State of Delaware - Quarterly Financial Reporting

FY19 Q4 Cost Analysis

August 2019

State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q4 Executive Summary

Summary plan information

- FY19 Q1 - Q4 compared to FY18 Q1 - Q4:

Summary (total)	FY19 (Q1 - Q4)			FY18 (Q1 - Q4)			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Total program cost ($M)[1]	$624.5	$180.8	$807.7	$595.9	$167.1	$765.5	▲ 4.8%	▲ 8.2%	▲ 5.5%
Premium contributions ($M)[2]	$631.9	$188.5	$822.9	$630.4	$186.7	$817.0	▲ 0.2%	▲ 1.0%	▲ 0.7%
Total cost PEPY	$8,746	$2,532	$11,313	$8,486	$2,380	$10,902	▲ 3.1%	▲ 6.4%	▲ 3.8%
Total cost PMPY	$4,939	$1,430	$6,388	$4,779	$1,340	$6,140	▲ 3.4%	▲ 6.7%	▲ 4.0%
Average employees	71,388			70,218			▲ 1.7%		
Average members	126,435			124,687			▲ 1.4%		
Loss ratio	98%			94%					
Net income ($M)	$15.1			$51.5					

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

- FY19 Q1 - Q4 Actual compared to Original Budget (approved in August 2018):

Summary (total)	FY19 (Q1 - Q4) Actual			FY19 (Q1 - Q4) WTW Budget			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1,2]	Medical	Rx	Total
Total program cost ($M)[1]	$624.5	$180.8	$807.7	$647.0	$193.0	$842.6	▼ 3.5%	▼ 6.3%	▼ 4.1%
Total cost PEPY	$8,746	$2,532	$11,313	$8,910	$2,766	$11,711	▼ 1.8%	▼ 8.4%	▼ 3.4%
Total cost PMPY	$4,939	$1,430	$6,388	$5,034	$1,562	$6,616	▼ 1.9%	▼ 8.5%	▼ 3.5%
Net income ($M)	$15.1			($8.8)			-		

[1] Total program cost includes office operational expenses
[2] WTW Budget excludes $2.1m in estimated fees for participating non-State groups

Plan performance dashboard - key observations for total GHIP population

- IBM Watson Executive Dashboard for July 2018 - June 2019 (compared to July 2017 - June 2018) details the following trends and cost drivers:
  - Well visits increased across all age ranges; well baby visits increased 2.1%, well child visits increased 10.1%, and adult preventive visits increased 6.4% over prior period; all metrics remained well above benchmarks
  - Portion of GHIP spent attributable to members with >$100k in medical and Rx payments continues to increase, but increase has slowed, with a 2% increase in claimants per 1,000 and 4% increase in payments per claimant since prior period
  - The percent of prescription drug allowed amounts attributable to specialty medications increased by 3 percentage points over the prior period to 39% driven by a 20% increase in utilization (unit cost for specialty medications decreased 2%)
  - Inpatient admit frequency decreased 7%, offset by a 6% increase in cost per admit

Additional notes

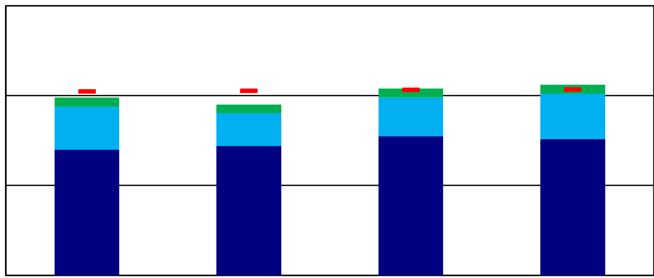
- Claims and expenses are reported on a paid basis
- FY19 budget rates were held flat from FY18
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI; costs include operating expenses
- Expenses are broken down into two categories:
  - ASO Fees: includes fees for vendor administration, 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

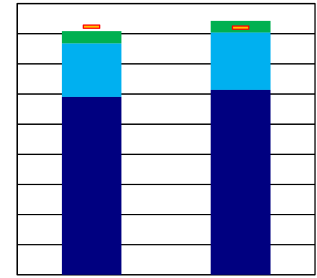
State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q4 Plan Cost Analysis

	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 2019	Q2 2019	Q3 2019	Q4 2019	FY19 YTD Actual	FY19 YTD WTW Budget[7]	Difference vs. Budget
Total Program Cost	**$197,645,539**	**$190,099,839**	**$207,945,750**	**$212,058,723**	**$807,749,851**	**$842,591,591**	▼ 4.1%
- Paid Claims	187,583,503	180,419,615	197,916,163	202,215,734	768,135,014	804,022,628	▼ 4.5%
- Medical (includes capitation[1])	139,660,686	144,019,067	154,728,451	151,629,495	590,037,699	613,571,308	▼ 3.8%
- Rx (Including Rebates and EGWP)	47,922,817	36,400,548	43,187,712	50,586,239	178,097,315	190,451,320	▼ 6.5%
- *Rx Paid Claims*	70,594,214	59,634,280	64,546,520	75,135,748	269,910,761	279,959,233	▼ 3.6%
- *EGWP*	(7,667,369)	(7,445,078)	(7,338,448)	(8,232,091)	(30,682,985)	(32,772,120)	▼ 6.4%
- Direct Subsidy	(1,171,202)	(989,025)	(724,202)	(940,734)	(3,825,163)	(3,627,178)	▲ 5.5%
- CGDP	(4,617,691)	(4,168,854)	(2,986,714)	(4,977,857)	(16,751,115)	(15,492,454)	▲ 8.1%
- Catastrophic Reinsurance[2]	(1,878,476)	(2,287,199)	(3,627,532)	(2,313,500)	(10,106,707)	(13,652,488)	▼ 26.0%
- *Rx Rebates*[3]	(15,004,029)	(15,788,655)	(14,020,360)	(16,317,418)	(61,130,461)	(56,735,793)	▲ 7.7%
- ASO Fees	9,492,829	9,102,042	9,388,940	9,147,092	37,130,903	36,004,167	▲ 3.1%
- Operational Expenses	569,208	578,182	640,647	695,897	2,483,934	2,564,796	▼ 3.2%
Medical/Rx Premium Contributions[4]	**$204,602,482**	**$205,192,602**	**$206,403,870**	**$206,696,377**	**$822,895,331**	**$ 819,196,015**	▲ 0.5%
- Net Income	6,956,943	15,092,763	(1,541,881)	(5,362,346)	15,145,480	(23,395,576)	
- Total Cost as % of Budget	97%	93%	101%	103%	98%	103%	
Current Year Per Capita							
- Total per employee per year[5]	11,158	10,693	11,604	11,797	11,313	11,711	▼ 3.4%
- Total % change over prior	8.3%	1.6%	3.7%	1.9%	3.8%		
- Medical per employee per year	8,371	8,575	9,121	8,919	8,746	8,910	▼ 1.8%
- Medical % change over prior	8.0%	1.2%	2.7%	1.0%	3.1%		
- Rx per employee per year	2,755	2,086	2,447	2,839	2,532	2,766	▼ 8.4%
- Rx % change over prior	9.5%	3.3%	7.6%	4.9%	6.4%		
- Medical per member per year	4,715	4,834	5,152	5,053	4,939	5,034	▼ 1.9%
- Rx per member per year	1,552	1,176	1,382	1,609	1,430	1,562	▼ 8.5%
- Total per member per year[5]	6,285	6,028	6,555	6,684	6,388	6,616	▼ 3.5%
Prior Year Results	**Q1 2018**	**Q2 2018**	**Q3 2018**	**Q4 2018**	**Q1-Q4 2018**		
- Total Program Cost	179,673,085	184,441,784	196,815,037	204,588,408	765,518,315	-	-
- Total Program Cost $ Change	17,972,454	5,658,054	11,130,714	7,470,315	42,231,536	-	-
- Total per employee per year[5]	10,302	10,527	11,190	11,579	10,902	-	-
- Medical per employee per year	7,749	8,473	8,882	8,831	8,486	-	-
- Rx per employee per year	2,516	2,020	2,274	2,708	2,380	-	-
EE Contributions[6]	**$39,772,641**	**$39,632,218**	**$39,515,763**	**$39,509,150**	**$158,429,772**		
- Net SoD	157,872,898	150,467,620	168,429,988	172,549,573	649,320,079	-	-
- SoD Subsidy %	80%	79%	81%	81%	80%	-	-
Headcount							
- Enrolled Ees	70,854	71,115	71,680	71,905	71,388	71,949	▼ 0.8%
- Enrolled Members	125,792	126,147	126,895	126,905	126,435	127,350	▼ 0.7%
- Member/EE Ratio	1.8	1.8	1.8	1.8	1.8	1.8	

