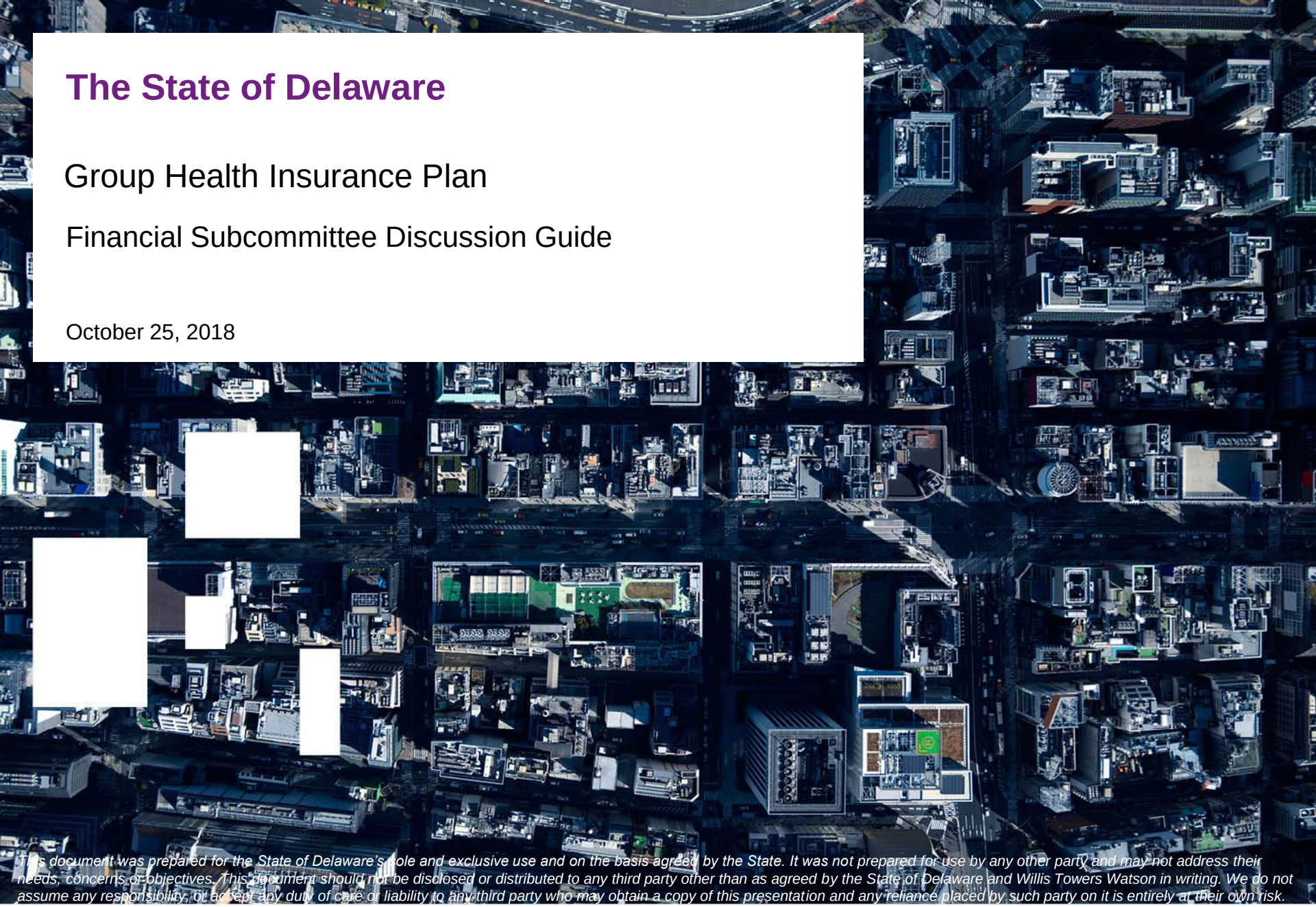
The State of Delaware

Group Health Insurance Plan

Financial Subcommittee Discussion Guide

October 25, 2018

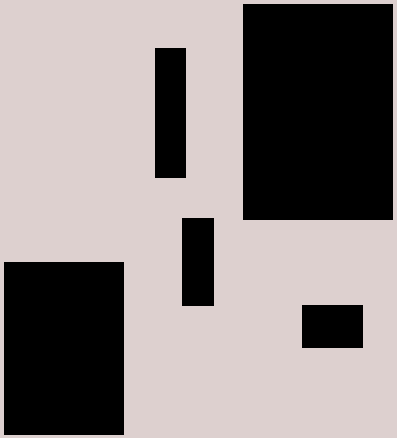


Willis Towers Watson

Today's discussion

- Overview and History of Group Health Financials
  - GHIP FY12-FY18 historical lookback
  - Historical GHIP cost increases
  - GHIP claims experience per member by quarter
  - GHIP premium rate action history
  - Long term cost projections (recap)
- Quarterly Financial Reporting Format
  - Current financial reporting and timing
  - Discussion of reporting enhancements
- Trend Methodology
  - Health care cost trend overview
  - Key budget setting decision points
- Next steps

