

# State of Delaware - Quarterly Financial Reporting

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FY20 Q3 Cost Analysis

May 2020

**State of Delaware**

Health Plan Quarterly Financial Reporting  
 FY20 Q3 Plan Cost Analysis

**Summary plan information**

- FY20 Q1-Q3 compared to FY19 Q1-Q3:

Summary (total)	FY20 thru Q3			FY19 thru Q3			% Change		
	Medical	Rx	Total <sup>1</sup>	Medical	Rx	Total <sup>1</sup>	Medical	Rx	Total
Total program cost (\$M) <sup>1</sup>	\$484.1	\$144.5	\$630.4	\$464.2	\$132.6	\$598.6	▲ 4.3%	▲ 9.0%	▲ 5.3%
Premium contributions (\$M) <sup>2</sup>	\$492.9	\$132.7	\$625.6	\$474.6	\$141.6	\$618.1	▲ 3.8%	▼ 6.3%	▲ 1.2%
Total cost PEPY	\$8,916	\$2,664	\$11,604	\$8,676	\$2,480	\$11,189	▲ 2.8%	▲ 7.4%	▲ 3.7%
Total cost PMPY	\$5,052	\$1,512	\$6,576	\$4,900	\$1,400	\$6,320	▲ 3.1%	▲ 8.0%	▲ 4.1%
Average employees	72,745			71,324			▲ 2.0%		
Average members	128,283			126,278			▲ 1.6%		
Loss ratio	101%			97%					
Net income (\$M)	(\$4.8)			\$19.5					

<sup>1</sup> Total program cost includes office operational expenses

<sup>2</sup> Includes fees for participating non-State groups

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

Summary (total)	FY20 thru Q3 Actual			FY20 thru Q3 Budget			% Change		
	Medical	Rx	Total <sup>1</sup>	Medical	Rx	Total <sup>1</sup>	Medical	Rx	Total
Total program cost (\$M) <sup>2</sup>	\$484.1	\$144.5	\$630.4	\$488.5	\$131.5	\$620.1	▼ 0.9%	▲ 9.9%	▲ 1.7%
Total cost PEPY	\$8,916	\$2,664	\$11,604	\$8,457	\$2,870	\$11,361	▲ 5.4%	▼ 7.2%	▲ 2.1%
Total cost PMPY	\$5,052	\$1,512	\$6,576	\$4,797	\$1,628	\$6,445	▲ 5.3%	▼ 7.1%	▲ 2.0%
Net income (\$M)	(\$4.8)			\$8.0					

<sup>1</sup> Total program cost includes office operational expenses (medical and Rx splits exclude these expenses)

<sup>2</sup> Total program cost 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 April 2019 - March 2020 (compared to April 2018 - March 2019) details the following trends and cost drivers:
  - Chronic condition prevalence remained relatively stable for asthma, diabetes and hypertension; larger increases observed for osteoarthritis and depression
  - Increase in portion of GHIP spend attributable to members with >\$100k in medical and Rx payments increased, driven by an 8% increase in total high cost claimants; payments per high cost claimant decreased 1% over prior period
  - The percent of prescription drug allowed amounts attributable to specialty medications increased by 4 percentage points over the prior period to 42%
  - Inpatient admit frequency decreased by 3%, offset by a 3% increase in length of stay

**Additional notes**

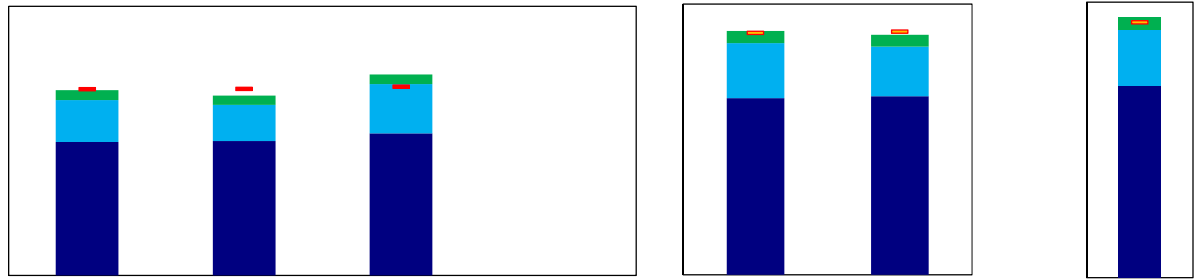
- Claims and expenses are reported on a paid basis
- FY20 budget rates were held flat from FY19
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI; costs include operating expenses
- Expenses are broken down into two categories:
  - ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (PCORI), IBM Watson data analytics, EAP, and WTW consulting
  - 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 Q3 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 <sup>8</sup>	Difference vs. Budget	FY20 Projected <sup>9</sup>
<b>Total Program Cost</b>	<b>\$206,234,229</b>	<b>\$200,218,517</b>	<b>\$223,931,568</b>		<b>\$630,384,313</b>	<b>\$620,062,093</b>	<b>▲ 1.7%</b>	<b>\$849,234,201</b>
- Paid Claims	195,393,297	189,894,742	213,282,464		598,570,503	590,025,133	▲ 1.4%	807,884,587
- <b>Medical (includes capitation<sup>1</sup>)</b>	148,761,351	149,813,400	158,141,759		456,716,510	461,540,225	▼ 1.0%	627,109,642
- <b>Rx (Including Rebates and EGWP)</b>	46,631,946	40,081,342	55,140,705		141,853,993	128,484,908	▲ 10.4%	180,774,944
- Rx Paid Claims	75,507,949	65,184,395	81,400,192		222,092,535	204,349,512	▲ 8.7%	291,260,510
- EGWP <sup>2</sup>	(10,604,944)	(9,601,456)	(7,160,377)		(27,366,777)	(27,383,783)	▼ 0.1%	(36,810,053)
- Direct Subsidy	(771,080)	(752,004)	(514,102)		(2,037,186)	(2,151,434)	▼ 5.3%	(2,740,144)
- CGDP	(5,921,576)	(5,959,864)	(3,386,561)		(15,268,001)	(15,340,352)	▼ 0.5%	(20,536,431)
- Catastrophic Reinsurance <sup>3</sup>	(3,912,288)	(2,889,588)	(3,259,714)		(10,061,590)	(9,891,996)	▲ 1.7%	(13,533,477)
- Rx Rebates <sup>4</sup>	(18,271,059)	(15,501,597)	(19,099,110)		(52,871,766)	(48,480,821)	▲ 9.1%	(73,675,513)
- <b>ASO Fees</b>	10,269,920	9,800,002	9,949,877		30,019,800	28,174,009	▲ 6.6%	38,865,680
- <b>Operational Expenses</b>	571,012	523,772	699,227		1,794,011	1,862,950	▼ 3.7%	2,483,934
<b>Medical/Rx Premium Contributions<sup>5</sup></b>	<b>\$207,540,932</b>	<b>\$207,772,274</b>	<b>\$210,247,506</b>		<b>\$625,560,712</b>	<b>\$ 628,084,634</b>	<b>▼ 0.4%</b>	<b>\$834,245,053</b>
- Net Income	1,084,467	7,098,750	(13,006,818)		(4,823,602)	8,022,541		(14,989,148)
- Total Cost as % of Budget	99%	96%	107%		101%	99%		102%
<b>Current Year Per Capita</b>								
- Total per employee per year <sup>6</sup>	11,412	11,100	12,312		11,604	11,361	▲ 2.1%	11,700
- Total % change over prior	2.1%	2.8%	5.1%		3.3%			3.4%
- Medical per employee per year	8,748	8,808	9,192		8,916	8,457	▲ 5.4%	9,137
- Medical % change over prior	4.5%	3.2%	0.8%		2.8%			4.5%
- Rx per employee per year	2,652	2,280	3,108		2,664	2,870	▼ 7.2%	2,530
- Rx % change over prior	-4.6%	2.3%	21.7%		5.7%			-0.1%
- Medical per member per year	4,956	4,980	5,208		5,052	4,797	▲ 5.3%	5,181
- Rx per member per year	1,500	1,284	1,752		1,512	1,628	▼ 7.1%	1,434
- Total per member per year <sup>6</sup>	6,468	6,276	6,984		6,576	6,445	▲ 2.0%	6,635
<b>Prior Year Results</b>	<b>Q1 FY19</b>	<b>Q2 FY19</b>	<b>Q3 FY19</b>	<b>Q4 FY19</b>	<b>Q1 FY19</b>			<b>FY 2019</b>
- Total Program Cost	198,069,057	192,811,944	209,847,345		600,728,346	-	-	807,749,851
- Total Program Cost \$ Change	8,165,172	7,406,572	13,032,308		28,604,052	-	-	41,484,350
- Total per employee per year <sup>6</sup>	11,182	10,796	11,710		11,229	-	-	11,313
- Medical per employee per year	8,371	8,536	9,121		8,676	-	-	8,746
- Rx per employee per year	2,778	2,228	2,553		2,520	-	-	2,532
<b>EE Contributions<sup>7</sup></b>	<b>\$40,928,715</b>	<b>\$40,824,809</b>	<b>\$41,124,630</b>		<b>\$40,959,385</b>			<b>\$164,498,522</b>
- Net SoD	165,305,514	159,393,708	182,806,937		169,168,720	-	-	684,735,679
- SoD Subsidy %	80%	80%	82%		80%	-	-	81%
<b>Headcount</b>								
- Enrolled Ees	72,317	72,136	72,745		72,399	72,768	▼ 0.5%	72,581
- Enrolled Members	127,519	127,523	128,283		127,775	128,282	▼ 0.4%	127,995
- Member/EE Ratio	1.8	1.8	1.8		1.8	1.8		1.8