[1] Capitation payments apply to HMO plan only
[2] Includes $1.3m CY2017 true-up payment received in January 2019 to align with cash flow timing in Fund
[3] Reflects actual paid rebates attributable to FY19 Q1/Q2 and estimated rebates attributable to FY19 Q3/Q4; estimated rebates based on WTW analysis of expected rebates under ESI contract effective July 2018 and actual rebates through FY19 Q2
[4] Premium contributions include fees for participating non-State groups
[5] Program cost and PEPM values also include ASO fees and operational expenses
[6] Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized
[7] WTW Budget based on 24 months of claims experience (7/1/2016 through 6/30/2018), weighted 35% earlier / 65% later with 6.5% medical / 10% pharmacy trend (3% medical trend for Medicfill population); headcounts as of July 2018; excludes $2,143,764 in estimated fees for participating non-State groups (actual WTW FY2019 Budget is $840,447,827)

FY19 YTD Reporting Reconciliation	WTW FY19 Q4 Financial Report	OMB June 2019 Fund Equity Report
Total Program Cost	**$807,749,851**	**$903,966,515**
Paid Claims	859,948,460	864,351,678
Medical Claims	590,037,699	595,823,447
Rx Claims[1]	178,097,315	268,528,231
Rx Paid Claims	269,910,761	268,528,231
EGWP	(30,682,985)	28,203,575
Direct Subsidy	(3,825,163)	3,844,331
CGDP	(16,751,115)	14,271,706
Catastrophic Reinsurance [2]	(10,106,707)	10,087,538
Rx Rebates	(61,130,461)	61,338,797
Total Rx Claim (Offsets)/Revenue[3]	(91,813,446)	89,542,372
Total Fees	39,614,837	39,614,837
ASO Fees	37,130,903	37,130,903
Operational Expenses	2,483,934	2,483,934
Premium Contributions/Operating Revenues[4]	**$822,895,331**	**$915,886,029**
Net Income	15,145,480	11,919,515
Total Cost as % of Budget	98%	99%

[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 FY19 reinsurance includes $1.3m CY2017 true-up payment received in January 2019 to align with cash flow timing in Fund
[3]WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims; OMB reflects these items as additions to operating revenues
[4]OMB premium contributions represent total operating revenues, including premium contributions, Rx revenues (EGWP and rebates), other revenues, and participating group fees totaling $5,934,679; 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 on a calendar year basis. 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 June 2019 Fund Equity Report; 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 actual rebates for FY19 Q1/Q2 and estimated rebates for FY19 Q3/Q4; estimated rebates based on WTW analysis of expected rebates under ESI contract effective July 2018 and actual rebates through FY19 Q2; 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 actual direct subsidy and prospective reinsurance payments received through June 2019 and coverage gap discount payments received through December 2018; remaining payments attributable to FY19 estimated based on projected amounts provided by ESI; 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.

Budget/contributions

10 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.
11 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors.
12 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.
13 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.
14 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.
15 HRA funding for CDH plans are included in the paid claims reported in this document.

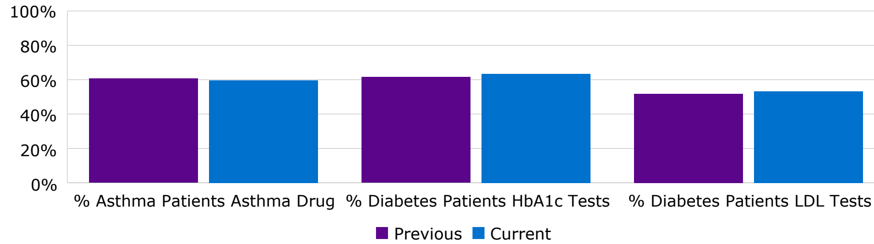
Terminology	Acronym	Definition
Administrative Services Only	ASO	When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as “self-funded”. Currently, the GHIP has ASO contracts 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.