Overview and History of Group Health Financials



GHIP FY12-FY18 Historical Lookback

FY12-FY18 gross claims and revenue per member

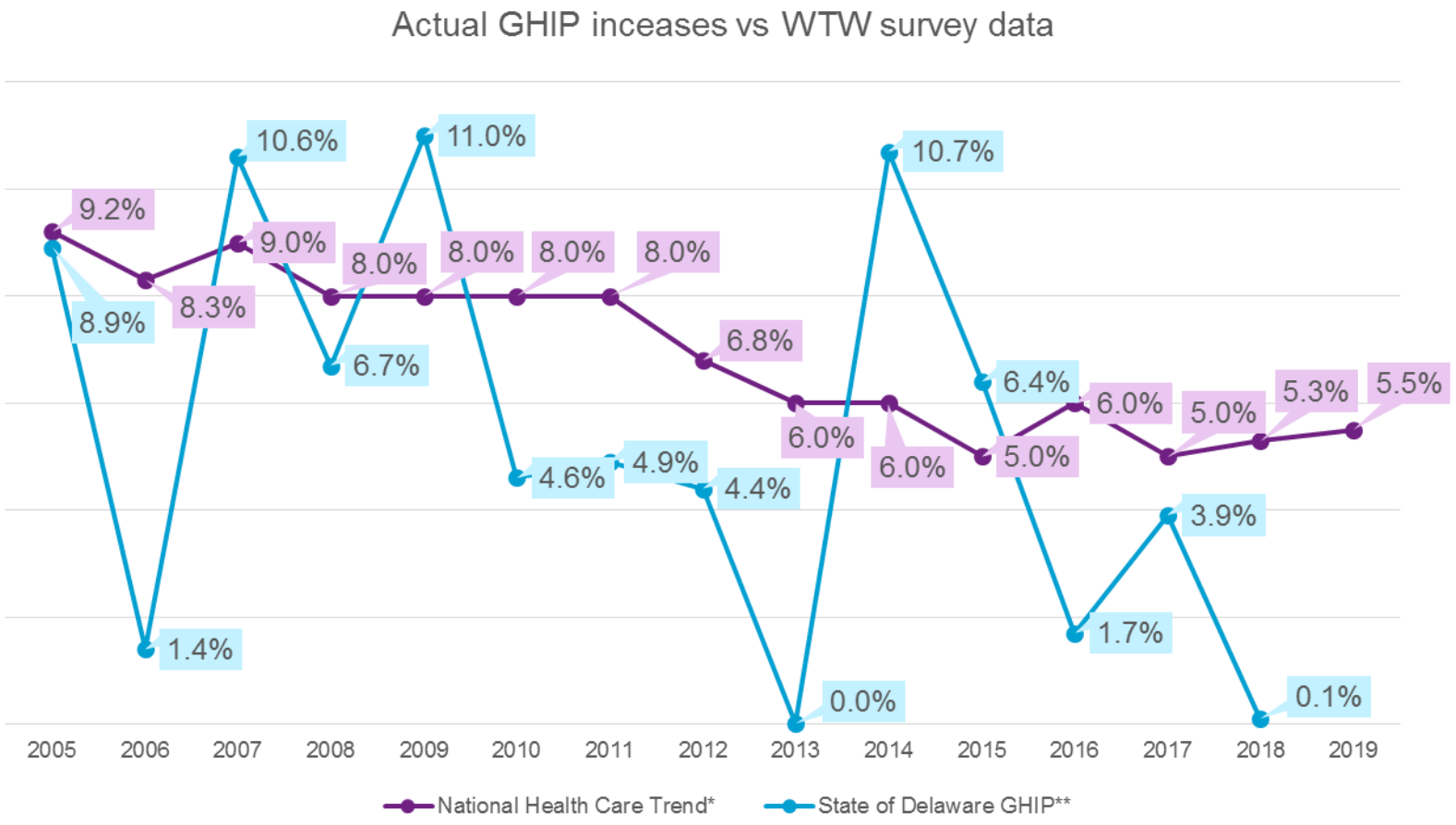
Plan Year	Gross Claims[1]		National Average Trend[2]	Premium Contributions[3]		Members	
	Per Member Per Year	Annual Increase/ (Decrease)		Per Member Per Year	Annual Increase/ (Decrease)	Average	Annual Increase/ (Decrease)
FY12	$5,009	4%	7%	$5,088	-1%	115,357	4%
FY13	$5,056	1%	6%	$4,979	-2%	117,421	2%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