<sup>1</sup> Capitation payments apply to HMO plan only  
<sup>2</sup> Direct subsidy and catastrophic reinsurance prospective payments reflect actual payments received during quarter; CGDP estimated based on payment attributable to quarter; projected EGWP PMPM amounts provided by ESI  
<sup>3</sup> Includes \$1.2m prospective reinsurance adjustment payment received in August 2019 to align with cash flow timing in Fund  
<sup>4</sup> 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  
<sup>5</sup> Premium contributions include fees for participating non-State groups  
<sup>6</sup> 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  
<sup>7</sup> Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized  
<sup>8</sup> WTW Budget based on final FY20 Budget approved by SEBC on 8/26/2019  
<sup>9</sup> FY20 Projected based on 24 months of claims experience through FY20 Q1; reflects average headcounts during Q1 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% composite medical/Rx trend; EGWP revenues and prescription drug rebates projected based on the period revenues are attributable

## State of Delaware

### Health Plan Quarterly Financial Reporting

#### FY20 Q3 Reporting Reconciliation (WTW vs DHR Fund Equity Report)

FY20 YTD Reporting Reconciliation	WTW FY20 Q3 Financial Report	DHR March 2020 Fund Equity Report
<b>Total Program Cost</b>	<b>\$630,384,313</b>	<b>\$720,306,972</b>
<b>Paid Claims</b>	598,570,503	688,069,458
Medical Claims	456,716,510	466,436,716
Rx Claims <sup>1</sup>	141,853,993	221,632,742
Rx Paid Claims	222,092,535	221,632,742
EGWP	(27,366,777)	(30,515,055)
<i>Direct Subsidy</i>	(2,037,186)	(2,049,377)
<i>CGDP</i>	(15,268,001)	(13,186,123)
<i>Catastrophic Reinsurance</i> <sup>2</sup>	(10,061,590)	(15,279,555)
Rx Rebates	(52,871,766)	(53,833,105)
Total Rx Claim (Offsets)/Revenue <sup>3</sup>	(80,238,543)	(84,348,160)
<b>Total Fees</b>	31,813,811	31,813,811
ASO Fees	30,019,800	30,019,800
Operational Expenses	1,794,011	1,794,011
<b>Premium Contributions/Operating Revenues<sup>4</sup></b>	<b>\$625,560,712</b>	<b>\$714,136,057</b>
Net Income	(4,823,602)	(6,170,915)
Total Cost as % of Budget	101%	101%

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

<sup>2</sup>WTW FY20 reinsurance includes \$1.2m prospective reinsurance adjustment payment received in August 2019 to align with cash flow timing in Fund

<sup>3</sup>WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims; DHR reflects these items as additions to operating revenues

<sup>4</sup>DHR premium contributions represent total operating revenues, including premium contributions, Rx revenues (EGWP and rebates), other revenues totaling \$3,199,145, and participating group fees totaling \$4,512,426; 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

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##### 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 FY20 Q1; 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, prospective reinsurance and coverage gap discount payments received through March 2020; 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 FY19 Financial Reports

##### Budget/contributions

- 9 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.
- 10 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.
- 11 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.
- 12 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.
- 13 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.
- 14 HRA funding for CDH plans are included in the paid claims reported in this document.

**State of Delaware**

Health Plan Quarterly Financial Reporting  
Glossary of Important Health Care Terms

**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 <i>bundled payments</i> or other <i>value-based payments</i> .
Consumer Driven Health Plan	CDHP	Allows members to use health savings accounts (HSA), health reimbursement accounts ( <i>HRA</i> ), or other similar medical payment products to pay routine health care expenses directly. GHIP currently offers a CDHP with <i>HRA</i> .
Coverage Gap Discount Program	CGDP	One of the funding components of an <i>EGWP</i> . 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.

## State of Delaware

### Health Plan Quarterly Financial Reporting Glossary of Important Health Care Terms

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Health Reimbursement Account	HRA	Employer-funded account that reimburses employees for out-of-pocket medical expenses. Employees can choose how to use their HRA funds to pay for medical expenses, but the employer can determine what expenses are reimbursable by the HRA (e.g., employers often designate prescription drug expenses as ineligible for reimbursement by an HRA). Funds are owned by the employer and are tax-deductible to the employee. GHIP only offers HRA to employees and non-Medicare eligible retirees who enroll in the CDH Gold plan.
High Cost Claimant	HCC	An insured who incurs claims over a catastrophic claim limit during the plan year. For purposes of cost tracking, this threshold is \$100K.
Per Employee Per Month	PEPM	A monthly cost basis measured on an employee/contract/subscriber level
Per Employee Per Year	PEPY	A yearly cost basis measured on an employee/contract/subscriber level
Per Member Per Month	PMPM	A monthly cost basis measured on a member level
Per Member Per Year	PMPY	A yearly cost basis measured on a member level
Patient-Centered Outcomes Research Trust Fund Fee	PCORI	The Patient-Centered Outcomes Research Trust Fund fee is a fee on plan sponsors of self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings. This fee is part of the Affordable Care Act legislation.