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 June 30, 2019

Medical and Prescription Drug Dashboard - All Members

Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

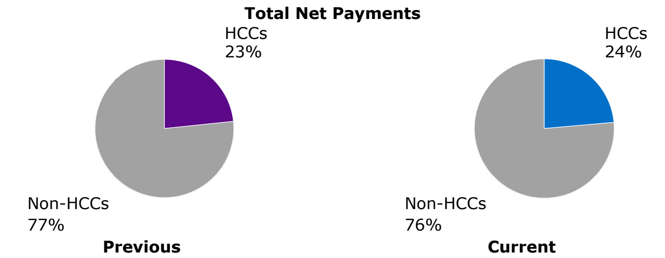
3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits Per 1000 Well Baby	5,727.3	5,849.7	2.1%	5,374.1 ●
Visits Per 1000 Well Child	829.3	913.2	10.1%	758.4 ●
Visits Per 1000 Prevent Adult	399.4	424.9	6.4%	360.0 ●

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	70,146	71,366	2%
Average Members	124,314	125,861	1%
Family Size	1.8	1.8	0%
Member Age	42.9	42.9	0%
Members % Male	45%	45%	0% pts

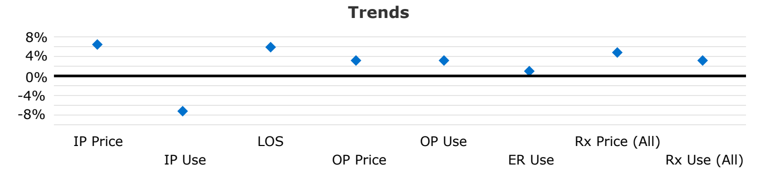
2. High Cost Claimants*



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

	Previous	Current	Trend
Patients	966	1,000	4%
Patients per 1,000	7.3	7.4	2%
Payments (in millions)	$185.6	$199.9	8%
Payment per Patient	$192,157	$199,928	4%

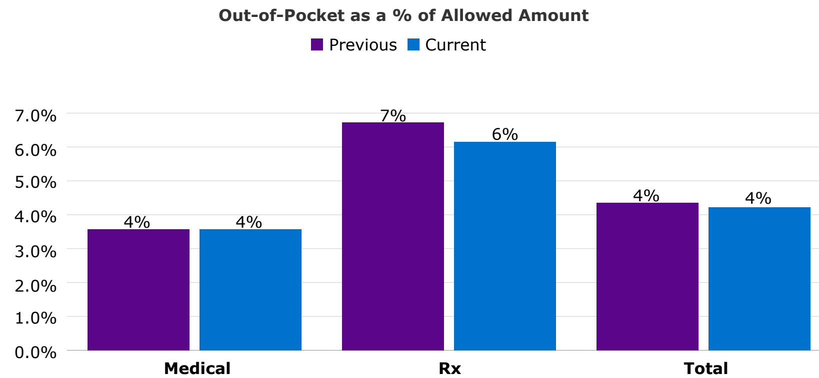
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$22,813	$29,195	●	6%
Admits per 1,000	82.7	55.3	■	-7%
Days LOS	5.2	4.5	■	6%
Outpatient				
Allowed per Service	$125	$124	◆	3%
Services PMPY	41.7	30.6	■	3%
Emergency Room Visits per 1,000	349	227	■	1%
Prescription Drugs				
Allowed/Days Supply	$2			0%
Days Supply PMPY	646			3%
Specialty Drugs				
Allowed/Days Supply	$91			-2%
Days Supply PMPY	10			20%
All Prescription Drugs				
Allowed/Days Supply	$4	$4	◆	5%
Days Supply PMPY	656	373	●	3%

● 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

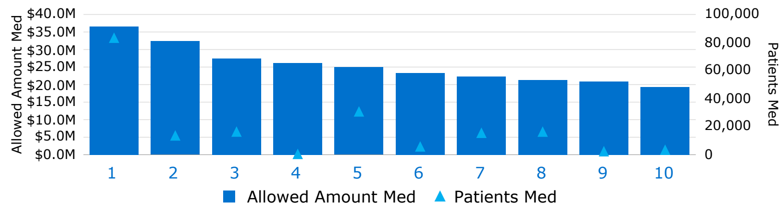


IBM Watson Health

Medical and Prescription Drug Dashboard - All Members

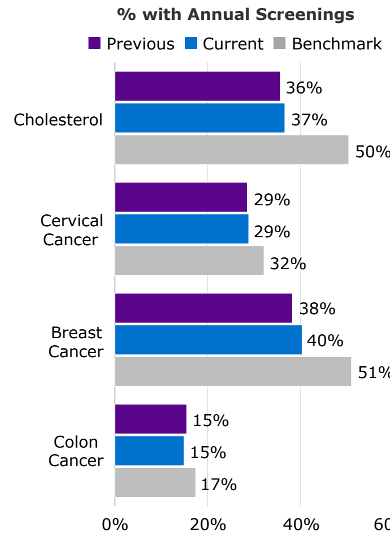
Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

7. Top Medical Conditions (by cost)

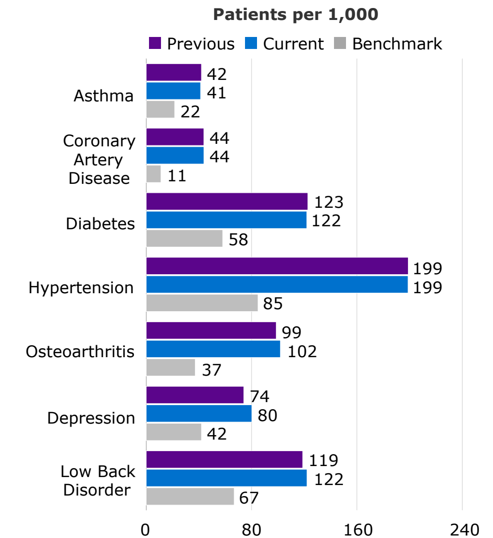


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$36,511,974	83,434	$438
2	Osteoarthritis	$32,365,437	13,784	$2,348
3	Spinal/Back Disord, Low Back	$27,409,364	16,515	$1,660
4	Chemotherapy Encounters	$26,160,060	619	$42,262
5	Arthropathies/Joint Disord NEC	$24,947,318	30,897	$807
6	Coronary Artery Disease	$23,327,832	5,927	$3,936
7	Respiratory Disord, NEC	$22,309,666	15,673	$1,423
8	Gastroint Disord, NEC	$21,327,394	16,503	$1,292
9	Pregnancy without Delivery	$20,895,772	2,520	$8,292
10	Renal Function Failure	$19,286,627	3,571	$5,401

