



Calendar Year 2020 Results

Benchmark Trend Report

State of Delaware

Department of Health and Social Services

Delaware Health Care Commission

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1. Executive Summary

This is the second annual Benchmark Trend Report (Report) produced by the Delaware Health Care Commission (DHCC). This Report summarizes the spending and quality data collected from all payers who voluntarily participated in the benchmark data collection process. Unless otherwise noted, the data contained herein represents spending and quality data incurred (i.e., dates of service) in:

- Calendar year (CY) 2020 Estimate (spending)
- CY 2019 Final
- CY 2018 Final

It is important to remind users of this report that the benchmark data collection process has its own unique reporting requirements and methodology and the process is voluntary for entities to participate in. Therefore, direct comparisons of this data to any other external data source of Delaware health care spending or per capita values should not be done. All spending data is net of pharmacy rebates.

The DHCC considers this Report an important tool for raising awareness and spurring dialogue regarding the level of and type of health care spending occurring in Delaware along with what Delawareans are receiving in terms of quality outcome results. Please note, the spending data in this report does not include federal or state COVID-19 relief/special payments. See page 10 for more information about COVID-19 relief/special payments.

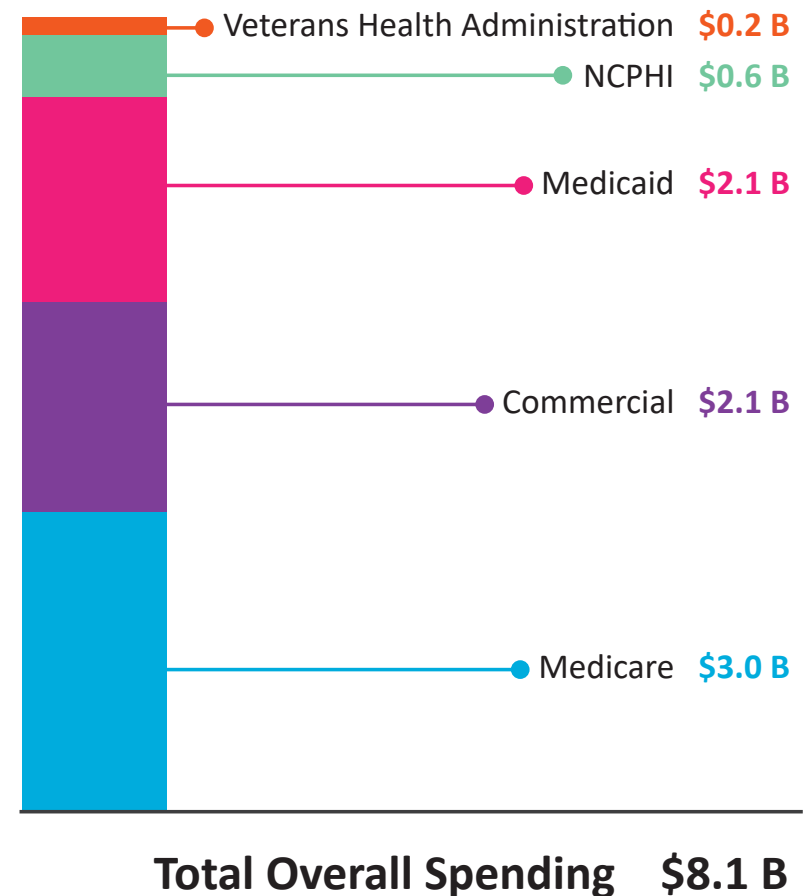
CY 2020 Per Capita Spending versus Spending Benchmark

Delaware's spending benchmark is the year-over-year percentage change in total health care expenditures (THCE) expressed on a per capita basis. For the CY 2020 performance period, the spending benchmark was set at a 3.5 percent growth rate. As shown in Figure 1-1, Delaware's total CY 2020 THCE was approximately \$8.1 billion. The per capita amount was \$8,173 which represents a 1.2 percent year-over-year decrease.



On a per capita basis, THCE decreased 1.2% relative to the CY 2020 spending benchmark of 3.5%.

Figure 1-1: CY 2020 State Total Health Care Expenditures
Aggregate and Per Capita



CY 2020 Quality Results versus Quality Benchmarks

In addition to the State level per capita spending benchmark, Delaware established annual quality benchmarks for several different quality measures. For the respective quality measures, Delaware-specific benchmarks were set through CY 2021.

DHCC added the Use of Opioids at High Dosages as a new quality benchmark beginning with the CY 2020 performance period while discontinuing the Adult Tobacco Use and High School Students Who Were Physically Active quality benchmarks.

For the CY 2020 performance period, the National Committee for Quality Assurance (NCQA) significantly changed the methodology for reporting Emergency Department Utilization which is the basis for this quality benchmark. As a result, NCQA gave the new measure first year status for CY 2020 and thus no results were available. DHCC expects to include reporting on Emergency Department Utilization in the CY 2021 Report.

As seen in the table below, relative to each respective quality benchmark, CY 2020 results across the six quality measures were mixed:

Quality Measures	CY 2020 Benchmark	CY 2020 Results	Notes
Adult Obesity	29.4%	36.5%	Lower result/score is better
Use of Opioids at High Dosages	12.4%	11.1%	Lower result/score is better
Opioid-related Overdose Deaths	15.5 deaths per 100,000	43.9 deaths per 100,000	Lower result/score is better
Emergency Department Utilization	184.0 visits per 1,000 Commercial only	Results were unavailable	Lower result/score is better
Persistence of Beta-Blocker Treatment After a Heart Attack	84.9% Commercial 80.1% Medicaid	91.7% Commercial 78.1% Medicaid	Higher result/score is better
Statin Therapy for Patients with Cardiovascular Disease	80.5% Commercial 61.5% Medicaid	83.6% Commercial 72.6% Medicaid	Higher result/score is better

Conclusion

The DHCC appreciates and thanks everyone, particularly our valued insurer partners, who participated in the benchmark process including consultants from Mercer Health & Benefits LLC that assisted in the production of this Report. We look forward to the ongoing collaboration with our stakeholders and data partners to make this Report meaningful and useful to the benefit of all Delawareans.

2. Introduction

This is the second annual Benchmark Trend Report (Report) produced by the Delaware Health Care Commission (DHCC). This Report summarizes the spending and quality data collected from all payers who voluntarily participated in the benchmark data collection process. Unless otherwise noted, the data contained herein represents spending and quality data incurred (i.e., dates of service) in:

- CY 2020 Estimate (spending)
- CY 2019 Final
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The DHCC considers this Report an important tool for raising awareness and spurring dialogue regarding the level of and type of health care spending occurring in Delaware along with what Delawareans are receiving in terms of quality outcome results. Please note, the spending data in this report does not include federal or state COVID-19 relief/special payments. See page 10 for more information about COVID-19 relief/special payments.

Refreshed CY 2019 Spending Data

For this benchmark data collection cycle, CY 2019 spending data was collected again. All Figures in this Report reflect the refreshed CY 2019 spending data.

Spending Data and Benchmark

The spending benchmark is measured as the annual change in Delaware's per capita total health care expenditures (THCE). The reported per capita change is then compared to the established spending benchmark target applicable to each CY. THCE sums total medical expense (TME) and the estimated net cost of private health insurance (NCPHI) at the State level and divides by Delaware's state population to arrive at a State level per capita figure for each CY. Please see the Glossary in Section 8 for more information about the terms used throughout this Report.

The spending benchmark for CY 2020 (i.e., the per capita change from CY 2019) was set at a 3.5 percent growth rate.

More information on the development of the benchmarks, the data collection process, and the implementation manual can be found on DHCC's website at <https://dhss.delaware.gov/dhcc/global.html>. In an addition to this Report, DHCC will post an Appendix 1 - Benchmark Data Tables CY 2020 that is an Excel-based document containing all the underlying data that were used to create this report.

DHCC thanks every entity that participated in this process and we look forward to an ongoing collaboration in each annual cycle.

Table 2-1: Spending Data Sources

Spending Data	Data Source	Notes
Commercial Data	<p>Carriers serving Delaware:</p> <ul style="list-style-type: none"> • Aetna • Cigna • Highmark • United Healthcare (UHC) 	Carriers with multiple lines of business were asked to provide data on all lines. For example, Cigna provided spending data on their commercial operations as well as their Medicare Advantage operations (i.e., Cigna Bravo). United Healthcare did not provide data on their Medicare Advantage program.
Medicaid Data ¹	<ul style="list-style-type: none"> • Delaware’s Division of Medicaid and Medical Assistance (DMMA) • Amerihealth Caritas of Delaware (ACDE) and Highmark Health Options (Highmark) 	DMMA was the source of Medicaid fee-for-service (FFS) spending data. The insurers provided data on the Medicaid managed care program.
Medicare Data	<ul style="list-style-type: none"> • Centers for Medicare and Medicaid Services (CMS) • Aetna • Cigna 	CMS provided Medicare Part A and B spending on FFS beneficiaries only as well as total Part D ² (pharmacy) spending for all Medicare FFS and managed care enrollees. The insurers provided spending data on Medicare Advantage (managed care).
VHA Data	<ul style="list-style-type: none"> • Veterans Health Administration public report 	Detailed spending from the VHA is not available. Only aggregate member count and total health care spending on Delaware veterans is available. VHA data is reported on a federal fiscal year (FFY) basis which runs October-September. For purposes of this report FFY 2020 = CY 2020.
NCPHI	<ul style="list-style-type: none"> • Insurer reported data 	NCPHI was computed using insurer submitted revenue and expenditure data.

¹ Unless otherwise noted, references to “Medicaid” in this Report includes data on both the Title XIX Medicaid program and the Title XXI CHIP program.

² CMS did not provide any Part D pharmacy rebate data and hence the CMS pharmacy spending data is gross of rebates. The only pharmacy rebate information applicable to the Medicare program was provided by the insurers on their respective Medicare Advantage operations.

Quality Data and Benchmarks

Delaware also established annual benchmarks for select number of quality measures.

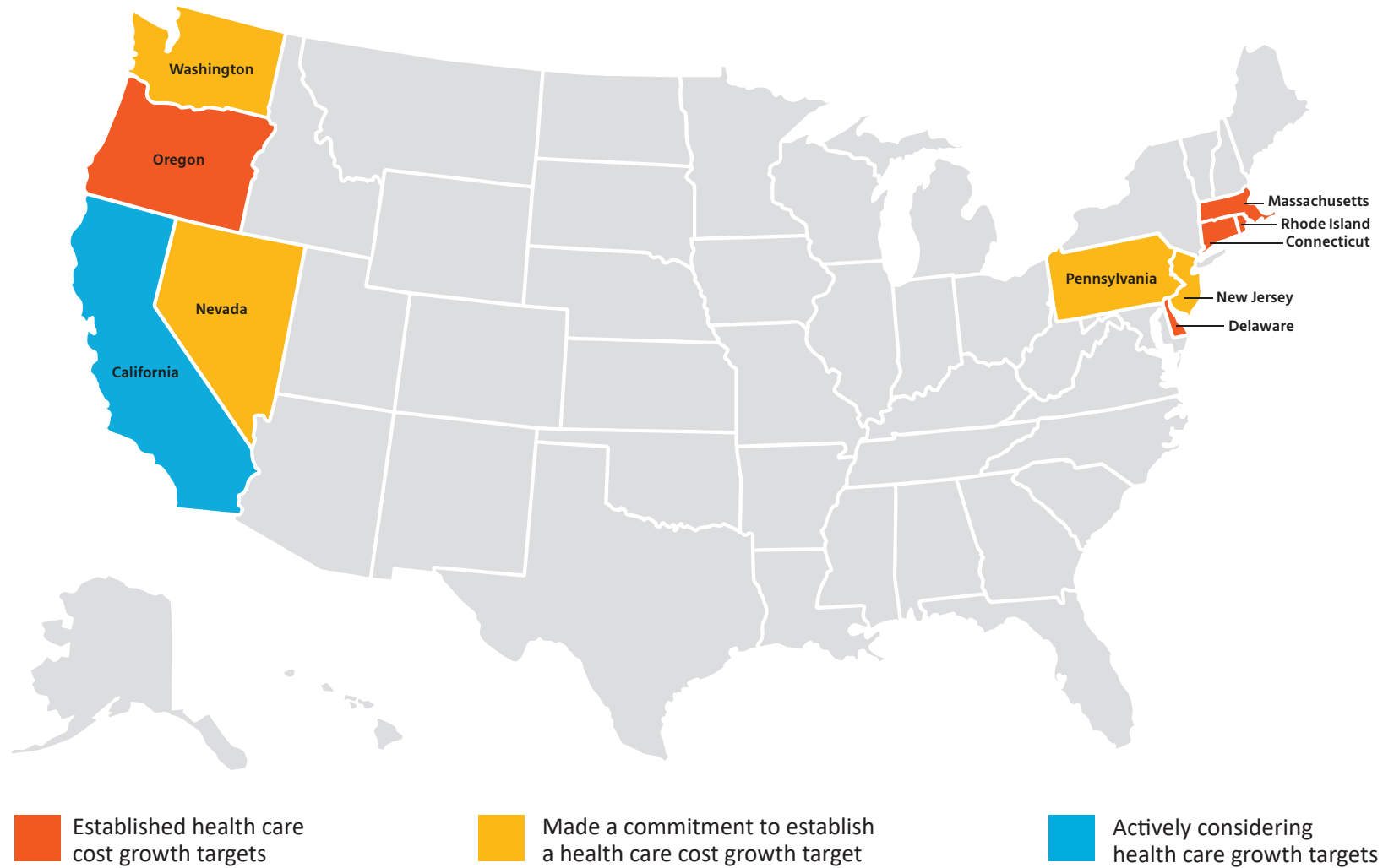
Beginning with the CY 2020 performance period, DHCC added the Use of Opioids at High Dosages as a new quality benchmark while discontinuing the Adult Tobacco Use and High School Students Who Were Physically Active quality benchmarks.

For the CY 2020 performance period, the National Committee for Quality Assurance (NCQA) significantly changed the methodology for reporting Emergency Department Utilization which is the basis for this quality benchmark. As a result, NCQA gave the new measure first year status for CY 2020 and thus no results were available. DHCC expects to include reporting on Emergency Department Utilization in the CY 2021 Report.

Table 2-2: Quality Measures, Population, Data Sources and CY 2020 Benchmark

Quality Measure	Population	Data Source	CY 2020 Benchmark
Adult Obesity	<ul style="list-style-type: none"> Statewide (all populations) 	<ul style="list-style-type: none"> CDC public report 	29.4 percent
Use of Opioids at High Dosages	<ul style="list-style-type: none"> Statewide (all populations) 	<ul style="list-style-type: none"> Delaware Prescription Monitoring Program 	12.4 percent
Opioid-related Overdose Deaths	<ul style="list-style-type: none"> Statewide (all populations) 	<ul style="list-style-type: none"> CDC public report 	15.5 deaths per 100,000
Emergency Department Utilization	<ul style="list-style-type: none"> Commercial market 	<ul style="list-style-type: none"> Delaware insurers 	184.0 visits per 1,000
Persistence of Beta-Blocker Treatment After a Heart Attack	<ul style="list-style-type: none"> Commercial market Medicaid market (managed care only) 	<ul style="list-style-type: none"> Delaware insurers 	<ul style="list-style-type: none"> 84.9 percent (Commercial) 80.1 percent (Medicaid)
Statin Therapy for Patients with Cardiovascular Disease	<ul style="list-style-type: none"> Commercial market Medicaid market (managed care only) 	<ul style="list-style-type: none"> Delaware insurers 	<ul style="list-style-type: none"> 80.5 percent (Commercial) 61.5 percent (Medicaid)

Statewide Health Care Cost Growth Benchmark



Five states have now established statewide health care cost growth targets, ranging from 2.9% to 3.4%, with many additional states considering similar proposals.

Source: <https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/> and <https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/>

3. Spending Data: State Level



This Section includes several different views of Delaware’s health care spending data at the State level.

Even though multiple views of the data have been provided, the value that is directly comparable to the spending benchmark is the State level change in per capita THCE which is shown in Figure 3-3. Other year-over-year comparisons are for informational purposes only.

COVID-19 Impact on CY 2020 Results

This Report focuses on the CY 2020 performance period, a period in which health care utilization, service delivery, and payer and provider finances were significantly impacted by the COVID-19 pandemic. This Report contains actual reported spending and quality results consistent with the benchmark data reporting requirements. Due to the impact of COVID-19, the results for CY 2020 should be viewed in the context of the unprecedented and extraordinary circumstances that occurred throughout CY 2020 and even subsequently into later years. CY 2020 results may not be indicative of the results associated with future years.



CY 2020 THCE increased just 0.5% compared to CY 2019



CY 2020 THCE decreased in the Commercial, Medicaid, and Medicare Markets, but VHA spending increased



Medicare continues to be the largest Market in Delaware



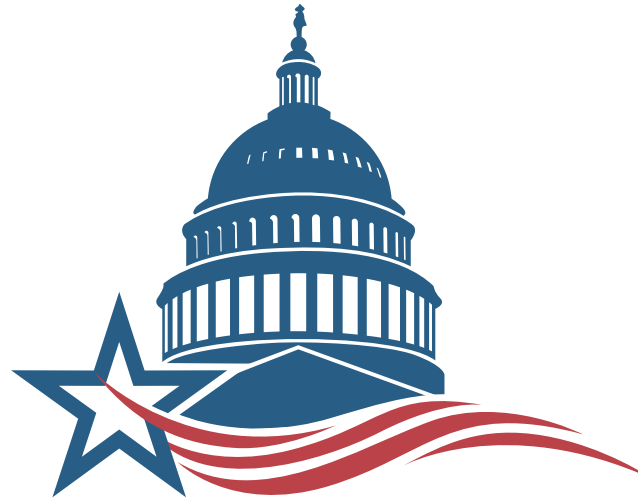
Hospital Inpatient continues to be the largest single service category of TME at the State level



Delaware’s total State population increased 1.7%



On a per capita basis, CY 2020 THCE decreased 1.2%



As of April 2022, Delaware had received \$483 million in relief funds.