## State of Delaware

### Health Plan Quarterly Financial Reporting Glossary of Important Health Care Terms

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#### 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

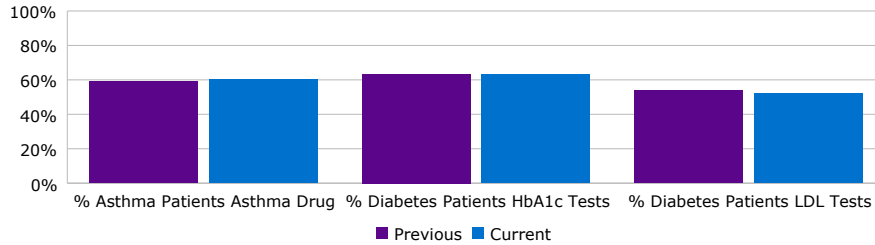


# Medical and Prescription Drug Dashboard - Total Member Population

Previous Period: Apr 2018 - Mar 2019 (Paid)

Current Period: Apr 2019 - Mar 2020 (Paid)

## 1. Quality Metrics\*



\*Quality Metrics are based on Incurred Rolling Year.

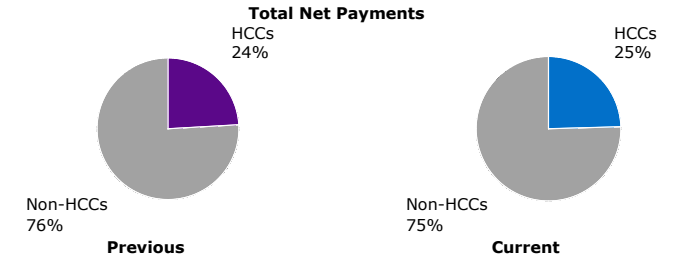
## 3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark	
Visits Per 1000 Well Baby	5,854.0	5,715.5	-2.4%	5,430.4	●
Visits Per 1000 Well Child	902.5	849.4	-5.9%	778.1	●
Visits Per 1000 Prevent Adult	427.4	428.9	0.4%	362.0	●

## 4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	71,020	72,503	2%
Average Members	125,442	127,371	2%
Family Size	1.8	1.8	-1%
Member Age	42.9	43.0	0%
Members % Male	45%	45%	0% pts

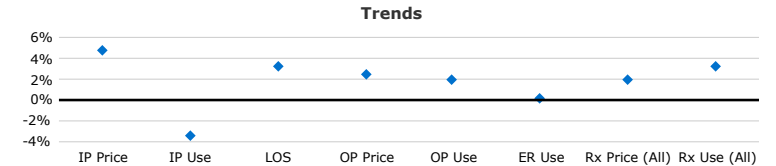
## 2. High Cost Claimants\*



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

	Previous	Current	Trend
Patients	1,028	1,113	8%
Patients per 1,000	7.6	8.1	7%
Payments (in millions)	\$201.8	\$216.7	7%
Payment per Patient	\$196,281	\$194,738	-1%

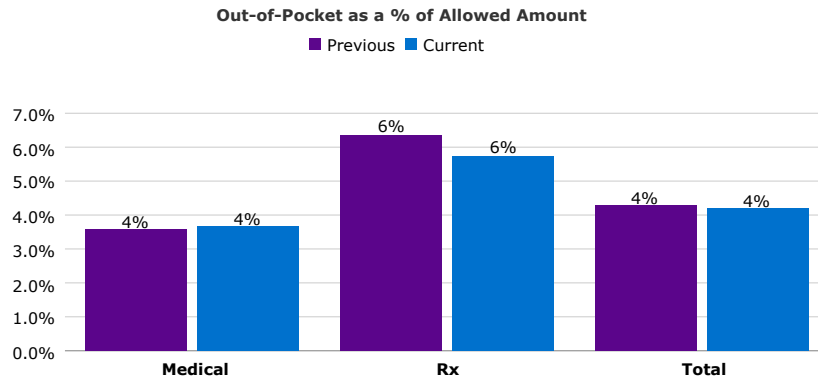
## 5. Price and Use



	Current	Benchmark	Trend
<b>Inpatient</b>			
Allowed per Admit	\$23,552	\$30,969	● 5%
Admits per 1,000	81.5	54.5	■ -3%
Days LOS	5.3	4.4	■ 3%
<b>Outpatient</b>			
Allowed per Service	\$128	\$131	◆ 2%
Services PMPY	42.4	30.7	■ 2%
Emergency Room Visits per 1,000	349	226	■ 0%
<b>Prescription Drugs</b>			
Allowed/Days Supply	\$2		-5%
Days Supply PMPY	655		3%
<b>Specialty Drugs</b>			
Allowed/Days Supply	\$86		-6%
Days Supply PMPY	12		24%
<b>All Prescription Drugs</b>			
Allowed/Days Supply	\$4	\$4	● 2%
Days Supply PMPY	667	365	● 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

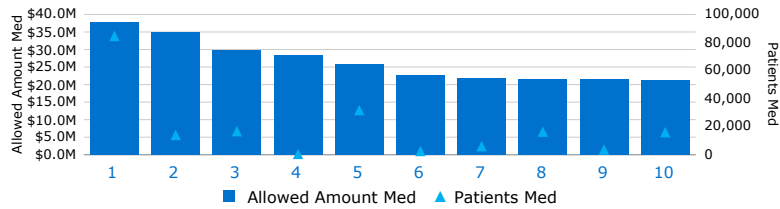


# Medical and Prescription Drug Dashboard - Total Member Population

Previous Period: Apr 2018 - Mar 2019 (Paid)

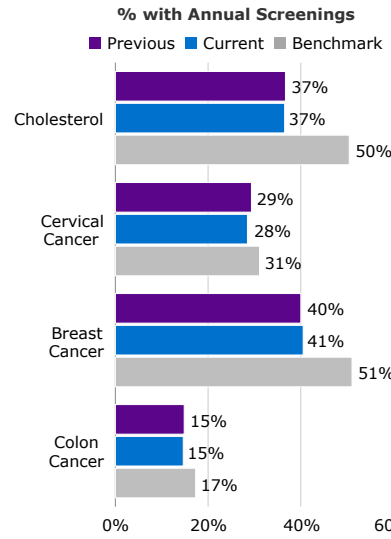
Current Period: Apr 2019 - Mar 2020 (Paid)

## 7. Top Medical Conditions (by cost)

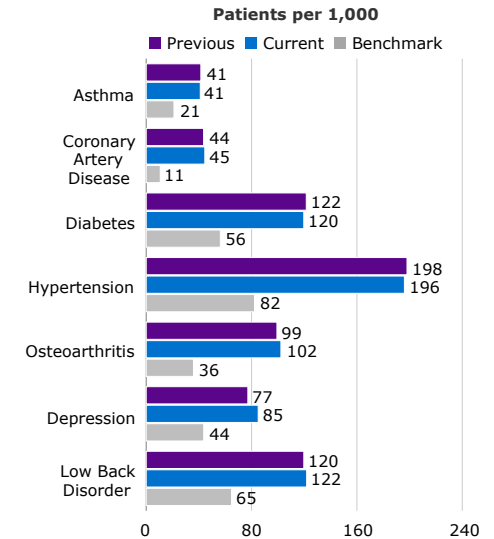


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient	
1	Prevent/Admin Hlth Encounters	\$37,891,752	84,691	\$447
2	Osteoarthritis	\$35,018,085	14,113	\$2,481
3	Spinal/Back Disord, Low Back	\$29,732,716	16,809	\$1,769
4	Chemotherapy Encounters	\$28,351,120	635	\$44,647
5	Arthropathies/Joint Disord NEC	\$25,802,232	31,848	\$810
6	Pregnancy without Delivery	\$22,671,557	2,681	\$8,456
7	Coronary Artery Disease	\$21,894,457	6,141	\$3,565
8	Gastroint Disord, NEC	\$21,517,507	16,482	\$1,306
9	Renal Function Failure	\$21,427,967	3,716	\$5,766
10	Respiratory Disord, NEC	\$21,125,627	16,105	\$1,312

