282,862	$216,461,472	$46,404,070	$8,761,673	$4,948,467	$374,859	$67,140,172	$283,601,644
Average Number of Employees	2,147	229	23,051	3,968			25,884			254	55,532	10,150	1,906	2,166	169	14,391	69,923
Program Cost/Employee/Yr.	$6,765	$7,377	$12,513	$15,874			$2,200			$10,101	$7,796	$9,144	$9,196	$4,569	$4,436	$9,331	$8,111
Change from prior period (pepy)	10.0%	-66.9%	-2.6%	13.8%			-8.4%			-40.2%	-8.0%	-9.0%	-24.3%	-32.9%	-43.8%	-5.0%	-5.0%
Average Number of Members	4,229	341	54,660	5,980			25,884			489	91,581	24,999	3,081	4,563	272	32,914	124,495
Program Cost/Member/Yr.	$3,435	$4,954	$5,277	$10,533			$2,200			$5,247	$4,727	$3,713	$5,688	$2,169	$2,761	$4,080	$4,556
Change from prior period (pmpy)	0.3%	-70.8%	-2.6%	12.6%			-8.4%			-40.0%	-1.2%	-11.1%	-22.5%	-31.0%	-49.2%	-5.9%	-4.2%
Express Scripts, Inc.																	
Paid Claims	$1,617,806	$227,278	$36,306,239	$8,374,238	$18,757	$8,078	$53,852,183	$180,177	$46,918	$310,578	$100,765,209	$12,026,595	$3,409,073	$2,084,307	$178,519	$17,875,538	$118,640,747
Administration	$45,612	$4,895	$491,656	$84,715	$0	$0	$552,257	$0	$0	$5,426	$1,184,562	$216,782	$40,678	$46,200	$3,609	$307,269	$1,491,831
Estimated EGWP Savings	$0	$0	$0	$0	$0	$0	($15,838,217)	$0	$0	$0	($15,838,217)	$0	$0	$0	$0	$0	($15,838,217)
Estimated Rebates[1]	($321,943)	($45,228)	($7,224,942)	($1,666,473)	($3,733)	($1,608)	($9,424,132)	($35,855)	($9,337)	($61,805)	($18,759,824)	($2,393,292)	($678,405)	($414,777)	($35,525)	($3,557,232)	($22,317,056)
Total Rx Program Cost	$1,341,474	$186,945	$29,572,953	$6,792,480	$15,025	$6,471	$29,142,091	$144,322	$37,582	$254,199	$67,351,729	$9,850,085	$2,771,345	$1,715,730	$146,603	$14,625,575	$81,977,305
Average Number of Employees	2,147	229	23,051	3,968			25,884			254	55,532	10,150	1,906	2,166	169	14,391	69,923
Program Cost/Employee/Yr.	$1,250	$1,633	$2,566	$3,424			$2,252			$2,002	$2,426	$1,941	$2,909	$1,584	$1,735	$2,033	$2,345
Change from prior period (pepy)	47.0%	28.3%	-2.6%	-0.5%			-4.1%			1.0%	-0.5%	-10.5%	-36.0%	-12.3%	85.2%	-15.7%	-3.8%
Average Number of Members	4,229	341	54,660	5,980			25,884			489	91,581	24,999	3,081	4,563	272	32,914	124,495
Program Cost/Member/Yr.	$634	$1,096	$1,082	$2,272			$2,252			$1,040	$1,471	$788	$1,799	$752	$1,080	$889	$1,317
Change from prior period (pmpy)	34.1%	13.2%	-2.7%	-1.5%			-4.1%			1.2%	6.8%	-12.5%	-34.5%	-9.9%	67.4%	-16.5%	-2.9%
Total Medical and Rx																	
Premium	$13,508,080	$1,293,820	$188,929,651	$25,991,408			$71,578,070			$1,481,666	$302,782,695	$77,174,016	$11,649,145	$14,843,107	$1,055,738	$104,722,006	$407,504,702
Program Cost (prior to operational)	$8,603,812	$1,031,658	$173,792,604	$38,282,479			$57,615,562			$1,537,062	$283,813,202	$56,254,155	$11,533,018	$6,664,196	$521,461	$81,765,748	$365,578,949
Operational Expenses	$38,139	$4,079	$410,174	$70,631			$460,642			$4,523	$988,188	$180,716	$33,919	$38,543	$3,009	$256,187	$1,244,375
Total Program Cost	$8,641,951	$1,035,737	$174,202,777	$38,353,110	$647,437	$48,724	$58,076,205	$7,610,782	$1,436,000	$1,541,584	$284,801,389	$56,434,871	$11,566,938	$6,702,739	$524,470	$82,021,934	$366,823,324
Surplus / (Deficit)	$4,866,129	$258,083	$14,726,874	($12,361,702)			$13,501,865			($59,918)	$17,981,306	$20,739,145	$82,207	$8,140,368	$531,268	$22,700,072	$40,681,378
Total Cost as % of Budget	**64.0%**	**80.1%**	**92.2%**	**147.6%**			**81.1%**			**104.0%**	**94.1%**	**73.1%**	**99.3%**	**45.2%**	**49.7%**	**78.3%**	**90.0%**
Average Number of Employees	2,147	229	23,051	3,968			25,884			254	55,533	10,150	1,906	2,166	169	14,391	69,923
Program Cost/Employee/Yr.	$8,050	$9,046	$15,115	$19,334			$4,487			$12,138	$10,257	$11,120	$12,141	$6,189	$6,207	$11,399	$10,492
Change from prior period (pepy)	14.3%	-61.6%	-2.6%	10.9%			-6.4%			-35.8%	-6.3%	-9.3%	-27.5%	-28.5%	-30.0%	-7.1%	-4.8%
Average Number of Members	4,229	341	54,660	5,980			25,884			489	91,581	24,999	3,081	4,563	272	32,914	124,495
Program Cost/Member/Yr.	$4,087	$6,075	$6,374	$12,828			$4,488			$6,305	$6,220	$4,515	$7,510	$2,938	$3,863	$4,984	$5,893
Change from prior period (pmpy)	4.3%	-66.1%	-2.6%	9.8%			-6.3%			-35.6%	0.5%	-11.4%	-25.7%	-26.5%	-36.7%	-8.0%	-4.0%
Prior Period Program Cost (FY17)																	
Per Employee Per Year																	
Medical	$6,153	$22,257	$12,841	$13,954			$2,403			$16,879	$8,470	$10,050	$12,150	$6,808	$7,894	$9,822	$8,540
Rx	$850	$1,272	$2,636	$3,442			$2,348			$1,982	$2,438	$2,169	$4,544	$1,806	$937	$2,410	$2,436
Total[2]	$7,044	$23,570	$15,517	$17,436			$4,792			$18,901	$10,948	$12,259	$16,734	$8,655	$8,871	$12,273	$11,017
Per Member Per Year																	
Medical	$3,424	$16,943	$5,417	$9,351			$2,403			$8,749	$4,786	$4,175	$7,342	$3,145	$5,435	$4,335	$4,756
Rx	$473	$968	$1,112	$2,306			$2,348			$1,027	$1,377	$901	$2,746	$834	$645	$1,064	$1,357
Total[2]	$3,920	$17,942	$6,546	$11,684			$4,792			$9,797	$6,186	$5,093	$10,113	$3,998	$6,108	$5,417	$6,136