AMERICAN RESCUE PLAN
INVESTING *in* DELAWARE

As of March 30, 2022, Delaware had distributed \$122.1 million to hospitals and other local health care operations.

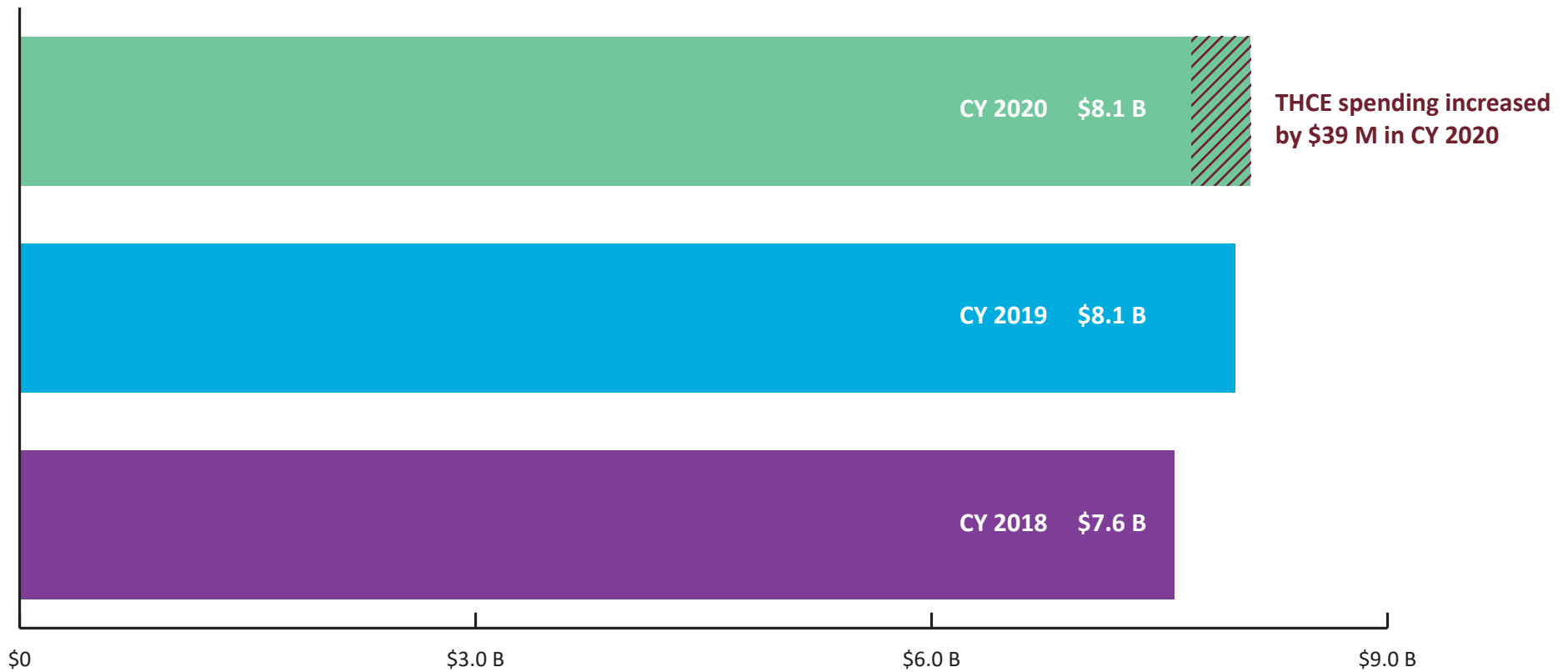
COVID-19 RELIEF & SUPPORT
**Governor Carney Announces
Health Care Relief Fund**

In 2020 and 2021, DHSS distributed \$92 million in CARES Act funds to more than 359 health care entities.

The State and Federal COVID-19 relief payments supported Delaware's health care systems through the pandemic by providing financial assistance, medical equipment, and numerous other valuable resources to help keep Delaware residents as safe and healthy as possible.



Figure 3-1: State Level Total Health Care Expenditures, Total Spending

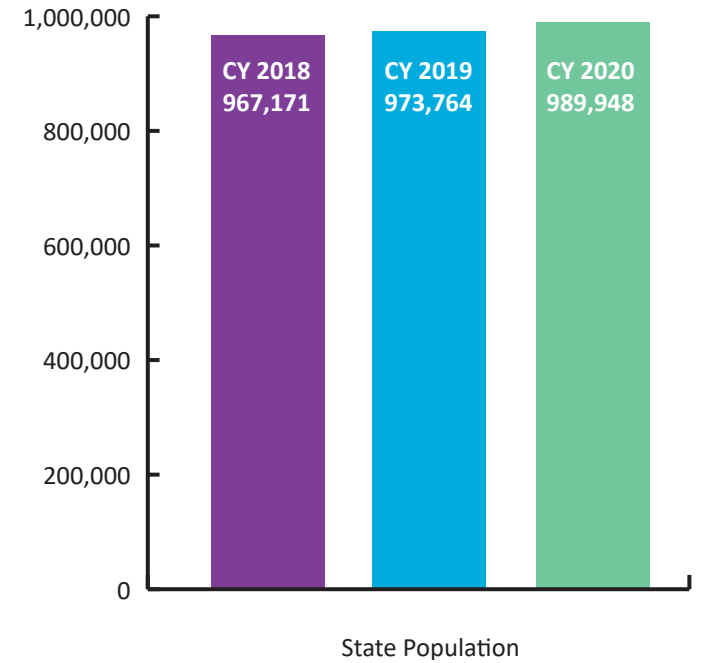
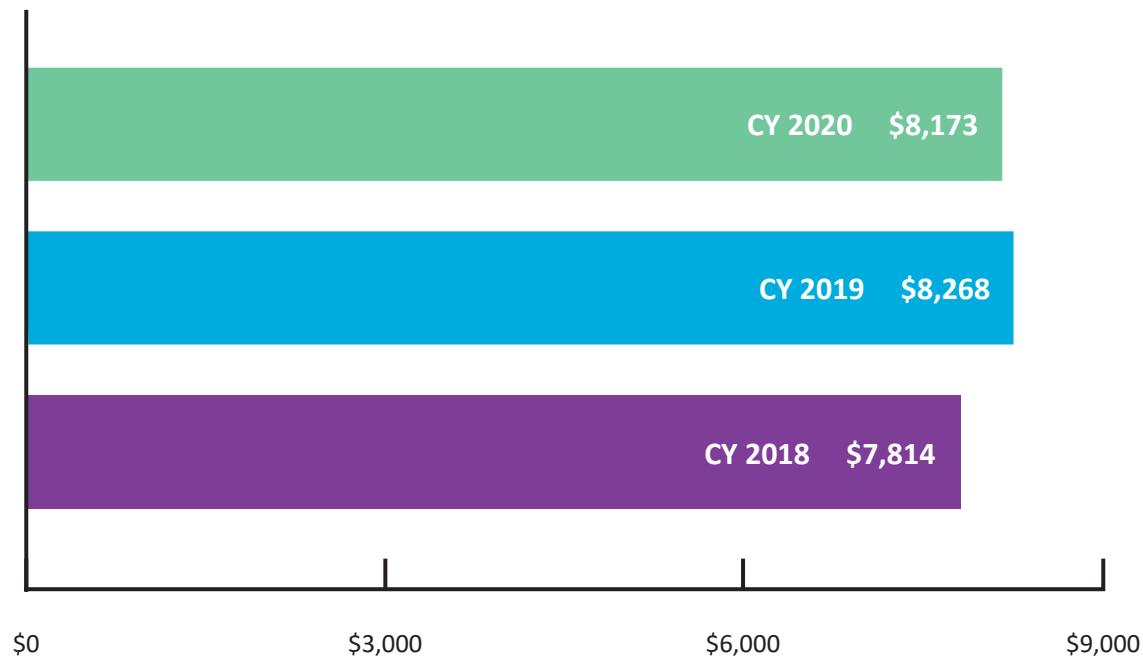


0.5%

THCE spending increased 0.5% or by \$39 million in CY 2020.



Figure 3-2: State Level Total Health Care Expenditures, Per Capita



On a per capita basis, THCE spending decreased by 1.2% in CY 2020.

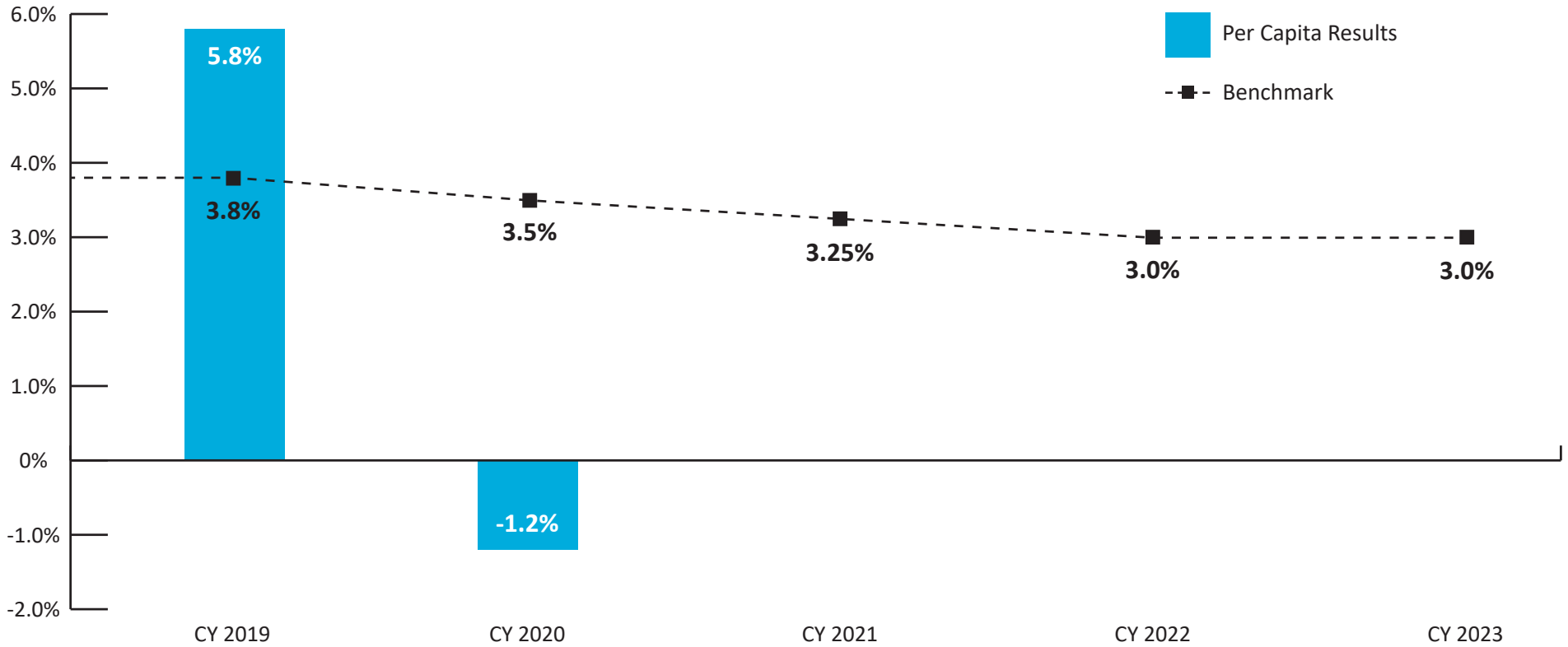


Delaware's population increased by 1.7%.

State Level Total Health Care Expenditures Spending and Per Capita Amount



Figure 3-3: State Level Total Health Care Expenditures, Change in Per Capita versus Spending Benchmark



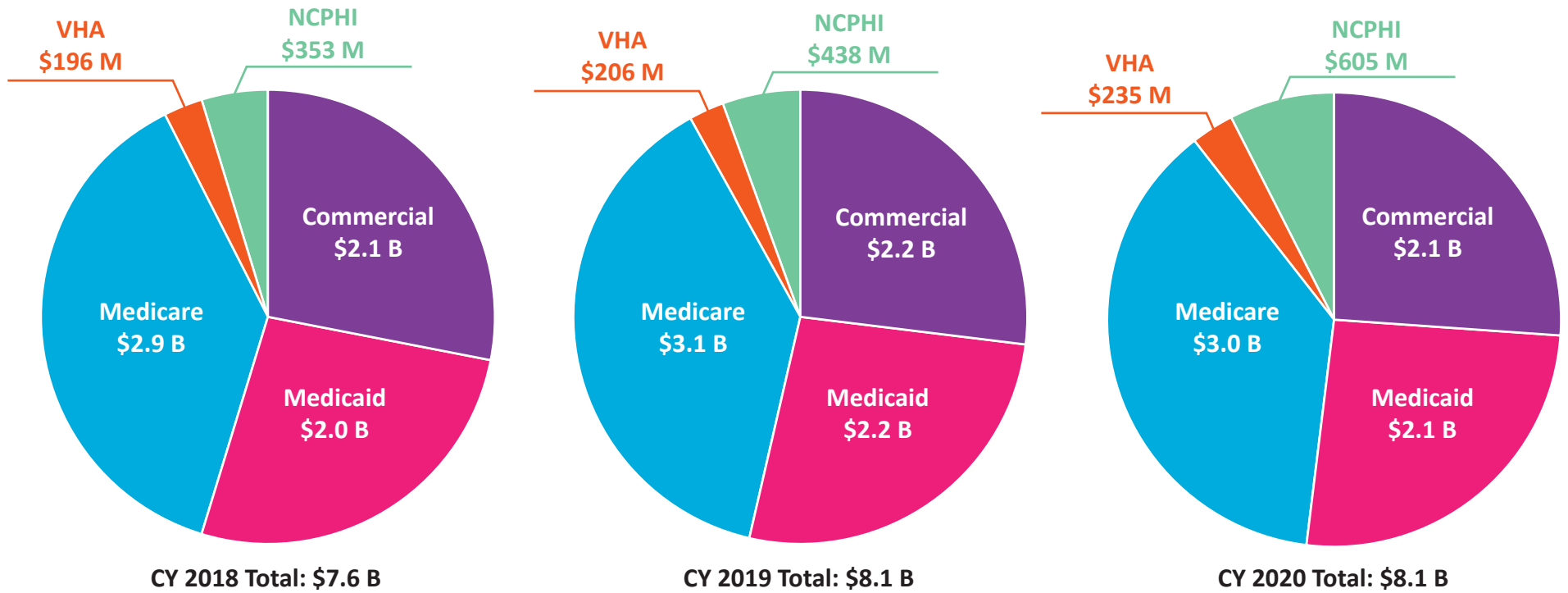
1.2%

On a per capita basis, THCE decreased 1.2% relative to the CY 2020 spending benchmark of 3.5%.

State Level Spending by Total Health Care Expenditures Component



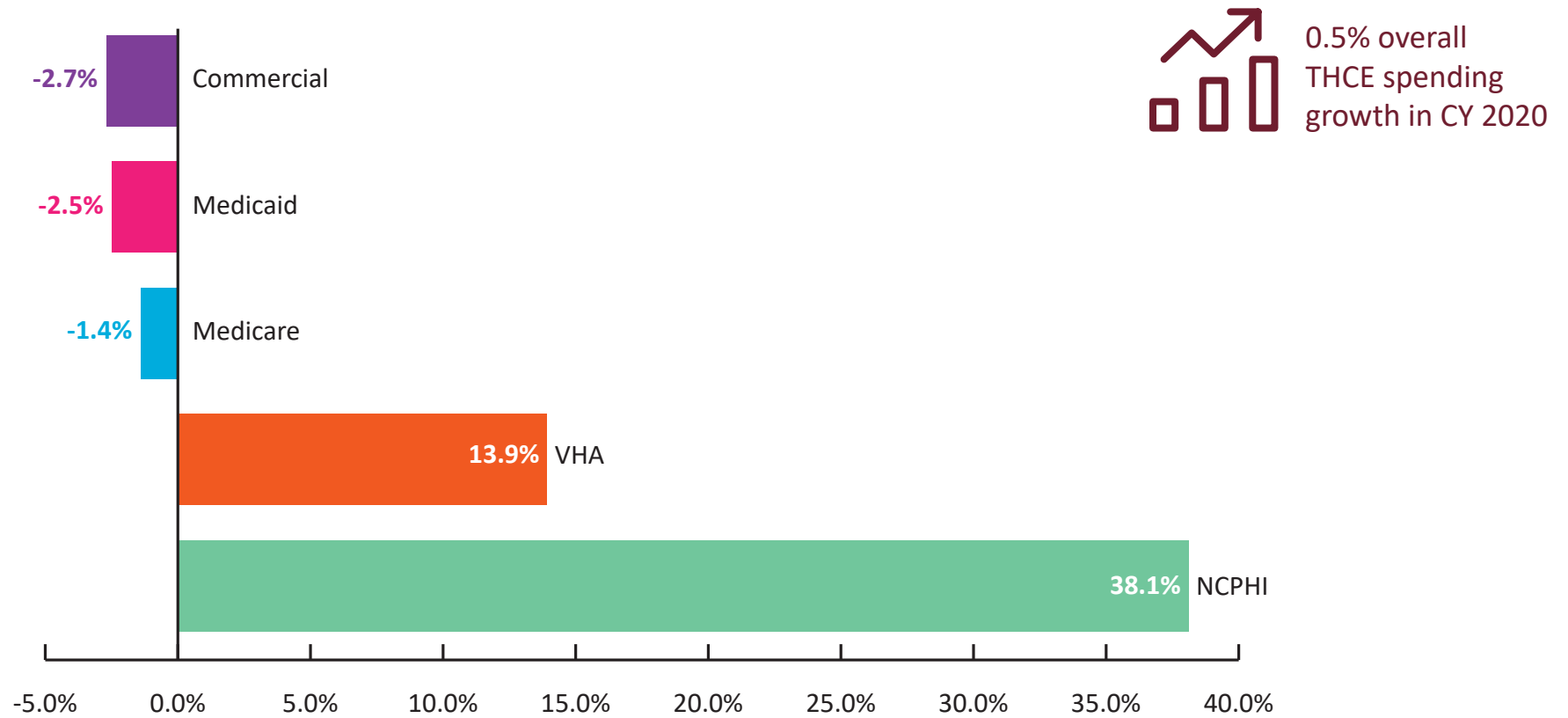
Figure 3-4: Total Health Care Expenditures, Statewide THCE by Component



The Medicare market (inclusive of FFS and managed care) was the largest component of all health care spending.



