State of Delaware - Quarterly Financial Reporting

FY20 Q2 Cost Analysis

February 2020

Willis Towers Watson

State of Delaware
Health Plan Quarterly Financial Reporting
FY20 Q2 Plan Cost Analysis

Summary plan information

- FY20 Q2 compared to FY19 Q2:

Summary (total)	FY20 Q2			FY19 Q2			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Gross claims[1]	$295.8	$140.6	$436.5	$278.4	$130.2	$408.6	▲ 6.3%	▲ 8.0%	▲ 6.8%
Total program cost ($M)[2]	$316.8	$88.8	$406.7	$300.7	$87.9	$389.7	▲ 5.3%	▲ 1.1%	▲ 4.4%
Premium contributions ($M)[3]	$327.6	$88.1	$415.7	$316.1	$94.3	$411.6	▲ 3.6%	▼ 6.6%	▲ 1.0%
Total cost PEPY	$8,755	$2,472	$11,244	$8,453	$2,471	$10,957	▲ 3.6%	▲ 0.0%	▲ 2.6%
Total cost PMPY	$4,959	$1,392	$6,372	$4,775	$1,395	$6,188	▲ 3.9%	▼ 0.2%	▲ 3.0%
Average employees	72,377			71,147			▲ 1.7%		
Average members	127,764			125,970			▲ 1.4%		
Loss ratio	98%			95%					
Net income ($M)	$9.0			$21.9					

[1] Gross claims include paid medical and pharmacy claims as reported by Aetna, Highmark, and ESI

[2] Total program cost includes gross claims, pharmacy rebate and EGWP payment offsets, ASO fees, and office operational expenses

[3] Includes fees for participating non-State groups

- FY20 Actual compared to Original Budget (approved in August 2019):

Summary (total)	FY20 Q2 Actual			FY20 Q2 Budget			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Gross claims[1]	$295.8	$140.6	$436.5	$304.7	$139.7	$444.5	▼ 2.9%	▲ 0.7%	▼ 1.8%
Total program cost ($M)[2]	$316.8	$88.8	$406.7	$325.0	$87.4	$412.3	▼ 2.5%	▲ 1.6%	▼ 1.4%
Total cost PEPY	$8,755	$2,472	$11,244	$8,860	$2,438	$11,332	▼ 1.2%	▲ 1.4%	▼ 0.8%
Total cost PMPY	$4,959	$1,392	$6,372	$5,026	$1,383	$6,428	▼ 1.3%	▲ 0.6%	▼ 0.9%
Net income ($M)	$9.0			($5.9)					

Note: WTW Budget reflects 14 assumed ESI pharmacy invoices, compared to 13 invoices reflected in ESI's paid claim reporting for FY20 Q1 and Q2. Smoothing for this difference, the actual cost per member would be about 2% above the WTW budget.

[1] Gross claims include paid medical and pharmacy claims as reported by Aetna, Highmark, and ESI

[2] Total program cost includes office operational expenses under the Total column only (medical and Rx splits exclude theses expenses).
Excludes fees for participating non-State groups (these fees are included in premium contributions)

Plan performance dashboard - key observations for total GHIP population

- IBM Watson Executive Dashboard for January 2019 - December 2019 (compared to January 2018 - December 2018) details the following trends and cost drivers:
  - Chronic condition prevalence decreased for asthma, diabetes and hypertension; well child, well baby and preventive adult visits remain well above benchmark; screening rates for cholesterol and breast cancer increased from the prior period
  - Increase in portion of GHIP spend attributable to members with >$100k in medical and Rx payments is on the rise, with a 6% increase in claimants per 1,000 and 10% increase ($19.1m) in payments attributable to these members
  - The percent of prescription drug allowed amounts attributable to specialty medications increased by 5 percentage points over the prior period to 42% driven by a 27% increase in utilization; unit cost for specialty medications decreased 6%; generic dispensing rate is 2 points below benchmark
  - Inpatient admit frequency decreased 4%, offset by a 7% increase in cost per admit and 6% increase in length of stay

Additional notes

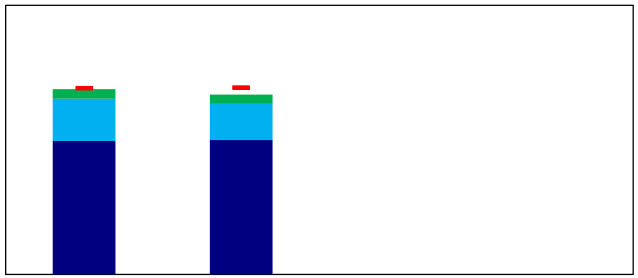
- Claims and expenses are reported on a paid basis
- FY20 budget rates were held flat from FY19
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI; costs include operating expenses
- Expenses are broken down into two categories:
  - ASO Fees: includes fees for vendor administration, 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; participating group fees are included in premium contributions

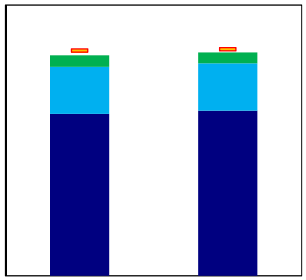
State of Delaware
Health Plan Quarterly Financial Reporting
FY20 Q2 Plan Cost Analysis

