State of Delaware - Quarterly Financial Reporting

FY19 Q3 Cost Analysis

May 2019

Willis Towers Watson

State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q3 Executive Summary

Summary plan information

- FY19 Q1 - Q3 compared to FY18 Q1 - Q3:

Summary (total)	FY19 (Q1 - Q3)			FY18 (Q1 - Q3)			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Total program cost ($M)[1]	$464.2	$132.6	$598.6	$439.8	$119.3	$560.9	▲ 5.5%	▲ 11.2%	▲ 6.7%
Premium contributions ($M)[2]	$474.6	$141.6	$618.1	$475.0	$135.0	$612.1	▼ 0.1%	▲ 4.9%	▲ 1.0%
Total cost PEPY	$8,676	$2,480	$11,189	$8,369	$2,270	$10,673	▲ 3.7%	▲ 9.2%	▲ 4.8%
Total cost PMPY	$4,900	$1,400	$6,320	$4,710	$1,278	$6,006	▲ 4.0%	▲ 9.6%	▲ 5.2%
Average employees	71,324			70,066			▲ 1.8%		
Average members	126,278			124,508			▲ 1.4%		
Loss ratio	97%			92%					
Net income ($M)	$19.5			$51.1					

[1] Total program cost includes office operational expenses
[2] Includes fees for participating non-State groups

- FY19 Q1 - Q3 Actual compared to Original Budget (approved in August 2018):

Summary (total)	FY19 (Q1 - Q3) Actual			FY19 (Q1 - Q3) WTW Budget			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Total program cost ($M)[1]	$464.2	$132.6	$598.6	$478.6	$142.8	$623.2	▼ 3.0%	▼ 7.1%	▼ 4.0%
Total cost PEPY	$8,676	$2,480	$11,189	$8,931	$2,782	$11,745	▼ 2.9%	▼ 10.9%	▼ 4.7%
Total cost PMPY	$4,900	$1,400	$6,320	$4,962	$1,546	$6,525	▼ 1.2%	▼ 9.4%	▼ 3.1%
Net income ($M)	$19.5			($8.8)			-		

<u>Note</u>: WTW Budget reflects 20 assumed ESI pharmacy invoices, compared to 19 invoices reflected in ESI's paid claim reporting for FY19 Q1, Q2 and Q3. Smoothing for this difference, the actual cost per member would be about 1.7% below the WTW budget.

[1] Total program cost includes office operational expenses

Plan performance dashboard - key observations for total GHIP population

- IBM Watson Executive Dashboard for January 2018 - March 2019 (compared to January 2017 - March 2018) details the following trends and cost drivers, consistent with the observations from FY19 Q2:
  - Well visits increased across all age ranges; well baby visits increased 1.2%, well child visits increased 8.4%, and adult preventive visits increased 9.6% over prior period
  - Prevalence of members with >$100k in medical and Rx net payments increased 9%; total payments for these members increased $23.3M
  - The percent of prescription drug allowed amounts attributable to specialty medications increased by 3 percentage points over the prior period to 38%; specialty drug unit cost increased 3% while utilization increased 15% over prior period
  - Screening rates for cholesterol, cervical cancer, breast cancer and colon cancer are all below benchmark

Additional notes

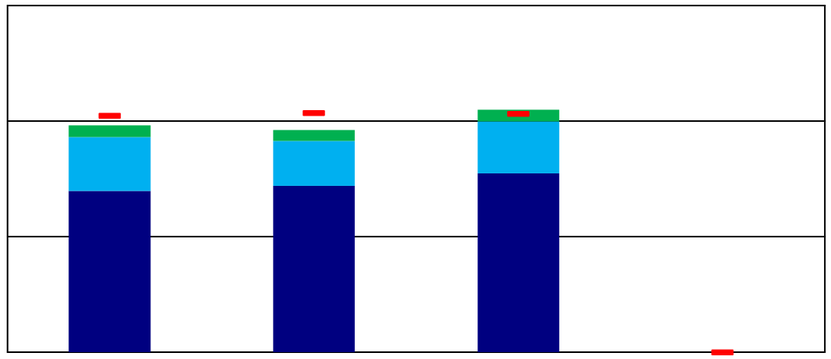
- Claims and expenses are reported on a paid basis
- Medical/Rx budget is based on FY19 budget rates, which were held flat from FY18
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI; costs include operating expenses
- Expenses are broken down into two categories:
  - ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (PCORI), IBM Watson data analytics, EAP, and WTW consulting fees
  - 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 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

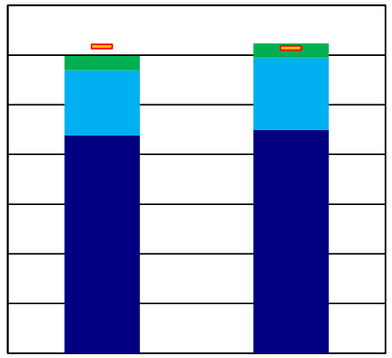
State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q3 Plan Cost Analysis

