Calendar Year 2019 Results

Benchmark Trend Report

State of Delaware
Department of Health and Social Services
Delaware Health Care Commission

Contents

1. Executive Summary

This is the first 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) 2019
- CY 2018

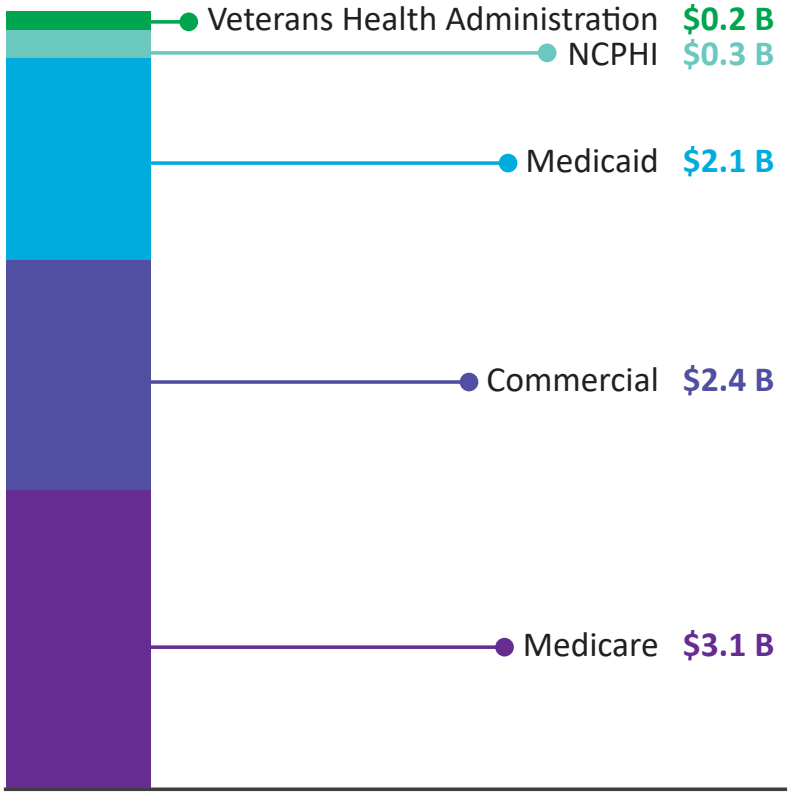
The data contained in this report was collected from September 2020 through February 2021. Each insurer attested to the accuracy and completeness of their summary level data and each were given an opportunity to review their data for inclusion in this public report. As the benchmark data collection process evolves, the DHCC expects the data collection process will become more efficient. For purposes of this first Report, the data were deemed reasonable and appropriate to release publicly. 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.

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.

CY 2019 Per Capita Spending versus Spending Benchmark

As directed by Executive Order (EO) 25, 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 2019 performance period, the spending benchmark was set at a 3.8 percent growth rate. Based on all reported health care spending, the actual per capita change in THCE from CY 2018 to CY 2019 was a 7.8 percent growth rate. The computed per capita amount was $7,814 in CY 2018 compared to $8,424 in CY 2019. All figures are expressed net of pharmacy rebates unless otherwise specified.

Figure 1.1: CY 2019 State Total Health Care Expenditures
Aggregate and Per Capita



CY 2019 Quality Results versus Quality Benchmarks

In addition to the State level per capita spending benchmark, EO 25 established annual quality benchmarks for several different quality measures. For the respective quality measures, Delaware-specific benchmarks were set through CY 2021. Please note that since publication of EO 25, the Overlapping Opioid and Benzodiazepine Prescriptions (OOBP) quality benchmark has been replaced with a High Dose Opioid measure. Since there was no CY 2019 quality benchmark set for the original OOBP, the new High Dose Opioid measure will be incorporated into the next round of data collection starting with the CY 2020 performance year.

Additionally, Delaware-specific CY 2019 results were not published by the Centers for Disease Control and Prevention (CDC) for the High School Students Who Were Physically Active quality measure due to a lack of credible sample size. Since this measure was by design only reported by the CDC every-other year, the DHCC has decided to retire this measure to eliminate a quality benchmark for which data may or may not be obtainable in the future. As a result, there were six quality measures applicable to CY 2019 for which results can be reported on.

It is important to note that CY 2019 was the first year data has been collected on the quality measures. Therefore, no prior year comparisons are included in this Report although comparisons to the respective CY 2019 benchmark are provided. As seen in the table below, relative to each respective quality benchmark, CY 2019 results across the six quality measures were mixed:

Quality Measures	CY 2019 Benchmark	CY 2019 Results	Notes
Adult Obesity	30.0%	34.4%	Lower result/score is better
Adult Tobacco Use	17.1%	15.9%	Lower result/score is better
Opioid-related Overdose Deaths	16.2 deaths per 100,000	43.0 deaths per 100,000	Lower result/score is better
Emergency Department Utilization	190.0 visits per 1,000 Commercial only	193.2 visits per 1,000	Lower result/score is better
Persistence of Beta-Blocker Treatment After a Heart Attack	82.5% Commercial 78.8% Medicaid	93.9% Commercial 73.5% Medicaid	Higher result/score is better
Statin Therapy for Patients with Cardiovascular Disease	79.9% Commercial 59.2% Medicaid	85.3% Commercial 65.1% Medicaid	Higher result/score is better

Conclusion

The DHCC's goal is that this Report and all subsequent Reports, provide useful insights into Delaware's health care spending and quality results. Later this year, the DHCC will be undertaking the next cycle of benchmark data collection and will be obtaining CY 2019 spending data again, CY 2020 spending data for the first time and CY 2020 quality data. The next iteration of this Report will reflect this new and additional data.

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 first 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 first 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 2019
- CY 2018

The data contained in this report was collected from September 2020 through February 2021. Each insurer attested to the accuracy and completeness of their summary level data and each were given an opportunity to review their data for inclusion in this public report. As the benchmark data collection process evolves, the DHCC expects the data collection process will become more efficient. For purposes of this first Report, the data were deemed reasonable and appropriate to release publicly. 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.

The DHCC is responsible for the collection, aggregation and reporting of benchmark spending and quality data. This report contains the results of the first complete cycle of benchmark data collection from all participants. The DHCC thanks every entity that participated in this process and we look forward to an ongoing collaboration in each annual cycle.

Spending Data and Benchmark

Per Executive Order (EO) 25, the annual change in Delaware's per capita total health care expenditures (THCE) is to be evaluated against the State's spending benchmark applicable to each CY. For comparison against the spending benchmark, 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. The spending benchmark for CY 2019 (i.e., the per capita change from CY 2018) was set at a 3.8 percent growth rate.

THCE encompasses all health care spending associated with Delaware residents from private and public sources. THCE is computed by summing TME across various claims and non-claims categories with an estimate of the NCPHI. For insurers, the NCPHI is an estimate of 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. The TME spending data contained herein reflects the allowed amount which captures the provider payment rate and all patient cost sharing as applicable. All spending data is net of reported pharmacy rebates unless otherwise specified. Any personal out-of-pocket spending by individuals that was not covered by insurance are not reflected in this data.

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.

Summary level spending data was provided by all participants on a voluntary basis. Due the summary nature of this data, the DHCC was able to obtain data from private health insurers on their respective commercial lines of business including the self-insured market segment. Self-insured data is not identifiable in the benchmark data collection process, but the inclusion of the self-insured data makes this data set unique in how much of the Delaware landscape it captures. The table bellows documents each data source:

Table 2-1: Spending Data Sources

Spending Data	Data Source	Notes
Commercial Data	Carriers serving Delaware: • Aetna • Cigna • Highmark • United Healthcare	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]	• Delaware's Division of Medicaid and Medical Assistance (DMMA) • Amerihealth Caritas of Delaware and Highmark Health Options	DMMA was the source of Medicaid fee-for-service (FFS) spending data. The insurers provided data on the Medicaid managed care program.
Medicare Data	• Centers for Medicare and Medicaid Services (CMS) • Cigna • Aetna	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	• Veterans Health Administration public report	Detailed spending from the VHA was not available only aggregate member count and total health care spending on Delaware veterans. VHA data is reported on a federal fiscal year (FFY) basis which runs October-September. For purposes of this report FFY 2019 = CY 2019 and FFY 2018 = CY 2018.
NCPHI	• Insurer produced reports and financial statements (e.g., supplemental health care exhibits, medical loss ratio reports, financial statements)	Figures were computed based off of available public information data sources. Refinements to the computation of NCPHI is expected to occur in subsequent iterations of this Report.

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

EO 25 also established annual benchmarks for select number of quality measures. Please note that since the publication of EO 25, the Overlapping Opioid and Benzodiazepine Prescriptions (OOBP) quality measure has been replaced with a Use of Opioids at a High Dosage measure to highlight opportunities for improvement and to enable the use of the State's prescription monitoring program data. Since there was no CY 2019 quality benchmark set for the original OOBP, the new Use of Opioids at a High Dosage measure will be incorporated into the next cycle of data collection starting with the CY 2020 performance reporting year.

Additionally, Delaware-specific CY 2019 results were not published by the Centers for Disease Control and Prevention (CDC) for the High School Students Who Were Physically Active quality measure due to a lack of credible sample size. Since this measure was by design only reported by the CDC every-other year, the DHCC has decided to retire this measure to eliminate a quality benchmark for which data may or may not be obtainable in the future. As a result, the six quality benchmarks that remained for CY 2019, the population for which results will be compared to the applicable benchmark and the data source for each quality measure are shown in the following table.

Table 2-2: Quality Measures, Population, Data Sources and CY 2019 Benchmark

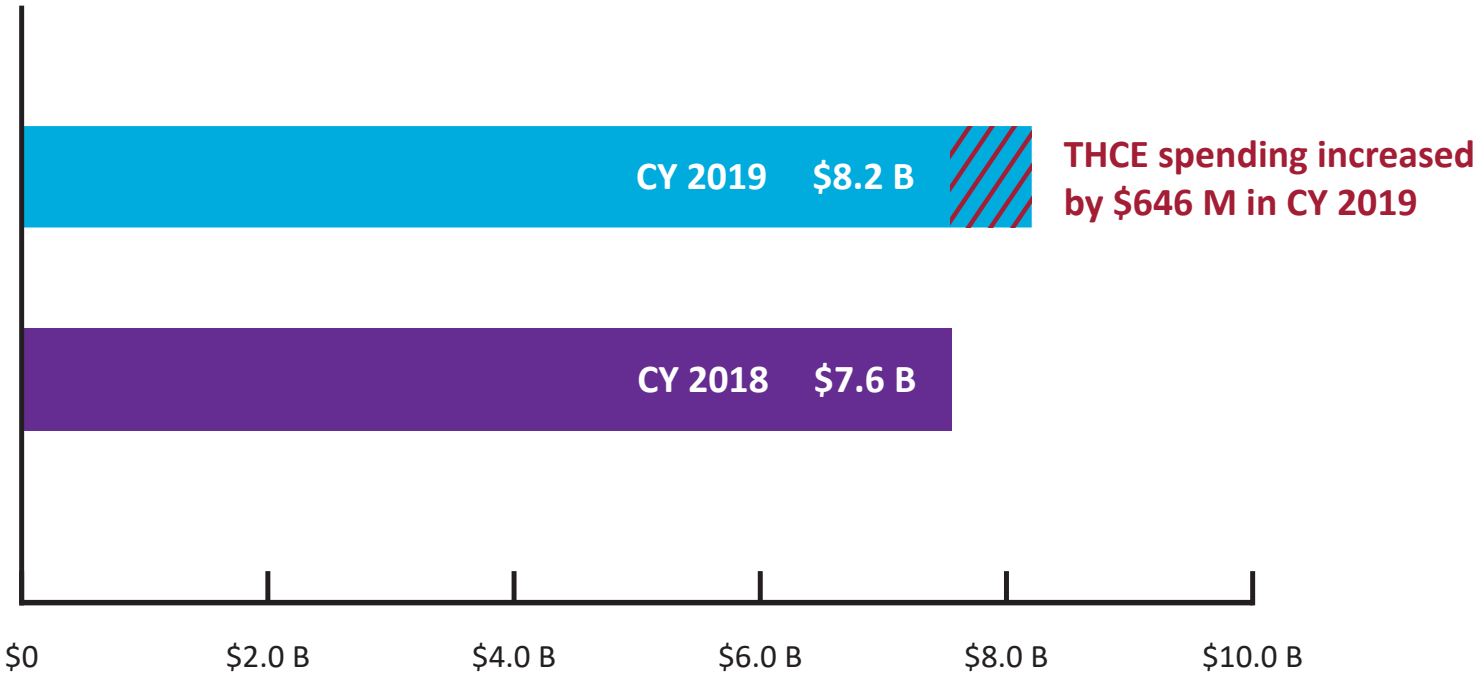
Quality Measure	Population	Data Source	CY 2019 Benchmark
Adult Obesity	• Statewide (all populations)	• CDC public report	30.0 percent
Adult Tobacco Use	• Statewide (all populations)	• CDC public report	17.1 percent
Opioid-related Overdose Deaths	• Statewide (all populations)	• CDC public report	16.2 deaths per 100,000
Emergency Department Utilization Rate	• Commercial market only	• Delaware insurers	190.0 visits per 1,000
Persistence of Beta-Blocker Treatment After a Heart Attack	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 82.5 percent (Commercial) • 78.8 percent (Medicaid)
Statin Therapy for Patients with Cardiovascular Disease	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 79.9 percent (Commercial) • 59.2 percent (Medicaid)

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. All spending data reported at the State and Market levels has not been adjusted for health risk of the population. When insurer-specific spending data is shown (see Section 5), that data has been adjusted for reported health risk to enable better year-over-year comparisons for the same insurer.

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

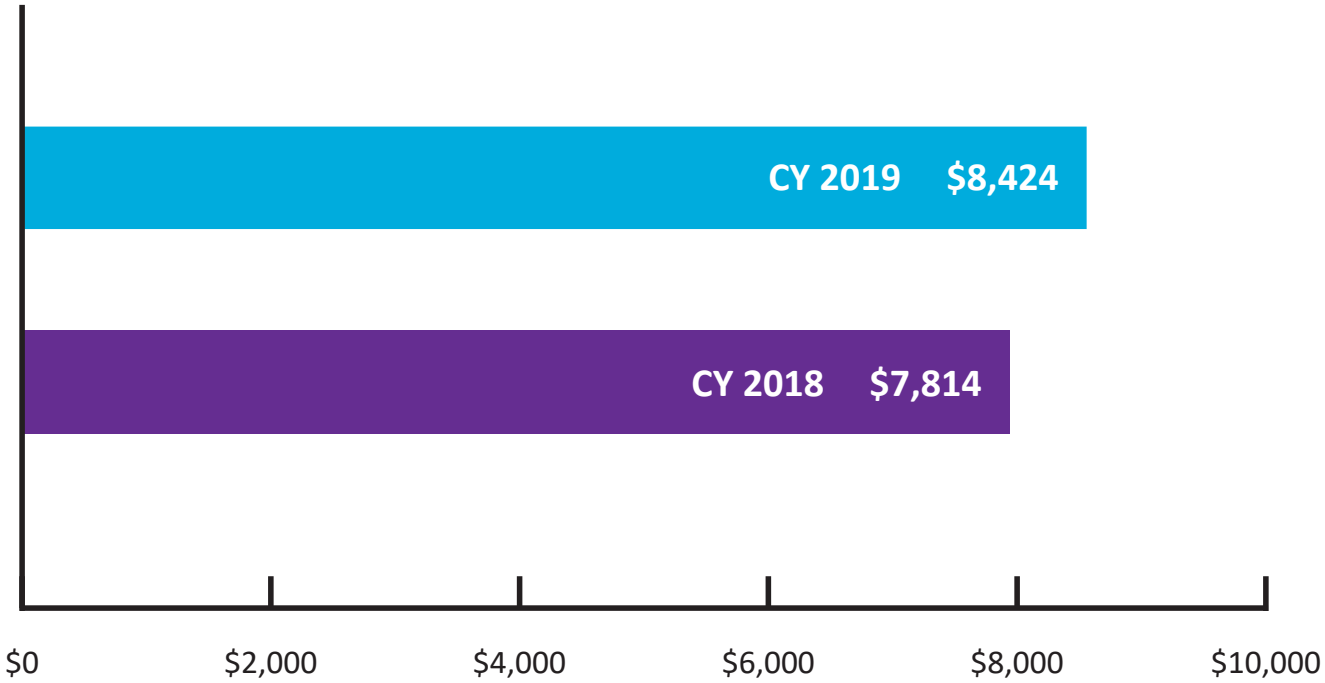


8.5%

THCE spending increased 8.5% or by $646 million in CY 2019.