Figure 3-5: Total Health Care Expenditures, Annual Change in Statewide THCE by Component



NCPHI had the largest reported increase in THCE spending at 38.1% in CY 2020.

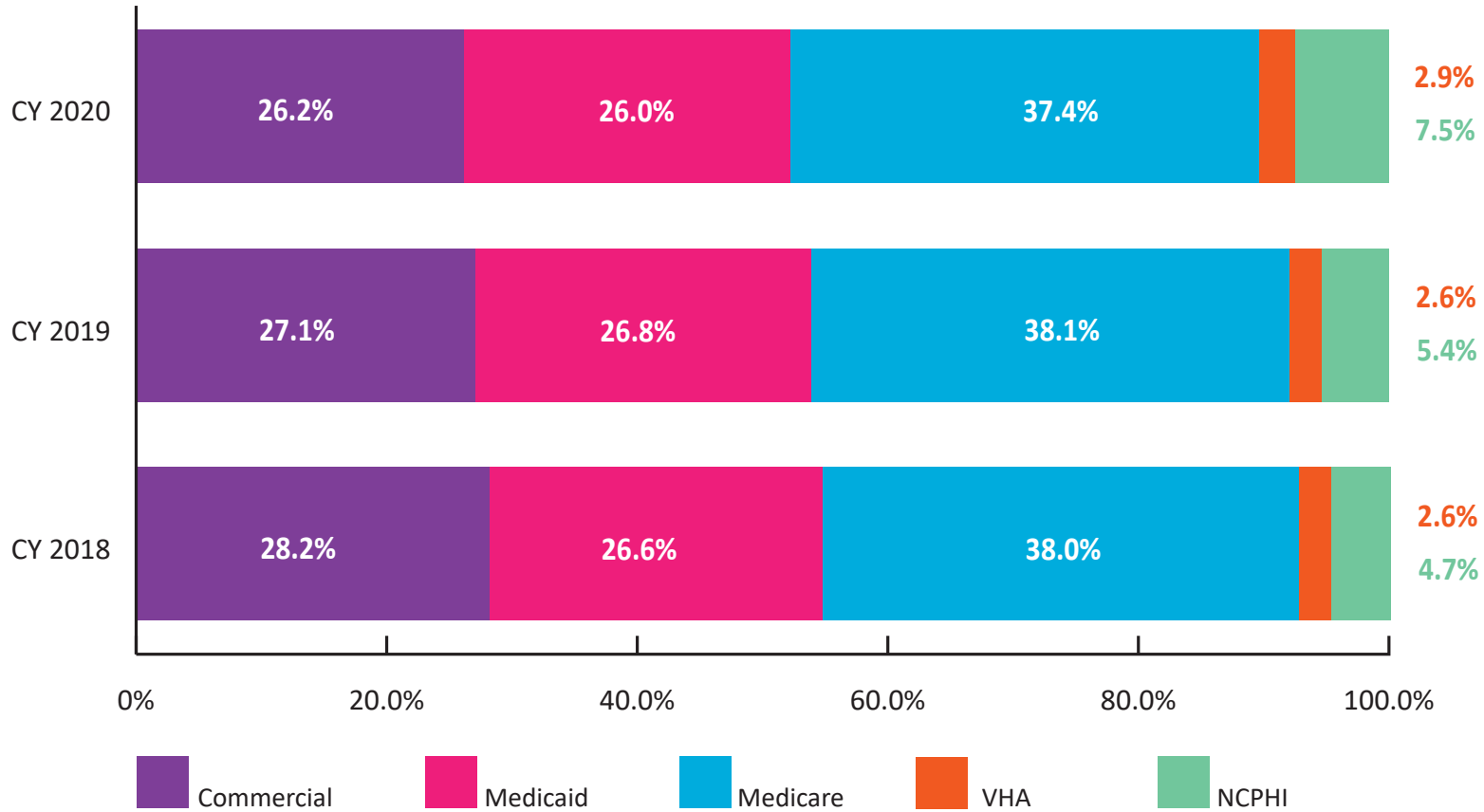


Variations in each Component share of THCE is expected as enrollment and spending patterns vary from year to year.

State Level Total Health Care Expenditures Spending by Component



Figure 3-6: Total Health Care Expenditures, Proportion of State Level THCE by Component



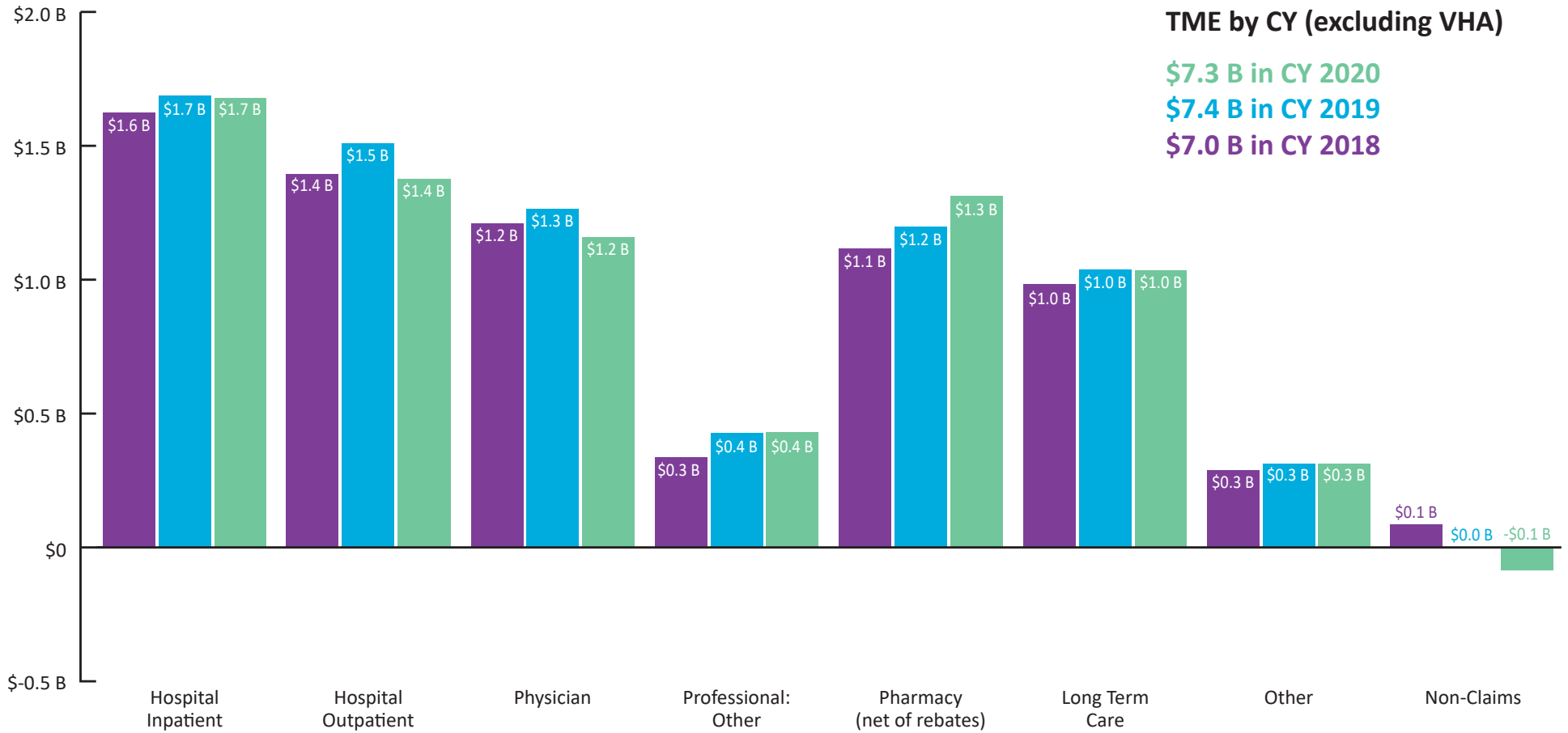
By Component, the proportion of THCE remained relatively consistent between CY 2018 and CY 2020.



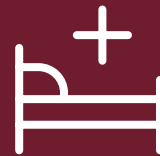
The VHA remained the smallest component of all health care spending, representing 2.9% of THCE in CY 2020.



Figure 3-7: State Level TME by Service Category (excluding VHA)



TME decreased 2.1% in total in CY 2020.

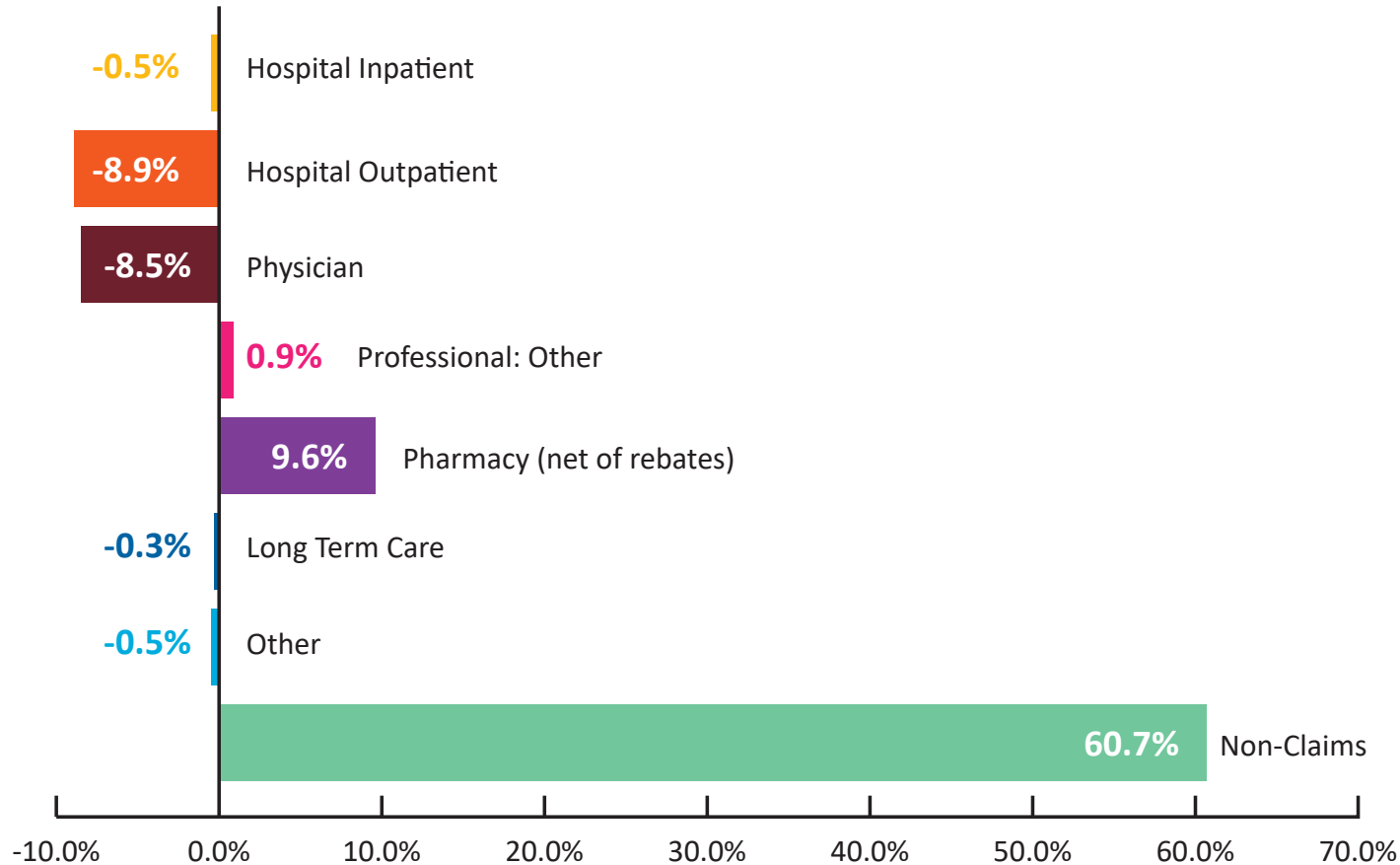


Hospital Inpatient continues to be the largest, single TME service category.

State Level Total Medical Expense Spending by Major Service Category



Figure 3-8: CY 2020 Change in State Level TME by Service Category (excluding VHA)



Non-Claims spending had the largest percentage change going from -\$33 million in CY 2019 to -\$53 million in CY 2020.



Pharmacy spending (net of rebates) increased the most in CY 2020 among the claims categories.

4. Spending Data: Market Level



For purposes of this section of the Report, DHCC is including summaries of the benchmark spending data on the four Markets for which data was collected:

- Commercial
- Medicare (managed care and FFS)
- Medicaid (managed care and FFS)
- VHA

In the Commercial market, the insurers offer different insurance products/coverages (e.g., fully insured, self-insured, preferred provider organizations, etc.). NCPHI is only applicable to insurers.

In the Medicaid market, the vast majority of individuals are mandatorily enrolled in managed care resulting in most spending being reported by the two insurers under contract with DMMA. However, DMMA did provide Medicaid FFS spending information on individuals not enrolled in managed care as well as FFS spending on services that are excluded from managed care (e.g., pediatric dental services). NCPHI is not applicable to the Medicaid FFS data.

In the Medicare market, the majority of spending is through the traditional FFS program and hence provided by CMS. Medicare managed care (i.e., Medicare Advantage) spending data was also provided by some insurers. Since CMS did not provide any pharmacy rebate information, the rebates reported by insurers is used to at least partially account for some level of Medicare pharmacy rebates. NCPHI is not applicable to the Medicare FFS data.

The VHA market has limited data available and thus only aggregate health care spending is obtainable. NCPHI is not applicable to the VHA data.

Per member per year (PMPY) values were computed as total CY expenditures divided by estimated number of members in the respective CY.



CY 2020 TME decreased by \$128 million



TME decreased in all Markets except VHA



Using a revised methodology for computing NCPHI for CY 2020 and CY 2019, NCPHI increased by \$167 million

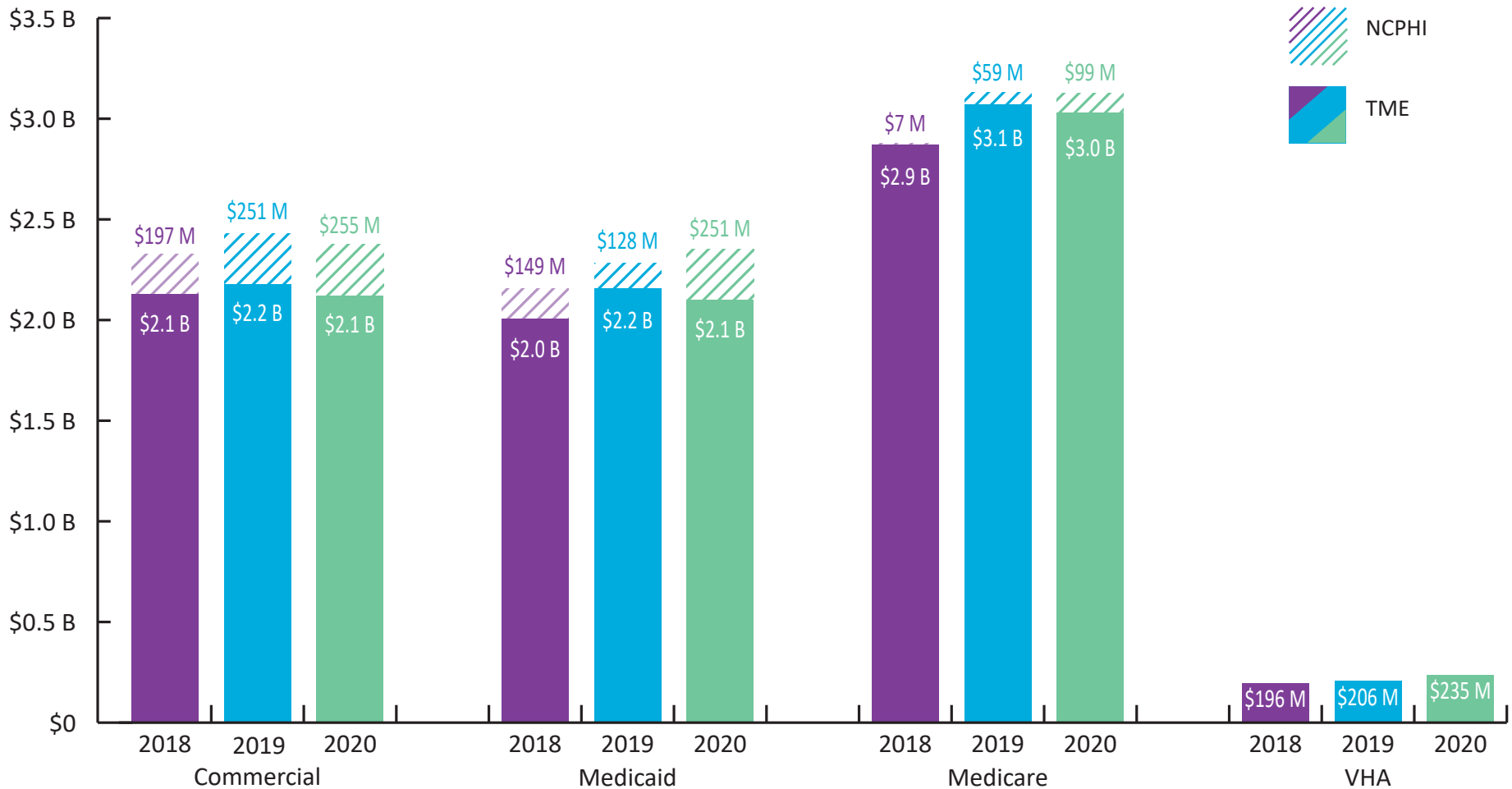


Excluding VHA, the Medicare Market had the largest per capita change in THC with a 3.5% decrease