## 8. Screening Rates

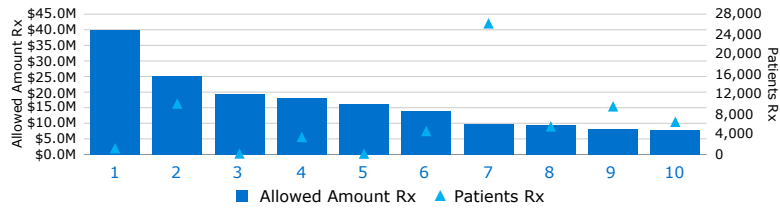


## 9. Chronic Condition Prevalence



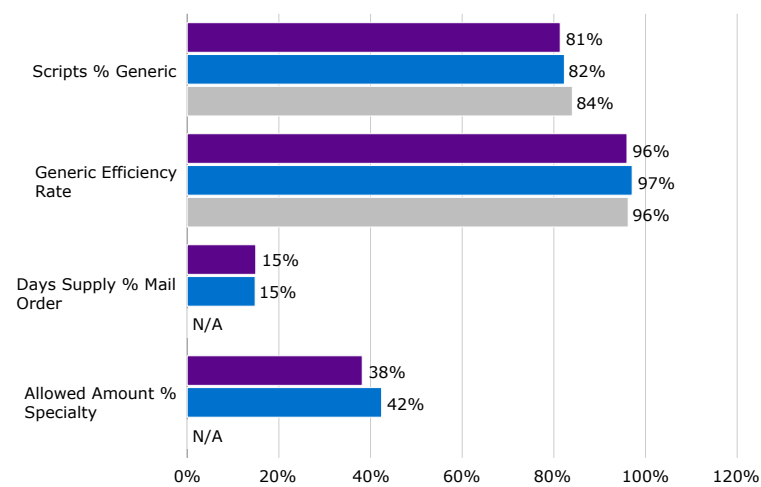
## 10. Prescription Drug Metrics

### Top 10 Therapeutic Classes (by cost)



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient	
1	Immunosuppressants, NEC	\$39,809,068	1,245	\$31,975
2	Antidiabetic Agents, Misc	\$25,244,953	10,166	\$2,483
3	Molecular Targeted Therapy	\$19,321,417	208	\$92,891
4	Antidiabetic Agents, Insulins	\$18,081,857	3,495	\$5,174
5	Biological Response Modifiers	\$16,263,854	181	\$89,856
6	Coag/Anticoag, Anticoagulants	\$13,883,614	4,674	\$2,970
7	Adrenals & Comb, NEC	\$9,879,439	26,181	\$377
8	Stimulant, Amphetamine Type	\$9,527,295	5,603	\$1,700
9	Antivirals, NEC	\$8,042,364	9,616	\$836
10	Misc Therapeutic Agents, NEC	\$7,982,334	6,528	\$1,223

### Script and Specialty Metrics

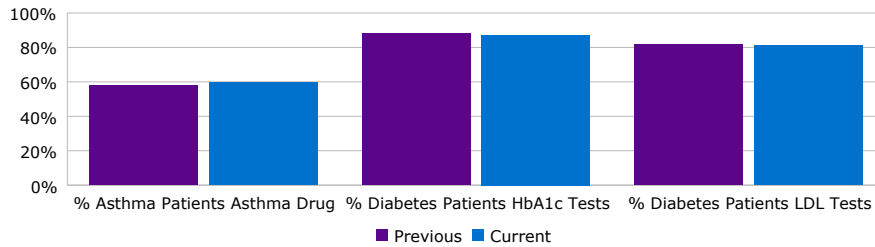


# State of Delaware Medical and Prescription Drug Dashboard - Actives

Previous Period: Apr 2018 - Mar 2019 (Paid)

Current Period: Apr 2019 - Mar 2020 (Paid)

## 1. Quality Metrics\*



\*Quality Metrics are based on Incurred Rolling Year.

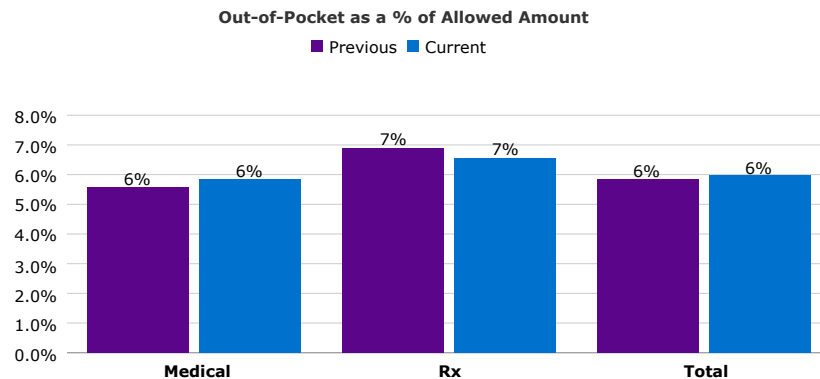
## 3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits Per 1000 Well Baby	5,860.5	5,717.1	-2.4%	5,430.4 ●
Visits Per 1000 Well Child	901.6	849.9	-5.7%	778.1 ●
Visits Per 1000 Prevent Adult	497.4	498.5	0.2%	328.0 ●

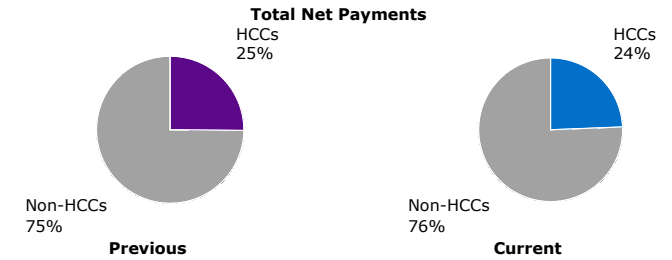
## 4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	38,112	38,427	1%
Average Members	88,884	89,100	0%
Family Size	2.3	2.3	-1%
Member Age	32.9	32.8	0%
Members % Male	46%	46%	0% pts

## 6. Cost Sharing



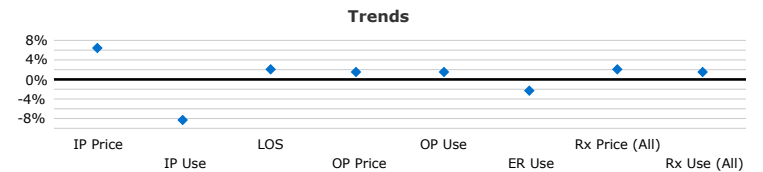
## 2. High Cost Claimants\*



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

	Previous	Current	Trend
Patients	744	752	1%
Patients per 1,000	7.5	7.6	1%
Payments (in millions)	\$138.9	\$137.2	-1%
Payment per Patient	\$186,651	\$182,426	-2%