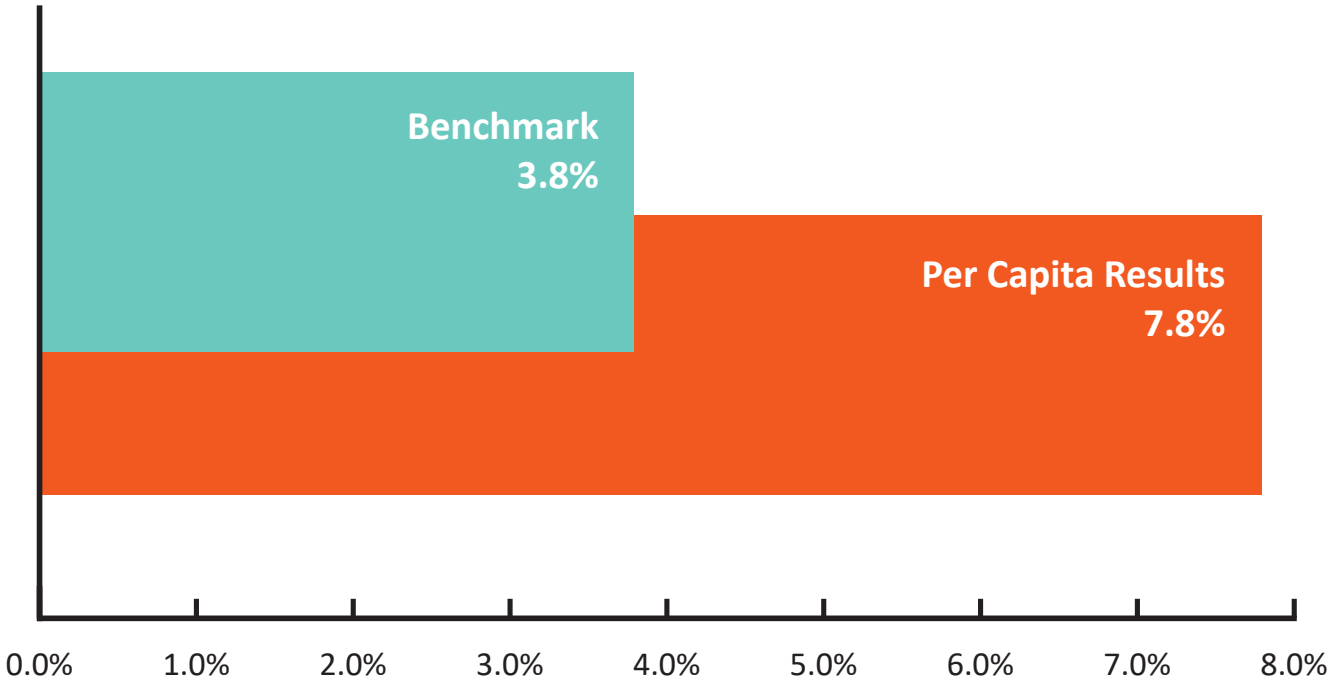
Delaware's population increased by 0.7%.

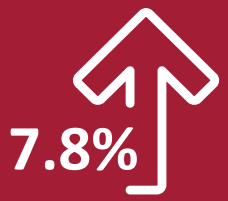
Figure 3-2: State Level Total Health Care Expenditures, Per Capita



On a per capita basis, THCE spending increased to $8,424 in CY 2019.

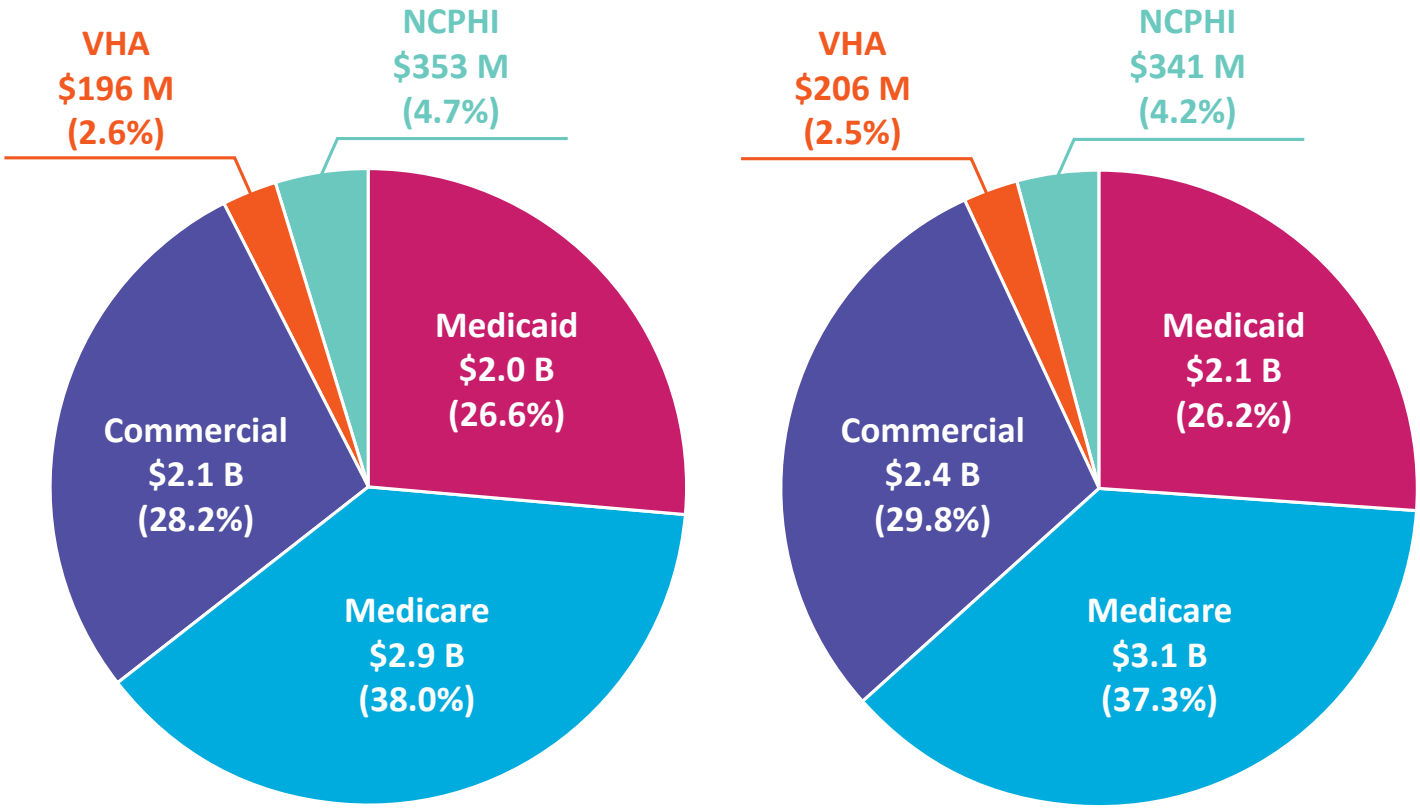
Figure 3-3: CY 2019 Change in the State Level Total Health Care Expenditures, Per Capita versus Spending Benchmark





THCE spending per capita increased 7.8% relative to the CY 2019 spending benchmark of 3.8%.

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

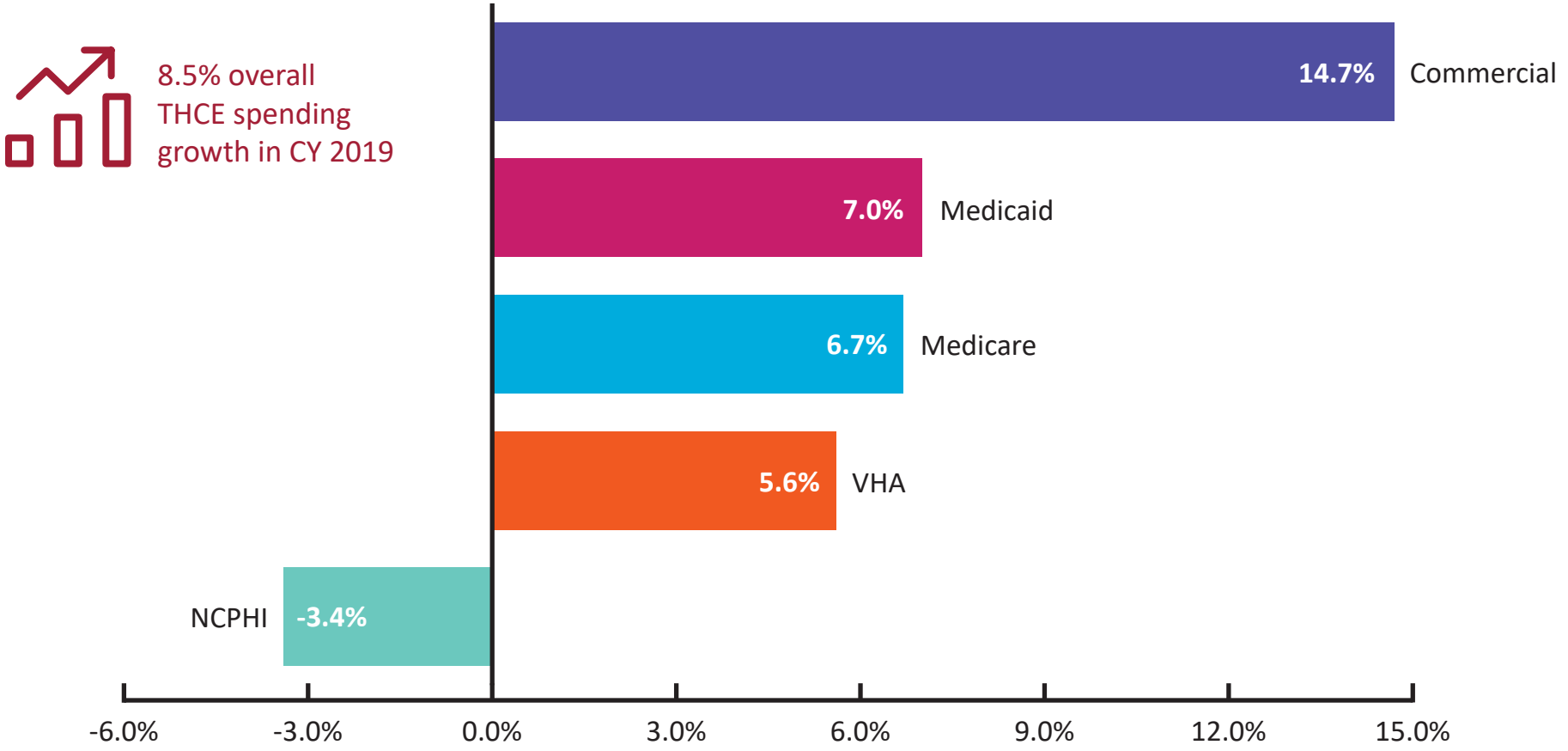


The Medicare market (inclusive of FFS and managed care[3]) was the largest component of all health care spending, representing 37.3% of THCE in CY 2019.

The Commercial market (inclusive of fully and self-insured spending) was the second largest component of all health care spending, representing 29.8% of THCE in CY 2019.

3 Medicare managed care is also referred to as the Medicare Advantage program.

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



The Commercial market had the largest reported increase in THCE spending at 14.7% in CY 2019.

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

Figure 3-6: **Total Health Care Expenditures, Proportion of State Level THCE by Component: CY 2019 versus CY 2018**

By Component, the proportion of THCE remained relatively consistent between CY 2018 and CY 2019.

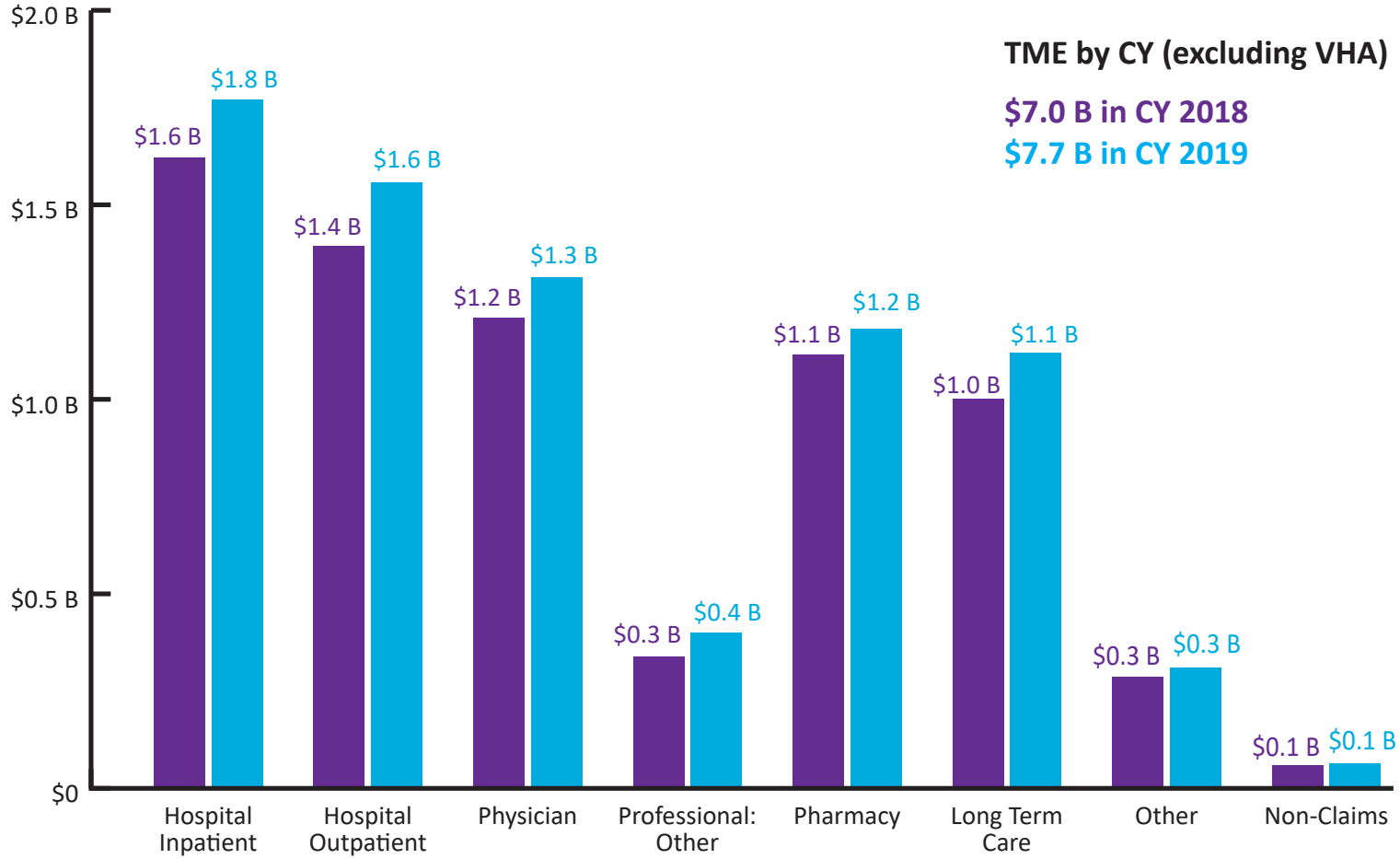
The VHA remained the smallest component of all health care spending, representing 2.5% of THCE in CY 2019.

4 NCPHI is not applicable to Medicare FFS, Medicaid FFS or the VHA.

In addition to spending by component, the benchmark data collection process asked payers to separate their TME spending into nineteen different major categories: eight claims-related categories and eleven non-claims-related categories (not all categories are applicable to all payers[5]). The VHA data source does not provide any details by service category of VHA spending. Therefore, the following data points and all Figures with service category detail excludes VHA spending.

5 For example, DMMA provided aggregate payments to their PACE organization(s) and to their non-emergency medical transportation vendor as two separate non-claims categories applicable to DMMA only; CMS did not separate primary care from specialists, but instead provided data on "physician" collectively.

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

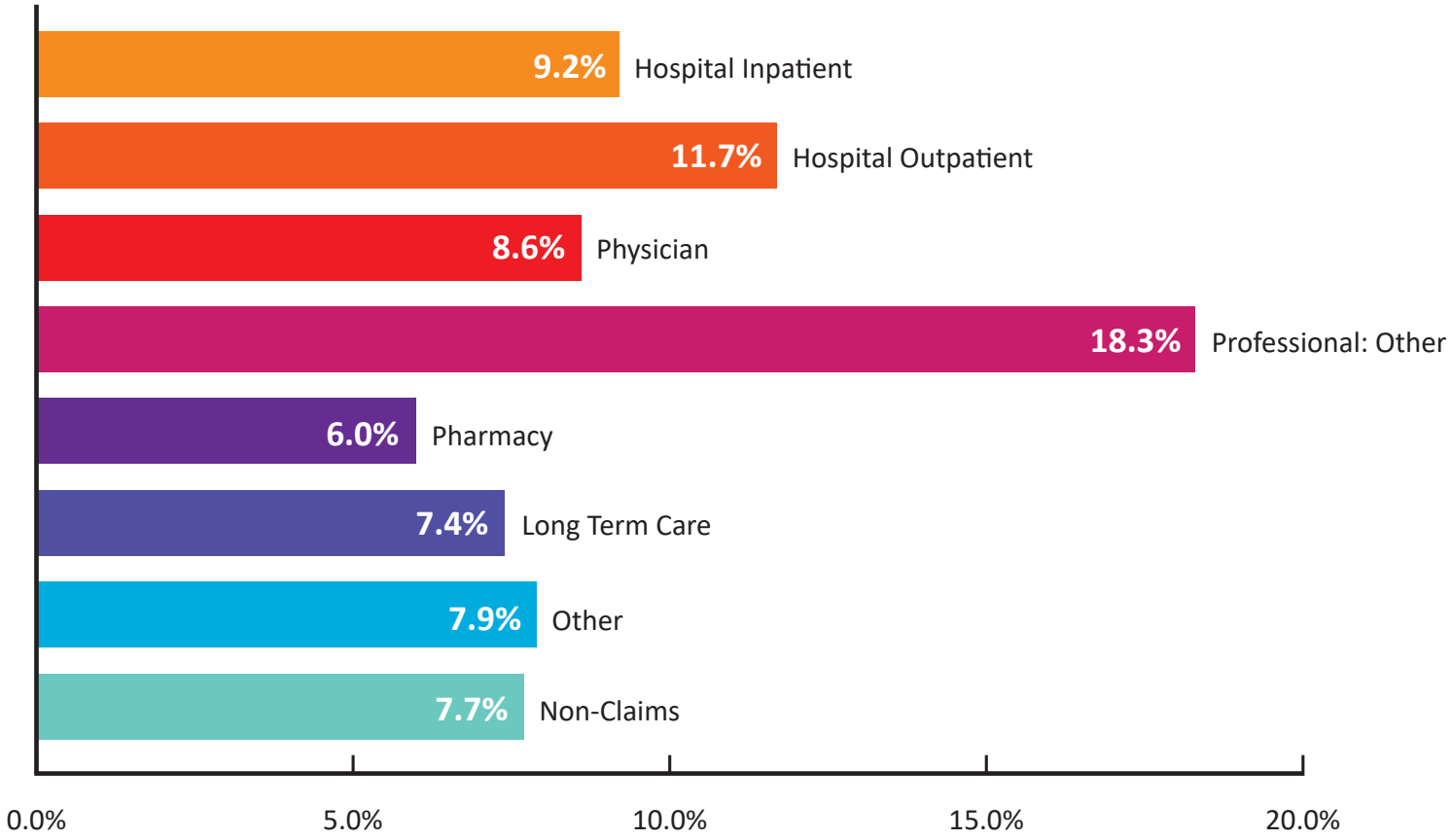


9.2%

TME increased 9.2% in total in CY 2019.