Market Level Total Health Care Expenditures Spending



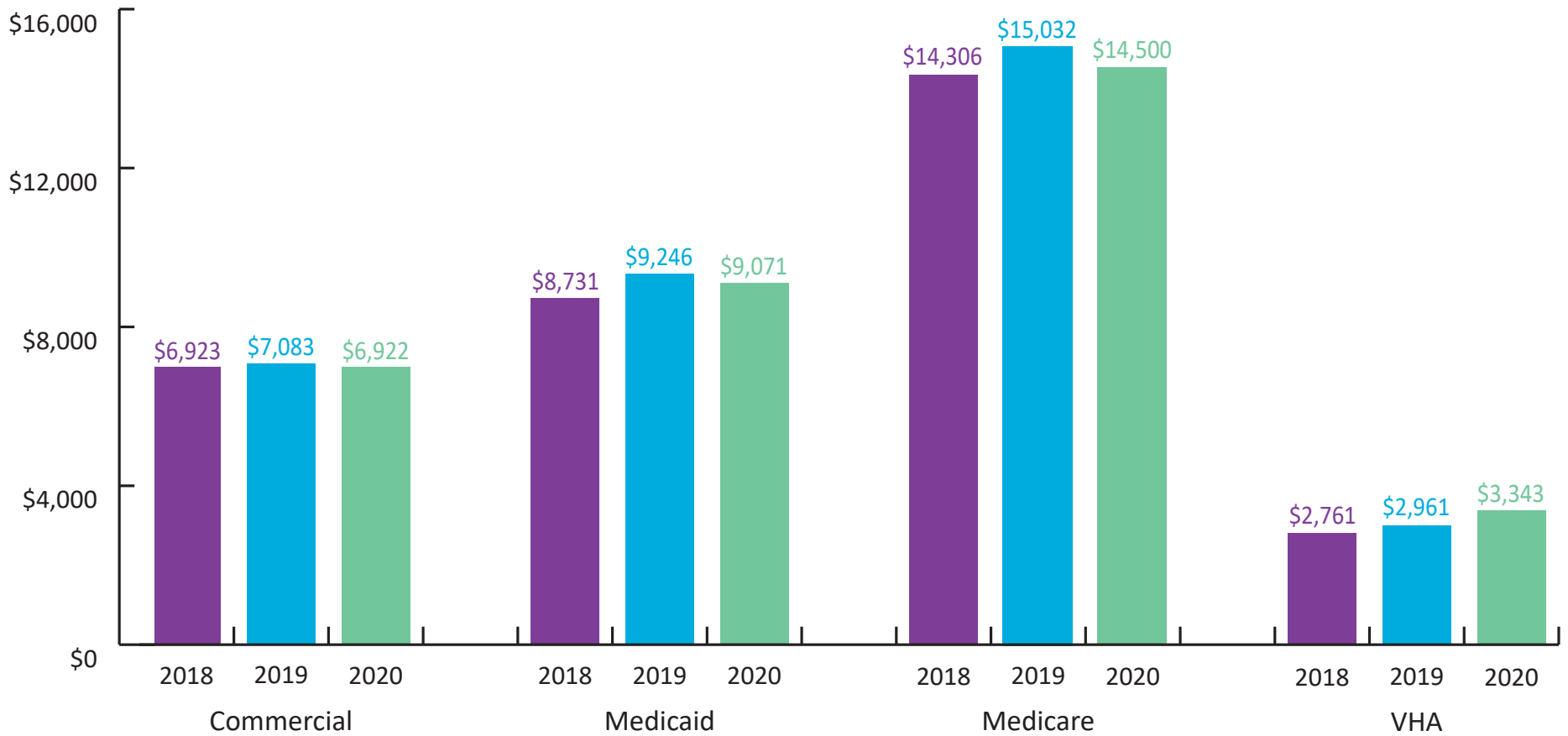
Figure 4-1: Total Health Care Expenditures, Total Spending by Market



TME decreased in CY 2020 in all Markets except the VHA.



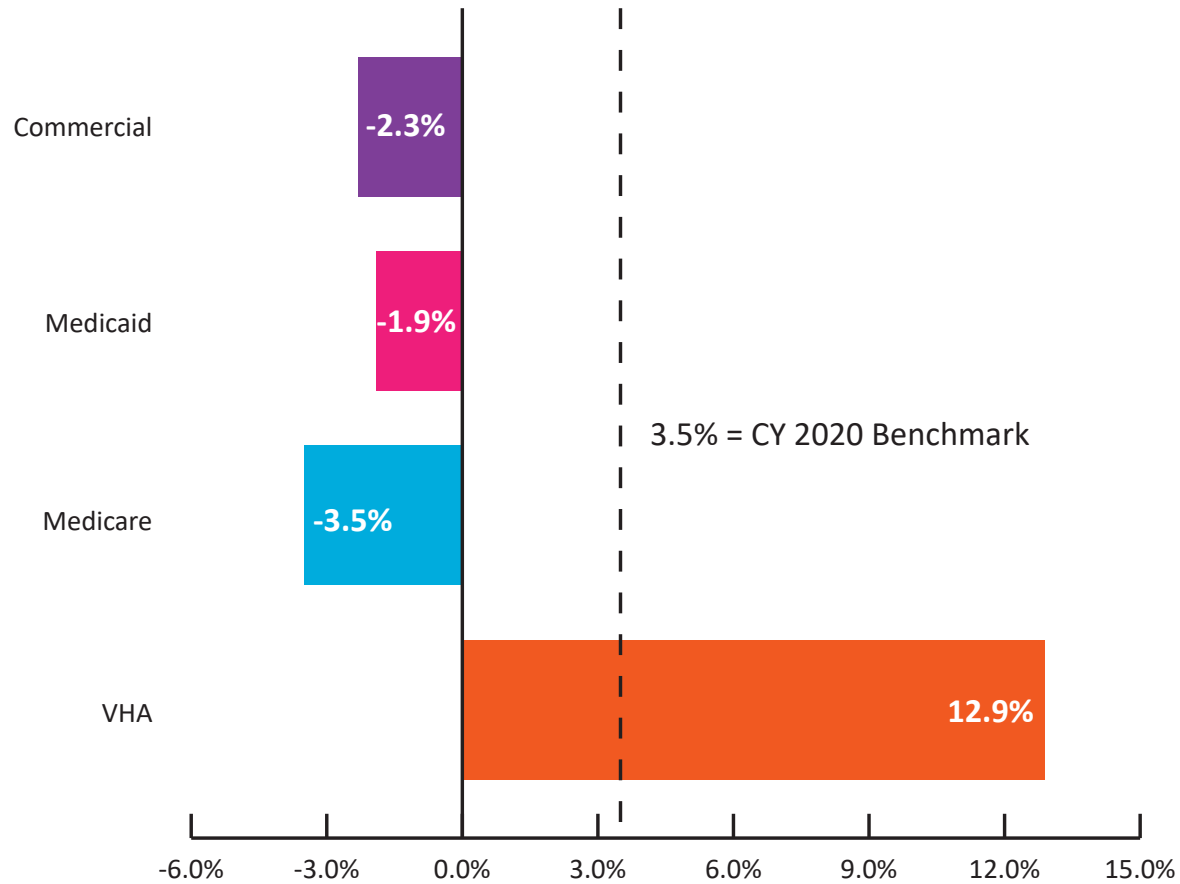
Figure 4-2: Total Health Care Expenditures, THCE Per Member Per Year by Market



Member counts were estimated for each Market to compute PMPY values. Since members may have coverage in more than one program (e.g., Medicare and Medicaid), member counts are not mutually exclusive.



Figure 4-3: Total Health Care Expenditures, CY 2020 THCE Per Member Per Year Change by Market



The THCE spending benchmark is measured at the State level as shown in Figure 3-3.

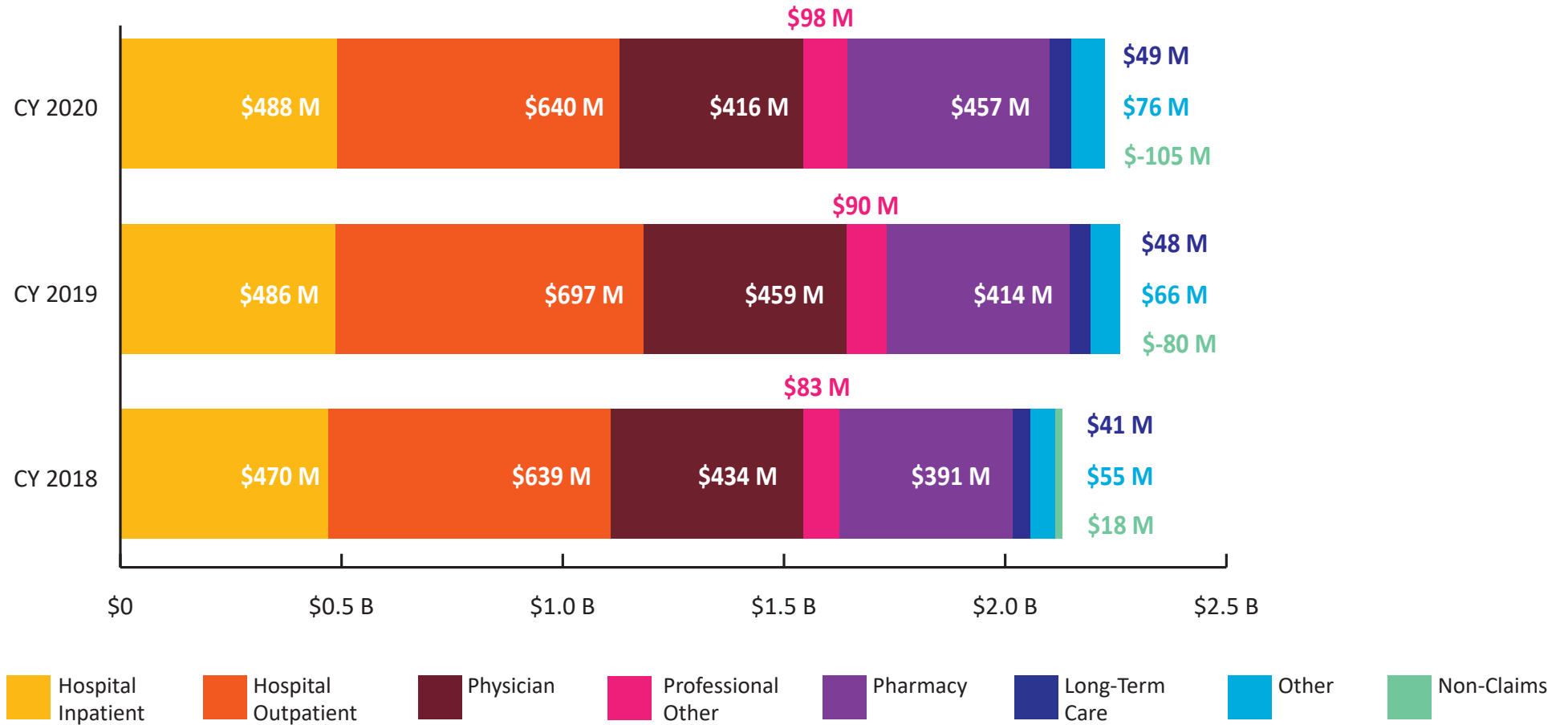


The CY 2020 THCE per member per year change at the Market level is provided for informational purposes only.

Market Level TME Spending by Major Service Category—Commercial Market



Figure 4-4: TME by Service Category – Commercial Market



Commercial Market

2.7%

TME decreased 2.7% in total in CY 2020.

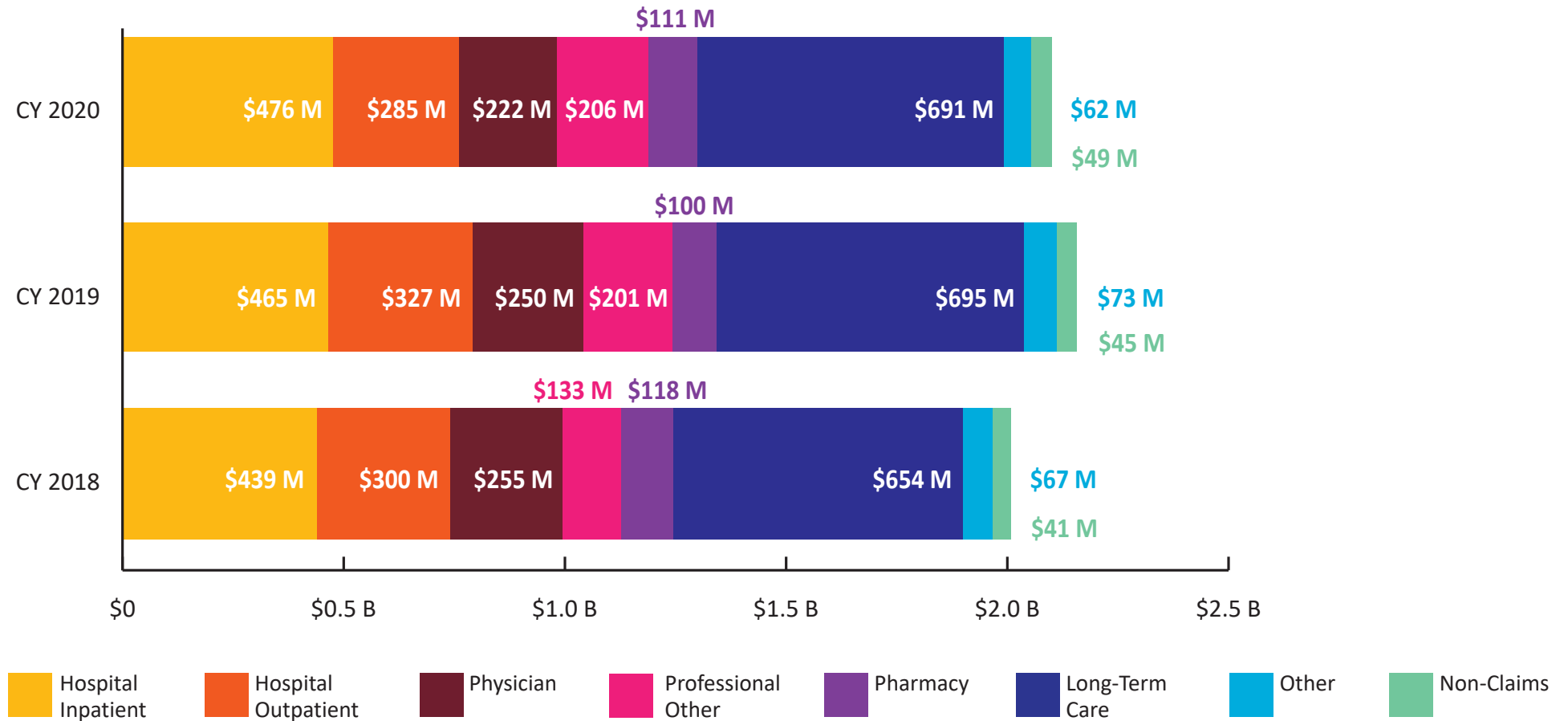
\$

\$2.1 B in CY 2020 TME spend versus \$2.2 B in CY 2019.



Market Level TME Spending by Major Service Category—Medicaid Market

Figure 4-5: TME by Service Category – Medicaid Market



2.5%
↓

TME decreased 2.5% in total in CY 2020.

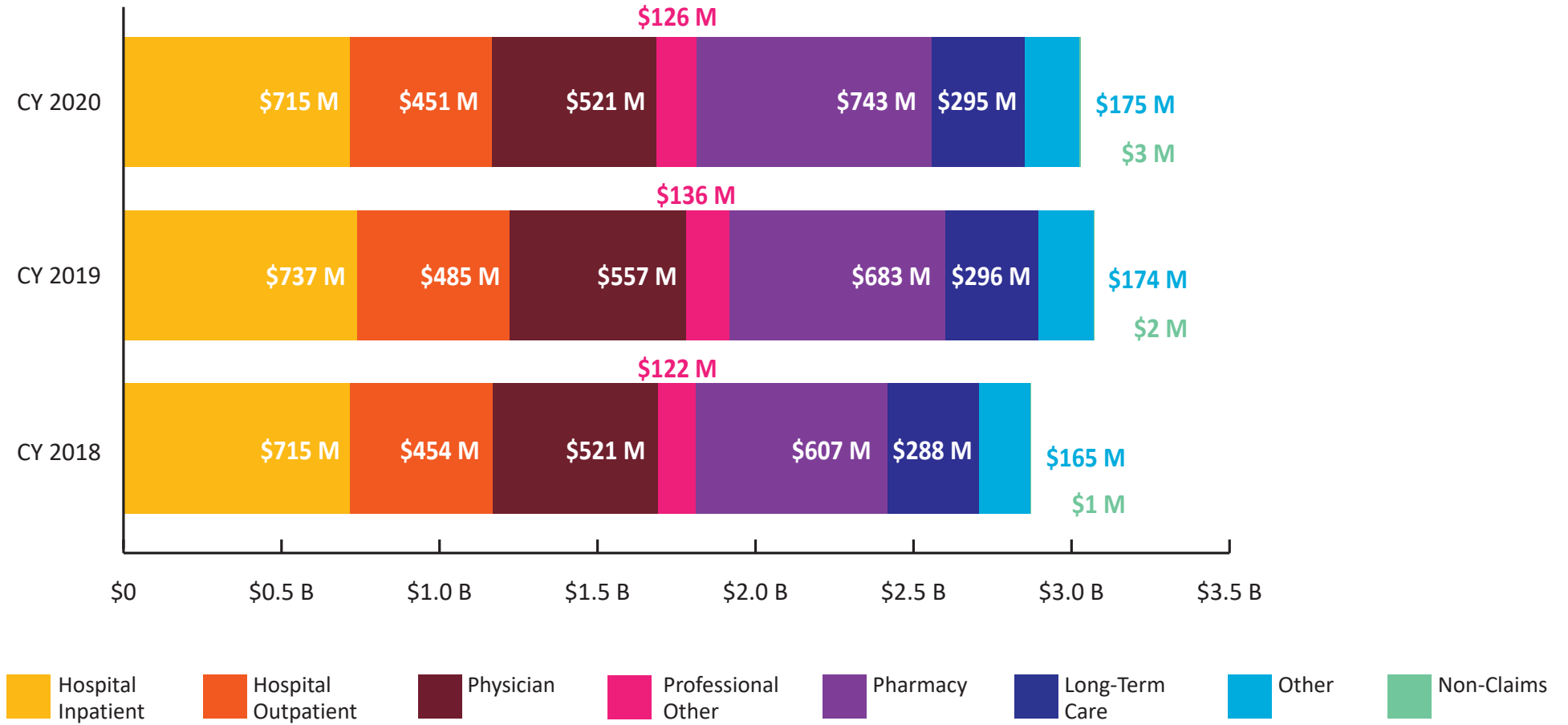


\$2.1 B in CY 2020 TME spend versus \$2.2 B in CY 2019.