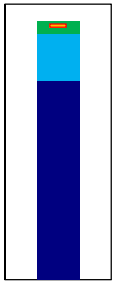
Total GHIP Results

Legend

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







	Q1 2020	Q2 2020	Q3 2020	Q4 2020	FY20 YTD Actual	FY20 YTD WTW Budget[8]	Difference vs. Budget	FY20 Projected[9]
Total Program Cost	**$206,527,703**	**$200,171,983**			**$406,699,686**	**$412,309,722**	▼ 1.4%	**$845,700,432**
- Paid Claims	195,686,771	189,848,416			385,535,187	392,198,522	▼ 1.7%	888,609,598
- Medical (includes capitation[1])	148,761,351	149,813,400			298,574,752	304,749,294	▼ 2.0%	648,422,560
- Rx (Including Rebates and EGWP)	46,925,420	40,035,015			86,960,435	87,449,228	▼ 0.6%	156,157,727
- Rx Paid Claims	75,507,949	65,138,068			140,646,017	139,709,197	▲ 0.7%	262,326,221
- EGWP[2]	(10,604,944)	(9,601,456)			(20,206,400)	(19,114,715)	▲ 5.7%	(37,898,626)
- Direct Subsidy	(771,080)	(752,004)			(1,523,084)	(1,655,764)	▼ 8.0%	(2,523,288)
- CGDP	(5,921,576)	(5,959,864)			(11,881,440)	(11,946,856)	▼ 0.5%	(20,909,990)
- Catastrophic Reinsurance[3]	(3,912,288)	(2,889,588)			(6,801,876)	(5,512,094)	▲ 23.4%	(14,465,348)
- Rx Rebates[4]	(17,977,585)	(15,501,597)			(33,479,182)	(33,145,255)	▲ 1.0%	(69,503,781)
- ASO Fees	10,269,920	9,800,001			20,069,922	18,869,233	▲ 6.4%	38,636,211
- Operational Expenses	571,012	523,772			1,094,784	1,241,967	▼ 11.9%	2,483,934
Medical/Rx Premium Contributions[5]	**$207,540,932**	**$208,148,345**			**$415,689,277**	**$ 418,202,070**	▼ 0.6%	**$830,046,827**
- Net Income	(1,013,228)	(7,976,362)			(8,989,590)	(5,892,348)		(15,653,605)
- Total Cost as % of Budget	100%	96%			98%	99%		102%
Current Year Per Capita								
- Total per employee per year[6]	11,448	11,054			11,244	11,332	▼ 0.8%	11,643
- Total % change over prior	2.4%	2.6%			2.6%			-1.47%
- Medical per employee per year	8,744	8,778			8,755	8,860	▼ 1.2%	9,423
- Medical % change over prior	4.5%	3.6%			3.6%			7.74%
- Rx per employee per year	2,664	2,247			2,472	2,438	▲ 1.4%	2,186
- Rx % change over prior	-4.1%	0.0%			0.0%			-27.98%
- Medical per member per year	4,959	4,967			4,959	5,026	▼ 1.3%	5,341
- Rx per member per year	1,500	1,272			1,392	1,383	▲ 0.6%	1,239
- Total per member per year[6]	6,492	6,255			6,372	6,428	▼ 0.9%	6,599
Prior Year Results	**Q1 FY19**	**Q2 FY19**	**Q3 FY19**	**Q4 FY19**	**Q2 FY19**			**FY 2019**
- Total Program Cost	198,069,057	192,811,944			390,881,001	-	-	135,472,376
- Total Program Cost $ Change	8,458,646	7,360,039			15,818,685	-	-	710,228,056
- Total per employee per year[6]	11,182	10,796			10,989	-	-	5,071
- Medical per employee per year	8,371	8,536			8,453	-	-	2,466
- Rx per employee per year	2,778	2,228			2,503	-	-	2,571
EE Contributions[7]	**$40,928,715**	**$41,012,844**			**$81,941,560**			**$520,977**
- Net SoD	166,098,761	159,159,139			325,257,900	-	-	845,179,455
- SoD Subsidy %	80%	80%			80%	-	-	100%
Headcount								
- Enrolled Ees	72,317	72,436			72,377	72,768	▼ 0.5%	72,635
- Enrolled Members	127,519	128,008			127,764	128,282	▼ 0.4%	128,148
- Member/EE Ratio	1.8	1.8			1.8	1.8		1.8

[1] Capitation payments apply to HMO plan only
[2] Direct subsidy and catastrophic reinsrance prospective payments reflect actual payments received during quarter; CGDP estimated based on payment attributable to quarter; projected EGWP PMPM amounts provided by ESI
[3] Includes $1.2m prospective reinsurance adjustment payment received in August 2019 to align with cash flow timing in Fund
[4] Reflects estimated rebates attributable to FY20; prior quarters to be updated with actual FY20 rebates when received; estimated rebates based on WTW analysis of expected rebates under ESI contract effective July 2019
[5] Premium contributions include fees for participating non-State groups
[6] Total per employee per year (PEPY) and per member per year (PMPY) values include operational expenses; these expenses are excluded from medical and Rx PEPY/PMPY splits
[7] Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized
[8] WTW Budget based on final FY20 Budget approved by SEBC on 8/26/2019
[9] FY20 Projected based on 24 months of claims experience through FY20 Q2; reflects average headcounts through Q2 with 1% assumed enrollment growth during FY20; reflects costs and savings attributable to all GHIP initiatives effective 7/1/19, including impact of passed legislation; 5% medical/8% pharmacy trend; EGWP revenues and prescription drug rebates projected based on the period revenues are attributable

State of Delaware
Health Plan Quarterly Financial Reporting
FY20 Q2 Reporting Reconciliation (WTW vs DHR Fund Equity Report)

FY20 YTD Reporting Reconciliation	WTW FY20 Q2 Financial Report	DHR December 2019 Fund Equity Report
Total Program Cost	**$406,699,686**	**$478,103,121**
Paid Claims	385,535,187	456,938,415
Medical Claims	298,574,752	305,006,974
Rx Claims[1]	86,960,435	151,931,440
Rx Paid Claims	140,646,017	151,931,440
EGWP	(20,206,400)	15,589,507
Direct Subsidy	(1,523,084)	1,533,696
CGDP	(11,881,440)	7,264,547
Catastrophic Reinsurance[2]	(6,801,876)	6,791,264
Rx Rebates	(33,479,182)	35,549,470
Total Rx Claim (Offsets)/Revenue[3]	(53,685,582)	51,138,977
Total Fees	21,164,707	21,164,707
ASO Fees	20,069,922	20,069,922
Operational Expenses	1,094,784	1,094,784
Premium Contributions/Operating Revenues[4]	**$415,689,277**	**$470,424,397**
Net Income	8,989,590	(7,678,724)
Total Cost as % of Budget	98%	102%

Note: Fund reflects 14 actual ESI pharmacy invoices, compared to 13 invoices reflected in ESI's paid claim reporting for FY20 Q1 and Q2.

1WTW Rx claims shown net of EGWP revenue and Rx rebates; DHR Rx claims reflect gross claim dollars excluding additional revenue (EGWP and rebates)

[2]WTW FY20 reinsurance includes $1.2m prospective reinsurance adjustment payment received in August 2019 to align with cash flow timing in Fund

[3]WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims; DHR reflects these items as additions to operating revenues

[4]DHR premium contributions represent total operating revenues, including premium contributions, Rx revenues (EGWP and rebates), other revenues totaling $2,918,399, and participating group fees totaling $3,007,953; WTW premium contributions represent FY20 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 FY2020 represents the time period July 1, 2019 through June 30, 2020 for all statuses; note Medicfill plan for Medicare eligible retirees runs on a calendar year basis. Therefore, FY2020 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; Medicare enrollment provided separately for retirees enrolled in medical (Highmark) and Rx (ESI).

Benefit costs/fees

4 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 DHR

5 Administration fees and operational expenses from DHR-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.

6 Pharmacy drug rebates are shown based on the period to which rebates are attributable; prior quarters to be updated with actual FY20 rebates when received; estimated rebates based on WTW analysis of expected rebates under ESI contract effective July 2019 and actual rebates through FY19 Q4; active/non-Medicare eligible retiree rebates assigned to each plan on a contract count basis; may differ from actual payments received during FY2020 due to payment timing lag.

7 EGWP payments based on actual and expected payments attributable to the period July 1, 2019 through June 30, 2020; reflects actual direct subsidy and prospective reinsurance payments received through December 2019 and coverage gap discount payments received through November 2019; remaining payments attributable to FY20 estimated based on projected amounts provided by ESI; may differ from actual payments received during FY2020 due to payment timing lag.