[1] Reflects estimated rebates attributable to FY18, based on WTW analysis of expected rebates under new ESI contract and actual paid rebates attributable to FY17.
[2] Includes Medical, Rx, and Operational Expenses.
[3] Run-out for Highmark CDH and Highmark Blue Care HMO plans allocated between Highmark total and Aetna total based on FY18 plan migration (70% Aetna / 30% Highmark). As a result, individual Highmark and Aetna plans do not sum to the Total Highmark and Total Aetna columns.

State of Delaware
FY2018 Financial Analysis of Health/Rx Plans - Paid Basis
Projected July 1, 2017 - June 30, 2018

Vendor	Highmark											Aetna					Total
Plan	Basic Active	Basic Non Medicare Retirees	PPO Active	PPO Non Medicare Retirees	CDH Active (termed 7/1/2017)[3]	CDH Non Medicare Retirees (termed 7/1/2017)[3]	Medicare Primary Retirees	Blue Care HMO Active (termed 7/1/2017)[3]	Blue Care HMO Non Medicare Retirees (termed 7/1/2017)[3]	POS	Total Highmark[4]	Aetna HMO Active	Aetna HMO Non Medicare Retirees	Aetna CDH Active	Aetna CDH Non Medicare Retirees	Total Aetna[4]	Total
Medical																	
Paid Claims	$14,894,404	$1,989,493	$296,383,711	$60,171,598	$632,412	$42,253	$49,373,989	$7,466,460	$1,398,419	$3,365,356	$429,066,991	$89,497,866	$19,284,477	$10,454,036	$867,592	$126,755,075	$555,822,066
Capitation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,184,877	$1,230,584	$0	$0	$11,415,461	$11,415,461
Administration	$1,037,332	$108,043	$10,968,396	$1,879,876	$0	$0	$12,299,948	$0	$0	$120,137	$26,413,733	$4,804,350	$903,634	$1,030,576	$80,008	$6,818,568	$33,232,301
Total Medical Program Cost	$15,931,737	$2,097,536	$307,352,108	$62,051,474	$632,412	$42,253	$61,673,937	$7,466,460	$1,398,419	$3,485,493	$455,480,724	$104,487,093	$21,418,695	$11,484,612	$947,601	$144,989,104	$600,469,829
Average Number of Employees	2,149	229	23,081	3,972			25,909			254	55,595	10,163	1,908	2,168	169	14,408	70,003
Program Cost/Employee/Yr.	$7,412	$9,149	$13,316	$15,622			$2,380			$13,707	$8,193	$10,281	$11,228	$5,296	$5,601	$10,063	$8,578
Change from prior period (pepy)	20.5%	-58.9%	3.7%	12.0%			-0.9%			-18.8%	-3.3%	2.3%	-7.6%	-22.2%	-29.0%	2.5%	0.4%
Average Number of Members	4,233	341	54,711	5,985			25,909			489	91,668	25,022	3,083	4,567	272	32,945	124,613
Program Cost/Member/Yr.	$3,764	$6,145	$5,618	$10,368			$2,380			$7,121	$4,969	$4,176	$6,946	$2,515	$3,487	$4,401	$4,819
Change from prior period (pmpy)	9.9%	-63.7%	3.7%	10.9%			-0.9%			-18.6%	3.8%	0.0%	-5.4%	-20.0%	-35.8%	1.5%	1.3%
Express Scripts, Inc.																	
Paid Claims	$3,122,395	$435,009	$79,109,580	$18,035,387	$18,757	$8,078	$115,593,664	$180,177	$46,918	$631,883	$217,004,805	$28,053,703	$8,876,355	$4,533,392	$287,738	$41,928,232	$258,933,037
Administration	$87,347	$9,130	$925,706	$158,759	$0	$0	$1,038,293	$0	$0	$10,149	$2,229,385	$405,800	$76,304	$86,979	$6,758	$575,840	$2,805,225
Estimated EGWP Savings	$0	$0	$0	$0	$0	$0	($30,203,447)	$0	$0	$0	($30,203,447)	$0	$0	$0	$0	$0	($30,203,447)
Estimated Rebates[1]	($621,357)	($86,567)	($15,742,806)	($3,589,042)	($3,733)	($1,608)	($20,228,891)	($35,855)	($9,337)	($125,745)	($40,409,708)	($5,582,687)	($1,766,395)	($902,145)	($57,260)	($8,343,718)	($48,753,426)
Total Rx Program Cost	$2,588,386	$357,572	$64,292,480	$14,605,104	$15,025	$6,471	$66,199,619	$144,322	$37,582	$516,287	$148,621,035	$22,876,816	$7,186,264	$3,718,226	$237,236	$34,160,354	$182,781,389
Average Number of Employees	2,149	229	23,081	3,972			25,909			254	55,595	10,163	1,908	2,168	169	14,408	70,003
Program Cost/Employee/Yr.	$1,204	$1,560	$2,785	$3,677			$2,555			$2,030	$2,673	$2,251	$3,767	$1,715	$1,402	$2,371	$2,611
Change from prior period (pepy)	41.6%	22.6%	5.7%	6.8%			8.8%			2.4%	9.7%	3.8%	-17.1%	-5.1%	49.7%	-1.6%	7.2%
Average Number of Members	4,233	341	54,711	5,985			25,909			489	91,668	25,022	3,083	4,567	272	32,945	124,613
Program Cost/Member/Yr.	$612	$1,048	$1,175	$2,440			$2,555			$1,055	$1,621	$914	$2,331	$814	$873	$1,037	$1,467
Change from prior period (pmpy)	29.2%	8.2%	5.7%	5.8%			8.8%			2.7%	17.7%	1.5%	-15.1%	-2.4%	35.3%	-2.5%	8.1%
Total Medical and Rx																	
Premium	$27,016,161	$2,587,640	$377,859,302	$51,982,816			$143,156,139			$2,963,333	$605,565,391	$154,348,033	$23,298,291	$29,686,213	$2,111,476	$209,444,013	$815,009,403
Program Cost (prior to operational)	$18,520,123	$2,455,109	$371,644,587	$76,656,578	$647,437	$48,724	$127,873,557	$7,610,782	$1,436,000	$4,001,780	$604,101,760	$127,363,909	$28,604,959	$15,202,837	$1,184,836	$179,149,457	$783,251,217
Operational Expenses	$87,863	$9,361	$882,272	$152,284	$0	$0	$989,561	$0	$0	$9,659	$2,130,999	$391,473	$71,953	$79,869	$6,802	$550,097	$2,681,096
Total Program Cost	$18,607,985	$2,464,470	$372,526,859	$76,808,862	$647,437	$48,724	$128,863,118	$7,610,782	$1,436,000	$4,011,439	$606,232,759	$127,755,382	$28,676,912	$15,282,706	$1,191,638	$179,699,555	$785,932,313
Surplus / (Deficit)	$8,408,175	$123,170	$5,332,444	($24,826,046)			$14,293,021			($1,048,106)	($667,369)	$26,592,651	($5,378,622)	$14,403,507	$919,838	$29,744,458	$29,077,090
Total Cost as % of Budget	**68.9%**	**95.2%**	**98.6%**	**147.8%**			**90.0%**			**135.4%**	**100.1%**	**82.8%**	**123.1%**	**51.5%**	**56.4%**	**85.8%**	**96.4%**
Average Number of Employees	2,149	229	23,081	3,972			25,909			254	55,595	10,163	1,908	2,168	169	14,408	70,003
Program Cost/Employee/Yr.	$8,657	$10,750	$16,140	$19,338			$4,974			$15,775	$10,904	$12,571	$15,032	$7,048	$7,043	$12,472	$11,227
Change from prior period (pepy)	22.9%	-54.4%	4.0%	10.9%			3.8%			-16.5%	-0.4%	2.5%	-10.2%	-18.6%	-20.6%	1.6%	1.9%
Average Number of Members	4,233	341	54,711	5,985			25,909			489	91,668	25,022	3,083	4,567	272	32,945	124,613
Program Cost/Member/Yr.	$4,396	$7,220	$6,809	$12,833			$4,974			$8,196	$6,613	$5,106	$9,300	$3,346	$4,385	$5,455	$6,307
Change from prior period (pmpy)	12.1%	-59.8%	4.0%	9.8%			3.8%			-16.3%	6.9%	0.2%	-8.0%	-16.3%	-28.2%	0.7%	2.8%
Prior Period Program Cost (FY17)																	
Per Employee Per Year																	
Medical	$6,153	$22,257	$12,841	$13,954			$2,403			$16,879	$8,470	$10,050	$12,150	$6,808	$7,894	$9,822	$8,540
Rx	$850	$1,272	$2,636	$3,442			$2,348			$1,982	$2,438	$2,169	$4,544	$1,806	$937	$2,410	$2,436
Total[2]	$7,044	$23,570	$15,517	$17,436			$4,792			$18,901	$10,948	$12,259	$16,734	$8,655	$8,871	$12,273	$11,017
Per Member Per Year																	
Medical	$3,424	$16,943	$5,417	$9,351			$2,403			$8,749	$4,786	$4,175	$7,342	$3,145	$5,435	$4,335	$4,756
Rx	$473	$968	$1,112	$2,306			$2,348			$1,027	$1,377	$901	$2,746	$834	$645	$1,064	$1,357
Total[2]	$3,920	$17,942	$6,546	$11,684			$4,792			$9,797	$6,186	$5,093	$10,113	$3,998	$6,108	$5,417	$6,136