8. Screening Rates

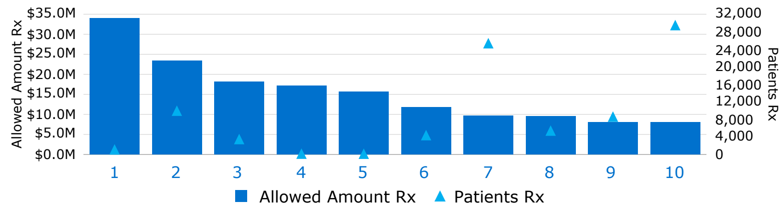


9. Chronic Condition Prevalence

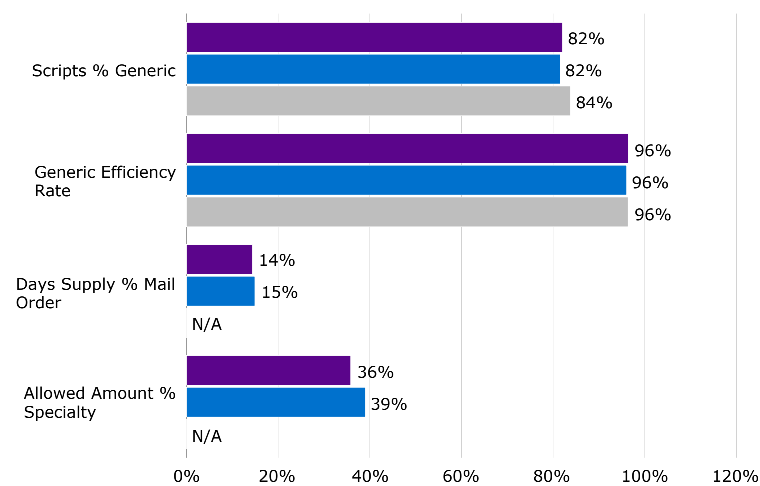


10. Prescription Drug Metrics

Top 10 Therapeutic Classes (by cost)



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$34,047,398	1,149	$29,632
2	Antidiabetic Agents, Misc	$23,333,373	9,990	$2,336
3	Antidiabetic Agents, Insulins	$18,125,718	3,522	$5,146
4	Molecular Targeted Therapy	$17,136,855	192	$89,254
5	Biological Response Modifiers	$15,626,077	178	$87,787
6	Coag/Anticoag, Anticoagulants	$11,802,720	4,418	$2,672
7	Adrenals & Comb, NEC	$9,637,108	25,384	$380
8	Stimulant, Amphetamine Type	$9,533,321	5,450	$1,749
9	Antivirals, NEC	$8,065,249	8,641	$933
10	Antihyperlipidemic Drugs, NEC	$8,031,607	29,518	$272

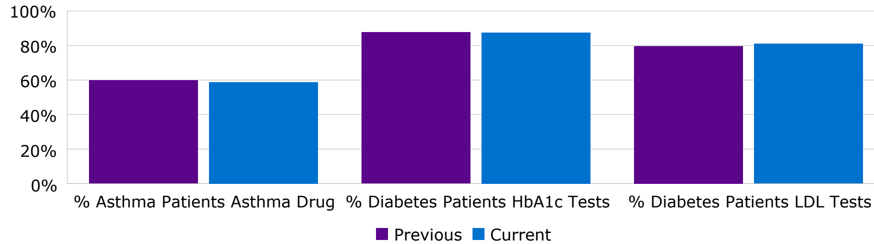


IBM Watson Health

State of Delaware Medical and Prescription Drug Dashboard - Active Employees

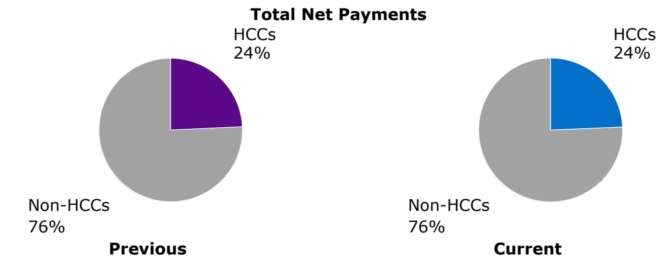
Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

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	667	722	8%
Patients per 1,000	6.9	7.4	7%
Payments (in millions)	$127.3	$134.7	6%
Payment per Patient	$190,887	$186,508	-2%

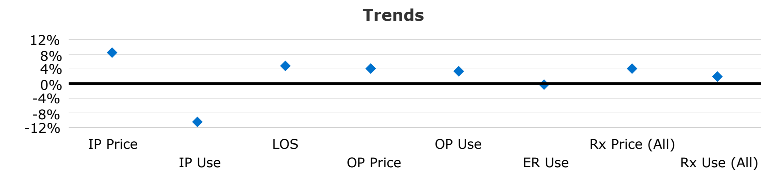
3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits Per 1000 Well Baby	5,729.0	5,857.1	2.2%	5,374.1 ●
Visits Per 1000 Well Child	828.5	912.1	10.1%	754.8 ●
Visits Per 1000 Prevent Adult	466.8	494.6	6.0%	325.0 ●

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	37,847	38,127	1%
Average Members	88,509	88,803	0%
Family Size	2.3	2.3	0%
Member Age	33.0	32.9	0%
Members % Male	47%	46%	0% pts

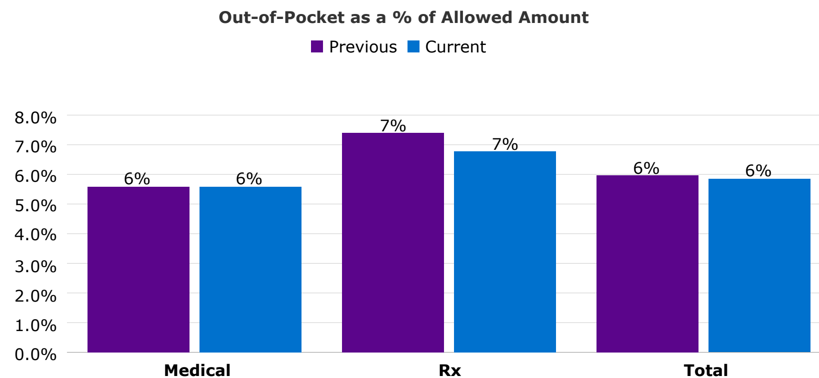
5. Price and Use



	Current	Benchmark		Trend
Inpatient				
Allowed per Admit	$26,660	$24,434	■	9%
Admits per 1,000	54.8	53.9	◆	-11%
Days LOS	4.5	4.3	■	5%
Outpatient				
Allowed per Service	$131	$124	■	4%
Services PMPY	31.0	29.4	■	3%
Emergency Room Visits per 1,000	279	226	■	0%
Prescription Drugs				
Allowed/Days Supply	$2			0%
Days Supply PMPY	382			1%
Specialty Drugs				
Allowed/Days Supply	$85			-3%
Days Supply PMPY	7			16%
All Prescription Drugs				
Allowed/Days Supply	$4	$4	◆	4%
Days Supply PMPY	389	336	●	2%

