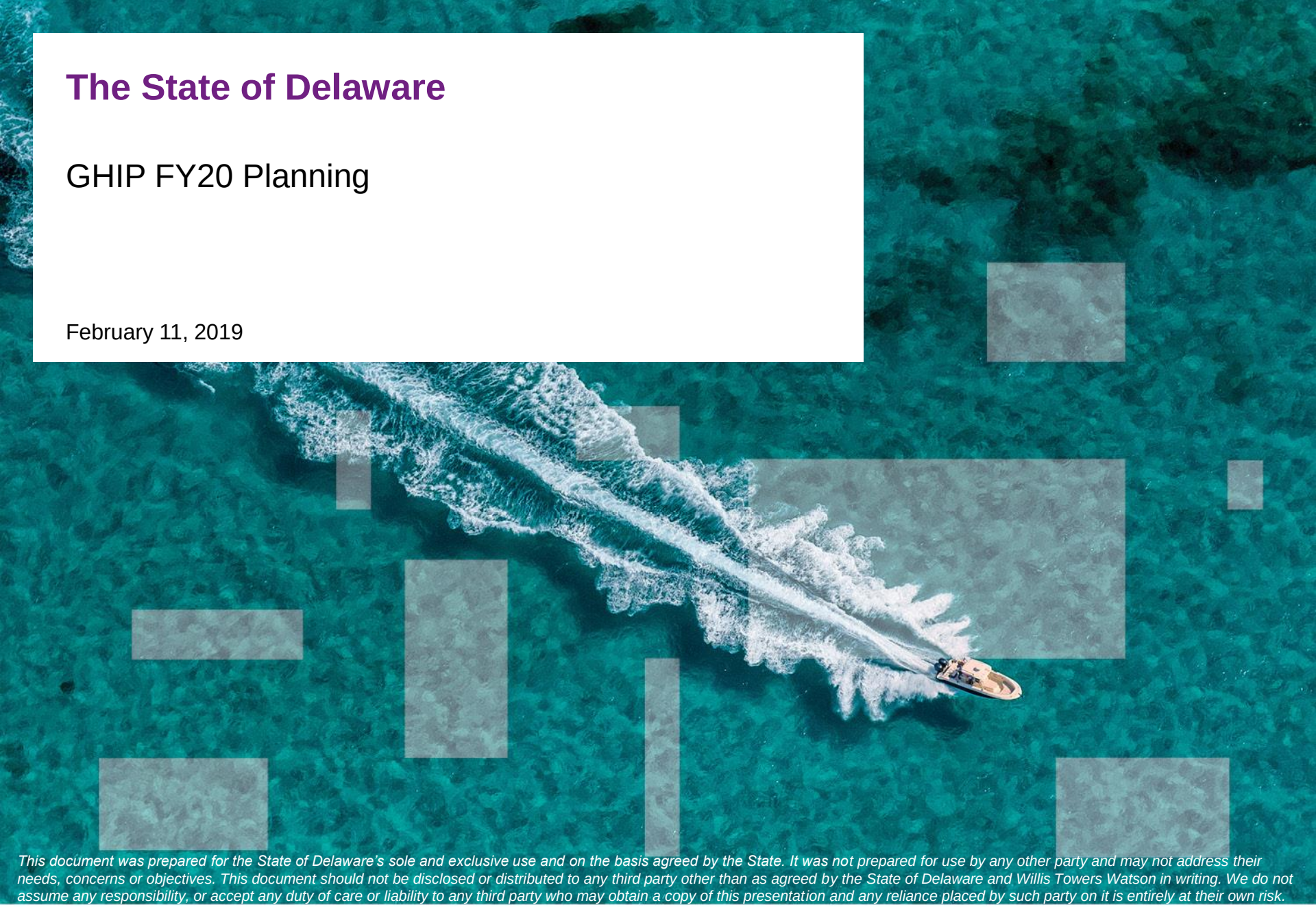
The State of Delaware

GHIP FY20 Planning

February 11, 2019



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Contents

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Overview

- Over the last several months, the Health Policy & Planning and Financial subcommittees met to discuss GHIP program and financial strategy, with a focus on changes and opportunities for FY20
- The following pages provide a brief overview of the subcommittees' recommendations for changes to the following components of the GHIP for FY20:
  1. Site-of-care steerage
  2. Diabetes management point solution through Livongo
  3. Medical premium rates
- These recommendations have been previously discussed with the SEBC and have been compiled in this document in anticipation of the Committee voting at the February 11 meeting on items #1 and #2 above
  - A vote on FY20 medical premium rates (#3) will be deferred to a future SEBC meeting