## 5. Price and Use



	Current	Benchmark	Trend
<b>Inpatient</b>			
Allowed per Admit	\$27,596	\$25,986	6%
Admits per 1,000	52.6	53.2	-8%
Days LOS	4.6	4.2	2%
<b>Outpatient</b>			
Allowed per Service	\$133	\$131	2%
Services PMPY	31.4	29.5	2%
Emergency Room Visits per 1,000	273	225	-2%
<b>Prescription Drugs</b>			
Allowed/Days Supply	\$2		-5%
Days Supply PMPY	385		1%
<b>Specialty Drugs</b>			
Allowed/Days Supply	\$81		-6%
Days Supply PMPY	8		22%
<b>All Prescription Drugs</b>			
Allowed/Days Supply	\$4	\$4	2%
Days Supply PMPY	393	329	2%

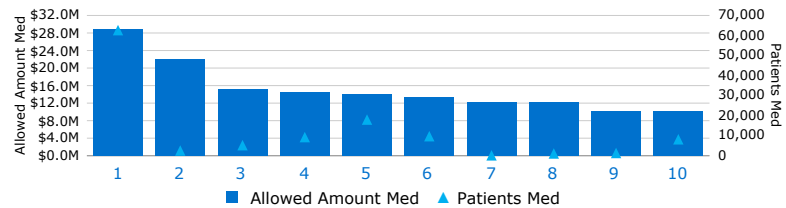
● Represents a lower than -3% comparison to the benchmark  
 ◆ Represents a comparison to the benchmark within +/-3%  
 ■ Represents a higher than 3% comparison to the benchmark

# State of Delaware Medical and Prescription Drug Dashboard - Actives

Previous Period: Apr 2018 - Mar 2019 (Paid)

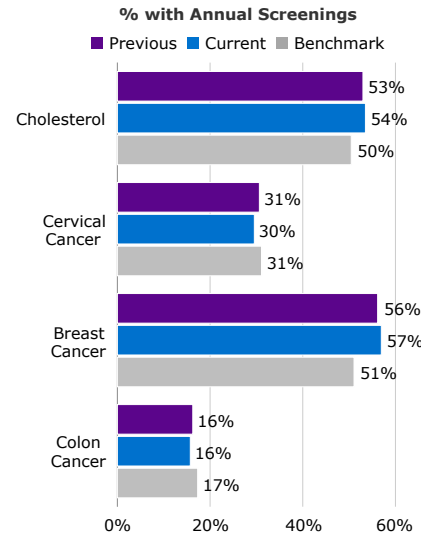
Current Period: Apr 2019 - Mar 2020 (Paid)

## 7. Top Medical Conditions (by cost)

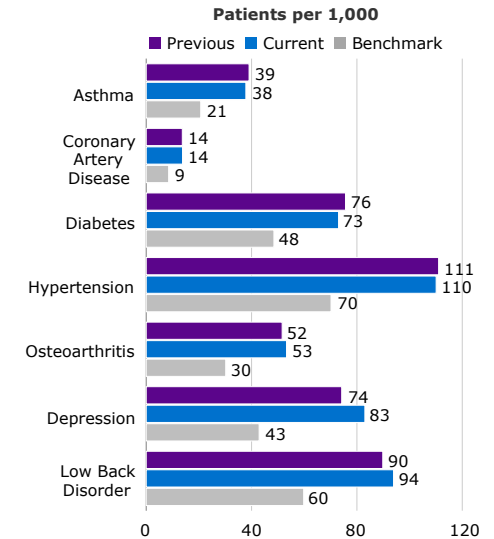


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient	
1	Prevent/Admin Hlth Encounters	\$28,943,699	62,678	\$462
2	Pregnancy without Delivery	\$22,108,808	2,599	\$8,507
3	Osteoarthritis	\$15,065,927	5,274	\$2,857
4	Spinal/Back Disord, Low Back	\$14,545,364	9,297	\$1,565
5	Arthropathies/Joint Disord NEC	\$14,094,387	18,043	\$781
6	Gastroint Disord, NEC	\$13,403,472	9,754	\$1,374
7	Chemotherapy Encounters	\$12,221,839	195	\$62,676
8	Newborns, w/wo Complication	\$12,142,898	1,137	\$10,680
9	Coronary Artery Disease	\$10,242,197	1,365	\$7,503
10	Spinal/Back Disord, Ex Low	\$10,161,257	8,216	\$1,237

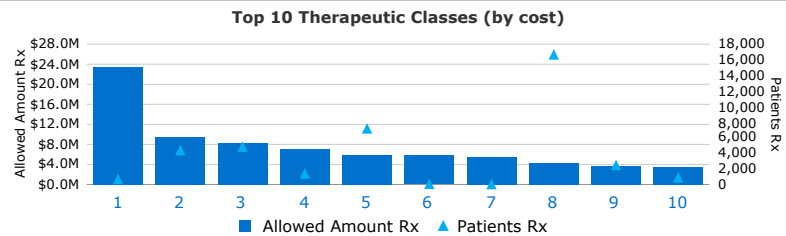
## 8. Screening Rates



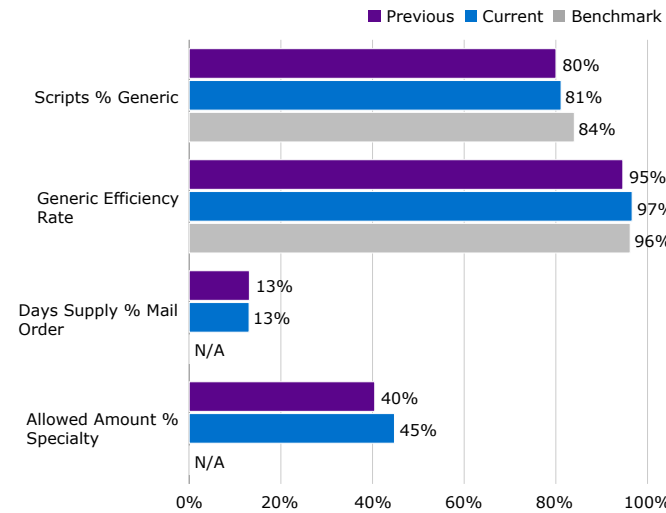
## 9. Chronic Condition Prevalence



## 10. Prescription Drug Metrics



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient	
1	Immunosuppressants, NEC	\$23,508,526	704	\$33,393
2	Antidiabetic Agents, Misc	\$9,431,420	4,410	\$2,139
3	Stimulant, Amphetamine Type	\$8,310,968	4,861	\$1,710
4	Antidiabetic Agents, Insulins	\$7,081,882	1,410	\$5,023
5	Antivirals, NEC	\$5,846,379	7,192	\$813
6	Biological Response Modifiers	\$5,779,114	79	\$73,153
7	Molecular Targeted Therapy	\$5,548,260	56	\$99,076
8	Adrenals & Comb, NEC	\$4,232,901	16,689	\$254
9	Misc Therapeutic Agents, NEC	\$3,749,069	2,497	\$1,501
10	Antidiabetic Ag, SGLT Inhibitr	\$3,477,386	922	\$3,772