Hospital inpatient spending was the single largest service representing a consistent 23.2% of TME in both CYs.

Figure 3-8: CY 2019 Change in State Level TME by Service Category (excluding VHA)



Professional Other spending increased the most in CY 2019, but is a small piece of TME.

Hospital outpatient spending outgrew hospital inpatient spending by 2.5 percentage points.

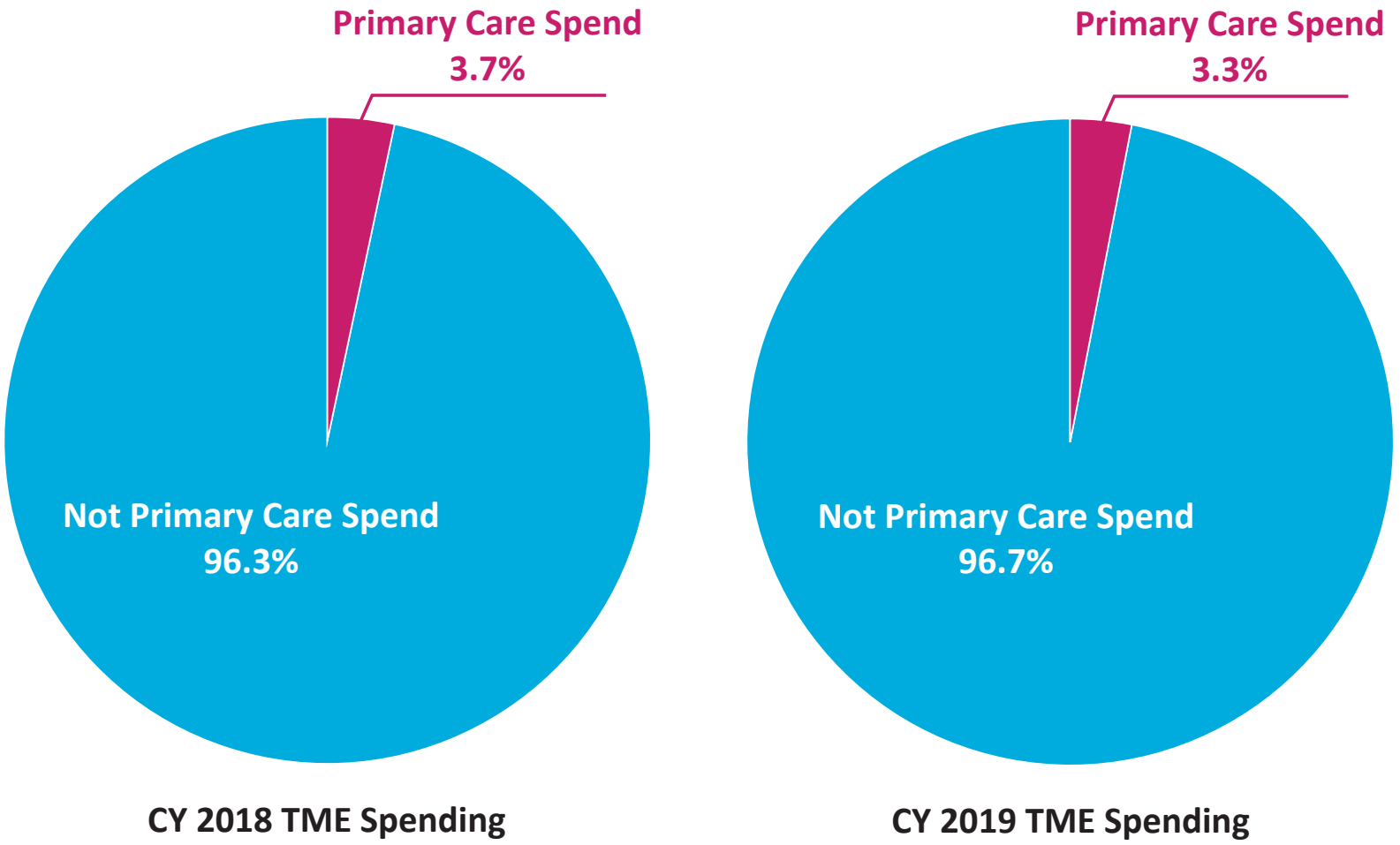
Pharmacy spend increased the least in CY 2019 at 6.0%. Total rebates reported increased to $245 million in CY 2019 from $204 million in CY 2018.

An important initiative within Delaware is to increase the proportion of health care spending that goes towards primary care while at the same time limiting the growth in total spending. In an effort to support this initiative, the DHCC requested payers separate spending on primary care services from other service categories. Moreover, for consistency and to avoid confusion to benchmark data contributors, the DHCC used the same definition of primary care that was developed in early 2020 by the Delaware Department of Insurance (DOI) in its efforts to evaluate health care affordability within the State. Please see Section 9 for the primary care definition used to collect the CY 2018 and CY 2019 benchmark spending data. The DHCC's goal is to continue to leverage DOI's most current definition of primary care in each annual benchmark data collection process.

Please note, in the Medicare Part A and B spending data provided by CMS, the federal government did not provide any delineation of Medicare FFS spending between primary care and specialists. Instead, CMS provided one aggregate "Physician" service category. Accordingly, at this time, it is not possible to report on primary care spending in the Medicare market. Therefore, primary care spending is only available for the Commercial and Medicaid markets. Since Medicaid covers a larger proportion of long-term care services, the percent of TME was lower in the Medicaid market, 2.6 percent, relative to the Commercial market, 4.0%, in CY 2019. The overall average was 3.3 percent for both markets combined.

For purposes of this computation, the DHCC included all claims and non-claims spending attributed to primary care. Claims-related spending on primary care composed approximately 90 percent of all reported primary care spending. The total amount reported in primary care spending was consistent in each year at approximately $153 million. However, as a percent of total TME, the primary care percentage declined given the increase in overall TME spending.

Figure 3-9: State Level Primary Care Spending as a Percentage of Total TME (Commercial and Medicaid markets combined)



4. Spending Data: Market Level

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

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

As noted previously, spending data at the Market level has not been adjusted for health risk, but is net of reported pharmacy rebates.

In the Commercial market, the insurers offer different insurance products/coverages (e.g., fully insured, self-insured, preferred provider organizations, etc.). The applicable spending data was aggregated across all products/coverages and hence no delineation is possible within the benchmark data.

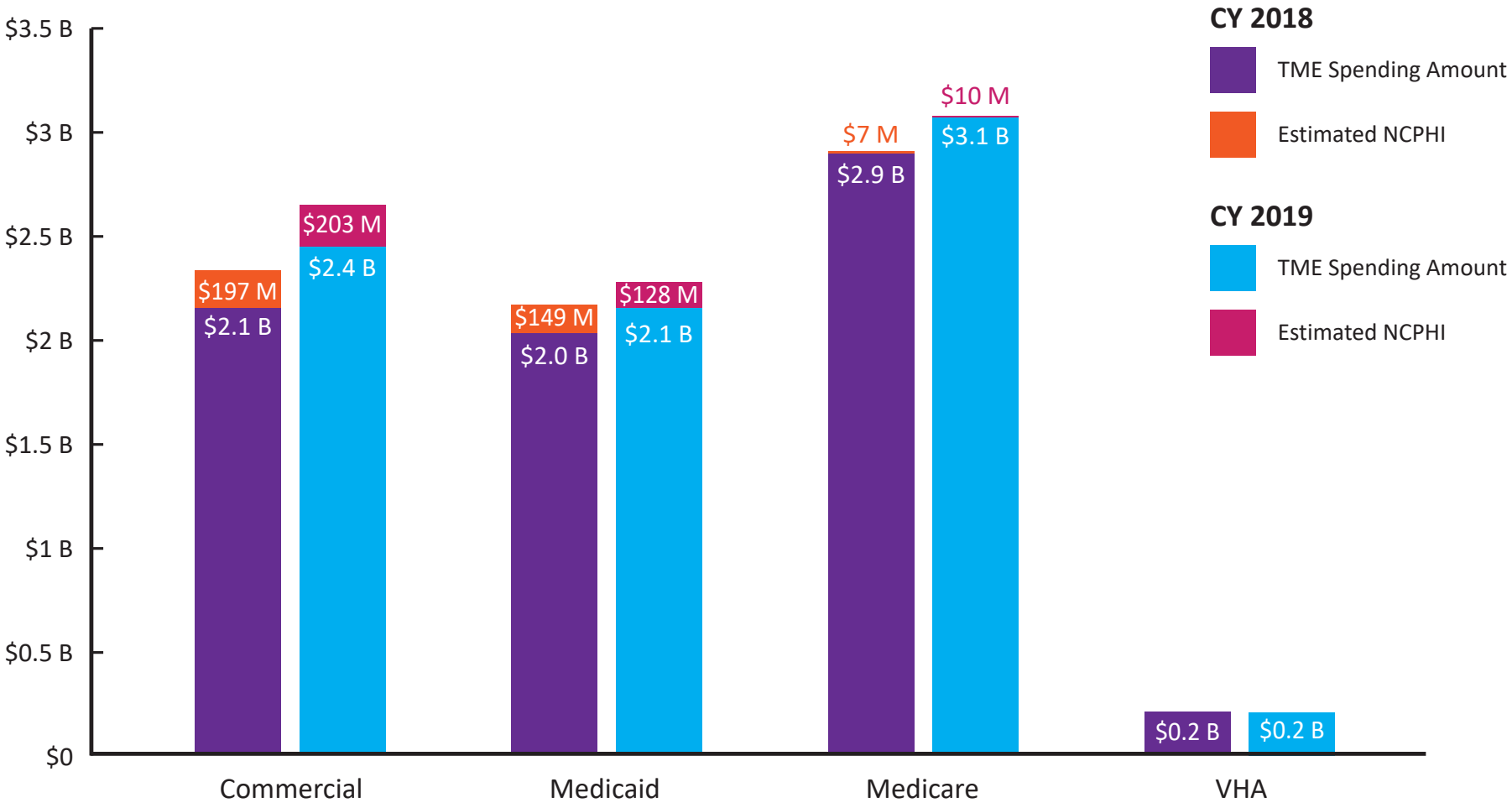
In the Medicaid market, the vast majority of individuals are mandatorily enrolled in managed care resulting in most spending being reported by the two insurers under contract with DMMA. However, DMMA did provide Medicaid FFS spending information on individuals not enrolled in managed care as well as FFS spending on services that are excluded from managed care (e.g., pediatric dental services). DMMA also provided its summary level payment data to PACE organizations and to their non-emergency medical transportation vendor. 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. At the Market level, total Medicare spending on Part D pharmacy services for both FFS and managed care enrollees was provided by CMS in their data submission. To avoid duplication with the pharmacy spending reported by insurers, the insurers' Medicare pharmacy spend has been excluded. However, 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.

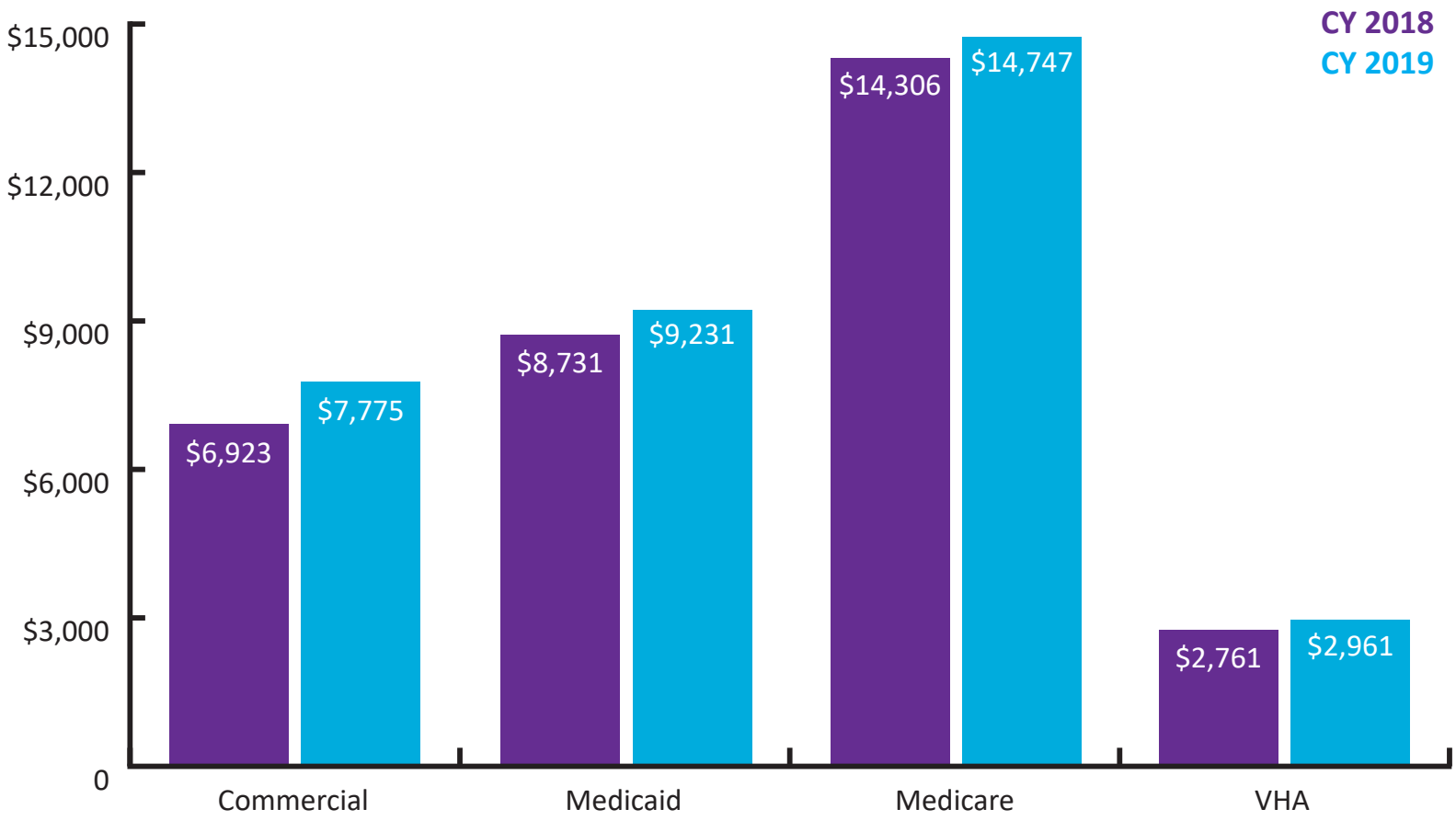
Per member per year (PMPY) values were computed as total CY expenditures divided by estimated number of members in the respective CY.

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



Note: Medicaid and Medicare are inclusive of both fee-for-service and managed care. NCPHI is not applicable to FFS.