8 Prior year costs calculated from WTW's FY20 Q2 Financial Reporting provided in February 2019.

9 FY20 Projected based on 24 months of claims experience through FY20 Q2; reflects average headcounts through Q2 with 1% assumed enrollment growth during FY20; reflects costs and savings attributable to all GHIP initiatives effective 7/1/19, including impact of passed legislation; 5% medical/8% pharmacy trend; EGWP revenues and prescription drug rebates projected based on the period revenues are attributable

Budget/contributions

10 Active and non-Medicare eligible retiree budget rates and contributions reflect rates effective July 1, 2019. Medicare eligible retiree budget rates reflect rates effective January 1, 2019 for FY20 Q1 and Q2, and rates effective January 1, 2020 for FY20 Q3 and Q4. Budget rates include FY20 risk fees for Participating groups (excludes $2.70 PEPM charge). FY20 budget rates were held flat from FY19.

11 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors; assumes 1% enrollment growth during FY20.

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; participating group fees are included in premium contributions.

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.

Terms directly tied to cost tracking

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.

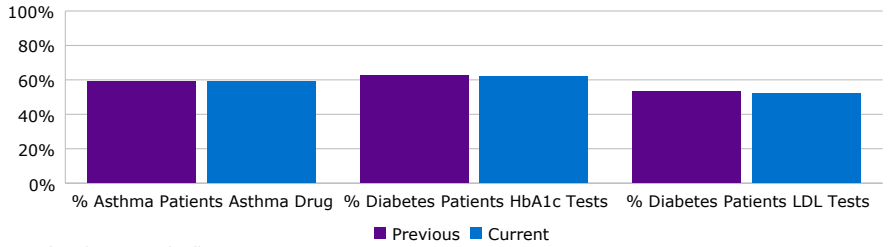
Terms directly tied to cost tracking

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, 2019 to June 30, 2020

Medical and Prescription Drug Dashboard - Total Member Population

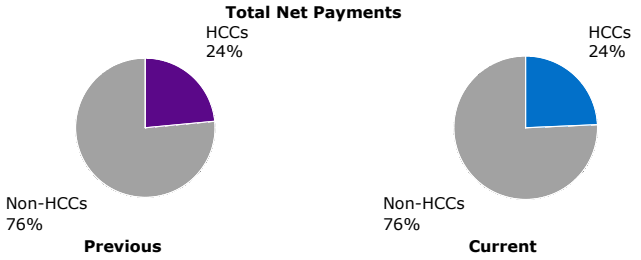
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

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	1,004	1,081	8%
Patients per 1,000	7.4	7.9	6%
Payments (in millions)	$193.6	$212.7	10%
Payment per Patient	$192,830	$196,738	2%

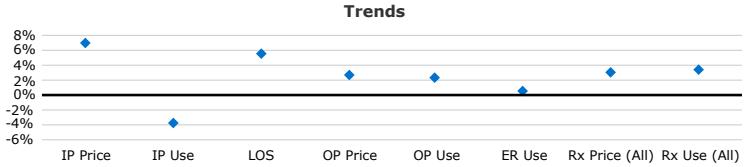
3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark	
Visits Per 1000 Well Baby	5,824.4	5,764.1	-1.0%	5,374.2	●
Visits Per 1000 Well Child	889.9	860.6	-3.3%	758.4	●
Visits Per 1000 Prevent Adult	415.5	429.6	3.4%	358.7	●

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	70,699	72,109	2%
Average Members	125,020	126,826	1%
Family Size	1.8	1.8	-1%
Member Age	42.9	43.0	0%
Members % Male	45%	45%	0% pts

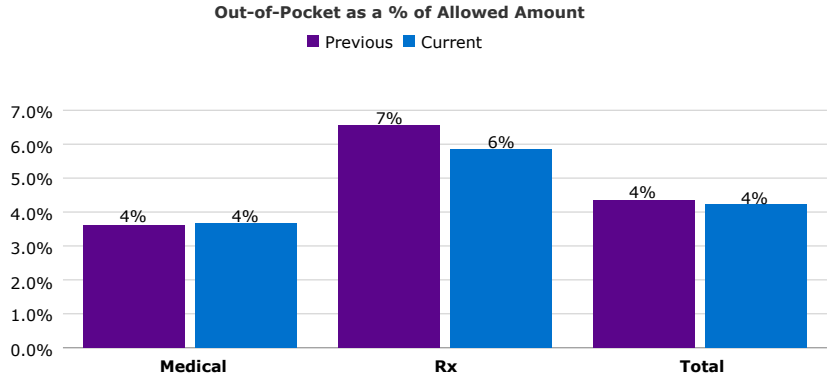
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$23,461	$29,748	●	7%
Admits per 1,000	83.1	55.1	■	-4%
Days LOS	5.3	4.6	■	6%
Outpatient				
Allowed per Service	$127	$124	◆	3%
Services PMPY	42.3	30.5	■	2%
Emergency Room Visits per 1,000	352	226	■	0%
Prescription Drugs				
Allowed/Days Supply	$2			-4%
Days Supply PMPY	651			3%
Specialty Drugs				
Allowed/Days Supply	$87			-6%
Days Supply PMPY	11			27%
All Prescription Drugs				
Allowed/Days Supply	$4	$4	◆	3%
Days Supply PMPY	663	370	●	4%

● 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

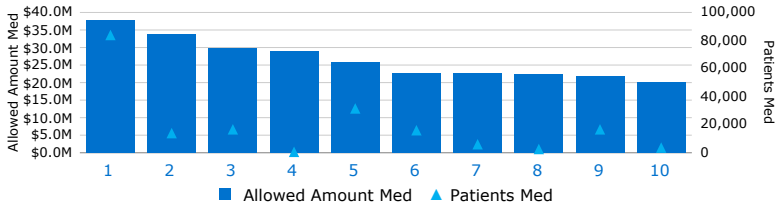


IBM Watson Health

Medical and Prescription Drug Dashboard - Total Member Population

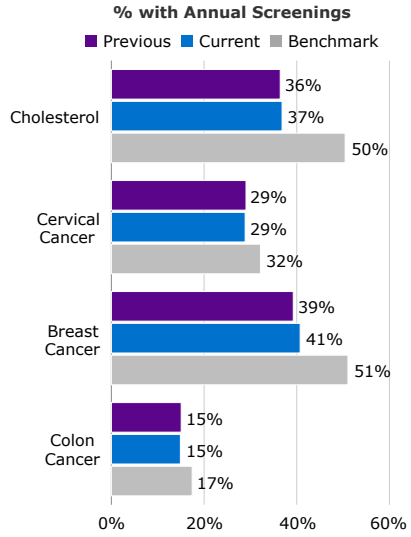
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