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Site-of-care steerage – imaging services

Recommendations for FY20 changes

Service *For PPO and HMO plans only*	FY19 Current	FY20 Recommended Design
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $50 copay
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $75 copay

Rationale for recommendation:

- Prior changes to high tech imaging copays were effective in the initial year, but not sufficient in sustaining desired behavior in the subsequent year
- Copays for preferred sites of care remain unchanged at $0, so members who continue to utilize preferred sites of care have no out of pocket cost

Carrier	Recommended Design	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	Non-preferred basic imaging increases +$15/visit, high tech increases +$25/visit	0.49%	$0.8m	$0.5m
Highmark		0.20%	$0.9m	$0.6m
Total Cost Avoidance Opportunity – Recommended Design:			**$1.7m**	**$1.1m**

Recommended Design reflects the plan provisions captured in "Option 3" first presented to the SEBC at the 1/14/19 meeting.
The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Cost avoidance for active and pre-65 retiree populations only, for the Comprehensive PPO and HMO plans only; based on each vendor's best estimate of the expected utilization at the desired site of care. Estimated number and percent of services steered toward preferred site of care: basic imaging: 2,781 (5%), high tech imaging: 1,052 (6%).
Cost avoidance largely attributable to copay differential rather than changes in member behavior.

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Site-of-care steerage – outpatient lab

Recommendations for FY20 changes

Service *For PPO and HMO plans only*	FY19 Current	FY20 Recommended Design
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $50 copay

Rationale for recommendation:

- Builds upon prior year's design steerage to preferred labs
- Copay for preferred labs remains unchanged, so members who continue to utilize preferred labs will pay the lowest out of pocket cost

Carrier	Recommended Design	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	Non-preferred lab copay increases +$30/visit	0.51%	$0.9m	$0.6m
Highmark		0.40%	$1.8m	$1.2m
Total Cost Avoidance Opportunity – Recommended Design:			**$2.6m**	**$1.7m**

Recommended Design reflects the plan provisions captured in "Option 3" first presented to the SEBC at the 1/14/19 meeting.
The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Cost avoidance for active and pre-65 retiree populations only, for the Comprehensive PPO and HMO plans only; based on each vendor's best estimate of the expected utilization at the desired site of care. Estimated number and percent of services steered toward preferred site of care: 7,715 (4%). Preferred labs for both Aetna and Highmark: Quest and Labcorp.
Cost avoidance largely attributable to copay differential rather than changes in member behavior.

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Site-of-care steerage – emergency / urgent care

Recommendations for FY20 changes

Service *For PPO and HMO plans only*	FY19 Current	FY20 Recommended Design
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	▪ $15/$20 copay ▪ $150 copay	▪ $15/$20 copay ▪ $200 copay

Rationale for recommendation:

- Builds upon prior year's design steerage to preferred site of care for non-emergent care
- There is still opportunity to reduce the number of non-emergent visits to the ER, which has ranged between 120 and 140 visits/1,000 each quarter since Q1 FY16[1]
- Urgent care copays remain unchanged as a lower cost alternative to the ER for non-emergent care

Carrier	Recommended Design	Annual Claim Cost Avoided (%)	Annual Claim Cost Avoided ($)	Annual Claim Cost Avoided, General Fund ($)
Aetna	ER copay increases +$50/visit	0.51%	$0.9m	$0.6m
Highmark		0.40%	$1.8m	$1.2m
Total Cost Avoidance Opportunity – Recommended Design:			**$2.6m**	**$1.7m**

Recommended Design reflects the plan provisions captured in "Option 2" first presented to the SEBC at the 1/14/19 meeting.
The percentage of cost paid by the State subsidy from the general fund and non-general fund based on FY 2018 premium contributions and revenue as reported by DHR Financial Services/OMB PHRST.
Cost avoidance for active and pre-65 retiree populations only, for the Comprehensive PPO and HMO plans only; based on each vendor's best estimate of the expected utilization at the desired site of care. Estimated number and percent of services steered toward preferred site of care: 454 (2%).
Cost avoidance largely attributable to copay differential rather than changes in member behavior.
1 Source: IBM Watson, Health Impact of Copayment Changes to Urgent Care and High-Tech Imaging Services, FY18, 4th Quarter Update. Delivered to the SBO on November 29, 2018.