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:

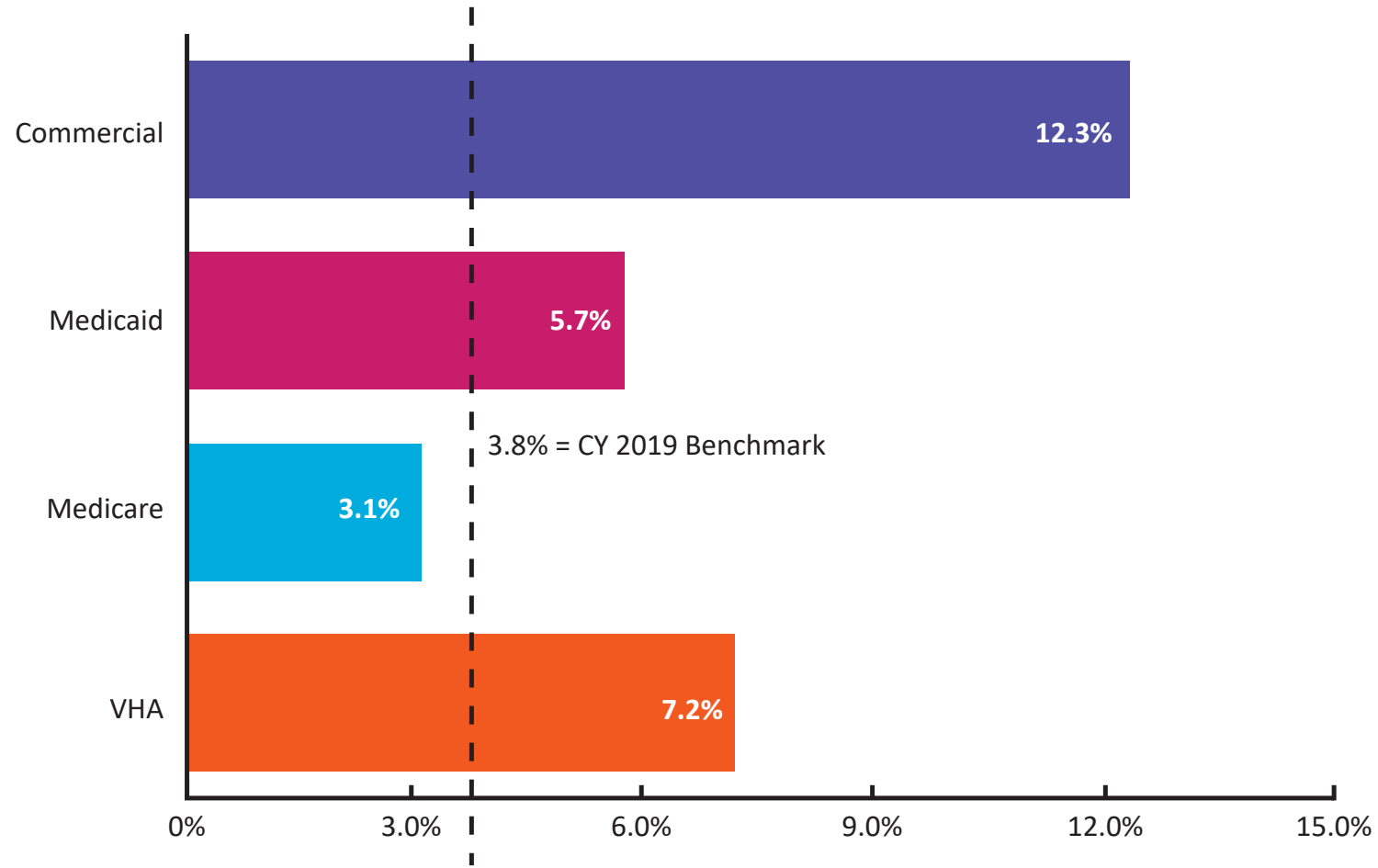
Commercial: CY 2018 - 336,130
CY 2019 - 340,360

Medicaid: CY 2018 - 246,983
CY 2019 - 246,647

Medicare: CY 2018 - 201,210
CY 2019 - 208,421

VHA: CY 2018 - 70,798
CY 2019 - 69,715

Figure 4-3: **Total Health Care Expenditures, CY 2019 THCE Per Member Per Year Change by Market**



The THCE spending benchmark is measured at the State level and was 7.8% in CY 2019 as shown in Figure 3-3.

The CY 2019 THCE per member per year change at the Market level is provided for informational purposes only.

Market Level Total Medical Expense Spending by Major Service Category

Similar to the State level reporting, TME spend by major service category is available on a Market level basis. As before, VHA data is excluded from these figures since no service category information was available from the VHA. TME spending by service category varies across the Markets reflecting the demographics and health needs of the respective populations. For example, Medicaid pays for a significant amount of long-term care services (e.g., nursing facility, home health care, etc.) for Delawareans relative to the Commercial market, but conversely Medicaid collects significantly higher levels of pharmacy rebates under current federal law. Across all three Markets, hospital inpatient, hospital outpatient and professional spending composed the majority of total TME.

Commercial market highlights (see Figure 4-4):

- Aggregate TME spending increased 14.7 percent ($314 million), totaling $2.4 billion in CY 2019.
- Hospital outpatient spending was the single largest service category, representing 30.5 percent ($746 million) of TME in CY 2019.
- Professional spending (e.g., primary care, specialists, other professionals) was the second largest service category, representing 24.3 percent ($594 million) of TME in CY 2019.
- Hospital inpatient spending was the third largest service category, representing 23.5 percent ($573 million) of TME in CY 2019.

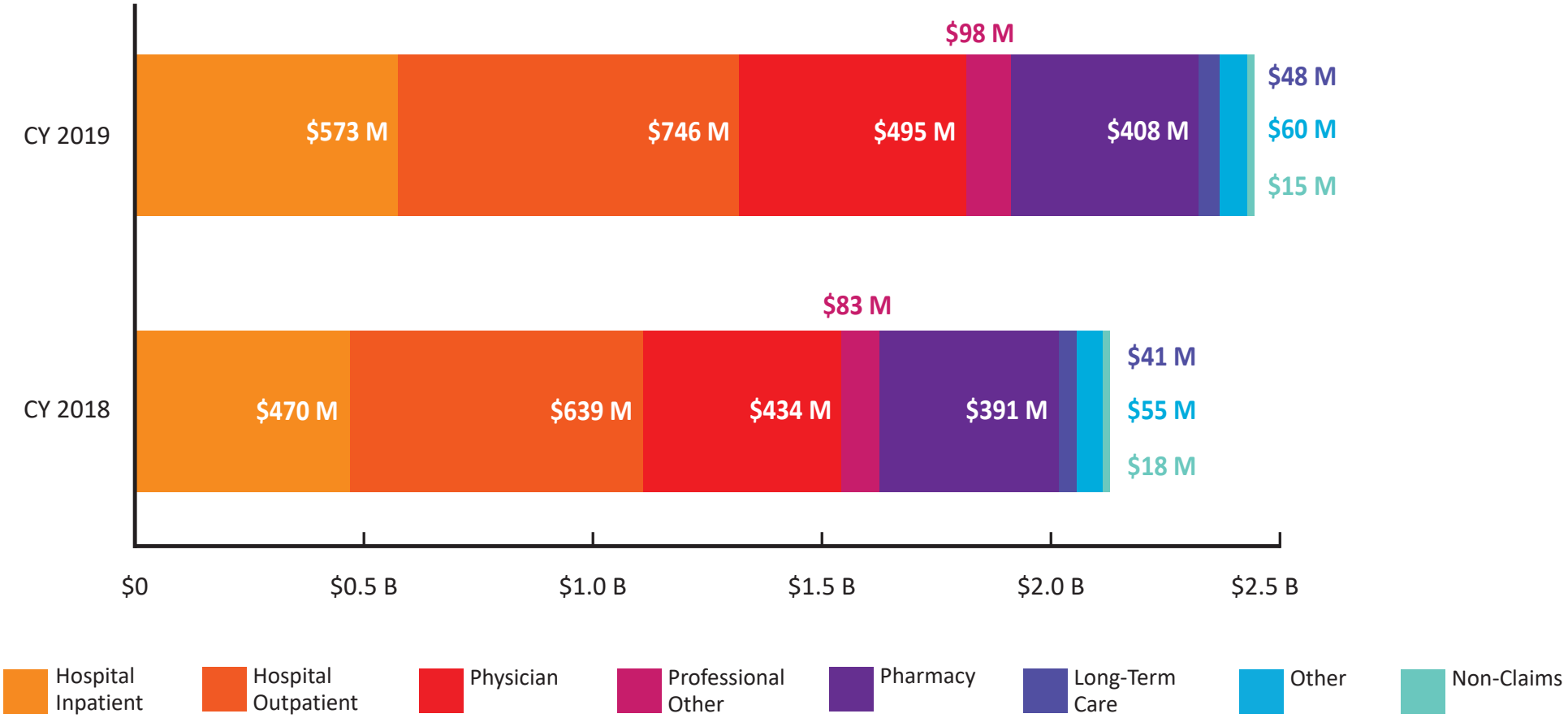
Medicaid market highlights (see Figure 4-5):

- Aggregate TME spending increased 7.0 percent ($141 million), totaling $2.1 billion in CY 2019. On an aggregate TME basis, the Medicaid market was the smallest of the three major Markets.
- Long term care spending was the single largest service category, representing 33.1 percent ($711 million) of TME in CY 2019.
- Hospital inpatient spending was the second largest service category, representing 21.5 percent ($463 million) of TME in CY 2019.
- Professional spending (e.g., primary care, specialists, other professionals) was the third largest service category, representing 19.8 percent ($426 million) of TME in CY 2019.

Medicare market highlights (see Figure 4-6):

- Aggregate TME spending increased 6.7 percent ($191 million), totaling $3.1 billion in CY 2019. On a Market level basis, Medicare is the largest market of TME spend in Delaware.
- Hospital inpatient spending was the single largest service category, representing 24.1 percent ($738 million) of TME in CY 2019.
- Professional spending (e.g., primary care, specialists, other professionals) was the second largest service category, representing 22.6 percent ($693 million) of TME in CY 2019.
- Pharmacy spending, net of rebates, was the third largest service category, representing 22.0 percent ($674 million) of TME in CY 2019. However, since CMS did not provide any rebate dollars on Medicare FFS pharmacy spend, the only Medicare rebate information available was the amount reported under managed care by insurers (which is a relatively small portion of the total Medicare market).

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

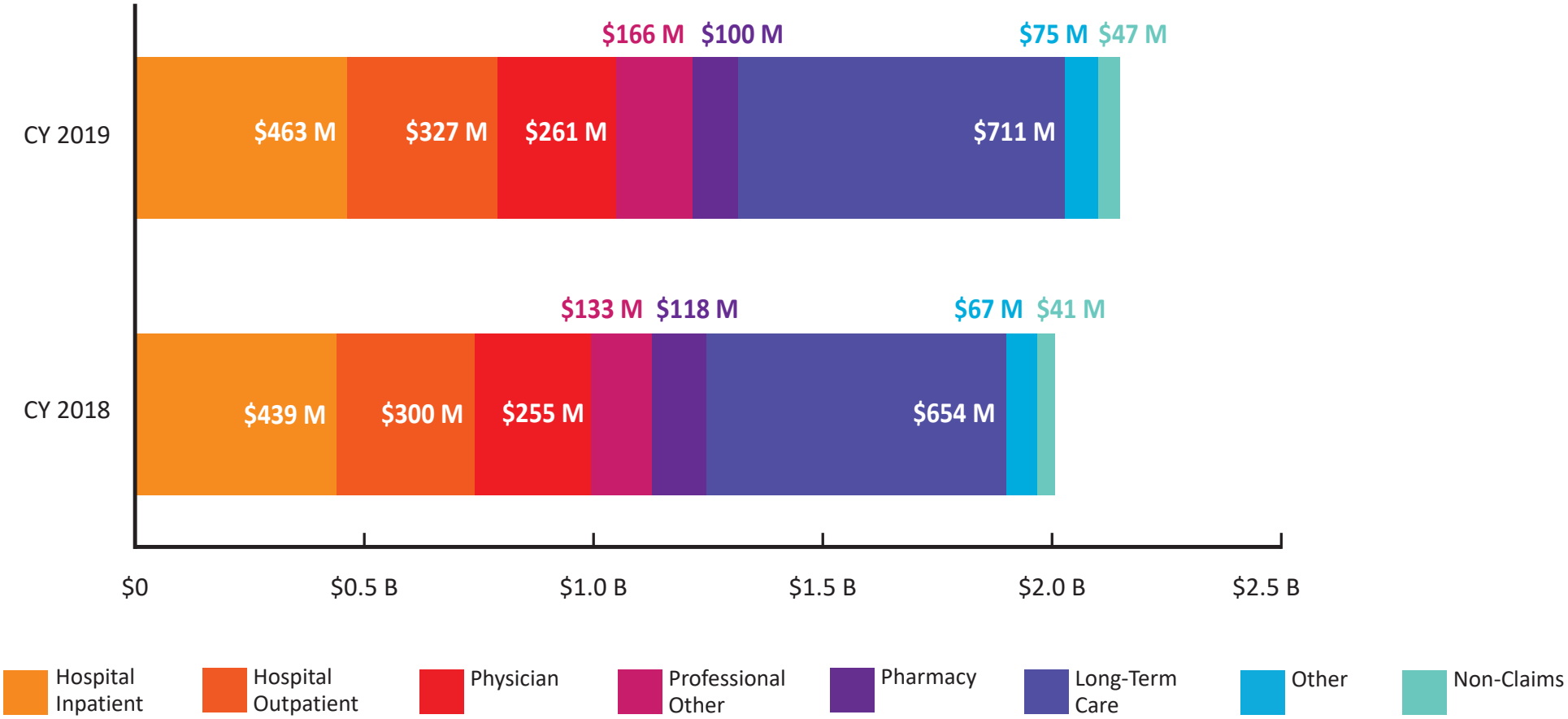


Commercial Market

14.7% TME increased 14.7% in total in CY 2019.

$2.4 B in CY 2019 TME spend versus $2.1 B in CY 2018.

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



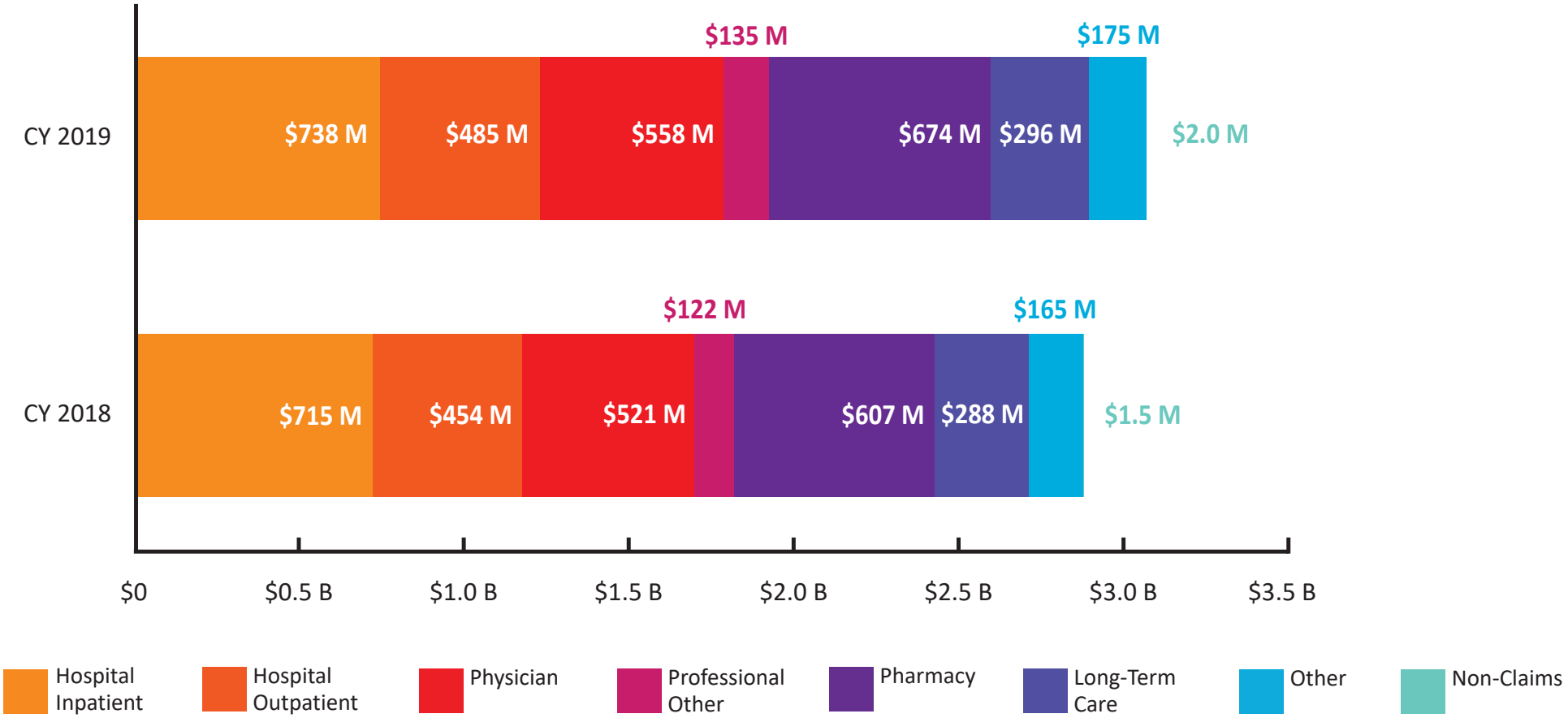
Medicaid Market

7.0% TME increased 7.0% in total in CY 2019.

$2.1 B in CY 2019 TME spend versus $2.0 B in CY 2018.

Note: Medicaid is inclusive of both fee-for-service and managed care.

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



Medicare Market

6.7% TME increased 6.7% in total in CY 2019.

$3.1 B in CY 2019 TME spend versus $2.9 B in CY 2018.

Note: Medicare is inclusive of both fee-for-service and managed care.