7. Top Medical Conditions (by cost)

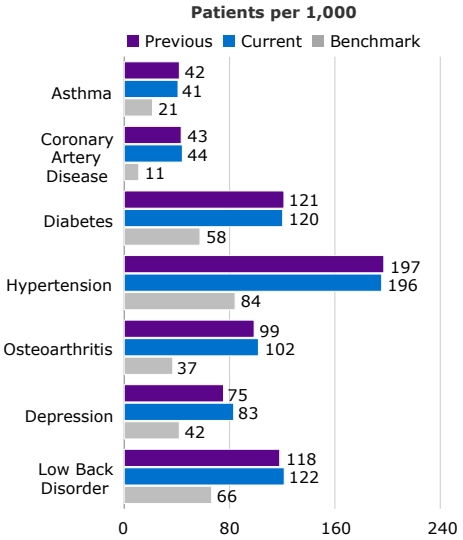


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$37,654,082	83,945	$449
2	Osteoarthritis	$33,866,137	14,002	$2,419
3	Spinal/Back Disord, Low Back	$29,916,601	16,696	$1,792
4	Chemotherapy Encounters	$28,935,065	651	$44,447
5	Arthropathies/Joint Disord NEC	$25,856,219	31,588	$819
6	Respiratory Disord, NEC	$22,772,515	16,053	$1,419
7	Coronary Artery Disease	$22,656,371	6,066	$3,735
8	Pregnancy without Delivery	$22,290,047	2,659	$8,383
9	Gastroint Disord, NEC	$21,829,521	16,684	$1,308
10	Renal Function Failure	$20,138,969	3,673	$5,483

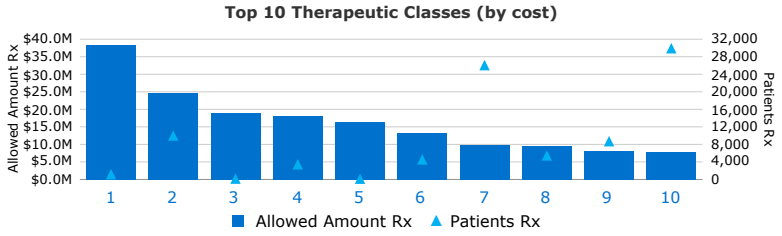
8. Screening Rates



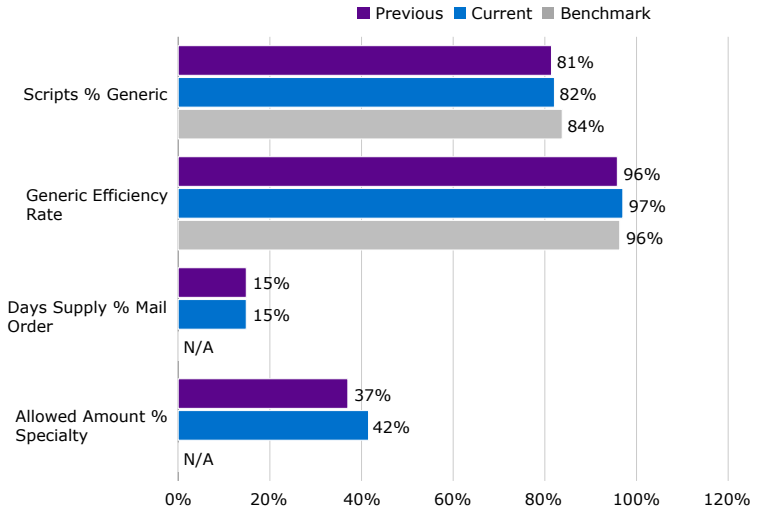
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



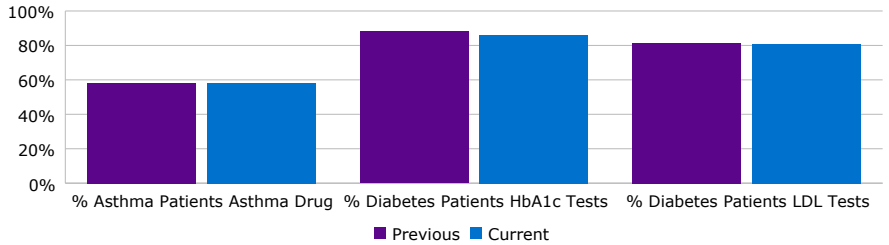
	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$38,347,103	1,209	$31,718
2	Antidiabetic Agents, Misc	$24,609,519	10,029	$2,454
3	Molecular Targeted Therapy	$19,007,537	204	$93,174
4	Antidiabetic Agents, Insulins	$18,106,387	3,471	$5,216
5	Biological Response Modifiers	$16,294,202	181	$90,023
6	Coag/Anticoag, Anticoagulants	$13,181,113	4,579	$2,879
7	Adrenals & Comb, NEC	$9,818,210	26,090	$376
8	Stimulant, Amphetamine Type	$9,554,545	5,486	$1,742
9	Antivirals, NEC	$8,169,651	8,727	$936
10	Antihyperlipidemic Drugs, NEC	$7,945,638	29,944	$265



State of Delaware Medical and Prescription Drug Dashboard - Actives

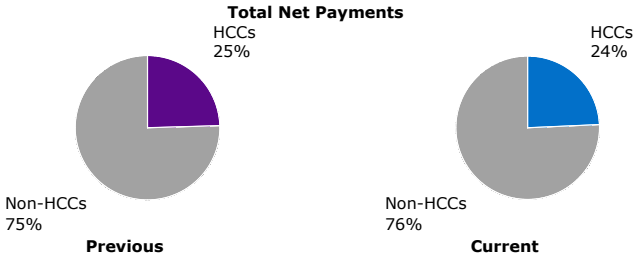
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

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	720	744	3%
Patients per 1,000	7.3	7.5	2%
Payments (in millions)	$133.5	$136.4	2%
Payment per Patient	$185,432	$183,315	-1%

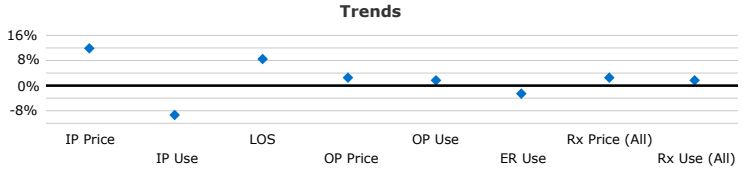
3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark	
Visits Per 1000 Well Baby	5,830.3	5,766.3	-1.1%	5,374.2	●
Visits Per 1000 Well Child	890.1	860.7	-3.3%	758.4	●
Visits Per 1000 Prevent Adult	483.9	499.3	3.2%	323.8	●

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	38,060	38,250	1%
Average Members	88,846	88,824	0%
Family Size	2.3	2.3	-1%
Member Age	32.9	32.8	0%
Members % Male	46%	46%	0% pts