Source: GHIP Fund Equity FY12 – FY18

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

Historical GHIP cost increases

Actual GHIP increases vs. WTW survey data

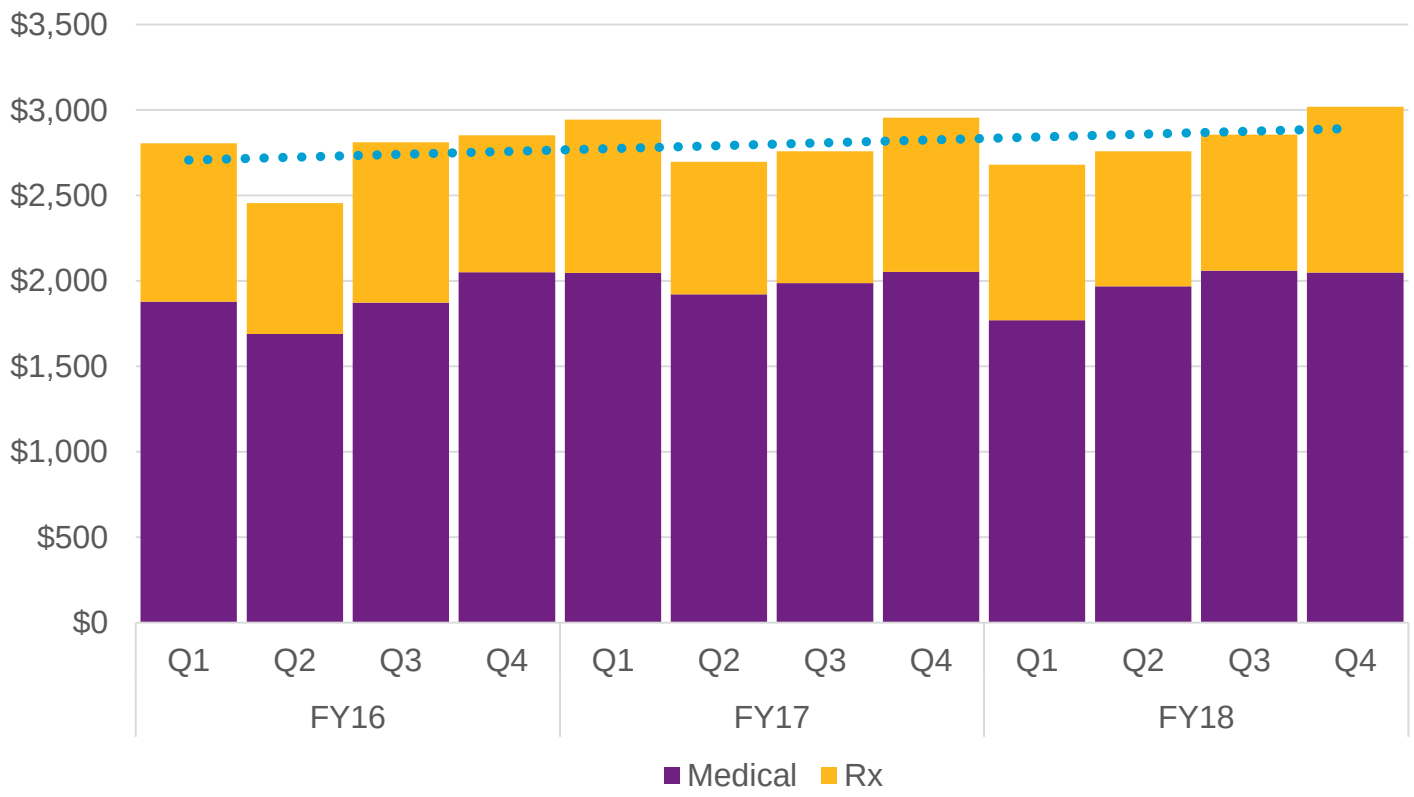


*National Benchmark Source: Willis Towers Watson Best Practices in Healthcare survey. Based on respondents with at least 1,000 employees and median trends for medical and drug claims for active employees including both employer and employee contributions but excludes employee OOP costs. 2018 and 2019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

Historical GHIP claims costs

Medical and pharmacy gross claims per employee/retiree per quarter

Quarterly Claim Cost



GHIP trend line for period shown: 2.5% annual increase (3.4% Medical, 0.4% Rx)

*Based on combined active, pre-65 retiree, and post-65 Medicare retiree gross medical and pharmacy claims, provided by Highmark, Aetna, and ESI; does not include offsets from drug rebates and EGWP payments