5. Spending Data: Insurer Level

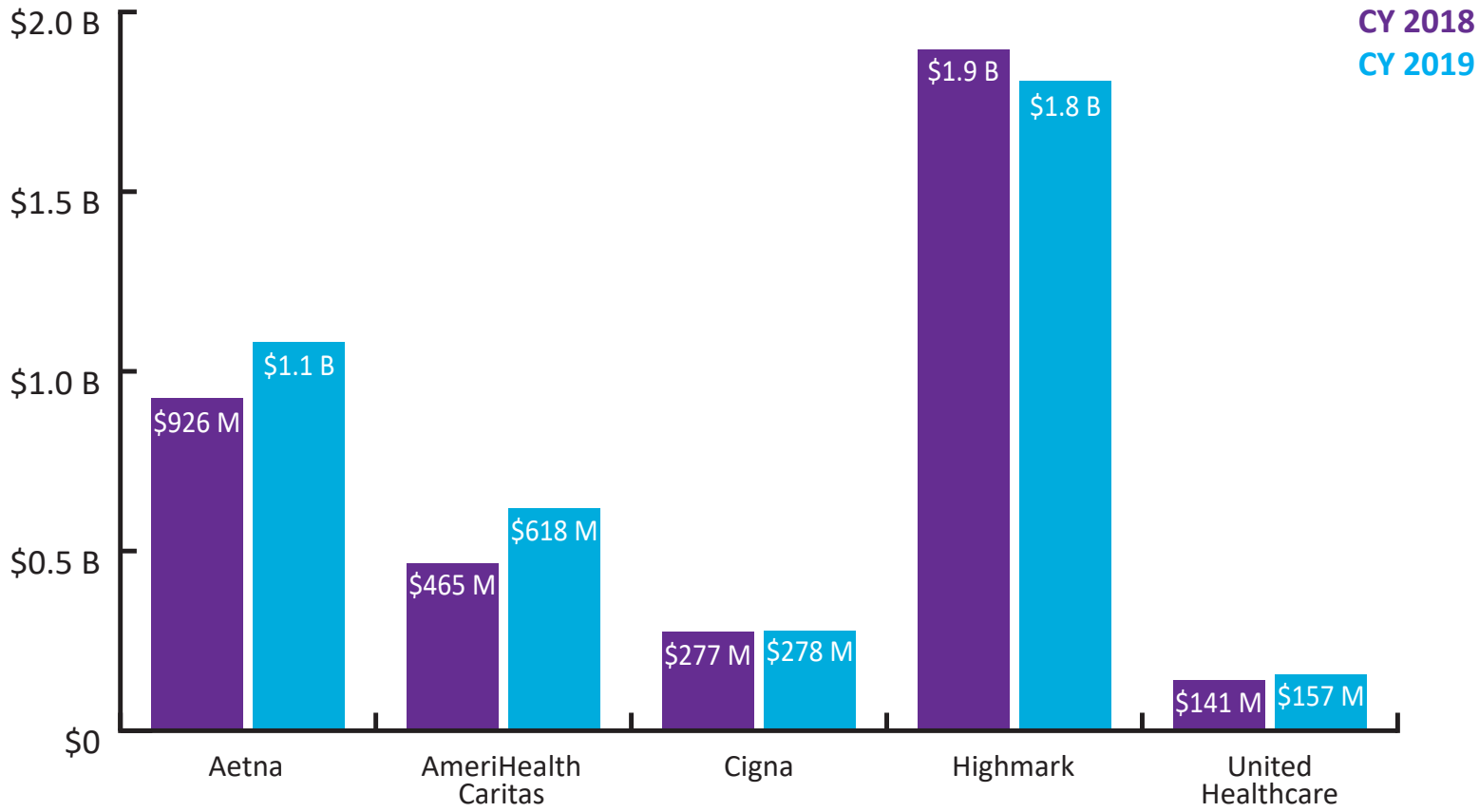
The five major health insurers in Delaware all voluntarily provided benchmark spending data as requested by the DHCC. This data included both fully-insured and self-insured programs. Each insurer attested to the accuracy and completeness of their data and each were given an opportunity to review their 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. Each insurer provided their health risk adjustment (HRA) factors based on the risk adjustment model of their choosing. 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.

The HRA spending data is net of the insurer-specific reported pharmacy rebate amounts. To protect the confidence of the rebate levels, specific rebate data is not included in this 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. Because of these inherent differences among the insurers, direct comparisons across insurers are not recommended. Instead, the reader should focus on the relative level of spending and the change in each insurer's own reported data.

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

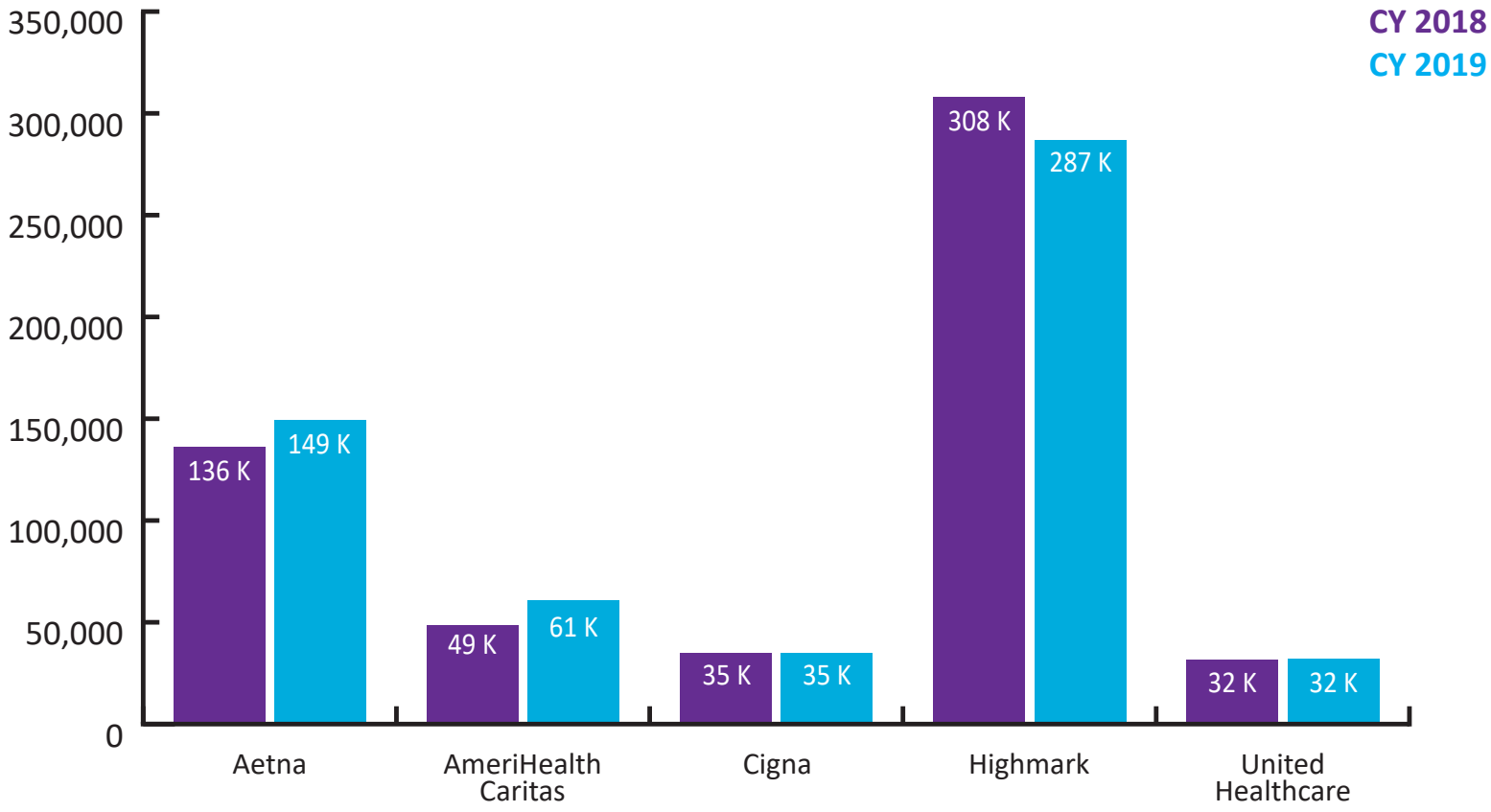


32.8%

AmeriHealth Caritas had the largest increase in HRA THCE at 32.8%, driven in large part by membership growth.

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

Figure 5-2: **Estimated Membership by Insurer**



24.7%

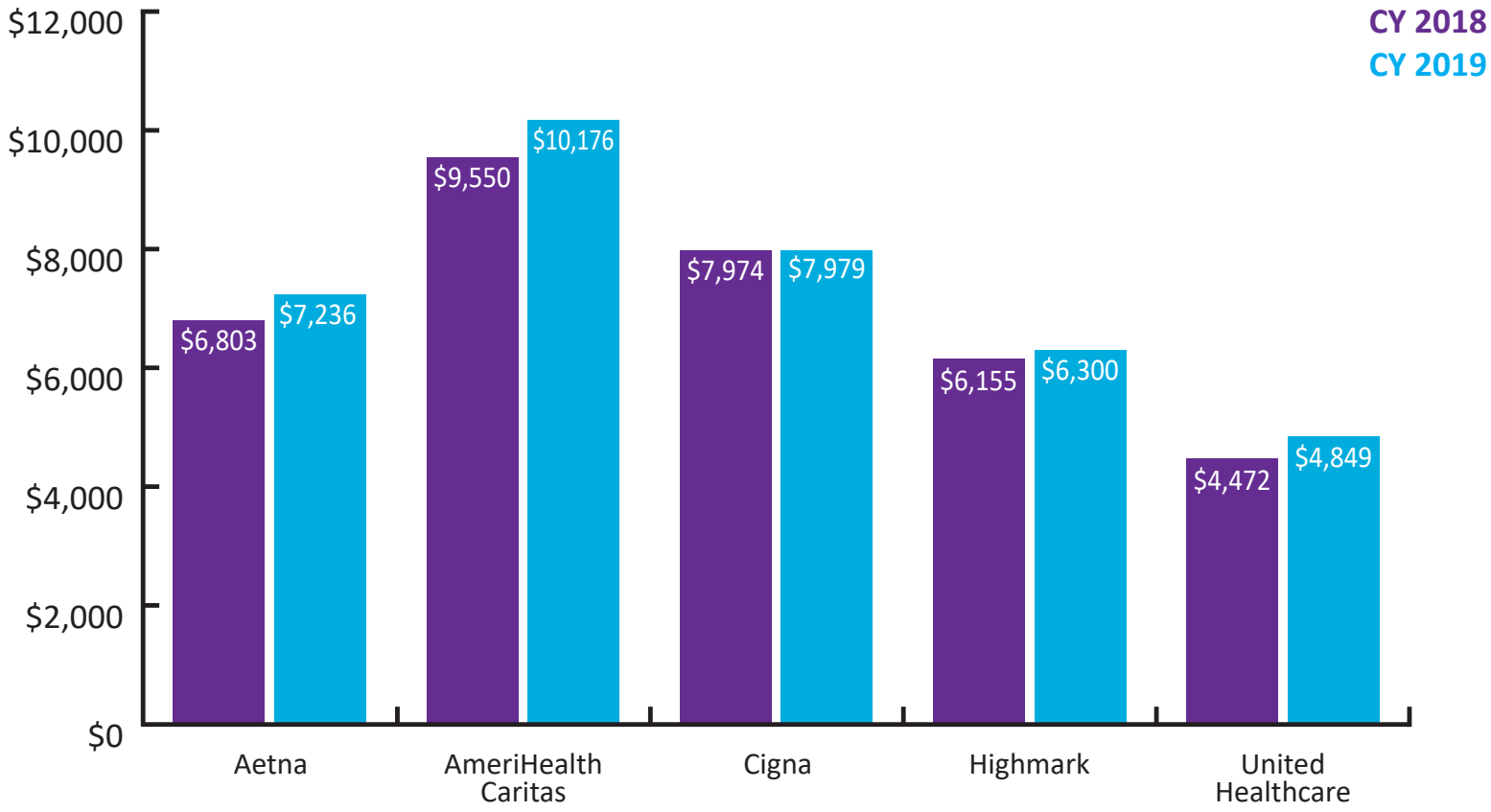
Membership in Amerihealth Caritas of Delaware, a Medicaid managed care only insurer, increased 24.7 percent in CY 2019.[7]

6.9%

Membership in Highmark, a multi-line insurer, decreased by 6.9 percent in CY 2019.

7 Insurer membership was estimated by taking each entity's total reported member months for the respective year and dividing by 12.

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

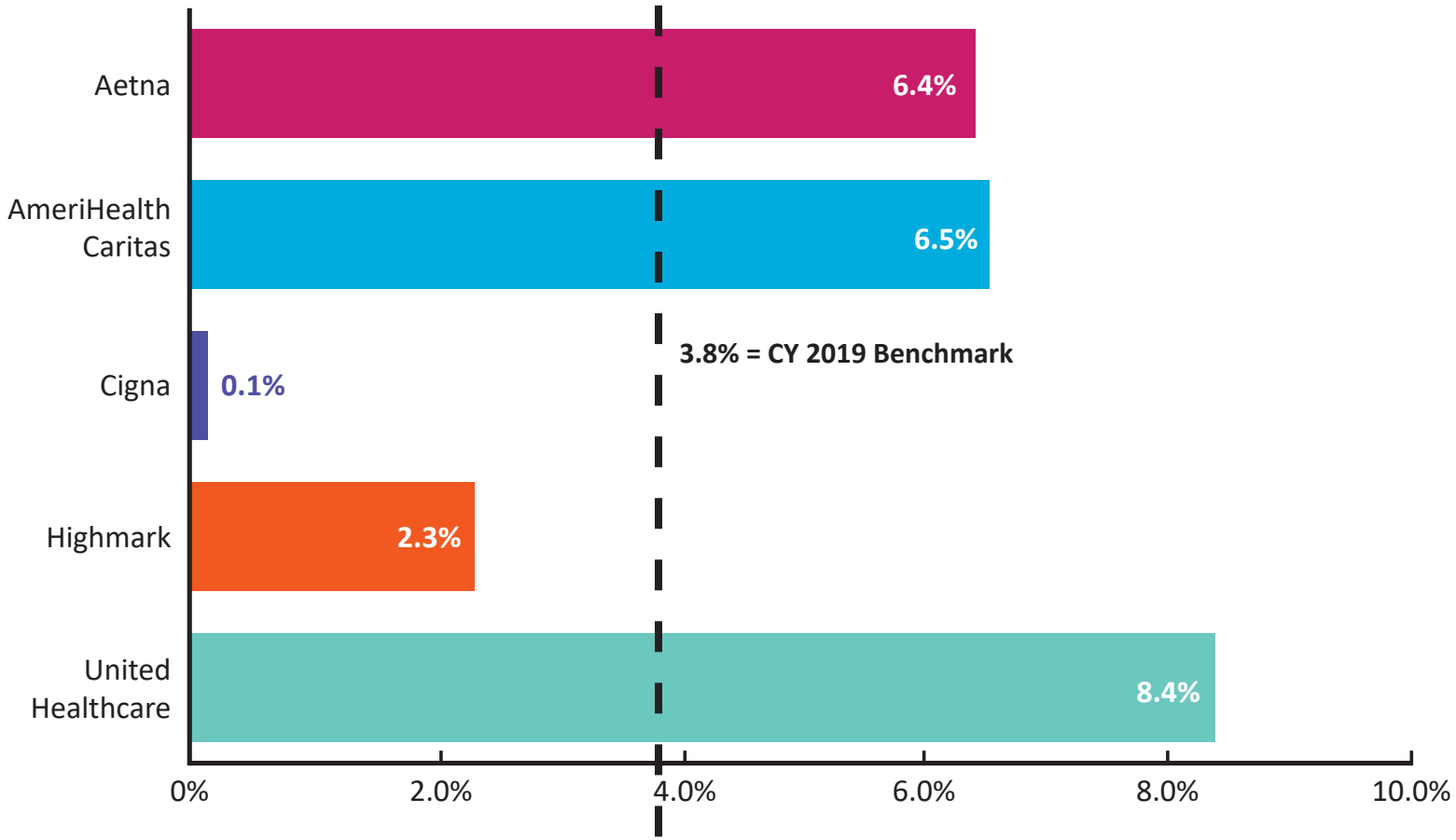


Data reflects all lines of business reported by each insurer. Insurers do not have all the same lines of business (e.g., AmeriHealth Caritas is a Medicaid-only insurer).

United Healthcare has the smallest estimated membership, but had the highest percentage increase in HRA PMPY.

7 Insurer membership was estimated by taking each entity's total reported member months for the respective year and dividing by 12.

Figure 5-4: Total Health Care Expenditures, CY 2019 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 7.8% in CY 2019 as shown in Figure 3-3.

The CY 2019 HRA THCE PMPY change at the insurer level is provided for informational purposes only.