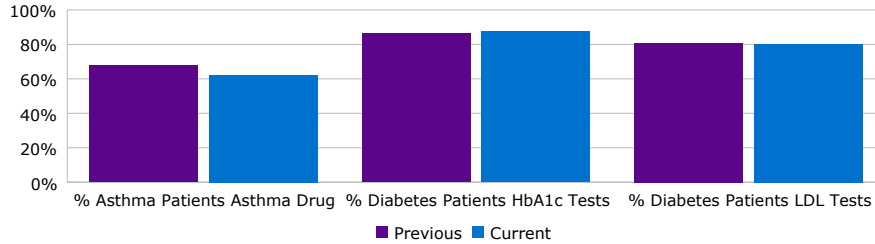


# Medical and Prescription Drug Dashboard - Early Retirees

Previous Period: Apr 2018 - Mar 2019 (Paid)

Current Period: Apr 2019 - Mar 2020 (Paid)

## 1. Quality Metrics\*



\*Quality Metrics are based on Incurred Rolling Year.

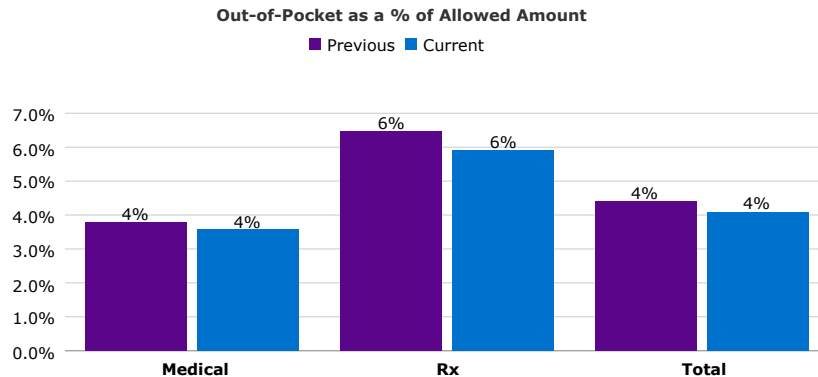
## 3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits Per 1000 Well Baby	5,581.4	4,736.8	-15.1%	5,430.4 ●
Visits Per 1000 Well Child	994.5	807.7	-18.8%	778.1 ●
Visits Per 1000 Prevent Adult	504.1	511.1	1.4%	461.0 ●

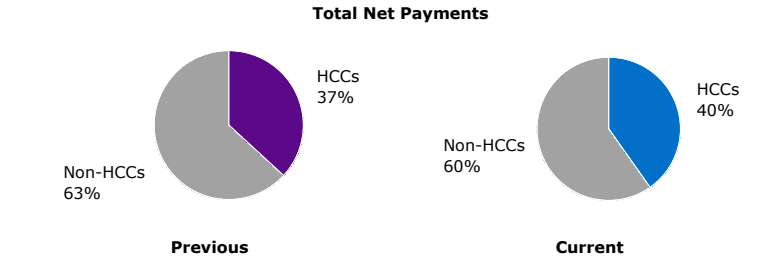
## 4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	5,926	6,158	4%
Average Members	9,268	9,866	6%
Family Size	1.6	1.6	2%
Member Age	50.5	49.6	-2%
Members % Male	42%	41%	0% pts

## 6. Cost Sharing



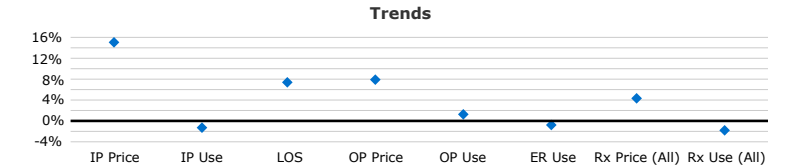
## 2. High Cost Claimants\*



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

	Previous	Current	Trend
Patients	237	267	13%
Patients per 1,000	19.9	22.5	13%
Payments (in millions)	\$39.2	\$50.0	27%
Payment per Patient	\$165,464	\$187,206	13%

## 5. Price and Use



	Current	Benchmark	Trend
<b>Inpatient</b>			
Allowed per Admit	\$40,598	\$37,248	■ 15%
Admits per 1,000	79.7	63.0	■ -1%
Days LOS	6.1	5.1	■ 7%
<b>Outpatient</b>			
Allowed per Service	\$157	\$131	■ 8%
Services PMPY	50.8	40.7	■ 2%
Emergency Room Visits per 1,000	366	233	■ -1%
<b>Prescription Drugs</b>			
Allowed/Days Supply	\$2		-5%
Days Supply PMPY	775		-2%
<b>Specialty Drugs</b>			
Allowed/Days Supply	\$87		-1%
Days Supply PMPY	16	16%	
<b>All Prescription Drugs</b>			
Allowed/Days Supply	\$4	\$3	■ 4%
Days Supply PMPY	792	650	● -2%

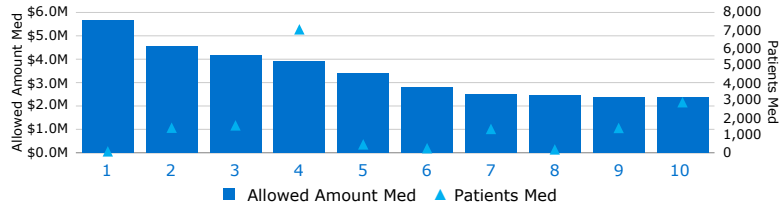
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# Medical and Prescription Drug Dashboard - Early Retirees

Previous Period: Apr 2018 - Mar 2019 (Paid)

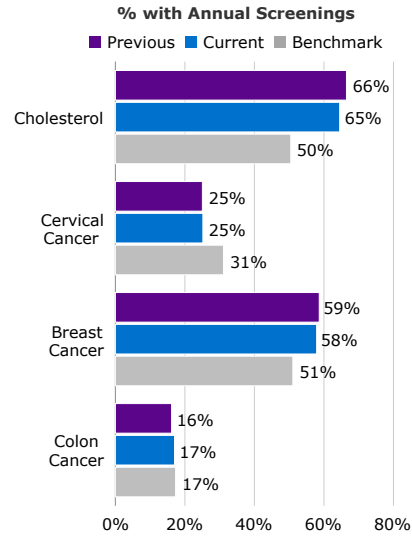
Current Period: Apr 2019 - Mar 2020 (Paid)