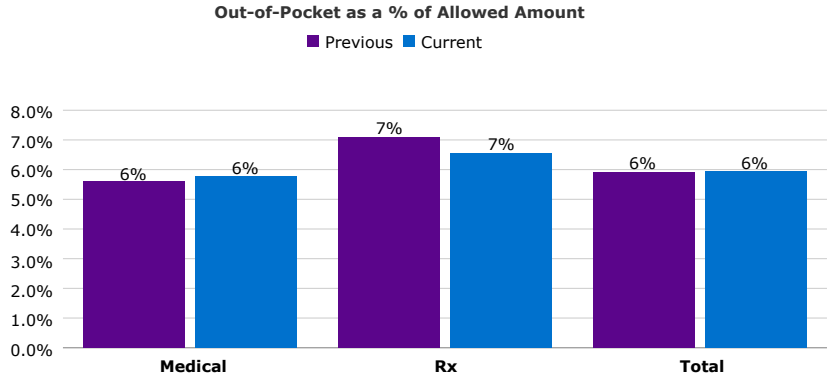
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$27,752	$25,421	■	12%
Admits per 1,000	53.8	53.6	◆	-9%
Days LOS	4.6	4.3	■	8%
Outpatient				
Allowed per Service	$132	$125	■	2%
Services PMPY	31.4	29.2	■	2%
Emergency Room Visits per 1,000	277	225	■	-2%
Prescription Drugs				
Allowed/Days Supply	$2			-4%
Days Supply PMPY	383			1%
Specialty Drugs				
Allowed/Days Supply	$82			-6%
Days Supply PMPY	8			24%
All Prescription Drugs				
Allowed/Days Supply	$4	$4	◆	3%
Days Supply PMPY	391	333	●	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

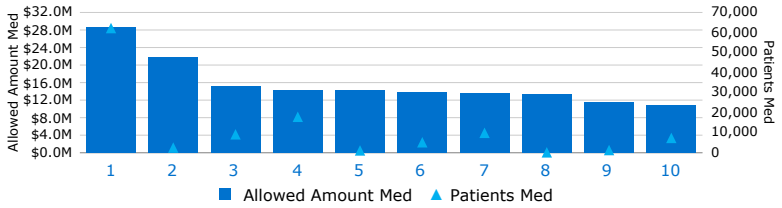


IBM Watson Health

State of Delaware Medical and Prescription Drug Dashboard - Actives

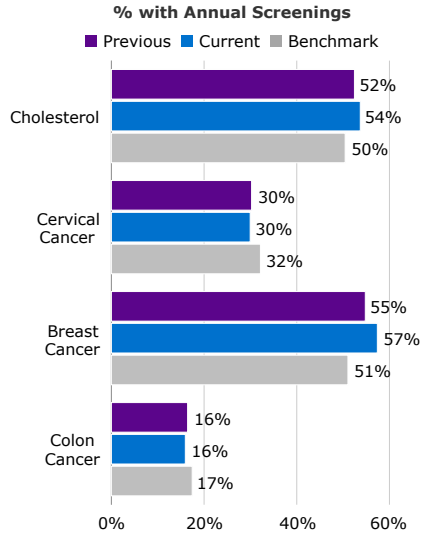
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

7. Top Medical Conditions (by cost)

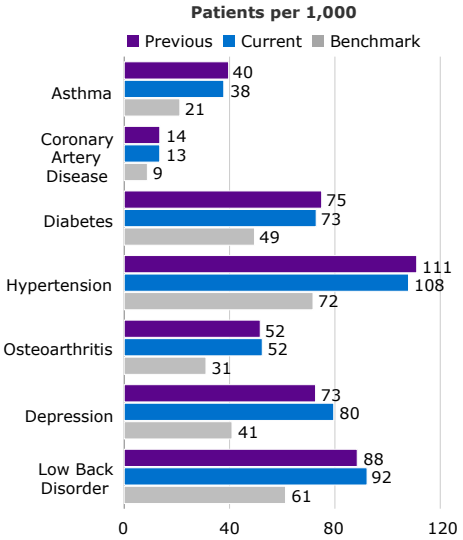


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$28,737,904	62,214	$462
2	Pregnancy without Delivery	$21,786,811	2,582	$8,438
3	Spinal/Back Disord, Low Back	$15,070,415	9,192	$1,640
4	Arthropathies/Joint Disord NEC	$14,160,876	17,939	$789
5	Newborns, w/wo Complication	$14,151,667	1,159	$12,210
6	Osteoarthritis	$13,797,752	5,225	$2,641
7	Gastroint Disord, NEC	$13,531,780	9,946	$1,361
8	Chemotherapy Encounters	$13,278,166	207	$64,146
9	Coronary Artery Disease	$11,447,751	1,345	$8,511
10	Respiratory Disord, NEC	$10,904,368	7,395	$1,475

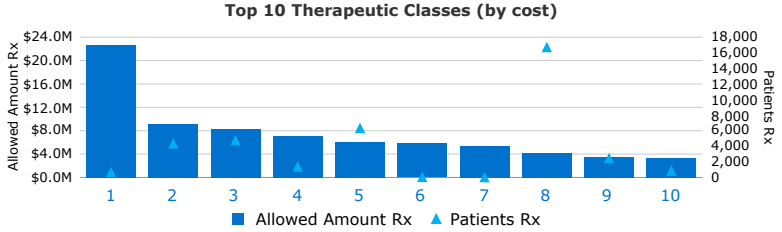
8. Screening Rates



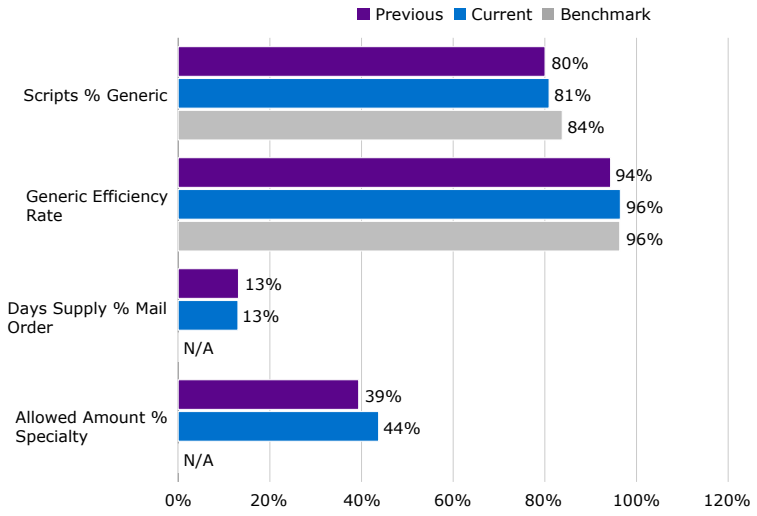
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