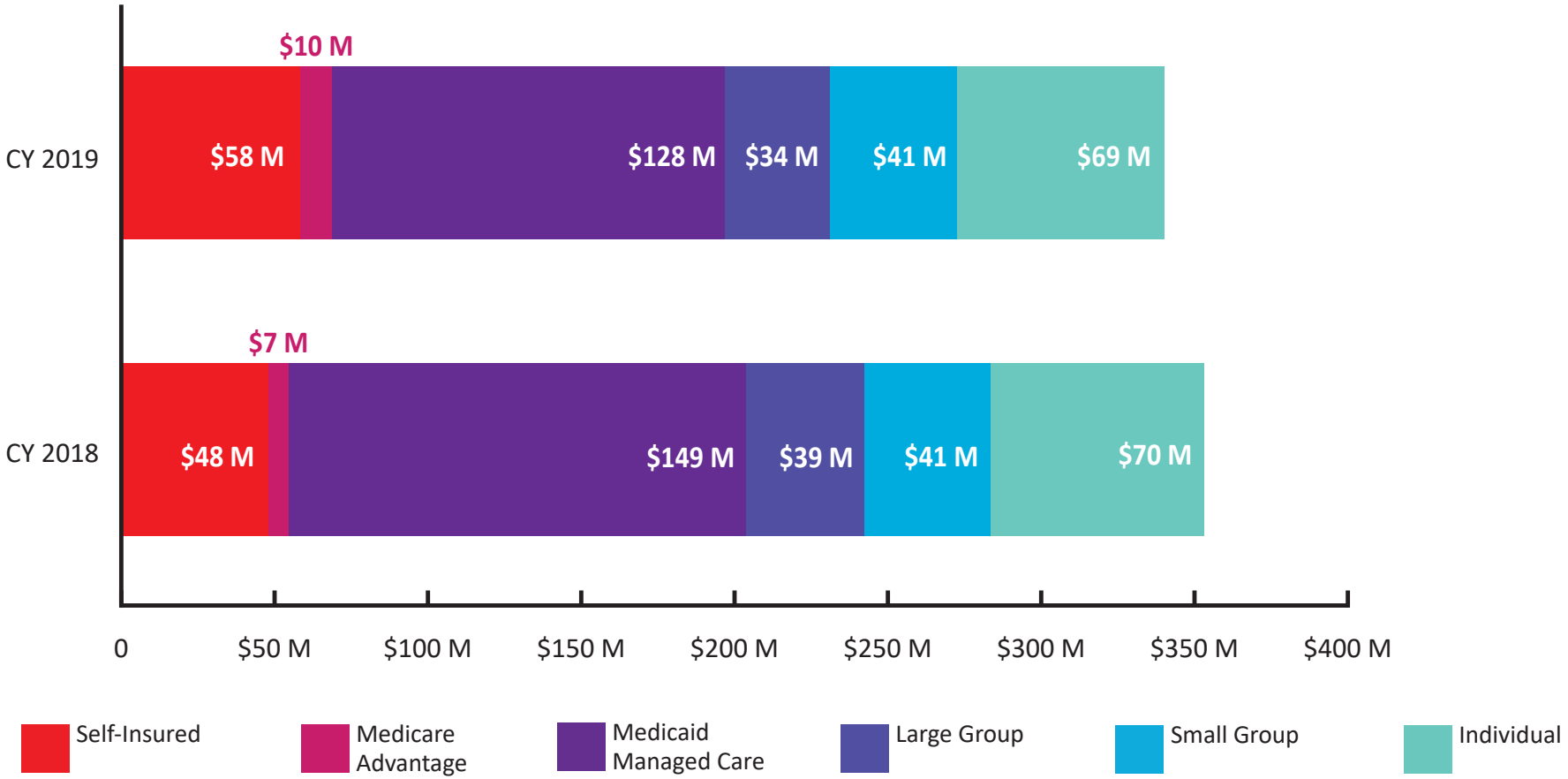
7 Insurer membership was estimated by taking each entity's total reported member months for the respective year and dividing by 12.

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. The NCPHI is estimated based on evaluation of public and confidential data sources such as the insurers' supplemental health care exhibits, medical loss ratio reports and audited financial statements. The DHCC intends to examine the NCPHI in more detail in future Reports and may revise our methodology for computing NCPHI accordingly.

Figure 6-1: **Estimated NCPHI Amounts by Insurance Segment**

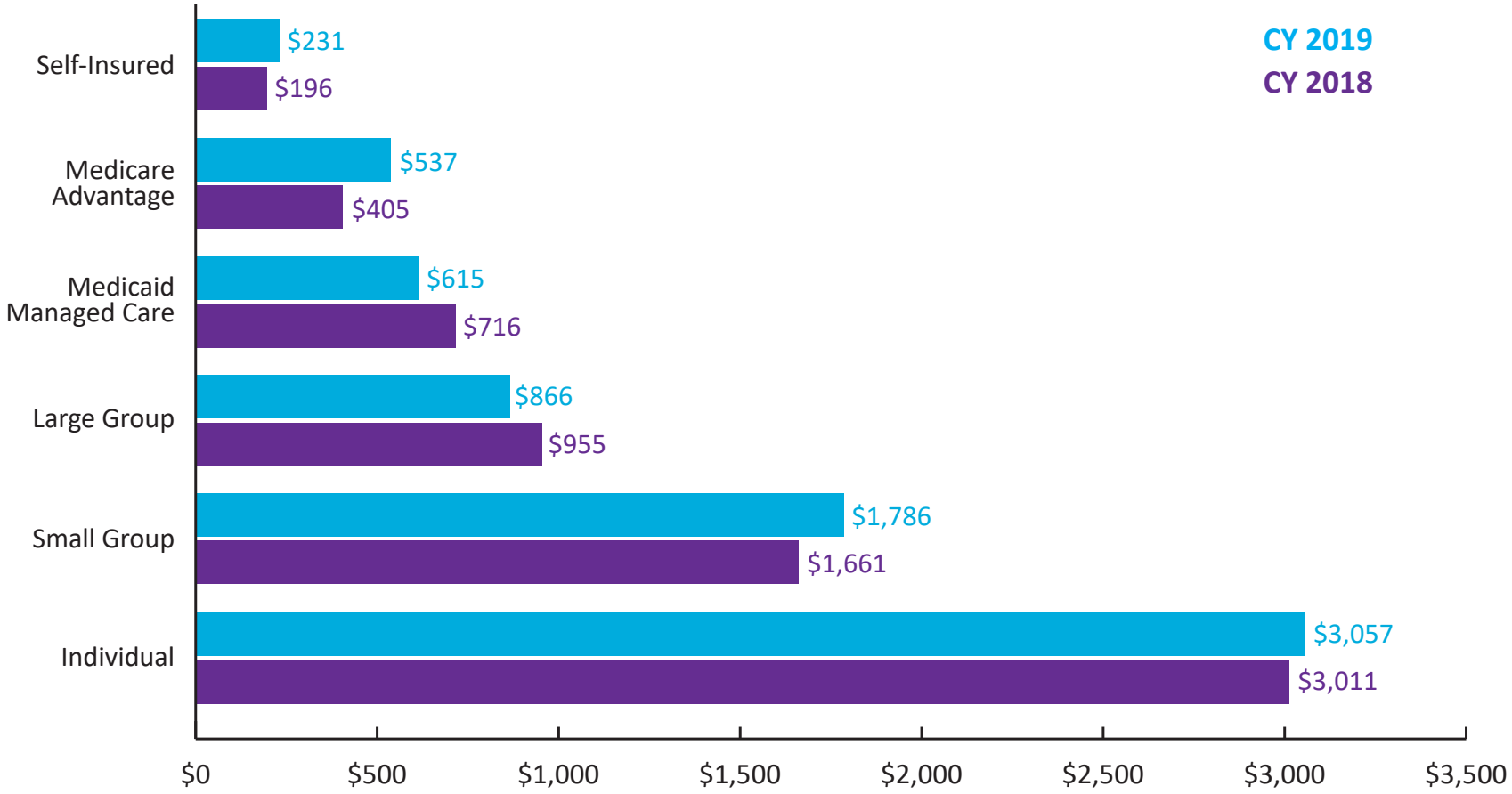


3.4%

NCPHI was estimated to have decreased by approximately $12 million or 3.4% in CY 2019, totaling $341 million.

The Medicaid managed care insurance segment had the largest share of total estimated NCPHI coming in at $128 million in CY 2019.

Figure 6-2: **Estimated PMPY NCPHI by Insurance Segment**



4.6%

On a PMPY basis, the overall estimated NCPHI average value decreased by 4.6% going from $633 in CY 2018 to $604 in CY 2019.

On a PMPY basis, based on the available data, the individual market segment had the highest estimated NCPHI while the self-insured had the lowest.

7. Quality Data

EO 25 also established annual benchmarks for a select number of quality measures.

The six quality benchmarks applicable to CY 2019 and the population for which results will be evaluated relative to the respective benchmark are listed below. Three of the CY 2019 quality measures are only reported at a State level since the data source is publicly available information on state level performance (i.e., CDC public data). The other three measures are specific to either the Commercial and/or Medicaid market (managed care only) with data provided by the Delaware insurers.

Adult Obesity

Statewide population

Adult Tobacco Use

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

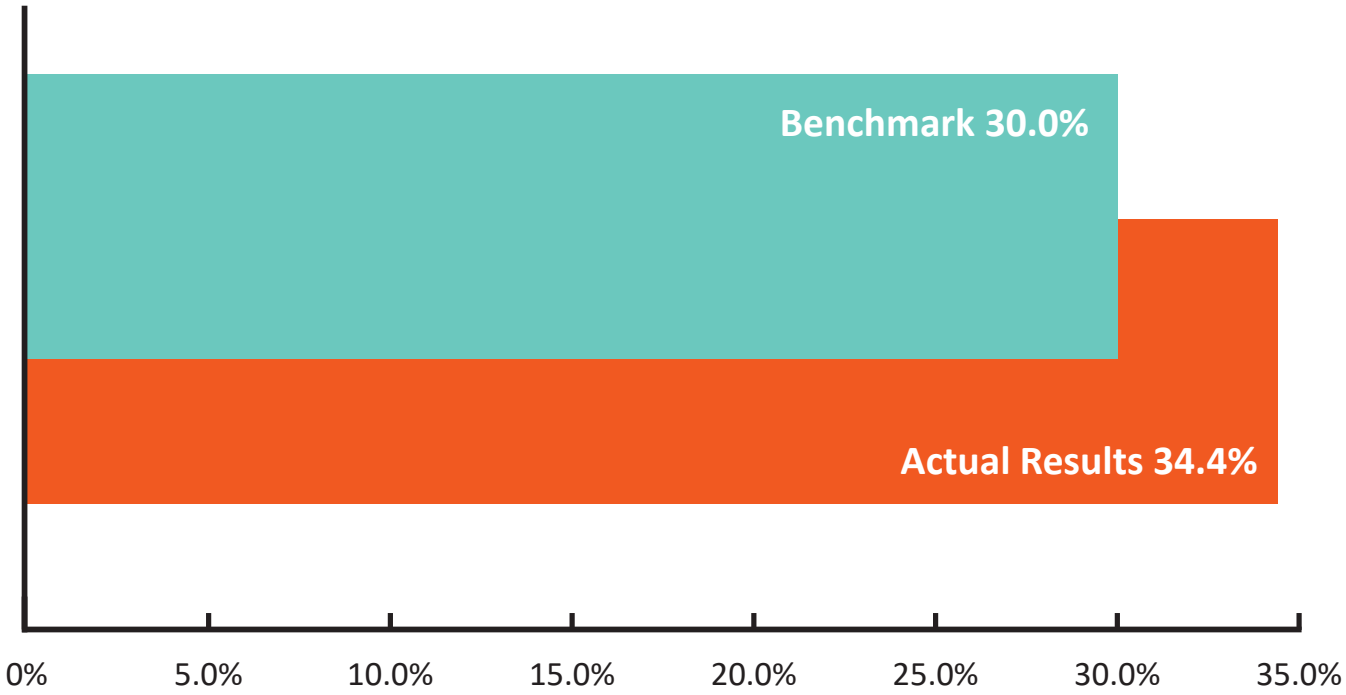
Commercial and Medicaid populations, respectively

Statin Therapy for Patients with Cardiovascular Disease

Commercial and Medicaid populations, respectively

This quality measure evaluates the percentage of adults with a body mass index (BMI) greater than or equal to 30.0 at the State level only. The measure is computed based on weight, in kilograms, divided by the square of height in meters (i.e., kilograms/meters^2) as defined by the CDC. Delaware's CY 2019 benchmark was set at 30.0 percent. For this quality measure, a lower result is better.

Figure 7-1: Adult Obesity



Adult Obesity

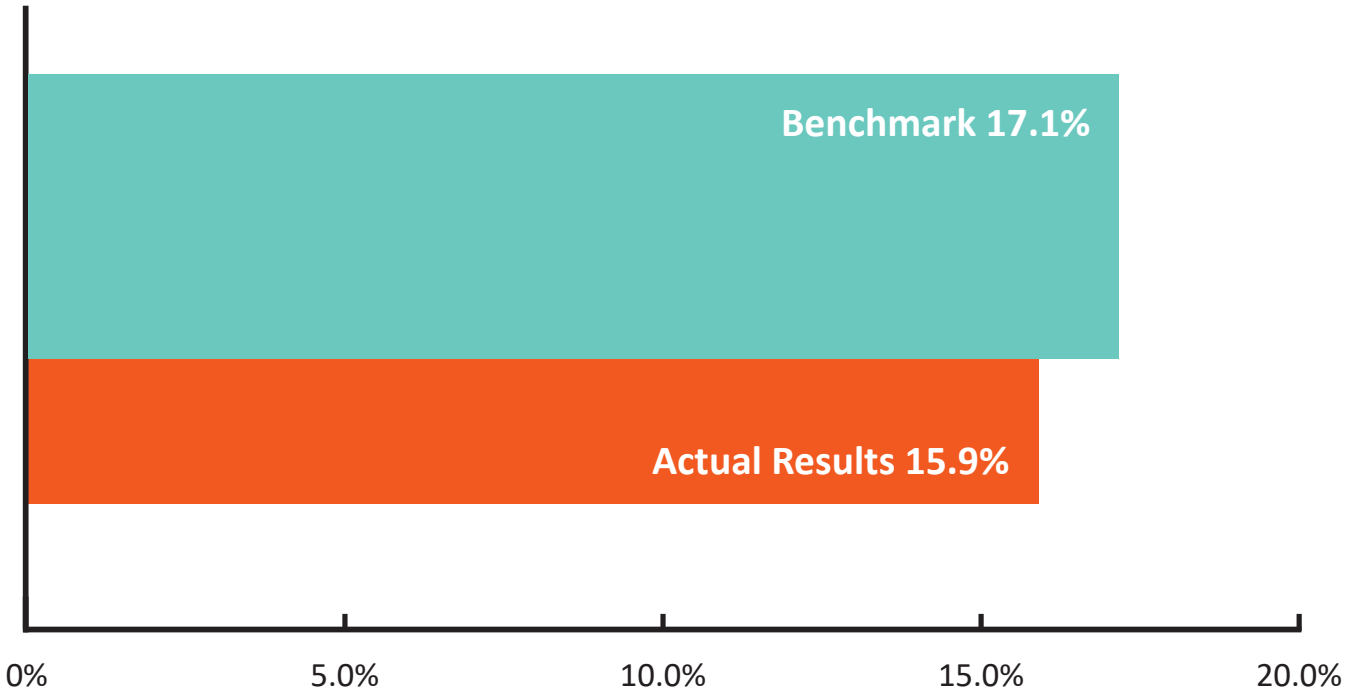
A lower result/score is better for this measure

4.4 Points

Results were 4.4 percentage points higher (worse) than the benchmark in CY 2019.

This quality measure evaluates the percentage of adults who reported that they are current smokers at the State level only. Current smokers is defined as persons who reported smoking at least 100 cigarettes during their lifetime and who, at that the time they participated in the survey, reported smoking every day or some days as defined by the CDC. Delaware's CY 2019 benchmark was set at 17.1 percent. For this quality measure, a lower result is better.

Figure 7-2: Adult Tobacco Use



Adult Tobacco Use

A lower result/score is better for this measure

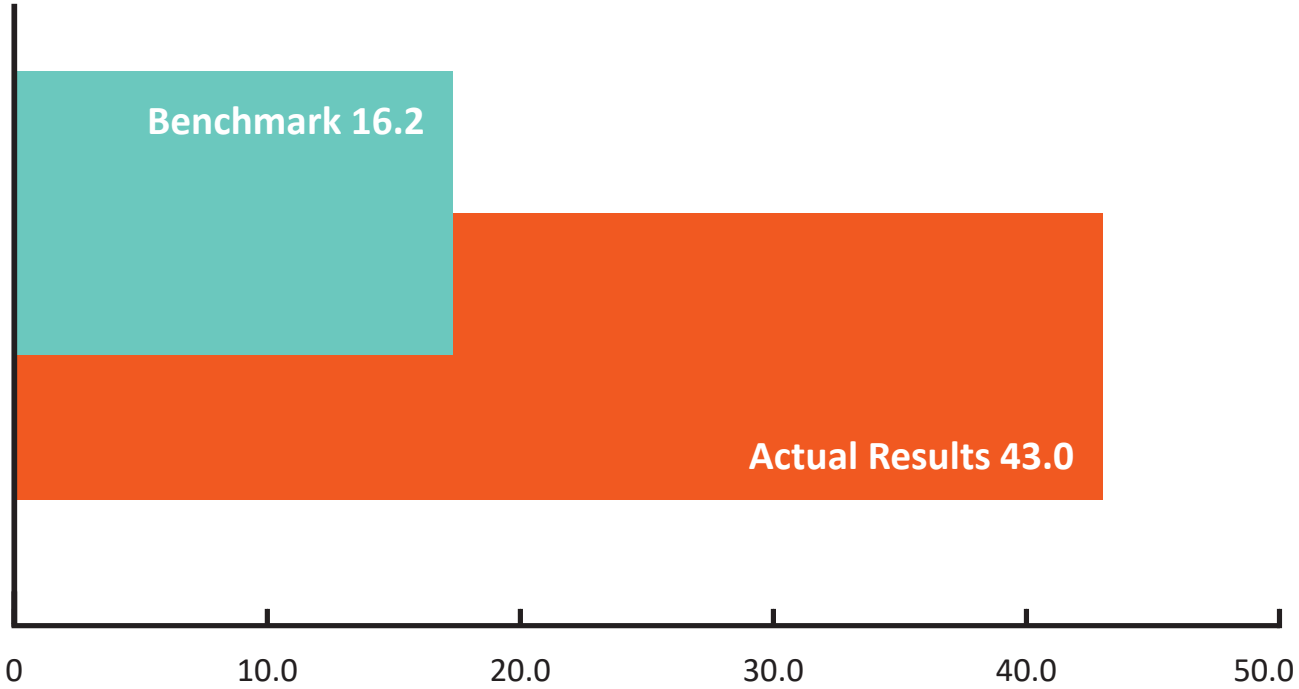
1.2% Points

Results were 1.2 percentage points lower (better) than the benchmark in CY 2019.