Market Level TME Spending by Major Service Category—Medicare Market



Figure 4-6: TME by Service Category – Medicare Market



Medicare Market

1.4%

TME decreased 1.4% in total in CY 2020.

\$3.0 B in CY 2020 TME spend versus \$3.1 B in CY 2019.

5. Spending Data: Insurer Level



The five major health insurers in Delaware all voluntarily provided benchmark spending data as requested by the DHCC. This data included both fully-insured and self-insured programs. Each insurer attested to the accuracy and completeness of their data and each were given an opportunity to review their data for inclusion in this public report.

At an insurer level, changes in the health risk of the respective insurer's member population can change from year-to-year impacting spending levels. A higher risk population is expected to incur higher costs than a lower risk population all else being equal. Therefore, the spending data contained in this section of the Report has been adjusted based on the estimated health risk of each insurer's member population. Since different insurers used different risk adjustment models, results are not directly comparable across insurers. The reader should focus on comparisons of the same insurer for the data provided in this Section of the Report.

Aggregate spending by insurer is a function of the size of the insurer's membership. Insurers with more members are likely to have more spending relative to smaller insurers. On a per member basis, the relative size of each insurer is normalized to a degree.



On a HRA-basis, CY 2020 TME decreased by \$98 million in total for all insurers



CY 2020 NCPHI increased by \$167 million in total for all insurers



Highmark continues to be the largest single Delaware insurer



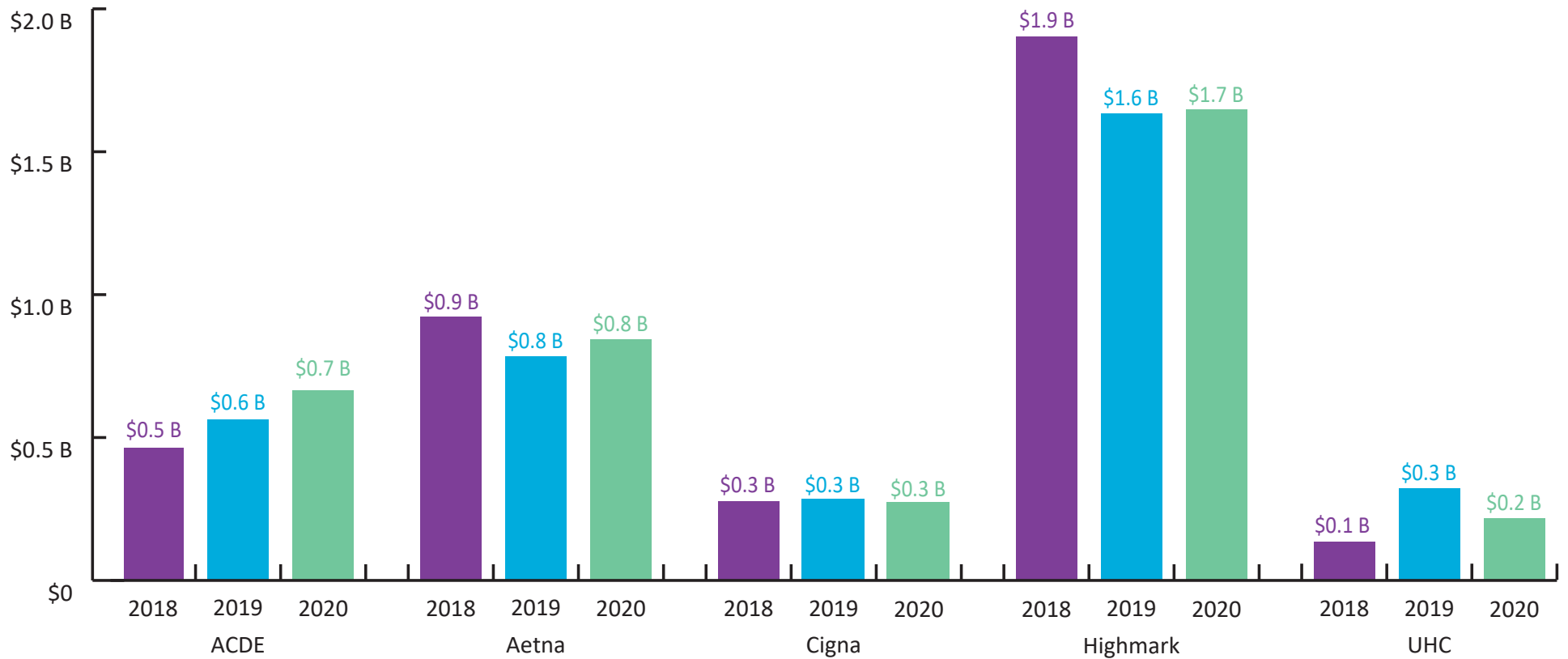
ACDE, Cigna and UHC all reported a decrease in their respective CY 2020 THCE PMPYs



Aetna and Highmark reported an increase in their respective CY 2020 THCE PMPYs



Figure 5-1: Total Health Care Expenditures, Health Risk Adjusted THCE by Insurer



18.3%

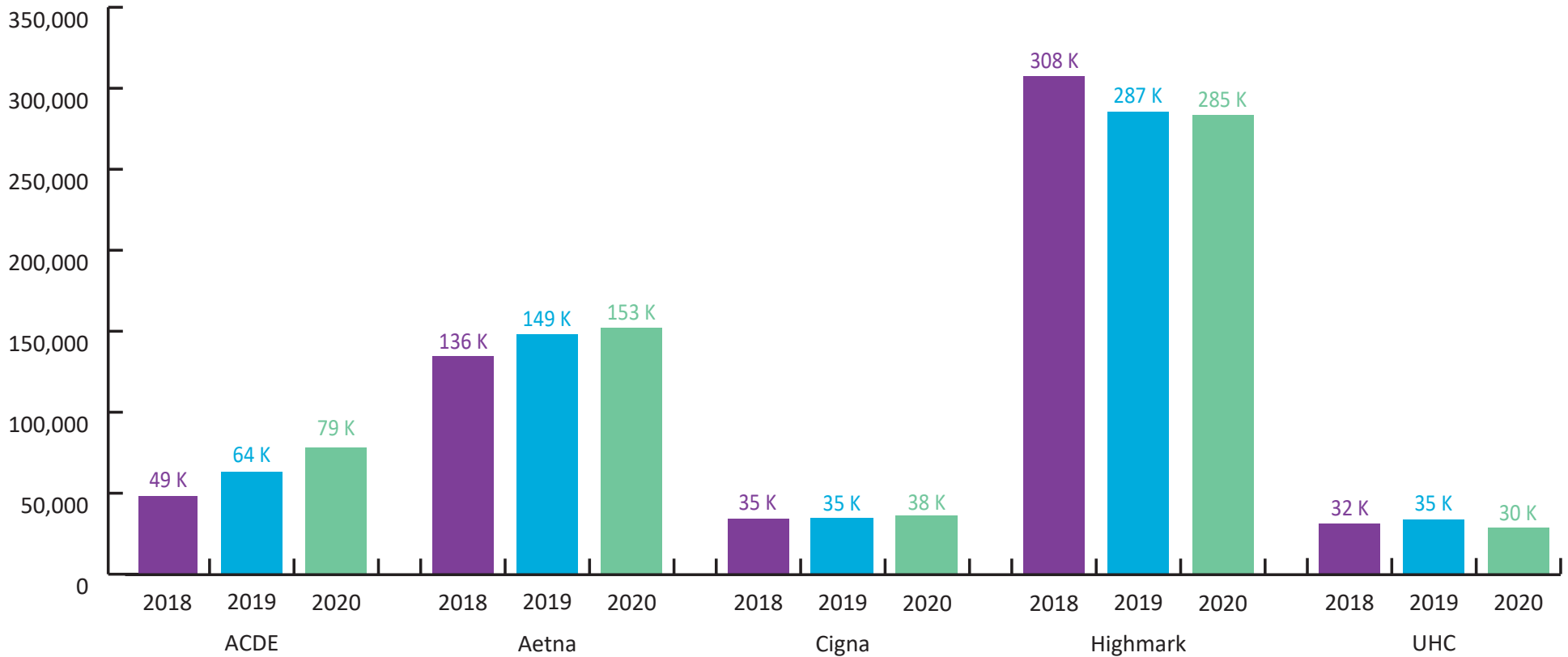
ACDE has the largest increase in HRA THCE at 18.3%, drive in large part by membership growth.



Highmark was the largest insurer in Delaware in terms of HRA THCE in all CYs.



Figure 5-2: Estimated Membership by Insurer



23.6%

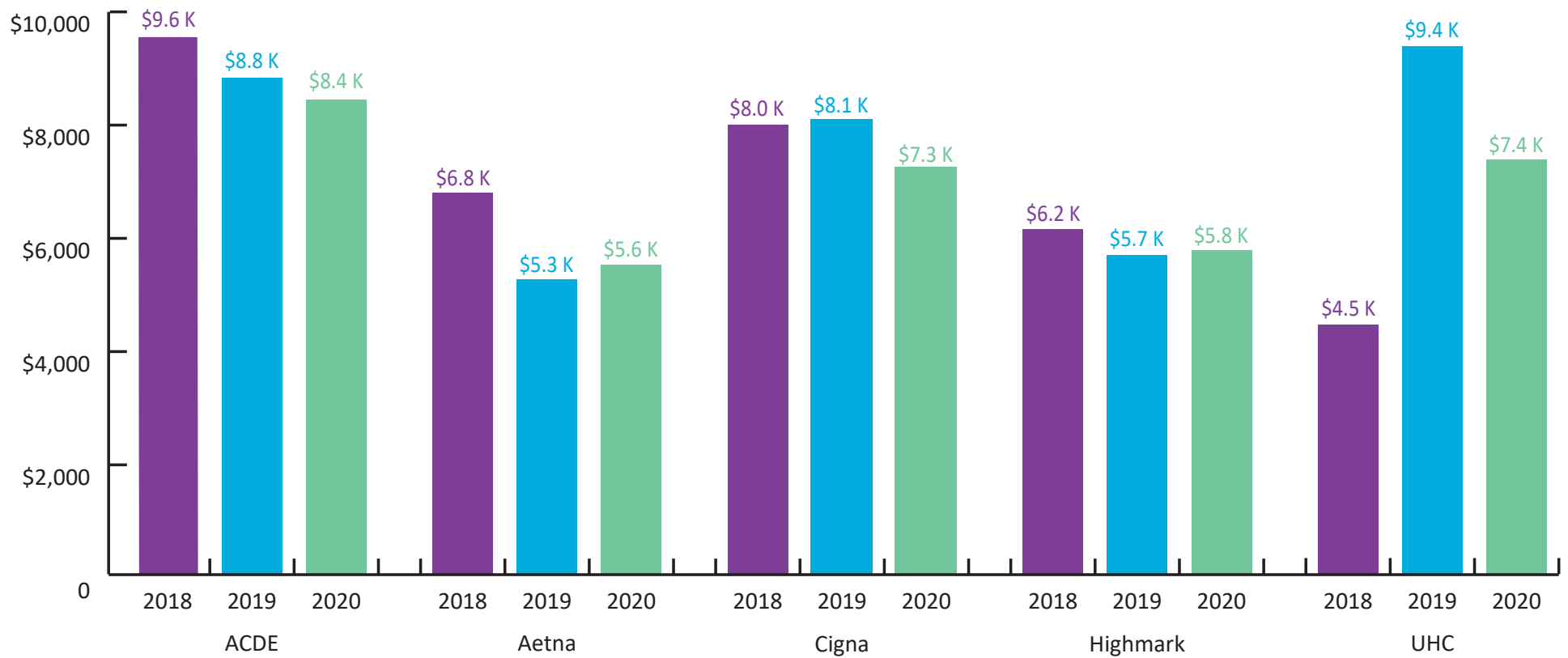
Estimated membership in ACDE, a Medicaid managed care only insurer, increased 23.6% in CY 2020.

0.5%

Membership in Highmark, a multi-line insurer, decreased by 0.5% in CY 2020.



Figure 5-3: Total Health Care Expenditures, Health Risk Adjusted THCE PMPY by Insurer



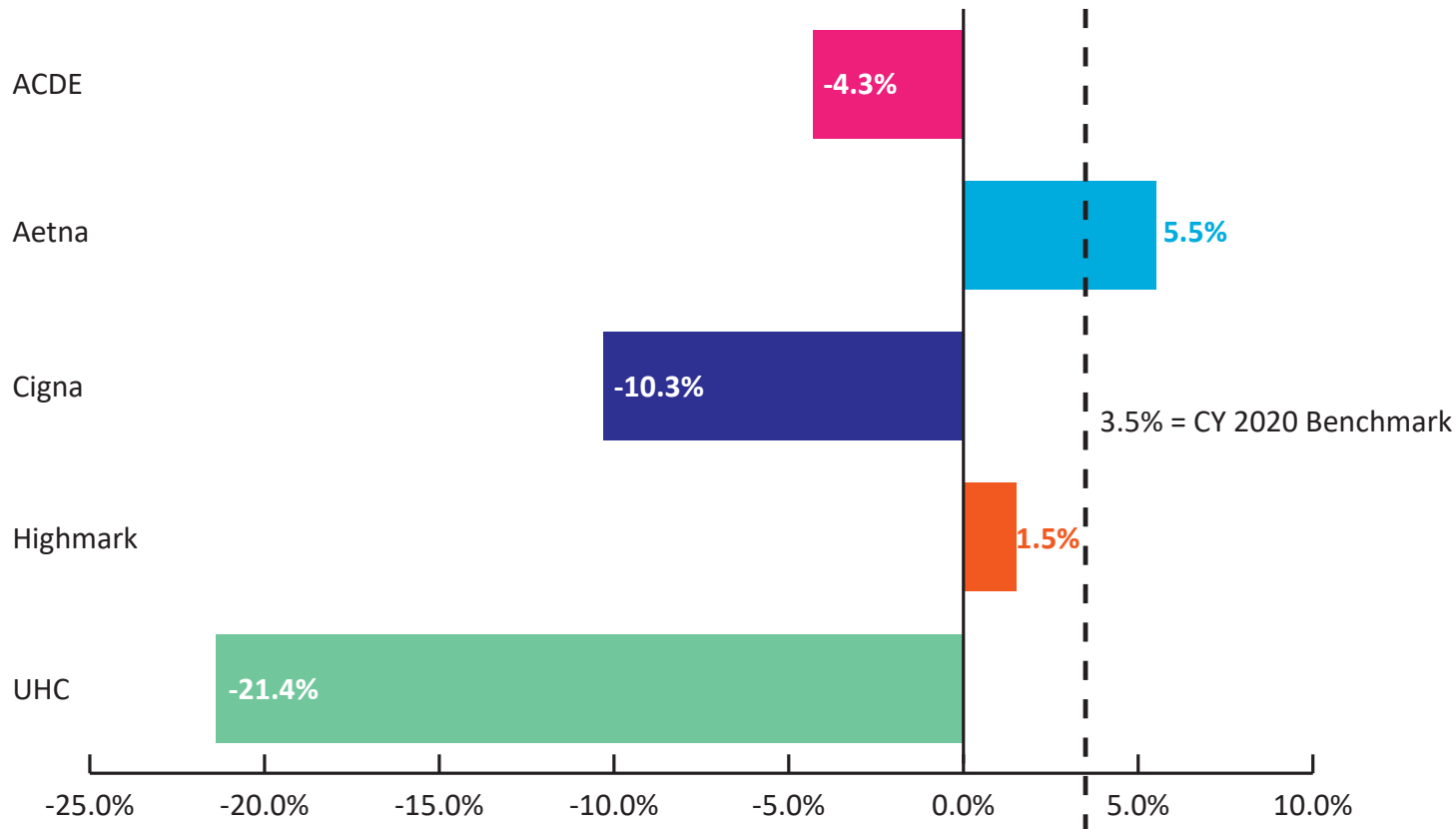
Data reflects all lines of business reported by each insurer. Insurers do not have all the same lines of business (e.g., ACDE is a Medicaid-only insurer).



UHC has the smallest estimated membership, but had the largest percentage increase in HRA PMPY.



Figure 5-4: Total Health Care Expenditures, CY 2020 Change in Health Risk Adjusted THCE PMPY by Insurer



The THCE per capita change relative to the benchmark is measured at the State level and was 3.5% in CY 2020 as shown in Figure 3-3.



The CY 2020 HRA THCE PMPY change at the insurer level is provided for informational purposes only.