[1] Additional ESI contract savings independently projected by WTW
[2] Includes Medical, Rx, and Operational Expenses
[3] FY18 projections include FY18 Q1 and Q2 run-out for Highmark BlueCare HMO and Highmark CDH Gold plans terminated on 7/1/2017.
[4] Run-out for Highmark CDH and Highmark Blue Care HMO plans allocated between Highmark total and Aetna total based on FY18 plan migration (70% Aetna / 30% Highmark). As a result, individual Highmark and Aetna plans do not sum to the Total Highmark and Total Aetna columns.

State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q2 Reporting Reconciliation (WTW vs OMB Fund Equity Report)

FY18 YTD Reporting Reconciliation	WTW FY18 Q2 Financial Report	OMB December 2017 Fund Equity Report
Total Program Cost	**$366,823,324**	**$412,595,874**
Paid Claims	385,366,065	392,983,342
Medical Claims	266,725,317	273,619,494
Rx Claims[1]	80,485,474	119,363,848
Rx Paid Claims	118,640,747	119,363,848
EGWP	(15,838,217)	11,296,963
Direct Subsidy	(2,693,247)	2,703,079
CGDP	(8,559,692)	4,619,123
Catastrophic Reinsurance	(4,585,278)	3,974,762
Rx Rebates	(22,317,056)	26,101,320
Total Rx Claim (Offsets)/Revenue[2]	(38,155,274)	37,398,283
Total Fees	19,612,533	19,612,533
ASO Fees	18,368,158	18,368,158
Operational Expenses	1,244,375	1,244,375
Premium Contributions	**$407,504,702**	**$403,739,087**
Budget[3]	**$407,504,702**	**$441,464,053**
Surplus/(Deficit)	40,681,378	28,868,179
Total Cost as % of Budget	90%	93%

[1]WTW Rx claims shown net of EGWP revenue and Rx rebates. OMB Rx claims reflect gross claim dollars excluding additional revenue (EGWP and rebates).
[2]WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims. OMB reflects these items as additions to operating revenues.
[3]OMB Budget includes premium contributions, Rx revenues (EGWP and rebates) and Other Revenues totaling $326,683; excludes participating group fees totaling $1,062,299.