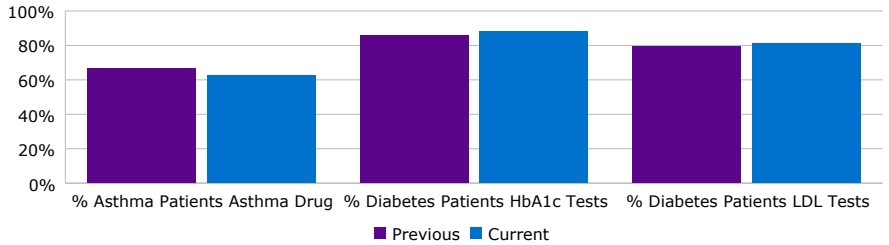
	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$22,706,190	689	$32,955
2	Antidiabetic Agents, Misc	$9,188,732	4,376	$2,100
3	Stimulant, Amphetamine Type	$8,341,304	4,798	$1,738
4	Antidiabetic Agents, Insulins	$7,053,482	1,411	$4,999
5	Antivirals, NEC	$6,023,875	6,366	$946
6	Biological Response Modifiers	$5,814,713	78	$74,548
7	Molecular Targeted Therapy	$5,424,750	56	$96,871
8	Adrenals & Comb, NEC	$4,188,387	16,741	$250
9	Misc Therapeutic Agents, NEC	$3,465,746	2,495	$1,389
10	Antidiabetic Ag, SGLT Inhibitr	$3,254,791	884	$3,682



Medical and Prescription Drug Dashboard - Early Retirees

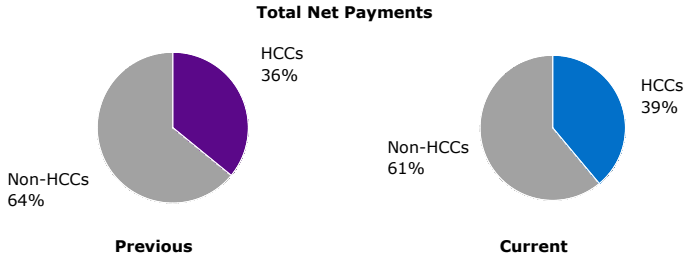
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

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	228	253	11%
Patients per 1,000	20.7	21.3	3%
Payments (in millions)	$37.9	$47.2	25%
Payment per Patient	$166,163	$186,521	12%

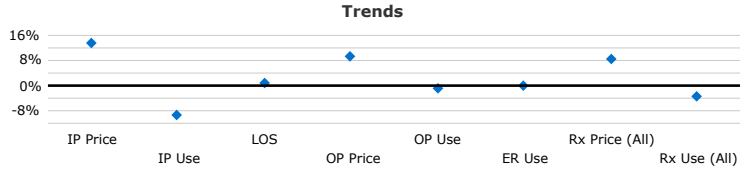
3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark	
Visits Per 1000 Well Baby	5,581.4	4,800.0	-14.0%	5,374.2	■
Visits Per 1000 Well Child	800.0	878.6	9.8%	758.4	●
Visits Per 1000 Prevent Adult	498.3	510.9	2.5%	461.0	●

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	5,886	6,142	4%
Average Members	9,140	9,826	8%
Family Size	1.6	1.6	3%
Member Age	50.7	49.7	-2%
Members % Male	41%	41%	0% pts

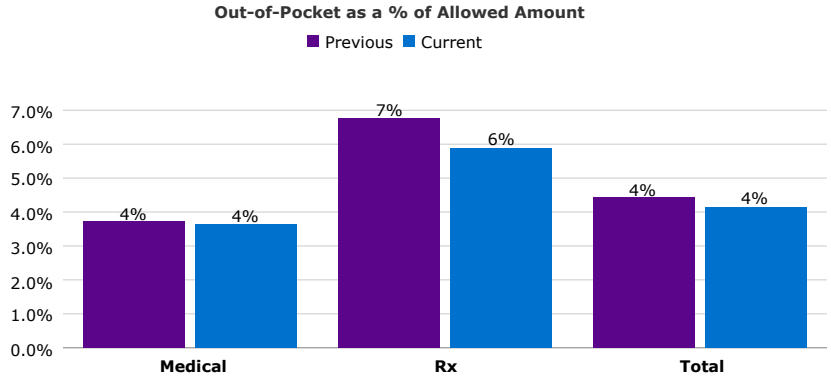
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$38,741	$34,483	■	13%
Admits per 1,000	78.6	65.3	■	-9%
Days LOS	5.8	5.2	■	1%
Outpatient				
Allowed per Service	$156	$124	■	9%
Services PMPY	50.2	40.7	■	-1%
Emergency Room Visits per 1,000	370	233	■	0%
Prescription Drugs				
Allowed/Days Supply	$2			-3%
Days Supply PMPY	772			-4%
Specialty Drugs				
Allowed/Days Supply	$89			3%
Days Supply PMPY	16			18%
All Prescription Drugs				
Allowed/Days Supply	$4	$3	■	8%
Days Supply PMPY	788	659	●	-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

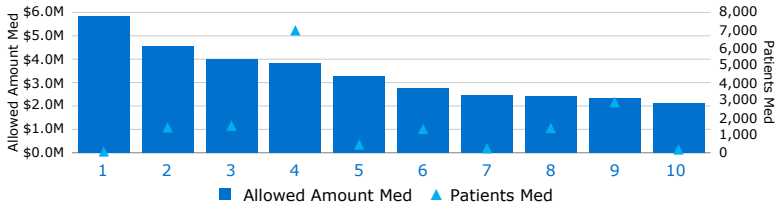


IBM Watson Health

Medical and Prescription Drug Dashboard - Early Retirees

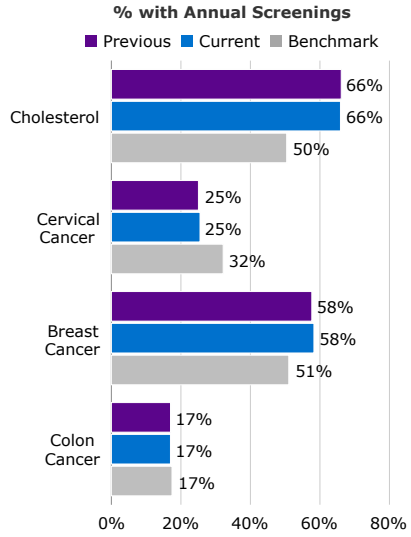
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