GHIP rate action history

FY00 – FY18 annual rate increase

Rates Effective	Comp. PPO Single Rate	Increase/ (Decrease)
7/1/2000	$ 275.72	--
7/1/2001	$ 312.16	13%
7/1/2002	$ 332.12	6%
7/1/2003	$ 365.38	10%
7/1/2004	$ 414.72	14%
7/1/2005	$ 459.16	11%
7/1/2006	$ 486.40	6%
7/1/2007	$ 485.74	(0%)
7/1/2008	$ 520.72	7%
7/1/2009	$ 535.58	3%

Rates Effective	Comp. PPO Single Rate	Increase/ (Decrease)
7/1/2010	$ 587.46	10%
7/1/2011	$ 587.46	0%
7/1/2012	$ 587.46	0%
7/1/2013	$ 624.94	6%
7/1/2014	$ 627.28	0%
7/1/2015	$ 688.20	10%
9/1/2015	$ 737.22	7%
7/1/2016	$ 793.86	8%
7/1/2017	$ 793.86	0%
7/1/2018	$ 793.86	0%

+17% FY16

Rate increase at or below national average trend

Rate increase above national average trend

Presented at 9/24 SEBC meeting

GHIP long term health care cost projections

Illustrative: Increase premium rates by 2% annually starting in FY20

GHIP Costs ($ millions)	FY17 Actual	FY18 Actual	FY19 Projected[1]	FY20 Projected[6]	FY21 Projected[6]	FY22 Projected[6]	FY23 Projected[6]
Average Enrolled Members	123,132	125,488	127,350	129,897	132,495	135,145	137,848
GHIP Revenue							
Premium Contributions (Increasing with Enrollment)[2]	$799.0	$810.9	$817.1	$833.4	$850.1	$867.1	$884.4
2.0% Annual Premium Increase Starting FY20	-	-	-	*$16.7*	$34.1	$52.9	$72.8
Other Revenues[3]	$81.6	$92.1	$91.7	$98.0	$105.0	$112.5	$120.5
Total Operating Revenues	**$880.6**	**$903.0**	**$908.8**	**$948.1**	**$989.2**	**$1,032.5**	**$1,077.7**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)	$816.8	$853.9	$932.1	$999.7	$1,070.7	$1,146.7	$1,228.1
% Change Per Member		*2.6%*	*7.6%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Excise Tax Liability[4]						$9.1	$16.3
Adjusted Net Income (Revenue less Expense)	**$63.8**	**$49.1**	**($23.3)**	**($51.6)**	**($81.5)**	**($123.3)**	**($166.7)**
Balance Forward	$38.9	$102.7	$151.8	$128.5	$76.9	($4.6)	($127.9)
Ending Balance	$102.7	$151.8	$128.5	$76.9	($4.6)	($127.9)	($294.6)
- Less Claims Liability[5]	*$54.0*	*$58.9*	*$61.3*	*$65.7*	*$70.4*	*$75.4*	*$80.8*
- Less Minimum Reserve[5]	*$24.0*	*$24.0*	*$24.3*	*$26.1*	*$28.0*	*$30.0*	*$32.1*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$68.9**	**$42.9**	**($14.9)**	**($103.0)**	**($233.3)**	**($407.5)**

Note: FY17 Actual based on final June 2017 Fund Equity report; FY18 Actual based on final June 2018 Fund Equity report; FY19 enrollment as of July 2018; reflects ESI FY17 Q4 restated claims; numbers in table may not add up due to rounding

[1] Includes approved design changes for site-of-care steerage for imaging/outpatient lab and COE services and proposed design changes for $0 statin coverage and preventive 3D mammography effective 7/1/2018; includes financial impact of legislative bills impacting GHIP ($1.2m increase to FY19 budget and $2.4m increase to FY20 projection); assumes no additional program changes in FY20 and beyond.

[2] Includes State and employee/pensioner premium contributions; assumes 2% annual enrollment growth for FY20-FY23; FY17 and FY18 actual premiums include 5% risk fee surcharge for participating non-State groups but not reflected in FY19 through FY23 premium totals

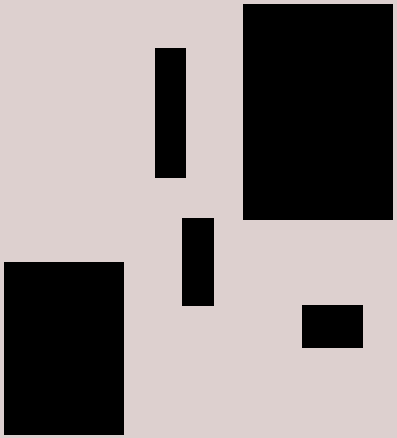
[3] Includes Rx rebates, EGWP payments, other revenues; FY17/FY18 Actuals and FY19 Projected include participating group fees; assumed to increase proportionally with membership growth and health care trend