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 *bundled payments* or other *value-based payments*.
Consumer Driven Health Plan	CDHP	Allows members to use health savings accounts (HSA), health reimbursement accounts *(HRA)*, or other similar medical payment products to pay routine health care expenses directly. GHIP currently offers a CDHP with *HRA*.
Coverage Gap Discount Program	CGDP	One of the funding components of an *EGWP*. 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.

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, 2017 to December 31, 2017

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 FY2018 represents the time period July 1, 2017 through June 30, 2018 for all statuses; note Medicfill plan for Medicare eligible retirees runs from January 1, 2018 through December 31, 2018. Therefore, FY2018 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 FY2018 Q2: we assumed State / Participating split follows the same ratio as the August 2017 enrollment census provided by Truven. 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 December 2017 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 rebates for Q1 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 FY2018 due to payment timing lag; these rebates reflect updated ESI contract effective 7/1/2017 following WTW independent contract analysis.

9 EGWP payments based on actual and expected payments attributable to the period July 1, 2017 through June 30, 2018; reflects estimated direct subsidy reimbursements, projected coverage gap discount payments, and estimated Calendar Year 2017 catastrophic reinsurance payments from ESI (calculated by WTW). May differ from actual payments received during FY2018 due to payment timing lag.

10 Prior year costs calculated from WTW's FY17 Q4 Financial Reporting.

11 FY18 costs projected based on the most recent 12 months of data (1/1/2017 – 12/31/2017) 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, 2017. Medicare eligible retiree budget rates reflect rates effective January 1, 2017 for FY17 Q1 and Q2, and rates effective January 1, 2018 for FY17 Q3 and Q4. Budget rates include FY18 risk fees for Participating groups (excludes $2.70 PEPM charge). FY18 budget rates were held flat from FY17.

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.

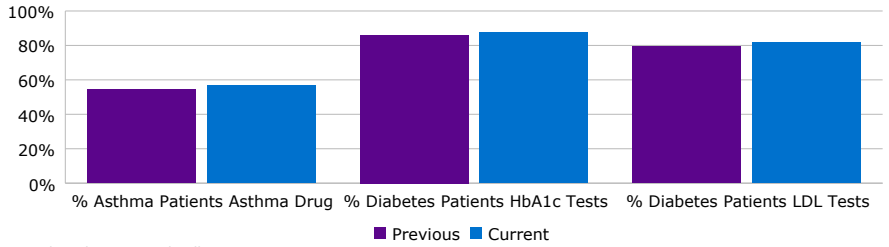
16 While COBRA enrollment and claims are reflected in the expenses, all medical/Rx participants are assumed to pay active contributions since COBRA participants make up less than 0.1% of the total population.

17 HRA funding for CDH plans are included in the paid claims reported in this document.

State of Delaware Medical and Prescription Drug Dashboard - Actives

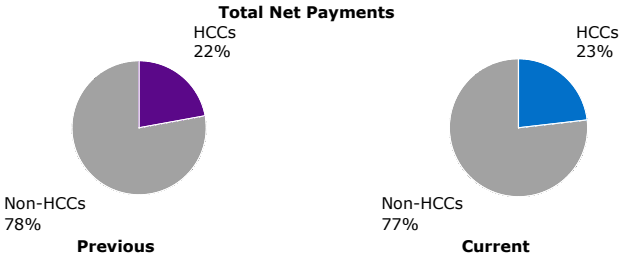
Previous Period: Jan 2016 - Dec 2016 (Paid)
Current Period: Jan 2017 - Dec 2017 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*



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

	Previous	Current	Trend
Patients	602	647	7%
Patients per 1,000	6.1	6.6	7%
Payments (in millions)	$112.3	$119.5	6%
Payment per Patient	$186,577	$184,769	-1%

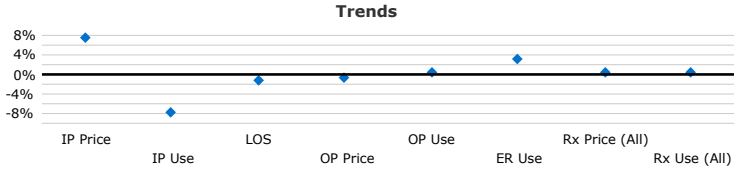
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	5,940.2	5,691.4	-4.2%
Visits Per 1000 Well Child	826.7	832.5	0.7%
Visits Per 1000 Prevent Adult	448.8	453.7	1.1%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	37,480	37,761	1%
Average Members	88,461	88,640	0%
Family Size	2.4	2.3	-1%
Member Age	33.0	33.0	0%
Members % Male	47%	47%	0% pts

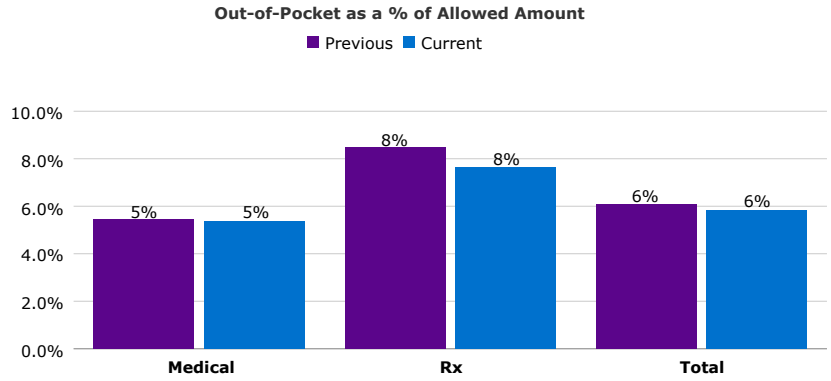
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$24,966	$22,849	■	7%
Admits per 1,000	62.1	56.0	■	-8%
Days LOS	4.5	4.0	■	-1%
Outpatient				
Allowed per Service	$128	$117	■	-1%
Services PMPY	28.8	29.3	◆	1%
Emergency Room Visits per 1,000	278	228	■	3%
Non-Specialty Drugs				
Allowed/Days Supply	$2			-7%
Days Supply PMPY	380			0%
Specialty Drugs				
Allowed/Days Supply	$106			10%
Days Supply PMPY	4			9%
All Prescription Drugs				
Allowed/Days Supply	$3	$4	◆	1%
Days Supply PMPY	384	329	●	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