Opioid-related Overdose Deaths per 100,000

This quality measure evaluates the number of age-adjusted opioid-related overdose deaths per 100,000 person at the State level only. Opioid overdose deaths were identified using underlying cause-of-death codes related to drug/alcohol induced causes, drug-induced causes with ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4 or T40.6 as defined by the CDC. Delaware's CY 2019 benchmark was set at 16.2 deaths per 100,000. For this quality measure, a lower result is better.

Figure 7-3: Opioid-related Overdose Deaths per 100,000 Quality Measure: CY 2019 Actual Results versus Benchmark



Opioid-related Overdose Deaths per 100,000

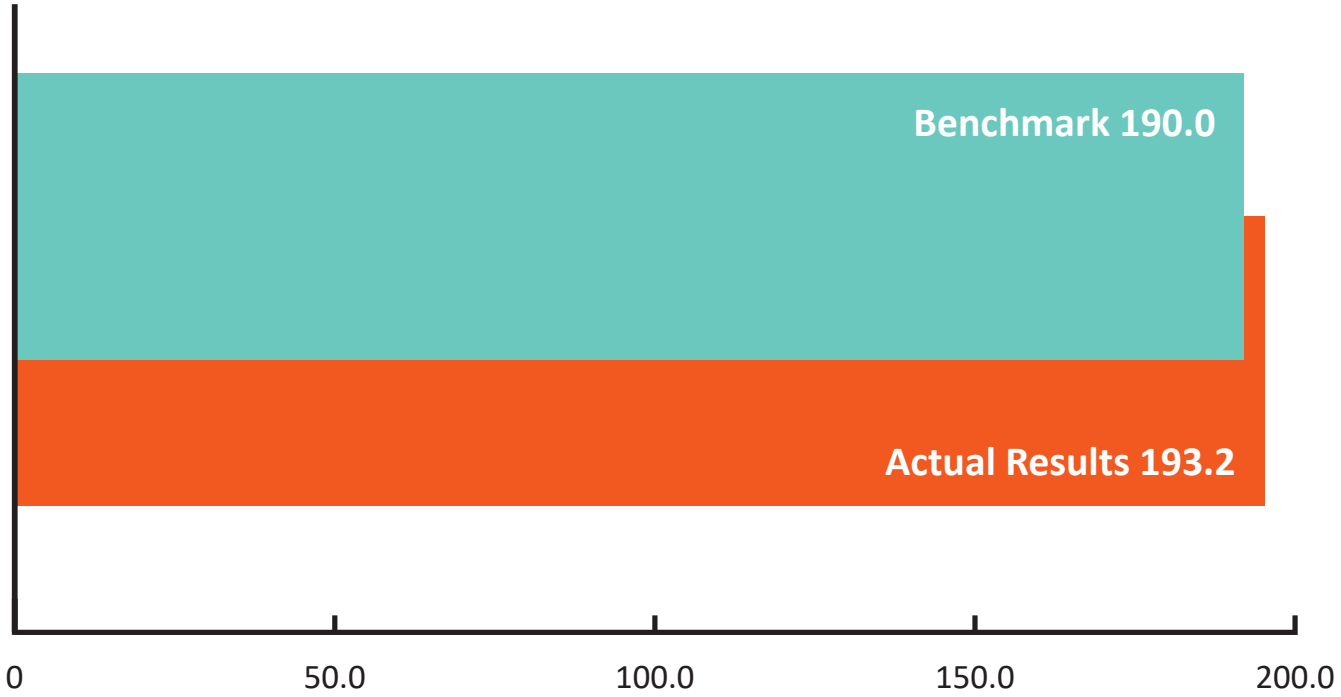
A lower result/score is better for this measure

26.8 Deaths

Results were 26.8 deaths per 100,000 higher (worse) than the benchmark CY 2019.

This quality measure evaluates the number of emergency department visits per 1,000 by individuals age 18 and older during the measurement year. This quality measure was adapted from the National Committee on Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®). This quality measure is applicable to the Commercial market only. Delaware's CY 2019 benchmark was set at 190.0 visits per 1,000. For this quality measure, a lower result is better.

Figure 7-4: Emergency Department Utilization Quality Measure: CY 2019 Actual Results versus Benchmark



Emergency Department Utilization

A lower result/score is better for this measure

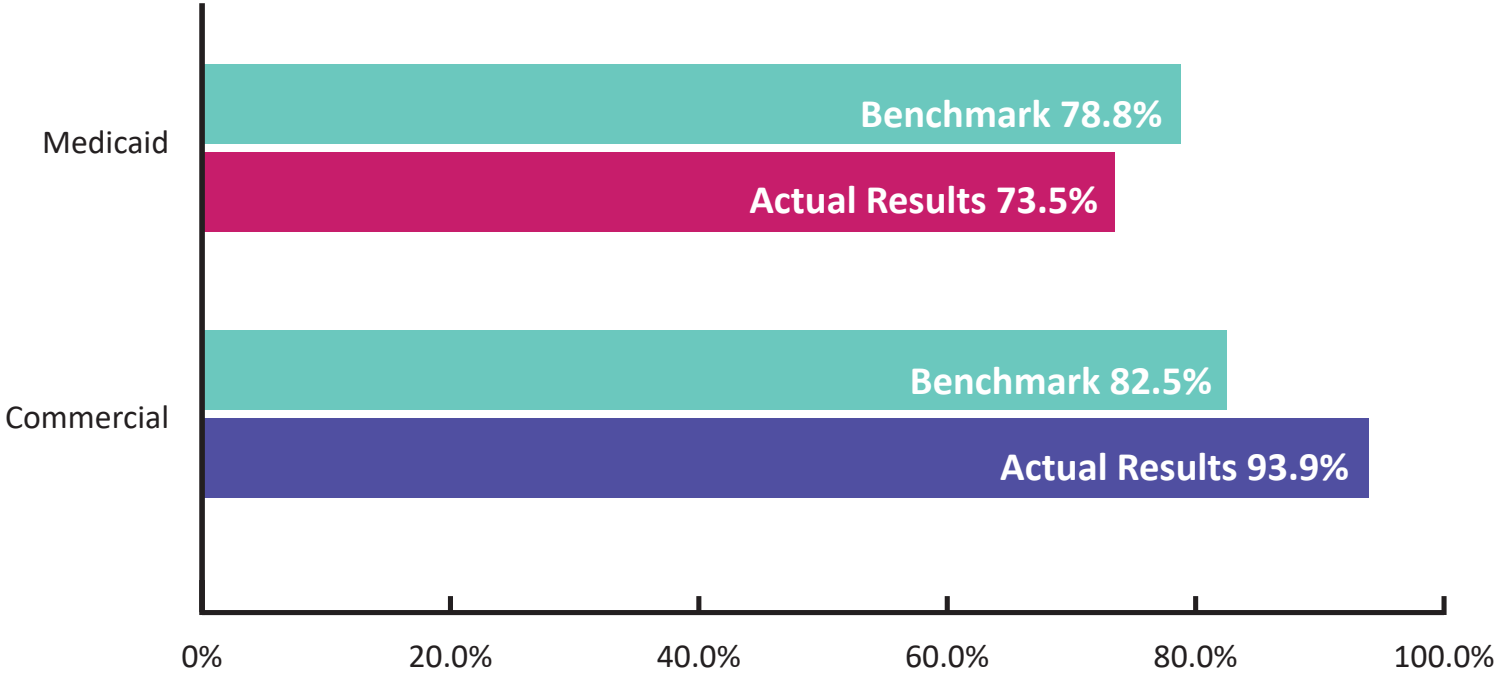
3.2 visits per 1,000

Results were 3.2 visits per 1,000 higher (worse) than the benchmark in CY 2019.

Persistence of Beta-Blocker Treatment After a Heart Attack

This quality measure evaluates the percentage individuals 18 years of age or older during the measurement year who were hospitalized and discharged from July 1 of the prior year to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge as defined by HEDIS® (2018 specification). This quality measure is applicable to the Commercial market and Medicaid managed care market with each Market having a different benchmark. Delaware's CY 2019 benchmark was set at 82.5 percent for the Commercial market and 78.8 percent for the Medicaid managed care market. For this quality measure, a higher result is better.

Figure 7-5: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure: CY 2019 Actual Results versus Benchmark



Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result/score is better for this measure

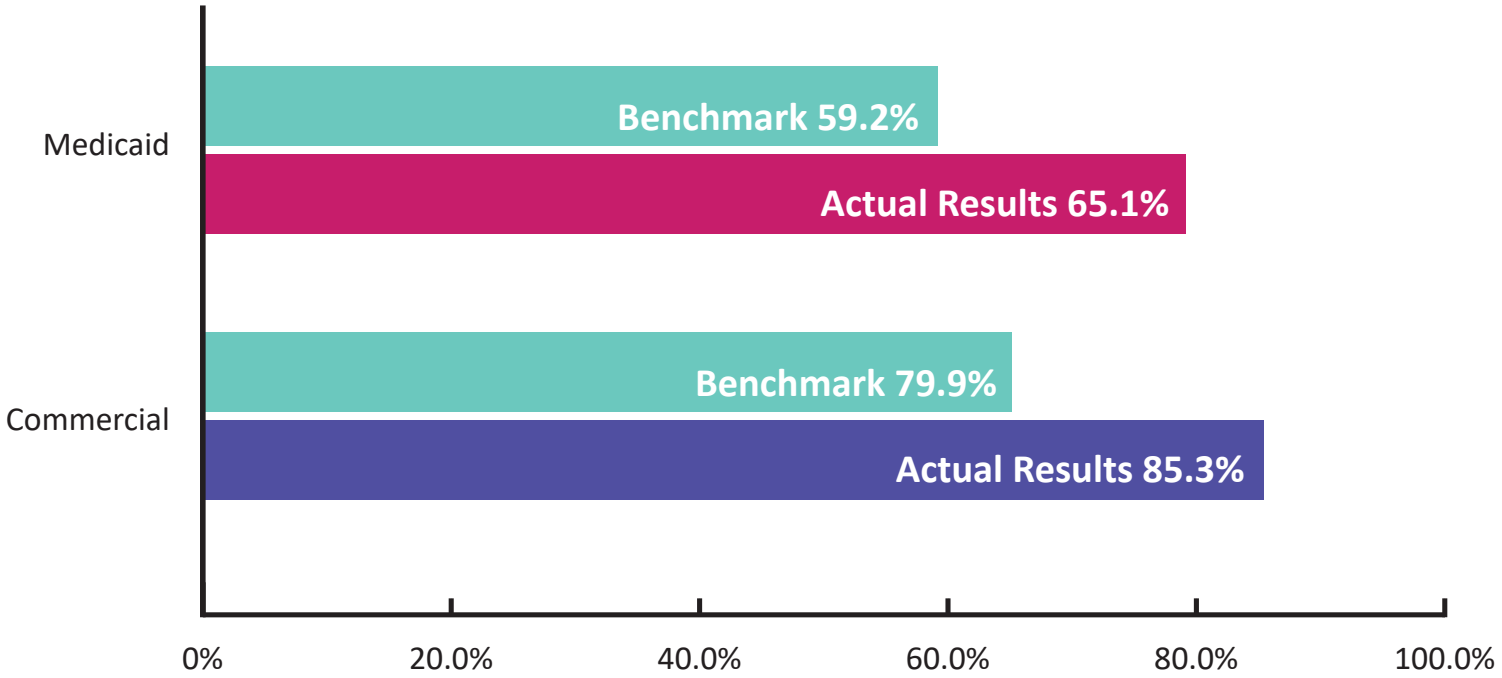
The Medicaid market was 5.3 percentage points lower (worse) than the CY 2019 benchmark.

The Commercial market was 11.4 percentage points higher (better) than the CY 2019 benchmark.

Statin Therapy for Patients with Cardiovascular Disease

This quality measure evaluates the percentage of males 21 years to 75 years of age and females 40 years to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease and who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period as defined by HEDIS® (2018 specification) This quality measure is applicable to the Commercial market and Medicaid managed care market with each Market having a different benchmark. Delaware's CY 2019 benchmark was set at 79.9 percent for the Commercial market and 59.2 percent for the Medicaid market. For this quality measure, a higher result is better.

Figure 7-6: Statin Therapy for Patients with Cardiovascular Disease Quality Measure: CY 2019 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 2019.

The Medicaid market was 5.9 percentage points better and the Commercial market was 5.4 percentage points better than their respective benchmark.

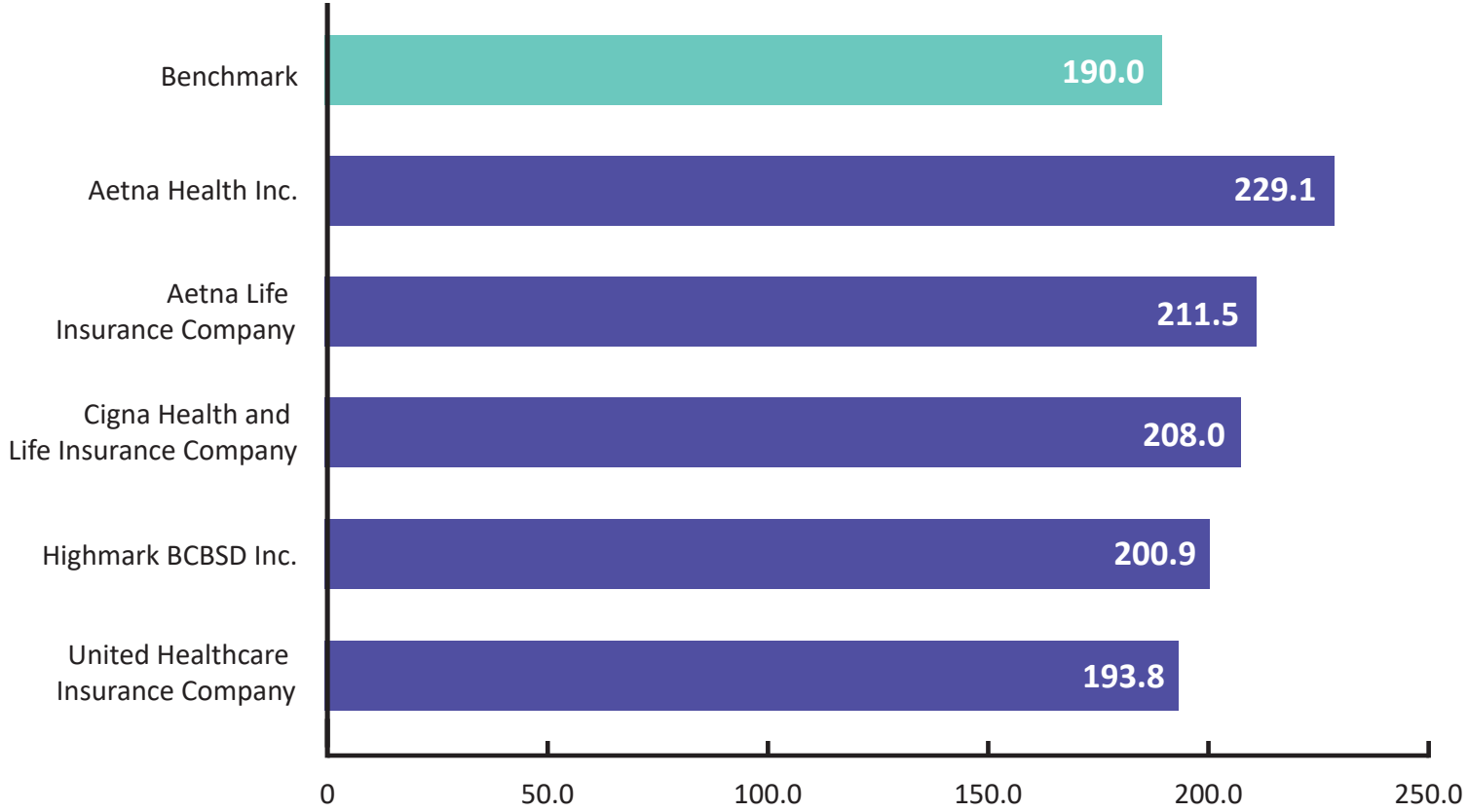
For the three quality measures specific to the Commercial and/or Medicaid managed care markets, insurer-specific results can be computed from the data provided. The respective quality benchmarks are applicable at the Market level only, but results by insurer can provide additional information and insights. The table below lists each insurer and the applicable quality measure for which CY 2019 results are available.