## 7. Top Medical Conditions (by cost)

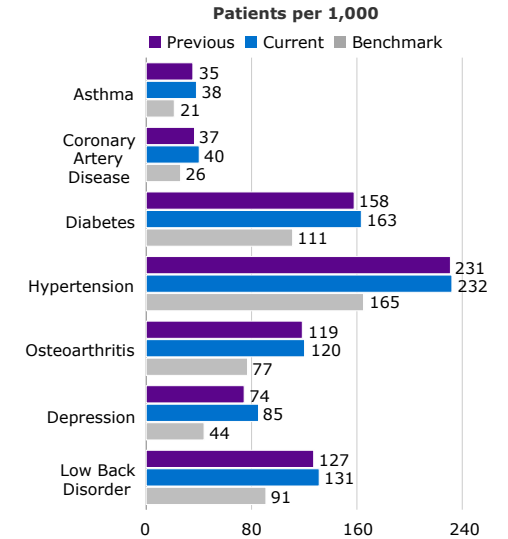


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient	
1	Chemotherapy Encounters	\$5,655,389	79	\$71,587
2	Osteoarthritis	\$4,534,898	1,428	\$3,176
3	Spinal/Back Disord, Low Back	\$4,184,252	1,560	\$2,682
4	Prevent/Admin Hlth Encounters	\$3,897,719	7,038	\$554
5	Coronary Artery Disease	\$3,409,651	478	\$7,133
6	Renal Function Failure	\$2,793,403	260	\$10,744
7	Respiratory Disord, NEC	\$2,503,017	1,359	\$1,842
8	Cancer - Breast	\$2,459,123	190	\$12,943
9	Gastroint Disord, NEC	\$2,373,057	1,414	\$1,678
10	Arthropathies/Joint Disord NEC	\$2,361,021	2,882	\$819

## 8. Screening Rates

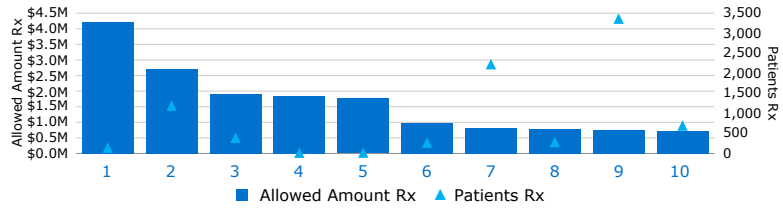


## 9. Chronic Condition Prevalence

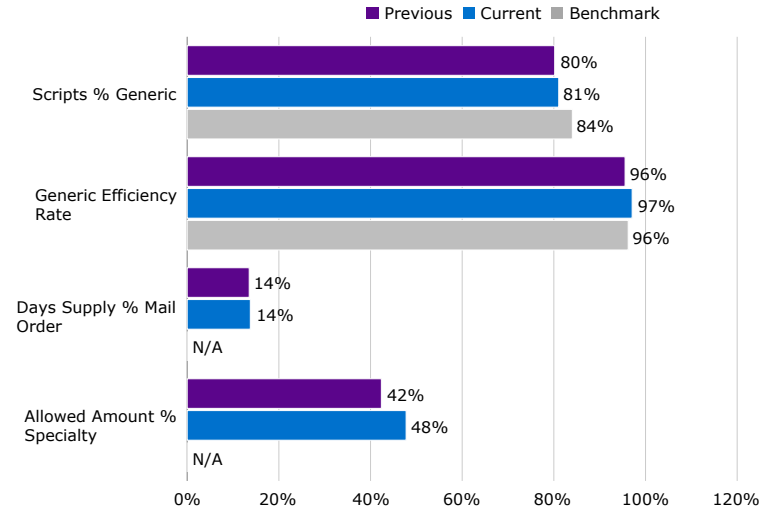


## 10. Prescription Drug Metrics

### Top 10 Therapeutic Classes (by cost)



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient	
1	Immunosuppressants, NEC	\$4,229,529	146	\$28,969
2	Antidiabetic Agents, Misc	\$2,721,593	1,195	\$2,277
3	Antidiabetic Agents, Insulins	\$1,898,684	392	\$4,844
4	Molecular Targeted Therapy	\$1,834,010	19	\$96,527
5	Biological Response Modifiers	\$1,764,324	23	\$76,710
6	Antidiabetic Ag, SGLT Inhibitr	\$963,315	270	\$3,568
7	Adrenals & Comb, NEC	\$830,066	2,229	\$372
8	CNS Agents, Misc.	\$793,686	286	\$2,775
9	Antihyperlipidemic Drugs, NEC	\$750,675	3,365	\$223
10	Antivirals, NEC	\$724,559	698	\$1,038

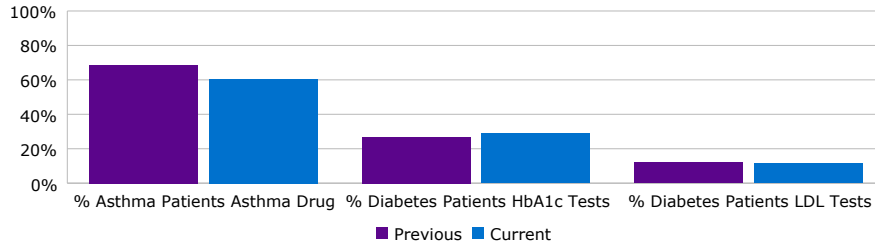


# Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Apr 2018 - Mar 2019 (Paid)

Current Period: Apr 2019 - Mar 2020 (Paid)

## 1. Quality Metrics\*



\*Quality Metrics are based on Incurred Rolling Year.

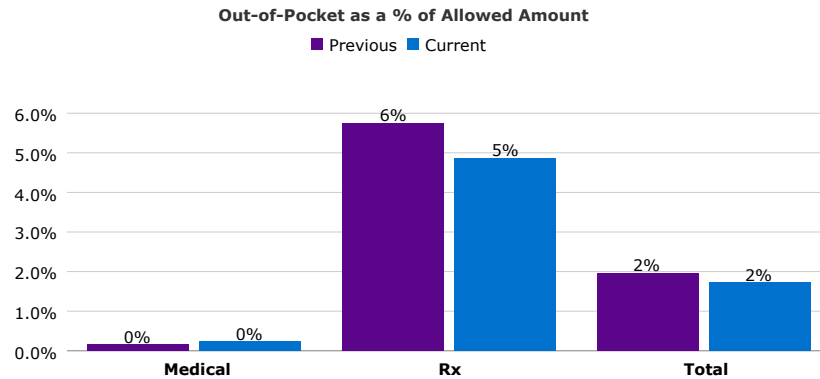
## 3. Well Care and Preventive Visits

	Previous	Current	Trend	Benchmark
Visits Per 1000 Prevent Adult	236.1	242.7	2.8%	444.0 ●

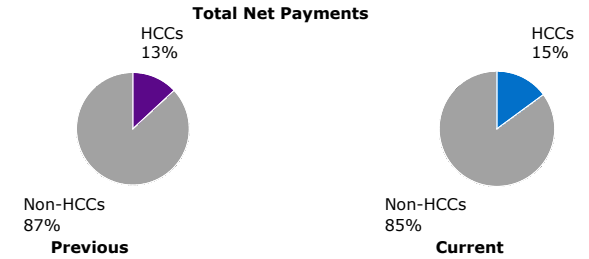
## 4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	24,576	25,437	4%
Average Members	24,712	25,715	4%
Family Size	1.0	1.0	1%
Member Age	73.1	72.9	0%
Members % Male	42%	42%	0% pts

## 6. Cost Sharing



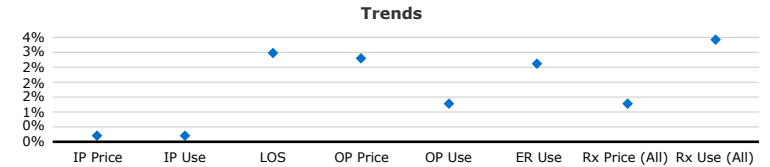
## 2. High Cost Claimants\*



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

	Previous	Current	Trend
Patients	154	182	18%
Patients per 1,000	5.9	6.7	15%
Payments (in millions)	\$21.1	\$26.3	25%
Payment per Patient	\$136,994	\$144,550	6%