[4] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2022. Threshold assumed to increase at 2% annually

[5] FY19 Claims Liability and FY19 Minimum Reserve levels updated with data through June 2018; future years assumed to increase with overall GHIP expense growth

[6] FY20-FY23 projections based on 5% composite trend (assumes 6% underlying trend less 1% for future GHIP cost reduction initiatives); assumes no additional program changes in FY20; assumes 2% annual growth in GHIP membership.

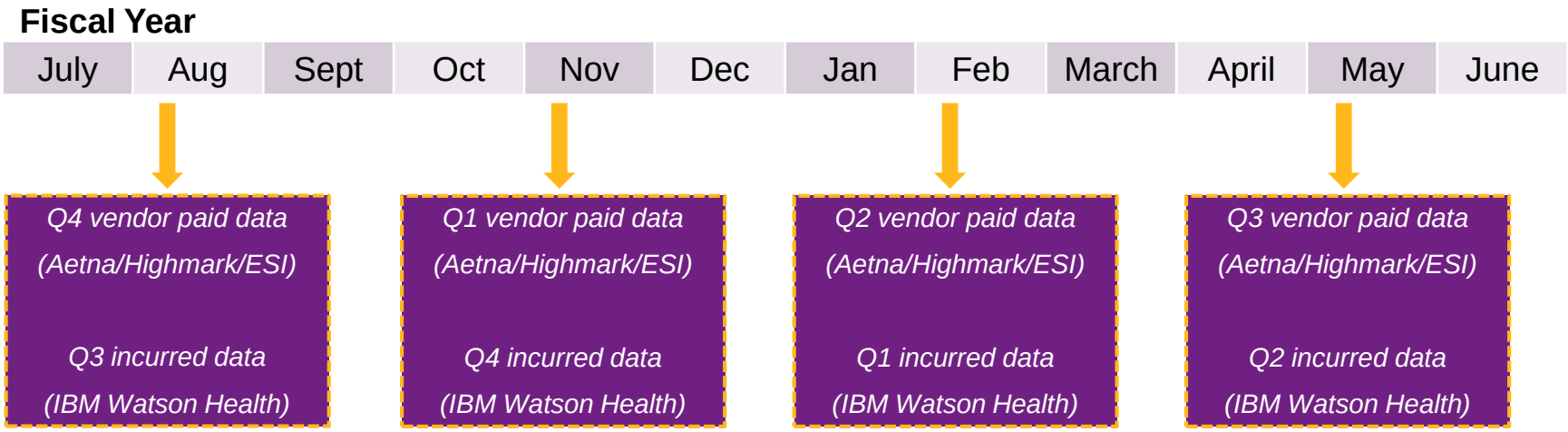
Quarterly Financial Reporting Format



Financial reporting

Current financial reporting and timing

- Current reporting:
  - Monthly Fund Equity report (cash basis)
  - WTW Quarterly Financial Report – budget vs. actual, year-over-year trend (paid basis)
  - IBM Watson Executive Dashboard – key utilization metrics (paid basis)
  - IBM Watson Quarterly Modeling Report – key utilization metrics (incurred basis)
  - Quarterly financial and utilization reports from Aetna, Highmark, and ESI (paid basis)



Financial reporting

Discussion of reporting enhancements

WTW Financial Report – Executive Summary (sample)

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

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

** Total program cost includes office operational expenses

Potential enhancements to quarterly financial reporting:

- **Budget vs. actual tracking** captures YTD plan results compared to YTD budget
  - What basis should claims be reported on (incurred vs. paid, etc.)
- **Year-over-year tracking** compares actual and budget plan results to prior year
- **Target metrics** summarize utilization including key health factors, conditions, and interventions
  - Select key utilization metrics and other performance measures that align with SEBC initiatives and areas of focus
  - Measure impact of GHIP program changes – similar to Urgent Care and High Tech Imaging incurred reporting
- How much information should be presented to SEBC?