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

6. Cost Sharing

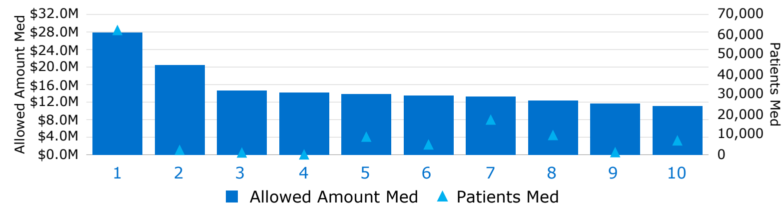


IBM Watson Health

State of Delaware Medical and Prescription Drug Dashboard - Active Employees

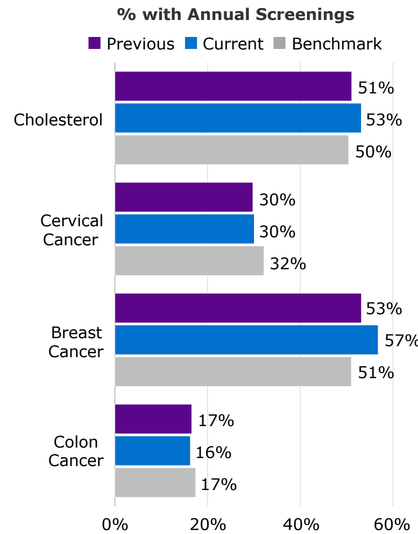
Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

7. Top Medical Conditions (by cost)

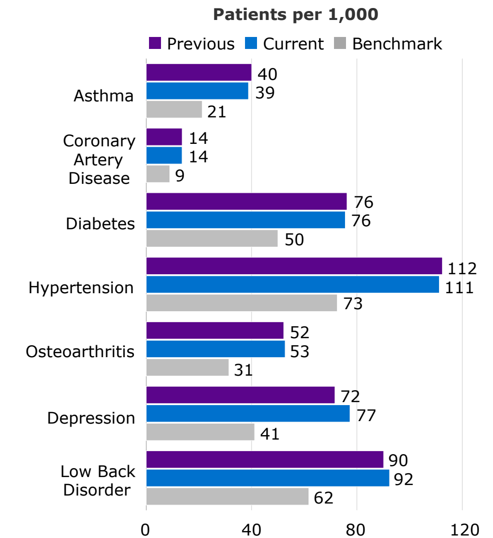


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$27,900,353	62,270	$448
2	Pregnancy without Delivery	$20,457,550	2,453	$8,340
3	Newborns, w/wo Complication	$14,684,854	1,147	$12,803
4	Chemotherapy Encounters	$14,206,825	208	$68,302
5	Spinal/Back Disord, Low Back	$13,904,360	9,050	$1,536
6	Osteoarthritis	$13,511,011	5,166	$2,615
7	Arthropathies/Joint Disord NEC	$13,272,776	17,583	$755
8	Gastroint Disord, NEC	$12,415,878	9,869	$1,258
9	Coronary Artery Disease	$11,730,600	1,333	$8,800
10	Respiratory Disord, NEC	$11,124,524	7,196	$1,546

8. Screening Rates

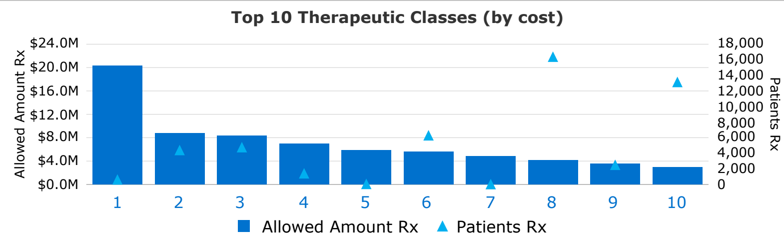


9. Chronic Condition Prevalence

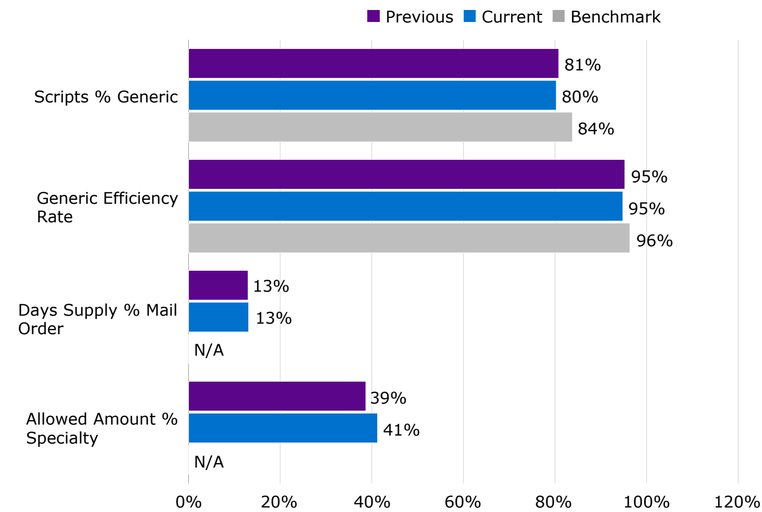


10. Prescription Drug Metrics

Top 10 Therapeutic Classes (by cost)



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$20,281,499	642	$31,591
2	Antidiabetic Agents, Misc	$8,761,634	4,421	$1,982
3	Stimulant, Amphetamine Type	$8,365,443	4,788	$1,747
4	Antidiabetic Agents, Insulins	$6,974,151	1,433	$4,867
5	Biological Response Modifiers	$5,856,571	76	$77,060
6	Antivirals, NEC	$5,628,685	6,312	$892
7	Molecular Targeted Therapy	$4,863,224	51	$95,357
8	Adrenals & Comb, NEC	$4,127,690	16,399	$252
9	Misc Therapeutic Agents, NEC	$3,553,083	2,524	$1,408
10	Psychother, Antidepressants	$2,975,199	13,156	$226

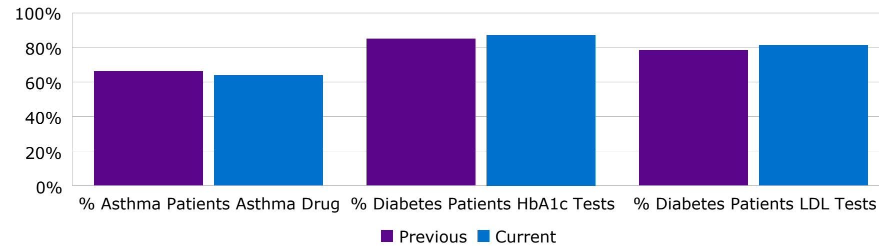


IBM Watson Health

Medical and Prescription Drug Dashboard - Early Retirees

Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

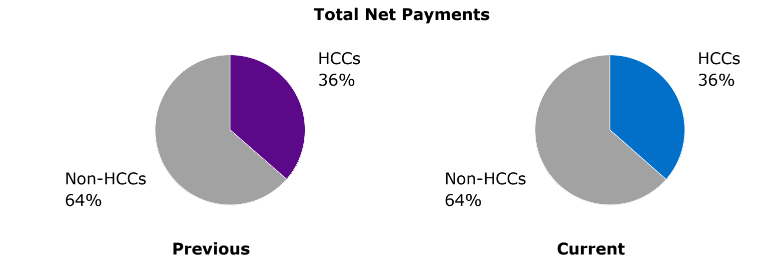
1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*

