State of Delaware - Quarterly Financial Reporting

FY18 Q4 Cost Analysis

August 2018
(updated September 2018)

Willis Towers Watson

State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q4 Executive Summary

Summary plan information

- Summary Plan Information for FY18 Q1-Q4 compared to FY17 Q1-Q4:

Summary (total)	FY18 (Q1-Q4)			FY17 (Q1-Q4)*			% Change		
	Medical	Rx	Total**	Medical	Rx	Total**	Medical	Rx	Total
Total program cost ($M)	$595.9	$167.1	$765.5	$591.4	$159.7	$753.9	▲ 0.8%	▲ 4.6%	▲ 1.5%
Budgeted cost ($M)	$630.4	$186.7	$817.0	$615.6	$186.7	$802.3	▲ 2.4%	▲ 0.0%	▲ 1.8%
Total cost PEPM	$8,486	$2,380	$10,902	$8,540	$2,306	$10,887	▼ 0.6%	▲ 3.2%	▲ 0.1%
Total cost PMPM	$4,779	$1,340	$6,140	$4,756	$1,284	$6,063	▲ 0.5%	▲ 4.4%	▲ 1.3%
Average employees	70,218			69,251			▲ 1.4%		
Average members	124,687			124,344			▲ 0.3%		
Loss ratio	94%			94%					
Surplus/(Deficit) ($M)	$51.5			$48.3					

* Prior Year Results adjusted to correct overstatement of pharmacy paid claims due to double counting of 4/7/2017 invoice in ESI reporting package.

** Total program cost includes office operational expenses

Additional notes

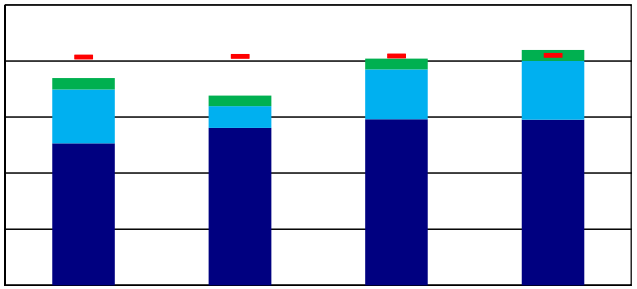
- Claims and expenses are reported on a paid basis
- Medical/Rx budget is based on FY18 budget rates, which were held flat from FY17
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI; costs include operating expenses
- Expenses are broken down into two cateogires:
  - ASO 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 ot which offsets are attributable, rather than 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

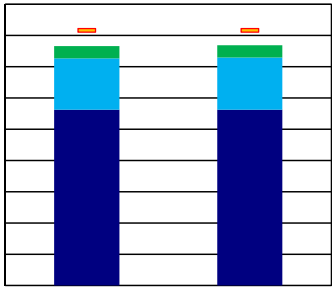
State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q4 Plan Cost Analysis