Financial reporting

Discussion of reporting enhancements – Fund Equity

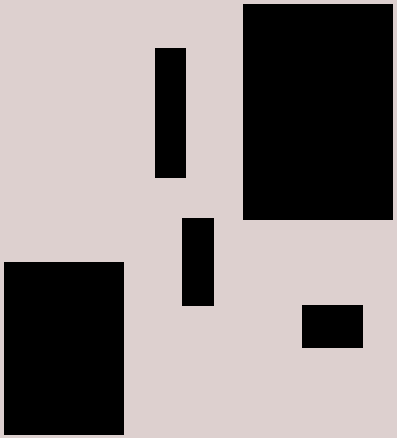
FY18 YTD Reporting Reconciliation	WTW FY18 Q4 Financial Report	OMB June 2018 Fund Equity Report
Total Program Cost	**$765,518,315**	**$853,887,827**
Paid Claims	805,247,453	815,007,448
Medical Claims	562,116,878	570,183,222
Rx Claims[1]	164,521,058	244,824,226
Rx Paid Claims	243,130,575	244,824,226
EGWP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

		YTD		EOY	
	Target	Budget	Actual	Budget	Forecast*
Fund Equity	85.6	146.7	156.9	128.4	138.6
Claim Liability	61.3	61.3	61.3	61.3	61.3
Reserve	24.3	24.3	24.3	24.3	24.3
Surplus/Deficit	0	61.1	71.3	42.8	53.0

*Forecast = Actual + Remaining Budget

- Are changes or enhancements needed to the Fund Equity reporting format?
- Are the Fund Equity and quarterly financial reporting aligned appropriately?
- Use of different reporting sources for SEBC: Fund Equity (cash) vs. vendor paid claims reporting vs. incurred reporting
- Any other reporting needs for discussion?

Trend Methodology



Health care cost trend overview

Summary of key components

- Health care cost trend is made up of three main components:
  - **Unit cost**: the cost of a fixed basket of medical and Rx services
  - **Utilization**: the size of the basket of services used (i.e., whether more services are going to be used next year relative to this year)
  - **Mix**: how the assortment of services in the basket changes year over year (i.e., more urgent care visits, but fewer ER visits; more specialty drug use, etc.)
- Data sources for consideration in setting health care trend assumption for projecting GHIP claims cost:
  - GHIP historical claims experience
  - National survey data from leading healthcare consulting firms
  - Book of business trend data from the GHIP carriers (Aetna, Highmark, ESI)
  - Other external factors expected to impact the GHIP
- WTW recommends reviewing trend assumptions annually

Health care cost trend overview

Market data – active/pre-65 retiree

Source	Medical/Rx		Medical Only	Rx Only
	Gross[1]	Net[2]	Gross[1]	Gross[1]
Willis Towers Watson	5.5%	5.0%		
Aon	6.5%	4.1%		
Mercer	5.3%	4.1%		
PricewaterhouseCoopers	6.0%			
Segal			7.1%[3]	7.5%
Aetna	*Data collection in progress*			
Highmark DE				
Express Scripts				
Average	**TBD**	**TBD**	**TBD**	**TBD**

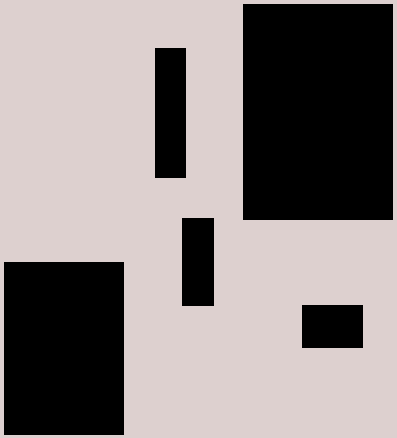
[1] Before plan changes
[2] After plan changes
[3] Trend reflects open access PPO/POS plans

FY20 budget rate setting

Discussion topics and decision points

- Process for establishing budget setting methodology, including trend assumption
- Reserve methodology – how much reserve is needed for GHIP *[to be covered in more detail for November 7th subcommittee meeting]*
- Use of available surplus in excess of reserves
- Should there be a minimum level of premium rate increase each fiscal year?
- Recommended rate action for 7/1/2019

Next Steps



Next steps

Financial Subcommittee topics through December 2018

October 25th

Discussion Topics:

1. Committee business rules
2. Overview and history of GHIP financials
3. Quarterly reporting format
4. Trend methodology

November 7th

Discussion Topics:

1. Reserve methodology
2. GHIP FY20 premium rate discussion

December 4th

Discussion Topics:

1. FY18 financial results (deeper dive)
2. FY19 Q1 financial reporting
3. FY19/FY20 recast budget projections

December 18th

Discussion Topics:

1. GHIP FY20 premium rate discussion*

November 13th SEBC Meeting

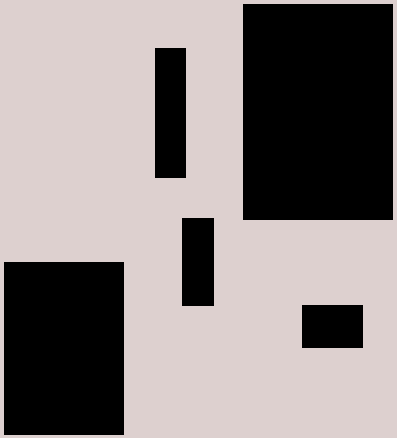
1. October Fund Equity
2. Financial Subcommittee update