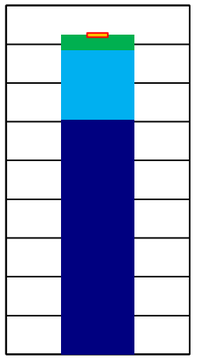
	Drop-Down Choices
Status	Total
Vendor	Total
Plan	Total

Legend

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







	Q1 2019	Q2 2019	Q3 2019	Q4 2019	FY19 YTD Actual	FY19 YTD WTW Budget[6]	Difference vs. Budget	FY19 Projected[7]
Total Program Cost	**$196,347,127**	**$192,397,878**	**$209,847,345**		**$598,592,349**	**$623,237,794**	▼ 4.0%	**$825,125,306**
- Paid Claims	186,285,090	182,717,654	199,817,757		568,820,501	594,239,119	▼ 4.3%	785,523,642
- Medical (includes capitation[1])	139,660,686	144,019,067	154,728,451		438,408,204	449,084,403	▼ 2.4%	604,192,089
- Rx (Including Rebates and EGWP)	46,624,404	38,698,587	45,089,306		130,412,297	145,154,716	▼ 10.2%	181,331,553
- Rx Paid Claims	70,594,214	59,634,280	64,546,520		194,775,014	211,674,295	▼ 8.0%	270,719,225
- EGWP	(8,965,781)	(8,743,490)	(6,273,492)		(23,982,763)	(23,622,230)	▲ 1.5%	(34,055,538)
- Direct Subsidy	(1,171,202)	(989,025)	(724,202)		(2,884,429)	(2,941,729)	▼ 1.9%	(3,525,365)
- CGDP	(4,617,691)	(4,168,854)	(2,836,214)		(11,622,758)	(10,781,085)	▲ 7.8%	(16,293,065)
- Catastrophic Reinsurance	(3,176,889)	(3,585,612)	(2,713,075)		(9,475,575)	(9,899,416)	▼ 4.3%	(14,237,108)
- Rx Rebates[2]	(15,004,029)	(12,192,203)	(13,183,722)		(40,379,954)	(42,897,349)	▼ 5.9%	(55,332,134)
- ASO Fees	9,492,829	9,102,042	9,388,940		27,983,811	27,075,078	▲ 3.4%	37,089,318
- Operational Expenses	569,208	578,182	640,647		1,788,037	1,923,597	▼ 7.0%	2,512,346
Medical/Rx Premium Contributions[3]	**$204,602,482**	**$207,047,037**	**$206,403,870**		**$618,053,389**	**$ 614,397,011**	▲ 0.6%	**$824,071,186**
- Net Income	8,255,355	14,649,160	(3,443,475)		19,461,040	(8,840,782)		(1,054,120)
- Total Cost as % of Budget	96%	93%	102%		97%	101%		100%
Current Year Per Capita								
- Total per employee per year[4]	11,085	10,773	11,710		11,189	11,745	▼ 4.7%	11,569
- Total % change over prior	7.6%	2.3%	4.6%		4.8%			6.1%
- Medical per employee per year	8,371	8,536	9,121		8,676	8,931	▼ 2.9%	8,954
- Medical % change over prior	8.0%	0.7%	2.7%		3.7%			5.5%
- Rx per employee per year	2,681	2,205	2,553		2,480	2,782	▼ 10.9%	2,580
- Rx % change over prior	6.6%	9.2%	12.3%		9.3%			8.4%
- Medical per member per year	4,715	4,834	5,152		4,900	4,962	▼ 1.2%	5,057
- Rx per member per year	1,510	1,249	1,442		1,400	1,546	▼ 9.4%	1,457
- Total per member per year[4]	6,244	6,101	6,615		6,320	6,525	▼ 3.1%	6,534
Prior Year Results	**Q1 2018**	**Q2 2018**	**Q3 2018**		**Q1-Q3 2018**			**FY 2018**
- Total Program Cost	179,673,085	184,441,784	196,815,037		560,929,907	-	-	765,518,315
- Total Program Cost $ Change	16,674,041	7,956,093	13,032,308		37,662,442	-	-	59,606,991
- Total per employee per year[4]	10,302	10,527	11,190		10,673	-	-	10,902
- Medical per employee per year	7,749	8,473	8,882		8,368	-	-	8,486
- Rx per employee per year	2,516	2,020	2,274		2,270	-	-	2,380
EE Contributions[5]	**$39,772,641**	**$39,752,739**	**$39,515,763**		**$119,173,349**			**$238,346,698**
- Net SoD	156,574,486	152,645,139	170,331,582		479,419,000	-	-	586,778,608
- SoD Subsidy %	80%	79%	81%		80%	-	-	71%
Headcount								
- Enrolled Ees	70,854	71,439	71,680		71,324	70,750	▲ 0.8%	71,324
- Enrolled Members	125,792	126,147	126,895		126,278	127,350	▼ 0.8%	126,278
- Member/EE Ratio	1.8	1.8	1.8		1.8	1.8		1.8

Note: WTW Budget reflects 20 assumed ESI pharmacy invoices, compared to 19 invoices reflected in ESI's paid claim reporting for FY19 Q1, Q2 and Q3.