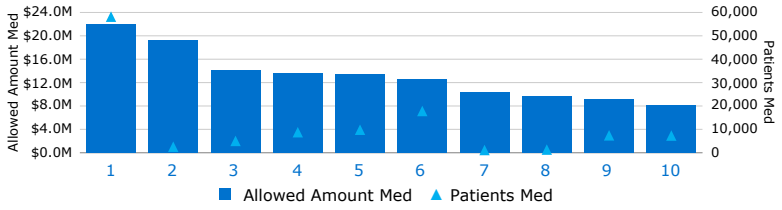
6. Cost Sharing



State of Delaware Medical and Prescription Drug Dashboard - Actives

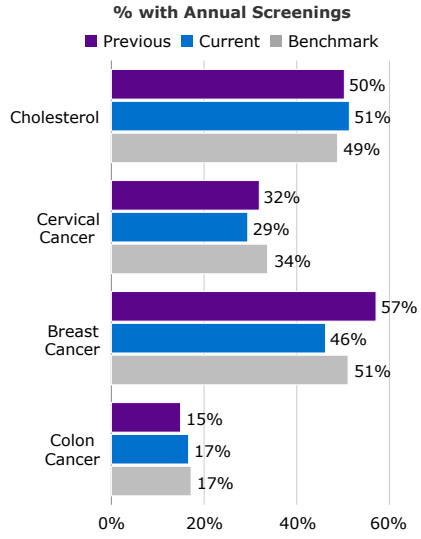
Previous Period: Jan 2016 - Dec 2016 (Paid)
Current Period: Jan 2017 - Dec 2017 (Paid)

7. Top Medical Conditions (by cost)

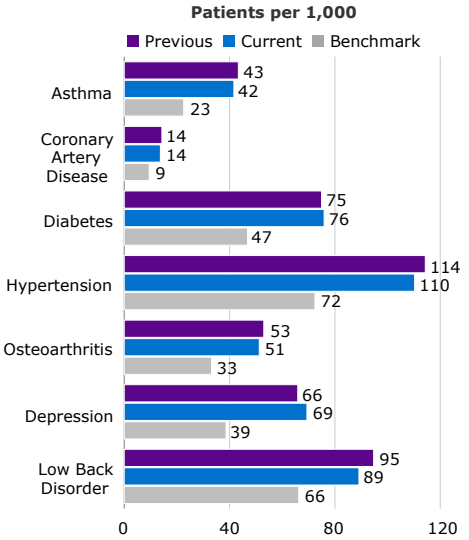


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$21,909,361	58,201	$376
2	Pregnancy without Delivery	$19,294,340	2,576	$7,490
3	Osteoarthritis	$14,058,729	5,051	$2,783
4	Spinal/Back Disord, Low Back	$13,568,823	8,780	$1,545
5	Gastroint Disord, NEC	$13,420,528	9,846	$1,363
6	Arthropathies/Joint Disord NEC	$12,621,340	17,853	$707
7	Newborns, w/wo Complication	$10,357,434	1,161	$8,921
8	Coronary Artery Disease	$9,625,739	1,352	$7,120
9	Respiratory Disord, NEC	$9,152,611	7,443	$1,230
10	Spinal/Back Disord, Ex Low	$8,140,450	7,348	$1,108

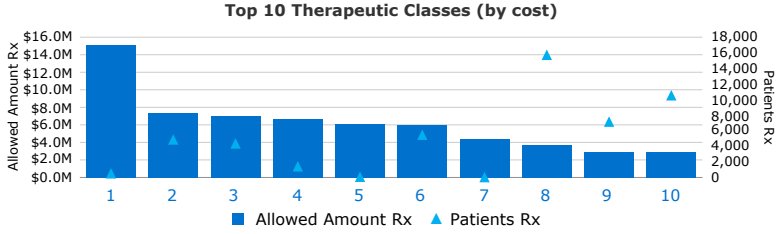
8. Screening Rates



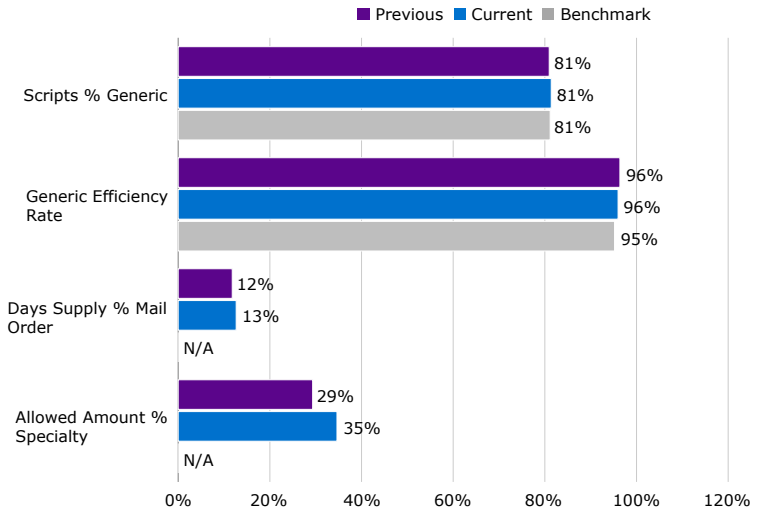
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$15,068,334	534	$28,218
2	Stimulant, Amphetamine Type	$7,353,879	4,881	$1,507
3	Antidiabetic Agents, Misc	$6,961,966	4,368	$1,594
4	Antidiabetic Agents, Insulins	$6,702,194	1,435	$4,671
5	Biological Response Modifiers	$6,072,557	98	$61,965
6	Antivirals, NEC	$5,944,400	5,490	$1,083
7	Molecular Targeted Therapy	$4,386,477	52	$84,355
8	Adrenals & Comb, NEC	$3,720,409	15,742	$236
9	Gastrointestinal Drug Misc,NEC	$2,944,203	7,169	$411
10	Antihyperlipidemic Drugs, NEC	$2,913,903	10,549	$276



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 2015 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

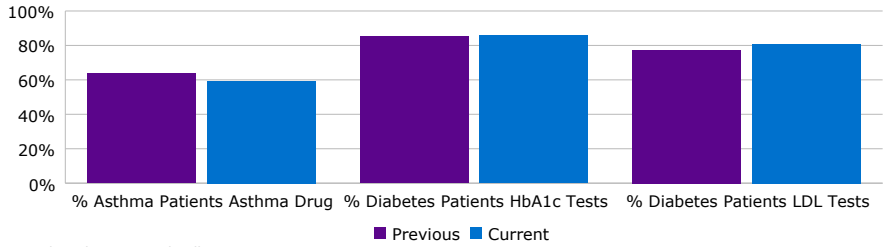
11. Prescription Drug Metrics

- **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)