Total Net Payments



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

	Previous	Current	Trend
Patients	241	219	-9%
Patients per 1,000	22	18.7	-15%
Payments (in millions)	$38.2	$40.2	5%
Payment per Patient	$158,665	$183,393	16%

3. Well Care and Preventive Visits

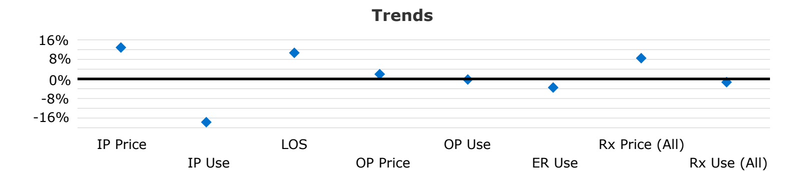
	Previous	Current	Trend	Benchmark
Visits Per 1000 Well Baby	5,478.3	5,581.4	1.9%	5,374.1 ●
Visits Per 1000 Well Child	882.4	974.6	10.5%	758.4 ●
Visits Per 1000 Prevent Adult	468.4	504.5	7.7%	457.0 ●

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	5,912	6,003	2%
Average Members	9,139	9,467	4%
Family Size	1.5	1.6	2%
Member Age	50.8	50.2	-1%
Members % Male	41%	42%	1% pts

5. Price and Use

Trends

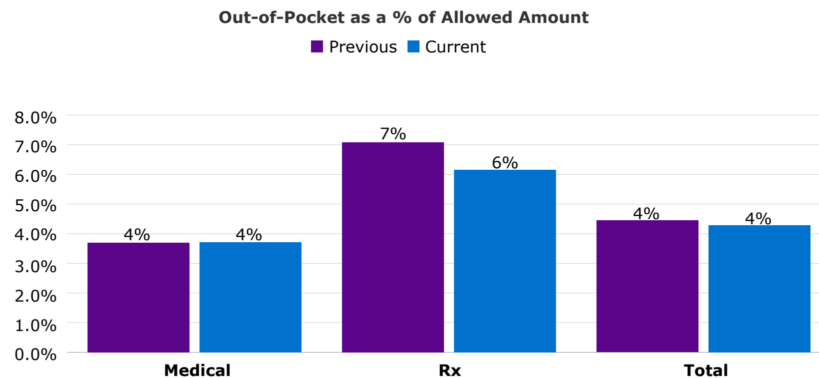


Inpatient	Current	Benchmark		Trend
Allowed per Admit	$37,216	$34,183	■	12%
Admits per 1,000	75.0	66.0	■	-17%
Days LOS	5.8	5.1	■	10%
Outpatient				
Allowed per Service	$148	$124	■	2%
Services PMPY	49.4	41.1	■	0%
Emergency Room Visits per 1,000	356	233	■	-3%
Prescription Drugs				
Allowed/Days Supply	$2			1%
Days Supply PMPY	786			-2%
Specialty Drugs				
Allowed/Days Supply	$90			0%
Days Supply PMPY	14			18%
All Prescription Drugs				
Allowed/Days Supply	$4	$3	■	9%
Days Supply PMPY	800	670	●	-2%

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

6. Cost Sharing

Out-of-Pocket as a % of Allowed Amount

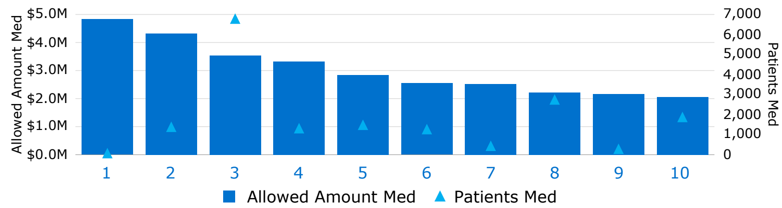


IBM Watson Health

Medical and Prescription Drug Dashboard - Early Retirees

Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

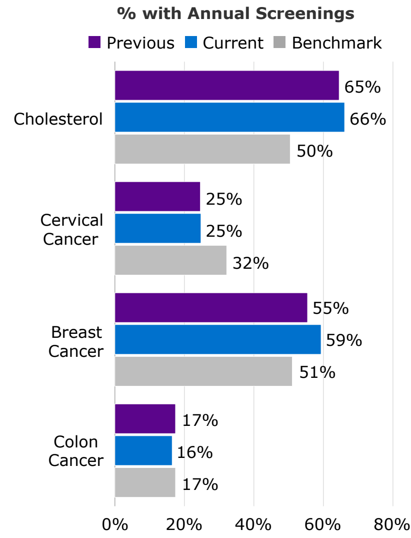
7. Top Medical Conditions (by cost)



	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Chemotherapy Encounters	$4,828,576	82	$58,885
2	Osteoarthritis	$4,317,207	1,395	$3,095
3	Prevent/Admin Hlth Encounters	$3,530,767	6,794	$520
4	Gastroint Disord, NEC	$3,316,417	1,326	$2,501
5	Spinal/Back Disord, Low Back	$2,844,731	1,494	$1,904
6	Respiratory Disord, NEC	$2,547,215	1,280	$1,990
7	Coronary Artery Disease	$2,527,625	447	$5,655
8	Arthropathies/Joint Disord NEC	$2,214,760	2,759	$803
9	Condition Rel to Tx - Med/Surg	$2,167,115	297	$7,297
10	Diabetes	$2,056,884	1,886	$1,091