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Site-of-care steerage – telemedicine

Recommendations for FY20 changes

Service *For PPO and HMO plans only*	FY19 Current	FY20 Recommended Design
Telemedicine	▪ $15/$20 copay (HMO/PPO)	▪ $0 copay (HMO/PPO)

Rationale for recommendation:

- Removes financial barrier to accessing acute episodic care
- Supports the State's efforts to expand access to primary care
- De minimus cost impact to the State

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Site-of-care steerage – infusion therapy program under Highmark

Recommendations for FY20 changes

Recommendation:

- Implement Highmark's infusion therapy site-of-care steerage program ($2.0m claim savings potential[1], $1.3m to General Fund)

Rationale for recommendation:

- Advantages to administering infusion therapy outside of a hospital – significantly reduced cost of drug administration, reduced risk of patient exposure to hospital-acquired illnesses, enhanced privacy and comfort, potentially reduced travel time and associated expenses
- Potential savings associated with steerage to non-hospital sites of care
- Highmark program provides additional clinical oversight via review of medical appropriateness and assists members with locating alternative sites of care; includes appeal process to address denied requests
- Similar program currently in place for Aetna GHIP plan participants

Follow-ups from presentation to the SEBC on January 14, 2019

- Highmark confirmed that this program does not include infused medications for chemotherapy treatment (consistent with Aetna program)
- In response to a request for the latest information on the number of members engaged in the Aetna program, in FY18 there were 15 patients identified, of which 6 were successfully shifted to an alternative site of care; the remaining 9 are not actively being managed by the program at this time for a variety of reasons[2]

1 Note: Reflects savings potential; actual savings are not guaranteed and should not be relied upon for budgeting purposes. Based on most recent incurred data (August 2017 – July 2018) for targeted drugs delivered in a hospital setting; reflects 67 members with 388 claims for 10 targeted drugs.
2 Reasons include: High risk of complications, pediatric patient, member/provider approved for exception, therapy was delayed for medical reasons, patient no longer on therapy.

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Diabetes management point solution – Livongo

Recommendations for FY20 changes

Recommendation:

- Implement Livongo through Aetna, Highmark and Express Scripts ($720k claim savings potential, $500k to General Fund)

Rationale for recommendation:

- Remote monitoring program that includes Livongo meter, unlimited testing supplies and 24/7/365 personalized support and coaching
- Serves diabetic population - types 1 and 2 - across both non-Medicare and Medicare population
- Member experience designed with convenience, ease of use and patient safety in mind:
  - No out-of-pocket costs
  - Cellular meter connects directly to Livongo cloud
  - Real-time (within 3 minutes) outreach driven by dangerous readings
  - Coaching by Livongo Certified Diabetes Educators
  - Outreaches provided by phone, text and email
- Supports tactics outlined in the GHIP strategic framework as well as other statewide health initiatives

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Policy subcommittee recommendations for FY20 changes

- Implement the following changes for FY20:

Service *For PPO and HMO plans only*	FY19 Current	FY20 Proposed Change
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $50 copay
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $75 copay
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $50 copay
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	▪ $15/$20 copay ▪ $150 copay	▪ $15/$20 copay ▪ $200copay
Telemedicine	▪ $15/$20 copay (HMO/PPO)	▪ $0 copay (HMO/PPO)

Combined annual claim cost avoidance opportunity: $6.9m ($4.6m to General Fund)

- Implement Highmark's infusion therapy site-of-care steerage program ($2.0m claim savings potential, $1.3m to General Fund)
- Implement Livongo through Aetna, Highmark and Express Scripts ($720k claim savings potential, $500k to General Fund)
- ***Total annual claim cost avoidance opportunity: $9.6m ($6.4m to General Fund)***

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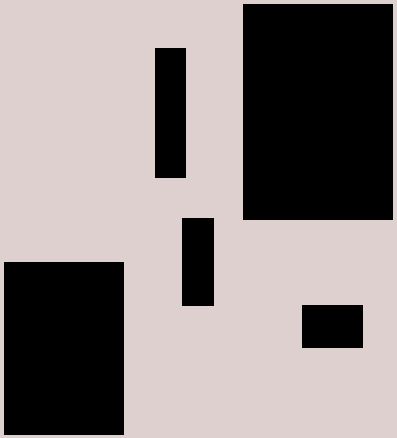
FY20 Premium Rate Considerations