Medical and Prescription Drug Dashboard - Early Retirees

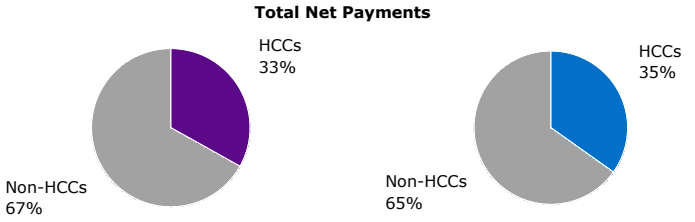
Previous Period: Jan 2016 - Dec 2016 (Paid)
Current Period: Jan 2017 - Dec 2017 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*



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

	Previous	Current	Trend
Patients	214	229	7%
Patients per 1,000	18.9	20.2	7%
Payments (in millions)	$33.3	$35.2	6%
Payment per Patient	$155,563	$153,501	-1%

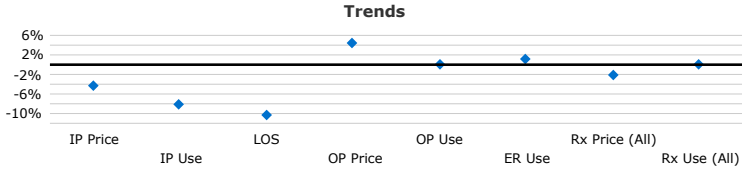
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	5,684.2	4,588.2	-19.3%
Visits Per 1000 Well Child	729.4	801.8	9.9%
Visits Per 1000 Prevent Adult	451.9	461.0	2.0%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	6,016	5,955	-1%
Average Members	9,262	9,170	-1%
Family Size	1.5	1.5	0%
Member Age	51.1	51.0	0%
Members % Male	41%	41%	0% pts

5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$32,464	$29,674	■	-4%
Admits per 1,000	87.2	69.0	■	-8%
Days LOS	5.4	4.7	■	-10%
Outpatient				
Allowed per Service	$149	$116	■	4%
Services PMPY	46.2	42.2	■	0%
Emergency Room Visits per 1,000	336	232	■	1%
Non-Specialty Drugs				
Allowed/Days Supply	$2			-11%
Days Supply PMPY	807			0%
Specialty Drugs				
Allowed/Days Supply	$111			3%
Days Supply PMPY	9			17%
All Prescription Drugs				
Allowed/Days Supply	$3	$3	■	-2%
Days Supply PMPY	816	679	●	0%

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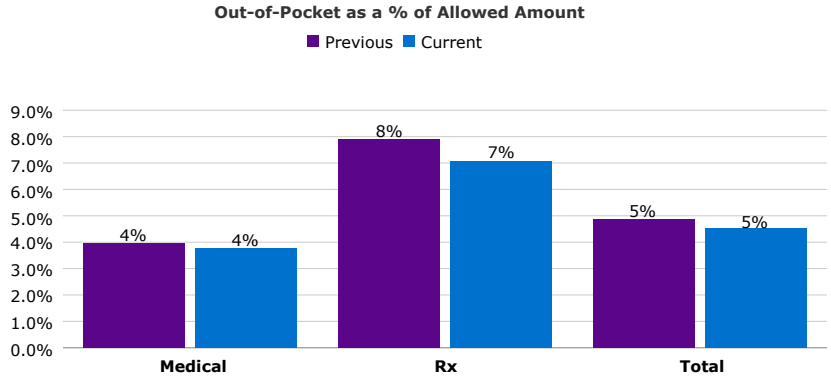
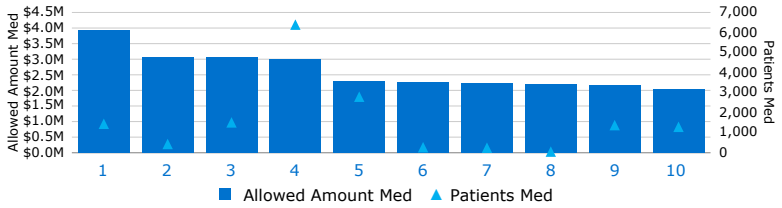
6. Cost Sharing



Medical and Prescription Drug Dashboard - Early Retirees

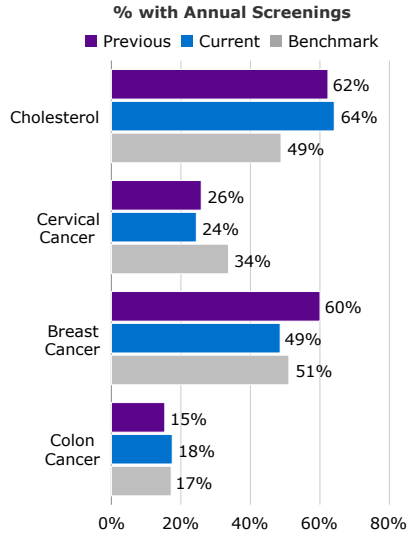
Previous Period: Jan 2016 - Dec 2016 (Paid)
Current Period: Jan 2017 - Dec 2017 (Paid)

7. Top Medical Conditions (by cost)

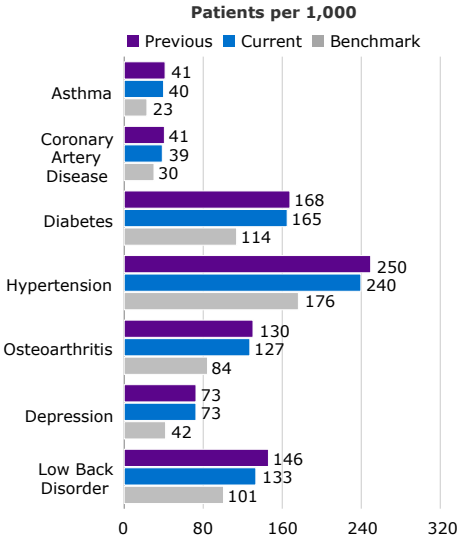


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$3,940,625	1,445	$2,727
2	Coronary Artery Disease	$3,063,148	438	$6,993
3	Spinal/Back Disord, Low Back	$3,050,745	1,514	$2,015
4	Prevent/Admin Hlth Encounters	$3,010,716	6,393	$471
5	Arthropathies/Joint Disord NEC	$2,281,577	2,796	$816
6	Mental Hlth - Substance Abuse	$2,256,572	277	$8,146
7	Renal Function Failure	$2,232,355	252	$8,859
8	Chemotherapy Encounters	$2,203,740	57	$38,662
9	Gastroint Disord, NEC	$2,150,585	1,378	$1,561
10	Respiratory Disord, NEC	$2,029,102	1,294	$1,568