December 10th SEBC Meeting

1. November Fund Equity
2. FY19 Q1 financial reporting
3. Long Term Projections (Q1 data)
4. Financial subcommittee update

* Denotes subcommittee vote on recommendations for further consideration by the SEBC

Appendix



Financial reporting

FY18 Budget vs. Actual

	2018 Actual	2018 WTW Budget	Diff.
Total Program Cost[1]	**$765.5 M**	**$798.7 M**	▼ -4.2%
- Paid Claims	726.6	760.0	▼ -4.4%
- Medical (includes capitation)[2]	562.1	586.3	▼ -4.1%
- Rx (Including Rebates and EGWP)	164.5	173.6	▼ -5.2%
- Rx Paid Claims	243.1	256.4	▼ -5.2%
- EGWP	-29.0	-34.2	▼ -15.1%
- Rx Rebates[3]	-49.6	-48.6	▲ 2.1%
- ASO Fees	36.3	36.1	▲ 0.7%
- Operational Expenses	2.6	2.7	▼ -6.0%
Medical/Rx Budget	**817.0**	**810.3**	▲ 0.8%
- Surplus/(Deficit)	51.5	11.6	
- Total Cost as % of Budget	94%	99%	

[1] Aggregate totals includes run-off medical and pharmacy claims from Highmark BlueCare HMO and Highmark CDH Gold plans terminated 7/1/2017
[2] Capitation payments apply to HMO and POS plans only
[3] Reflects estimated rebates attributable to FY18, based on WTW analysis of expected rebates under new ESI contract and actual paid rebates attributable to FY17

Health care budget development

Overview of budget development process

step 1 — Data Collection

- Groups: Active employees and pre-65 retirees (Aetna/Highmark/ESI) and post-65 Medicare retirees (Highmark/ESI)
- Headcount: Employees and dependents enrolled within the recent 24 months of experience
- Utilizing this data from vendor experience reports (claims, enrollment, rebates) and OMB's monthly health fund report (expenses), self-insured medical/Rx budget rates and employee contributions are developed

step 2 — Assumption & Pricing Analysis

- Claims experience is adjusted to reflect:
  - Plan design/vendor/network changes
  - Legislative changes
- IBNR factors complete the claims experience, estimating the value of claims *incurred but not reported*
- Health care inflation factors, determined annually from marketplace and Willis Towers Watson survey data, and with approval from SEBC, project past claims into the future
- Offsets for prescription drug rebates and Medicare EGWP income reduce claims cost
- Health care administrative and legislative fees, including applicable ACA fees, are added to projected claims experience
- Uniform rate action applied to all plans, including Medicfill – individual plan rates may not align with the underlying *actuarial value* of plan options

step 3 — Aggregate Budget Development

- State of Delaware's July 1st fiscal year budget is based on the developed budget rates calculated in Steps 1-2, leveraging prior year claims experience and current enrollment patterns to project future cost
  - Timing requires that the claims data used to project the upcoming plan year is nearly two years old (e.g., CY18 data primarily used to set FY20 budget rates)
  - Preliminary FY20 budget developed in August/Sept 2018 based on claims experience through Q4 FY18
  - Budget projection to be revised with data through Q1 FY19 once available, prior to SEBC approval of final rate action in February 2019 timeframe