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Summary of proposed FY20 premium increases

- The financial subcommittee has evaluated several FY20 premium rate increase scenarios effective 7/12019, assuming 5% trend and recommended FY20 program changes
  - **+3.2%:** based on FY20 projection as of **FY19 Q1**, spreads FY19 surplus over two years
  - **+0.8%:** based on FY20 projection as of **FY19 Q2**, spreads FY19 surplus over two years
  - **+2.0%:** increase FY20 rates at historical baseline
  - **+5.0%:** increase FY20 rates at national health care trend
- Additional details provided in separate FY19 Q2 Financial Update document

Proposed FY20 Premium Increase	Premium Revenue Increase ($M)	Employee Premium Increase (annual)	State Subsidy Increase (annual)	FY20 Adjusted Net Income ($M)	FY20 Surplus/ (Deficit) ($M)
FY19 Q1 Update					
+3.2%	+$26.6	$10.68 - $104.76	$256.32 - $686.04	**($21.8)**	**$26.1**
FY19 Q2 Update					
+0.8%	+$6.6	$2.64 - $26.16	$64.08 - $171.06	**($21.8)**	**$26.1**
+2.0%	+$16.6	$6.72 - $65.52	$160.20 - $428.76	**($11.7)**	**$36.1**
+5.0%	+$41.5	$16.68 - $163.68	$400.56 - $1,071.96	**$13.2**	**$61.0**

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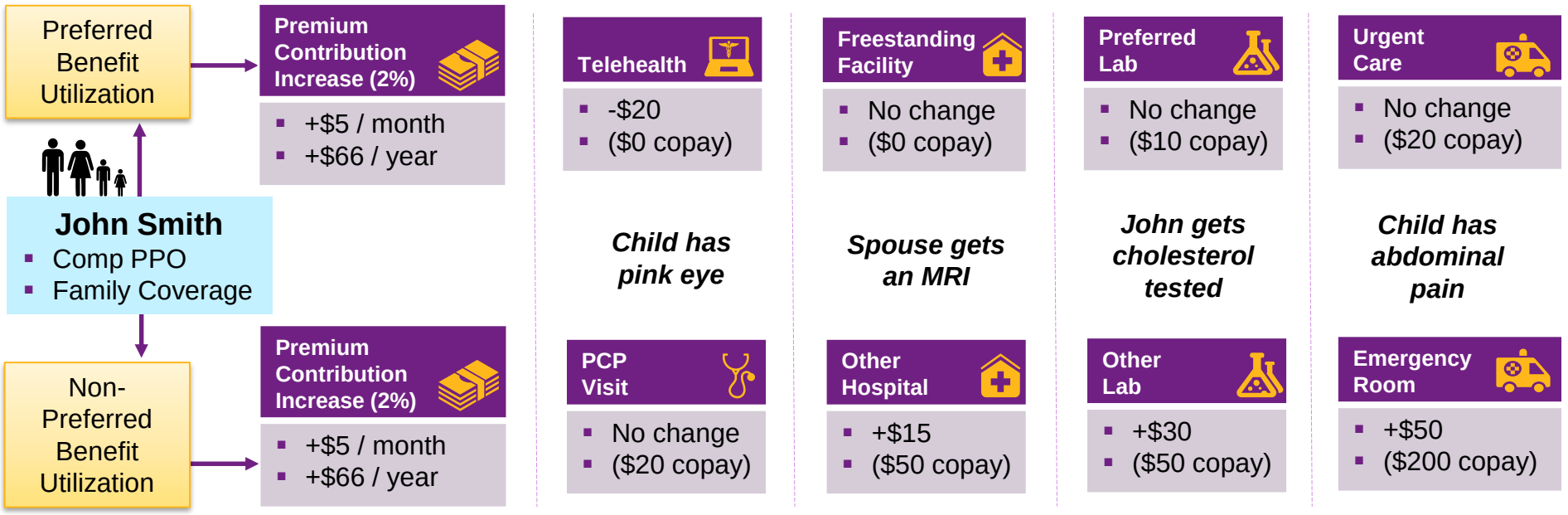
Member impact of recommended FY20 program changes

Includes impact of 2% premium increase effective 7/1/2019



Benefit Utilization	Cost Breakdown	Total Cost
Preferred	($66 premium increase)+($0 telehealth) + ($0 basic imaging) + ($10 lab) + ($20 urgent care)	**$96**
Non-Preferred	($66 premium increase)+($20 PCP) + ($50 basic imaging) + ($50 lab) + ($200 ER)	**$386**
Without Changes[1]	($105 premium increase)+($20 telehealth) + ($0 basic imaging) + ($10 lab) + ($20 urgent care)	**$155**

1. Without adoption of recommended program changes, premium would have increased an additional 1.2%; John pays $59 less in FY20 for the same services with preferred benefit utilization if FY20 changes are adopted.