Table 7-1: Quality Measure by Insurer

Quality Measure	Commercial Insurer	Medicaid Insurer
Emergency Department Utilization	• Aetna Health Inc. • Aetna Life Insurance Company • Cigna Health and Life Insurance Company • Highmark BCBSD Inc. • United Healthcare Insurance Company	N/A
Persistence of Beta-Blocker After a Heart Attack	• Aetna Health Inc. • Aetna Life Insurance Company • Cigna Health and Life Insurance Company • Highmark BCBSD Inc. • United Healthcare Insurance Company	• AmeriHealth Caritas • Highmark
Statin Therapy for Patients with Cardiovascular Disease	• Aetna Health Inc. • Aetna Life Insurance Company • Cigna Health and Life Insurance Company • Highmark BCBSD Inc. • United Healthcare Insurance Company	• AmeriHealth Caritas • Highmark

As noted previously, Delaware's CY 2019 benchmark was set at 190.0 visits per 1,000 for the Commercial market only. For this quality measure, a lower result is better.

Figure 7-7: Emergency Department Utilization Quality Measure: CY 2019 Actual Results versus Benchmark by Insurer



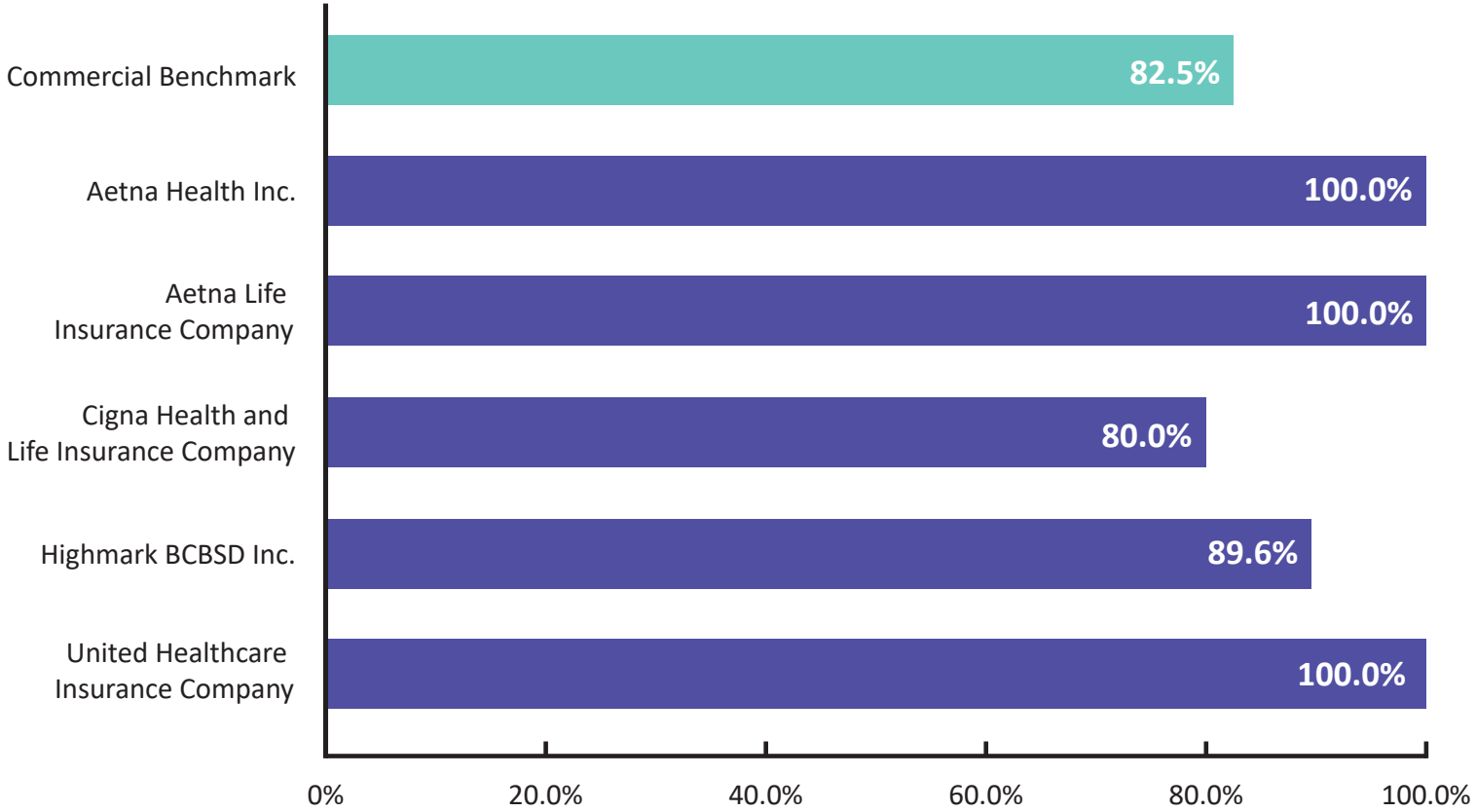
Emergency Department Utilization

A lower result/score is better for this measure

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

As noted previously, Delaware's CY 2019 benchmark was set at 82.5 percent for the Commercial market and 78.8 percent for the Medicaid managed care market. For this quality measure, a higher result is better.

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

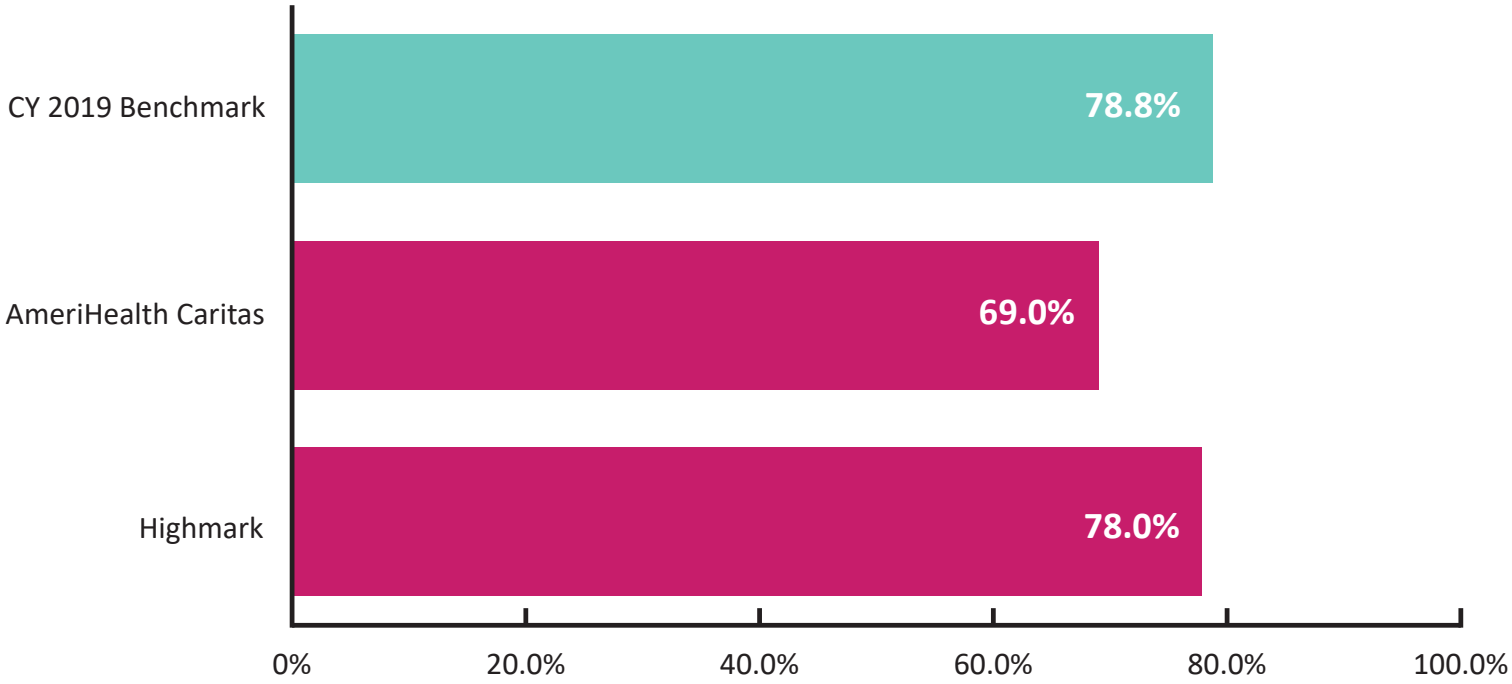


Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result/score is better for this measure

Four out of the five Commercial entities did better than the CY 2019 benchmark.

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



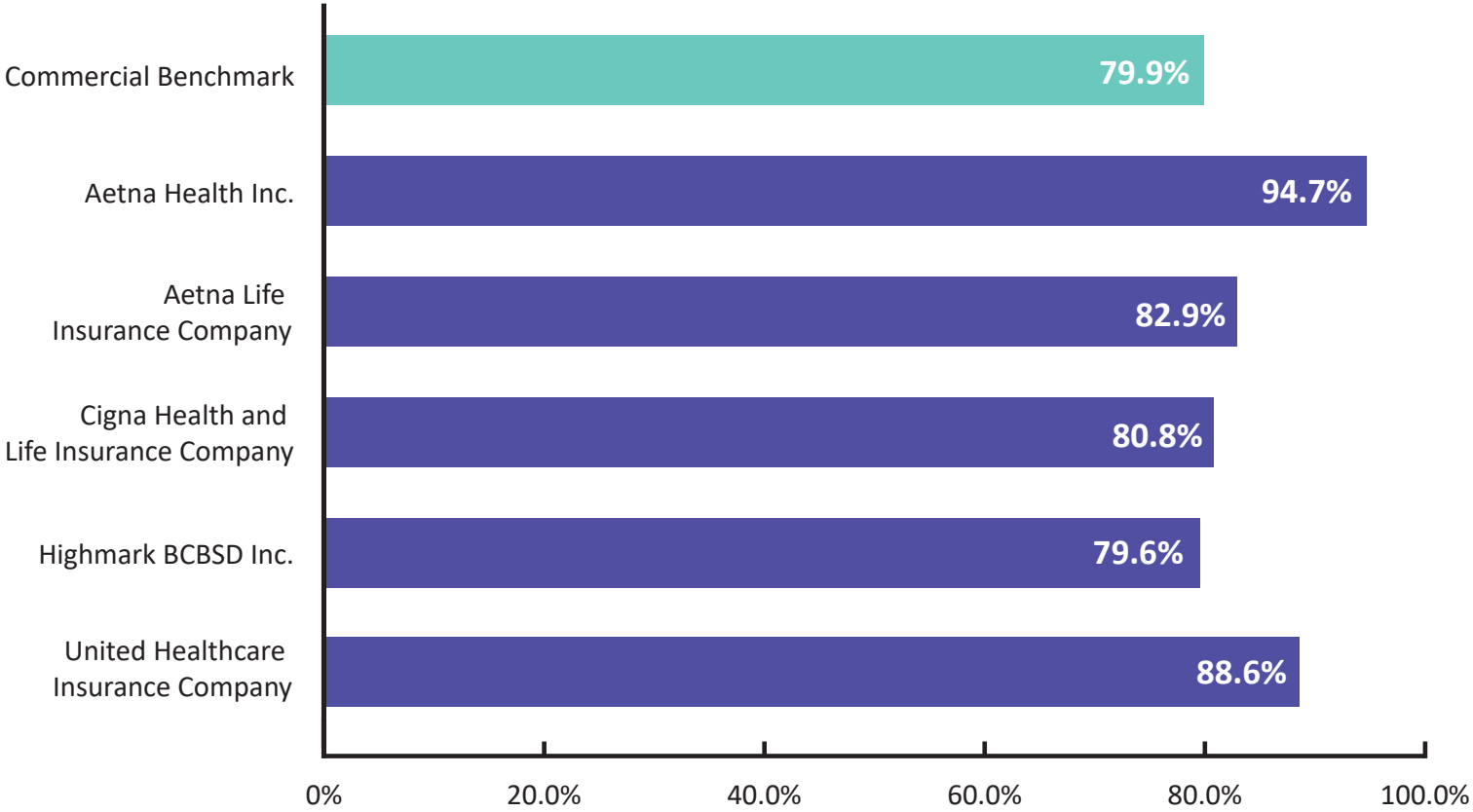
Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result/score is better for this measure

The Medicaid Beta-Blocker benchmark was not met in CY 2019.

As noted previously, Delaware's CY 2019 benchmark was set at 79.9 percent for the Commercial market and 59.2 percent for the Medicaid managed care market. For this quality measure, a higher result is better.

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

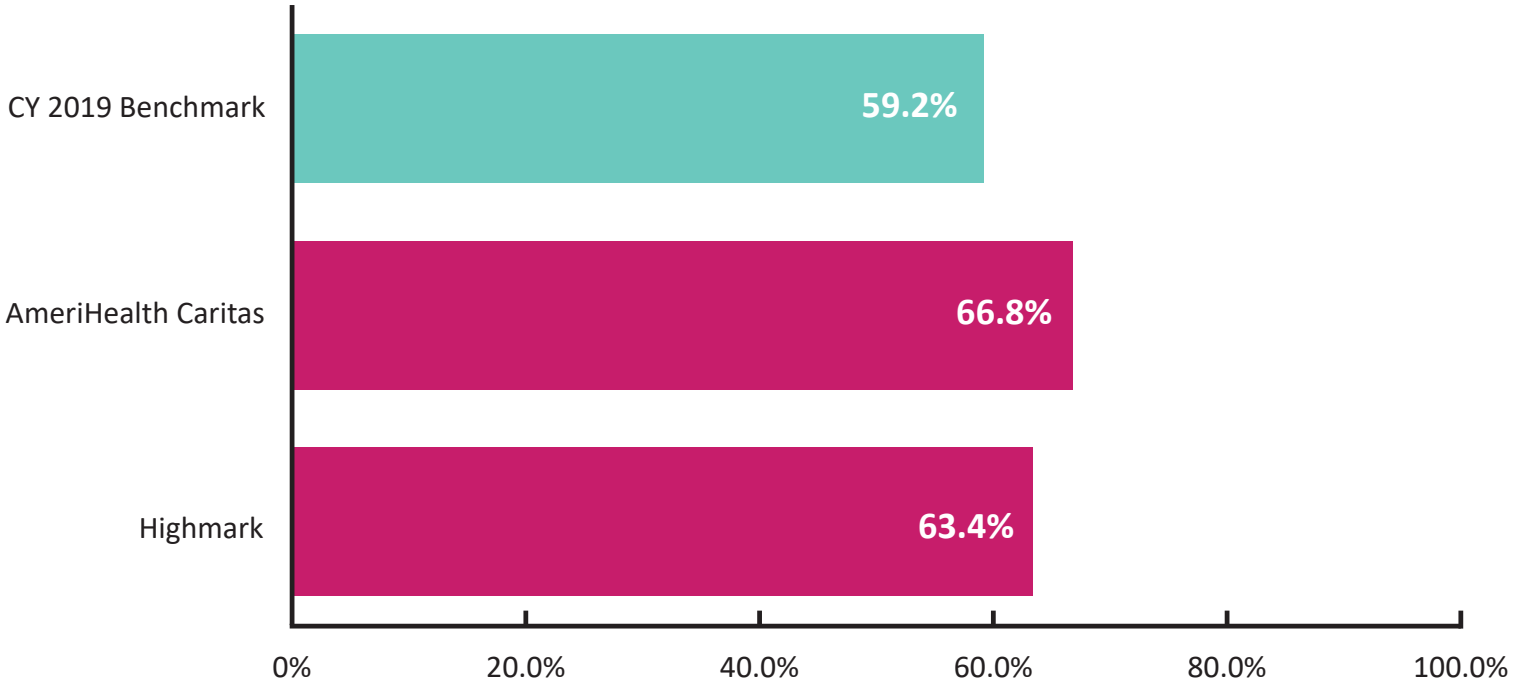


Statin Therapy

A higher result/score is better for this measure

Four out of the five Commercial entities did better than the CY 2019 benchmark.

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



Statin Therapy

A higher result/score is better for this measure

Both Medicaid managed care entities did better than the CY 2019 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/Children's Health Insurance Program (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.

9. Primary Care Service Definition

For consistency and to avoid confusion to benchmark data contributors, the DHCC used the same definition of primary care that was developed in early 2020 by the Delaware Department of Insurance (DOI) in its efforts to evaluate health care affordability within the State. The DHCC used the following definition of primary care to collect the CY 2018 and CY 2019 benchmark spending data. The DHCC's goal is to continue to leverage DOI's most current definition of primary care in each annual benchmark data collection process.

- Taxonomy = 207Q00000X, 207QA0505X, 207QG0300X, 208D00000X, 207R00000X, 207RG0300X, 208000000X, 363L00000X, 363LA2200X, 363LP0200X, 363A00000X, 363AM0700X, 363LF0000X, 363LG0600X or 363LP2300X.

AND

- Place of Service = 11, 71, 50, 17, 20, 02 or 12.

AND

- Procedure Code = 90460, 90461, 90471-90474, 98966, 98967, 98968, 98969, 99201-99205, 99211-99215, 99241-99245, 99339-99340, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354-99355, 99358, 99359, 99381-99385, 99386-99387, 99391-99395, 99396-99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, 99441, 99442, 99443, G2010, 99444, 99495-99496, G0008, G0009, G0402, G0438-G0439, G0444, G0463, G0502-G0507, S9117, T1015, 99492-99494, 99483, 99487, 99489, 99490, G0506, G0511, G0467, G0468 or G0010.