6. Net Cost of Private Health Insurance (NCPHI)



NCPHI measures the costs to Delaware residents associated with the administration of private health insurance.

NCPHI is broadly defined as the estimated difference between health premiums earned and benefits incurred and consists of insurers' costs of processing claims, advertising/marketing, staff salaries, commissions, other administrative costs, premium taxes and any applicable profits or losses.

NCPHI is only applicable to insurers. NCPHI is not reported by CMS for the Medicare market nor DMMA for the Delaware Medicaid FFS program. If an insurer participates in Medicare Advantage and/or Delaware's Medicaid managed care program, the NCPHI applicable to those lines of business are included herein.

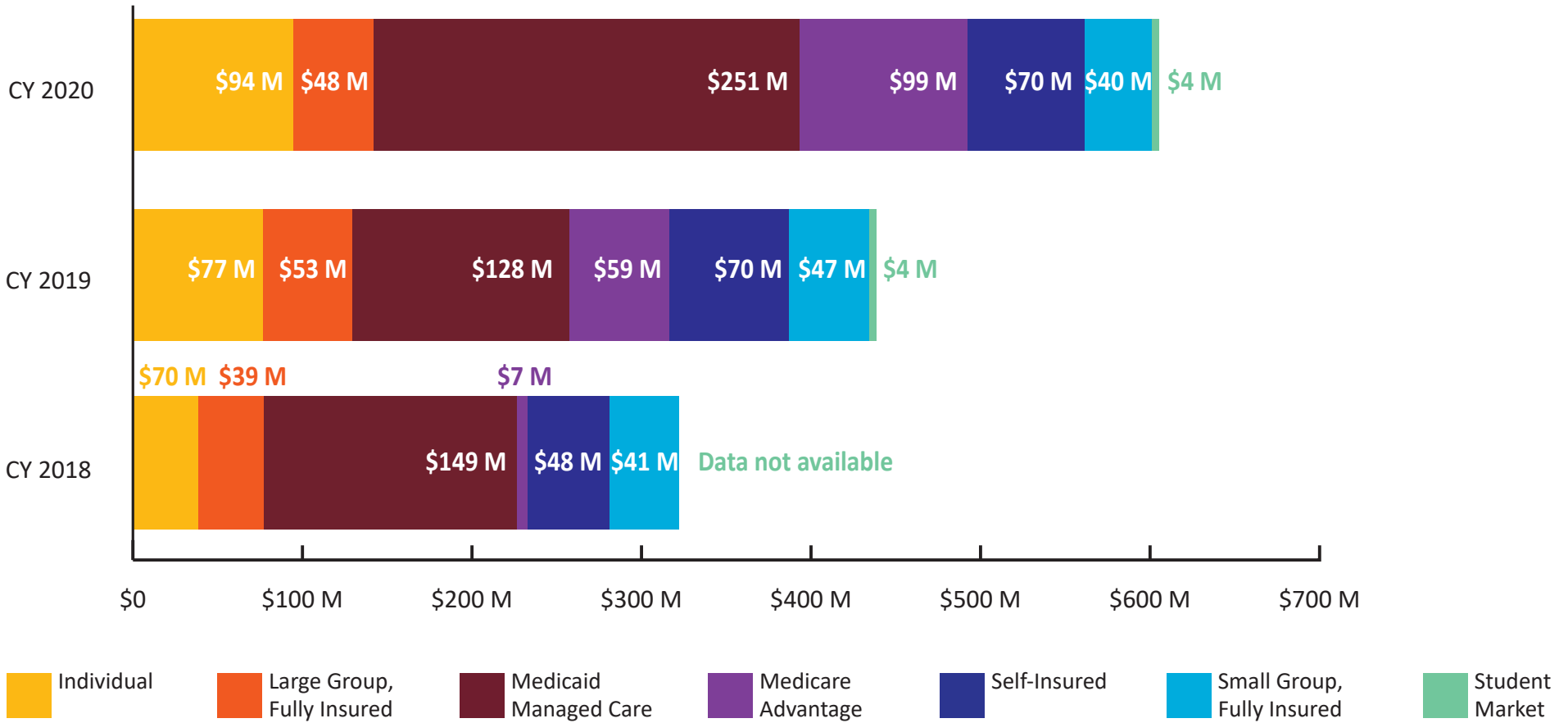
For insurers that have multiple lines of business, NCPHI is computed for each line of business and then aggregated across all insurers in that respective line of business.

As part of the CY 2020 benchmark data collection cycle, DHCC revised the process for collecting data to compute NCPHI. Each insurer was asked to provide by line of business their respective Premium Revenues and Total Net Paid Expenditures for purposes of computing NCPHI. The purpose of this change was to standardize and simplify the methodology for computing NCPHI and rely on data submitted by each insurer. Accordingly, the CY 2020 and CY 2019 NCPHI figures are comparable, however, comparisons to CY 2018 should be done with caution as CY 2018 NCPHI was determined through a different methodology.

Net Cost of Private Health Insurance Level Spending



Figure 6-1: Estimated NCPHI Amounts by Insurance Segment

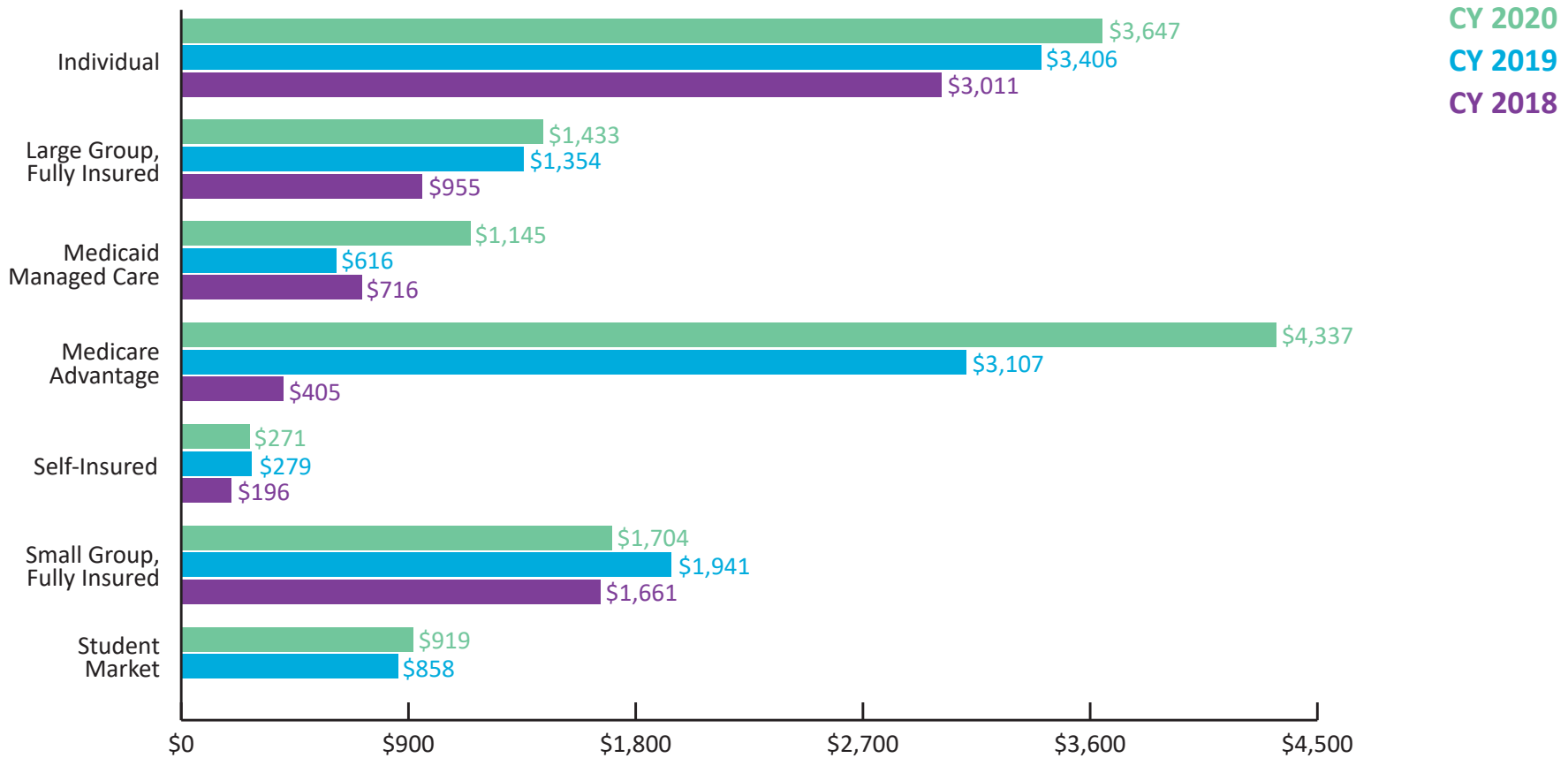


38.1%

Estimated NCPHI increased by \$167 million or 38.1% in CY 2020, totaling \$605 million.



Figure 6-2: Estimated PMPY NCPHI by Insurance Segment



For CY 2020, based on the available data, the Medicare Advantage market segment had the highest estimated NCPHI while the self-insured market had the lowest.

7. Quality Data

Delaware also established annual benchmarks for a select number of quality measures.



The six quality benchmarks applicable to CY 2020 and the population for which results will be evaluated relative to the respective benchmark are listed below.



Adult Obesity

Statewide population



Use of Opioids at High Dosages

Statewide population



Opioid-related Overdose Deaths per 100,000

Statewide population



Emergency Department Utilization

Commercial population only



Persistence of Beta-Blocker Treatment After a Heart Attack

Commercial and Medicaid populations, respectively



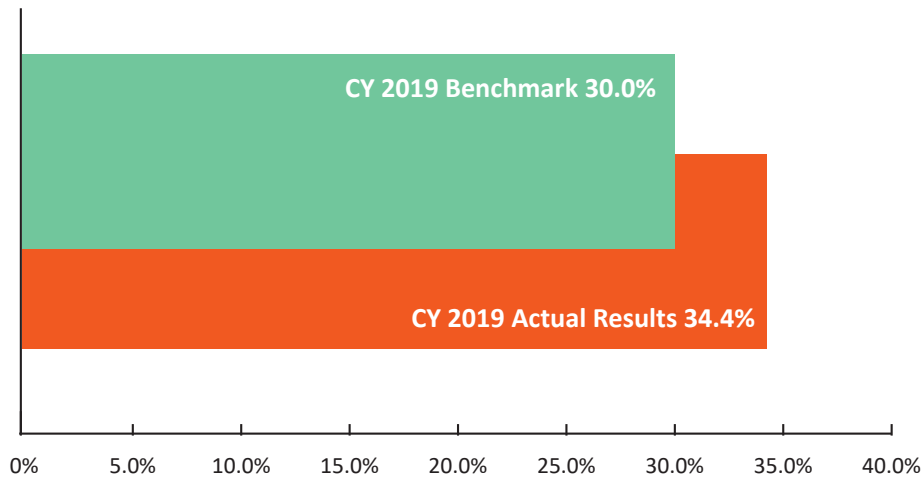
Statin Therapy for Patients with Cardiovascular Disease

Commercial and Medicaid populations, respectively

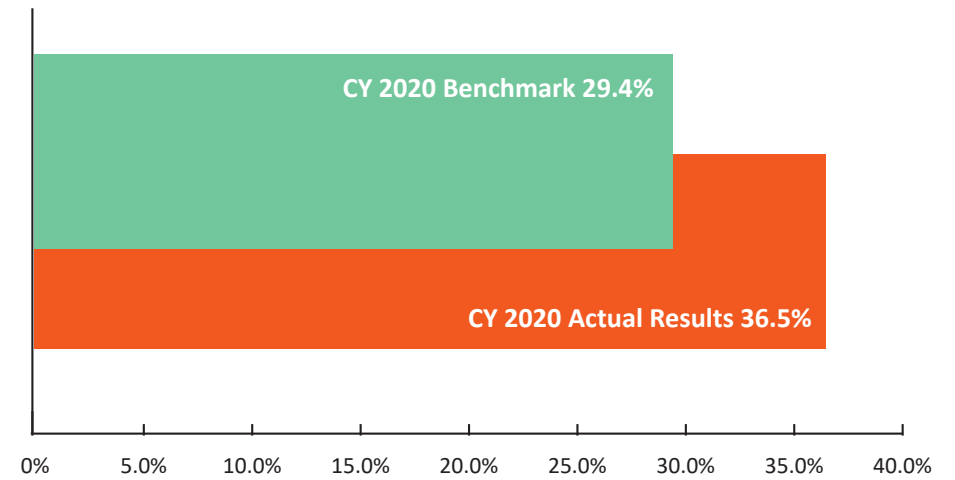


Figure 7-1: Adult Obesity

CY 2019 Actual Results versus Benchmark



CY 2020 Actual Results versus Benchmark



Adult Obesity

A lower result/score is better for this measure

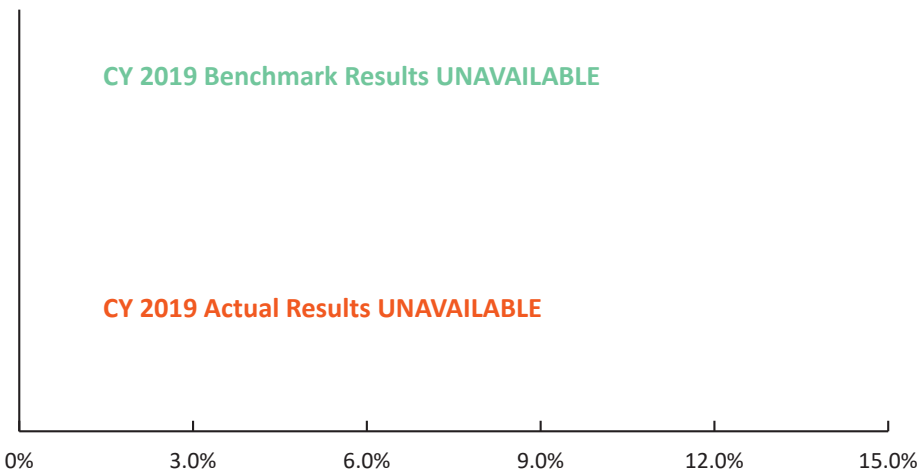
7.1% Points 

Results were 7.1 percentage points higher (worse) than the benchmark in CY 2020.

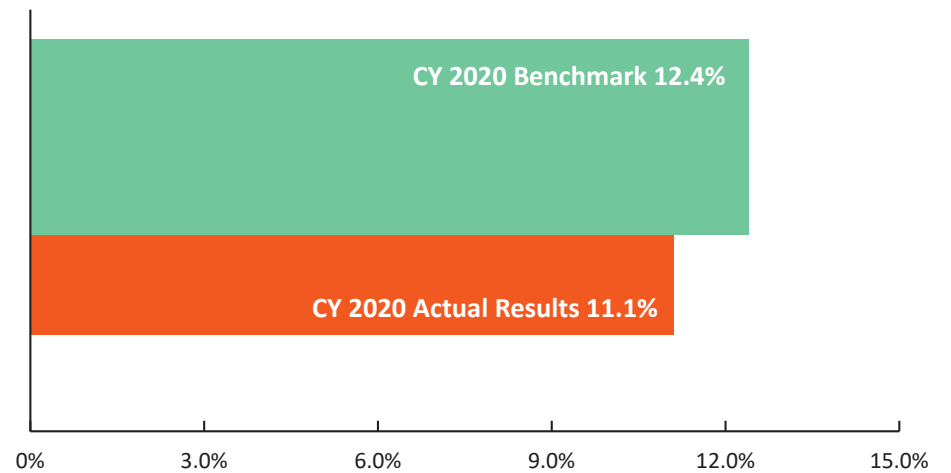


Figure 7-2: Use of Opioids at High Dosages

CY 2019 Actual Results versus Benchmark



CY 2020 Actual Results versus Benchmark



Use of Opioids at High Dosages

A lower result/score is better for this measure

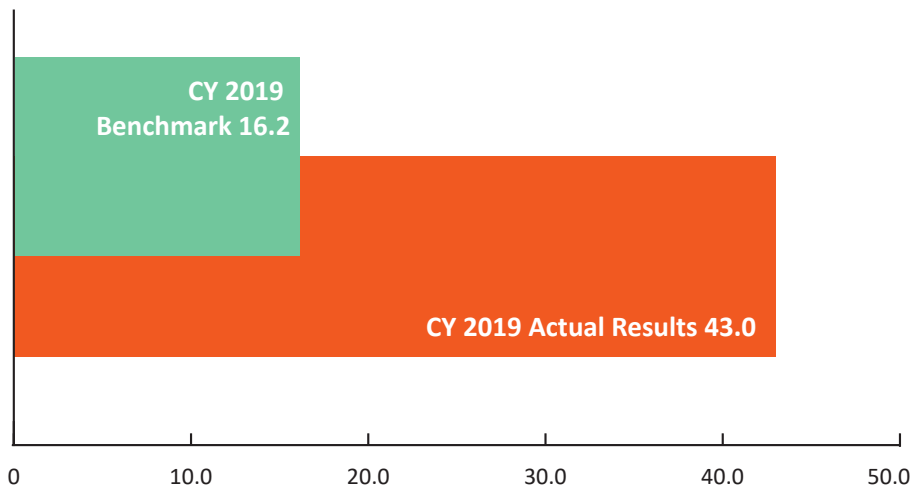
1.3% Points

Results were 1.3 percentage points lower (better) than the benchmark in CY 2020.