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Next steps

- Discussion on potential FY20 premium increases (no premium rate vote at today's meeting)
- SEBC vote on FY20 program changes outlined on Slides 3-8 at the conclusion of today's meeting

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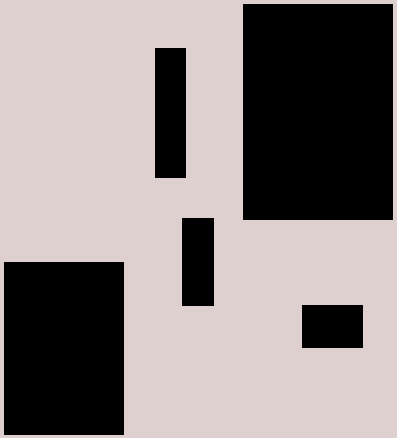
Appendix



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FY20 opportunities

Site-of-care steerage

Subcommittee recommended site-of-care steerage options effective 7/1/19 (12/18/2018 meeting)

- Aetna and Highmark were asked to assist with estimating the cost impact of the following plan design options for FY20
  - Impact of each type of service was modeled (details in Appendix)
  - Each option was modeled as if it were a standalone change – e.g., modeling for "Option 1" changes to outpatient lab copay does not include cost avoidance for "Option 1" changes to emergency room copay
- Both vendors were also asked to provide their recommendations for these plan design changes (details in Appendix)

Service *For PPO and HMO plans only*	FY19 Current	FY20 Design Options			Range of Cost Avoidance Opportunity
		Option 1	Option 2	Option 3	
Basic Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $40 copay	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $50 copay	$0.8m – $1.7m annual claim savings ($0.5m – $1.1m to General Fund)
High Tech Imaging ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $60 copay	▪ $0 copay ▪ $65 copay	▪ $0 copay ▪ $75 copay	
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $30 copay	▪ $10 copay ▪ $40 copay	▪ $10 copay ▪ $50 copay	$1.6m – $2.6m annual claim savings ($1.1m – $1.7m to General Fund)
Emergency / Urgent Care ▪ Urgent Care (HMO/PPO copay) ▪ Emergency Room	▪ $15/$20 copay ▪ $150 copay	▪ $15/$20 copay ▪ $175 copay	▪ $15/$20 copay ▪ $200 copay		$1.4m – $2.6m annual claim savings ($0.9m – $1.7m to General Fund)
Telemedicine	▪ $15/$20 copay (HMO/PPO)	▪ $0 copay (HMO/PPO)			De minimus cost impact to the State

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FY20 opportunities

Infusion therapy site-of-care steerage

Subcommittee recommends implementing Highmark infusion therapy steerage program effective 7/1/19 (12/18/2018 meeting)

Infusion therapy defined:

- Intravenous administration of certain medications that treat conditions such as autoimmune disorders, enzyme replacement and rare/esoteric diseases
- Administered under the supervision of a medical professional
- Several possible sites of care: outpatient hospital facility, infusion center, doctor's office, or patient's home

Advantages to administering outside of a hospital: *significantly reduced cost of drug administration, reduced risk of patient exposure to hospital-acquired illnesses, enhanced privacy and comfort, potentially reduced travel time and associated expenses*

Aetna capabilities – *In place today*	**Highmark capabilities – *Not in place today***
▪ Site-of-care steerage program is currently in place for the State	▪ Site-of-care steerage program is available for self-funded plan sponsors
▪ Drugs are segmented into two categories: Mandatory and Voluntary (based on clinical rule)	▪ Also managed by a prior authorization initiated by the member's doctor, and includes review for medical necessity and clinical appropriateness
▪ Requires member's doctor to request prior authorization for infusion therapy from Aetna	▪ Authorization will be denied if medical documentation submitted by doctor is insufficient to justify requested site-of-care or use of infusion
▪ Aetna reviews request for medical necessity and clinical appropriateness	▪ Includes resubmission and appeal processes to address denied requests for prior authorization
▪ Aetna will reach out to doctor to suggest alternative site of care if appropriate	▪ Includes assistance for members currently in treatment with a targeted drug; Customer Care Advocate will help member find alternative sites of care if member wishes to do so
	▪ Does not apply to Medicfill plan

★ ***Estimated annual claim savings potential* for adding Highmark program:*** *$2.0m in FY20*

*Note: Reflects savings potential; actual savings are not guaranteed and should not be relied upon for budgeting purposes. Based on most recent incurred data (August 2017 – July 2018) for targeted drugs delivered in a hospital setting; reflects 67 members with 388 claims for 10 targeted drugs.