[1] Capitation payments apply to HMO plan only

[2] Reflects actual rebates attributable to FY19 Q1 and estimated rebates attributable to FY19 Q2 and Q3; based on WTW analysis of expected rebates under ESI contract effective July 2018 and actual rebates as of February 2019

[3] Premium contributions include fees for participating non-State groups

[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] WTW projected budget based on 24 months of claims experience (1/1/2017 through 12/31/2018, weighted 35% 2017 / 65% 2018), with 6.5% medical / 10% pharmacy trend (3% medical trend for Medicfill population)

[7] Projections based on most recent 12 months of claims experience (1/1/2018 through 12/31/2018)

State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q3 Reporting Reconciliation (WTW vs OMB Fund Equity Report)

FY19 YTD Reporting Reconciliation	WTW FY19 Q3 Financial Report	OMB March 2019 Fund Equity Report
Total Program Cost	**$598,592,349**	**$677,797,478**
Paid Claims	633,183,218	648,025,630
Medical Claims	438,408,204	443,311,554
Rx Claims[1]	130,412,297	204,714,076
Rx Paid Claims	194,775,014	204,714,076
EGWP	(23,982,763)	(20,780,487)
Direct Subsidy	(2,884,429)	(2,901,656)
CGDP	(11,622,758)	(10,102,852)
Catastrophic Reinsurance	(9,475,575)	(7,775,979)
Rx Rebates	(40,379,954)	(45,550,143)
Total Rx Claim (Offsets)/Revenue[2]	(64,362,717)	(66,330,630)
Total Fees	29,771,848	29,771,848
ASO Fees	27,983,811	27,983,811
Operational Expenses	1,788,037	1,788,037
Premium Contributions[3]	**$618,053,389**	**$684,380,763**
Net Income	19,461,040	6,583,285
Total Cost as % of Budget	97%	99%

Note: Fund Equity Report reflects 20 ESI pharmacy invoices, compared to 19 invoices reflected in ESI's paid claim reporting for FY19 Q1, Q2 and Q3.

[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 premium contributions represent total operating revenues, including premium contributions, Rx revenues (EGWP and rebates), other revenues, and participating group fees totaling $4,425,050; WTW premium contributions represent FY19 budget rates and headcounts (net of Rx revenues), including participating group fees

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 FY2019 represents the time period July 1, 2018 through June 30, 2019 for all statuses; note Medicfill plan for Medicare eligible retirees runs from January 1, 2018 through December 31, 2018. Therefore, FY2019 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 All Medicare eligible retirees are assumed to be enrolled in medical and Rx coverage.

Benefit costs/fees

5 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

6 Administration fees and operational expenses from OMB-provided March 2018 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 (PCORI), IBM Watson data analytics, EAP and WTW consulting fees.

b. Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.

7 Pharmacy drug rebates are shown based on the period to which rebates are attributable and reflect estimated rebates for Q2 and Q3 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 FY2019 due to payment timing lag.

8 EGWP payments based on actual and expected payments attributable to the period July 1, 2018 through June 30, 2019; reflects estimated direct subsidy reimbursements, projected coverage gap discount payments, and estimated Calendar Year 2018 and Calendar Year 2019 catastrophic reinsurance payments from ESI (calculated by WTW). May differ from actual payments received during FY2019 due to payment timing lag.

9 Prior year costs calculated from WTW's FY18 Q4 Financial Reporting provided in October 2018.

10 FY19 costs projected based on the most recent 12 months of data (4/1/2018 – 3/31/2019) 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

11 Active and non-Medicare eligible retiree budget rates and contributions reflect rates effective July 1, 2018. Medicare eligible retiree budget rates reflect rates effective January 1, 2018 for FY19 Q1 and Q2, and rates effective January 1, 2019 for FY19 Q3 and Q4. Budget rates include FY19 risk fees for Participating groups (excludes $2.70 PEPM charge). FY19 budget rates were held flat from FY18.

12 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors.

13 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.

14 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.

15 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.

16 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.

State of Delaware
Health Plan Quarterly Financial Reporting
Glossary of Important Health Care Terms

Terminology	Acronym	Definition
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, 2018 to March 31, 2019