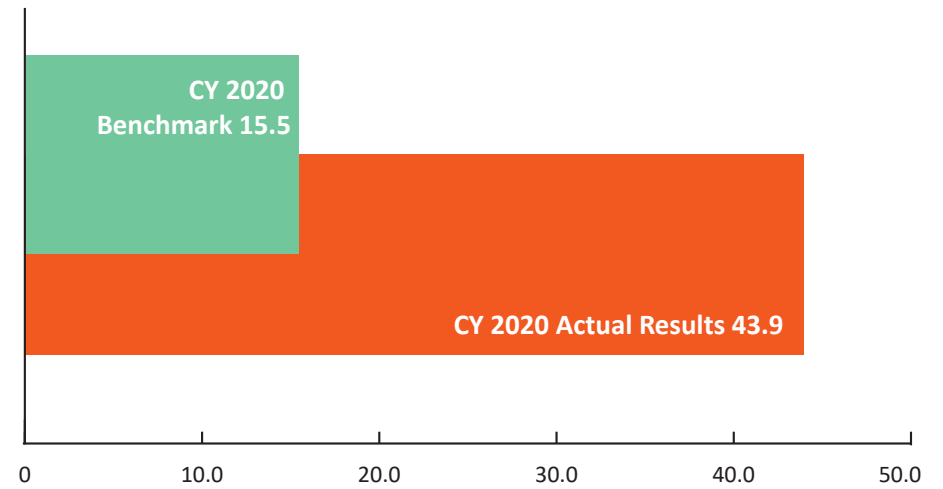


Figure 7-3: Opioid-related Overdose Deaths per 100,000 Quality Measure

CY 2019 Actual Results versus Benchmark



CY 2020 Actual Results versus Benchmark



Opioid-related Overdose Deaths per 100,000

A lower result/score is better for this measure

28.4 Deaths

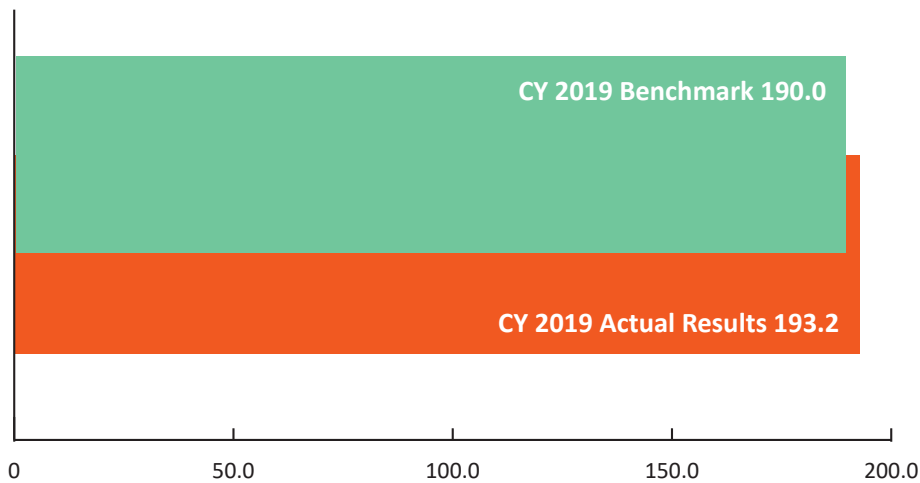


Results were 28.4 deaths per 100,000 higher (worse) than the benchmark CY 2020.

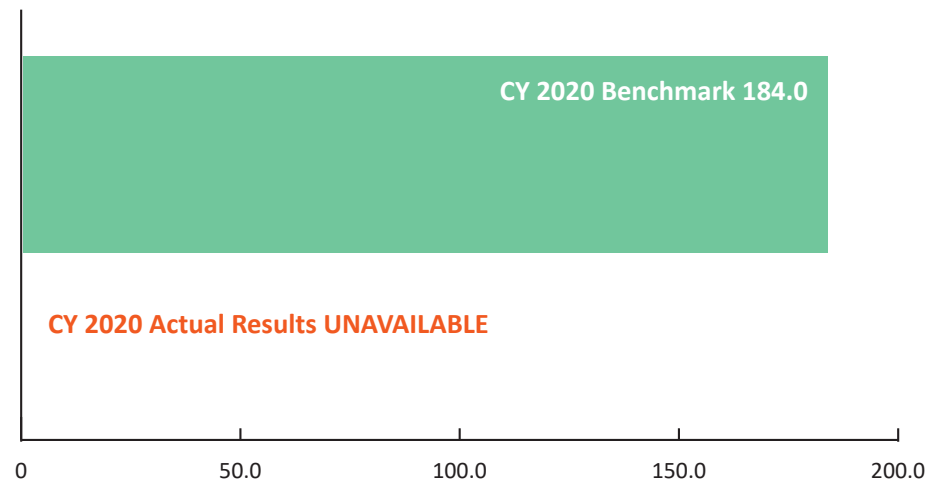


Figure 7-4: Emergency Department Utilization Quality Measure

CY 2019 Actual Results versus Benchmark



CY 2020 Actual Results versus Benchmark



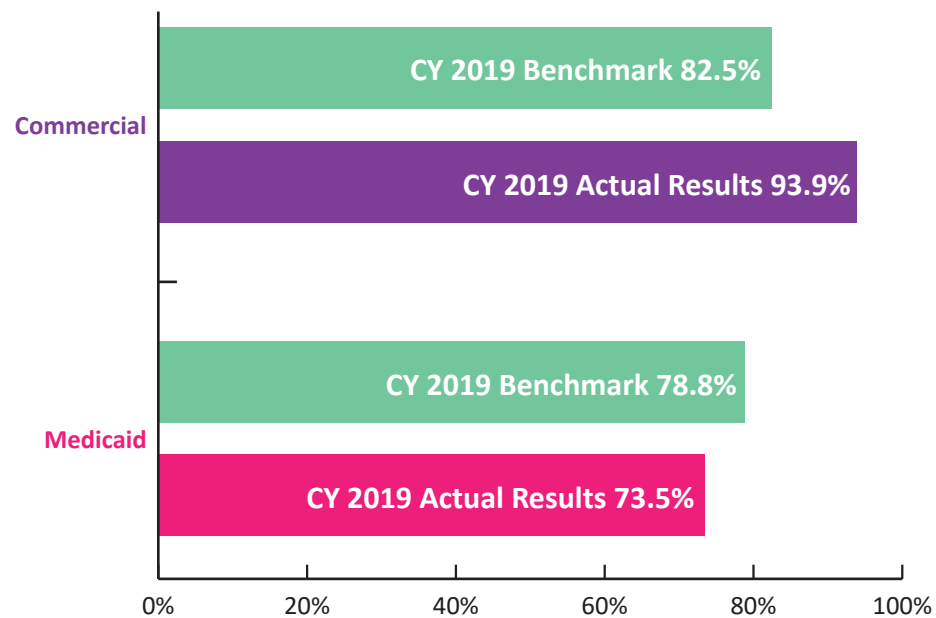
Emergency Department Utilization

Note: Per the National Committee for Quality Assurance (NCQA), the measures steward, this measure was given first year status for measure year (MY) 2020 due to significant changes in the methodology. Therefore, no public reporting of EDU data for CY 2020 was available.

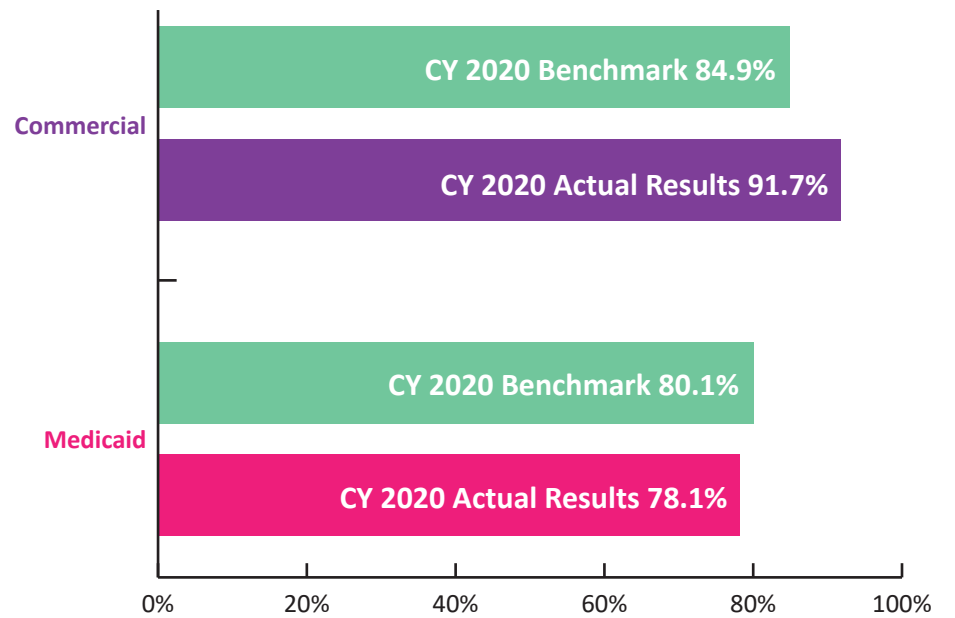


Figure 7-5: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure

CY 2019 Actual Results versus Benchmark



CY 2020 Actual Results versus Benchmark



Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result/score is better for this measure



The Medicaid market was 2 percentage points lower (worse) than the CY 2020 benchmark.

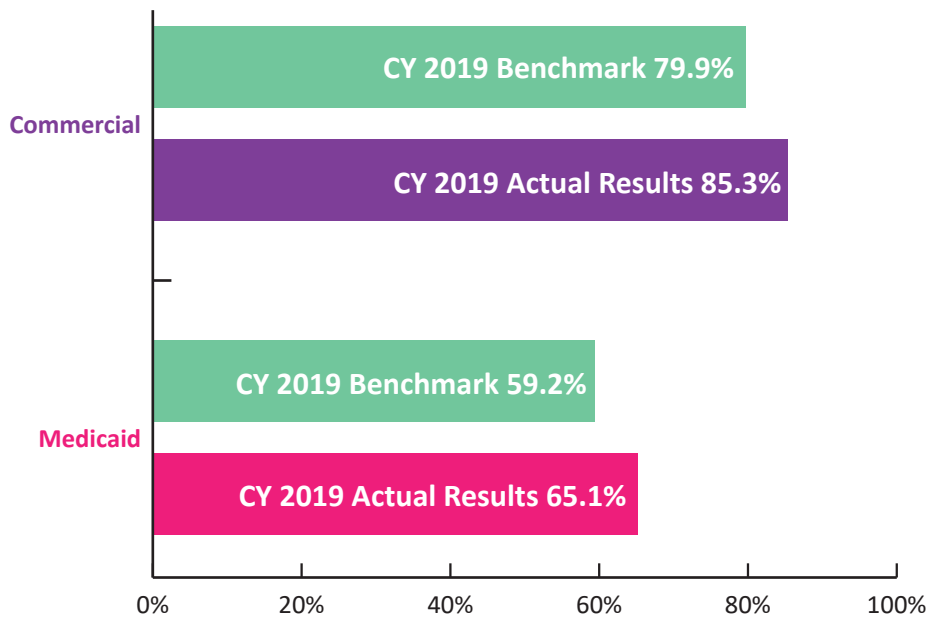


The Commercial market was 6.8 percentage points higher (better) than the CY 2020 benchmark.

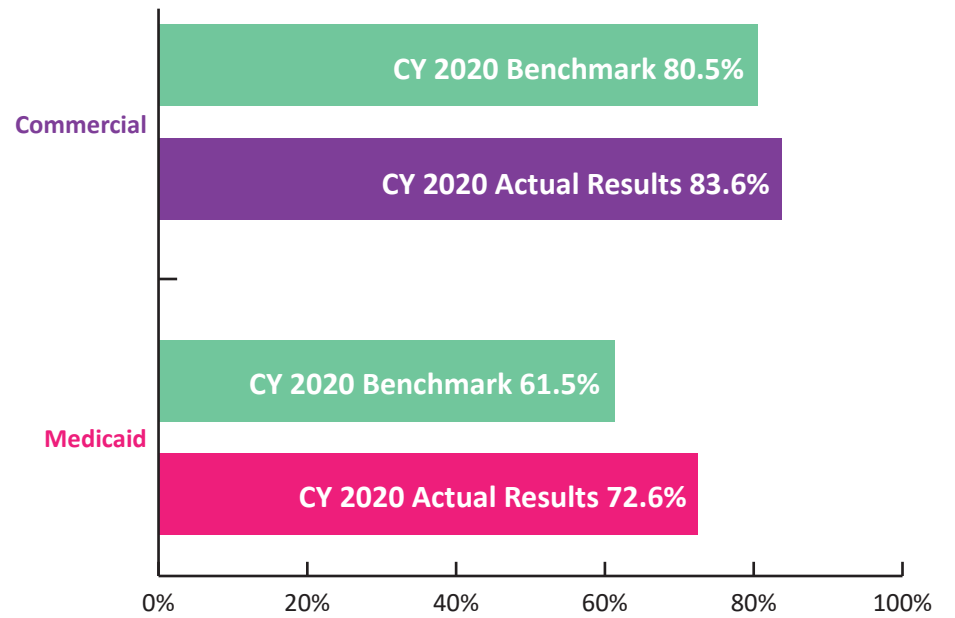


Figure 7-6: Statin Therapy for Patients with Cardiovascular Disease Quality Measure

CY 2019 Actual Results versus Benchmark



CY 2020 Actual Results versus Benchmark



Statin Therapy

A higher result/score is better for this measure



For both markets, results were higher (better) than the respective benchmark in CY 2020.

Insurer-specific Quality Measure Results



For the three quality measures specific to the Commercial and/or Medicaid managed care markets, insurer-specific results can be computed from the data provided. The respective quality benchmarks are applicable at the Market level only, but results by insurer can provide additional information and insights.

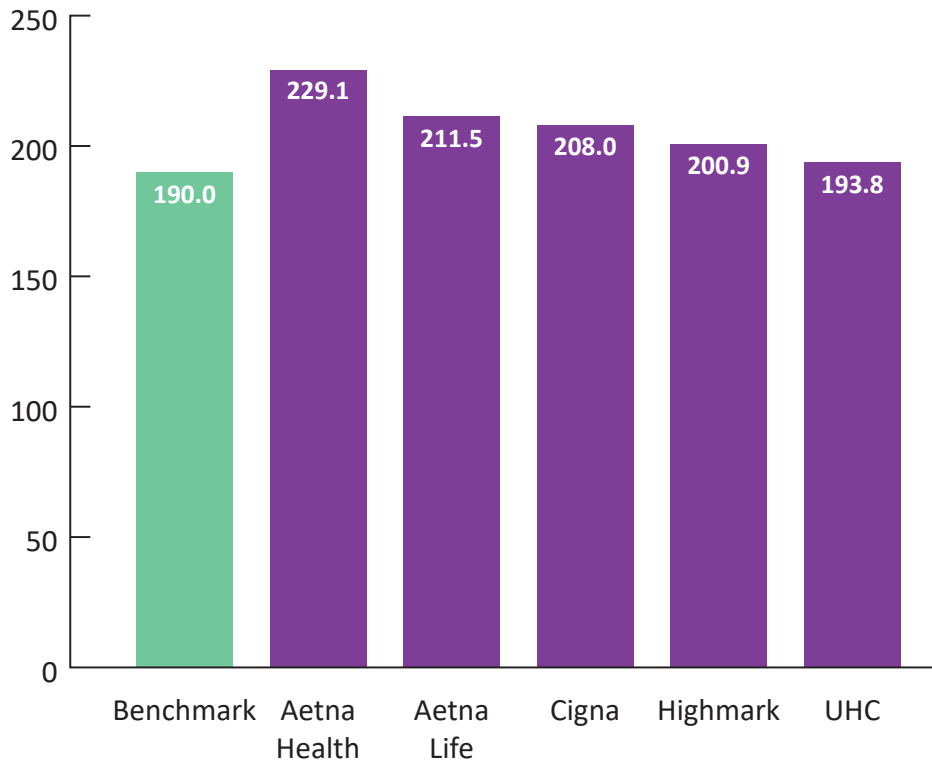
Table 7-1: Quality Measure by Insurer

Quality Measure	Commercial Insurer	Medicaid Insurer
Emergency Department Utilization	<ul style="list-style-type: none"> • Aetna Health Inc. (Aetna Health) • Aetna Life Insurance Company (Aetna Life) • Cigna • Highmark • UHC 	N/A
Persistence of Beta-Blocker After a Heart Attack	<ul style="list-style-type: none"> • Aetna • Cigna • Highmark • UHC 	<ul style="list-style-type: none"> • ACDE • Highmark
Statin Therapy for Patients with Cardiovascular Disease	<ul style="list-style-type: none"> • Aetna • Cigna • Highmark • UHC 	<ul style="list-style-type: none"> • ACDE • Highmark