Health care budget development

Assumption and pricing analysis details

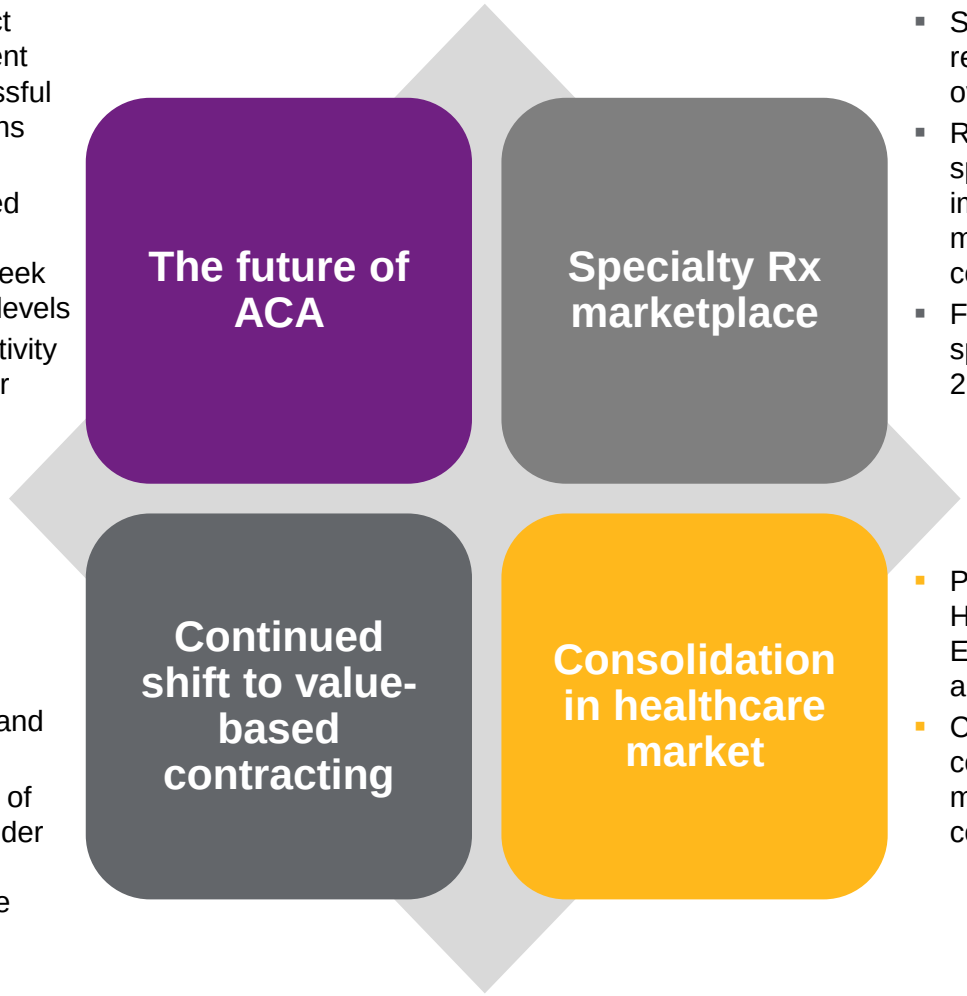
- **Claims experience** provided by vendors (Highmark, Aetna, and ESI) reflect paid claims and enrollment for the most recent available 24 months, or two experience periods
- Claims experience adjusted for **claim offsets** from pharmacy rebates and EGWP funding
- **Incurred But Not Reported (IBNR)** adjustments convert paid claims to an incurred basis based on the lag between when a claim is incurred and when it is paid
- **Exposure** adjustments convert claims experience into a *per adult* equivalent claims cost
- **Inflation and trend** adjustments increase the claims costs to reflect expected year-over-year increases to the cost of services
- **Plan Design** adjustments applied to the claims costs to reflect any plan design changes or movement across plans, and are based on the relative difference in *actuarial value* of the plans
- **Vendor adjustments** reflect results from medical TPA RFP and other adopted vendor initiatives
- **Self-insured fixed costs** are added to the adjusted claims cost to develop the **total budget**; this includes administrative service fees and operational expenses

WTW projected total budget is based on a best estimate of projected GHIP expenses (claims, fees, etc.) and does not assume any surplus offset or deficit recoup based on current Fund balance

Health care cost trend overview

External environment considerations

- Although Affordable Care Act (ACA) repeal and replacement efforts have not been successful to date, future of ACA remains uncertain
- Changes may drive increased health care cost trend as providers and health plans seek to maintain current revenue levels
- Ongoing discussions and activity in Congress to amend and/or repeal elements of ACA



- Specialty utilization continues to represent a greater share of overall market drug spend
- Release of new high-cost specialty drugs continue to improve patient outcomes but may represent extended ongoing cost for plans
- For the GHIP, specialty drug spend per member increased by 21% from FY17 to FY18

- Shift in provider reimbursements from discounted fee-for-service to value-based is expected to influence healthy outcomes and health care cost
- Ultimate impact on total cost of care will vary based on provider results; long-term impact to GHIP trend may be favorable

- Pending merger activity (CVS Health and Aetna, Cigna and Express Scripts) continues to alter the competitive landscape
- Continued pressure on healthcare costs as insurers seek to increase market share and reduce competition

Marketplace trend data – survey sources

- WTW 2018 Best Practices in Health Care Survey
- 2019 Aon Global Medical Trend Rates Report
- Mercer's National Survey of Employer-Sponsored Health Plans 2018
- PWC Health Research Institute – Behind the Numbers 2019
- 2019 Segal Health Plan Cost Trend Survey
- Wells Fargo Annual Insurance Carrier Survey: Healthcare claim trend projections for 2018

[1] Industry-specific data available for active populations only