7. Top Medical Conditions (by cost)

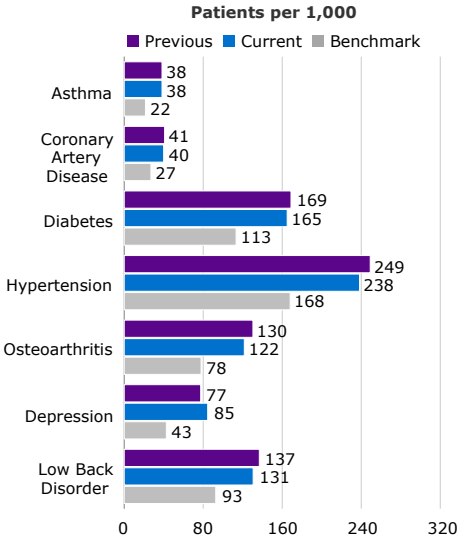


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Chemotherapy Encounters	$5,840,378	80	$73,005
2	Osteoarthritis	$4,560,701	1,443	$3,161
3	Spinal/Back Disord, Low Back	$4,016,025	1,549	$2,593
4	Prevent/Admin Hlth Encounters	$3,818,946	6,982	$547
5	Coronary Artery Disease	$3,255,332	474	$6,868
6	Respiratory Disord, NEC	$2,771,641	1,362	$2,035
7	Renal Function Failure	$2,450,479	260	$9,425
8	Gastroint Disord, NEC	$2,434,935	1,414	$1,722
9	Arthropathies/Joint Disord NEC	$2,324,194	2,893	$803
10	Cancer - Breast	$2,105,733	192	$10,967

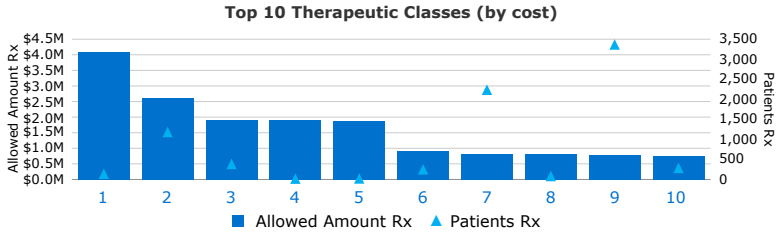
8. Screening Rates



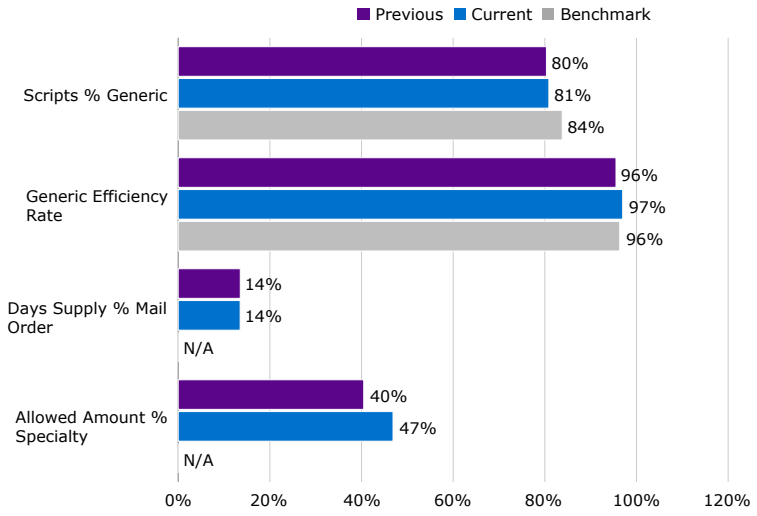
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



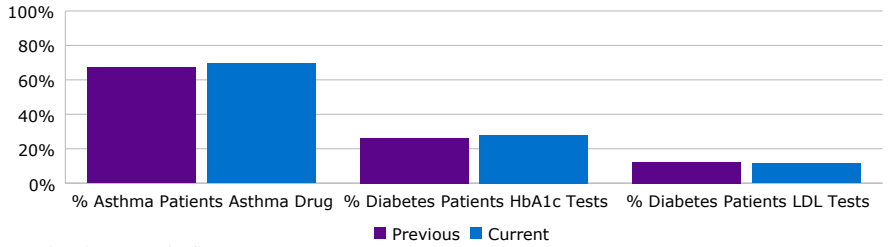
	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$4,097,803	143	$28,656
2	Antidiabetic Agents, Misc	$2,626,101	1,184	$2,218
3	Antidiabetic Agents, Insulins	$1,921,573	387	$4,965
4	Molecular Targeted Therapy	$1,907,301	21	$90,824
5	Biological Response Modifiers	$1,876,949	26	$72,190
6	Antidiabetic Ag, SGLT Inhibitr	$921,952	253	$3,644
7	Adrenals & Comb, NEC	$827,712	2,239	$370
8	Chemotherapy	$814,052	86	$9,466
9	Antihyperlipidemic Drugs, NEC	$773,447	3,368	$230
10	CNS Agents, Misc.	$758,957	289	$2,626



Medical and Prescription Drug Dashboard - Medicare Retirees

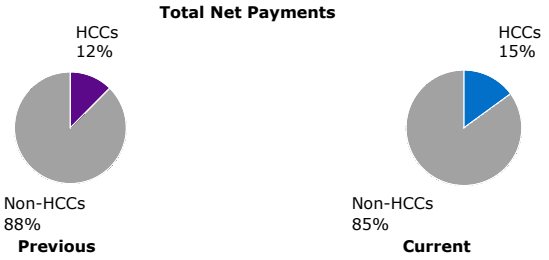
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

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	139	188	35%
Patients per 1,000	5.4	7	30%
Payments (in millions)	$19.5	$26.0	33%
Payment per Patient	$140,127	$138,159	-1%

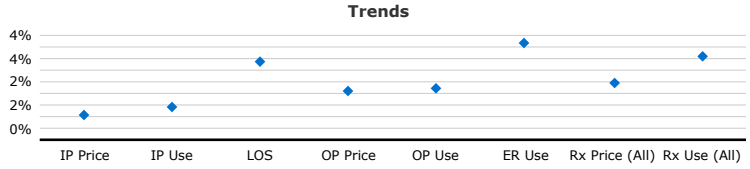
3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark	
Visits Per 1000 Prevent Adult	224.9	242.4	7.8%	440.1	■

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	24,364	25,255	4%
Average Members	24,472	25,514	4%
Family Size	1.0	1.0	1%
Member Age	73.2	72.9	0%
Members % Male	42%	42%	0% pts

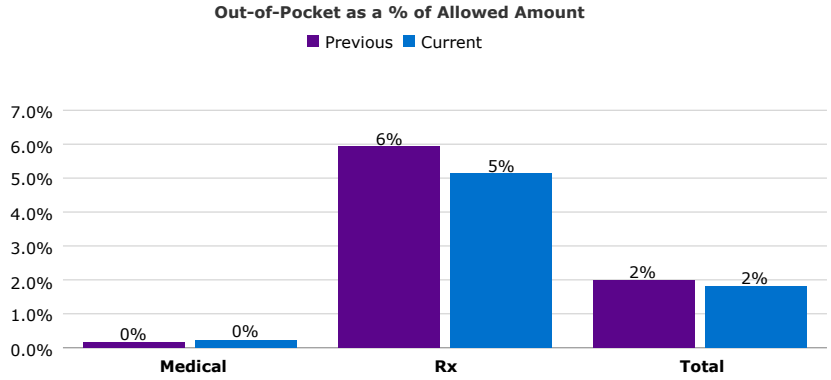
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$17,112	$33,371	●	1%
Admits per 1,000	174.3	56.3	■	1%
Days LOS	5.9	4.7	■	3%
Outpatient				
Allowed per Service	$111	$124	●	2%
Services PMPY	74.4	30.9	■	2%
Emergency Room Visits per 1,000	563	225	■	4%
Prescription Drugs				
Allowed/Days Supply	$2			-4%
Days Supply PMPY	1,486			3%
Specialty Drugs				
Allowed/Days Supply	$93			-8%
Days Supply PMPY	22			31%
All Prescription Drugs				
Allowed/Days Supply	$3	$4	●	2%
Days Supply PMPY	1,508	385	◆	4%