	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	2018 Actual	2018 WTW Budget[6]	Diff.
Total Program Cost[1]	**$184,746,969**	**$169,117,786**	**$201,940,094**	**$209,713,466**	**$765,518,315**	**$796,161,005**	▼ -3.8%
- Paid Claims	174,560,113	159,692,109	192,381,030	200,004,684	726,637,937	759,953,542	▼ -4.4%
- Medical (includes capitation[2])	126,441,323	140,283,995	147,907,605	147,483,956	562,116,878	586,325,676	▼ -4.1%
- Rx (Including Rebates and EGWP)	48,118,791	19,408,114	44,473,426	52,520,727	164,521,058	173,627,866	▼ -5.2%
- Rx Paid Claims	63,458,837	55,181,910	57,588,156	66,901,672	243,130,575	256,406,543	▼ -5.2%
- EGWP	(7,802,622)	(7,364,947)	(6,753,186)	(7,122,148)	(29,042,903)	(34,219,296)	▼ -15.1%
- Direct Subsidy	(1,406,523)	(1,286,724)	(988,096)	(984,791)	(4,666,134)	(5,087,120)	▼ -8.3%
- CGDP	(4,110,986)	(3,778,059)	(1,988,566)	(3,314,276)	(13,191,886)	(16,434,804)	▼ -19.7%
- Catastrophic Reinsurance	(2,285,113)	(2,300,165)	(3,776,523)	(2,823,081)	(11,184,883)	(12,697,372)	▼ -11.9%
- Rx Rebates[3]	(7,537,424)	(28,408,849)	(6,361,545)	(7,258,796)	(49,566,613)	(48,559,382)	▲ 2.1%
- ASO Fees	9,533,474	8,834,684	8,954,771	8,992,649	36,315,579	33,479,463	▲ 8.5%
- Operational Expenses	653,382	590,993	604,293	716,133	2,564,800	2,728,000	▼ -6%
Medical/Rx Budget	**$203,451,156**	**$204,084,021**	**$204,515,206**	**$204,972,458**	**$817,022,841**	**$ 810,340,695**	▲ 0.8%
- Surplus/(Deficit)	18,704,187	34,966,234	2,575,113	(4,741,008)	51,504,526	14,179,690	
- Total Cost as % of Budget	91%	83%	99%	102%	94%	98%	
Current Year Per Capita							
- Total per employee per year[4]	10,593	9,652	11,482	11,869	10,902	11,436	▼ -4.7%
- Total % change over prior	-5.7%	-5.8%	2.8%	8.9%	0.1%[7]		
- Medical per employee per year	7,749	8,473	8,882	8,831	8,486	8,866	▼ -4.3%
- Medical % change over prior	-11.2%	3.5%	4.9%	0.6%	-0.6%		
- Rx per employee per year	2,807	1,145	2,565	2,998	2,380	2,531	▼ -6%
- Rx % change over prior	13.9%	-43.2%	-3.6%	44.1%	3.2%[7]		
- Medical per member per year	4,350	4,761	5,018	4,984	4,779	4,926	▼ -3%
- Rx per member per year	1,576	643	1,449	1,692	1,340	1,406	▼ -4.7%
- Total per member per year[4]	5,947	5,423	6,486	6,699	6,140	6,354	▼ -3.4%
Prior Year Results[7]	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**			
- Total Program Cost[4]	192,489,481	177,399,275	194,616,244	189,408,541	753,913,542	-	-
- Total Program Cost $ Change	-7,742,512	-8,281,489	7,323,849	20,304,924	11,604,773	-	-
- Total per employee per year[4]	11,231	10,248	11,170	10,899	10,887	-	-
- Medical per employee per year	8,725	8,190	8,468	8,777	8,540	-	-
- Rx per employee per year	2,465	2,017	2,661	2,081	2,306	-	-
EE Contributions	**$41,098,154**	**$39,856,517**	**$39,986,950**	**$40,130,510**	**$161,072,131**		
- Net SoD[5]	143,648,815	129,261,269	161,953,144	169,582,956	604,446,184	-	-
- SoD Subsidy %	78%	76%	80%	81%	79%	-	-
Headcount							
- Enrolled Ees	69,762	70,083	70,352	70,675	70,218	69,618	▲ 0.9%
- Enrolled Members	124,258	124,731	124,534	125,225	124,687	125,307	▼ -0.5%
- Member/EE Ratio	1.8	1.8	1.8	1.8	1.8		

[1] Aggregate totals includes run-off medical and pharmacy claims from Highmark BlueCare HMO ($9,756,202) and Highmark CDH Gold ($897,988) 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] Based on WTW recommended budget approved by SEBC on 8/21/17

[7] Prior Year Results adjusted to correct overstatement of pharmacy paid claims due to double counting of 4/7/2017 invoice in ESI reporting package.

State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q4 Reporting Reconciliation (WTW vs OMB Fund Equity Report)

FY18 YTD Reporting Reconciliation	WTW FY18 Q4 Financial Report	OMB June 2018 Fund Equity Report
Total Program Cost	**$765,518,315**	**$853,887,827**
Paid Claims	805,247,453	815,007,448
Medical Claims	562,116,878	570,183,222
Rx Claims[1]	164,521,058	244,824,226
Rx Paid Claims	243,130,575	244,824,226
EGWP	(29,042,903)	36,506,265
Direct Subsidy	(4,666,134)	4,680,633
CGDP	(13,191,886)	12,508,168
Catastrophic Reinsurance	(11,184,883)	19,317,465
Rx Rebates	(49,566,613)	51,907,415
Total Rx Claim (Offsets)/Revenue[2]	(78,609,516)	88,413,680
Total Fees	38,880,378	38,880,378
ASO Fees	36,315,579	36,315,579
Operational Expenses	2,564,800	2,564,800
Premium Contributions	**$817,022,841**	**$810,949,874**
Budget[3]	**$817,022,841**	**$900,861,558**
Surplus/(Deficit)	51,504,526	46,973,732
Total Cost as % of Budget	94%	95%

[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 $1,498,004; excludes participating group fees totaling $2,141,045.

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 did not provide enrollment data split by State and Participating for FY2018 Q1. Following FY2018 Q2, WTW assumed Q1 State / Participating split follows the same ratio as subsequent Q2 enrollment provided by Highmark. The ratio is calculated by status (Active, non-Medicare eligible retiree, and Medicare eligible retiree), by plan and by contracts/members.
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 June 2018 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 actual rebates for Q1/Q2 and estimated rebates for Q3/Q4 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 and Calendar Year 2018 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 (7/1/2017 – 6/30/2018) 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 FY18 Q1 and Q2, and rates effective January 1, 2018 for FY18 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
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 June 30, 2018