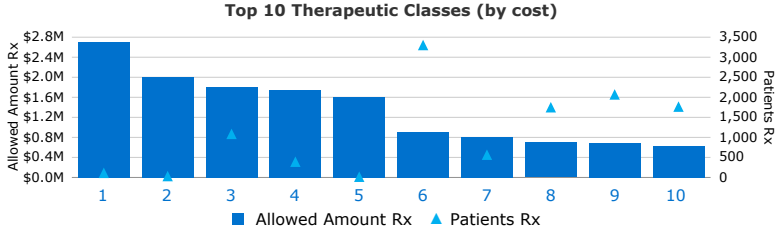
8. Screening Rates



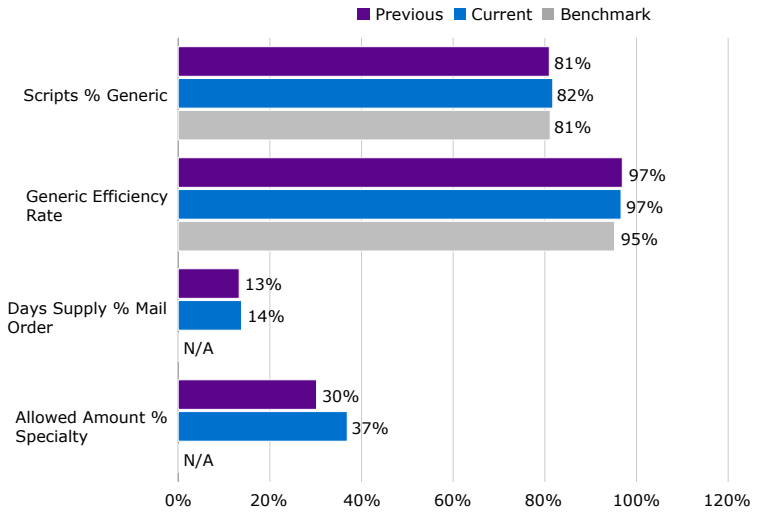
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$2,700,322	116	$23,279
2	Biological Response Modifiers	$2,009,525	35	$57,415
3	Antidiabetic Agents, Misc	$1,801,421	1,088	$1,656
4	Antidiabetic Agents, Insulins	$1,754,810	393	$4,465
5	Molecular Targeted Therapy	$1,605,318	19	$84,490
6	Antihyperlipidemic Drugs, NEC	$912,700	3,305	$276
7	Antivirals, NEC	$804,837	568	$1,417
8	Gastrointestinal Drug Misc,NEC	$698,506	1,753	$398
9	Adrenals & Comb, NEC	$690,278	2,072	$333
10	Analg/Antipyr, Opiate Agonists	$626,806	1,768	$355



Medical and Prescription Drug Dashboard - Early Retirees

Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2015 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

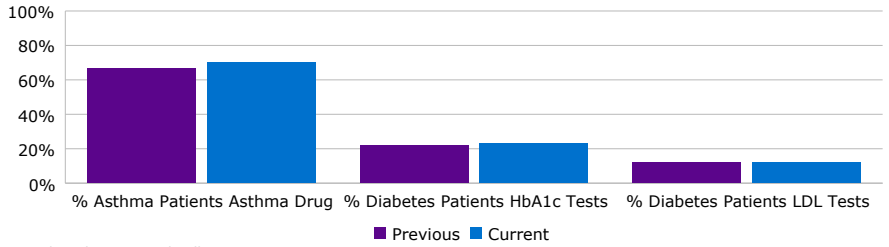
11. Prescription Drug Metrics

- **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)

Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Jan 2016 - Dec 2016 (Paid)
Current Period: Jan 2017 - Dec 2017 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*

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

	Previous	Current	Trend
Patients	87	117	34%
Patients per 1,000	3.6	4.7	29%
Payments (in millions)	$9.8	$12.3	25%
Payment per Patient	$113,167	$105,067	-7%

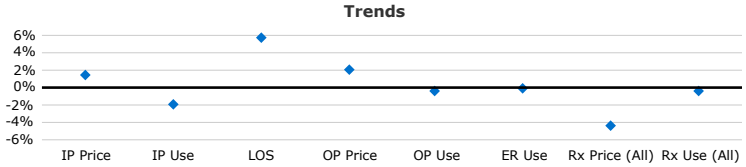
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Prevent Adult	171.4	198.0	15.5%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	22,638	23,601	4%
Average Members	22,649	23,659	4%
Family Size	1.0	1.0	0%
Member Age	73.2	73.2	0%
Members % Male	42%	42%	0% pts

5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$15,623	$27,424	●	2%
Admits per 1,000	178.5	58.0	■	-2%
Days LOS	5.5	4.2	■	6%
Outpatient				
Allowed per Service	$105	$116	●	2%
Services PMPY	71.8	31.0	■	0%
Emergency Room Visits per 1,000	543	227	■	0%
Non-Specialty Drugs				
Allowed/Days Supply	$2			-11%
Days Supply PMPY	1,491			-1%
Specialty Drugs				
Allowed/Days Supply	$81			9%
Days Supply PMPY	16			6%
All Prescription Drugs				
Allowed/Days Supply	$3	$3	●	-4%
Days Supply PMPY	1,508	378	◆	0%

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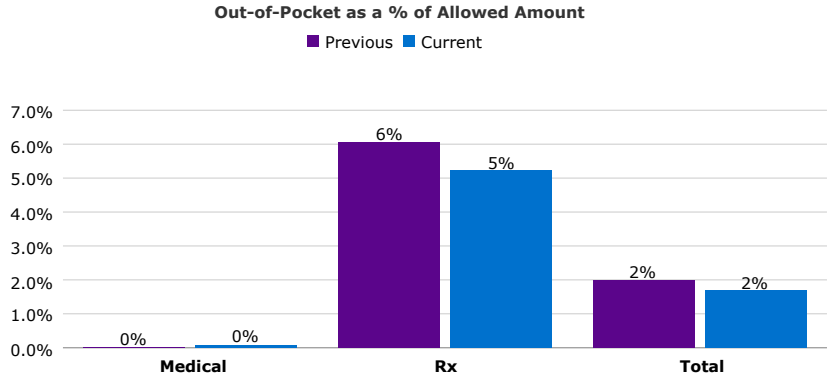
◆ Represents a comparison to the benchmark within +/-3%
■ Represents a higher than 3% comparison to the benchmark