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FY20 opportunities

Diabetes prevention services

Subcommittee recommends implementing Livongo through Aetna, Highmark, and ESI effective 7/1/19 (12/18/2018 meeting)

- The Health Policy & Planning subcommittee recommends implementing Livongo through Aetna and Highmark (for active employees and non-Medicare retirees) and Express Scripts (for Medicare retirees) for diabetes prevention services
  - Remote monitoring program that includes Livongo meter, unlimited testing supplies and 24/7/365 personalized support and coaching
  - Serves diabetic population- types 1 and 2
  - Non-Medicare and Medicare members
  - Eligible members identified through claims
  - 60 day implementation period, assigned Livongo implementation lead, “recruit” potential members through claims, provide communications through mail and email
  - Client reporting package includes executive summary, metrics, dashboards and various reports (member satisfaction, member engagement and clinical outcomes)
- Livongo member experience:
  - No out-of-pocket costs
  - Cellular meter connects directly to Livongo cloud
  - Real-time (within 3 minutes) outreach driven by dangerous readings
  - Coaching by Livongo Certified Diabetes Educators
  - Outreaches provided by phone, text and email

★ ***Estimated annual claim savings potential for adding Livongo program*** : $720k in FY20

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Reserve and claim liability discussion

Current claim liability methodology

Claims Liability Targets by Quarter

12/31/16	3/31/17	6/30/17	9/30/17	12/31/17	3/31/18	6/30/18
$54.3m	$54.3m	$56.5m	$59.5m	$58.9m	$58.9m	$61.3m

- Recommended Claim Liability target is based on estimated incurred but not paid ("IBNP") liability as of 6/30/2018
  - Medical Claim Liability (Highmark and Aetna): $52.8M
  - Pharmacy Claim Liability (ESI Commercial and EGWP): $8.5M
- IBNP liability is based on paid claims for the period 7/1/2017 – 6/30/2018 and lag factors developed by Willis Towers Watson as of 6/30/2018
  - Lag factors represent the average period of time between when a claim is incurred and then paid by the State, and were developed separately for Aetna, Highmark, and ESI based on data provided by each vendor
  - Lag factors are reviewed and updated (if needed) annually
  - Claim Liability target is updated quarterly based on most recent 12 months of paid claims data
- IBNP liability has been increasing over time, driven by an increase in paid claim levels and an increase in Aetna's lag factor

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Reserve and claim liability discussion

Current minimum reserve methodology

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$833.0M	
70% Confidence Interval	$821.4M	$844.5M
90% Confidence Interval	$814.6M	$851.3M
95% Confidence Interval	$811.1M	$854.9M
97% Confidence Interval	$808.8M	$857.3M

At the 97% confidence interval level, the upper bound is $24.3M higher than the projected budget

- During March 6, 2017 meeting, SEBC approved a motion to set minimum reserve based on upper bound of 97% confidence interval of Willis Towers Watson health care trend variability tool, set annually based on final fiscal year budget
  - Confidence intervals represent the probability that the budget estimate will fall between an upper and lower bound of a health care claims distribution

The above analysis is based on GHIP data available through FY19 Q1, current enrollment as of September 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

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Reserve and claim liability discussion

Minimum reserve methodology – ***Alternative 1***

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value (without margin)	$833.0M	
70% Confidence Interval	$821.4M	$844.5M
90% Confidence Interval	$814.6M	$851.3M
95% Confidence Interval	$811.1M	$854.9M
97% Confidence Interval	$808.8M	$857.3M
98.5% Confidence Interval	$805.8M	$860.1M

At the 97% confidence interval level, the upper bound is $24.3M higher than the projected budget

→ $27.1M at 98.5% confidence interval

- The above exhibit reflects reforecasted FY19 projected costs based on data through FY19 Q1
- Increasing the confidence interval from 97% to 98.5% increases the FY19 minimum reserve from $24.3M to $27.1M