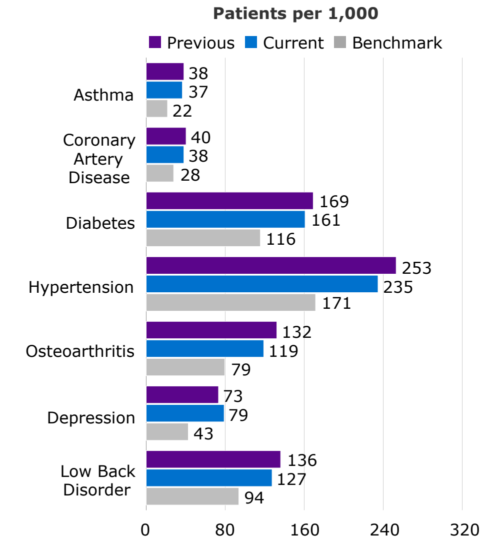
8. Screening Rates

% with Annual Screenings



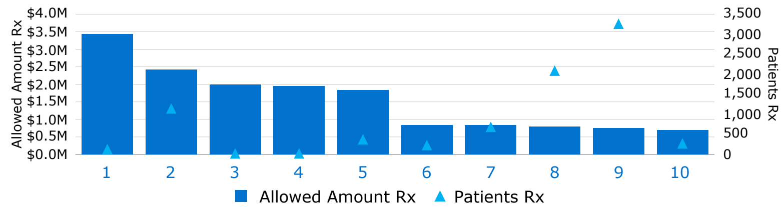
9. Chronic Condition Prevalence

Patients per 1,000

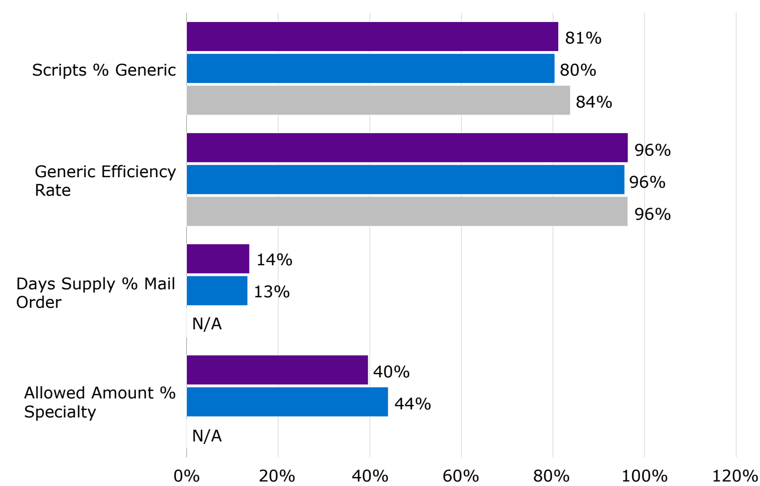


10. Prescription Drug Metrics

Top 10 Therapeutic Classes (by cost)



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$3,431,882	136	$25,234
2	Antidiabetic Agents, Misc	$2,411,520	1,148	$2,101
3	Biological Response Modifiers	$1,990,731	27	$73,731
4	Molecular Targeted Therapy	$1,948,082	27	$72,151
5	Antidiabetic Agents, Insulins	$1,831,700	379	$4,833
6	Antidiabetic Ag, SGLT Inhibitr	$838,738	235	$3,569
7	Antivirals, NEC	$834,959	689	$1,212
8	Adrenals & Comb, NEC	$797,684	2,091	$381
9	Antihyperlipidemic Drugs, NEC	$746,616	3,261	$229
10	CNS Agents, Misc.	$696,981	277	$2,516

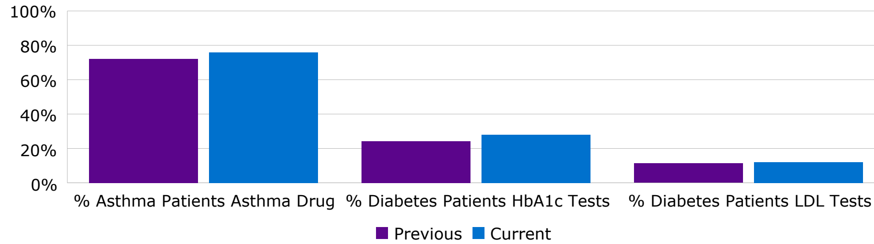


IBM Watson Health

Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

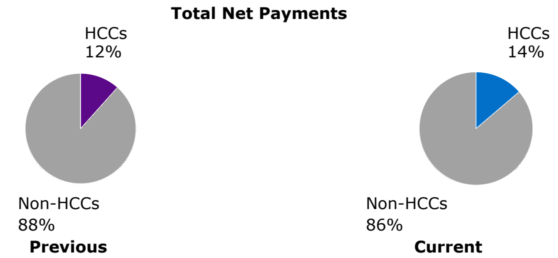
1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*

Total Net Payments



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

	Previous	Current	Trend
Patients	145	160	10%
Patients per 1,000	5.7	6.1	6%
Payments (in millions)	$17.3	$22.9	32%
Payment per Patient	$119,065	$142,898	20%

3. Well Care and Preventive Visits

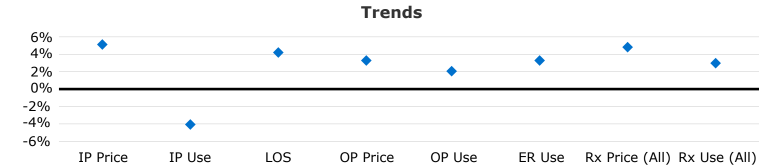
	Previous	Current	Trend	Benchmark
Visits Per 1000 Prevent Adult	213.7	234.9	10.0%	440.0 ■

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	24,024	24,812	3%
Average Members	24,126	24,988	4%
Family Size	1.0	1.0	0%
Member Age	73.2	73.0	0%
Members % Male	42%	42%	0% pts

5. Price and Use

Trends

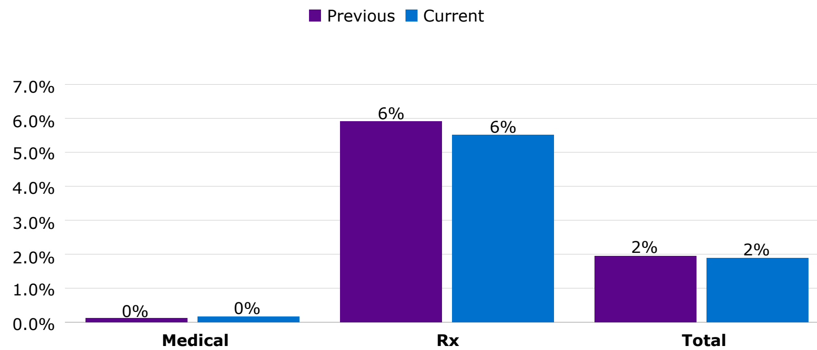


Inpatient	Current	Benchmark		Trend
Allowed per Admit	$17,070	$33,707	●	5%
Admits per 1,000	171.2	56.3	■	-4%
Days LOS	5.8	4.7	■	4%
Outpatient				
Allowed per Service	$111	$124	●	3%
Services PMPY	73.6	31.0	■	2%
Emergency Room Visits per 1,000	555	225	■	3%
Prescription Drugs				
Allowed/Days Supply	$2			-1%
Days Supply PMPY	1,482			3%
Specialty Drugs				
Allowed/Days Supply	$98			-1%
Days Supply PMPY	19			22%
All Prescription Drugs				
Allowed/Days Supply	$3	$4	●	5%
Days Supply PMPY	1,501	386	●	3%