● 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

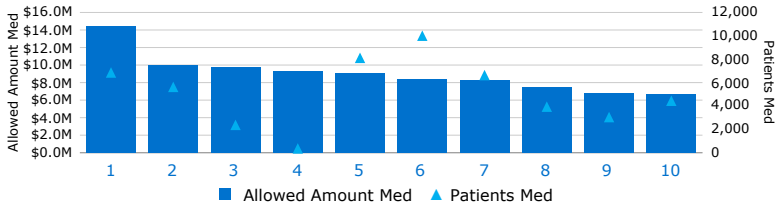


IBM Watson Health

Medical and Prescription Drug Dashboard - Medicare Retirees

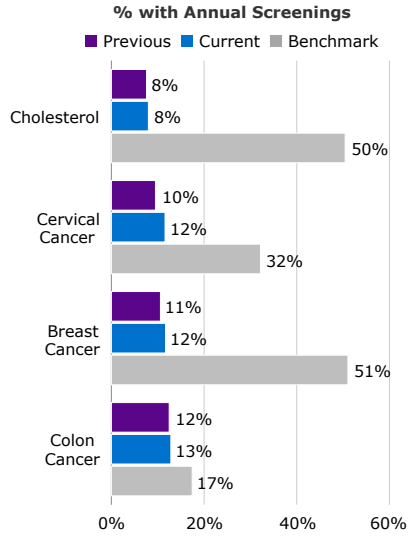
Previous Period: Jan 2018 - Dec 2018 (Paid)
Current Period: Jan 2019 - Dec 2019 (Paid)

7. Top Medical Conditions (by cost)

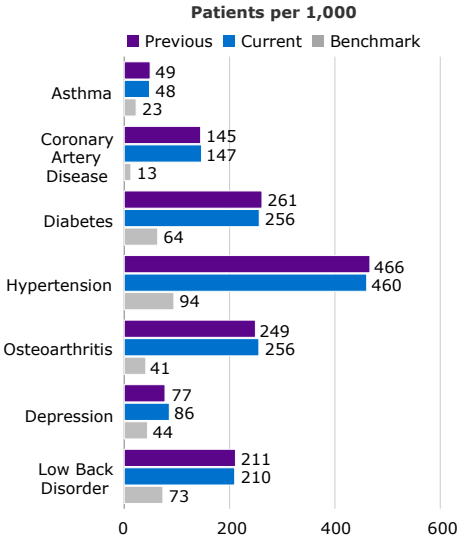


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$14,405,862	6,865	$2,098
2	Spinal/Back Disord, Low Back	$9,932,821	5,633	$1,763
3	Renal Function Failure	$9,793,642	2,384	$4,108
4	Chemotherapy Encounters	$9,326,447	368	$25,344
5	Eye Disorders, Degenerative	$9,120,012	8,118	$1,123
6	Arthropathies/Joint Disord NEC	$8,362,148	10,013	$835
7	Respiratory Disord, NEC	$8,297,188	6,641	$1,249
8	Coronary Artery Disease	$7,489,379	3,942	$1,900
9	Cerebrovascular Disease	$6,787,727	3,051	$2,225
10	Cardiac Arrhythmias	$6,704,316	4,449	$1,507

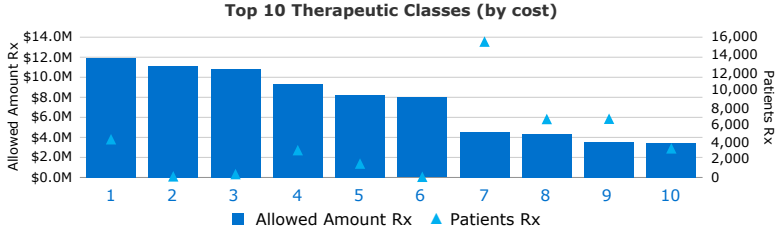
8. Screening Rates



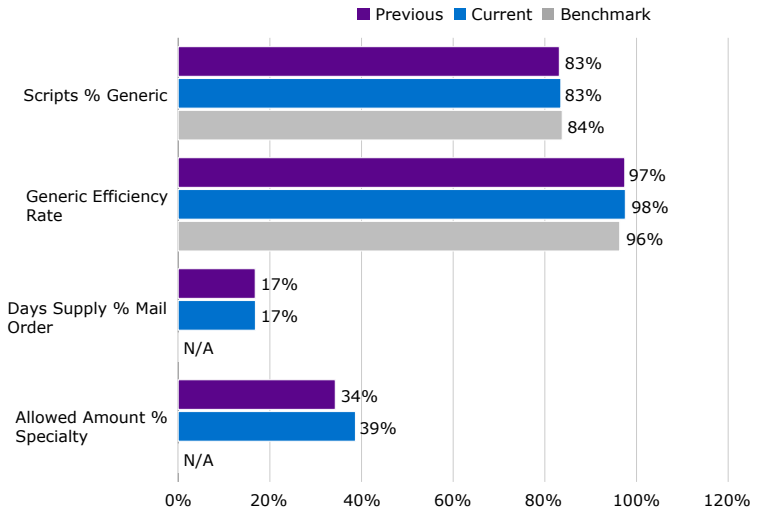
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Antidiabetic Agents, Misc	$11,920,489	4,361	$2,733
2	Molecular Targeted Therapy	$11,153,197	129	$86,459
3	Immunosuppressants, NEC	$10,798,758	387	$27,904
4	Coag/Anticoag, Anticoagulants	$9,306,624	3,118	$2,985
5	Antidiabetic Agents, Insulins	$8,258,406	1,585	$5,210
6	Biological Response Modifiers	$7,979,422	78	$102,300
7	Antihyperlipidemic Drugs, NEC	$4,516,121	15,498	$291
8	Adrenals & Comb, NEC	$4,337,944	6,672	$650
9	Gastrointestinal Drug Misc,NEC	$3,506,131	6,701	$523
10	Misc Therapeutic Agents, NEC	$3,430,809	3,321	$1,033



Medical and Prescription Drug Dashboard - Medicare Retirees

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)