The above analysis is based on GHIP data available through FY19 Q1, current enrollment as of September 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

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Reserve and claim liability discussion

Minimum reserve methodology – ***Alternative 2***

FY19 Cost Estimate		
Variability Description	**Lower Bound**	**Upper Bound**
Expected Value	$833.0M	
Expected Value plus 1% population risk load	$840.9M	
70% Confidence Interval	$829.4M	$852.5M
90% Confidence Interval	$822.6M	$859.3M
95% Confidence Interval	$819.0M	$862.8M
97% Confidence Interval	$816.7M	$865.1M
98.5% Confidence Interval	$813.8M	$868.1M

At the 97% confidence interval level, the upper bound with load is $32.1M higher than the projected budget of $833.0M

→ $35.1M at 98.5% confidence interval

- The above exhibit reflects reforecasted FY19 projected costs based on data through FY19 Q1, plus additional 1% load for potential population risk volatility not captured by the variability tool
- Increasing the confidence interval from 97% to 98.5% and including a 1% population risk load increases the FY19 minimum reserve from $24.3M to $35.1M

The above analysis is based on GHIP data available through FY19 Q1, current enrollment as of September 2018, decisions approved to date by the SEBC, and other pricing assumptions as outlined in this document. The estimated confidence intervals shown are directional and intended to reflect the potential random fluctuation in claim cost given the current size and risk profile of the GHIP. The model does not contemplate potential change in cost due to shifts in enrollment, demographics or morbidity of the population, unexpected changes in provider networks, or significant changes in regulations affecting the health care market, which could exceed the 1% population risk load.

Source: Willis Towers Watson Trend Variability tool including proprietary Health Care Claims Continuance table based on 2017 data

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GHIP FY12-FY18 Historical Lookback

FY12-FY18 gross claims and revenue per member

Plan Year	Gross Claims[1]		National Average Trend[2]	Premium Contributions[3]		Members	
	Per Member Per Year	Annual Increase/ (Decrease)		Per Member Per Year	Annual Increase/ (Decrease)	Average	Annual Increase/ (Decrease)
FY12	$5,009	4%	7%	$5,088	-1%	115,357	4%
FY13	$5,056	1%	6%	$4,979	-2%	117,421	2%
FY14	$5,488	9%	6%	$5,120	3%	119,225	2%
FY15	$5,980	9%	5%	$5,148	1%	121,167	2%
FY16	$6,190	4%	6%	$6,021	17%	122,238	1%
FY17	$6,331	2%	6%	$6,512	8%	122,693	0%
FY18	$6,533	3%	6%	$6,500	0%	124,754	2%

Source: GHIP Fund Equity FY12 – FY18

[1]Includes total medical and prescription drug claims for actives, pre-65 retirees and Medicare retirees; excludes claim offsets (e.g., Rx rebates and EGWP revenues).
[2]National Benchmark Source: Willis Towers Watson Emerging Trends survey. Based on respondents with at least 1,000 employees and median trends for medical and drug claims for active employees including both employer and employee contributions but excludes employee OOP costs.
[3]Includes State and employee share of health fund premiums for actives and retirees. Excludes other revenue sources and employee out-of-pocket costs.