● 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

Out-of-Pocket as a % of Allowed Amount

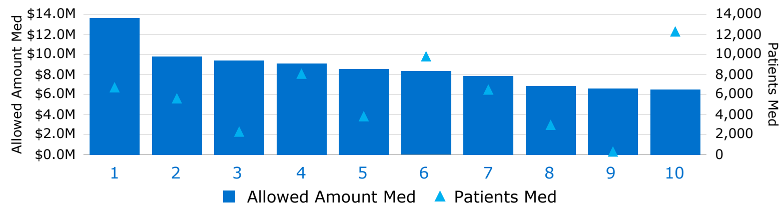


IBM Watson Health

Medical and Prescription Drug Dashboard - Medicare Retirees

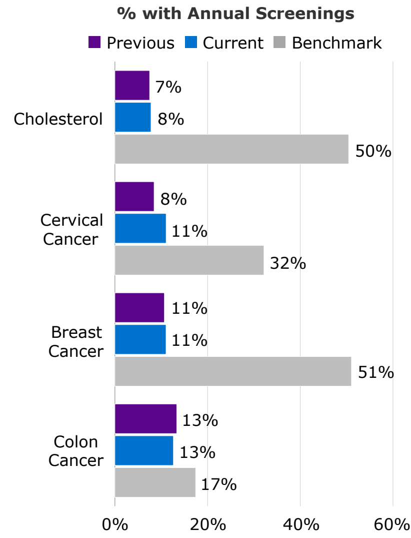
Previous Period: Jul 2017 - Jun 2018 (Paid)
Current Period: Jul 2018 - Jun 2019 (Paid)

7. Top Medical Conditions (by cost)

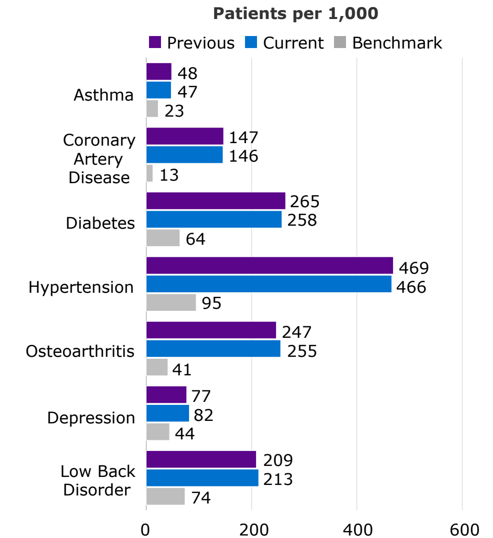


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$13,641,954	6,741	$2,024
2	Spinal/Back Disord, Low Back	$9,815,664	5,639	$1,741
3	Renal Function Failure	$9,413,092	2,314	$4,068
4	Eye Disorders, Degenerative	$9,104,419	8,094	$1,125
5	Coronary Artery Disease	$8,570,871	3,851	$2,226
6	Arthropathies/Joint Disord NEC	$8,330,133	9,835	$847
7	Respiratory Disord, NEC	$7,852,643	6,514	$1,206
8	Cerebrovascular Disease	$6,864,608	2,989	$2,297
9	Chemotherapy Encounters	$6,597,318	330	$19,992
10	Hypertension, Essential	$6,514,571	12,313	$529

8. Screening Rates

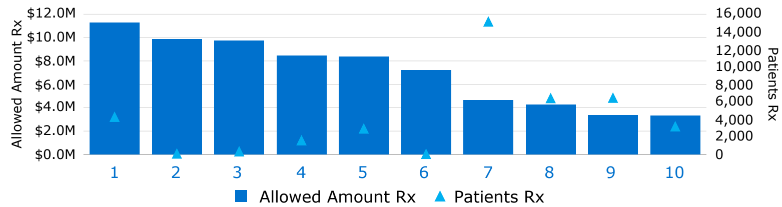


9. Chronic Condition Prevalence

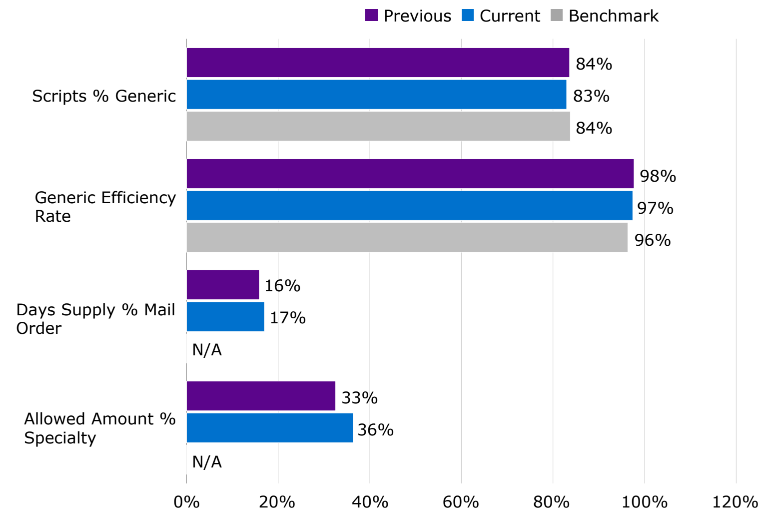


10. Prescription Drug Metrics

Top 10 Therapeutic Classes (by cost)



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Antidiabetic Agents, Misc	$11,287,215	4,308	$2,620
2	Molecular Targeted Therapy	$9,865,867	120	$82,216
3	Immunosuppressants, NEC	$9,722,181	372	$26,135
4	Antidiabetic Agents, Insulins	$8,449,141	1,634	$5,171
5	Coag/Anticoag, Anticoagulants	$8,347,265	2,973	$2,808
6	Biological Response Modifiers	$7,211,476	78	$92,455
7	Antihyperlipidemic Drugs, NEC	$4,635,638	15,176	$305
8	Adrenals & Comb, NEC	$4,256,114	6,443	$661
9	Gastrointestinal Drug Misc,NEC	$3,342,847	6,484	$516
10	Misc Therapeutic Agents, NEC	$3,296,806	3,225	$1,022



IBM Watson Health

State of Delaware Medical and Prescription Drug Dashboard
Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2017 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)