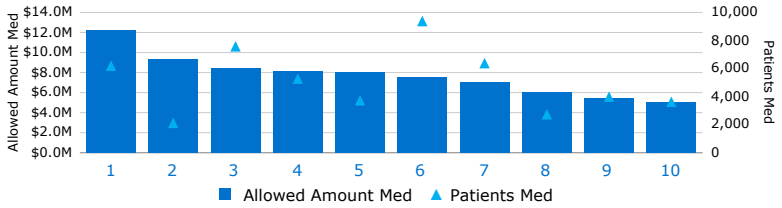
6. Cost Sharing



Medical and Prescription Drug Dashboard - Medicare Retirees

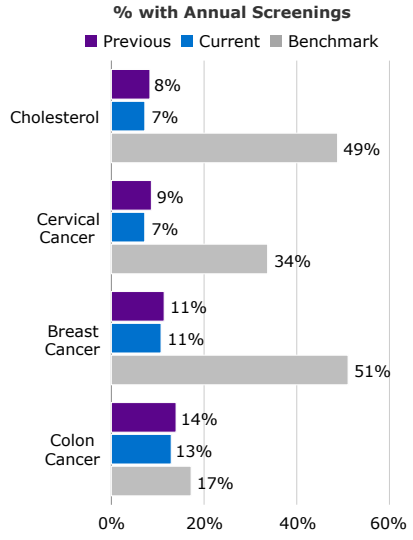
Previous Period: Jan 2016 - Dec 2016 (Paid)
Current Period: Jan 2017 - Dec 2017 (Paid)

7. Top Medical Conditions (by cost)

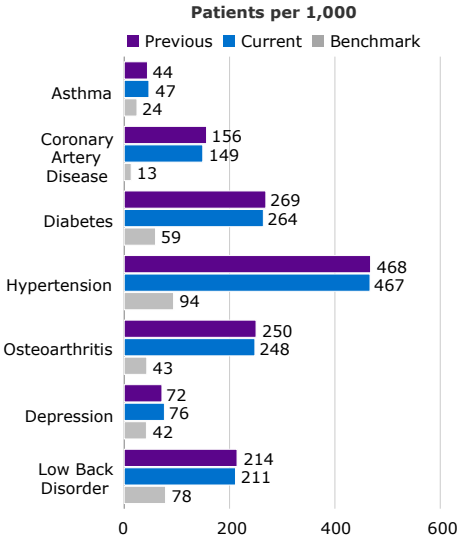


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$12,212,351	6,208	$1,967
2	Renal Function Failure	$9,373,602	2,129	$4,403
3	Eye Disorders, Degenerative	$8,448,707	7,586	$1,114
4	Spinal/Back Disord, Low Back	$8,089,241	5,286	$1,530
5	Coronary Artery Disease	$8,063,605	3,733	$2,160
6	Arthropathies/Joint Disord NEC	$7,568,861	9,388	$806
7	Respiratory Disord, NEC	$7,073,257	6,387	$1,107
8	Cerebrovascular Disease	$6,033,670	2,741	$2,201
9	Cardiac Arrhythmias	$5,478,114	3,994	$1,372
10	Infections, NEC	$5,030,504	3,632	$1,385

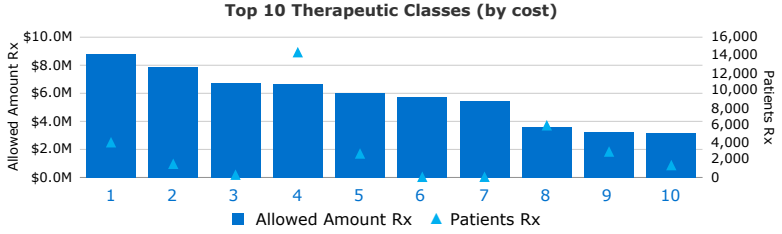
8. Screening Rates



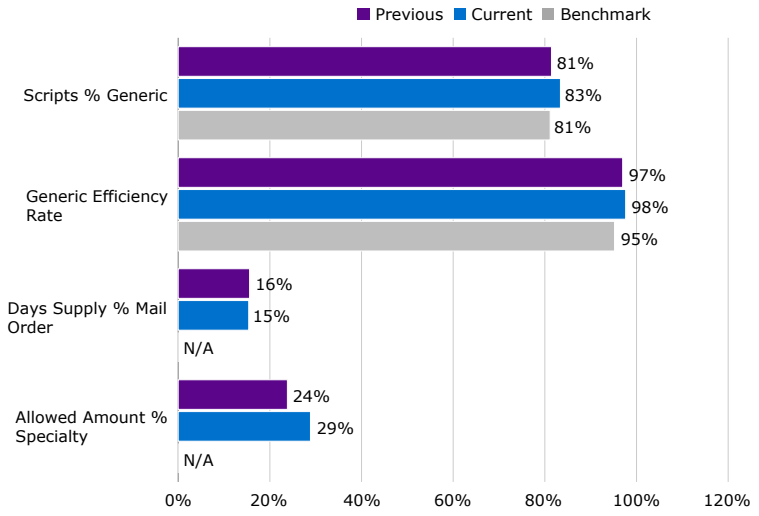
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Antidiabetic Agents, Misc	$8,819,956	4,020	$2,194
2	Antidiabetic Agents, Insulins	$7,872,792	1,563	$5,037
3	Immunosuppressants, NEC	$6,721,959	321	$20,941
4	Antihyperlipidemic Drugs, NEC	$6,661,500	14,295	$466
5	Coag/Anticoag, Anticoagulants	$6,017,027	2,737	$2,198
6	Molecular Targeted Therapy	$5,757,138	80	$71,964
7	Biological Response Modifiers	$5,429,094	84	$64,632
8	Adrenals & Comb, NEC	$3,623,349	5,957	$608
9	Misc Therapeutic Agents, NEC	$3,253,377	2,961	$1,099
10	CNS Agents, Misc.	$3,191,680	1,415	$2,256



Medical and Prescription Drug Dashboard - Medicare Retirees

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- **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)