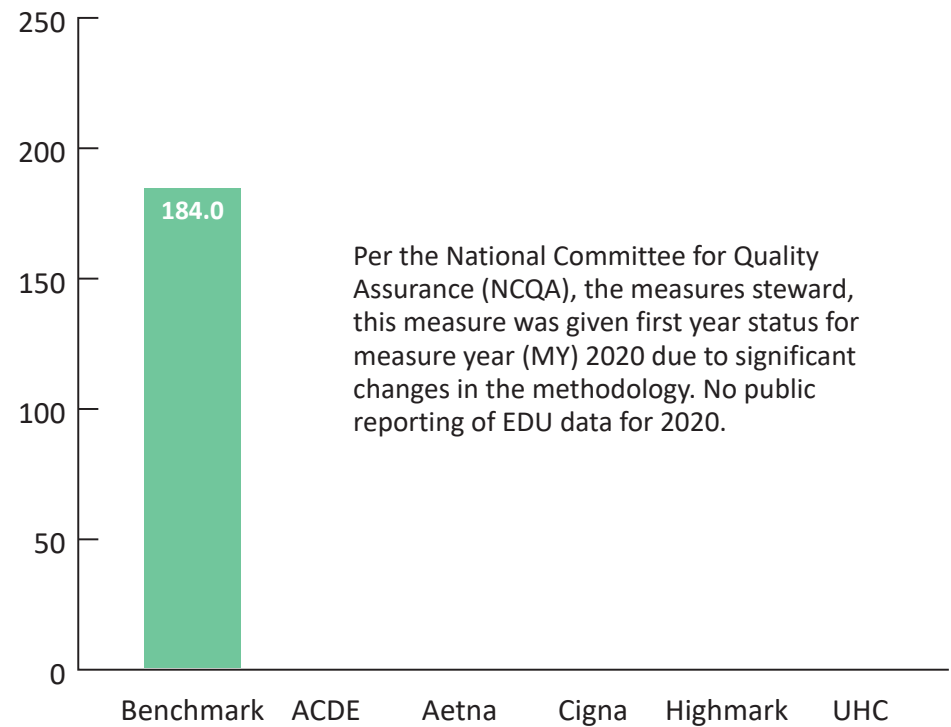


Figure 7-7: Emergency Department Utilization Quality Measure

CY 2019 Actual Results versus Benchmark by Insurer



CY 2020 Actual Results versus Benchmark by Insurer



Emergency Department Utilization

A lower result/score is better for this measure

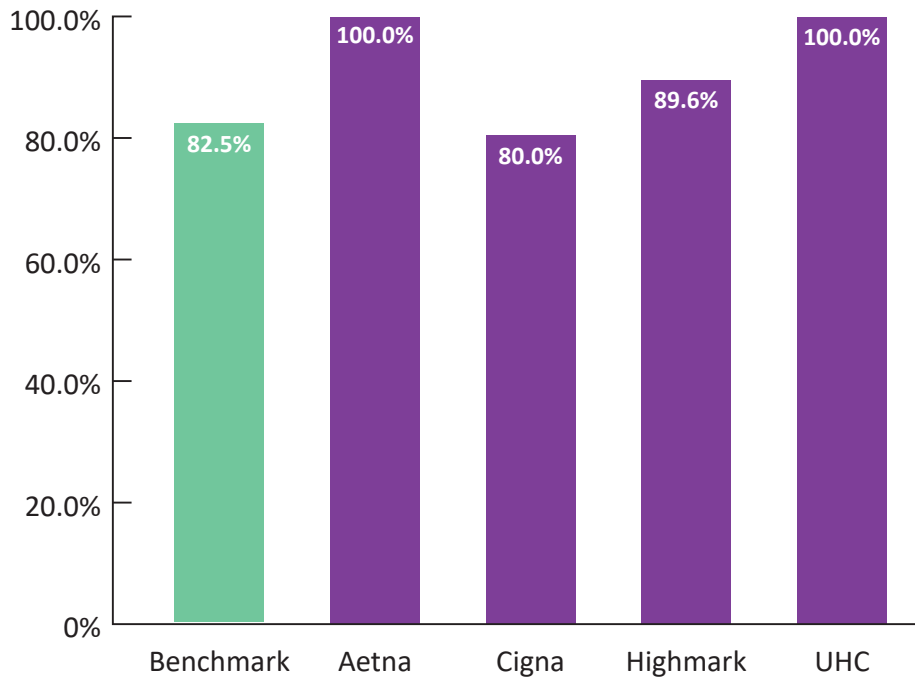


The Emergency Department Utilization benchmark was not met in CY 2019.

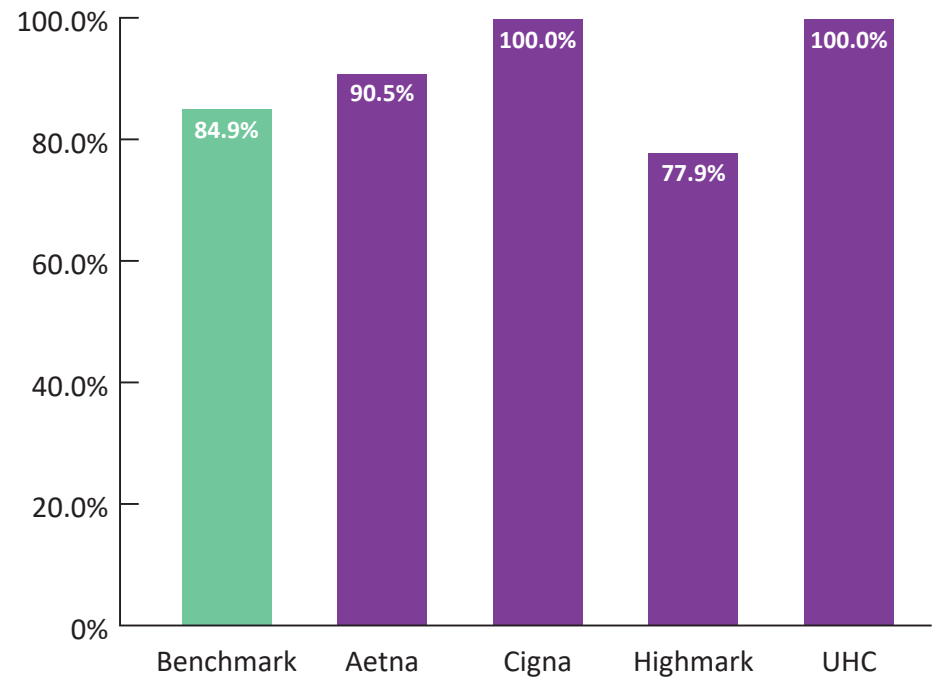


Figure 7-8: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure

CY 2019 Actual Results versus Benchmark by Commercial Insurer



CY 2020 Actual Results versus Benchmark by Commercial Insurer



Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result/score is better for this measure

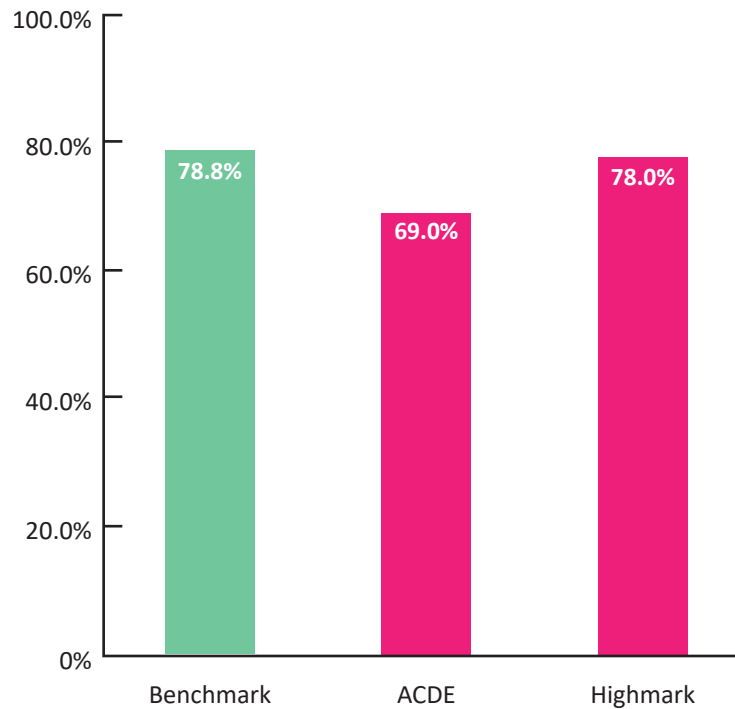


Four out of the five Commercial entities did better than the CY 2020 benchmark.

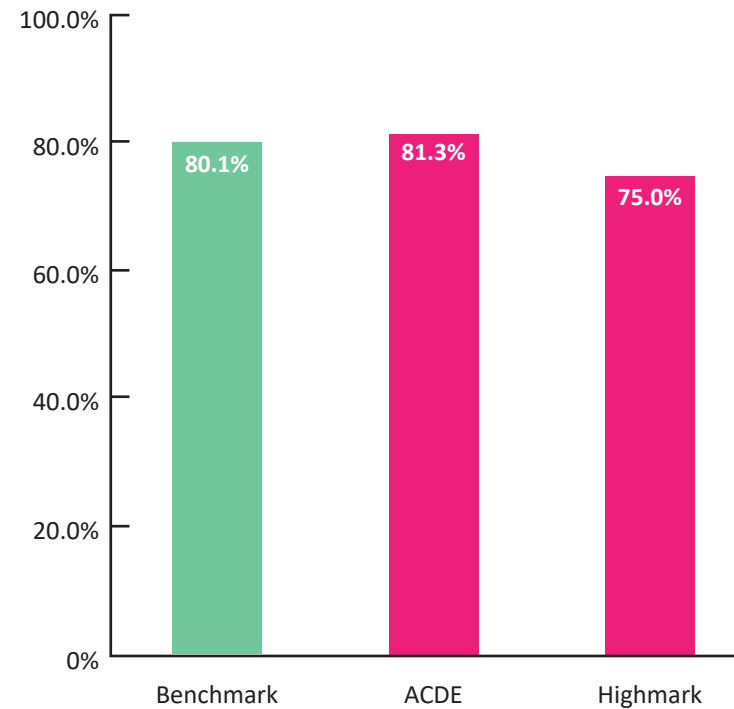


Figure 7-9: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure

CY 2019 Actual Results versus Benchmark by Medicaid Insurer



CY 2020 Actual Results versus Benchmark by Medicaid Insurer



Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result/score is better for this measure

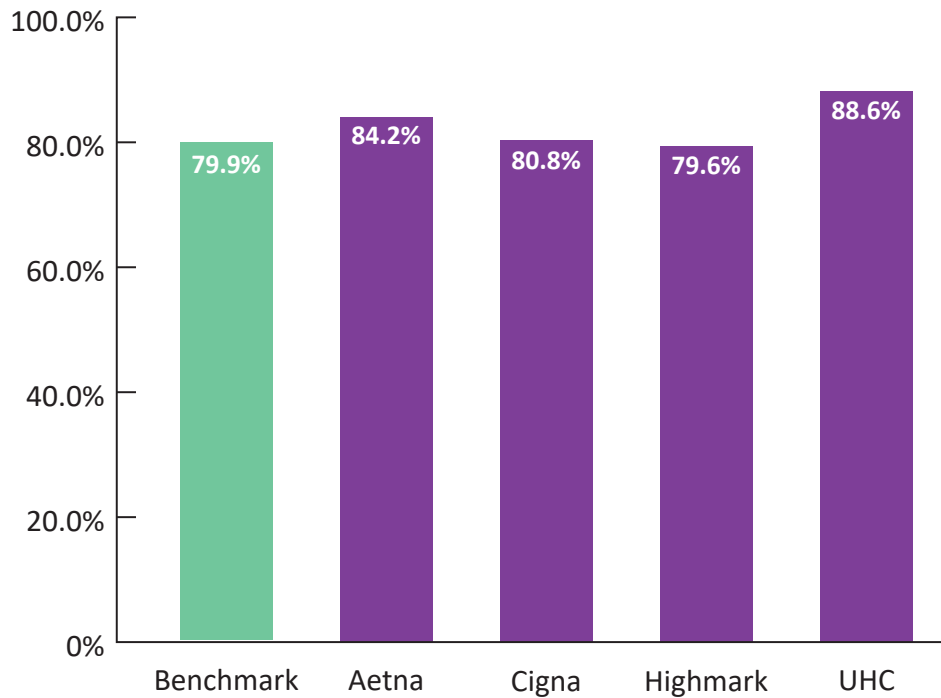


ACDE met the Medicaid benchmark in CY 2020.

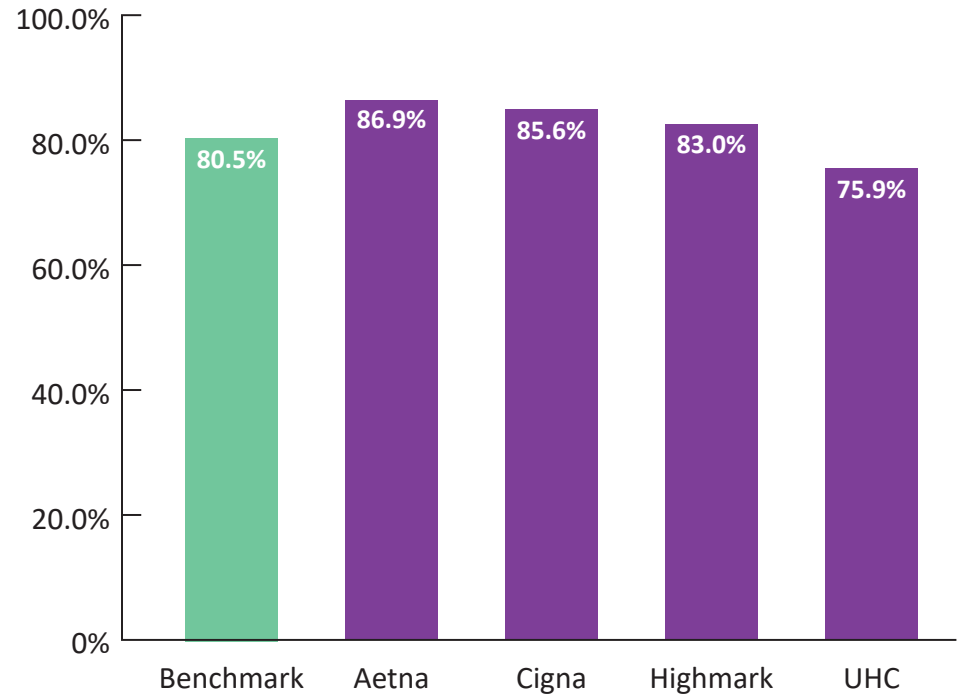


Figure 7-10: Statin Therapy for Patients with Cardiovascular Disease Quality Measure

CY 2019 Actual Results versus Benchmark by Commercial Insurer



CY 2020 Actual Results versus Benchmark by Commercial Insurer



Statin Therapy

A higher result/score is better for this measure

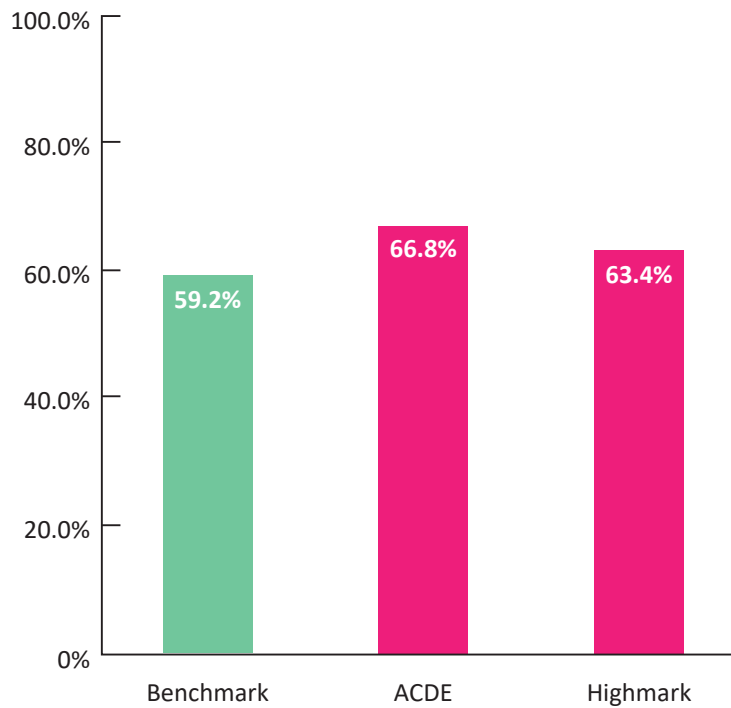


Three out of the four Commercial entities did better than the CY 2020 benchmark.



Figure 7-11: Statin Therapy for Patients with Cardiovascular Disease Quality Measure

CY 2019 Actual Results versus Benchmark by Medicaid Insurer



CY 2020 Actual Results versus Benchmark by Medicaid Insurer



Statin Therapy

A higher result/score is better for this measure



Both Medicaid managed care entities did better than the CY 2020 benchmark.

8. Glossary of Key Terms

Allowed Amount: The amount the payer paid plus any member cost sharing for a claim. Allowed amount is the basis for measuring the claims component of medical expenses for purposes of the benchmark spending data.

Centers for Medicare & Medicaid Services (CMS): Federal government entity responsible for Medicare, Medicaid and CHIP program oversight, administration and monitoring.

Claims Data: Medical expense spending that payers reported that are associated with incurred claims. Examples include hospital inpatient, hospital outpatient, professional: primary care, long term care and other.

Delaware Health Care Commission (DHCC): The State agency responsible for overseeing and administration of the benchmark data collection and reporting processes. The DHCC is also responsible for selecting and/or updating the benchmark quality measures.

Division of Medicaid and Medical Assistance (DMMA): The State agency responsible for oversight, administration and monitoring of Delaware's Medicaid/CHIP program.

Health Risk Adjustment: A process that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

Insurer: A private health insurance company that offers one or more of the following: commercial insurance, Medicare managed care products and/or are Medicaid/CHIP managed care organization products.

Market: The highest level of categorization of the health insurance market. For example, Medicare fee-for-service (FFS) and Medicare managed care are collectively referred to as the "Medicare market." Medicaid/CHIP FFS and Medicaid/CHIP MCO managed care are collectively referred to as the "Medicaid market." Individual, self insured, small and large group markets and student health insurance are collectively referred to as the "Commercial market."

Net Cost of Private Health Insurance (NCPHI): Measures the costs to Delaware residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses.

Non-Claims: Medical expense spending data reported by payers that was not associated with a specific incurred claim. Examples include provider capitation payments, provider incentives, recoveries or risk settlements.

Payer: A term used to refer collectively to all entities submitting data to DHCC.

Pharmacy Rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer provided fair market value bona fide service fees.

Quality Benchmark: The annual target results/score for the selected quality measures.

Spending Benchmark: The annual target change in the per capita THCE measured at the State level.

Total Health Care Expenditures (THCE): The total medical expense (TME) incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC plus insurers' NCPHI.

Total Health Care Expenditures Per Capita: Total health care expenditures (as defined above) divided by Delaware's total state population.

Total Medical Expense (TME): The total claims and non-claims medical expense incurred by Delaware residents for all health care benefits/services as reported by payers submitting data to the DHCC.

Veterans Health Administration (VHA): The federal agency responsible for provision of health care benefits to veterans.