## 5. Price and Use



	Current	Benchmark	Trend
<b>Inpatient</b>			
Allowed per Admit	\$17,037	\$35,111	● 0%
Admits per 1,000	169.9	55.5	■ 0%
Days LOS	5.9	4.5	■ 3%
<b>Outpatient</b>			
Allowed per Service	\$113	\$130	● 3%
Services PMPY	74.3	31.1	■ 1%
Emergency Room Visits per 1,000	561	226	■ 3%
<b>Prescription Drugs</b>			
Allowed/Days Supply	\$2		◆ -5%
Days Supply PMPY	1,493		◆ 3%
<b>Specialty Drugs</b>			
Allowed/Days Supply	\$92		◆ -7%
Days Supply PMPY	22		◆ 26%
<b>All Prescription Drugs</b>			
Allowed/Days Supply	\$3	\$4	● 1%
Days Supply PMPY	1,515	378	◆ 3%

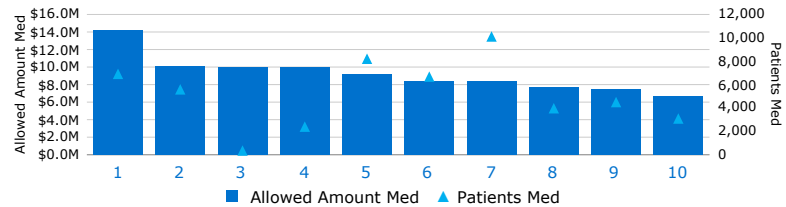
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# Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Apr 2018 - Mar 2019 (Paid)

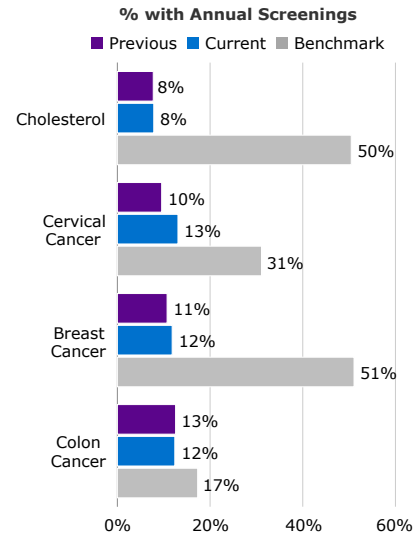
Current Period: Apr 2019 - Mar 2020 (Paid)

## 7. Top Medical Conditions (by cost)

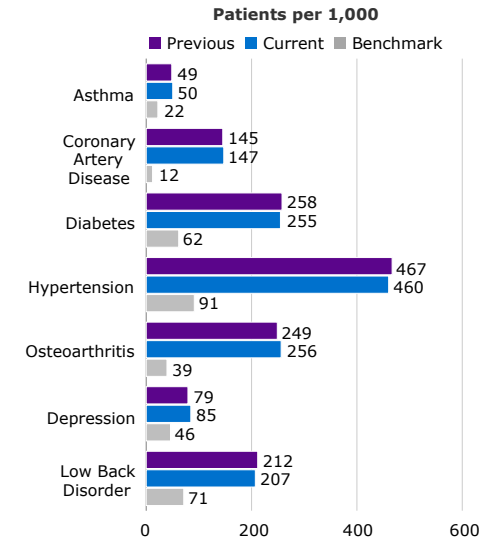


Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1 Osteoarthritis	\$14,230,582	6,919	\$2,057
2 Spinal/Back Disord, Low Back	\$10,042,392	5,595	\$1,795
3 Chemotherapy Encounters	\$10,020,118	358	\$27,989
4 Renal Function Failure	\$9,992,376	2,404	\$4,157
5 Eye Disorders, Degenerative	\$9,135,085	8,212	\$1,112
6 Respiratory Disord, NEC	\$8,360,891	6,679	\$1,252
7 Arthropathies/Joint Disord NEC	\$8,351,287	10,118	\$825
8 Coronary Artery Disease	\$7,689,158	3,978	\$1,933
9 Cardiac Arrhythmias	\$7,421,108	4,505	\$1,647
10 Cerebrovascular Disease	\$6,706,751	3,098	\$2,165

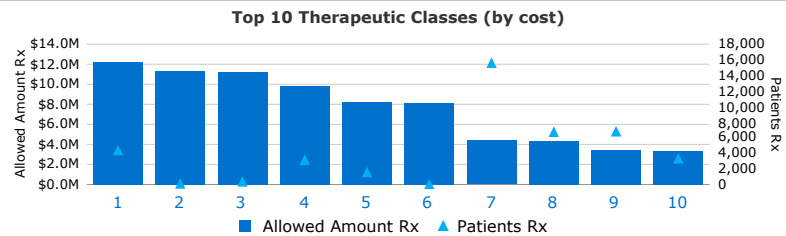
## 8. Screening Rates



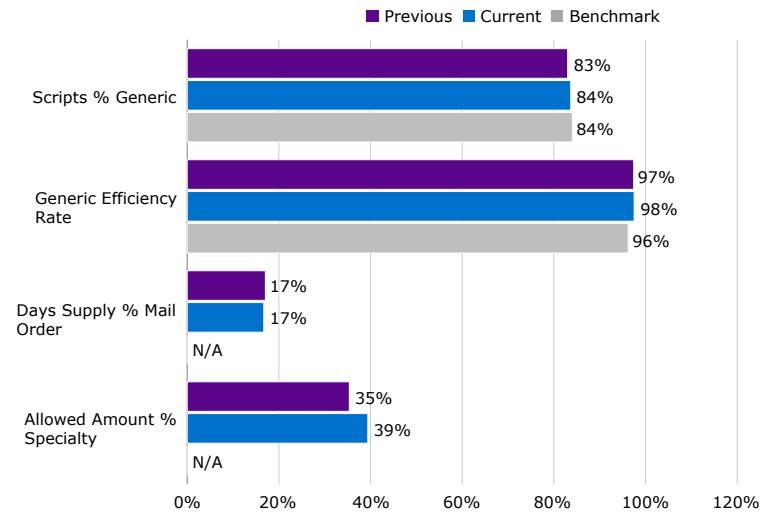
## 9. Chronic Condition Prevalence



## 10. Prescription Drug Metrics



Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1 Antidiabetic Agents, Misc	\$12,192,249	4,428	\$2,753
2 Molecular Targeted Therapy	\$11,323,060	132	\$85,781
3 Immunosuppressants, NEC	\$11,256,911	399	\$28,213
4 Coag/Anticoag, Anticoagulants	\$9,822,954	3,179	\$3,090
5 Antidiabetic Agents, Insulins	\$8,227,140	1,599	\$5,145
6 Biological Response Modifiers	\$8,125,280	78	\$104,170
7 Antihyperlipidemic Drugs, NEC	\$4,387,733	15,631	\$281
8 Adrenals & Comb, NEC	\$4,365,233	6,770	\$645
9 Gastrointestinal Drug Misc, NEC	\$3,469,308	6,831	\$508
10 Misc Therapeutic Agents, NEC	\$3,382,113	3,356	\$1,008





# Medical and Prescription Drug Dashboard - Medicare Retirees

## Dashboard Glossary

### General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2018 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)