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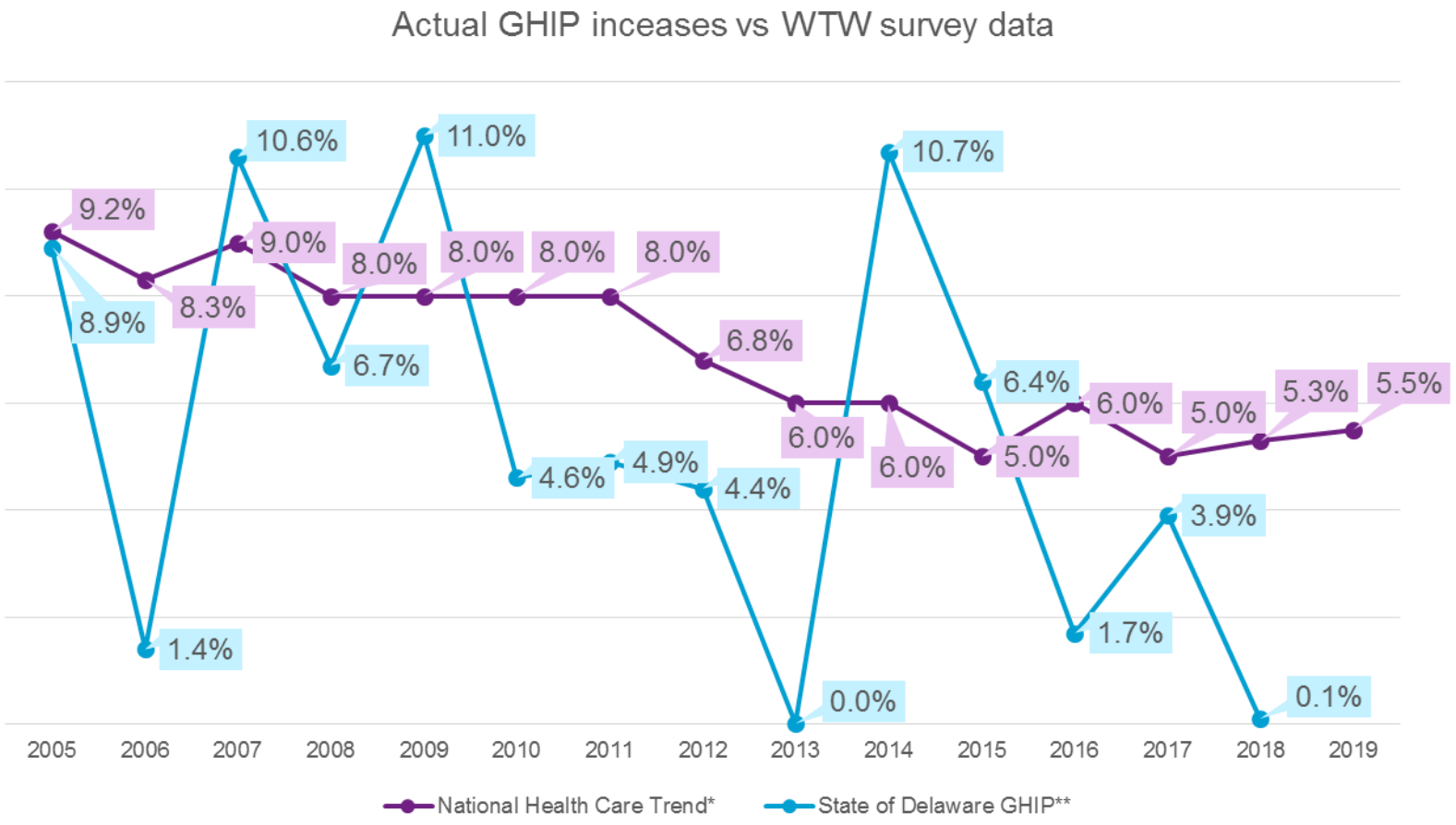
Historical GHIP cost increases

Actual GHIP increases vs. WTW survey data



*National Benchmark Source: Willis Towers Watson Best Practices in Healthcare survey. Based on respondents with at least 1,000 employees and median trends for medical and drug claims for active employees including both employer and employee contributions but excludes employee OOP costs. 2018 and 2019 benchmark data is projected.
**2007-2015 GHIP Trend data estimated based on Segal's State_of_Delaware_-_Trend_History_thru_Q2_FY16 030416.pdf
**2016-18 GHIP trend based on WTW financial reporting for corresponding fiscal year (includes net paid claims and fees) on a per employee per year basis

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Presented at 10/25 financial subcommittee meeting (updated 12/4 meeting)

Health care cost trend overview

Projected market data for 2019 – active/pre-65 retiree

Source	Medical/Rx		Medical Only	Rx Only	
	Gross[1]	Net[2]	Gross[1]	Gross[1]	Net[2]
Willis Towers Watson	5.5%	5.0%			
Aon	6.5%	4.1%			
Mercer	5.3%	4.1%			
PricewaterhouseCoopers	6.0%				
Segal			7.1%[3]	7.5%	
Aetna			11.0%[4]		
Highmark DE			4.5%[5]		
Express Scripts					2.4%[6]
Average	**5.8%**	**4.4%**	**7.5%**	**7.5%**	**2.4%**

[1] Before plan changes
[2] After plan changes
[3] Trend reflects open access PPO/POS plans
[4] Trend reflects Delaware book of business
[5] Trend reflects active population only
[6] Net of plan changes, rebates, and contract pricing changes

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